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June 5, 2000

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O. Treasury

**Remarks by Treasury Secretary Lawrence H. Summers
United Nations Conference on Women and Development
New York
June 6, 2000**

Good morning. We come together today to discuss an integral part of the global development effort – the empowerment of women – at a time when that effort is in the spotlight in a way that it has not been for a long time.

When G7 finance ministers meet in Japan next month in the lead-up to the G8 Summit in Okinawa, issues of development will be on the top of the agenda, with the continuation of the Highly Indebted Poor Countries debt relief initiative; with the much strengthened emphasis on reducing global poverty that has been part of that initiative; and with the increasingly universal belief that the dawn of the 21st century must be a time of more global hope and opportunity.

I am going to Sub-Saharan Africa next week to talk with officials and others in the region about the development challenges that they face – because it is the region where the challenges are at once the most profound and the most urgent. It needs hardly be added that it is the region that is home to the largest number of the world's poorest women (*). There may be issues with greater potential global financial impact today than the successful economic development of Africa. But there is none with greater potential human impact.

That is why I would like to focus my remarks today on sub-Saharan Africa: the enormous obstacles that it faces; and the pressing need for a stronger and more effective international development effort to help its countries begin to overcome them.

I. Sub-Saharan Africa Today

Those who say that the global development effort has failed are badly wrong: in the past two decades, more people have been lifted out of poverty in China and other parts of Asia than at any time in world history. Average life expectancy in the developing world has risen by ** years – roughly the increase we would see here in the US by eliminating all cancer. And infant mortality has been reduced from * per 1,000 to *.

At the same time, with very few exceptions, it must today be acknowledged that in Sub Saharan Africa the global development effort has so far failed. Per capita incomes in Africa in the late 1990s were lower than they were thirty years ago. Average incomes for a region of 600 million are now only 65 cents a day. And across large parts of the continent, children are more likely to die before their first birthday than to learn to read.

No one country is the same and there are a many factors that have contributed to economic failure in each case: the legacies of colonialism; the Cold War; long periods of authoritarian governments and kleptocracies and the ongoing impact of civil and regional conflict. All of these

TREASURY



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April 11, 2000

**STATEMENT BY TREASURY SECRETARY SUMMERS
TESTIMONY BEFORE THE SENATE APPROPRIATIONS
SUBCOMMITTEE ON FOREIGN OPERATIONS.**

Thank you, Chairman McConnell, for inviting me to testify on the President's Millennium Initiative to help combat infectious diseases. Let me also thank Senator Leahy for the leadership he has shown on this matter. Along with the leadership of Senator Kerry and Congresswoman Pelosi and others, your support has made a real difference.

Increasingly, as integration proceeds, the world is confronting a broad class of problems that cross borders and defy easy solution by individual governments and markets. Whether it is money laundering and financial crime, climate change or reductions in global bio-diversity - the solutions to these problems will be global public goods, requiring concerted global cooperation.

The proposals that the Administration has put forward in its Millennium Initiative seek to catalyze a global response to one of the most urgent and morally compelling of such problems: the scourge of infectious diseases that hit hardest the countries that are least able to cope.

Today I would like to address the three points that form the basis for the President's Initiative.

- First, the development and delivery of vaccines and effective treatments for infectious diseases is now one of the effective investments that we can make in successful economic development in the poorest countries.
- Second, both the lessons of recent development experience and the advance of scientific discovery have put us in a position to have a real impact on the global spread of these diseases.
- Third, public-private cooperation, both at the national and international level, is needed to achieve this - and elements of the President's Initiative provide the most effective means of setting the right kinds of cooperation in train.

LS-533

I. Combating Infectious Diseases as a Moral and an Economic Imperative

It might seem surprising that the Treasury Secretary is devoting so much attention to the goal of preventing and controlling disease in the developing world. But, as Treasury Secretary, I am constantly aware of the enormous national economic, humanitarian, and security stake that the United States has in the successful development of the poorest countries.

A more global prosperity will produce better trading partners for the US: time and again, as poor countries grow richer, they become the fastest growing markets for US goods and services. Already, developing countries account for some 42 percent of US exports. A more global prosperity will also promote peace: from Bosnia to East Timor, from Rwanda to the Middle East. It will also promote human freedom. Nations that succeed economically are much more likely to become democratic. And a more global prosperity will help us to meet the profound challenge of protecting the global environment. Environmental degradation spawned by dire poverty is a global concern.

Today, it does not overstate the case to say that the greatest single obstacle to human development in these countries and to a more inclusive global prosperity is the specter of disease.

The spread of HIV/AIDS in recent years has been swift and particularly brutal:

- Fifty million people worldwide have been infected with the HIV virus; more than 16 million have died; and annual AIDS-related fatalities hit a record 2.5 million last year.
- In sub-Saharan Africa, where 85 percent of all AIDS deaths have occurred, life expectancy is now declining sharply in many countries, reversing decades of hard-won gains. In at least five African countries, over 20 percent of adults are HIV-positive. In southern Africa, life expectancy is expected to drop from a high of 59 in the early 1990s to 45 within the next 5-10 years – a level not seen since the 1950s. And the highest rates of new infection are often among young women who will soon be mothers.
- Most worrisome is the rate at which HIV/AIDS is spreading, and the very real danger that what is happening in Africa is about to happen elsewhere. Infection rates in Asia are climbing rapidly, with several countries on the brink of a large-scale pandemic and needing to take action immediately to forestall the disaster that Africa has suffered. Parts of Latin America and the Caribbean – our own neighbors – also show high and rising rates of infection. And the former Soviet Union countries and Eastern Europe are vulnerable as well, with Russia experiencing the highest increase in infection rates in the world last year.

At the same time, it bears emphasis millions of the world's people still fall prey to diseases that are centuries old.

- Tuberculosis accounts for over 2 million deaths annually, and drug-resistant strains are spreading. Indeed, thousands of people who are HIV-positive actually die of TB; their damaged immune systems allow active TB to develop, which then can spread to people who are not HIV-positive.

- Malaria strikes hundreds of millions of people each year and results in more than one million deaths, mostly children. Diarrheal and respiratory infections are even more devastating, killing almost 6 million people each year.
- And millions die of diseases for which cheap vaccines are available today. Fewer than half of Africa's children are vaccinated against basic diseases like measles and diphtheria – even though such vaccines are one of the most cost-effective ways to improve health. And in South Asia, less than three-quarters of the children are vaccinated.

All told, infectious diseases are the leading cause of death worldwide, causing almost half of all deaths among people under the age of 45. The end result is not merely a humanitarian crisis, but a broader social and economic crisis.

- Life expectancy is falling mainly because of rising mortality among prime age adults and research has shown that economic growth depends importantly on the share of the population that is of working-age. A recent World Bank study estimates that AIDS is likely to subtract about 1 percent a year from GDP in 30 sub-Saharan African countries.
- The burden of coping with these diseases further reinforces the poverty that allowed these diseases to take root. Health care budgets and facilities are overwhelmed by the heavy burden of caring for those who are infected. And families that are already impoverished are forced to liquidate assets and defer expenses for essentials such as education in order to pay for costly medical care – thus sending them into a deeper downward economic spiral. AIDS, alone, has orphaned an alarming number of children – over 11 million worldwide, with all but one-half million in Africa.

The implications of this crisis are global:

- Because infectious diseases do not respect the boundaries of states and geography – as we have seen with HIV/AIDS, with the resurfacing of tuberculosis in parts of the United States, and with last year's outbreak of West Nile encephalitis in New York.
- Because if these countries do not develop they cannot contribute to the broader global growth in which we have such a stake, at a time when already, more than 40 percent of our exports already go to developing countries.
- And because the national economic distress and political instability that inevitably accompany this scale of human loss can cause greater damage to the global system as a whole.

For all of these reasons, support for the development and delivery of vaccines and effective treatments for infectious diseases is one of the most cost-effective investments we can make both in successful economic development in these economies, and in the prosperity and stability of the global economy as a whole.

We believe this is fundamentally a humanitarian imperative. It is also a national economic and security imperative. And it is an imperative that global experience and the pace of scientific discovery have now put us in a much stronger position to address.

II. The Ability to Make a Real Difference

We cannot sit back and wait for these critical discoveries. We must deal now with the ongoing and immediate impact of infectious and other diseases of poverty.

The record of past international efforts to combat infectious disease suggests that there are no easy, simple solutions to this problem. But we are in a much stronger position today than we were even a few years ago to help countries make concrete progress, for three reasons.

First, because of the rapid growth in relevant scientific understanding.

Clearly, one reason for the high incidence of infectious diseases is the remaining gaps in our scientific knowledge about those diseases. The development of vaccines and medicines simply cannot exceed the frontiers of available basic science. But, as one pharmaceutical executive said at a recent meeting on this subject with the President, this is a “golden age” for research and implementation. Important recent advances are being made on malaria, pneumococcus, and AIDS. As I will describe in a few moments, we believe that public policy can provide a critical boost to private research efforts in this area.

Second, because we have new tools for potentially channeling significant internal and external resources toward this effort.

A sheer lack of financial resources relative to the cost of even the most basic investments in health is clearly an even greater obstacle to improving health outcomes in these countries.

- On average, the poorest nations in the world spend just \$15 per person on health care each year – less than it costs to fully vaccinate a child against nine basic diseases including polio, measles, and tetanus. In the United States, we spend thousands of dollars per person on health care each year.
- In the poorest developing countries, there are only 14 doctors and 26 nurses on average for every 100,000 patients, compared to 245 doctors and 878 nurses in the United States. And 800 million people live on less than \$1 a day. The harsh reality is that the cost of caring for patients with AIDS the way we do in the United States far exceeds the per capita income of most developing countries.

We cannot hope to eliminate the relative gap in countries’ economic resources. But in the Heavily Indebted Poor Countries Initiative we do have a tool for increasing the funds they have available – and ensuring that they are channeled to core human development priorities such as basic healthcare.

The HIPC Initiative, created in 1996 and further enhanced last year, has already helped some of the poorest nations in the world free up precious resources for human development that would otherwise have been spent on servicing debt. Fully funded and implemented, the enhanced HIPC initiative has the potential to be an even more powerful tool for helping countries devote more resources to combating infectious disease.

Third, we have greater understanding of the importance of – and pre-requisites for – effective delivery of vaccines and treatments.

Clearly, it does no good to ship vaccines and medicines to the ports of poor nations if they do not end up in the throats or arms of the people who need them. Just as clearly, it does little good to administer vaccines and medicines to people who do not receive basic tools for maintaining health, such as nutritional interventions like vitamin A and iron, or preventing disease, such as bed nets for malaria and education to prevent the spread of HIV/AIDS.

These problems have often been important obstacles to international efforts to combat heart diseases in the past. However, the tight linkages between different aspect of health care are now well understood in the development community and are being successfully put into practice. As I will note in a few moments, this is reflected in both the President's Millennium Initiative and plans now being developed by the World Bank, which focus on shifting significant resources to improving the delivery of basic health services including vaccines and medicines.

We also understand better that this is not a problem of money alone – but also competence and enduring commitment. Specifically, developing country governments need to commit themselves to specific targets for improving health care delivery and health outcomes. And donor countries, international organizations, and non-government entities in developing nations need to cooperate to find solutions that will work best for the country in question. And applying these principles is yielding concrete results. For example:

- In Uganda and Thailand, recent innovative programs supported by the international community have begun to reverse HIV infection rates of high-risk groups. And in Senegal, an early investment in prevention programs has helped to keep HIV infection rates low.
- In Bangladesh, which can spend only \$4 per person per year on health, the World Bank, USAID, and other donors have supported the development of networks of non-physician personnel fanning out to thousands of villages and urban slums, which have helped to reduce the infant mortality rate from 132 to 75 between 1980 and 1997.

III. The President's Millennium Vaccine Initiative

The President's Millennium Vaccine Initiative, outlined in his State of the Union address, draws on both of these realities: the scale and urgency of the problem, and the greater scope that we have today for launching an effective global response.

In these efforts, we are building on the support of the private sector, including pharmaceutical companies that can provide the research and development that is so necessary to

developing the right vaccines; we are also drawing on the commitment of the non-profit sector, including organizations like the Gates Foundation that has contributed so generously to the fight against disease; and we are utilizing the expertise of government so that it can act as a catalyst to ensure that these efforts are expanded on an international scale.

The President's initiative has four basic components.

First, mobilizing additional international resources to help the poorest countries purchase existing vaccines for their children.

Many poor countries often cannot afford to buy vaccines. To help address this problem:

The President's FY2001 budget proposes a \$50 million contribution to the Global Alliance for Vaccines and Immunization (GAVI) to purchase existing vaccines for children. This contribution should help catalyze significant contributions from other countries and foundations. It will also add critical credibility to the international community's commitment to provide a market for new vaccines, including vaccines for AIDS, when they are developed. Further, the President has helped to catalyze commitments from the pharmaceutical industry to donate hundreds of millions of dollars worth of existing vaccines.

Second, shifting existing international resources toward building infrastructure in poor countries that can deliver vaccines and medicines and provide essential basic health services.

President Clinton has called on the multilateral development banks to shift an additional \$400 million to \$900 million annually of concessional resources into basic health care. Of course, an essential element of such care is prevention and treatment of infectious diseases, including AIDS. These banks are the right institutions for investing in health infrastructure and health care:

- First, because these activities fall clearly within the poverty reduction and development mandate of the banks, and no other institutions can bring to bear the funding and policy dialogue on the scale needed for the task.
- And second, because one crucial part of the problem is that there is not a visible market for new treatments and vaccines in many of the countries worst affected. And the World Bank and other institutions can do much to create a market, through its lending programs and the policies they support.

As I noted earlier, the Administration is also using the enhanced HIPC debt initiative to support our efforts on infectious diseases. The HIPC countries will be developing Poverty Reduction Strategy Papers, in a participatory process with civil society and donors, to establish comprehensive plans with monitorable targets. We have already requested that our Embassies and USAID missions in these countries stress the use of debt-reduction savings for bolstering basic education and health, including the fight against infectious diseases. We expect that all PRSPs that are prepared by HIPC candidates will discuss the adequacy of budget resources and policy reforms devoted to basic health care.

The early evidence from HIPC beneficiaries is encouraging. Last year, the Ugandan government saved \$45 million in debt service under the original HIPC program. Its expenditures on health and education increased by \$55 million, including a major effort to combat the HIV/AIDS epidemic. Immunization rates for children in Uganda are expected to increase from 55 percent in 1996 to 60 percent in 2002. One of the key priorities for health spending in the future, which would be facilitated by enhanced HIPC debt relief, is to extend HIV/AIDS education outreach, particularly to rural communities.

These measures do not require additional budget commitments. However, our influence within the multilateral development banks and on HIPC depends on our ability to meet our existing commitments. I would note here that for FY2001 we are requesting a total of \$1.6 billion for Treasury international programs, of which by far the largest share is taken up by commitments to the MDBs – some of them required to clear arrears – and appropriations to enable us to play our part in funding HIPC. It will be very important to the overall success of this Initiative that these requests are passed.

Third, intensifying the search for more effective ways of treating and preventing diseases that widely afflict developing countries especially HIV/AIDS, malaria and tuberculosis.

The President's FY2001 budget for the National Institutes of Health also includes a significant increase in research critical to creating vaccines for deadly diseases that afflict primarily developing countries. Funding for AIDS vaccine research will increase substantially in FY 2001 and will have more than doubled since FY 1997.

The President has also proposed an additional \$100 million for HIV prevention and AIDS treatment in Africa, Asia and other developing countries. We can make crucial headway against HIV and AIDS by providing clear information on prevention strategies and treating sexually transmitted diseases. We are calling on other countries to join us in committing money for these purposes.

Fourth, harnessing the scientific and technological skills of the private sector in the development of new vaccines and medicines for infectious diseases.

While important progress is being made, it is widely recognized that the market does not provide sufficient incentive for pharmaceutical companies to develop vaccines and medicines for diseases that disproportionately affect developing nations. Indeed, the WHO estimates that only perhaps 10 percent of the \$50-60 billion spent worldwide each year on health research is directed towards diseases that afflict 90 percent of the world's population.

To start to address this problem:

- The President is proposing a new tax credit for sales of vaccines against malaria, tuberculosis, HIV/AIDS, or any infectious disease that causes over one million deaths annually worldwide. Under the proposal, the seller of a qualified vaccine could claim a credit equal to 100 percent of the amount paid by a qualifying nonprofit organization (such as UNICEF) that received a credit allocation from the U.S. Agency for International Development (AID). The tax credit

would match the purchaser's expenditures dollar-for-dollar, thereby doubling its purchasing power. For 2002 through 2020, AID could designate up to \$1 billion of vaccine sales as eligible for the credit. This credit would provide a specific and credible commitment to purchase vaccines for the targeted diseases once they become available. The President is calling on other governments to make similar purchase commitments, so that we can ensure a future market for these critically needed vaccines.

- In addition, the Administration has expressed its willingness to support a tax credit for qualified clinical testing expenses for certain vaccines, similar to the existing orphan drug tax credit. The credit would be for 30 percent of the expenses for human clinical testing of vaccines for the diseases targeted by the President's initiative. This credit will provide an additional incentive for drug manufacturers to undertake research on new vaccines and accelerate their development.

IV. Concluding Remarks

Mr. Chairman, the sheer magnitude and complexity of the challenge of combating infectious diseases, and their resistance to the efforts of the past, have a tendency to overwhelm hope with a sense of futility. Around the world, infectious diseases – including AIDS – are killing millions of children and weakening and killing tens of millions of prime-age adults. The devastating human and economic consequences are clear.

However, in Uganda, Thailand, Senegal and elsewhere. We have now seen compelling examples of concrete progress. And we have seen in the past well-coordinated global efforts can have an enormous impact. One need only consider the eradication of smallpox; the nearly complete campaign against polio – and the remarkable global effort to combat river blindness (onchocerciasis), which has halted the transmission of that disease has been halted in eleven African countries and prevented 185,000 who were already infected from going blind.

As I have said, we believe that we now have a historic opportunity to make headway against the other killer diseases that today exact such a toll on the developing economies. What is crucial is that we act not to catalyze a broad international effort to address the problem at its root. We look forward to working with the Congress to try to mobilize the necessary resources and shape the incentives and strategies that can contribute to enduring solutions. Thank you. I would now welcome any questions that you might have.

O-treasury

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To: Cheryl Bauerly Date: May 11, 1999
Fax #: 456-2439 Pages: 1, including this cover sheet.
From: David Ickson

Subject: A Question About HIV/AIDS incidence

COMMENTS:

The Secretary would like to say the following in his remarks:

"Health problems, such as the startling xx% HIV positive incidence of the Sub-Saharan Africa population...." *among adults 15-49* — *16% in South Africa*

He thinks it's about 20%.

26% in Zimbabwe

I've gotten various facts that almost answer this:

34
- ~~30~~ million w/HIV-AIDS worldwide, *22.5* million in SSA = 3.1% of population (which doesn't quite meet the 20% test)

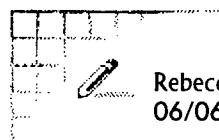
- Of six million new HIV infections in the past year, *WAV* 70% were in Africa. *OK*
- In the hardest-hit countries of Botswana, Namibia, Swaziland, and Zimbabwe, 20-26% of adults are HIV-positive or have AIDS. (this might be closest to what we're looking for) *15-49*
- Since the onset of the epidemic, 83% of global AIDS deaths have been in Africa and 95% of the world's AIDS orphans are African. *OK*

But, do you have a number just for Sub-Saharan Africa that matches up with the 20% figure?

Thanks

David

*10M deaths cumulative
5,500 per day
13,000 " " in 2005*



Rebecca L. Walldorff
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FROM THE OFFICE OF PUBLIC AFFAIRS

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June 6, 2000

LS-681

"Africa and the Global Development Challenge"
Remarks by Treasury Secretary Lawrence H. Summers
United Nations Conference on Women and Development
New York, NY

Good morning. We come together today to discuss an integral part of the global development effort - the empowerment of women. The spotlight in a way that it has not been for a long time. The Beijing plus 5 initiative has made a crucial contribution to this effort, and we applaud for what you have all achieved.

I am going to sub-Saharan Africa next week to talk with officials and others in the region about the development challenges where the challenges are at once the most profound and the most urgent. There may be issues with greater potential global economic development of Africa. But there is none with greater potential human impact.

When G7 finance ministers meet in Japan next month in the lead-up to the Summit in Okinawa, questions of development will be a top priority. The continuation of the Heavily Indebted Poor Countries (HIPC) debt relief initiative; with the much strengthened emphasis on the completion of that initiative; and with the increasingly universal belief that the dawn of the 21st century must be a time of more global development.

For all these reasons, let me focus my remarks today on sub-Saharan Africa: the enormous obstacles that it faces; and the powerful and effective international development effort to help its countries begin to overcome them.

I. Sub-Saharan Africa Today

For all the problems that still exist, in most parts of the world the global development effort has had enormous successes in the past. More than 1 billion people have been lifted out of poverty,

especially in China and other parts of Asia, than at any time in world history. Average life expectancy in the developing countries rose from 52 to 59 in 1980, from 52 to 59. That is considerably more than the increase we would see here in the US by eliminating all cancer. A decline of nearly 30 percent.

At the same time, while there are certainly exceptions, sub-Saharan Africa today stands out as a region that still lags far behind.

On average, output per capita in sub-Saharan Africa was lower, in real terms last year than it was in 1960. In some countries, it fell by as much as 50 percent. And the average individual income in a region of 600 million people is now only 65 cents a day.

The region's share in global trade has fallen from 3 percent in the 1950s to less than 2 percent in the mid-1990s - a decline of nearly \$70 billion each year, or just over 20 percent of regional GDP.

Across large parts of the continent, 200 of every 1,000 children die before the age of five, and young girls have only a few years of primary school. Indeed, in many countries, children are more likely to die before reaching five than to learn to read.

Africa's problems have no single explanation and differ considerably from country to country. But most observers attribute the problems in the past few decades to a number of factors, including: poor national economic policies; the prevalence of kleptocratic and corrupt governments; regional conflicts; and, not least, the challenges posed by its natural environment, which leaves Africa particularly vulnerable to drought and difficult to produce adequate food or trade with the global economy.

All of these problems are being exacerbated by the HIV/AIDS pandemic. The facts are known to many of you here but they have not caught the attention of many of the world's finance ministers when World Bank President Jim Wolfensohn so valuably highlighted the situation at a meeting in Washington this spring.

Of the 16 million deaths from AIDS to date, 14 million have been African. Last year, the combined wars in Africa killed more than 10 million people, overtaking malaria to become the Continent's greatest single killer. Yet it is estimated that 90 percent of the deaths from HIV/AIDS that will be brought to Africa are still to come.

As you know, women are increasingly bearing the brunt of HIV/AIDS, both as the primary care providers and, among them, the most vulnerable to the disease. In many places, HIV/AIDS infection among young women is 3 to 5 times higher than among men. In Africa, where I will be visiting next week, nearly one-third of pregnant women are testing HIV positive, compared to just 10 percent elsewhere. And where women perform an inordinate share of the physical labor and contribute in critical ways to the household economy, the impact of the disease is especially cruel.

Today, 23 million Africans are infected, and 11,000 are added to the list every day. In the countries worst hit, more than 10 percent of the population are now HIV positive - and more than 10 percent of the population are AIDS orphans. Yet the total per capita health budget in Africa is less than \$5 a year.

AIDS is wiping out several generations of improvement in life expectancy and mortality rates. In southern Africa, life expectancy has fallen from a high of 59 in the early 1990s to 45 within the next 5-10 years, a level not seen since the 1950s. In the countries where the impact has been less severe, it has been suggested that life expectancy could soon fall back to the 35 years characteristic of biblical times.

Confronting these problems is a global moral imperative. But in a shrinking world, it also has direct implications for the international interest in a strong global economy; in avoiding conflicts into which they may be drawn and the threats posed by rogue states; and in the spread of diseases that are no respecters of national boundaries.

II. A Platform for Further Action

For all the problems, it is encouraging that both within sub-Saharan Africa and across the international community there is a growing awareness of the situation and the need to act. This is reflected in the activities that many of you here have been involved in since Beijing. We also see it:

In the pockets of real progress in Africa: including Nigeria, where the first civilian elected President in 20 years has put economic development on his agenda; Uganda and Tanzania and their successful efforts to support growth and poverty reduction in the 1990s; and Mozambique, where rapid growth have replaced two decades of devastating civil war. Mozambique has been one of the fastest growing economies in the world. And even as it deals with major flooding and a looming malaria epidemic, the government is working to keep its growth on track. In the recognition, at both the national and the global level, of the scale of the threat posed by HIV/AIDS, including the commitment of the agencies and the Vice-President's pledge of much strengthened efforts to combat AIDS at the first-ever UN Security Council meeting in January.

And in the global community's embrace of the strengthened HIPC initiative in Cologne last year, which focuses on ensuring that countries to reform can spend more of their precious resources on their people - and less on paying off official debts.

These positive trends are a platform on which we must seek to build in the future as we work to help African countries forge

III. The Agenda for the Future

If we are to move forward with this effort we have to move beyond the debates of the past.

There are people who argue that international assistance without conditions and without governments that are committed is useless. And they are right.

There are people who argue that even with the best policies - and the best governments - in the world, if you are one small geographically isolated part of the world and 20 percent of your population is affected by HIV/AIDS it is going to be extremely difficult for things to happen. And they too are right.

Nations shape their own destiny. In recent years we have learned and re-learned the lesson that the international community can help a country's development more than a country's own government or its people do.

But at the same time, it is equally a mistake to overlook what might be called the tyranny of geography: to suggest that the problems of nations with poor soil, an erratic climate and vulnerability to infectious disease can be traced simply to the failure of government or environment.

The challenges are colossal. The record of past economic reform and assistance efforts is worse than mixed. And certainly, it is important to remember that there are high return investments in growth and poverty reduction that are not being pursued because of the high economic cost - because of a lack of official resources.

There are four crucial lessons from the past few decades that must inform a more effective international approach.

First, the need for selectivity

Recent World Bank research has shown that targeted to the right policies and governments, official assistance can be highly effective. One percent of GDP in official assistance translates roughly one-for-one into reduced poverty and lower rates of infant mortality, increased amount in inflows of new private investment. Yet a large portion of global bilateral aid has flowed to countries with poor policies that has been shown to do little good. While countries with good policies have tended to face declining official support, just when outside support can do most good.

Going forward, we must work to target scarce official resources more effectively on countries and programs with a proven capacity.

That means that we must more often decline to provide assistance to corrupt or uncommitted governments - in Africa or elsewhere - or the capacity to invest those resources for the good of all of their people.

And it means that where countries are committed to effective policies, we must stick with them, and resist the common temptation to withdraw. What Africa needs most today are success stories. When countries are using official assistance well they should be able to pay for it.

Second, the importance of economic integration

Economic integration is the transforming global dynamic of our time. No developing country, much less a small and underdeveloped one, has achieved rapid economic growth in the past fifty years without joining the global market and achieving rapid growth in exports. Those countries that have taken advantage effectively - most notably in East Asia - have moved from subsistence to skyscrapers in barely a generation.

It is easy to be cynical about the capacity for information technology to speed the global development effort at a time when only a small fraction of the world uses a telephone - and 40 percent of African adults cannot read. At the same time, we cannot ignore the possibility that in Africa there might open up a new range of opportunities for core and periphery to compete on more equal terms, and so converge. This is what happened in Asia. In Africa, three years ago, when I encountered an Internet provider from Mozambique. His main concern was the advent of the Internet.

That is one reason why HIPC, in Mozambique and elsewhere, is so important. It will help free governments to realize the potential of their countries - by removing the drag on growth and investor confidence that an unsustainable foreign debt creates.

And that is why the African Growth and Opportunity Act, which President Clinton signed into law last month, is so important. It provides new opportunities for many African economies by significantly expanding their access to the US market, especially in apparel.

As part of this effort, the official donor community will perhaps also need to be more accepting of the need for government to have learned the hard way that selective protection of industry and national champions are not reliable strategies for growth. But it is difficult to achieve change in a country when governments lack a clear vision of what that change might achieve. In this context, with an increase in focus on human development indicators, future official assistance programs will put more emphasis on measures that play such a crucial role in every major development success story of our time.

Third, the crucial role of education

In a former capacity I undertook research that convinced me that girls' education represented the single highest return investment the world could make. Nothing that has occurred since then has led me to change my view.

The World Bank has recently estimated that if the Sub-Saharan Africa had seen just the East Asian rate of improvement in the 1970s, GDP and living standards would be 15-25 percent higher in those countries today.

And if the ratio of female-to-male years of schooling were near parity today, Africa's rate of infant mortality would be 20 percent lower.

Education always pays off. What is especially attractive about educating girls is the additional benefit that accrues to empower them with the greatest capacity to alter the life prospects of the generations to come.

Letting girls go to school, learn to read, and experience more of the world beyond their homes makes them better off immediately. The result, in country after country, is smaller, healthier families enjoying longer, happier lives. The cost of keeping girls in school is small compared to themselves in the social and economic benefits in the form of higher incomes, and smaller numbers of infant and maternal deaths.

It bears emphasis today that educating girls holds the further benefit of helping to prevent the spread of HIV/AIDS. Studies suggest strongly that higher rates of female secondary school enrollment have been associated with a much slower rate of transmission. In the developing world, DHS data confirm that levels of education are now highly correlated with the probability that women will have fewer children.

That is why the new approach to official lending that is part of the HIPC initiative puts core investments in female education at center stage. Uganda saved \$45 million in debt service under the original HIPC. This relief has helped them expand primary education in just two years. Under the enhanced HIPC, Uganda is expected to receive an additional \$650 million in concessional terms to invest in universal primary education and other basic human priorities.

And that is why we are asking the international community to consider concrete, multi-year targets for substantial increases in education - particularly for basic education and to narrow the gap between girls and boys. And we are working to build a strong link between education and health at the upcoming G7 meeting in Okinawa next month.

Fourth, the importance of core investments in health

I believe strongly in the power of markets, economic growth and strong policies. But anyone who studies the statistics on HIV/AIDS in sub-Saharan Africa today has to conclude that without a more effective approach to these problems, no national economic program, if implemented, is going to yield significant positive results. They have also to conclude that African countries themselves will not be able to do it on their own.

None of this is to absolve national governments for the waste of national resources that has taken place in recent decades, and for their inaction in responding to the threat of AIDS. But the rest of the world has to be doing more, not simply as a moral imperative but as a practical one.

We must ensure that HIPC and other assistance to the poorest countries in the future deliver concrete improvements in health. We must improve programs for preventing and treating disease. Efforts to improve the efficiency of all health expenditures will be especially important. Patients in public health facilities in Africa may receive benefits worth only \$12 for every \$100 of public spending on health. The population on average receives only around 12 percent of subsidies in public health.

We must upgrade our national and international efforts to help countries address the challenge of HIV/AIDS. USAID has

stories in this area - notably in Uganda, where the prevalence of HIV among 15-24 year-olds in urban areas has been cut in half. The additional \$100 million that the President has requested for AIDS programs in next year's budget would signifi- cantly increase the impact of these examples in the future.

And we must work to mobilize global resources and expertise for the development and dissemination of vaccines for the developing world, as the President has highlighted in his Millennium Vaccines Initiative:

By providing more resources for countries to purchase the vaccines that already exist.

By shifting existing international resources - notably multilateral development bank lending - toward support for local infrastructure to deliver vaccines and medicines and provide essential basic health services.

By intensifying the search for more effective ways of treating and preventing the major killer diseases in the poorest countries - malaria and tuberculosis: for example, through greater public support for such research under the auspices of the National Institutes of Health.

And by strengthening private sector incentives to develop new vaccines for these diseases. In the era of Viagra, it cannot be surprising that of the 13 new medicines patented between 1975 and 1997, only 13, or 1 percent, were for tropical diseases that afflict 90 percent of the world's population. Of those 13 new products, only 4 came from research efforts that were aimed at curing humans. As a small step forward, the President has called for sales of vaccines for any infectious disease that causes over one million deaths annually worldwide. We are calling for similar commitments, to help guarantee a future market for these urgently needed vaccines.

IV. Concluding Remarks: the Need to Expand Global Assistance Capacity

By applying these four core lessons: the importance of selectivity, support for integration, and substantial increased investment in health care, we can substantially improve the quality of the resources that the international community brings to bear on the challenges that face the world.

This is crucially important. With the lessons of experience now clearly understood, there can be no excuse in the future for letting the interests of their palaces before their people; or for letting optimism or geopolitical considerations triumph over a hardheaded assessment of the facts. No way that money given to corrupt governments harms no one as much as the people who live in those countries themselves.

And yet, we must also face up to the fact that when the average per capita health budget in sub-Saharan Africa will barely cover the needs of the very best governments in the region today face problems that they will not come close to addressing without major outside assistance. That with the devastation that is coming from HIV/AIDS, and the enormous progress being made in other parts of the world, the gap by which Africa will fall even further behind in the generation to come.

This is not something that any of us should be prepared to accept. It has been an important part of your agenda for some time, and it will be a central part of the global financial agenda in the years ahead. Thank you.

Message Sent To:

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DEPARTMENT OF THE TREASURY
WASHINGTON, D.C. 20220

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To: SANDY THURMAN From: TOBIAS READ
Fax: 456-2439 Date: 5 JUNE 2000
Phone: 456-2437 Pages: 7 TO FOLLOW
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June 5, 2000

DRAFT

**Remarks by Treasury Secretary Lawrence H. Summers
United Nations Conference on Women and Development
New York
June 6, 2000**

Good morning. We come together today to discuss an integral part of the global development effort – the empowerment of women – at a time when that effort is in the spotlight in a way that it has not been for a long time.

When G7 finance ministers meet in Japan next month in the lead-up to the G8 Summit in Okinawa, issues of development will be on the top of the agenda, with the continuation of the Highly Indebted Poor Countries debt relief initiative; with the much strengthened emphasis on reducing global poverty that has been part of that initiative; and with the increasingly universal belief that the dawn of the 21st century must be a time of more global hope and opportunity.

I am going to Sub-Saharan Africa next week to talk with officials and others in the region about the development challenges that they face – because it is the region where the challenges are at once the most profound and the most urgent. It needs hardly be added that it is the region that is home to the largest number of the world's poorest women (*). There may be issues with greater potential global financial impact today than the successful economic development of Africa. But there is none with greater potential human impact.

That is why I would like to focus my remarks today on sub-Saharan Africa: the enormous obstacles that it faces; and the pressing need for a stronger and more effective international development effort to help its countries begin to overcome them.

I. Sub-Saharan Africa Today

Those who say that the global development effort has failed are badly wrong: in the past two decades, more people have been lifted out of poverty in China and other parts of Asia than at any time in world history. Average life expectancy in the developing world has risen by ** years – roughly the increase we would see here in the US by eliminating all cancer. And infant mortality has been reduced from * per 1,000 to *.

At the same time, with very few exceptions, it must today be acknowledged that in Sub Saharan Africa the global development effort has so far failed. Per capita incomes in Africa in the late 1990s were lower than they were thirty years ago. Average incomes for a region of 600 million are now only 65 cents a day. And across large parts of the continent, children are more likely to die before their first birthday than to learn to read.

No one country is the same and there are a many factors that have contributed to economic failure in each case: the legacies of colonialism; the Cold War; long periods of authoritarian governments and kleptocracies and the ongoing impact of civil and regional conflict. All of these

have surely played their part. Yet what we perhaps emphasize too little are the challenges that come from nothing more than geography.

Africa has suffered from what might be called the tyranny of geography in at least three senses:

- First, being relatively remote from the rest of the world and therefore disadvantages in competing in trade and benefiting from the forces of global convergence and "catch-up" growth. Less than one fifth of Africans live within 100 kilometers of a coast, and the sheer scale of the Continent relative to its coastline greatly increases the difficulty and cost of transporting goods.
- Second, being a natural environment and a climate that is prone to infectious, debilitating disease, natural disasters and difficulties producing adequate food. Africa loses twice as much labor through illness as any other region. It has been estimated that malaria alone reduced the growth rate of 31 countries in Africa by up to 1.3 percentage points a year between 1980 and 1995 – giving a cumulative loss of nearly one fifth of GNP.
- Third, at least since the latter part of the 19th century, Sub Saharan Africa has been a region of many small states. This brings the obvious economic handicap of smaller internal markets. Perhaps less well understood has been the greatly increased risk of conflict. The chances of a civil war somewhere among 100 million people roughly triple when those people live in 10 nations of 10 million. Today one in five Africans severely disrupted by an ongoing war.

And of course, to these age-old ^{miseries} ~~blights on Africa~~ we must now add the most recent and devastating misfortune of ~~having been present at the creation of~~ HIV/AIDS. The facts are known to many of you here but they are worth repeating:

- Of the 13 million deaths from AIDS to date, 11 million have been African. Last year, the combined wars in Africa killed 200,000 people. AIDS killed ten times that number, overtaking Malaria to become the Continent's greatest single killer. Yet it is estimated that 90 percent of the illness and death that HIV/AIDS will bring to Africa is still to come.
- Today, 23 million Africans are infected, and ^{11,000} ~~5,000~~ are added to the list every day. In the countries worst hit, more than 1 in 4 of the adult population may now be HIV positive – and more than 10 percent of the population are AIDS orphans. Yet the total per capita health budget in many countries is often as low as \$5 a year (*).
- The pandemic is wiping out several generations of improvement in life expectancy and mortality rates. In southern Africa, life expectancy is expected to drop from a high of 59 in the early 1990s to 45 within the next 5-10 years, a level not seen since the 1950s. And the highest rates of new infection are often among young women who will soon be mothers. In parts of South Africa, where I will be visiting next week, ^{as well as infant-child} ~~roughly 20 percent~~ of women attending ante-natal clinics are testing HIV positive – compared to just 1 percent in 1990. ^{nearly 1/4}

In an era of information technology, economic integration and the 'death of distance', there are grounds for hoping that some of Africa's natural handicaps could weigh less heavily on its

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governments and peoples in the years ahead. We believe that the US and other industrial countries should do everything that we can to help African countries seize these possibilities, at a time when they account for just 2 percent of world trade, and their share of global manufactured exports is close to zero. That is the goal at the heart of the African Growth and Opportunity Act, which President Clinton signed into law last month, and which significantly expands Sub-Saharan African countries' access to the US market, especially in the apparel sector

This is an important step – and one that we hope other industrial countries will follow. But we should not delude ourselves that the offer of more open markets can be the extent of our efforts to help Sub-Saharan Africa turn itself around.

II. The Challenge for the International Community

There are people who argue that international assistance without conditions and without governments that are committed to doing the right things is worse than useless. And they are right.

There are people who argue that even with the best policies – and the best governments – in the world, if you are one small country of many in a tropical, geographically isolated part of the world and 20 percent of your population is ~~afflicted~~ ^{affected} by HIV/AIDS it is going to be extraordinarily difficult to make good things happen. And they too are right.

The World Bank estimates that simply preventing an increase in the number of Africa's absolute poor over the next 15 years will require annual growth of more than 5 percent – almost twice the rate achieved since 1973. Yet in South Africa, for example, the largest economy in the region, more than one third of the prime age workforce is expected to be infected with HIV by 2010 (*).

The challenges are colossal. The record of past economic reform efforts is worse than mixed. And the right answers today are not readily apparent to any of us. But the enormity of the task should not blind us to the fact that there are high return investments in growth and poverty reduction that are not being pursued in Africa today because of a lack of official resources.

Let me highlight just one example here: investments in girls' education. In a former capacity I undertook research that convinced me that girls' education represented the single highest return investment that any developing country in the world could make. Nothing that has occurred since then has led me to change my view.

- The World Bank has estimated that if the Sub-Saharan Africa had seen just the East Asian rate of improvement gender gap in education, average economic growth would have been 0.5 to 0.9 percentage points faster per year since 1970*.
- And if the ratio of female-to-male years of schooling was near parity, Africa's rate of infant mortality would be 25 percent lower (*).

Educating girls is cheap. And it generates exactly the same increase in productivity – and thus wages – as educating boys. What makes it uniquely attractive are the additional benefits that

accrue to empowering the member of the household with the greatest potential to alter the life prospects of the generations to come.

Letting girls go to school, learn to read, and experience more of the world beyond their homes makes them better off immediately and enriches their families. Over time, getting girls into school can transform whole societies as their sons and daughters and granddaughters and grandsons reap the benefits. Notably: women spend more of their income on children than their husbands do, and educated women are more likely to seek medical care and to improve sanitation practices. They also have fewer children and can provide more for those they do have.

The result, in country after country, is smaller, healthier families enjoying longer, happier lives. The cost of keeping girls in school just one more year more than pay for themselves in the social and economic benefits in the form of higher incomes, and smaller numbers of infant and maternal deaths.

What will offer the best prospect for helping Sub-Saharan Africa in the years ahead is very substantial assistance, much better targeted to such high return investments – and to governments that are committed to making those investments bear fruit.

[Recent World Bank research has shown that targeted to the right policies and governments, 1 percent of GDP in official assistance translates roughly one-for-one into reduced poverty and lower rates of infant mortality, and helps generate nearly 2 percent of GDP in foreign private investment. Yet in 1997, OECD donors contributed less in aid as a share of their GNPs than at any time since comparable statistics began in the 1950s: less than one-quarter of 1 percent. And overall, as much bilateral aid went to countries with good policies and those with good policies.]

Once again, none of us has all the answers. But we are taking concrete steps to make the global development effort more effective in two areas:

- First, through the strengthened HIPC initiative.
- ~~Second~~ *Second*, and more recently, through strengthened efforts to promote the provision of vaccines and effective treatments for infectious diseases, such as HIV/AIDS, malaria and tuberculosis.

1. HIPC and the new approach to official assistance for the poorest

The enhanced HIPC initiative starts from the recognition that governments that are working to achieve rapid growth and poverty reduction in their countries should be in a position to focus more of their precious resources on schools and health clinics – and less on paying off debt. The goal is to ensure that not just debt relief, but all official lending in the poorest countries is more reliably invested in core social investments.

To this end, as a condition for receiving debt relief and new concessional loans, countries are required not only to have established a solid track record of reform, but they also must produce a forward-looking Poverty Reduction Strategy Paper. These strategies will be will clearly define

concrete and monitorable national poverty reduction goals, such as reducing infant mortality and malnutrition, and identify the medium term costs associated with achieving these goals.

In support of these strategies, we are supporting new mechanisms to ensure that programs have a genuine impact on the allocation of resources to core priorities such as basic health and education, and that the additional public funds made available by reducing debt result in additional poverty reduction efforts. There will also be much strengthened efforts to enhance government accountability and transparency, particularly in their fiscal management, and to encourage civil society participation, and country ownership of reforms.

This is ongoing effort, both within the World Bank and IMF and in the HIPC countries themselves. But I am glad to say that HIPC is already having an impact:

- Last year, Uganda saved \$45 million in debt service under the original HIPC. As a result, expenditures on health and education increased by \$55 million. This relief helped the country to double enrollment in primary education in just two years. Under the enhanced HIPC, going forward Uganda is expected to receive an additional \$650 million in debt relief in net present value terms.
- And next week I will have a chance to assess the potential benefits of HIPC in Mozambique and Tanzania, both of which are expecting to qualify for enhanced relief this year. Channeling the resources freed up by debt relief into core social investments must now be a crucial priority in countries that last year were able to spend, in the case of Mozambique, just \$4.50 per capita on education and \$2.50 on health care, or one fifth of what it had to spend on servicing debt.

2. *Strengthened efforts to help countries combat HIV/AIDS and other infectious diseases.*

At a time when new economy creating more personal wealth than the world has ever seen it is the right time to harness that new economy for the benefit of the world's poor. And there can be no higher priority in this regard than strengthening our efforts, both national and global, and both in the public and in the private sector, to help countries combat infectious diseases.

Once again, the record suggests that there are no easy, simple solutions. But with much greater understanding today of what works and what does not, and with the very rapid development of global scientific knowledge, we are in a much stronger position today than we were even a few years ago to help countries make concrete progress.

We believe that realizing these opportunities will involve four core elements, all highlighted in the President's Millennial Vaccines Initiative that was announced earlier this year.

- *First, mobilizing additional international resources to help the poorest countries purchase existing vaccines for their children.* Many poor countries often cannot afford to buy even the vaccines that do exist. Expanding the resources they have available for this purpose is a priority that the UN, the Gates Foundation and others have rightly worked to put on the international agenda. To help build further momentum, the President has proposed a \$50

million contribution to the Global Alliance for Vaccines and Immunization (GAVI) to purchase existing vaccines for children.

- *Second, shifting existing international resources toward building infrastructure in poor countries that can deliver vaccines and medicines and provide essential basic health services.* To this end, President Clinton has called on the multilateral development banks to shift an additional \$400 million to \$900 million annually of concessional resources into basic health care. We are also stressing the importance of such programs in the context of HIPC.
- *Third, intensifying the search for more effective ways of treating and preventing diseases that widely afflict developing countries especially HIV/AIDS, malaria and tuberculosis.* That is why the President has asked for a significant increase in funding for the National Institute of Health's research to support the creation of vaccines for diseases that afflict primarily developing countries. The goal is that AIDS vaccine research will increase substantially in FY 2001, to more than double its 1997 level. The President has also proposed an additional \$100 million for HIV prevention and AIDS treatment in developing countries.
- *Fourth, strengthening private sector incentives to develop new vaccines.* In the era of Viagra, it cannot be right that of the 1233 new medicines patented between 1975 and 1997, only 13, or 1 percent, were for tropical diseases that afflict 90 percent of the world's population – and that of those 13 new products, only 4 came from research efforts that were aimed at curing humans. As a small step forward, the President is proposing a new tax credit for sales of vaccines against malaria, tuberculosis, HIV/AIDS, or any infectious disease that causes over one million deaths annually worldwide. This credit would provide a specific and credible commitment to purchase vaccines for the targeted diseases once they become available. We are calling on other governments to make similar purchase commitments, so that we can ensure a future market for these critically needed vaccines. But as the major pharmaceutical companies have themselves recognized, we can and must do more. (*)

III. Concluding Remarks: the Need to Expand Global Assistance Capacity

By focusing our assistance more effectively on core social investments, and by harnessing modern breakthroughs in the treatment and prevention of infectious diseases, we can substantially improve the quality of the resources that the international community brings to bear on the challenges that Sub-Saharan Africa faces today.

This is crucially important. With the lessons of experience now clearly understood, there can be excuse in the future for letting aid fill the pockets of elites who put their palaces before their people; or for letting optimism or geopolitical considerations triumph over a hardheaded assessment of the facts. We have learned the hard way that money given to corrupt governments harms no one as much as the people who live in those countries themselves.

And yet, we must also face up to the fact that when the average per capita health budget in Africa will barely cover the cost of a tse tse fly trap, the very best governments in the region today face problems that they will not be able to come close to addressing without substantial outside resources. And we have to face up to the fact that at a time when net transfers per capita to

Africa are now more than one third lower, in real terms, than they were in 1990, the international community does not presently have the capacity to meet that need.

This has been a central goal of the Clinton Administration these past 7 and a half years. And while we have had some important successes, I regret to say that is a goal that remains unmet. The women of the world have the greatest stake of any in the international community rising to this challenge in the years ahead. Thank you.

*** TX REPORT ***

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OFFICE OF NATIONAL AIDS POLICY
EXECUTIVE OFFICE OF THE PRESIDENT
THE WHITE HOUSE

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NOTES/COMMENTS:

Tobias- Sandy Thurman is on travel and was unable to review the attached. Michael Iskowitz who works with us reviewed it and offers the attached



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EXECUTIVE OFFICE OF THE PRESIDENT
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FACSIMILE TRANSMITTAL SHEET

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NOTES/COMMENTS:

Tobias- Sandy Thurman is on travel and was unable to review the attached. Michael Iskowitz who worked with us reviewed it instead and offers the attached suggestions. Many thanks for sharing it with us. Please call me with questions - 456-2959 Cheryl

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- Position paper -
- assume concurrence -

Teresa Stoltz
(Mike Cassella)

FAX TRANSMISSION

Department of the Treasury

Office of International Debt Policy

Office 202-622-0212

Fax 202-622-0218

To: Sandra L. Thurman

Date: 28 May 1999

Fax #: 456-2438

Pages: 1, including this cover sheet.

From: Max Hudgins

Subject: Debt Reduction to Fight AIDS

COMMENTS:

It was a great pleasure to meet you on Monday. As you requested, I am supplying you with some estimates of the amount of local currency that could be generated to fight AIDS and the cost to the Treasury to reduce these debts. You had requested these calculations for eight countries: Côte d'Ivoire, Zambia, Kenya, Tanzania, Uganda, Rwanda, Burundi, and Zimbabwe. Only four of these countries, Côte d'Ivoire, Kenya, Zambia, and Zimbabwe, have debts to the USG. The table below provides you with my results.

Local Currency Generated to Fight AIDS Treatment of Debt by Selected African Countries (all amounts in \$ millions)			
Country	Debt/Kind	Budget Cost	Local Currency
Côte d'Ivoire	\$91/PL-480	\$7	\$7.0
Kenya	\$38/USAID	0	\$3.0
Zambia	\$7/PL-480	\$1	\$15.2
Zimbabwe	49/PL-480 & \$4/USAID	0	\$4.0
Total	\$315	\$8	\$25.0

I assumed that we would reduce only 25 percent of the outstanding debt, and permit the interest on the remaining 75 percent to be paid in local currency to fight AIDS. This is how it was done under the Enterprise for the Americas Initiative (EAI), implemented in 1991 and 1992 to support the environment and child survival in selected Latin American and Caribbean countries.

Please call me with any questions you may have. Since these are my own estimates, I would appreciate that you not release them. They are for discussion purposes only. Any final figures would have to be cleared by OMB, as well as my superiors.



DEPARTMENT OF THE TREASURY
WASHINGTON, D.C. 20220

D-Treasury

JUL 01 1999

MEMORANDUM FOR SANDRA THURMAN
WHITE HOUSE OFFICE OF NATIONAL AIDS POLICY

GAYLE SMITH
NATIONAL SECURITY COUNCIL

ROBERT KYLE
OFFICE OF MANAGEMENT AND BUDGET

FROM:

William E. Schuerch *WES*
Deputy Assistant Secretary
International Development, Debt and Environmental Policy, and

Daniel M. Zelikow *DMZ*
Deputy Assistant Secretary
Asia, the Americas and Africa

SUBJECT:

Treasury Department Briefing Materials on AIDS in Africa

Please find attached some informal thoughts which we should discuss further on possible initiatives that could be taken by the World Bank and the African Development Bank to combat AIDS in Africa. We also have enclosed a fact sheet on the Koln debt initiative and some off-the-shelf briefing materials on existing activities being done by the World Bank and the African Development Bank on AIDS.

If we can provide additional information or assistance to you, please let us know. We look forward to continue working with you through the inter-agency process.

Attachments

Possible AIDS Initiatives Which Might Be Supported by Treasury

Intensify IFI Coordination: Both the World Bank and the African Development Bank have already undertaken initiatives in Africa to combat AIDS. In fact, the World Bank is one of the leading financiers of HIV/AIDS activities in the world. We could call for the continuation of these initiatives by both the World Bank and the AFDB, particularly focusing on public education and health activities to promote prevention and behavioral change, not scientific research, and urge the two institutions to coordinate their efforts. We could also urge that AIDS initiatives and prevention strategies be included where appropriate in the Country Assistance Strategies approved by the World Bank and African Development Bank boards in borrowing countries.

AIDS Education Initiatives: The U.S. Executive Director of the World Bank and the AFDB could call for AIDS prevention and education programs being inserted into education and health (sector) loans funded by the IFIs in borrowing countries where AIDS is prevalent. Even where the disease is nascent, such an initiative should be encouraged to prevent its spread.

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

AIDS Debt-Swaps: AIDS education and prevention programs, in addition to children's anti-poverty and environmental programs, could be included as eligible activities we support with our debt-swap and exchange programs. Such an initiative developing AIDS education and prevention debt-swaps will require new legislation, which this Administration would support.

IMF Support: We could commit to urge the IMF to structure fiscal adjustment that countries make as part of the IMF programs in a way that does not undermine social sector spending in public health and education programs, including AIDS issues.

Regional Programs: We could ask the World Bank and the AFDB to explore and undertake regionally-oriented programs where AIDS has a cross-border dimension (e.g. truck drivers), particularly in southern and eastern Africa.

Economic Study on the Impact of AIDS in Africa: We could ask the IMF/World Bank /and the AFDB and even UNECA to collaborate on a literature review and study on the economic dimension and impact of AIDS in Africa, to be delivered at the Bank/Fund annual meetings (September 28-30, 1999), Development Committee, or G8 finance ministers.

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Finance Ministry Discussions: We could commit to have senior Treasury officials raise and discuss the issue of AIDS and development, particularly in Africa, at international meetings and in their discussions with African Finance Ministers to raise its profile and gain national support for preventive measures within financial planning and budgetary priorities.

Treasury 6/29/99

The Cologne Debt Initiative

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

- **New focus on poverty:** The Cologne Initiative calls on the International Financial Institutions to develop a new framework for linking debt relief with poverty reduction that centers around better targeting of budgetary resources for priority social expenditures, for health, child survival, AIDS prevention, education, greater transparency in government budgeting, and much wider consultation with civil society in the development and implementation of economic programs.
- **Substantially deeper relief:** Together with earlier debt relief commitments, the Cologne Initiative provides for reduction of up to 70 percent of the total debts for these countries, (reducing the stock) from about \$127 billion today to as low as \$37 billion with the cancellation of official development assistance (ODA) debt by G-7 and other bilateral creditors. In today's dollars (net present value - NPV terms), this would more than triple the amount of relief to be provided from \$13 billion under the current HIPC framework to as much as \$50 billion. This would be accomplished by reducing the HIPC program target ratios for the NPV of outstanding debt to 150 percent of exports, and 250 percent of government revenues, with fiscal thresholds of 30 percent exports to GDP and 15 percent revenues to GDP, and by providing full cancellation of ODA debts.
- **Faster relief:** Relief will be available significantly faster than under the current framework by providing early cash flow relief ("Interim Relief") and allowing earlier stock reduction.
- **Broader participation:** The number of countries expected to qualify for HIPC relief would rise from 26 to 33, meaning that more than 430 million people could ultimately be affected.
- **Releasing resources for priority needs:** For the average HIPC country, the share of scarce government revenue devoted to debt service could fall by 10 percentage points to a ratio for debt service to revenues of well below 20 percent and close to 10 percent in some cases. This is equivalent to a reduction in actual payments of about 25 percent. Mozambique's debt will be reduced by some \$3.5 billion (\$1.7 billion in NPV terms), for example, which could cut in half the share of government revenues allocated to external debt service from over 30 percent to about 15 percent in 1999 and free about \$30 million in budgetary resources each year. These savings are equivalent to over half the health budget in 1999 in a country where children are 3 times more likely to die before the age of five than they are to go to secondary school.

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

THE WORLD BANK AND HIV/AIDS ACTIVITIES IN AFRICA

Overview

Recognizing that HIV/AIDS is not only a health issue, but also a development problem threatening the economic and social growth of many nations, the World Bank is one of the leading financiers of HIV/AIDS activities in the world. The Bank has programmed over \$800 million to more than 70 current and future projects around the world aimed at preventing and controlling HIV/AIDS and STDs (Sexually Transmitted Diseases), mainly through IDA, its concessional loan window for the poorest countries. Over forty percent was for projects in Africa. Given the prevalence of HIV/AIDS in Sub-Saharan Africa, the Bank will continue to regard this region as a funding priority.

The fact that HIV/AIDS mainly affects people in the most productive age group, aged 15-49, increases the impact of this pandemic in Africa on economic productivity and development. Loss of skilled workers harms the development prospects in society, including individual households and vital sectors such as education, transport, and agriculture. The impact of the disease is especially hard on the poor. "Although it is difficult to project accurately the loss in terms of productivity, savings and investment, studies have clearly shown the ripple effect of AIDS on developing economies. AIDS is projected to slow per capita income growth, through its effects on savings and productivity, by an average of 0.3 percent point annually between now and 2025 in the ten sub-Saharan countries with the most advanced epidemics." (African Development Bank African Development Report 1998, pg. 157.)

Country specifics - Bank Operations

Uganda: the World Bank Group has funded two projects containing HIV/AIDS components – The Health Project for \$42.5 million approved in FY88 and ended in 3/96, and a Sexually Transmitted Infections Project for \$50 million approved in FY94 and ending in 12/00. This project includes a relatively small component for District Work Plans which are developed at the local government level with assistance from the Ministry of Health and from NGOs, and can include care and support for community initiatives, including AIDS families and AIDS Orphans. Knowledge of needs in the community including those of extended families unable to cope with deaths in the family have been referred to the District Medical Officers for inclusion in the District Work Plans by the World Bank staff working on the project.

Zambia: a Social Recovery loan for \$20 million was approved in FY 91 and the project ended in 7/98. The Ministry of Finance and Economic Development/Micro-projects Unit was in charge of the implementation of the project.

Zimbabwe: A Family Health II Project for \$25 million was approved in FY 91 with a closing date of 12/98. Due to delays in equipment procurement, the project implementation period is being extended. The Ministry of Health is in charge of its implementation. A Sexually Transmitted Infections Prevention and Care project was approved in FY 93 for \$64.5 million and will end in 12/00. The Ministry of Health and the National AIDS Coordination Program is in charge of its implementation.

For FY 99, the Bank has planned a Family Health III project for \$50 million for Zimbabwe to be implemented by the Ministry of Health. (These amounts are for the entire loan amount for the projects – to date the Bank does not yet have information for external use on the amounts spent just on HIV/AIDS components.)

South Africa: The World Bank does not have any projects with HIV/AIDS components in South Africa.

The Bank is leading the development of an African AIDS initiative, which was launched in December 1, 1998 (World AIDS Day). This initiative is being undertaken in collaboration with the UNAIDS (Joint United Nations Programme on HIV/AIDS) secretariat and other co-sponsors to create an effective subregional response to the epidemic among policy makers, government agencies, industry, NGOs, community organizations, and donor agencies, as well as to expand the Bank's involvement in HIV/AIDS support to Africa. The impetus for this initiative is the 22.5 million people in Sub-Saharan Africa who are living with HIV/AIDS and the rapid spread of this disease which is threatening to undermine 40 years of development progress.

The World Bank's Approach

The Bank believes that more than money needs to be provided to combat this disease. Strategies and programs need to be effective, and therefore based firmly on sound knowledge of local practice and traditions. The Bank works in partnership with UNAIDS, bilateral and non-government organization to assist countries to develop strategies and programs. The comparative advantage of the World Bank lies in its ability to engage in policy dialogue with client governments.

In a recent research/policy publication (1997), Confronting AIDS, the Bank promotes a strategy of enhanced epidemiological and behavioral data collection to better monitor the disease, education and information dissemination with an emphasis on prevention of the spread of disease through targeting of high-risk behavior through the use of condoms and other means such as bleach for sterilizing needles for drug users. Analysis to date (not surprisingly) suggests that targeting sex workers and others with multiple and concurrent sex partners is the most effective means of reducing the spread of the virus.

In addition the Bank participates in advocacy and public information activities, many of which are led by UNAIDS; funds research projects on alternative cost-effective approaches to reducing the spread of the disease; and cooperates with the International AIDS Vaccine Initiative.

While the World Bank has not yet undertaken a formal review of its AIDS projects, the projects in Uganda have been particularly successful due to the high commitment of the government to address the disease early on in its development.

AFRICAN DEVELOPMENT BANK AND HIV/AIDS ACTIVITIES

The African Development Bank's AIDS-related activities started around 1990 by integrating HIV/AIDS components in some selected health sector projects. The Bank's portfolio of health projects which include HIV/AIDS components is attached. Included is one project loan for Uganda for \$42.8 million approved in 1990 which is still on-going and is considered by the Bank to be successful in its implementation. Specifically, it includes an effective sub-component on Women in Development for supporting health education on AIDS in schools and rural districts, and has strengthened the institutional capacity of the Ministry of Health and local government to plan, organize, supervise and execute large health projects.

An HIV/AIDS Strategy Paper for the Bank Group was drafted in 1996 and is now being finalized. The prevention of AIDS has been identified as one of the major initiatives that the Bank Group will undertake.

Drafted By:
Treasury/OASIA/IDB

Cleared By:
Treasury/OASIA/ID

1/15/99

Attachment 1

African Development Bank/Fund
AFDB/AFDF
Health Projects with HIV/AIDS Components

Country	Project Title Loan amount	Approval Date/status	Component details	Effective
1. Côte d'Ivoire	Centre régional de transfusion sanguine à Daloa (ADF 13.2 mill UA)	1990 (on going)	- Construction of facilities - provision of equipment and supplies	Successful
2. Togo	Projet de réhabilitation des centres hospitaliers régionaux et de renforcement de la pharmacie d'approvisionnement (ADF 13 mill UA)	1991 (on going)	- Lab. Equipment for HIV/STD testing in 5 regional hospitals - training of med. staff and lab technicians; - certification program on HIV/AIDS and STD	Successful
3. Mali	Appui au PRODESS (SIP) (Amount to be determined)	Feb 1999	Regional initiative to control STD and HIV/AIDS	NA
4. Malawi	Institutional capacity building for the National AIDS Program (TAF Grant) approx. 1 mill UA	Feb 1999	Institutional capacity building	NA
5. Burundi	Health - Rehabilitation Project (ADF 7.9 mill UA) (TAF 0.7 mill UA)	Dec 1998	- Rehabilitation of blood screening facility - provision of lab equipment - training of staff	NA
6. Gabon	Health - Rehabilitation Project (ADB 10 mill UA)	Jan 1999	- Rehabilitation of blood screening facility - provision of lab equipment - training of staff	NA
7. Morocco	Projet de renforcement des soins de santé de base en milieu rural (ADF 18.5 mill UA) (ADB 18.42 mill UA)	1991 (on going)	Support to national program STD/HIV/AIDS; - provision of equipment supplies - training of staff - procurement of drugs	Successful
8. Mauritania	Sector Investment Program (Amount to be determined)	Jan 1999	Support to national program STD/HIV/AIDS; - provision of equipment supplies - training of staff - procurement of drugs	NA
9. Tanzania	Health Rehabilitation Project (ADF 15 mill UA)	Dec 1997	Support to the National AIDS Program; - EC and organization of workshops on HIV/AIDS involving private and commercial sector; - rehabilitation of labs and provision of improved equipment	Successful
10. Uganda	Health Rehabilitation Project ADF 25.3 mill UA and NTF 5.0 mill UA	1990	- Training seminar on HIV/AIDS/STD in District Schools	Successful



1998

EXPANDING THE RESPONSE:



WORLD BANK HIV/AIDS ACTIVITIES

THE WORLD BANK

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AIDS Policy

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WHY SHOULD THE BANK INVEST IN AIDS?

HIV/AIDS is not just a health problem. It is also a development problem. This epidemic threatens the economic and social growth of many nations. In addition to the extraordinary human suffering it causes, AIDS poses serious problems to a nation's health and productivity as well as the fabric of family and community life. Reasons for devoting extra attention to AIDS include:

- Economic:** AIDS mainly affects people in the most productive age groups (15-49). Loss of skilled workers harms the development prospects of society, including individual households and vital sectors such as education, transport, and agriculture.
- Societal:** AIDS exacerbates poverty. Although both the rich and the poor can be infected by HIV, the poor have fewer resources to cope and are therefore more likely to experience negative consequences. These include reductions in household assets, per capita food consumption, and child school enrollment.
- Health:** AIDS impacts public health spending. In addition, HIV leads to increased prevalence and incidence of other diseases, including tuberculosis (TB) and other sexually transmitted diseases (STDs).
- Human Rights:** AIDS may violate basic human rights by stigmatizing and discriminating against people living with HIV/AIDS, refugees and migrants, ethnic minorities, sex workers, injecting drug users and homosexuals.

THE TRENDS

By the end of 1996, approximately 23 million people were living with HIV infection or AIDS. Of these, 22 million are adults and 1 million are children. Approximately 42% of the 22 million are women and this proportion is growing. More than 6 million people have died of AIDS.

Over 90 percent of all adults and children with HIV/AIDS live in the developing world: 62 percent live in Sub-Saharan Africa, 24 percent in Asia, and 6.9 percent in Latin America and the Caribbean.

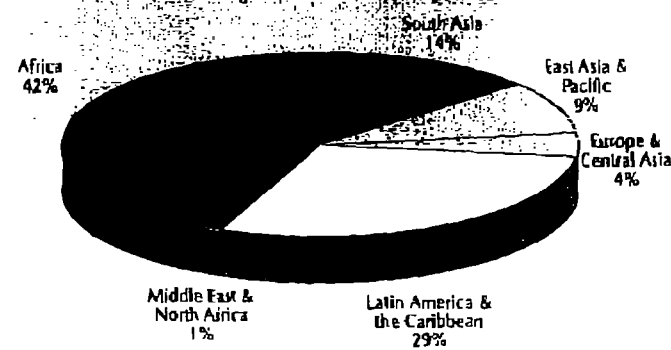
There were over 3 million new HIV infections in 1996, or approximately 8,500 new infections a day. The majority of newly infected adults are under 25 years of age.

Lending

The World Bank is one of the leading financiers of HIV/AIDS activities in the world. To date, the Bank has committed over \$800 million to more than 70 current and future projects around the world aimed at preventing and controlling HIV/AIDS and STDs. AIDS lending is likely to rise as more countries turn to the Bank for financial assistance in implementing strategies to fight the HIV/AIDS epidemic. The bulk of the World Bank's finance for HIV/AIDS-related projects is provided on highly concessional terms to low-income countries through the International Development Association (IDA).

In 1986 the Bank began providing funding for AIDS prevention as part of broader health and social sector projects. Freestanding AIDS projects have been funded since 1989. For example, \$84 million was approved in 1992 for a multi-pronged prevention strategy in India. The program aims to promote behavioral change and condom use, control STDs, strengthen blood safety, enhance surveillance and clinical management, raise the national and provincial capacity to manage HIV/AIDS control activities, and ensure humane treatment of people with HIV/AIDS. In addition, the Bank is engaged in discussions

CUMULATIVE WORLD BANK FUNDING OF HIV/AIDS PROJECTS, 1986-1997
(Freestanding or with an HIV/AIDS component)



Total HIV/AIDS lending, 1986-1997: US\$663.3

with the government of India and other partners about a second program—India II. In Zimbabwe, \$64.5 million was approved in 1993 to purchase condoms, drugs and diagnostic tests which can help prevent the transmission of HIV and other sexually transmitted infections, and for other activities.

Nearly half of the HIV/AIDS projects now funded by the Bank are in Sub-Saharan Africa, where most HIV infections currently occur. While the Bank will continue to regard this region as a funding priority, the Bank is also determined to assist countries where the full impact of the epidemic is yet to take effect.

The greatest epidemics of HIV/AIDS that the world now faces are those that will occur in the most populous nations: China, India and Indonesia. There is a window of opportunity in Asia where in some areas AIDS has come later and the problem is not yet out of control. Strategies to combat HIV are more likely to be cost-effective early on than after the epidemic has become mature.

Regional Initiatives

HIV/AIDS does not respect national borders, which is why the Bank also provides grants for initiatives which tackle this epidemic from a regional perspective. Programs in Western Africa, Southern and Eastern Africa, South East Asia, and Latin America and the Caribbean aim to strengthen regional co-operation and improve the capacity for neighboring countries to consult on policy and implementation issues.

Strategy and Program Development

While generous financial support is needed to fight HIV/AIDS, the Bank believes that more than money is needed if countries are to combat this disease. We must ensure that strategies and programs are effective. In allocating funds for HIV/AIDS projects the Bank works closely with individual governments, who are responsible for planning and implementing projects. For national HIV/AIDS programs to be successful it is imperative that they are based on a sound knowledge of local practice and traditions. The Bank also works in partnership with United Nations agencies (especially UNAIDS), bilateral donors and non-government organizations to assist countries to develop strategies and programs.

Research

The majority of World Bank finance is provided for countries to develop strategies and services on the ground. However, the Bank is also committed to learning how best to curb the HIV/AIDS epidemic. To this end the Bank has provided funding for experts from around the world, as well as its own staff and consultants, to undertake a variety of research projects.

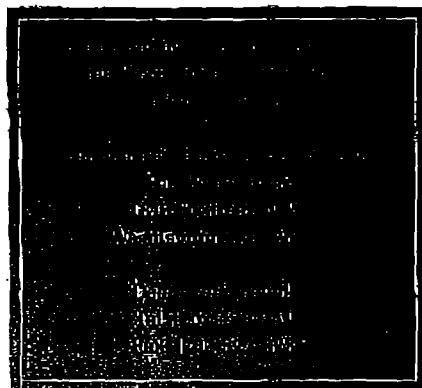
For example, the World Bank is part of a global collaboration of organizations that has created and funded the International AIDS Vaccine Initiative (IAVI). The purpose of IAVI is to accelerate progress toward an AIDS vaccine, or vaccines, effective for use in developing nations where the epidemic is spreading rapidly.

In addition, several studies on the social and economic impact of HIV/AIDS have been sponsored which will assist nations to identify the strategies and projects that most cost-effectively tackle this epidemic. A recent Policy Research Report "Confronting AIDS: Public Priorities in a Global Epidemic" provides an analytical foundation for policymakers and those in a position to influence the public response to the epidemic to consider how society and governments should respond to AIDS.

UNAIDS and the Bank

As one of six co-sponsors of the Joint United Nations Programme on HIV/AIDS (UNAIDS), the Bank is playing a role in shaping the global response to the HIV/AIDS epidemic. On January 1, 1990, UNAIDS replaced the World Health Organization's Global Program on AIDS (GPA). UNAIDS provides an expanded, multisectoral response to HIV/AIDS. The six co-sponsoring organizations are the World Bank, the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations Education, Scientific and Cultural Organization (UNESCO), and the World Health Organization (WHO).

Despite the efforts of governments, agencies and dedicated people throughout the world, the global AIDS problem is getting worse, not better. There are no easy solutions to the problems HIV/AIDS now poses. As we move towards the 21st Century and HIV/AIDS continues to challenge us all, the World Bank will play a major role in assisting countries to find culturally appropriate solutions to this devastating epidemic.



HIV Infection in Africa

Alan E. Greenberg, François Dabis, Lawrence H. Marum, and Kevin M. De Cock

CAPSULE SUMMARY

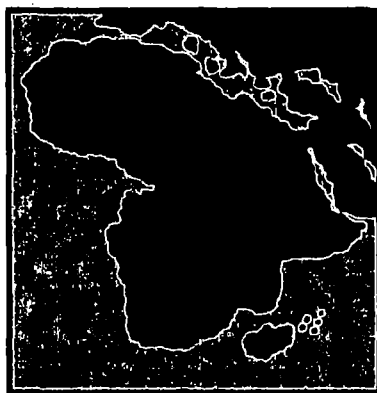
- Heterosexual transmission is the driving force of the HIV epidemic in sub-Saharan Africa; commercial sex work, migration patterns, and sexually transmitted diseases are thought to be important cofactors in the rapid heterosexual spread of HIV in Africa. Secondary epidemics through vertical transmission and the use of unscreened blood products are also prominent.
- The Joint United Nations Programme on HIV/AIDS (UNAIDS)/World Health Organization (WHO) estimates that 20.8 million (68.0%) of the 30.6 million persons with HIV/AIDS globally are living in sub-Saharan Africa, and that 7.4% of all persons 15 to 49 years old in sub-Saharan Africa are HIV infected.
- Although the HIV-1 epidemic is predominant in Africa, a concurrent epidemic of HIV-2 has occurred in West Africa. HIV-2 causes AIDS but progresses more slowly than does HIV-1; HIV-2 is also less transmissible than HIV-1 both heterosexually and vertically.
- Vertical transmission accounts for 90% of pediatric infections in Africa, and postnatal transmission through breast-feeding plays an important role in this setting.
- The complexity and cost of the ACTG 076 zidovudine regimen to reduce vertical transmission severely limits its applicability in sub-Saharan Africa. Consequently, alternative approaches are being evaluated, including short-course antiretroviral therapy, vaginal cleansing, vitamin A supplementation, passive immunizations, bottle feeding, and early weaning from breast-feeding.
- The results of a recent study conducted in Thailand demonstrated that a short term antenatal regimen of zidovudine administered to non-breast-feeding women infected with HIV reduced the risk of vertical HIV transmission by approximately half, but the efficacy of this regimen in a breast-feeding population has not been established.
- Bacterial infections and tuberculosis are the most important clinical manifestations of HIV in African adults. Among hospitalized African children infected with HIV, however, the most frequent clinical syndromes are acute respiratory infection, malnutrition, anemia, malaria, diarrheal disease, and meningitis, a disease spectrum that is similar to that of uninfected children.
- Limited access to adequate laboratory facilities to diagnose HIV infection and related illnesses, to antiretrovirals and antibiotics, and to trained medical personnel has adversely affected the provision of quality clinical care to children infected with HIV.
- Limiting number of sexual partners, avoiding commercial sex, using condoms regularly, and rapidly treating sexually transmitted diseases are currently the most effective strategies to prevent the spread of HIV in Africa.

*from Pizzo & Wilfert
Pediatric AIDS
3rd ed 1998*

PROTECTING HUMAN RIGHTS IN AFRICA

**STRATEGIES
AND ROLES OF
NON-GOVERNMENTAL
ORGANIZATIONS**

CLAUDE E. WELCH, JR.



Notes from Claude Welch's lecture at CDC (May 1999)

1/10th of world population
70% of AIDS cases
90% of children with HIV
95% of children made orphans by HIV
11 persons/day

Mostly rural
Extended Family
High birth/mortality rates
High presence of fertility (up to 9 live births/woman)
Polygamous marriages/serial monogamy
Poor economy
Poor access to care (low per capita)

Urban immigration
Highly mobile – *e.g.* mine in South African from various countries

Along truck routes
War-torn areas
Civil wars
Inferior status of women

Condoms

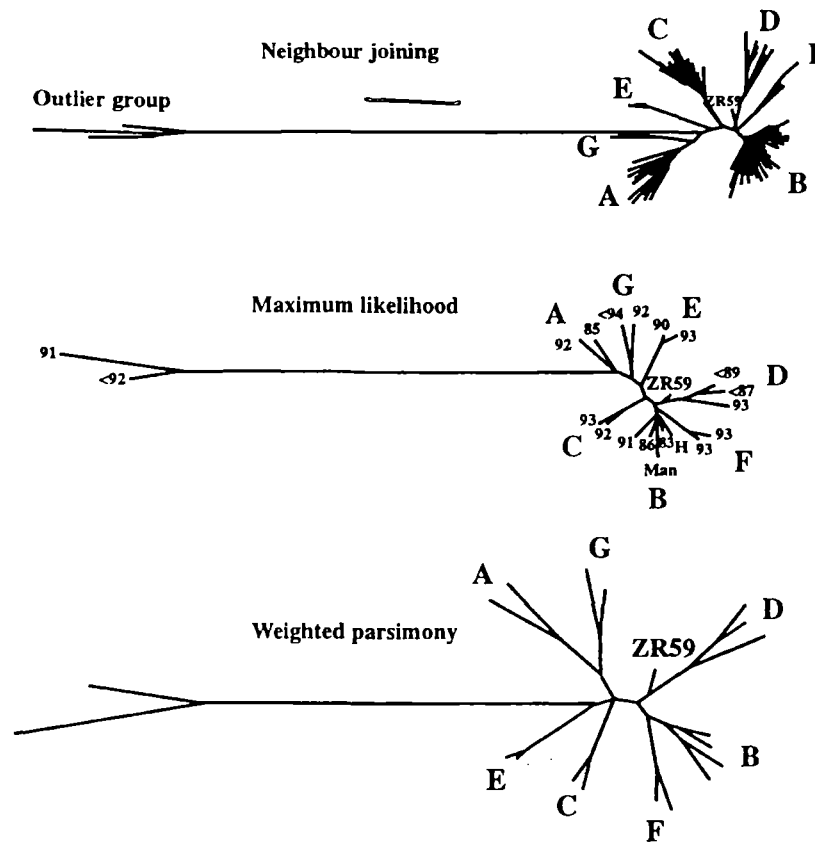
Cost
Breaks
Reluctance to use

Political Factors

African sensitivity to “blame”
Denial – Concern with tourism impact

Consequences of deaths, orphans, etc.
Widow dispossession
Loss of young men and women-including educated ones
Stress of extended family

Genital ulcers and HIV



1. Indicates that HIV-1 was introduced around 1950.
2. As the likely prototype, demonstrates the rapidity of subtype changes.

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**STATEMENT BY TREASURY SECRETARY LAWRENCE H. SUMMERS TO THE
SENATE APPROPRIATIONS SUB-COMMITTEE ON FOREIGN OPERATIONS.**

April 11, 2000

Thank you, Chairman Helms, for inviting me to testify on the President's Millennium Initiative to help combat infectious diseases. Let me also thank Senator Leahy for the leadership he has shown on this matter. Along with the leadership of Senator Kerry and Congresswoman Polosi, your support has made a real difference.

Increasingly, as integration proceeds, the world is confronting a broad class of problems that cross borders and defy easy solution by individual governments and markets. Whether it is money laundering and financial crime, global warming or reductions in global bio-diversity - the solutions to these problems will be global public goods, requiring concerted global cooperation.

The proposals that the Administration has put forward as part of its Millennium Initiative seek to catalyze a global response to one of the most urgent and morally compelling of such problems: the scourge of infectious diseases that hit hardest the countries that are least able to cope.

Today I would like to address the three points that form the basis for the President's Initiative.

- First, that the development and delivery of vaccines and effective treatments for infectious diseases is now one of the effective investments that we can make in successful economic development in the poorest countries.
- Second, that both the lessons of recent development experience and the advance of scientific discovery have put us in a position to have a real impact on the global spread of these diseases.
- Third, that public-private cooperation, both at the national and international level, is needed to achieve this – and that the various elements of the President's Initiative provide the most effective means of setting the right kinds of cooperation in train.

I. Combating Infectious Diseases as a Moral and an Economic Imperative

It might seem surprising that the Treasury Secretary is devoting so much attention to the goal of eradicating disease in the developing world. But, as Treasury Secretary, I am constantly reminded of the enormous national economic, humanitarian, and security stake that the United States has in the successful development of the poorest countries.

A more global prosperity will produce better trading partners for the US: time and again, as poor countries grow richer, they become the fastest growing markets for US goods and services.

Already, developing countries account for some 42 percent of US exports. A more global prosperity will also promote peace: from Bosnia to East Timor, from Rwanda to Palestine. And it will promote human freedom. Nations that succeed economically are much more likely to become democratic. And a more global prosperity will help us to meet the profound challenge of protecting the global environment. Environmental degradation spawned by dire poverty is a global concern.

Today, it does not overstate the case to say that the greatest single obstacle to human development in these countries and to a more inclusive global prosperity is the specter of disease.

The spread of HIV/AIDS in recent years has been swift and particularly brutal:

- Fifty million people worldwide have been infected with the HIV virus; more than 16 million have died; and annual AIDS-related fatalities hit a record 2.6 million last year.
- In sub-Saharan Africa, where 85 percent of all AIDS deaths have occurred, life expectancy is now declining sharply in many countries, reversing decades of hard-won gains. In at least five African countries, over 20 percent of adults are HIV-positive. In southern Africa, life expectancy is expected to drop from a high of 59 in the early 1990s to 45 within the next 5-10 years – a level not seen since the 1950s. And the highest rates of new infection are often among young women who will soon be mothers.
- Most worrying of all is the rate at which HIV/AIDS is spreading, and the very real danger that what is happening in Africa is about to happen elsewhere. Infection rates in Asia are climbing rapidly, with several countries on the brink of a large-scale pandemic and needing to take action immediately to forestall the disaster that Africa has suffered. Parts of Latin America and the Caribbean -- our own neighbors -- also show high and rising rates of infection. And the former Soviet Union countries and Eastern Europe are vulnerable as well, with Russia experiencing the highest increase in infection rates in the world last year.

At the same time, it bears emphasis millions of the world's people still fall prey to diseases that are centuries old. All told, infectious diseases are the leading cause of death worldwide, causing almost half of all deaths among people under age 45.

- Tuberculosis accounts for 2.3 million deaths annually, and drug-resistant strains are spreading. Indeed, thousands of people who are HIV-positive actually die of TB; their damaged immune systems allow active TB to develop, which then can spread to people who are not HIV-positive.
- Malaria strikes hundreds of millions of people each year and results in more than one million deaths, mostly children. The more common infectious diseases, diarrhea and respiratory infections, are even more devastating, killing almost 6 million people each year.
- And millions die of diseases for which cheap vaccines are available today. Fewer than half of Africa's children are vaccinated against basic diseases like measles and diphtheria – even

though such vaccines are one of the most cost-effective ways to improve health. And in South Asia, less than three-quarters of the children are vaccinated.

The end result is not merely a humanitarian crisis, but a broader social and economic crisis with implications not merely for these countries but the global economy as a whole.

- Life expectancy is falling mainly because of rising mortality among prime age adults. This will have particularly important long-term consequences for these economies – because research has shown that economic growth depends importantly on the share of the population that is of working-age.
- The burden of coping with these diseases further reinforces the poverty that allowed these diseases to take root. Health care budgets and facilities are overwhelmed by the heavy burden of caring for those who are infected. And families that are already impoverished are forced to liquidate assets and defer expenses for essentials such as education in order to pay for costly medical care – thus sending them into a deeper downward economic spiral. The death of both parents, which is very common once AIDS strikes the family, has led to an alarming number of orphans – over 11 million worldwide, with all but one-half million in Africa.

We are all vulnerable to this crisis.

- Because infectious diseases do not respect the boundaries of states and geography – as we have seen with HIV/AIDS, with the resurfacing of tuberculosis in parts of the United States, and with last year's outbreak of West Nile encephalitis in New York. The Global Health Council estimates that in the past 50 years, five times as many Americans have died from communicable diseases that have come from the developing world than have died in military conflicts.
- Because if these countries do not develop they cannot contribute to the broader global growth in which we have such a stake, at a time when already, more than 40 percent of our exports go to developing countries.
- And because the national economic distress and political instability that inevitably accompany this scale of human loss can cause greater damage to the global system as a whole.

For all of these reasons, support for the development and dissemination of vaccines and effective treatments for diseases such as HIV/AIDS and TB is probably the most effective, and cost-effective investment we can make today in successful economic development in these economies and, by extension – in the prosperity and stability of the global economy as a whole.

We believe this is fundamentally a humanitarian imperative. It is also a national economic and security imperative. Most important, it is an imperative that global experience and the pace of scientific discovery have put us in a much stronger position to address.

II. The Opportunity for a Breakthrough in Global Science

The record of past international efforts to combat infectious disease suggests that there are no easy, simple solutions to this problem. But we are in a much stronger position today than we were even a few years ago to help countries make concrete progress, for three reasons.

First, because of the rapid growth in relevant scientific understanding.

One problem contributing to the high incidence of infectious diseases is the remaining gaps in our scientific knowledge about those diseases. The development of vaccines and medicines simply cannot exceed the frontiers of available basic science. But, as one pharmaceutical executive said at a recent meeting on this subject with the President, this is a “golden age” for research and implementation. Important recent advances are being made on malaria, pneumococcus, and AIDS. As I will describe in a few moments, we believe that public policy can provide a critical boost to private research efforts in this area.

Second, because we have new tools for potentially channeling significant internal and external resources toward this effort.

A sheer lack of financial resources relative to the cost of even the most basic investments in health is clearly an even greater obstacle to improving health outcomes in these countries.

- On average, the poorest nations in the world spend just \$15 per person on health care each year – less than it costs to fully vaccinate a single child for polio, diphtheria, pertussis, measles, tetanus, hepatitis B, TB, yellow fever, and rubella. In the United States, we spend thousands of dollars per person on health care each year.
- In the poorest developing countries, there are only 14 doctors and 26 nurses on average for every 100,000 patients, compared to 245 doctors and 878 nurses in the United States. And 800 million people live on less than \$1 a day. The harsh reality is that the cost of caring for patients with AIDS the way we do in the United States far exceeds the per capita income of most developing countries.

We cannot hope to eliminate the relative gap in countries’ economic resources. But in the Heavily Indebted Poor Countries Initiative we do have a tool for increasing the resources they have available – and ensuring that they are channeled to core human development priorities such as basic health.

The HIPC Initiative, created in 1996 and further enhanced last year at the Cologne Summit, has already helped some of the poorest nations in the world free up precious resources for human development that would otherwise have been spent on servicing debt. Fully funded and implemented, the enhanced HIPC has the potential to be an even more powerful tool for helping countries devote more resources to combating infectious disease.

Third, we have greater understanding of the importance of – and pre-requisites for – effective delivery of vaccines and treatments.

Clearly, it does no good to ship vaccines and medicines to the ports of poor nations if they do not end up in the throats or arms of the people who need them. Just as clearly, it does little good to administer vaccines and medicines to people who do not receive basic tools for maintaining health, such as nutritional interventions like vitamin A and iron, or preventing disease, such as bed nets for malaria, and ~~condoms and sex~~ education ^{to prevent the spread of} for HIV/AIDS.

These have often been important obstacles to international efforts to combat these kinds of diseases in the past. However, the tight linkages between different aspect of health care are now well understood in the development community and are being successfully put into practice. As I will note in a few moments, this is reflected in both the President's Millennium Initiative and plans now being developed by the World Bank, which focus on shifting significant resources to improving the delivery of basic health services including vaccines and medicines.

We also understand better that this is not a problem of money alone – but also competence and enduring commitment. Specifically, developing country governments need to commit themselves to specific targets for improving health care delivery and health outcomes. And donor countries, international organizations, and non-government entities in developing nations need to cooperate to find solutions that will work best for the country in question. And applying these principles is yielding concrete results. For example:

- In Uganda and Thailand, recent innovative programs supported by the international community have begun to reverse HIV infection rates of high-risk groups. And in Senegal, an early investment in prevention programs has helped to keep HIV infection rates low.
- In Bangladesh, which can spend only \$4 per person per year on any health, the World Bank, USAID, and other donors have supported the development of networks of non-physician personnel fanning out to thousands of villages and urban slums, which have helped to reduce the infant mortality rate from 132 to 75 between 1980 and 1997.

III. The President's Millennium Vaccine Initiative

The President's Millennium Vaccine Initiative, outlined in his State of the Union address, draws on both of these realities: the scale and urgency of the problem, and the greater scope that we have today for launching an effective global response.

In these efforts, we are building on the support of the private sector, including pharmaceutical companies that can provide the research and development that is so necessary to developing the right vaccines; we are also drawing on the commitment of the non-profit sector, including organizations like the Gates Foundation that has contributed so generously to the fight against disease; and we are utilizing the expertise of government so that it can act as a catalyst to ensure that these efforts are expanded on an international scale.

The President's initiative has four basic components.

First, mobilizing additional international resources to help the poorest countries purchase existing vaccines for their children.

While important progress is being made, many poor countries often cannot afford to buy vaccines.

To help address this problem:

The President's FY2001 budget proposes a \$50 million contribution to the Global Alliance for Vaccines and Immunization (GAVI) to purchase vaccines for children. This contribution should help catalyze significant contributions from other countries and foundations. It will also add critical credibility to the international community's commitment to provide a market for new vaccines, including vaccines for AIDS, when they are developed. Further, the President has helped to catalyze commitments from the pharmaceutical industry to donate hundreds of millions of dollars worth of vaccines.

Second, intensifying the search for more effective ways of treating and preventing diseases that widely afflict developing countries especially HIV/AIDs, malaria and tuberculosis..

The President's FY2001 budget for the National Institutes of Health includes a significant increase in research critical to creating vaccines for deadly diseases that afflict primarily developing countries. Funding for AIDs vaccine research will increase substantially in FY 2001 and will have more than doubled since FY 1997.

The President has also proposed an additional \$100 million for HIV prevention and AIDS treatment in Africa and Asia. We can make crucial headway against HIV and AIDS by providing clear information on prevention strategies, ~~supplying condoms~~, and treating sexually transmitted diseases. We are calling on other countries to join us in committing money for these purposes.

Third, harnessing the scientific and technological skills of the private sector in the development of new vaccines and medicines for infectious diseases.

It is widely recognized that the incentive for pharmaceutical companies to develop vaccines that disproportionately affect poor countries is significantly diminished by the lack of purchasing power in these countries. Indeed, the WHO estimates that only perhaps 10 percent of the \$50-60 billion spent worldwide each year on health research is directed towards diseases that afflict 90 percent of the world's population.

To start to address this problem:

- The President is proposing a new tax credit for sales of vaccines against malaria, tuberculosis, HIV/AIDS, or any infectious disease that causes over one million deaths annually worldwide. Under the proposal, the seller of a qualified vaccine could claim a credit equal to 100 percent of the amount paid by a qualifying nonprofit organization (such as UNICEF) that received a credit allocation from the U.S. Agency for International

Development (AID). The tax credit would match the purchaser's expenditures dollar-for-dollar, thereby doubling its purchasing power. For 2002 through 2020, AID could designate up to \$1 billion of vaccine sales as eligible for the credit. This credit would provide a specific and credible commitment to purchase vaccines for the targeted diseases once they become available. The President is calling on other governments to make similar purchase commitments, so that we can ensure a future market for these critically needed vaccines.

- In addition, Treasury and other Administration agencies have recently conferred with others on this issue. And as a result, we now also support a tax incentive that would be applied at a developmental stage - a tax credit for qualified clinical testing expenses for certain vaccines, similar to the existing orphan drug tax credit. The credit would be for 30% of the expenses for human clinical testing of vaccines for the diseases targeted by the President's initiative. This credit will provide an additional incentive for drug manufacturers to undertake research on new vaccines and accelerate their development.

Fourth, shifting existing international resources toward building infrastructure in poor countries that can deliver vaccines and medicines and provide essential basic health services.

President Clinton has called on the multilateral development banks to shift an additional \$400 million to \$900 million annually of concessional resources into basic health care. Of course, an essential element of such care is prevention and treatment of infectious diseases, including AIDS. These banks are the right institutions for investing in health infrastructure and health care:

- First, because these activities fall clearly within the poverty reduction and development mandate of the banks, and no other institutions can bring to bear the funding and policy dialogue on the scale needed for the task.
- And second, because one crucial part of the problem is that there is not a visible market for new treatments and vaccines in many of the countries worst affected. And the World Bank and other institutions can do much to create a market, through its lending programs and the policies they support.

As I noted earlier, the Administration is also using the enhanced HIPC debt initiative to support our efforts on infectious diseases. The HIPC countries will be developing Poverty Reduction Strategy Papers (PRSPs), in a participatory process with civil society and donors, to establish comprehensive plans with monitorable targets. We have already requested that our Embassies and USAID missions in these countries stress the use of debt-reduction savings for bolstering basic education and health, including the fight against infectious diseases. We expect that all PRSPs that are prepared by HIPC candidates will discuss the adequacy of budget resources and policy reforms devoted to basic health care.

The early evidence from HIPC beneficiaries is encouraging. Last year, the Ugandan government saved \$45 million in debt service under the original HIPC program. Its expenditures on health and education increased by \$55 million, including a major effort to combat the HIV/AIDS epidemic. Immunization rates for children in Uganda are expected to increase from 55 percent in

1996 to 60 percent in 2002. One of the key priorities for health spending in the future, which would be facilitated by enhanced HIPC debt relief, is to extend HIV/AIDS education outreach, particularly to rural communities.

These measures do not require additional budget commitments. However, our influence within the multilateral development banks and on HIPC depends on our ability to meet our existing commitments. I would note here that for FY2001 we are requesting a total of \$1.6 billion for Treasury international programs, of which by far the largest share is taken up by commitments to the MDBs – some of them required to clear arrears – and appropriations to enable us to play our part in funding HIPC. It will be very important to the overall success of this Initiative that these requests are passed.

IV. Concluding Remarks

Mr. Chairman, the sheer magnitude and complexity of the challenge of combating infectious diseases, and their resistance to the efforts of the past, have a tendency to overwhelm hope with a sense of futility. Around the world, infectious diseases – including AIDS – are killing millions of children and weakening and killing tens of millions of prime-age adults. The devastating human and economic consequences are clear.

However, in Uganda, Thailand, Senegal and elsewhere. We have now seen compelling examples of concrete progress. And we have seen in the past well-coordinated global efforts can have an enormous impact. One need only consider the eradication of smallpox; the nearly complete campaign against polio – and the remarkable global effort to combat river blindness (onchocerciasis), which has halted the transmission of that disease has been halted in eleven African countries and prevented 185,000 who were already infected from going blind.

As I have said, we believe that we now have a historic opportunity to make headway against the other killer diseases that today exact such a toll on the developing economies. What is crucial is that we act not to catalyze a broad international effort to address the problem at its root. We look forward to working with the Congress to try to mobilize the necessary resources and shape the incentives and strategies that can contribute to enduring solutions. Thank you. I would now welcome any questions that you might have.



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MESSAGE:

Tim Geithner asked me to pass the attached to you.

Since this meeting, an informal discussion with the Bank suggests that the IDA base is higher, and that they are considering a more ambitious target.



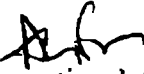
DEPARTMENT OF THE TREASURY
WASHINGTON, D.C.

INFORMATION

UNDER SECRETARY

June 20, 2000

MEMORANDUM FOR SECRETARY SUMMERS

FROM: Timothy F. Geithner 
Under Secretary (International Affairs)

SUBJECT: Global Vaccine Initiative

Here are a few key points from the Global Alliance for Vaccines and Immunization (GAVI) Symposium in Oslo, Norway on June 13. Steve Landry from AID, who sits on the working group of the GAVI Board, is the main U.S. participant in this endeavor and attended the preceding meeting of the GAVI Board. I was asked to make a presentation on financing. The principals around the table included the heads of WHO and UNICEF, Chris Lovelace from the World Bank, reps from the Gates and Rockefeller Foundations, and the Development Ministers of the Netherlands, Sweden, and Norway. The Prime Minister of Norway chaired part of the session.

1. So far GAVI has not made much progress in raising official funds or private money, though they have a relatively optimistic view of the prospects. As far as I can tell, only Norway has pledged specific numbers (something like \$125 million over five years). Other Nordics are likely to follow. Canada seems on the verge of a commitment. No other G-7 country has committed, and Japan and France at least seem to have definitively decided against. Gates seems to be the only private player at the moment.

In this context, it is worth noting that the Senate Foreign Ops bill funds our \$50 million request, but the House bill is likely to come out lower at \$38 million, with Flickner expressing some willingness to go higher in conference or in the end game.

2. They are still sorting through a few basic issues relating to how they allocate resources across the three objectives of providing resources for the provision of existing vaccines, strengthening the delivery infrastructure, and R&D for future vaccines. They do not yet seem to have a crisp, developed view of how the vaccines they purchase end up in the arms or mouths of real people. And they do not seem to have figured out how all their efforts should relate to or best compliment those of the other key players including the Bank.

That said, they have the right people at the table to figure out these things. They're still relatively new. And they seem to have achieved a lot just in creating a forum that brings together the key elements of a successful integrated approach.

3. There was a lot of interest/enthusiasm around the table in the U.S. tax initiatives, and some interest in pursuing similar measures in continental Europe.
4. We still face a complicated, practical problem in the issue of price discrimination, which in the view of some will undermine the potential benefits of the full incentive our tax credit is designed to provide. If the major U.S. players continue to believe that they cannot offer vaccines at substantially lower prices in developing countries without facing political pressure in the United States to sell at the same costs here, we may not get far in creating greater incentives for development. I can't tell if the Pelosi/TRIPS related EO magnifies this risk significantly or not.
5. GAVI is playing around with some interesting ideas for dealing with the myriad problems in delivering results in many poor developing countries, particularly those with weak political commitment and capacity, including the idea of disbursing funds only against demonstrated increases in vaccine coverage.
6. I still think the World Bank has to put together a more substantial effort if any of this is going to work. They have yet to define a target for increased assistance in the infectious disease area generally that is close to the aspirations we and they have set. The huge reduction in life expectancy across much of Africa, the decline in vaccine coverage rates for a range of diseases, and the HIV/AIDs pandemic should have provoked some time ago a much larger redirection of IDA spending priorities than we have seen so far.

Right now they have four overlapping targets: \$150 million additional annually in IDA and \$150 million additional annually in the IBRD for infectious diseases, \$500 million over some undefined period of time for HIV/Aids in Africa, presumably above existing programs, and a \$1 billion initial infectious diseases target that is not anchored with any time frame or relationship to existing base lines.

cc: Sandberg, Talisman, Robertson, Elmendorf, Schuerch, Jaskowiak, Walsh (with attachments)