Joint United Nations Programme on HIV/AIDS
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JOINT UNAIDS/WHO PRESS RELEASE

Preventing Mother-to-Child HIV Transmission – Technical Experts Recommend Use of Antiretroviral Regimens Beyond Pilot Projects

- Experts Say Benefits Outweigh Potential Adverse Effects -

Geneva, 25 October 2000 – Experts have concluded the safety and effectiveness of antiretroviral (ARV) regimens which prevent HIV transmission from mother to child warrant their use beyond pilot projects and research settings.

According to a technical consultation held in Geneva from 11-13 October 2000, the prevention of mother-to-child transmission of HIV – the virus that causes AIDS - should be included in the minimum standard package of care for HIV-positive women and their children. The meeting also recommended that "there is no justification to restrict use of any of these regimens to pilot project or research settings."

"We welcome these new recommendations, particularly those relating to the use of nevirapine", said Dr Awa-Marie Coll-Seck, UNAIDS Director of Policy, Strategy and Research. "It is my sincere hope that more women will now have access to mother-to-child prevention programmes in developing countries".

"A number of available regimens are known to be effective and safe," said Dr Winnie Mpanju-Shumbusho, Director of the HIV/AIDS/STI Initiative of WHO. "The choice should be determined according to local circumstances on the grounds of costs and practicality, particularly as related to the availability and quality of antenatal care."

The safety of preventive treatments including zidovudine alone, zidovudine and lamivudine, and nevirapine, has been studied extensively for both breastfeeding and non-breastfeeding populations worldwide. Information currently available does not suggest any adverse effects on the health of the mother, growth and development of infants, or the health and mortality of infants infected despite prophylaxis.

The most complex regimen includes antepartum and intrapartum zidovudine for the mother and post-natal doses for the infant. The simplest regimen requires a single dose of nevirapine at the onset of labour and a single dose for the newborn. These regimens work by decreasing viral load in the mother and through prophylaxis of the infant during and after exposure to virus.

Previous recommendations from March 2000 had stated that because of possible concerns about the rapid development of nevirapine-resistant virus in women using this intervention, nevirapine should be used within the context of pilot and research projects only.

While resistant virus may develop quickly to antiretroviral drug regimens that do not fully suppress viral replication, such as those including lamivudine and nevirapine, evidence indicates that virus containing drug resistant mutations decreases once the antiretroviral drugs are discontinued. Mutant virus may remain present in an individual in very low levels, which could reduce the effectiveness of future antiretroviral treatment for the mother. However, the meeting concluded that the benefit of decreasing mother-to-child HIV transmission with these antiretroviral drug prophylaxis regimens greatly outweighs any theoretical concerns related to development of drug resistance.

The prevention of mother-to-child transmission involves more than simple provision of antiretroviral drugs. It also requires appropriate counselling and testing services, as well as support for mothers and infants, including counselling on infant feeding options.

There is continued concern that up to 20% of infants born to HIV-positive mothers may acquire HIV through breastfeeding. The meeting concluded that the guidelines issued in 1998 remain valid. An HIV-infected women should receive counselling, which includes information about the risks and benefits of different infant feeding options, and specific guidance in selecting the option most likely to be suitable for her situation. The final decision should be the woman's, and she should be supported in her choice. For HIV-positive women who choose to breastfeed, exclusive breastfeeding is recommended for the first months of life, and should be discontinued when an alternative form of feeding becomes feasible.

Each year, more than 600 000 infants become infected by HIV/AIDS, mainly in developing countries. Since the beginning of the HIV epidemic, an estimated 5.1 million children worldwide have been infected with HIV. Mother-to-child transmission is responsible for more than 90% of these infections. Two-thirds are believed to occur during pregnancy and delivery, and about one-third through breastfeeding. As the number of women of childbearing age infected by HIV rises, so does the number of infected children.

The WHO Technical Consultation was held on behalf of the UNAIDS/UNICEF/UNFPA/WHO InterAgency Task Team on the Prevention of Mother-to-Child Transmission of HIV. Participants included scientists, managers of national AIDS control programmes, HIV-positive mothers, non-governmental organizations, and United Nations agencies. Participants came from Africa, Asia, Europe, the Caribbean and the Americas.

For more information, please contact Anne Winter, UNAIDS, Geneva, (+41 22) 791.4577, Dominique De Santis, UNAIDS, Geneva, (+41 22) 791.4509, Andrew Shih, UNAIDS, New York, (+1 212) 584.5024, Gregory Hartl, WHO, Geneva (+41 22) 791.4458 or Tim Farley, Department of Reproductive Health and Research, WHO, Geneva (+41 22) 791.3310. You may also visit the UNAIDS Home Page on the Internet for more information about the programme (http://www.unaids.org).

News

San Francisco Examiner
Wednesday Dec 01, 1999

World AIDS Day: Sobering Statistics

By Edith M. Lederer
ASSOCIATED PRESS

UNITED NATIONS — Three of the world's 11 million AIDS orphans told a U.N. symposium on World AIDS Day of their struggle to survive without their parents, and challenged decision-makers to give them hope instead of despair.

"We are tomorrow's world future and our voices are small, so please help us to blow the whistle - and listen to it," said 13-year-old Andrew Jackson Okurut of Uganda, who lost his father to AIDS when he was 5 months old and his mother on Sept. 24.

Hillary Rodham Clinton, who was among the 300 VIPS, experts and policy-makers listening to the AIDS orphans at the symposium on Wednesday, took up their appeal, saying these children of a lost generation must not be lost as well.

"Every one of us has a chance to choose whether we ignore and leave behind the children orphaned by AIDS or whether we put their lives, their hopes and dreams at the forefront of our hearts and efforts," the first lady said.

At the end of the daylong symposium, a "call for action" for children left behind by AIDS was issued by UNAIDS, the U.N. Children's Fund and the U.S. National Black Leadership Commission on AIDS. It called for global efforts to keep AIDS orphans in their families, which remain "their most cherished and valuable safety net."

A report released Wednesday by UNICEF and UNAIDS said the number of AIDS orphans is expected to rise from 11 million to more than 13 million by the end of 2000.

Namibia's Foreign Minister Theo-Ben Gurirab, who is president of the U.N. General Assembly, noted that 95 percent of AIDS orphans are in sub-Saharan Africa, a region afflicted by war and poverty.

"Had they lived in wealthy parts of North America or Europe, their fate would already have been declared a human tragedy," he said.

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human tragedy," he said.

The report called AIDS "the world's most deadly undeclared war" - and Mrs. Clinton said "increasingly children are caught in the cross-fire." By 2010, an estimated 40 million children will be orphaned by AIDS, she noted.

The three youngsters who lost their parents to the killer disease described the pain and difficulty of coping with life alone.

"I have no idea of what my father looked like, what his voice or footsteps sounded like," said Andrew, the young Ugandan, showing the audience a "memory book" his mother helped him make so he wouldn't forget his family.

Another teen-ager, Sang-sue-moon, 14, of Thailand, who lost his mother to AIDS when he was 11 months old and his father two years ago, is now living with an uncle. He wants to continue his education and get a good job.

"My wish - which will be unfulfilled - is to allow my parents to see me on my graduation day," he said.

He had some advice for other AIDS orphans: Don't go and break the law and do things that would be harmful to yourself and other people. Fight on. Have confidence in yourself.

Paris Lane, 17, told the audience how his life fell apart after his mother died of the virus in 1995 - he dropped out of school in New York City and experimented with drugs.

"One night ... I began to cry. I realized that I was proving everyone right and the route I was on I would end up in a cell or a casket," he said.

Paris said he decided to do something to make his parents proud "when they look down upon me from heaven." He found a new family and will soon be adopted. He enrolled in high school where he is on the honor roll and plays on the basketball team. And he hopes to go to college and major in criminal justice.

"You know now that there's life for children whose parents have died from AIDS - and I'm living proof," he said.

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REPORT

WORLD AIDS DAY FOCUSES ON CHILDREN

From Tribune News Services
December 2, 1999

UNITED NATIONS -- While AIDS activists handed out condoms on city buses in Bangkok and dropped them from a helicopter in Pretoria, much of the attention of World AIDS Day on Wednesday focused on the children --11 million of whom have lost their parents.

"I have no idea what my father looked like, what his voice or footsteps sounded like," Andrew Jackson Okrut of Uganda told a UN symposium in New York City attended by U.S. First Lady Hillary Rodham Clinton and about 300 other dignitaries and experts.

Also Wednesday, UN officials released a report estimating that 11 million children have been orphaned by the pandemic and it will reach 13 million by the end of next year.

Mrs. Clinton took up their appeal, saying these children of a lost generation must not be lost as well.

Eastern and southern Africa account for over 50 percent of the 33.6 million people infected with HIV

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AIDS Orphans Tell U.N. of Their Plight

By MAGGIE FARLEY, Times Staff Writer

UNITED NATIONS--Andrew Jackson Okurut, a 13-year-old from Uganda, can't remember his father, who died from AIDS complications when Andrew was 5 months old. So before his mother was struck down by the same disease in September, she put together a "memory book" of photos and writing so he wouldn't forget her too.

"She used to be very fat," Andrew said, slowly paging through the book. "Then she got very thin, and even her handwriting changed. I knew she had AIDS, but I didn't think she would die too."

Andrew spoke Wednesday at the United Nations on World AIDS Day to help the world remember some important faces often forgotten in the global crisis: the children left behind when their parents die.

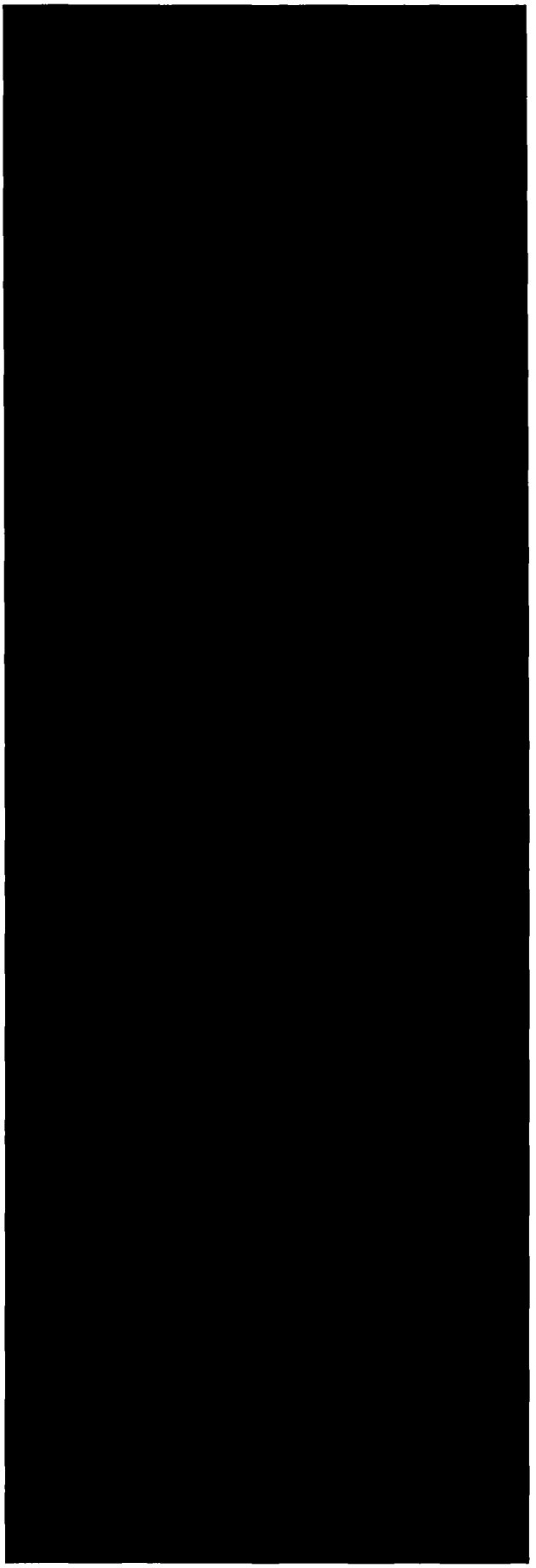
Dressed in a new black suit with a boy-size bow tie, Andrew seemed special as he implored an audience that included First Lady Hillary Rodham Clinton, singer Harry Belafonte and former basketball great Earvin "Magic" Johnson to remember the more than 11 million children who have been orphaned by the pandemic. But his case is all too common: A report by two U.N. agencies shows that 95% of the orphans, like him, live in sub-Saharan Africa.

The disease has unraveled decades of social advances, the report by UNAIDS and UNICEF says. The orphaned children often are thrown from poverty into destitution as grandparents and their communities become overburdened.

Many--especially girls--must drop out of school, and, without parental protection, some are sexually abused or exploited. More than half a million children have been infected with HIV--the virus that causes AIDS--by their mothers at birth or through breast feeding.

Noting that more people have died of AIDS than have been killed in wars this century, Urban Jonsson, UNICEF's regional director in Africa, highlighted important differences for the survivors.

"While war orphans receive gratitude and sympathy from everybody, AIDS orphans receive



little sympathy," he said. "They bear part of the 'fault' or the stigma and receive sometimes only pity, if they are lucky."

The conference ended with a "call to action" urging countries and communities to educate young people to make sound decisions about their relationships and practice safe sex. The U.N. agencies also encouraged special emphasis on education for girls, who tend to be pulled out of school first when money is tight or extra hands are needed at home but who can also have a greater impact on family finances and lifestyle when better educated.

Finally, the agencies asked for help to make medicine more affordable and to speed research on an AIDS vaccine.

At the conference, Khomsan Sang-sue-moon, a 14-year-old orphan from Thailand, represented the next wave of AIDS orphans expected in Asia. And Paris Lane, a 17-year-old from New York who also lost both parents to AIDS, reminded people that it is not only a problem of the developing world.

His father, who was in and out of jail throughout Paris' childhood, died six years ago. His mother, a drug user, went into rehabilitation so that she could care for her children but died five months ago.

"That's when I lost all faith in everything," Paris said. "I couldn't understand why God would take away someone who was trying to make right from wrong." His message to others in his situation: "Your life is not over when your parents have AIDS. You have to go on."

Andrew the Ugandan knows he has to go on, but it is difficult. He loves school, he said, and wants to obey his mother's wishes for him to study hard. "Since your father left you young, I have suffered with you so much," she wrote in his memory book underneath a picture of herself laughing with her family. "That's why I want you to read very hard if the chance is there."

But he thinks there is no chance. "It is time for me to work now," he said. "There is no one to pay schooling fees for me."

A representative of UNAIDS, Jim Carmichael, confirmed that there are no special plans to pay Andrew's tuition, which, including books and uniforms, is about $150 per year. "He's literally one of a million cases in Uganda," Carmichael said.

To help, contact Carmichael at UNAIDS: jcarmichael@unicef.org, or call (212) 824-6644.

* * *

* NIGHT OF MEMORIES: Angelenos who have lost loved ones to AIDS gathered for an interfaith service. B1

December 1, 1999

United Nations Marks World AIDS Day

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Filed at 12:15 p.m. EDT

By The Associated Press

UNITED NATIONS (AP) -- The United Nations marked World AIDS Day today with a sobering new set of statistics of the toll the virus has taken on children, 11 million of whom have been orphaned by the pandemic.

In a report, UNICEF and UNAIDS say the number of AIDS orphans is expected to rise to more than 13 million by the end of 2000. Already, 95 percent of those orphans are in sub-Saharan Africa.

``The skyrocketing number of AIDS orphans is -- in addition to the loss of life caused by AIDS -- putting a severe strain on traditional support systems in Africa,'' said UNICEF executive director Carol Bellamy. ``The grandparents who in so many cases are taking care of their orphaned grandchildren have limited resources.''

Addressing a U.S. symposium today first lady Hillary Rodham Clinton urged that the orphans not be forgotten after World AIDS Day is over.

``This is a potential that can be unlocked and nurtured or wasted and ignored, depending on what we in this room and others in position of decision- making around the world choose to do,'' she said.

Eastern and southern Africa is home to 4.8 percent of the world's population yet has over 50 percent of the world's HIV-positive people and accounts for 60 percent of all lives claimed by AIDS, according to U.N. data.

In developing countries, children who have lost one or both parents to AIDS are at a higher risk of malnutrition, illness, abuse and sexual exploitation than children orphaned by other causes, the report says.

Additionally, AIDS orphans in many parts of the world face stigma

and discrimination, leaving them socially isolated and often deprived of basic services such as education, the report found.

Dr. Peter Piot, executive director of UNAIDS, who released the report at a press conference today, said an effective vaccine for the virus was at least five years off ``and I'm afraid much longer.''

``Things will get worse before they get better,'' he said.

The U.N. report said that before AIDS approximately 2 percent of children in the developing world were orphaned, in 1997 the rates in some countries had risen to as high as 11 percent.

The report recommended that affected countries make a concerted effort to provide children with quality education so they can make sound decisions about their own relationships and sexuality and how to resist unsafe sex.

Ahead of World AIDS Day, Secretary-General Kofi Annan called for an end to the ``conspiracy of silence'' that surrounds AIDS, which he said contributes to widespread ignorance about the virus and discrimination toward its victims.

``And we must continue to battle the culture of shame,'' he said. ``Hiding AIDS behind a curtain of stigma helps to spread it. Speaking out about AIDS helps slow it down.''

In Johannesburg, South Africa, President Thabo Mbeki said today that South Africans should abstain from early sexual activity, be faithful to their partners and use condoms.

Later in the day, condoms were to be dropped from a helicopter in the center of Pretoria, and an orphanage that cares for HIV positive babies was to hold a memorial service for dead orphans. Politicians also made door to door calls to raise awareness of the disease.

Mbeki's support of condoms contrasts starkly with leaders elsewhere in Africa. Kenyan President Daniel Arap Moi said last week that the government could not endorse condom use because it would be morally wrong and give youth a license to practice casual sex.

The launch comes a day after 400 AIDS activists demonstrated in front of the White House to protest U.S. policies they say prevent poor countries from getting drugs needed to fight the disease. Ten were arrested.

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Orphans Are Focus Of World AIDS Day

By Andrew Selsky
Associated Press
Thursday, December 2, 1999; Page A35

JOHANNESBURG, Dec. 1 — While AIDS activists handed out condoms in city buses in Bangkok and dropped them from a helicopter in Pretoria, much of the attention of World AIDS Day focused on the children--11 million of whom have lost their parents.

"I have no idea of what my father looked like, what his voice or footsteps sounded like," Andrew Jackson Okrut of Uganda said at a U.N. symposium in New York, which was attended by first lady Hillary Rodham Clinton and about 300 other dignitaries and experts.

In a report released today, U.N. officials estimated that 11 million children have been orphaned by the pandemic, and that the number will reach 13 million by the end of next year.

It is almost unfathomable to think the suffering could increase in sub-Saharan Africa, home to 95 percent of AIDS orphans.

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Eastern and southern Africa account for only 4.8 percent of the world's population, yet account for more than 50 percent of the 33.6 million people infected with HIV, the virus that causes AIDS. The regions account for 60 percent of AIDS-related deaths, U.N. data shows.

Developed countries have largely ignored the orphans' plight. "Had they lived in wealthy parts of North America or Europe, their fate would already have been declared a human tragedy," said Namibia's Foreign Minister Theo-Ben Gurirab, who is president of the U.N. General Assembly.

In Nigeria, HIV is estimated to infect a new person every minute. By 2003, an estimated 4.9 million Nigerians aged 15-49 are expected to be infected with the virus, compared to about 2.6 million today, according to a Nigerian report released today.

With an estimated 1,700 Zimbabweans dying of AIDS-related sicknesses every week, President Robert Mugabe has pushed a 4 percent "AIDS levy" on personal income and corporate taxes that takes effect Jan. 1.

"This is a disaster devastating our society," Mugabe said. "We have to assist the many orphans who have been left behind."

Dr. Luc Montagnier, the French co-discoverer of the HIV virus, warned

Dr. Luc Montagnier, the French co-discoverer of the HIV virus, warned in Paris that an effective AIDS vaccine could be 30 years away unless governments encourage wider research.

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The Executive Director

Reference: CPP/MGB/rg

Ms Sandra Thurman
Director
Office of National AIDS Policy
Washington D.C.
Fax: 1 202 456 2439

22 December 1999

Dear Sandy,

I am writing to convey my sincere gratitude to you and your colleagues for your unstinting support in our efforts towards estabishment of the International Partnership against AIDS in Africa. The effective organization of the Washington meeting in November and your valuable contributions during the New York meeting convened by the Secretary-General earlier this month, are most appreciated.

By now you will have received the draft report of the proceedings of the New York meeting. We look forward to receiving any comments you may have in this regard. I believe that this meeting was an important milestone for the global response and provides an excellent foundation for our shared endeavour to combat the epidemic in the coming months and years.

In closing, I should also like to thank you for coponsoring the World AIDS Day event on 1 December.

With best wishes to you and your family for the New Year.

Yours sincerely,

Peter

Peter Piot

cc: Permanent Mission of the USA to the United Nations in Geneva

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MEDIA ADVISORY

REPORT EMBARGOED UNTIL
NOVEMBER 23, 9 A.M. EST

CONTACT: Andrew Shih
(212) 584-5024

** MEDIA ADVISORY – TELEPHONE MEDIA BRIEFING **

NEW WORLD AIDS DAY REPORT TRACKING GLOBAL HIV/AIDS EPIDEMIC TO BE RELEASED BY UNAIDS & WHO

-- Epidemic Surges Among African Women --
-- Former Soviet Union Sees Steep HIV Increases --

Telephone Briefing, Tuesday, November 23, 11 A.M. EST

WHAT: Telephone press briefing to review comprehensive new UNAIDS report on the global epidemic: *AIDS Epidemic Update –1999*
Participants will discuss:

- New 1999 statistics on HIV/AIDS worldwide
- The growing impact of HIV on women in Africa
- The rapid spread of HIV in the nations of the former Soviet Union
- Reasons for hope and concern in Asia

WHO: Speakers include:
- Peter Piot, Executive Director, UNAIDS
- Rene Loewenson, Director, Training and Research Support Center, Zimbabwe

WHEN: **Tuesday, November 23, 1999**
11: 00 a.m. EST

To register for the conference call, please call Andrew Shih at (212) 584-5024 or Mark Aurigemma at (212) 584-5017

Note: Information from the UNAIDS Report is embargoed until November 23 at 9:00 a.m. EST

B-ROLL: UNAIDS footage of AIDS in the developing world available

ORPHANS REPORT: *UNAIDS and UNICEF will also release a separate report focusing on AIDS orphans on December 1, 1999, as part of the World AIDS Day Observance at United Nations Headquarters. UNAIDS experts will also be available for comment on that date.*

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CONTACT: Andrew Shih
(212) 584-5024

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UNAIDS Events to Commemorate World AIDS Day

November 23:

- **Telephone Press Conference to Release New UNAIDS Global Epidemic Report**

December 1:

- **Press Conference at the United Nations to Release New AIDS Orphan Study**
- **U.N. to Host Major International Symposium on AIDS Orphan Crisis**

NOV. 23: 11 a.m. EST — **Telephone Press Conference** - UNAIDS and the World Health Organization (WHO) will release ***AIDS Epidemic Update: December 1999,*** a new report on the global AIDS epidemic. A telephone press conference will be held on **Tuesday, November 23rd, 11:00 a.m. EST** (Note: The *AIDS Update* report is embargoed until Tuesday, November 23, 9:00 a.m. EST)

To register for the call, please contact Andrew Shih at (212) 584-5024

DEC. 1: 9:30 a.m. EST — **UN Press Conference to release a new UNAIDS/UNICEF joint report on the AIDS orphan crisis.** Report will include comprehensive information on the global orphan crisis, including the social and economic consequences of the large scale breakdown of family units due to HIV/AIDS.

Press conference Wednesday, December 1st, 9:30 a.m. at the United Nations Press Room 226 will include **UNAIDS Executive Director Dr. Peter Piot, UNICEF Regional Representative for East and Southern Africa Urban Johnsson,** and **UNICEF Goodwill Ambassador Harry Belafonte** (Note: The AIDS Orphans report is embargoed until Wednesday, December 1 at 9:30 a.m. EST)

DEC. 1 10 a.m.–6 p.m. EST — ***The Children Left Behind*, a day-long United Nations symposium on AIDS orphans**. Program speakers will include **UN Secretary-General Kofi Annan, UNAIDS Executive Director Dr. Peter Piot, U.S. First Lady Hillary Rodham Clinton**, and many others.

B-ROLL: Footage of AIDS in the developing world available.

UN ACCESS: *UN accreditation required to attend the December 1 events. Please note that journalists seeking accreditation must be photographed in advance at UNITAR Building, Pass & Identification Unit, 45th Street and First Avenue. Fax requests for accreditation to UN Accreditation Office, fax: (212) 963-4642. Confirm receipt by calling (212) 963-6934/7164.*

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LONDON, 23 November 1999

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AIDS NOT LOSING MOMENTUM HIV HAS INFECTED 50 MILLION, KILLED 16 MILLION, SINCE EPIDEMIC BEGAN

- In Africa HIV-positive women now outnumber infected men by 2 million -
- Countries of former Soviet Union see infection rates double in just two years -
- Strong prevention efforts, care programmes, find success in certain regions -

Since the beginning of the AIDS epidemic, 50 million individuals worldwide have been infected with HIV, of whom more than 33 million are still alive and over 16 million have died, according to a report issued today by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO). The report, entitled AIDS Epidemic Update - December 1999, was released in advance of World AIDS Day, commemorated each year on 1 December. It shows that AIDS deaths reached a record 2.6 million this year and that new HIV infections continued unabated, with an estimated 5.6 million adults and children worldwide becoming infected in 1999.

"With an epidemic of this scale, every new infection adds to the ripple effect, impacting families, communities, households and increasingly, businesses and economies. AIDS has emerged as the single greatest threat to development in many countries of the world", said Peter Piot, Executive Director of UNAIDS.

"We have to ensure that health systems are capable of handling the increasing numbers of HIV-positive people who develop AIDS. De-stigmatization, access to health care and

low-cost measures such as the treatment of opportunistic infections become important. WHO is working with Ministries of Health across the world to ensure that adequate facilities and resources are made available to the millions of people likely to develop AIDS in the coming years", said Gro Harlem Brundtland, Director-General of WHO.

AIDS develops in an HIV-positive person after years of infection, as HIV steadily weakens the body's immune system and increases its vulnerability to pneumonia, tuberculosis, diarrhoea, tumours and other illnesses. With the number of people infected with HIV continuing to rise, the number of people falling sick and dying of AIDS will multiply.

HIV-positive women now outnumber HIV-positive men in Africa

In sub-Saharan Africa - still the global epicentre of the epidemic - new evidence shows clearly for the first time that women infected with HIV outnumber men. "Ten years ago, it was hard to make people listen when we were saying AIDS wasn't just a man's disease", said Dr Piot. "Today, we see the evidence of the terrible burden women now carry in Africa's epidemic."

- Fifty-five percent of infected adults in sub-Saharan Africa are women, which means more than six HIV-positive women for every five HIV-positive men. UNAIDS and WHO estimate that 12.2 million African women and 10.1 million African men aged 15-49 are living with HIV at the end of 1999.
- Studies in several countries have found that African girls aged 15-19 are five to six times more likely to be HIV-positive than boys the same age. Ease of male-to-female sexual transmission, and sex with older, infected men appear to be contributing factors to girls' greater vulnerability to HIV.

According to the United Nations Development Programme (UNDP), a number of African nations suffered downward changes this year in the Human Development Index, a ranking based on levels of health, wealth and education. Almost all of the major changes in rank could be attributed to declining life expectancy as a result of AIDS.

- Life expectancy at birth in southern Africa, which climbed from 44 in the early 1950s to 59 in the early 1990s, is expected to drop back to 45 sometime between 2005 and 2010.
- UNDP estimates that fewer than 50% of South Africans currently alive can expect to reach the age of 60,

compared with an average of 70% for all developing countries and 90% for industrialized countries.
- According to a survey of commercial farms in Kenya, illness and death have already replaced old-age retirement as the leading reason why employees leave service.

Yet there are reasons for optimism even in this most devastated region: a number of African countries have demonstrated a much stronger commitment to fighting AIDS than ever before. "I believe we are now at a turning point in the 20-year history of the AIDS epidemic in Africa. Everywhere I go, I hear the top African leaders speaking out about AIDS as the major threat to the continent's development", said Dr Piot. "This gives me grounds for hope that in the coming years, we will see stronger, more effective responses to AIDS in many more sub-Saharan African nations - responses to complement the strong programmes that already exist."

Injecting drug use in former USSR fuels world's steepest HIV increases

The report further reveals that the world's steepest HIV curve in 1999 was recorded in the newly independent states of the former Soviet Union, where the proportion of the population living with HIV doubled between 1997 and 1999. In the larger region comprising these nations and the remainder of Central and Eastern Europe, the number of HIV-infected rose by more than a third in 1999 alone, to reach an estimated 360 000.

- In the Russian Federation, nearly half of all reported cases of HIV infection since the start of the epidemic were recorded in the first nine months of 1999 alone.
- In Moscow, three times as many cases were reported in the first nine months of 1999 as in all previous years combined. Towns around Moscow had even sharper rises in HIV, with over five times as many infections reported in the first nine months of 1999 as in all previous years combined.
- Preliminary studies suggest that injecting drug use is becoming increasingly common among unemployed young people in many of the industrial cities of the Russian Federation and Ukraine. HIV is not limited to Russia's major metropolitan regions; in the Siberian city of Irkutsk, nearly 1300 infections have been reported, most of them in 1999.
- Injecting drug use appears to be well established even among Russian schoolchildren. An outreach programme for drug injectors in St Petersburg reported that the caseload for clients under age 14 increased 20-fold between 1997 and the first quarter of 1999.

Strong prevention efforts, care programmes, find success in certain regions

In the report, UNAIDS and WHO also point to some countries and regions which are managing to keep down the number of new infections or improve the well-being of those already infected. For example, evidence continues to mount that the strong prevention programmes of Thailand and the Philippines have had sustained success in reducing HIV risk and lowering or stabilizing HIV rates.

- In India, major efforts to improve the tracking of the epidemic more than tripled the number of HIV surveillance sites in 1998. Estimates now place total HIV infections in the country at around 4 million-more than in any other country, but fewer than projected on the basis of earlier surveillance estimates. Consequently, the regional estimate of HIV infections in Asia has been revised downward by 800 000.
- The AIDS Society in the Indian state of Tamil Nadu has enlisted the support of an advertising agency to encourage safer sexual behaviour, airing television advertisements during major sporting events. Casual sex among factory workers in the state reportedly fell by half between 1996 and 1998, while condom use with casual partners rose from 17% to 50%.
- Some Latin American countries have joined the ranks of those providing antiretroviral drugs to people infected with HIV. Brazil, for example, spent an estimated US $300 million to treat some 75 000 people in 1999. Brazilian health officials said the considerable expense was offset in part by savings in hospitalization and medical care; the country averted an estimated US $136 million in such costs between 1997 and 1998.

"Providing care to growing numbers of HIV-positive people when health systems are already overburdened is no straightforward task. But these examples show how countries around the world can make a difference in fighting the epidemic through both prevention and care. WHO has shown how relatively inexpensive modifications and additions to health-care systems can bring major benefits to people with HIV. Everyone, and every country, can learn and benefit from these examples", said Dr Brundtland.

No room for complacency

Releasing the report, UNAIDS Executive Director Peter Piot also urged industrialized nations to put more emphasis on HIV prevention efforts. "There is no room for complacency in any

discussion of this epidemic. The threat of HIV has not diminished in any country. We have even seen evidence from North America and Western Europe suggesting that availability of life-prolonging therapies may be contributing to an erosion of safer sexual behaviour. This is tragic", Dr Piot said.

"While antiretrovirals have brought hope to many people with HIV who are fortunate enough to have access to them, they are not a panacea, and they are not available in most of the world", Dr Piot said. "The key to fighting AIDS is preventing new infections. For this more resources are needed - to implement the prevention strategies we have today, and to develop new and better tools, such as microbicides and a vaccine."

Dr Brundtland added, "While prevention is the most promising strategy for managing the AIDS epidemic in the long term, we cannot lose sight of the fact that millions of people are infected today. For them, we must do a much better job of increasing access to health care and support, including inexpensive antibiotics that can add many months to the lives of people already sick with AIDS, to palliative therapies that can help increase comfort and reduce suffering, and to psychological and social support for patients and their families. WHO and UNAIDS will continue to engage the pharmaceutical industry to make new HIV-related drugs available at affordable prices for those in need. "

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Back to Top

^AM-UN-AIDS Report,0633<
^Number of worldwide AIDS cases at 30 million and growing<
^By SUE LEEMAN=
^Associated Press Writer=

LONDON (AP) _ Fueled by an increase in the use of injected drugs, the AIDS virus is spreading at an alarming rate, according to a report released Tuesday.

The U.N. Program on HIV/AIDS and the World Health Organization said 33.6 million people, including 1.2 million children, carry HIV, the virus that causes AIDS.

The number of infections worldwide is expected to keep climbing, the agencies warned.

``With an epidemic of this scale, every new infection adds to the ripple effect, impacting families, communities, households and increasingly, businesses and economies,'' said Dr. Peter Piot, executive director of UNAIDS.

But he told reporters in London the world ``is at a turning point'' in responding to the epidemic. ``Never before have so many heads of state spoken out ... (and) more investments are being made by the development agencies of the richer countries,'' Piot said.

Last year, 33.4 million people were HIV positive. However, the agencies said this year's increase is even larger than it appears because the 1998 figures in a few heavily populated Latin American and Asian countries were overestimated.

The agencies said that in 1999 alone, 5.6 million people will have become infected with HIV.

This year also will see 2.6 million deaths from AIDS, the highest annual global total since the disease began to take hold in the late 1970s _ despite so-called antiretroviral drugs that staved off AIDS deaths in the richer countries, they said.

Some 2.2 million people died of AIDS last year. And more than 16 million people have now died of the disease, which destroys the body's immune system, since the late 1970s, the agencies said.

But even if prevention programs manage to cut the number of new infections to zero _ which is highly unlikely _ deaths will increase for some years, the report said.

The report said about half of all people who acquire HIV become infected before they turn 25 and typically die before their 35th birthdays.

Ninety-five percent of people with HIV live in the developing world, a proportion that is likely to grow as infection rates continue to rise in countries where poverty, poor health systems and limited resources fuel the spread of the virus, it said.

The report said sub-Saharan Africa continues to be hardest-hit, with close to 70 percent of the global total of those with HIV.

Most will die in the next 10 years, joining the 13.7 million Africans who have already died of AIDS, the report said.

``Fewer than 50 percent of South Africans currently alive are expected to reach the age of 60,'' it added.

The report said HIV is now growing fastest in Eastern Europe and Central Asia, where the number of infected people rose by a third during 1999, to 360,000.

This was mainly due to an increase in the use of infected needles to inject drugs in Russia and Ukraine. More than 2,700 cases of HIV were reported in Moscow in the first nine months of

1999 _ three times as many as all previous years combined.

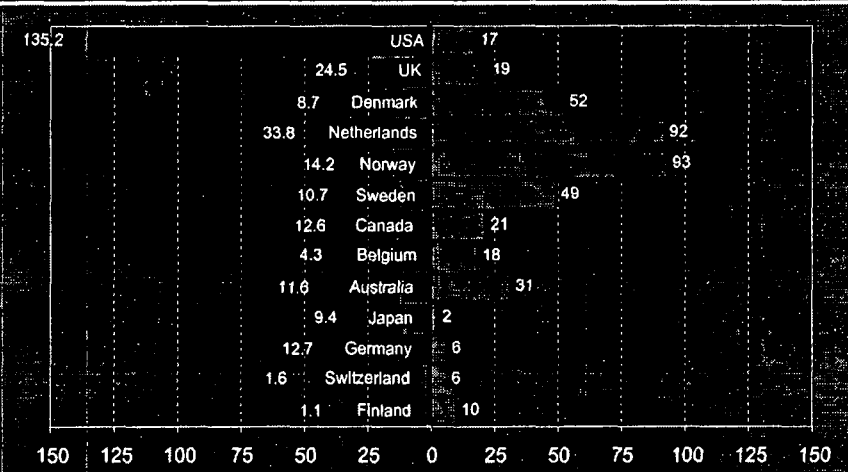
In some Asian countries, such as Thailand and the Philippines, prevention programs seem to have reduced HIV risks, the report said, but evidence from other nations _ such as Vietnam and Bangladesh _ indicates the use of injected drugs is spreading and that condom use is uncommon.

The report added that battling HIV rates is still a challenge in industrialized countries of the West, where there is ``extremely worrying evidence'' that safe sexual practices are declining among gay men.

While AIDS deaths in the United States decreased by 42 percent between 1996 and 1997, the figure dropped by only half that between 1997 and 1998.

APTV-11-23-99 1244CST<

HIV/AIDS official development assistance (ODA): total amount obligated, 1997, in US$ million and obligations reported by ODA agencies per US$ million 1997 GNP



UNAIDS Financing Report, 1999

World Health Organization

Joint United Nations Programme on HIV/AIDS

UNAIDS

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Facsimile

To:	**Office of Ms Sandra Thurman**	Fax:	00 1 202 456 2439
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Joint United Nations Programme on HIV/AIDS

UNAIDS

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UNESCO • WHO • WORLD BANK

The Executive Director

The Honourable William J. Clinton
President
The White House
United States of America

Reference: OED/fm

23 February 2000

Mr President,

On behalf of the Joint United Nations Programme on HIV/AIDS (UNAIDS), I should like to express our profound appreciation for your personal leadership and committment towards combatting the global HIV/AIDS pandemic, especially in Africa. The establishment of the LIFE initiative, the US sponsorship of the Special UN Security Council Session on HIV/AIDS, and most recently your speech to the National Summit on Africa, demonstrate clearly that you and your administration are asserting strong leadership in mobilizing critical resources towards achieving a more effective global response to this crisis.

UNAIDS recently launched the International Partnership Against AIDS in Africa (IPAA) which is mobilizing new partners, including the private sector, to contribute to this effort.

Mr. President, we would also like to acknowledge your leadership in helping African governments remove the burden of unsustainable debt that prevents adequate investment in combatting the epidemic and meeting other priorities. One key resource mobilization strategy that we are exploring under the IPAA is to explicitly link debt relief towards an expanded investment in the HIV/AIDS response. While there are many legitimate claimants on the budgetary savings to African governments that result from debt relief, we are advocating with African governments, bilateral creditors, and the multilateral banks, for a significant proportion of these resources to be spent on preventing and mitigating the impact of HIV/AIDS. Only with a dramatic increase in investment, that could result from linking debt relief to expanding the HIV/AIDS response, can we hope to turn the tide against HIV/AIDS.

We hope that your continued leadership on the HIV/AIDS issue can further our collective efforts to reverse the devastating impact of HIV/AIDS in Africa. I remain at your disposal to assist wherever possible.

Please accept, Mr President, the assurance of my highest consideration.

Peter Piot
Executive Director and
UN Assistant Secretary-General

cc: H.E. Ambassador G. Moose, Permanent Representative of the United States to the United Nations Office in Geneva
Ms Sandra Thurman, Director, Office of National AIDS Policy, The White House

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1.1 AIDS is now the leading killer in Sub-Saharan Africa. The progression of the disease has outpaced all projections. For example, WHO projected in 1991 that in 1999 there would be 9 million infected individuals and nearly 5 million cumulative deaths in Africa; estimates made in 1999 are two to three times higher, with 23.5 million infected individuals, and 13.7 cumulative deaths. In 1998 in Africa, where 200,000 people died as a result of conflict of war, AIDS killed 2.2 million people. Almost all of the major downward changes in rank could be ascribed to declining life expectancy – the direct result of AIDS. Life expectancy at birth in southern Africa, which rose from 44 years in the early 1950s to 59 in the early 1990s, is set to drop to just 45 between 2005 and 2010 because of AIDS.

1.2 New information suggests that between 12 and 13 African women are currently infected for every 10 African men. According to recent studies in several African populations, girls aged 15-19 are around five or six times more likely to be HIV-positive than boys their own age. Clearly, older men – who often coerce girls into sex or buy their favors with gifts -- are the main source of HIV for the teenage girls. Due to high levels of fertility, populations will generally continue to grow, but critical deficits will affect the economically active age groups.

1.3 The full dimensions of the AIDS crisis are now well documented. The need to mount an extraordinary response is inescapable. Current national AIDS activities in Africa must be expanded dramatically and rapidly to make a substantial impact on the course of the epidemic. We know what works. Experience from some countries shows that when governments commit their own political prestige and financial resources, involve civil society fully, respond to the epidemic through prevention and care, and support activities in a range of sectors, and thus attract more external resources, the rate of new infections can be slowed and societies can begin to cope effectively with the HIV epidemic.

The Progress Report on the International Partnership against AIDS in Africa

One year after Annapolis

Executive summary

Africa is the area of the world worst affected by HIV and AIDS. Infection levels are highest, access to care is lowest, and social and economic safety nets that might help families cope with the impact of the epidemic are badly frayed, in part because of the epidemic itself. About 23.3 million Africans south of the Sahara are HIV infected, that is almost 70% of the world's total in a region that is home to just 10% of the world's population.

In the light of this situation, the UNAIDS Cosponsors and the Secretariat, held a meeting in Annapolis, Maryland, USA, on 19-20 January 1999 and adopted a Resolution to Create and Support an International Partnership against AIDS in Africa (IPAA). The Cosponsors agreed the concept of intensification and the main lines of action of the IPAA. They committed themselves to elaborate and implement their own strategies to contribute to the IPAA overall goal: Curtail the spread of HIV, sharply reduce its impact on human suffering, and halt the further reversal of human, social and economic development in Africa.

Many of the IPAA activities that have been undertaken since January 1999, were in the field of advocacy and mobilizing political commitment in order to promote an enabling environment to intensify co-ordinate and focused HIV/AIDS related activities. African governments, regional organizations, bilateral development agencies, private sector and non-governmental organizations met to define goals, principles, relationships and operation mechanisms for the IPAA.

The Cosponsors, acting on the Annapolis resolution, have moved forward to develop their own complementary strategies, are reorienting their programs, and are finding ways to better coordinate plans and technical services.

UNICEF has identified HIV/AIDS as a top priority in Eastern, Southern Africa and West and Central Africa. It has started to massively reorient its programmes in Africa towards five HIV/AIDS areas (advocacy, mother to child transmission, young people, AIDS orphans, and AIDS in the UN workplace); is recruiting a large number of staff to this work and allocating more resources towards HIV/AIDS.

The World Bank launched in September its new strategy to combat the AIDS epidemic in Africa, in partnership with African governments and within the International Partnership against AIDS in Africa. HIV/AIDS is now be at the center of the Bank's development agenda in Africa. The multisectoral AIDS Campaign Team for Africa serves as the region's focal point on AIDS and provides a variety of services. The bank has started to develop an array of new AIDS related projects and impact studies in a number of sectors, including rural development, education and social funds.

UNFPA at the ICPD+5 meeting in early February, emphasized HIV/AIDS as a major part of UNFPA supported reproductive health programs and HIV/AIDS indicators were incorporated among the key targets in the report of the Hague meeting. UNFPA Country Support Team directors in Africa have all been briefed on the Partnership and the need to renew their commitments to prevention and control of HIV/AIDS in collaboration with other partners, especially the HIV/AIDS Theme Groups at country level.

UNDP has recommended new strategic directions and deployment of HIV/AIDS officers in all countries. UNDP Africa has committed itself to aggressively pursue three major objectives: reducing HIV transmission, reducing suffering and mitigating the impact of AIDS by building into the regional and national programs participatory methods enabling beneficiaries planning and implementing their response to AIDS.

WHO has focused its role within the IPAA to ensuring the development of strategies that place emphasis on the health aspects needed to address the spread and the impact of the epidemic, particularly at country level. Priority areas are (a) strengthening of health systems, (b) improvement and promotion of evidence-based prevention and care interventions and (c) strengthening health information systems and surveillance. Interventions have been defined in these areas. WHO's Cabinet has agreed to expand its activities in Africa by providing increased technical support to Africa. The WHO Africa Regional Office has been strengthened and priorities at country level identified through assessment and appraisal of national and district needs.

UNESCO has begun to develop effective strategies for education programmes and ways to convey them to decision makers. It is also studying the effects of HIV/AIDS on the education sector and will seek responses to decrease the spread of HIV within the sector and mitigate its impact, amongst other programmes.

UNDCP has began to integrate HIV/AIDS into its programmes and works with NGOs and other partners on education, counseling, treatment and care.

Representatives of African countries, the Cosponsors of UNAIDS, the OECD Contact Group and the UNAIDS Secretariat met in Washington DC on 17-18 November 1999 and agreed to provide strong coordinated technical and managerial support to the countries striving to intensify their national AIDS programs.

Building on the previous advocacy efforts and consultations, the UN Secretary General brought together in December 1999 for the first time the five constituencies of the Partnership and asked them to plan an unprecedented response commensurate with the scale of HIV/AIDS in Africa. The five constituent partner groups committed themselves to work together under a commonly negotiated framework for action, focusing at country level and in pursuit of locally set priorities. This important meeting also confirmed that African governments were willing and able to assume the leadership role in the response to AIDS in their countries; that partners from the five constituencies were ready to work together at all levels in order to intensify the response against AIDS in the countries. Six countries for country-level intensification of activities were identified for the first half of 2000, others will be proposed for the future.

Entry points, key functions and operation mechanism for the IPAA needed to be clarified. To do so, preparatory activities for shaping the Partnership at country level have been conducted, including four joint country missions to begin the initial work of creating partnerships at country level. National Strategic Plans were analyzed in order to identify entry points for IPAA activities. Generic steps to intensify national responses to HIV/AIDS were developed. Sub regional

consultations bringing together Theme Groups chairs, National AIDS Programme Managers and CPAs were held to reach a better understanding of the Partnership. A mechanism has been established for resource mobilization and development of regional technical capacity.

HIV/AIDS in Africa was the subject of the first United Nations Security Council meeting of the new century. It was the first time that the Security Council, which is tasked to preserving world peace and security, devoted a meeting to a development or health issue. The discussion brought visibility in a new forum. The support for unified action and for the IPAA couldn't have been greater and more explicit.

Opportunities that a year ago still seemed so far away are now coming closer. This is indeed a tide in the affairs of HIV/AIDS and we must seize the occasion. The challenges that confront the members of the Partnership are extra-ordinary and promising. The key priority for the IPAA is to deliver now at country level through truly working together under the leadership of national governments to enhance the national response within nationally negotiated partnership plans. These plans will include a shared and agreed analysis, identification of gaps, priorities, costing and indicators. Working arrangements that define responsibilities and uses mechanisms involving NGOs, CBOs and the private sector for resource transfer and technical resource coordination will be established. The IPAA will make a major effort not only to expanding funding of national AIDS activities from traditional bilateral sources, but will also seek substantial new financial resource flows from international private foundations and from national resources freed up as a result of debt relief under the enriched Highly Indebted Poor Countries (HIPC) programme. Communication within the Partnership and with other key actors in HIV/AIDS and development must be improved to ensure effective programmes and efficient use of resources.

Part one

Developing the Partnership

The context

1.1 AIDS is now the leading killer in Sub-Saharan Africa. The progression of the disease has outpaced all projections. For example, WHO projected in 1991 that in 1999 there would be 9 million infected individuals and nearly 5 million cumulative deaths in Africa; estimates made in 1999 are two to three times higher, with 23.5 million infected individuals, and 13.7 cumulative deaths. In 1998 in Africa, where 200,000 people died as a result of conflict of war, AIDS killed 2.2 million people. Almost all of the major downward changes in rank could be ascribed to declining life expectancy – the direct result of AIDS. Life expectancy at birth in southern Africa, which rose from 44 years in the early 1950s to 59 in the early 1990s, is set to drop to just 45 between 2005 and 2010 because of AIDS.

1.2 New information suggests that between 12 and 13 African women are currently infected for every 10 African men. According to recent studies in several African populations, girls aged 15-19 are around five or six times more likely to be HIV-positive than boys their own age. Clearly, older men – who often coerce girls into sex or buy their favors with gifts -- are the main source of HIV for the teenage girls. Due to high levels of fertility, populations will generally continue to grow, but critical deficits will affect the economically active age groups.

1.3 The full dimensions of the AIDS crisis are now well documented. The need to mount an extraordinary response is inescapable. Current national AIDS activities in Africa must be expanded dramatically and rapidly to make a substantial impact on the course of the epidemic. We know what works. Experience from some countries shows that when governments commit their own political prestige and financial resources, involve civil society fully, respond to the epidemic through prevention and care, and support activities in a range of sectors, and thus attract more external resources, the rate of new infections can be slowed and societies can begin to cope effectively with the HIV epidemic.

1.4 African leaders are demonstrating leadership in fighting the epidemic to an unprecedented extent and the time is ripe for an extraordinary effort to change the face of the epidemic.

What is the Partnership?

1.5 The Partnership is a *coalition* of actors who have chosen to work together to achieve a shared vision, common goals and objectives based on a set of mutually agreed principles, and a set of key milestones.

1.6 The challenge to members of the Partnership is to *scale-up*, significantly, our collective efforts in Africa. Only an urgent mobilization of a wide range of partners can curtail the spread of HIV, sharply reduce its impact on human suffering, and halt the further reversal of human, social and economic development in Africa. The International Partnership (IPAA) is intended to be such a mobilization. It builds on existing efforts, and seeks to enhance, expand and replicate successful actions, and address the political and institutional challenges involved in doing so. It creates no new structures.

1.7 The actors of the Partnership (African Governments; African and international civil society; the United Nations; donors; NGO networks, the private and corporate sector, and foundations) believe that by acting in synergy with others, the impact of individual actions can be dramatically enhanced. At present, impact on the epidemic is compromised by fragmentation; different actors pursue agendas in isolation from others. Actors, including the UN have tended to address HIV/AIDS

as an area for designing and implementing multiple, often small-scale projects, with their own objectives, management, monitoring and evaluation systems. The AIDS epidemic makes painfully visible many of the current shortcomings of development practice. The actors in the Partnership therefore will seek to build on best development practice at every level of the Partnership.

1.8 The value added of the IPAA lies in:

- **A *coordinated response:* nationally negotiated plans will help in identifying gaps and adding to efficiency;**
- **A *scaled-up response* by a better use of existing resources and bringing new resources. Resources are more likely to flow towards well-designed, clearly costed and well-implemented programmes;**
- ***A linked response:* countries will be properly linked to sub-regional, regional and international resources and initiatives and are thus able to benefit from other international and regional investments in addressing the epidemic;**
- ***A response based on best practice*: experience from two decades of the epidemic has generated a considerable body of good practice.**

The Annapolis resolution: Creating the Partnership

1.9 Following numerous discussions and the adoption of relevant resolutions at the OAU Summit of Heads of State and the second Tokyo International Conference on African Development (TICAD II) in 1998, the UNAIDS Secretariat had begun a broad programme of consultations with a view to establishing intensified action in sub-Saharan Africa. The discussions had revealed a growing political commitment to the fight against HIV/AIDS not just among Heads of State in Africa but also among other potential partners. The possibility of establishing an international partnership had therefore been discussed at the 1998 UNAIDS Cosponsor Retreat. Finally, in January 1999, the Cosponsors and the Secretariat agreed on the concept and adopted a resolution to Create and Support the International Partnership against HIV/AIDS in Africa.

1.10 UNAIDS- the Cosponsors and the Secretariat- made firm commitments at Annapolis. They:

- **resolved to work together on an emergency basis to develop and put into practice an "International Partnership against HIV/AIDS in Africa".**
- **urged all parties involved — and especially the primary actors, the African people and their governments — to act on an emergency basis to drastically slow the spread of HIV in Africa.**
- **committed themselves to building rapidly a coalition of all the key actors: African governments; NGOs and other civil society organizations including religious groups; bilateral and multilateral agencies; the private sector; and the UN system organizations.**
- **agreed that a sustainable political and social mobilization on an unprecedented scale would be crucial for mounting an effective response to HIV/AIDS on the ground in Africa.**
- **called upon the UNAIDS Secretariat to assume its responsibility to lead the further development and implementation of the Partnership.**

1.11 The Cosponsors also formulated comprehensive goals and principles. Aims and clear lines of action for 1999 were stated, which serve as our reference to measure the progress in shaping the IPAA one-year after the Annapolis Resolution.

1.12 This report summarizes the development under the International Partnership against AIDS in Africa with reference to the commitments made at the Annapolis meeting in January 1999, while outlining some of the challenges and next steps to further build the Partnership as a key instrument in the response to the HIV epidemic in Africa. Contributions of Cosponsors in developing and implementing their strategies in support of the Partnership are presented in Part five.

Part two

Commitments and achievements in the agreed IPAA main lines of action

2.1 **The Cosponsors agreed at Annapolis that the Partnership will focus on the following main lines of action for 1999:**

- **Mobilizing high-level African political support;**
- **Widening the partnership to other partners;**
- **Cooperating with and supporting African governments as they intensify their action;**
- **Mobilizing extra financial resources;**
- **Strengthening technical resources.**

"Mobilizing high-level African political support by:

- Discussing HIV/AIDS with African heads of state and striving to include AIDS in the central agendas of the Organization of African Unity (OAU), Economic Commission for Africa (ECA), Southern Africa Development Community (SADC), Economic Commission of West African States (ECOWAS), etc.
- Developing and disseminating widely advocacy materials emphasizing the gravity of the AIDS crisis and its catastrophic demographic, social and economic effects.
- Supporting the advocacy efforts of respected African figures from the political, cultural, religious, and sports spheres who seek to persuade African heads of state to commit themselves to attacking the AIDS crisis head-on."

Achievements

THIS MAY ALL BE INTERESTING BUT IS NOT REALLY COSPONSOR MATERIAL (GE)

2.2 The concept of the International Partnership against AIDS in Africa has received strong endorsement by Africa's finance and planning ministers at the annual meeting of the *Economic Commission for Africa* (ECA) in Addis Ababa in May 1999. ECA also agreed to focus the *African Development Forum* this year on the development impact of HIV/AIDS. The Forum to be held in October 2000 will be a major opportunity to increase awareness of decision-makers at the highest levels and challenge African leaders at all levels to act now and on a much larger scale than at present.

2.3 In July 1999, the Council of Ministers of the *Organisation of African Unity* in Algiers approved a resolution endorsing the International Partnership. Three months later, the Executive Director of UNAIDS signed an official Co-operation Agreement with the Organisation for African Unity to foster collaboration and partnership in the response to AIDS in Africa. *African Ministers of Health* at a meeting of the WHO Regional Committee for Africa in Windhoek in August focussed on intensifying national and regional actions against HIV/AIDS.

2.4 A lot of attention continues to be paid to involving African sub-regional economic development and political institutions in HIV/AIDS. These institutions include *African Development Bank (ADB), ECOWAS, SADC, ECCAS, COMESA, and the East African Community*. Official's contacts have been strengthened with these institutions to encourage them in advocacy for political commitment and resource mobilisation for HIV/AIDS. The ECA's five sub-regional offices will

participate actively in the fight against HIV/AIDS because of their comparative advantage for advocacy. ADB is currently developing an HIV/AIDS strategy that will guide its development activities in Africa. SADC has already formulated an HIV/AIDS strategy. In November 1999, SADC ministers of Health met at a meeting to discuss specific technical issues on mother-to-child transmission of HIV and vaccine development. ECOWAS is in the process of establishing a health desk.

2.5 Working closely with several Cosponsors and bilaterals, the UNAIDS Secretariat has developed an advocacy guide which was tested at the *ICASO conference* in *Lusaka* in September. The West Africa News Media Development Centre (WANAD), the PANOS Institute, and UNAIDS also hosted an important workshop for journalists to promote an effective role for the media in advocating for stronger national responses to AIDS in Africa. A two-page leaflet on the IPAA was developed for the Lusaka Conference and a new brochure is being printed. Funds are being channelled to the NGO groups to repackage the information on the IPAA in a way that is accessible and understandable to all NGOs/CBOs and to disseminate information and advocate for the IPA through newsletters, email. The Secretariat has started to communicate regularly on the IPAA to a wide range of partners at all levels and a section for the Partnership has been established in the UNAIDS website.

2.6 The AIDS development crisis was openly discussed in face-to-face contacts with a large number of senior African officials, including many *Heads of State*. Many African leaders have also spoken out strongly about the seriousness of the epidemic. In September 1999 during the launching of the National Strategic Plan to Combat STDs/HIV/AIDS, President Joachim Chissano stated that HIV/AIDS was an emergency for Mozambique and it needed to be faced as the priority among priorities across all sectors. In February 1999 the King of Swaziland during the official opening of Parliament described HIV/AIDS as a "national disaster" and urged the launching of a nation-wide campaign to change attitudes. A National HIV/AIDS Crisis Management Committee has been established in Swaziland. On December 1, 1999 while addressing youth to mark the World AIDS day, President Mugabe declared HIV/AIDS a National Disaster. He revealed that he himself had lost members of his family to AIDS. Heads of State and Presidents of Malawi, Nigeria, and Ghana have declared HIV/AIDS a major concern of government and have established high-powered commissions to handle it. Many other high-level officials made similar public statements. In Nigeria, the President now heads a newly constituted HIV/AIDS Ministerial Action Programme Committee which includes Ministries of Health, Education, Defense, Culture, Youth Development and the Vice President, amongst others.

"Widening the partnership to include African governments and other key constituent groups including national and international NGOs, the business community, and bilateral and multilateral development institutions. As part of this effort, a donors' meeting will be held in the first half of 1999, possibly as early as March, and similar meetings will be organized for major NGOs and business partners."[1]

Achievements

2.7 At a meeting in London in April 1999, co-hosted by the UK Government and UNAIDS, bilateral development agencies pledged to increase their efforts against AIDS in Africa and agreed to actively participate in the further development of the Partnership. The Köln Economic Summit of the G-8 addressed HIV/AIDS during their annual meeting of the Group's Head of State.

2.8 Individuals from the major *non-governmental organisations* pledged to intensify their collaboration with the UN system, local and national governments and among themselves when they

[1] Annapolis, Maryland: 19-20 January 1999- Meeting of the UNAIDS Cosponsoring Agencies and the Secretariat "Resolution to Create and Support the International Partnership against AIDS in Africa", V.2

met in Dakar, Senegal at the end of August 1999 to discuss the Partnership, the concept of local partnerships, and their role in building such partnerships. The NGO community forum in Lusaka in September 1999 devoted a half-day meeting to the Partnership. The same month, a consultation with Christian leaders and development organisations in Southern and Eastern Africa took place in Gaborone. The Secretariat has held discussions on local partnerships with representatives of African organisations.

2.9 The "HIV/AIDS Leadership Meeting" hosted by *Hillary Rodham Clinton* at the White House on September 7 provided an opportunity to discuss AIDS issues with US-based foundations and the private sector. The Bill and Melinda Gates Foundation hosted on 6-7 January 2000 a meeting of foundations and philanthropic organizations, which was co-sponsored by the MacArthur, Rockefeller and Packard Foundations. UNAIDS Secretariat was a part of the planning committee. This foundations' meeting focused upon identifying comparative advantages for private philanthropy in the International Partnership against AIDS in Africa. About 14 US-based organizations and one British trust were represented. The foundations group reaffirmed its commitments to the Partnership and agreed to utilize the discussions in this meeting as a catalyst for further collaborative planning and action.

2.10 The UNAIDS *Programme Co-ordinating Board* of June 1999 strongly endorsed the International Partnership against AIDS in Africa. A month later, the United Nations *Economic and Social Council* passed a resolution fully supporting the International Partnership.

2.11 **The first year's activities in this line of action reached a climax at a meeting summoned by the UN Secretary-General in New York from 6-7 December 1999. The SG called upon participants to plan a response of partnerships and action that is commensurate with the scale of AIDS in Africa. The meeting brought together for the *first time* representatives from the five constituent partner groups. Representatives of governments, African and OECD, heads of UN agencies, the private sector and NGOs fully supported the IPAA and *committed* themselves to work together on an *emergency basis* to put into practice the IPAA by *focusing on countries* and orienting to locally set priorities. The meeting made clear that African Governments are ready, willing and able to assume the *leadership* role in the response to AIDS in their countries.**

2.12 **The event was also a significant step in *the formulation of the framework for action* under the umbrella of the IPAA. Based on previous consultations in the course of 1999, the proposed framework sets out a strategy for working together to address the AIDS epidemic. It suggests a vision, principles and goals for international actions. It proposes priorities, specific outputs as a set of key milestones and further describes the process and mechanisms for the partnership, and the roles and responsibilities of all partners at all levels. The participants gave their *support to the principles and priorities* for the IPAA and the framework was agreed finalized by the UNAIDS Programme Coordinating Board (PCB) meeting in May 2000. Each constituent group defined *a process for concluding the consultations and actions for the next six months*. The five constituencies also agreed that by June 2000, national strategic plans of action would be negotiated and agreed upon in at least six countries with internal and external partners, in the form of national partnership plans. The negotiation and the agreement of national partnerships plans was agreed facilitated by the UNAIDS Secretariat.**

2.13 **Cosponsors and the UNAIDS Secretariat started the new millennium with a truly historical event. The Security Council of the United Nations, chaired by Ambassador Holbrooke held a session on AIDS in Africa. It was the first time that the Security Council, which is tasked to preserve world peace and security, devoted a meeting to a development or health issue. The discussion brought visibility in a new forum. The support for UNAIDS and for the IPAA could not have been greater and more explicit, be it from the UN, African countries and other countries.**

2.14 The SG meeting and the Security Council session were both important milestones in the development of the IPAA and have set out the IPAA agenda for the next months.

"Cooperate with and support African governments as they intensify their action, by:

- planning, refining and implementing intensified programs in at least 10 priority countries, selected by mutually agreed criteria, over the next 12 months;
- mobilizing additional financial resources to support these intensified programs through consultative group meetings and donor round-tables, incremental government financing (possibly linked to debt relief), and reallocation of existing funds already committed to social funds and ongoing projects in the health, education, transport, labor, justice and other sectors;
- Promoting active communication and information sharing among all actors, including African communities and local governments, focusing particularly on examples of successful national and local initiatives;"

Achievements

2.15 In January 1999, UNAIDS *Country Programme Advisers (CPAs)* in Africa gathered in Geneva to define how the CPAs could assist countries understand and define their roles in the Partnership. The CPAs have subsequently been collaborating with countries to advance the concept of the Partnership on advocacy to the local potential members of the Partnership (Burkina Faso, Malawi, Tanzania, Ghana), support to priority interventions (Tanzania, Ghana), and monitoring and evaluation. Financial support to undertake these activities was provided by the countries, partners in countries and the Secretariat. Technical programmes of the Secretariat have been reoriented to assist and support intensified activities in African countries.

2.16 **Substantial preparations have been made to address the "how" question to intensify action in countries. The lessons learnt from the joint *Partnership missions* to Namibia (June), Burkina Faso (June), Ghana (October) and Tanzania (November) have contributed to identify more clearly entry points, key functions and mechanisms of the IPAA. The missions helped:**

- **To reinforce African ownership and to promote *social mobilisation,* from the highest political level to local communities**
- **To stimulate the *building of partnerships* at country level by bringing together people who had not met or worked together before.**
- **To mobilise resources, though they were not intended to be funding missions.**
- **To see the *opportunities* that exist to scale up the response: a) In every country initiatives that work against HIV/AIDS exist, though still on too small a scale; b) There is growing political commitment, at all levels; c) The national strategic planning process is proving to be an important tool to mobilise and engage a wide range of partners for a multisectoral and decentralised response; d) The local partners have committed themselves to strengthen institutional capacities at both central and district level and to finalise national plans.**
- **To identify the *constraint*: a) The lack of a policy and social environment conducive to successful actions against HIV/AIDS; b) The persisting problem of stigma surrounding the disease; c) The lack of absorptive capacity and of appropriate disbursement mechanisms; d) The need for and effective use of technical support in a variety of areas, strategic management in particular; e) The relative weakness of Ministries of Health and National Aids Programmes; f) The weak involvement of sectors outside the health sector; g) Inadequate health delivery structures and systems; h) The under utilisation and involvement of non-governmental organisations and of the private sector.**

Annapolis, Maryland: 19-20 January 1999- Meeting of the UNAIDS Cosponsoring Agencies and the Secretariat "Resolution to Create and Support the International Partnership against AIDS in Africa", V.3

Update prepared for the UN Secretary General Meeting, p...

2.17 Reports on the country missions in Burkina Faso, Namibia, Ghana and Tanzania, including a first draft analysis were distributed to stakeholders. It is important to note that missions are not an end in itself but just one of the tools to get the support for country intensification and organized country-level activities. If we need other missions to give a boost to the IPAA at country level, we will involve a wider range of partners, follow some specific steps and have clear indicators that are consistent with the IPAA framework. More attention will be paid to ensure that follow up activities take place within reasonable time.

2.18 **The realities experienced during the missions helped to develop the key functions, entry points and mechanisms for intensification at country level. Emphasis was placed on intensification plans for the six countries agreed upon during the SG meeting (Burkina Faso, Ethiopia, Ghana, Malawi, Mozambique and Tanzania). Other countries will be identified for intensified action before the end of the year.**

- Intensification at country level means that members of the Partnership will work together under the leadership of national governments to enhance the national response within nationally negotiated partnership plans. The real challenge will be developing a credible national process for addressing HIV/AIDS, which anchors the efforts of all actors within national plans. A second major challenge will be to ensure that local and community level action is facilitated in this process, and that non-traditional partners are encouraged to become involved.

- **An analysis of the National Strategic Plans for AIDS of four of the six IPAA focus countries (Ethiopia, Malawi, Mozambique and Tanzania) was carried out in order to identify entry points for the IPAA actions in country. In countries without a plan, immediate actions will be taken to start the negotiation with partners on national partnership plans (being developed in Ghana and Burkina Faso).**

- **Generic steps for country intensification have been developed and discussed with Theme Group Chairs and CPAs, who are now taking it further with the national governments and interested partners in country. To ensure progress in the formulation, agreement and implementation of Partnership plans, a group of people with a particular knowledge and network in the respective country are currently analyzing the country's priorities and entry points for intensified action. They are also to assist countries to organize support according to the priorities, entry points, and needs identified.**

2.19 **Resource mobilization for the expanded national response to HIV/AIDS is being linked with debt relief (Zambia) and social funds (Tanzania, Ethiopia). Portfolios of the World Bank are being reviewed, linkages between AIDS and Heavily Indebted Poor Countries Initiative (HIPC) and the social funds will be strengthened in the priority countries in particular. As part of this effort, the UNAIDS Secretariat is consulting with the Cosponsors and a variety of partner agencies to assist willing countries put together their own policies and programs for debt relief and poverty alleviation. The Secretariat would serve as an agent of informed advocacy, linking potential debt relief with greater investments in human development through expanded responses to HIV/AIDS.**

2.20 To enhance communication, **country based UN Theme groups on HIV/AIDS, Cosponsors and the Secretariat have organized *sub-regional consultations* on the International Partnership against AIDS in Africa. Meetings covering Southern Africa, Eastern Africa and Western Africa were respectively held in June 1999 in Maputo, in January in Nairobi, in February 2000 in Abidjan. At these meetings, the participants clearly renewed their commitment for the implementation of the International Partnership against AIDS in Africa and provided their input to the framework for action.** After sharing their experiences in the various areas they emphasized the leading role of the African governments in the IPAA. Steps, challenges and constraints in expanding the national response were also identified. They stressed the need for

regional collaboration, Theme Group expansion and for setting-up a co-ordination unit into the main Regional African Bodies to enhance the fight against HIV-AIDS.

2.21 **The Government is in charge of the coordination of the national response to HIV/AIDS. The UN Theme Groups. Theme Groups are one of the mechanisms to facilitate the coordination. They are expanding rapidly beyond the UN system to include bilateral development agencies, representatives of the national response and NGOs.** This is a most welcome development for the IPAA, as robust mechanisms for working together in support of the national response intensification. Efforts have to be made to reach out to and include the private sector as part of the response at country level.

"Overall, mobilizing extra financial resources for intensified AIDS programs at both country and regional levels. Current spending on AIDS in Africa, estimated at about $150 million a year, needs to be doubled to more than $300 million by the end of the year 2000."

THIS IS VERY GENERAL ABOUT RESOURCE MOBILIZATION AND UNFORTUNATELY DOES NOT PROVIDE COUNTRY LEVEL SPECIFICS.

2.22 It is evident that resources are not keeping pace with the demands of the worsening epidemic. Country missions have proven to be an excellent tool to increase co-ordination among the players at national level and to identify avenues for social funds and private contributions. The country intensification plans will also address this issue. Recent signals and pledges from bilateral governments, Cosponsors and the business community as well as African governments indicate that they are in the process of greatly expanding their overall funding for national AIDS programmes in Africa.

2.23 African governments are allocating their own resources in the battle against AIDS. **In Botswana, a nationwide plan for combating AIDS was launched by the President last year, with 80% of the funding coming from within the country. The National AIDS Programme has been reorganized, empowered to facilitate the multisectoral mobilization. The National AIDS council is now chaired by the President himself. In Namibia, the Cabinet has approved a new national AIDS Programme structure, focusing on the decentralization of the response. AIDS is now included in the agenda of the National Planning Commission, which is currently planning the use of country resources for the next decade. In Ghana, the Government has committed itself to mobilize the country on HIV/AIDS in an official communiqué, following a joint country mission of the International Partnership against AIDS in Africa. The Government will mobilize resources within all the important sectors, empower the National AIDS Programme, and reinforce its social mobilization to respond to the AIDS epidemic. In many countries such as Burkina Faso, special funds have been created for HIV/AIDS.**

2.24 The **United States** Vice President Al Gore, presiding over the UN Security Council Session on AIDS announced $150 million in stepped-up US contributions in the worldwide battle against AIDS, particularly in Africa. He also said the US administration was seeking another $100 million from Congress in the 2001 budget to combat the virus abroad by reducing mother-to-child transmission, providing care for AIDS orphans, and increasing prevention programs. Next month's US budget proposals would include $50 million to help fund vaccine research and distribution for a variety of diseases, including AIDS. The new funds, in addition to those pledged earlier, amounted to a budget proposal of $325 million to combat AIDS and other diseases in the developing world.

2.25 **Sweden opened a new office in Harare this year to support a growing number of HIV/AIDS activities in the region. Several other donors indicated an increase in their**

Annapolis, Maryland: 19-20 January 1999- Meeting of the UNAIDS Cosponsoring Agencies and the Secretariat "Resolution to Create and Support the International Partnership against AIDS in Africa", V.4

investments on AIDS in Africa. Canada announced on World AIDS Day $50 million in new funding to support HIV/AIDS projects in Africa. Italy – at the Special Security Council on AIDS Italy announced that it would contribute approximately US$20 million to the International Partnership this year through multilateral and bilateral programs. The Netherlands donated an additional sum of 3,000,000 Netherlands guilders (approximately 1.5 million US$) to UNAIDS for the International Partnership and would appreciate regular discussions on developments relating to the Partnership. Norway provided a contribution of 28,500,000 Norwegian Kroner (approximately 3.6 million US$) to UNAIDS for programs within the framework of the Africa Partnership. UK has indicated that up to £25 million could be made available for the International Partnership against AIDS in Africa.

2.26 The World Bank, as part of its role as a United Nations Programme on HIV/AIDS (UNAIDS) partner, has committed almost US$1 billion to more than 81 HIV/AIDS-related projects in 51 countries, and AIDS lending is likely to rise as more countries turn to the Bank for financial and technical assistance in responds to the epidemic.

2.27 Private corporations are also taking up their roles in this battle—for instance by providing premises for HIV education, by giving protection and support to their employees, and by taking a lead within the wider community. Amongst other recent cases, throughout southern Africa, medical research projects, education efforts and social support mechanisms are being backed by the new public-private partnership **"Secure the Future", to which Bristol-Myers Squibb has donated $100 million for the next five years. In Nigeria, the Chevron Oil Company has taken an imaginative and tenacious approach to HIV prevention, working to protect the wider community as well as its own workforce. In South Africa, the electricity-generating company Eskom, which has over 37,000 employees, has for the last six years made HIV/AIDS one of its strategic priorities. As a result, it can now guarantee benefits to employees with AIDS and their families, and has funded clinics that offer tests, immune system monitoring, and medical support. In Zimbabwe, Rio Tinto has taken steps to protect its skilled workforce. It has formed AIDS action groups, led by volunteer employees, to act as counselors and lead education campaigns among their colleagues. And it is providing condoms to the largely male staff in its mining camps, many of whom face long periods of separation from their wives.**

"Strengthening technical resources to support national and local projects, by:
- reviewing and rationalizing existing technical clusters located in the region, including the UNAIDS Inter Country teams
- strengthening these technical groups through the hiring of additional key specialists
- building stronger networks of specialists in key program fields (e.g., strategic planning, STD treatment, MTCT prevention, community mobilization, etc) within and across countries."

1.28 The UNAIDS Secretariat has undertaken consultations on strengthening technical collaboration approaches with the cosponsors and a number of key bilateral agencies within Africa as well as with leading African technical institutions.

2.29 Representatives of African countries, the Cosponsors of UNAIDS, the OECD Contact Ground and the UNAIDS Secretariat met in Washington on 17-18 November 1999 to examine mechanisms to improve technical co-operation in Africa. As a result of this meeting, it was agreed to provide strong co-ordinated technical and managerial support to the first six priority countries in the IPAA, while building a better overall system of technical capacity building and advice to countries striving to intensify their national AIDS programs. Specifically, Cosponsors and bilaterals agreed to form stronger inter-agency groups, to develop AIDS technical inventories, information systems, resource networks around specific themes (e.g., migration, young people, GIPA) and to provide

Annapolis, Maryland: 19-20 January 1999- Meeting of the UNAIDS Cosponsoring Agencies and the Secretariat "Resolution to Create and Support the International Partnership against AIDS in Africa", V.5

expanded long-term support to African institutions capable of giving AIDS-related training and advisory services. At recent subregional meetings in Abidjan and Nairobi, participants reiterated these commitments, expressed their backing for this improved regional technical collaboration framework, and identified a number of their priority areas for immediate technical support at the country level and below.

2.30 Efforts are intensifying to support African governments and other partners to access appropriate assistance in a timely fashion. Cosponsors and bilaterals have taken steps to expand their AIDS technical support. These include the decision of the World Bank to establish in June 1999 a six-person AIDS Campaign Team (ACT-Africa), and decisions of the Cosponsors to add important regional technical posts or reconfigure existing regional AIDS projects to integrate them with broader regional technical co-operation efforts. In a similar vein, bilaterals are enhancing their technical support in the region. SIDA decided to place three experts in Harare, to provide technical support to Swedish embassies in the region. The DFID Southern Africa office developed a Regional AIDS/STD Project to increase the capacity of the SADC member countries to plan and implement programs to reduce the rate of transmission of HIV.

2.31 Work is underway on a directory of technical expertise, covering persons and institutions working on HIV/AIDS in Africa. A first draft of the inventory is completed. The UNAIDS Secretariat is developing a common database structure to assist Cosponsors and bilaterals in presenting a useful reference that is readily accessible. The completeness and usefulness of work will depend to a significant extent on the responsiveness of partners - i.e., focal points in Cosponsors and bilaterals - to requests for data and clarifications.

Part three

Challenges for the International Partnership

3.1 The Partnership has recorded key achievements, thanks to the political support of the countries and the unflinching commitment of the various organisations and institutions united in pursuing the goal of curtailing the spread of HIV and reducing the impact on humans and on development in Africa. As the organisation and operationalisation of the Partnership continues, a number of challenges have emerged and are being tackled. More collaboration and unity of efforts are needed to overcome these challenges, that form part of the germination and growth of the Partnership as it aims towards maturity. The challenges are enumerated below:

3.2 The initial commitment to identify and start activities under the Partnership started in six countries. The process to identify more countries is ongoing. This entails developing a high level of partnership with government to secure the political engagement. The key actors, including bilaterals, NGOs and the private sector, on HIV/AIDS and development are linked with government, and together they work hand in hand on a focused direction. The necessary intensified actions are also identified with a reasonably clear implementation plan. Although 10 priority countries were to be identified for start-up activities, the process above has taken longer than was envisaged. But given the lessons learned from the achievements made to date, it should be easier and faster to bring more countries into the fold.

3.3 Communication within the Partnership and among the key actors has been rather weak. Several important information and data that are required for better co-ordination and actions are not available, or not available on time. Information about activities of other external actors at global, regional and national levels on HIV/AIDS is not easily known by those who need to use them. The Secretariat has developed a draft communication strategy which will be implemented in stages. It will be dynamic and responsive to the needs of the partners and other key actors as they are identified. It is expected that, even with a modest start, communication within the Secretariat, amongst partners and with other countries, institutions, organizations and NGOs will improve significantly in the future.

1.4 Another sector where much more still needs to be done is the mobilisation and coordination of resources for activities of the Partnership, particularly in countries. The enthusiastic political commitment of the present times has attracted pledges and promises of financial support from various sources. Definitely, even more resources are still needed, hence the need to continue the mobilisation efforts. A mechanism for collection of the pledges, coordination of implementation and use of the resources that are and will be available is being proposed for your consideration and a decision on this is very important.

3.5 It is essential that efforts in support of national responses remain focused on laying a foundation for sustained impacts on the epidemic. Experiences from multi-party, multi-sectoral programs indicate the risk of increased processes and transaction costs, especially at the early phases. With HIV/AIDS, success should not be measured by improvements in administrative processes and consensus building, but by verifiable progress towards medium and long-term impact on the epidemic. In collaboration with African countries the Partnership will emphasise intensification of programmes whilst encouraging improvement of the processes for supporting such programmes.

Part four

Next steps

The Partnership agenda for 2000 includes:

Concluding the "Framework for Action"

4.1 By the UNAIDS Programme Coordinating Board (PCB) meeting in May 2000, we intend to deliver on our collective commitment, growing out of the Secretary General's meeting of 6 December to reach agreement among African governments, donor governments, the UN system organizations, and key partners from among the NGO and private sector, on a specific plan for a major intensification and mobilization to address the epidemic in Africa. The process to be followed for concluding the consultations on the framework:

- *March*: each constituency conducts its own internal consultation until beginning of March, facilitated by the Secretariat; At beginning of March, revised text submitted to Secretariat, together with names of representatives willing to form drafting committee; In March, Secretariat and drafting committee consult to produce revised draft (Draft 2);End of March, draft two circulated to all constituencies;
- *April*: internal consultations with five constituency groups; End of April, revised text submitted to Secretariat;
- *May:* Early May, drafting committee reconvenes; 24th - 25th May, draft Three issued: (if necessary), further meeting to resolve outstanding issues on framework; PCB endorses Framework for Action.

4.2 All constituencies are organizing the consultations allowing the collection of the input by the agreed deadlines:

- *African Governments*: The African Members of PCB through the Theme Groups Chairs and the Group of Ambassadors in Geneva will consult and brief countries in Sub Saharan Africa on the IPAA. The meeting in Abidjan on the West African Initiative on 7-8 February has been utilized to distribute the framework. The SADC Ministers of Health will discuss the framework in their meeting in April in Malawi. The OAU Ministers of Health in Ouagadougou 7-9 May 00 will agree on the revised framework.
- *Donor Countries*: Geneva missions were asked to take forward the discussions on the framework. Comments are being circulated in order to identify the key areas for discussion. A meeting on the 2-3 March in Geneva, facilitated by the Secretariat will bring together AIDS experts from capitals and Geneva missions to finalize the comments of the donor group.
- *UN agencies*: Consultations have taken place by email, teleconferences and will conclude in this meeting. Feedback to the UNAIDS Secretariat was submitted prior to the meeting by some of the agencies.
- *NGO*: A proposal by the NGO Group to organize the consultations was approved and will be funded by the Secretariat. Africaso will act as a focal point; information on the IPAA will be repacked in a way that is accessible to all NGOs/CBOs, information dissemination and advocacy for the IPAA will be done through newsletters, email. A continental meeting bringing together a whole range of NGO networks will then conclude on the Framework comments.
- *Corporate and Private Sector*: The Global Business Council against HIV/AIDS has made presentations during the World Economic Forum in Davos (February 2000); International Federation of Pharmaceutical Manufacturers Association (IFPMA) is consulting their members; The Secretariat of the Organization of African Trade Union Unity will meet in the next few months to develop the roles of the trade unions in the IPAA; The Council of Foundations has met in Seattle January 2000 to review their AIDS strategies and reach out to other organizations. The private sector group will convene in mid February at a meeting in London to compile all comments and select representatives for the drafting committee.

Intensifying country actions

4.3 Together with partners, agreement has been reached to develop, negotiate, finalize and sign intensification agreements in Burkina Faso, Ethiopia, Ghana, Malawi, Mozambique, Tanzania by June 2000. Though there is no recipe for country intensification -the process will differ in each country-, some generic steps have been developed and discussed with the Theme Group Chairs and CPAs of the respective countries. Proposed steps are:

- Analysis of National Strategic Plans (NSP) (has been done): in countries where the plans have not been finalized yet, the support to do so will be organized.
- Identification of stakeholders (major partners); inventory of technical and financial resources available
- Gap analysis (technical, financial, human) for NSP implementation,
- Barriers (institutional, organizational, political) and solutions identified for NSP implementation
- Negotiation of country Partnership agreements

4.4 These Partnership Agreements will include:

- *Country specific prioritized* needs or priority actions articulated in a *time-bound* partnership framework to accelerate implementation;
- Modalities *for enhanced country-level partnerships* working arrangements and responsibilities i.e. defined roles and use of comparative advantages of the five pillars of the partnership at country level;
- Specific action for strengthening the *institutional arrangements* for implementation of national strategic plans *or* identified priority actions including the completion of the plans and mechanisms for *joint review* or monitoring of *progress;*
- *Technical support requirements* for strengthening in-country human resources involved in HIV/AIDS related programs;
- Costing of agreed activities covering the envisaged time frame and *mechanism for allocation of resources* (financial/technical/human resources);
- Indicators to monitor the implementation of the agreement.

A second set of countries for intensifying action before the end of the year will be agreed upon

Intensified action at regional level

4.5 *At the regional level* emphasis will be on developing an effective approach to backstopping country-level work. Inventories of technical resources for the response to HIV/AIDS, including institutions, networks and individuals, are being developed and will be made available to national programs and theme groups. IPAA will support priority "communities of practice" within each region, i.e., Technical Resource Networks. Partners will also work to co-ordinate longer-term institution building to support regional and sub-regional institutions such as SAFAIDS and ICASO. It is crucial that these be based on a coordinated approach among external agencies and African institutions. In this regard several promising initiatives will be nurtured and extended as appropriate. For example, DFID (UK) will lead a discussion group on a proposed regional technical support fund for Southern Africa. Case studies of successful and/or promising TRNs will be documented and disseminated to promote access to examples of what works in practice.

Follow up Security Council meeting

4.6 In response to the requests of the Members of the Security Council, the UNAIDS Secretariat will be taking following actions in close collaboration with the UNAIDS Cosponsors, Member States and other international partners. These points were noted in the CCO summary statement to the Security Council:

- Within one month, the Secretariat will report to the Security Council on steps being taken in response to requests of Members that we intensify clearinghouse efforts on HIV/AIDS in Africa within the UN in order to assure the flow of current information to all of the Member States on the international response;
- To assure more consistent follow-up within the various UN system organization Governing Boards, Councils, Committees and Conferences on HIV/AIDS in general, and to enable more systematic co-ordination among those efforts and those of the Security Council in the development of the International Partnership Against AIDS in Africa;
- Within three months, the Secretariat will advance specific plans for intensifying efforts to address HIV/AIDS in emergencies, conflict situations and in the uniformed services in Africa;
- Within six months, the Secretariat will begin regular reporting to the Security Council on the status of implementation of this plan.

4.7 The Secretary General has already included HIV/AIDS on the agenda of the spring 2000 a meeting of the ACC. All UN system member organizations have been asked to report on their current and future priorities and strategies in combating the epidemic.

4.8 We will also work together with the Under Secretary General, Department of Peace Keeping Operations to review the current HIV/AIDS related polices and programs affecting peace keeping operations and to make recommendations to intensify appropriate actions.

4.9 Several Security Council members recommended proceeding with follow up deliberations. We should be prepared and most pleased to provide any support they may require.

African Development Forum (ADF)

4.10 In co-ordination with the UNAIDS Secretariat, the World Bank, and UNDP, the Economic Commission for Africa will focus on the development impact of HIV/AIDS during the *African Development Forum*, foreseen for 22-26 October. A preparatory Committee of the organisers is functional. The conference entitled "AIDS- the highest challenge to African Development Leadership over the next decade and beyond" expects about 800-1000 participants. High-level decision-makers of the public and private sector, civil society and private sector will be invited.

4.11 The aim of the conference is to identify and promote pathways to successful national action against HIV/AIDS in Africa by sharing our knowledge of the AIDS epidemic in Africa – its negative consequences and possible positive responses; to stimulate awareness at the highest levels of decision-making and challenge African leaders at all levels to act now and on a much larger scale than at present, by mounting nation-wide and multisectoral programs against HIV/AIDS that treat the epidemic as a complex emergency.

4.12 Conference themes will be AIDS and Development, the responses to the epidemic, including the sectoral impact analyses; intensification of national responses; good governance for AIDS responses and developing and managing mechanisms for implementing intensified responses:

Heads of State Summit

4.13 A summit of heads of state and governments has been proposed to be held three months after the ADF a *Summit on HIV/AIDS in Africa,* probably during the first quarter 2001. The goal would be to get high-level commitment to action on specific goals for a major intensification of efforts addressing the epidemic, including broad-based human development and social policy adjustments.

Part five

Contributions of Cosponsors

in developing and implementing their strategies

in support of the IPAA

Commitments and achievements of each Cosponsor

UNICEF

UNICEF commitments to the International Partnership on HIV/AIDS in Africa
Prepared by UNICEF Regional Office for Eastern and Southern Africa, Nairobi (J. Csete) with inputs and endorsement from Programme Division, UNICEF Headquarters, New York (D. Alnwick), 2nd April 1999

UNICEF's contribution to the International Partnership will be largely through its **country programmes of cooperation**, which are found with significant staff presence in every country in sub-Saharan Africa. Most UNICEF-supported programmes in Eastern and Southern Africa already have HIV/AIDS components, but these will be greatly strengthened.

UNICEF's work at the country level will be focused in **five areas**:

Advocacy for an expanded response to HIV/AIDS: UNICEF representatives and their teams have regular access to high-level policy makers as well as to a wide range of other partners, including community representatives and district level officials. UNICEF will use its extensive advocacy resources and experience to break the silence on HIV/AIDS with powerful messages on its implications and possible approaches to solutions.

Prevention among young people: UNICEF looks forward to a continuing partnership with the other co-sponsors in (1) defining IEC campaigns for youth with measurable objectives, focusing on key messages that every young person should be exposed to, (2) strengthening lifeskills education in schools and out-of-school programmes, and (3) ensuring the definition and implementation of a standard package of youth-friendly services both in and beyond the health system.

Prevention of mother-to-child transmission: In 1999, UNICEF offices in at least 10 countries in Africa will support the introduction and launching of a package of services for pregnant women, including access to voluntary counseling and testing, antiretroviral drugs, improved antenatal care and nutrition services, and improved childbirth practices. UNICEF's role in monitoring these experiences will be especially important. This support will be closely coordinated with UNAIDS, WHO Geneva, WHO AFRO and UNFPA and a coordinating mechanism has already been established. UNICEF, with help and support of UNAIDS, has already been successful in negotiating an initial supply of antiretroviral drugs for this programme, and UNICEF intends to continue to negotiate with suppliers of such drugs for additional free or very low cost supplies as the potential coverage of programmes increases. UNICEF will also assist in the supply of appropriately labeled breastmilk substitutes for mothers in the start-up projects.

Care of orphans and other children in AIDS-affected families: UNICEF will continue its support to needs assessments related to AIDS orphans, to working to help ensure access of affected children to basic services, and to strengthening the capacity of families and communities to protect and care for these children. This area is a major challenge that will demand broad partnerships and high levels of donor support.

Support for UNICEF staff affected by AIDS: UNICEF is working to ensure a minimum package of services for staff members affected by the epidemic.

In virtually all this work, the overall strategy will be a **combination** of support for participatory community assessment and analysis of the problem and advocacy/communication at all levels. UNICEF's work will be based on the premise that HIV/AIDS will not be conquered until programme design and implementation are based on the problem analysis of people affected by the problem. UNICEF's long history of support to community-based programmes in Africa will provide a base on which to build this experience.

UNICEF will continue its active involvement in **sector-wide approaches** and sectoral reform efforts in health and education, emphasizing HIV/AIDS-related measures to the greatest degree possible. Nonetheless, UNICEF will continue to work with donors and other partners to ensure that HIV/AIDS is understood as an intersectoral problem whose resolution transcends work in any one sector.

UNICEF achievements

To follow up on this commitment a Task Force was established to consult with UNICEF staff and other partners and to make recommendations to the Regional Director on how UNICEF's commitment to intensified action on HIV/AIDS could be operationalised. The Task Force met in Nairobi to flesh out the regional strategy and to identify the key steps, which need to be taken to intensify action by country offices within the East and Southern Africa Region. HIV/AIDS was identified as a top priority in Eastern and Southern Africa, a detailed regional plan prepared.

A number of activities to be undertaken to accelerate programming in each of these areas have been identified. Organizational implications were discussed and critical actions required to signal UNICEF's priority and to ensure improved guidance and coordination and enhances programming and technical support to enable expanded action on these priorities identified. These critical actions include among other things to:

- develop skills and equip UNICEF staff as HIV/AIDS advocates;
- building the alliance for children and position UNICEF's HIV/AIDS initiative in the context of the IPAA,
- define roles and contributions of UNAIDS cosponsors in supporting the implementation of UNICEF's 5 point plan;
- ensure Country Programs adjust/respond to intensify action on UNICEF's priorities,
- orient UNICEF staff and strengthen their technical and programming capacities,
- strengthen the Regional staffing capacity;
- orient workplans and mechanisms to respond to the priority of HIV/AIDS,
- develop community capacity development materials and methodologies
- mobilize resources to support action on HIV/AIDS priorities
- Develop a regional appeal to support country and regional level action to implement the 5-point plan.

At its Regional meeting in November 1999, WACARO (West and Central Africa Regional office) has decided that:

- Each of the UNICEF offices and programs in the region will consider as a priority, the development of strategies and activities in order to mitigate the impact of AIDS on the development, and in particular matters related to child survival
- Each office will systematically integrate an AIDS component in all the annual review and reports of UNICEF programs in the region
- Each UNICEF office will play a more active role in the functioning of the Theme group mechanism at country level
- The possibilities for recruiting a larger number of staff at regional and country level to support the process will be considered.

UNDP

UNDP Africa has also committed itself to aggressively pursue the three major objectives reduced HIV transmission, reduced suffering, and mitigate impact of AIDS. UNDP will:

- *Develop, refine and maintain participatory methods, tools and techniques* that enable stakeholders to actively participate in assessment, planning, implementation, monitoring and evaluation of activities hat will promote and operationalise the objectives of the partnership. This has been communicated to the Resident Co-ordinators in Cotonou, Benin on the Feb. 1, 1999 to Feb 6, 1999 meeting.
- Promote and support the use of *Participatory Assessment, Planning, Programme Implementation and Monitoring and Evaluation for HIV/AIDS* at national, district and community levels.
- Identify and establish a Multi-Track Communication system that is responsive to stakeholder needs and promotes communication between different stakeholder groups and develop capacity for effective and efficient operation and use of the HIV/AIDS MTC network.

UNDP Achievements

Immediate follow up actions to Annapolis have been taken:

- action at the regional level: UNDP Africa has initiated dialogue with the OAU and ECA. The dialogue has focussed on the implementation of the OAU resolutions, the role of ECA in developing regional strategies for the implementation of the these resolutions and the interface that needs to built between the regional level actions and country level work by Resident Co-ordinators. A UNDP Africa/ECA team will work out detailed plans of action;
- the recent UNDP/ECA WSSD follow-up of African Ministers of Economic Development in Nairobi has also recommended new strategic directions in line with the Intensified Action;
- a decision has also been taken to deploy HIV/AIDS officers in each country boasting the eleven positions that exist now. Financial implications are being worked out;
- A human development report for Sub-Saharan Africa focussed on HIV/AIDS is under discussion in the UNDP Africa Bureau;
- the most vulnerable countries such as the SADC, dialogue is going on to provide more core resources to the Intensified Action, apportioning new resources and siphoning funds from other less immediate development priorities. A pilot programme to use the UNDP SURF structure just set up in Addis Ababa is underway to concentrate its work on HIV AIDS.

Other actions have been taken in the framework of:

- The Alliance of Mayors and Municipal leaders on HIV/AIDS in Africa: The Alliance now covers 16 countries, with one more expressing interest in joining, and 59 municipalities. Its members participate in national, regional and international meetings to advocate more effective responses to the HIV/AIDS epidemic. In collaboration with UNDP and other partners, the Alliance has developed a $10 million pilot project in eight countries: the African Mayors' Initiative for Community Action on AIDS at the Local Level (AMICAALL). Under the project, local authorities and communities receive training on problem identification and on how to work in multi-disciplinary teams, as well as funds for micro-projects for prevention, behavior change, and care and support for people living with or affected by HIV/AIDS. Mechanisms are being put into place to link local, regional, and national authorities and policies, and exchange experience within and across countries.
- UNDP is strengthening capacity building of local governments and political leaders to identify problems in collaboration with communities and local development partners, including NGOs and the private sector, to support multi-sectoral community-based responses to the AIDS epidemic. The overall purpose of this initiative is to reduce the social and economic impact of HIV/AIDS on communities in urban centres and secondary towns in Africa;
- supporting the Regional Prevention of Maternal Mortality Network: through its support, UNDP has helped to transform the regional Prevention of Maternal Mortality Network from an operations network into an African regional centre of excellence. The Centre, based in

Accra, provides support for capacity building in the area of maternal mortality in 11 countries in Africa, and could be an important resource for groups dealing with HIV and women's health;

- providing support to the UN Resident Co-ordinate system throughout Africa, which helps ensure a more coordinated response at country level in support of national efforts.

The regional HIV/AIDS Programme has been reviewed and new strategic directions have been recommended in line with the Annapolis Resolution.

- At a meeting with the Southern African cluster in Windhoek in October 1999, the UNDP Administrator requested the Resident representatives of Southern Africa to develop a UNDP response to the unfolding human tragedy of HIV/AIDS in the region. A framework for action 200-2001 for an accelerated response to HIV/AIDS in Southern Africa was developed at a meeting in Malawi on 1-3 November bringing together cluster members and UNIDS inter country support teams;
- The first area of strategic support and action is UNDP's support to its development partners to address the impact of HIV/AIDS. This will be done by UNDP support to integrate HIV/AIDS in UNDP supported programmes, to key sectoral ministries (Finance, Health, Local Government, Public Service management), to national and sub-national levels (linked with the NSPP), to civil society and the private sector. Other areas of strategic action include the design and implantation of country specific activities, increasing UNDP country office capacity to respond to HIV/AIDS (deployment of HIV/AIDS officers in all countries), internal support to staff, inter-agency coordination and strengthening the UNDP Regional Programme on HIV and Development.
- The Africa Regional Programme on HIV and development, based in Pretoria will focus its attention on supporting UNFP country offices and intra-region initiatives within the context of this framework above, in close collaboration with the UNAIDS Inter country Support Team and the SADC Health Coordinating Unit.

World Bank

World Bank Africa (ref: Intensifying Action against HIV/AIDS In Africa: Responding to a Development Crisis)

The World Bank's strategic plan for the "Intensifying Action against HIV/AIDS in Africa" builds upon the Bank's existing HIV/AIDS-related work and focuses on its comparative advantage to rapidly increase the level of action and available resources and to bring to scale effective interventions. The strategy seeks to protect the next generation, while caring for those already infected and affected by HIV/AIDS. The plan is built around four pillars:

- advocacy to position HIV/AIDS as a central development issue and to increase and sustain an intensified response.
- increased resources and technical support for African partners and the Bank country teams to deal with HIV/AIDS activities in all sectors.
- Prevention efforts targeted at both general and specific populations and activities to enhance HIV/AIDS treatment and care.
- Expanded knowledge to help countries design and manage prevention, care and treatment programs based on epidemic trends, impact forecasts and identified best practice.

To help implement the new strategy, the Bank has created a multisectoral AIDS Campaign Team for Africa - ACT*africa*. This Team will ensure that the Bank builds AIDS into the center of all its Country Assistance Strategies and reorients social fund projects to include local AIDS initiatives.

World Bank achievements

The **World Bank** launched in September its new strategy to combat the AIDS epidemic in Africa, in partnership with African governments and within the International Partnership against AIDS in Africa. The strategic plan places HIV/AIDS at the center of the Bank's development agenda, and ensures it is integrated in all aspects of the Bank's work in Africa and in all channels of dialogue. AIDS components in many of its existing projects are being developed, new AIDS operations in a number of countries are under preparation

The strategy provides for ACT*africa* to engage in four types of actions through December 2000. The following section details the team's progress to date in each activity area.

Action One: Stimulate demand including:

- Supporting high-level advocacy and providing advocacy materials to senior management to use in high-level speeches, meetings, and consultations. *Outputs to date: Strategic plan officially launched at ICASA in Lusaka and presented at several other high level meetings, strategic plan and accompanying brochure widely disseminated throughout the Bank and to global media outlets*

- Supporting country-level advocacy and equipping Country Directors and Sector Directors to advocate and intensify action against HIV/AIDS with senior leaders and other non-specialist audiences. *Outputs to date: 48 country-specific HIV/AIDS toolkits developed for Country Directors in Africa; 10 country team meetings and several workshops on implementation of the plan held with bank staffs; Bank documents related to HIV/AIDS reviewed.*

- Capitalising on major development events; designing and delivering HIV/AIDS presentations and seminars at major development events, in addition to co-sponsoring, conducting, and taking part in conferences, workshops, and seminars on HIV/AIDS (e.g., Annual Meetings, SPA). *Outputs to date:Co-sponsored and delivered presentations at major international fora, e.g., the 1999 WB-IMF Annual Meetings, the Special Program for Africa meeting, the African-African-American Summit, the African Development Forum and others.*

- Developing easily accessible websites to enhance the sharing of information. *Outputs to date: Regional website (www.worldbank.org\afr\aids) on HIV/AIDS developed; more extensive sites under development.*

Action Two: Strengthen the Bank's Capacity to Respond, including

- Keeping management informed; *Outputs to date: monthly and quarterly progress reports.*
- Operational support to country teams; portfolio reviews, technical support and training *Outputs to date: Process for portfolio reviews developed and refined; portfolio reviews completed for nearly 10 countries ; country team meetings to discuss the feasibility of retrofitting existing projects held.*
- Disseminating information; *Outputs to date : ACTafrica serving as clearinghouse for HIV/AIDS-related information for the Region; information on current HIV/AIDS events and research circulated; HIV/AIDS resource center established.*

Action Three: Expand Available Resources

- Re-tooling existing instruments. *Outputs to date: Draft documents under preparation.*
- Raising trust funds. *Outputs to date: proposal for funding presented at annual consultation meeting of the Norwegian Royal Ministry for Foreign Affairs.*
- Mobilizing the international community to step up contributions and coordination in HIV/AIDS efforts. *Outputs to date: Retreat organized that led to the IPAA development*
- Maintaining and deepening partnerships and exchange of information and technical expertise with UNAIDS, donors, NGOs, academia, and the private sector.Outputs to date: *Dialogue with various groups expanded (e.g., Harvard Enhancing Care Initiative, Population Affinity Group, USAID); strategy presented to international NGOs*

Action Four: Expand Available Knowledge and Develop Additional Tools

- Developing economic tools; *Outputs to date: Cost estimates for scaling-up effective interventions to the national level prepared for 24 African countries; proposals reviewed for develop-ing strategic planning model and tools in collaboration with UNAIDS and UNDP.*

- Developing toolkits for HIV/AIDS in all sectors; designing toolkits to guide preparation of sector strategies, programs, and projects in non-health sectors. *Outputs to date: relevant toolkits to assess the impact of HIV/AIDS on various sectors under preparation.*

The key areas of future focus:

Scaling up in countries: This will require strong coordination, practical toolkits, coordinated and simplified procurement mechanisms, complementary and flexible funding. The Bank will work with UNAIDS and other partners to quickly mount this coordinated response. ACTafrica, in collaboration with the UNAIDS IPAA, has identified countries that place a high priority on scaling up their programs. ACTafrica is reviewing the portfolios of these countries to identify projects that can be retrofitted to strengthen HIV/AIDS prevention efforts and is working with Bank country teams to develop detailed implementation plans listing specific steps to be taken in all sectors.

- Identify Innovative Means of Financing the Development of Prevention Options, such as **Microbicides and Vaccines** to do so, the Bank has been working with the International AIDS Vaccine Initiative (IAVI) and established a Bank-wide AIDS Vaccine Task Force in 1998.

- Support **Research Efforts** to Provide Decision-Makers with the Data and Tools Needed to Intensify Efforts: The Enhancing Care Initiative, coordinated by the Harvard AIDS Institute, is meant to provide an overall assessment of the sustainability of HIV/AIDS care in a specific population or region. Care teams were set up in Senegal and South Africa, the Initiative will now be expanded to 21 countries.

- Establish **Linkages** between the Heavily Indebted Poor Countries (HIPC) and AIDS Initiatives: In collaboration with UNAIDS, the Bank will play a role in strengthening the linkages between these two key development initiatives. How the linkages will be established is currently under exploration among interested stakeholders in the Bank.

- **Build Bridges between AIDS and Education:** An impact study of HIV/AIDS on education is being conducted in Kenya, Uganda, Zambia, and Zimbabwe. HIV/AIDS is being integrated into school curricula.

UNFPA

UNFPA Africa (ref. UNFPA Guidelines for Support for Reproductive Health, including Family Planning and Sexual Health - November 1997)

Traditionally, UNFPA support in reproductive health has been directed to family planning activities, integrated within maternal and child health programmes. However, the broader issues of sexual and reproductive health and HIV/AIDS has attained much greater priority in the ICPD+5 Programme of Action.

Sexual health programmes for adolescents: UNFPA will support reproductive health information and service programmes for adolescents, which are both acceptable and accessible to them.

Increased support for reproductive health: UNFPA will build on its support for reproductive health and primary health care by developing services which (1) prevent and treat reproductive tract infections, including sexually transmitted diseases, (2) prevent HIV/AIDS, (3) prevent and provide appropriate treatment for infertility and other reproductive health conditions, and (4) discourage harmful practices such as FMG.

Prevention of HIV/AIDS: UNFPA will support the supply and distribution of condoms, in-school and out-of-school education activities on HIV/AIDS, training of reproductive health information and service providers in HIV/AIDS, and IEC activities on HIV/AIDS as part of population and reproductive health programmes.

UNFPA achievements

- At the ICPD+5 meeting in early February, HIV/AIDS was emphasized as a major part of UNFPA supported reproductive health programmes and HIV/AIDS indicators were incorporated among the key targets in the report of the Hague meeting. Examples of the targets include:
  - Countries, with the assistance of UN system and other donors, should, by year 2005, ensure that at least 90 percent of young men and women have access to information and skills required to reduce their vulnerability to HIV infection.
  - Countries should also use as a benchmark indicator HIV infection rates in 15 - 24 year olds, with a goal of ensuring that, by the year 2005, transmission of HIV in this age group is reduced (a) globally; and by 25% in the 25 most affected countries.

- Also at the Hague, UNFPA briefed all its Representatives and CST Directors in sub-Saharan Africa on the partnership and the need to renew their commitments to prevention and control of HIV/AIDS in collaboration with other partners, especially the HIV/AIDS Theme Groups at the country level. Copies of the Annapolis partnership meeting report was also distributed to all UNFPA Country Representatives.

- In the briefing organized by UNFPA for representatives of African missions to the UN, in preparation for the Commission on Population and Development and the Preparatory Committee for the Special Session of the General Assembly on the ICPD + 5, recommendations of the Africa Partnership on HIV/AIDS was emphasized. African governments were called upon to take leadership and increase their commitment and resources for prevention of HIV/AIDS. Copies of the Annapolis meeting report were also distributed to African delegates to the March 1999 Commission on the Status of Women.

- UNFPA had a discussion with Sida on recruitment of a CST Adviser on Sexual and Reproductive Health who would also cover HIV/AIDS and Youth issues. The Adviser will be supported by Sida and will be part of the UNFPA CST for Southern Africa based in Harare.

- UNFPA has also prepared a concept paper for a regional project on Advocacy for HIV/AIDS in sub-Sahara Africa. The advocacy project will target regional, sub-regional and national policy makers, opinion, community and religious leaders. The project will use audiovisual/graphic presentation to demonstrate the magnitude and impact of HIV/AIDS in the region. The regional project is planned to be implement by UNFPA and UNAIDS Secretariat in collaboration with

other co-sponsors of UNAIDS, other donors, ECA and the OAU. The details of the project will be developed by technical experts from the co-sponsors.

- UNFPA organized a Workshop on HIV/AIDS for all its CST advisers in sub-Sahara Africa region in Dakar 1999. The workshop discussed how to further incorporate HIV/AIDS into Reproductive Health and other Population programmes based on the needs and experiences in the region. The training will focus on windows of opportunity to address HIV/AIDS in the Regional Advisers respective areas of expertise;

- In Tanzania, the UNAIDS Theme Group chaired by the UNFPA representative Mr. Teferi Seyoum, who attended the Annapolis meeting, has mobilized the government to provide leadership and to coordinate combined efforts to prevent and control HIV/AIDS. This culminated in the launching of a Medium Term Plan (MTP III 1999 - 2002) for combating the spread of HIV/AIDS in the country on 26 March 1999. During the launching, presided over by the Prime Minister of Tanzania H. E Mr. Fredrick Sumaye, the government constituted an Advisory Board to the government, under the chairmanship of the former president of Tanzania Mr. Ali Hassan Mwinyi. Mr. Teferi Seyoum is also a member of the eleven-man Advisory Board.

- In South Africa, UNFPA, USAID, Population Reference Bureau, The Freedom Forum and the National Population Unit jointly sponsored a regional seminar on "International Conference on Population and Development" for print and electronic media representatives. The devastating impact of HIV/AIDS and the urgency to deal with Adolescent Reproductive Health was emphasized at this seminar. It is expected that this would improve the quality of their reporting on Reproductive health and HIV/AIDS. The seminar was attended by media representatives from South Africa, United Republic of Tanzania, Uganda, Ghana, Zambia and Cameroon.

- HIV/AIDS is of high priority within UNFPA-supported programmes, and attempts are being made to mobilize additional resources (multi-bi and private foundations) to support programmes on HIV/AIDS.

WHO

WHO Africa (reference: WHO Contribution to the International Partnership on HIV/AIDS in Africa – April 1999)

HIV/AIDS is overwhelming the health services of many member states. WHO will focus on strengthening health services to respond to the epidemic by supporting improved health policy planning and more effective health service delivery, including care from home, community and hospitals. WHO will drive home the message of the Partnership with African political leaders and will strengthen its cadre of AIDS specialists in the region. WHO has adopted the following strategy in support of the Partnership:

- strengthen health systems through development of appropriate policies and strategies for the provision of HIV prevention and care services;
- improve prevention through evidence-based interventions;
- improve care through evidence-based interventions;
- increase the amount and quality of information to meet requirements for monitoring and evaluation of the HIV/AIDS/STI epidemics.

WHO is expanding its activities in Africa through:

- strengthening the WHO Africa Regional Office to enable it to respond promptly and effectively to country demands relating to HIV prevention and care.
- identification of priorities at country level through assessment and appraisal of national and district needs within the broad spectrum of HIV/AIDS prevention, care and impact.

WHO achievements

A detailed workplan, including principles, priorities, monitoring and evaluation and budget for the IPAA based on the strategy above has been developed.

In order for countries to achieve the IPAA goals, WHO intends to provide additional technical support and assist them to mobilize the necessary resources for a selected priority list of evidence-based prevention and care activities which will have the potential to curtail the spread of the epidemic at a faster pace and to significantly ameliorate much of the impact of the disease on the individual, families and communities. This intensified collaboration and action will be focused on 24 sub-Sahara African countries.

WHO has focused its role within the IPAA to ensuring the development of strategies that place emphasis on the health aspects needed to address the spread and the impact of the epidemic, particularly at the country level. Specifically, WHO acts to strengthen country capacity to undertake or update needs assessments for HIV/AIDS prevention and care. The information obtained from these assessments has been used for setting priorities for HIV/AIDS-related interventions and to scale up ongoing activities. As a matter of policy WHO is guided by its own set of priority areas, for which it has comparative advantage and the capacity to assist countries.

The goal of WHO's contribution to the Partnership is to strengthen the capacity of the countries to guide the national response, and to effectively coordinate and implement HIV/AIDS control activities. To achieve this goal WHO has selected a number of areas that constitute a framework within which technical support will be provided as requested and where appropriate. These areas are:

- Promotion of evidence-based prevention interventions including
  a) Technical support for preventing transmission among the young and vulnerable people
  b) Prevention of Mother to Child Transmission by strengthening maternal and child health services

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These are (a) strengthening of health systems, (b) improvement and promotion of evidence-based prevention interventions, (c) improvement and promotion of evidence-based care interventions and (d) strengthening health information systems and surveillance.

including training and support of healthcare workers and community health workers

c) Prevention and treatment of STDs for preventing HIV transmission by provision of effective STD detection and treatment utilizing existing primary health care services, family planning and maternal and child health services.

d) Blood safety through blood screening and improved donor selection and counseling will protect blood donors and recipients.

- Promoting of evidence-based care interventions including
  a) The expansion of user-friendly and accessible Voluntary Counseling and Testing initiatives.
  b) Strengthening diagnosis and patient management by ensuring the availability of reagents and equipment required within the health services for the diagnosis of HIV/AIDS and monitoring patients' responses to treatment.
  c) Strengthening Home based and palliative care by providing financial, technical and material support to countries, to enable them to reduce the burden on the hospitals and develop more effective and less expensive alternatives such as community home-based care activities within a continuum of care.

- Strengthening of Health Systems, including technical support and advice to many countries in relation to the health reform process. Within this activity, special attention will be given to the policy formulation, human resources development, and strengthening of the health systems at district, local and community levels to enable them expand, intensify and adequately manage their HIV/AIDS response. HIV/AIDS prevention and care services will be integrated at all levels of the health care system in response to ongoing health reform process in order to take advantage of all the opportunities that exist. WHO will collaborate with countries to improve the rational selection and use of drugs for HIV and HIV-related conditions and their drug procurement and distribution system, so as to ensure the availability and the effective use of drugs needed for the treatment of HIV-related opportunistic infections, tuberculosis and sexually transmitted infections.

- Strengthening Health information systems and surveillance: WHO will provide technical support to strengthen national and global surveillance and health information systems.

WHO will monitor the Partnership activities through the Regional Office and the UN country theme groups whose membership includes the WHO country representatives.The indicators to be used will be based on the global targets and the targets set for the activities identified within each national strategic plan. Evaluation of the impact of the Partnership on the national HIV/AIDS implementation will be jointly undertaken in collaboration with all the partners. The first comprehensive evaluation will be undertaken at the end of the second year of the Partnership. The total budget for this Work Plan is US$ 997,820,000.

In addition to the development of the workplan, following activities within the IPAA have been undertaken since the adoption of the Annapolis Resolution.

- In the field of advocacy and mobilisation, 46 WHO country representatives of AFRO attending the 23rd Regional Programme Meeting (RPM) were briefed on the IPAA. The interdivisional working group in AFRO met to discuss mainstreaming of HIV/AIDS. In collaboration with UNAIDS, NGOs and Namibian government, a workshop was organized on HIV/AIDS confidentiality and disclosure. 46 WRs from AFRO region were briefed in September. AFRO set up a working group of WRs and RPA team to make recommendations on partnership activities.

- In the field of HIV/AIDS prevention and care related activities, AFRO in collaboration with UNAIDS initiated a project to assess HIV/AIDS magnitude, TB care and drug access in 12 southern African countries. Home-based care kits for the management of AIDS patients have been provided in the 15 countries that so far, benefited from the programme. In collaboration with WHO headquarters, UNAIDS, UNICEF, UNFPA plans were developed to establish pilot projects on the prevention of mother to child transmission in 10 sites. WHO Afro, in collaboration with UNESCO sub-regional office for Southern Africa also funded participants and facilitated at the

sub-regional workshop on harnessing cultural aspects to education for behaviour change in populations with special reference to the youth.WHO entered into dialogue with UNAIDS/ICT team for Southern African region to establish (a) technical resource base, (b) joint work plans. They further planned national capacity strengthening activities with special emphasis on developing national comprehensive care and support/counselling services for HIV/AIDS patients and families in addition to the development of training manuals for in-service and pre-service training programmes.

- In the arera of regional and country capacity building, the technical capacity of the regional office has been strengthened. Three health care specialists have been recruited and stationed in countries from where they provide technical support as needed. National Programme Officers (NPO) were recruited in 3 countries to support the WHO Country Offices for implementation of National Programmes Strategic Plans

- As far as Surveillance is concerned, an AFRO Intercountry Technical Network was initiated. Nigeria, Ethiopia, Mozambique and Zimbabwe received technical and financial support for strengthening HIV/AIDS/STI surveillance. WHO also participated and facilitated the National AIDS Control situation analysis and resource mobilization activities for implementation of findings from assessments of AIDS Control Programmes. They collaborated with UNAIDS/ICT/WCA on the development of the Regional Strategic Plan for STI training of national teams using syndromic management. An assessment of blood transfusion and HIV testing services for development of national HIV blood safety policy was carried out.

- In collaboration with UNAIDS, WHO AFRO participated in the NGOs meeting in Abidjan, country advocacy meetings in relation to the partnership in Burkina Faso, Ghana, Tanzania, as well as in the subregional meetings of UN theme group chairpersons and cosponsors in Mozambique, Nairobi and Abidjan. They provided a technical input into the framework for action of the International Partnership and technical resource strengthening documents prepared by UNAIDS secretariat.

UNESCO

UNESCO Africa *(ref: Intensifying Action Against HIV/AIDS in Africa: Responding to a Development Crisis; "Photo of the situation in struggling against AIDS in Africa with UNESCO – April 1999)*

UNESCO's aim is to encourage the development of effective educational strategies that help young people adopt attitudes and behaviours to avoid HIV infection.

Education strategies for AIDS prevention: UNESCO will promote education strategies to Ministries of Education, specialised institutes and non-governmental organisations. UNESCO will also promotes the integration of preventive education in the existing secondary school programme.

Comprehensive policy of communication: UNESCO will continue to implement its expanded network of community media addressing AIDS. It will encourage journalist training from its Institutes of Journalism, and help to develop specific programmes on AIDS with networks of local radios.

Transfer of knowledge and scientific research: UNESCO will continue to support the international network of research centres developed by the World Foundation for AIDS Research and prevention – including the first Africa regional Research Centre in Cote d'Ivoire. It will pursue research on cultural aspects of AIDS.

(1) **As regards to AIDS prevention**, UNESCO's aim is to encourage regionally the development of effective educational strategies adapted to various socio-cultural contexts, which would help young people to adopt attitudes and behaviours such as to avoid HIV infection. In particular, promoting awareness among girls in school for the prevention of AIDS.

(2) **Educational strategies for AIDS prevention** are communicated to decision-makers and those responsible for education to help them in planning policies for the design, execution and evaluation of efficient prevention programmes. UNESCO supports also the integration of preventive education in the existing secondary school programme, curriculum and materials.

(3) **Study on impact of AIDS on Education:** a pilot study has been done in Côte d'Ivoire. On the bases of the main results of this study (in particular the death of 7 teachers a week), the Government has given new priorities to the national programme on AIDS related to the Education policy. UNESCO/IEP (International Institute for Educational Planning) is in co-operation with UNESCO Field Offices to support new studies in this field in Africa.

(4) **Preventive information based on investigative Journalism in Africa:**
UNESCO is encouraging the training of journalists in the field of AIDS with the support of its Institutes of Journalism and the development of specific programmes on AIDS with the networks of local radios (for example in Southern Africa).

(5) Cultural approach to HIV/AIDS prevention and care:
On the bases of local studies, UNESCO is preparing proposals to facilitate the elaboration and the improvement of the national programmes of prevention of HIV/AIDS. A workshop was organized in Harare in May 1999.

(6) Transfer of knowledge/scientific research :
UNESCO supports the international network of research centers developed by the World Foundation for AIDS Research and Prevention. A first regional Research Center has been created in Côte d'Ivoire. This Center which includes a laboratory at the biosafety level 3 as well as a clinical area, follows 300 patients who benefit of the ARV treatments.

The creation of this pilot research center has reinforced the need of information and prevention from the medical, social, political community and it gives evidence that Science experts need to open their programs to educational input linked to testing approach.

In the context of this pilot research center, peer education is initiated there with the managers commitment, educational programs rapidly appear cost effective, compared to the social-economical impact of AIDS in staff and business. Natural leaders, unions, medical staff are part of the challenge. The external input is only required to train peer educators. The entire community takes advantage of it outside of the very urban workplace, as workers teach families, neighbours, relatives and native villages.

Finally, the activities already conducted by the Organization in Africa which it will strengthen under the Common Programme, can be grouped under five major headings: education, basic research, social and human sciences, human rights, public information and awareness activities, all of which will be supported by co-ordination and back-up machinery responsible for ensuring communication so that everyone is aware of all the implications of his specific role in carrying out a diversified transdisciplinary programme.

UNDCP

UNDCP Africa (ref: UNAIDS/UNDCP Programme Review - 24 September)

UNDCP addresses drug abuse and HIV/AIDS in Africa through:

- drug abuse preventive education and training in treatment and rehabilitation;
- the strengthening of NGOs and communities' involvement in drug abuse prevention;
- rapid assessments: UNDCP will coordinate the activities of its sub-regional offices in Senegal, Nairobi and Pretoria with those of other Cosponsors on the extent and pattern of drug abuse in relation to HIV/AIDS.

UNDCP Achievements

Within the context of the Africa Partnership, UNDCP's thematic priorities are to focus on drug abuse prevention and advocacy, mainly in the areas of the:

- relationship between HIV/AIDS and injecting drug abuse;
- assessment of the extent of HIV infection generated through irresponsible sexual behaviour caused by illicit drug abuse;
- drug education, awareness and information programmes, as well as ongoing counselling, treatment, community care and rehabilitation programmes including HIV components.

Joint United Nations Programme on HIV/AIDS

UNAIDS

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Facsimile

To:	Mrs Sandie THURMANN Office of National AIDS Policy The White House	Fax:	1 202 456 2439
		Pages:	3
		Ref.:	ag
From:	Anne GATEHOUSE Office of Dr Jim Sherry	Date:	3 September 1999
Subject:	Eric Lief		

Dear Mrs Thurmann,

Please find attached Mr Eric Lief's resume as requested by Dr Jim Sherry.

Best regards,

A Gatehouse

Anne Gatehouse

6/22/00

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Interim Data – 15 July

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QUALIFICATIONS

- Extensive expertise in public budget and financial practices, procedures, statutes and regulations.
- Specialized policy analysis, international affairs, political, legislative and strategic planning experience.
- Knowledge of multilateral organizations, budget and systems issues.
- Background in public organizational and personnel management and systems.
- Proven supervisory and managerial experience, including direction of multinational workforces.
- Understanding of management information systems and operations.
- Experience in professional staff work, speechwriting, and Congressional presentations.
- Experience living and working in foreign countries.
- Knowledge of foreign languages (French, Spanish, Dutch).

EDUCATION

M.P.A., Harvard University, John F. Kennedy School of Government, 1987.
B.A., International Affairs, University of Miami, Coral Gables, FL, 1975.

EMPLOYMENT

U.S. DEPARTMENT OF STATE, *Foreign Service Officer*, 1979-86, 1987-91, 1994-present,
Office of the Secretary, Resources, Plans & Policy Staff,
Budget & Policy Advisor, 1994-present.
Direct action on budget, management, policy and organizational issues affecting the Department, USAID, ACDA and USIA. Develop and manage implementation of Department-wide and interagency re-engineering proposals. Formulate budgets for all programs and activities in Europe, with particular focus on the former Soviet Union and Warsaw Pact countries, specializing in Democracy-building initiatives. Prepare analyses, options papers and Congressional budget presentations for the Secretary and other senior officials. Develop and execute legislative, budgetary and public relations strategies in support of Presidential budget and policy commitments. Coordinate interagency submissions to OMB and Congress. Brief Members of Congress, Congressional staff and interest groups on International Affairs budget issues.

Operations Director, Legislative Affairs, 1990-91.
Coordinated bureau activities and management. Developed and implemented plans for organizational change. Formulated legislative strategies, coordinated contacts with Members of Congress and Congressional staff. Directed the work of six subordinate offices. Represented the bureau in interagency meetings and working groups, and served as a senior contact with other Executive-branch offices. Significant achievements: formulated complete reorganization plan for the bureau, including staff changes, training and budget requirements.

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Received Time 8.Oct. 16:11

EMPLOYMENT (Cont'd)

U.S. DEPARTMENT OF STATE, *Foreign Service Officer* (Cont'd).

Special Assistant to the Comptroller, 1987-89.
Served as a personal policy advisor and organizational analyst. Represented the CFO on issues including Department-wide financial systems development, budget management and personnel management. Supervised the front-office staff, and coordinated day-to-day activities, including work for senior Department officials, of the CFO's three Deputy Assistant Secretaries, 400-employee organization and 23 overseas field offices. Conducted a variety of complex management analysis, enhancement and reorganization projects. Most significant achievements: Planning and establishment of the bureau's new Executive Office, including new personnel hiring, training and evaluation.

Budget Officer, Executive Office, Bureau of European Affairs, 1983-86.
Developed, formulated, presented and executed annual bureau budgets for personnel and funding required to accomplish policy goals, totaling over 4,000 employees and $350 million in 30 countries. Prepared bureau financial plans for appropriated and reimbursed funds. Served as the bureau's financial systems specialist, coordinating bureau implementation of worldwide FMIS applications.

Diplomatic Service abroad in Malaysia and South America.

U.S. CONGRESS

Deputy Staff Director, House International Operations Subcommittee, 1991-94.
Formulated and worked through to enactment key budget authorization bills, including biennial State Department, USIA, AID and ACDA Authorization Act totaling over $15 billion. Drafted legislation effecting major international affairs organizational and Foreign Service personnel system and labor-management relations changes. Conducted oversight activities on U.S. international affairs management, budget and personnel issues, including eight major Congressional hearings. Staffed the Chairman, in terms of his Budget Committee work, on the entire range of federal budget issues. Most significant achievements: Enactment of supplemental peacekeeping and Refugee funding acts totaling over a billion dollars, and major State Department reorganization legislation.

APSA Congressional Fellow

- Office of Congressman Howard L. Berman (D-CA), 1989-90.
- Office of Senator Richard Lugar (R-IN), 1990-91.

European Organization for Nuclear Research, Geneva, Switzerland,
Scientific Attaché, Special Assistant to the Director of Budgets & Planning, 1976-79.

PROFESSIONAL AFFILIATIONS

American Association for Budget & Program Analysis
American Foreign Service Association

PERSONAL

Security clearance: Top Secret
References: On Request

WORLD HEALTH ORGANIZATION

HIV VACCINE INITIATIVE

UNAIDS

PRESS RELEASE

Geneva, 22 February 2000

WHO AND UNAIDS JOIN FORCES TO LAUNCH HIV VACCINE INITIATIVE

Geneva, 22 February 2000 – Cooperation in the search for an AIDS vaccine is intensifying with the creation of a new initiative by the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) to promote the development of a vaccine.

The WHO-UNAIDS HIV Vaccine Initiative is set to heighten international cooperation into AIDS vaccines in the face of mounting urgency as the epidemic spreads. The initiative is guided by a new joint WHO-UNAIDS HIV Vaccine Advisory Committee, which meets for the first time from 21st to 23rd February.

"The new initiative provides an independent forum where everyone working on HIV vaccines, from North or South, from industry or from research agencies, and from affected communities, can identify common ground for collaboration and coordination," said Dr Jose Esparza, Coordinator of the new initiative. "This should help capitalize on the extensive experience of all organizations."

The HIV Vaccine Initiative will focus on strengthening the capacity in developing countries to ensure that vaccine trials are conducted with the highest ethical and scientific standards.

A major challenge facing HIV vaccine development is finding a vaccine which will be effective worldwide, including developing countries, where 95% of infections occur.

"Vaccines are among the most cost-efficient interventions to prevent infectious diseases," said Professor Barry Bloom, Dean of the Harvard School of Public Health and head of the new joint WHO-UNAIDS Vaccine Advisory Committee. "We are fortunate that new initiatives are being proposed to expand availability of existing vaccines in developing countries and to conduct research to develop new ones," he said.

According to Dr Esparza, the multitude of HIV strains and the number of potential vaccines being tested make it imperative to coordinate research efforts. "Vaccine development efforts require concentrated international coordination and collaboration, with the full involvement of industrialized and developing countries, the public and private sectors, governmental and nongovernmental organizations, and the pharmaceutical industry," he said. "They also require the creation of financial incentives to stimulate more research and development."

WHO-UNAIDS HIV Vaccine Initiative, Health Technology and Pharmaceuticals
World Health Organization, 20 avenue Appia, 1211 Geneva 27, Switzerland,
Tel: (41) 22 791 21 84

"There is clearly a need for a body which can broker partnerships between the public and private sectors. Without these partnerships, a viable vaccine may never happen," Dr Esparza said.

Less than 20 years after AIDS was identified, it has become the most important infectious disease, the first cause of death in Africa and the fourth worldwide. More than 15 000 new HIV infections occur every day, most of them in developing countries, and over 33 million people now live with HIV or AIDS.

The involvement of both WHO and UNAIDS in promoting AIDS vaccine development goes back nearly a decade. In 1991, WHO spearheaded a vaccine development effort that assisted Brazil, Thailand and Uganda in elaborating the framework to conduct vaccine trials under the highest ethical and scientific standards. All three countries either have conducted, or are now conducting, such trials.

The AIDS vaccine effort shifted to UNAIDS after the Programme's creation in 1996. UNAIDS established a vaccine team whose advisory committee was headed by Professor Bloom. The committee, which has now become a joint WHO-UNAIDS committee, provided a unique forum for collaboration, where scientists from different agencies and disciplines were able to meet to exchange ideas and explore future avenues of research.

The urgent need to accelerate the development of an AIDS vaccine prompted UNAIDS and WHO to join forces and officially establish the HIV Vaccine Initiative to coordinate that development. The joint initiative will profit from the experience of both organizations and from existing wisdom gleaned from vaccine efforts against two other major killers, tuberculosis and malaria.

"This is the ideal team," said Dr Esparza. "UNAIDS brings with it its expertise in social and behavioural research and community participation, which is essential for the conduct of human vaccine trials. Any future vaccine is also an integral component of AIDS prevention and control."

"WHO brings its vast experience in vaccinology and the conduits it has established with pharmaceutical firms in developing earlier vaccines. WHO will also be essential in the delivery of an effective vaccine once it is discovered," Dr Esparza said.

For more information, please contact Anne Winter, UNAIDS, Geneva, (+41 22) 791.4577, Gregory Hartl, WHO, Geneva, (+41 22) 791.4458, Dominique de Santis, UNAIDS, Geneva, (+41 22) 791.4509 or Andrew Shih, UNAIDS, New York, (+ 1 212) 584.5024. You may also visit the UNAIDS Home Page on the Internet for more information about the programme (http://www.unaids.org).

Joint United Nations Programme on HIV/AIDS
UNAIDS
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UNESCO • WHO • WORLD BANK

The Executive Director

Participants of the International
HIV/AIDS Funding Strategy Meeting

Reference: **OED/PP/**lpdo#15543

14 February 2000

Dear Colleague,

I greatly appreciated the opportunity to meet you and to participate in the important discussions in Seattle last month. In accordance with our agreement to provide further information about UNAIDS, I should like to refer you to our web site - www.unaids.org, which also contains a wide range of documents on best practice in AIDS prevention, care, and impact mitigation, as well as regular updates of the epidemiological situation and the response to the epidemic. Staff lists are also provided.

I am also attaching a briefing pack relating to AIDS as a security problem, prepared for the UN Security Council's session on AIDS in Africa on 10 January 2000. In addition, under separate cover, I am sending a small sample of materials produced by UNAIDS which may be of specific interest to you.

As discussed, I very much hope it will be possible to identify specific areas of collaboration and I look forward to hearing from the follow-up group formed under the auspices of Funders Concerned About AIDS.

Please do not hesitate to contact me or any of my colleagues if we can be of any assistance to you in your work, or if you would like to explore more collaborative efforts.

I am looking forward to working with you.

Yours sincerely,

Peter Piot

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Joint United Nations Programme on HIV/AIDS
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With the complements of
the Executive Director

17 February 2000

Re: International HIV/AIDS Funding
Strategy Meeting

Please find enclosed the materials
mentioned in my e-mail message of
14 February 2000.
With best wishes.
Peter Piot

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CHILDREN ORPHANED BY AIDS

Front-line responses from eastern and southern Africa

unicef

United Nations Children's Fund

Clinton Presidential Records
Digital Records Marker

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UNAIDS partnership: working together on AIDS

Joint United Nations Programme on HIV/AIDS

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Facsimile

To:	Office of the Director Office of National AIDS Policy	Fax:	00 1 202 456 2438
		Pages:	13
		Ref.:	OED
From:	Office of the Executive Director	Date:	13 June 2000
Subject:	Please see attached		

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Lotus cc:Mail for mccaulf

Date: 13/06/00
Sender: piotp (mccaulf)
To: sthurman@oa.eop.gov
cc: brennerc, dgillespie@usaid.gov, pdelay@usaid.gov
bcc: schwartlanderb, sherryj
Priority: Normal
Subject: scaling up HIV/AIDS programmes in developing countries

Dear Sandy,

Further to our discussions during the PCB, I am pleased to attach the following documents on estimated resource needs for scaling up HIV/AIDS programmes in developing countries and information on donor funding. These documents were also provided to AID's HIV/AIDS Division on 7 June.

You may wish to open the document entitled: "Needs_Total.doc" first, as this summarizes the whole set of materials provided. It should be noted that the estimates on overseas development assistance for HIV/AIDS activities are based on available data from those donors who could already provide information for 1999 and 2000. These numbers will obviously need to be revised as and when accounts are closed. Information from France and the EC was not available. In addition, the estimates are shown in 1997 US$ values for comparison of trends over time.

We will keep you informed of progress in updating the materials as and when information from the donor community is received. In addition, we will also update you on progress in the work on resource needs which is being carried out in collaboration with the World Bank, WHO, the London School of Hygiene and Tropical Medicine and AID's HIV/AIDS Division.

Best regards,
Peter


Cost_of_Care.xls


Explanation_of_Model.doc


briefing notes for costing model.doc


Needs_Total.doc


ODA_est2000.xls


costing_prev.DOC

Notes on estimated resource needs for scaling up the response to HIV/AIDS

1) The results of the cost estimates that are presented here are work in progress and are based on ongoing work of several institutions and experts, including the World Bank, London School of Hygiene and Tropical Medicine, WHO, Options Consulting London, the division of health economics of the National Institute of Health in Mexico, and the UNAIDS Secretariat.

2) The total cost for HIV programmes are calculated based on the following main costing models:

   a) a study on cost of scaling up HIV prevention programmes in sub-Saharan Africa (LSHTM, WB, UNAIDS)

   b) a further developed model on cost of HIV care for developing countries.

   Both models use the well accepted approach of applying unit costs to identified needs and estimated (target) coverage rates.

3) The cost for prevention are calculated as follows (a description of the assumptions is attached in annex 1):

TABLE 1: Low and high cost estimates for scaling up HIV/AIDS prevention activities in sub-Saharan Africa

BILLIONS US$

	LOW	HIGH
PREVENTION		
Youth focused interventions	.226	.335
Interventions focused on sex worker interventions	.105	.199
Increased public sector condom provision	.013	.037
Condom social marketing	.076	.149
Strengthening STI services	.467	.554
Voluntary counselling and testing	.044	.160
Workplace interventions	.082	.100
Strengthening blood transfusion services	.003	.011
MTCT	.005	.014
Mass media	.099	.105
Start-up capacity development (very low only)	.003	.012
TOTAL PREVENTION (billions US$)	**1.120**	**1.664**

Between 1.1 and 1.7 billion dollars will be needed every year (starting in 2000) if the defined increased target coverage rates are to be achieved by the year 2005. Resources needed to maintain current coverage levels are not included. Such resources come from national and international sources.

Similar calculations are not available for countries outside Africa. However, preliminary analyses lead to the plausible conclusion that the need for all developing countries are in the magnitude of twice the numbers calculated for sub Saharan Africa. **This would bring the total needs for scaling up prevention programmes globally to about 2-3 billion US $.**

4. The calculation for cost of care was done following the following basic assumtions:
   - Only coverage and cost of the public health sector is included (no valid information exists about quality and coverage of the private sector for the vast majority of developing countries).
   - There is a ceiling of what is feasible for "access to care for HIV/AIDS" in the public sector. This is estimated using the median of three generally available indicators: proportion deliveries attended by trained health care worker, proportion of all TB cases covered by DOTS, and vaccine coverage rate (DPT). It is assumed that coverage beyond this estimated ceiling cannot be realistically achieved within the near future.
   - All current and future target coverage rates are given as proportion of this estimated ceiling (rather than as a proportion of all people needing care).

5. The total cost for care given today's absorptive capacities of health care systems in developing countries are:
   - US$ 850 million, if HAART were made available to all countries at 1,400 US$ per person year.
   - US$ 990 million, if HAART were made available to all countries at 2,800 US$ per person year.
   - US$ 1.13 billion, if ARV were made available to all countries at 4,200 US$ per person year.

   For comparison, if it were possible to provide HAART to all HIV patients who need treatment today in developing countries, the total cost would be about 9 billion for ARV alone (including the necessary lab costs).

6. For 2005, with substantially increased coverage rates, the total cost for care would be:
   - US$ 1.8 billion, if HAART were made available to all countries at 1,400 US$ per person year. (an increase of 1 billion)
   - US$ 2.5 billion, if HAART were made available to all countries at 2,800 US$ per person year. (an increase of 1.5 billion)
   - US$ 3.1 billion, if ARV were made available to all countries at 4,200 US$ per person year. (an increase of 2 billion)

7. The above cost estimates do not include resources needed to increase the capacity of the health system in order to achieve the scaling up to the targets set for 2005.

8. In summary, the estimated additional resources needed in the year 2005 to implement prevention and care programmes in developing countries at ambitious, but not unrealistic target levels are:
   - approximately 2.5 billion US$ yearly for prevention activities and
   - 1 to 2 billion US$ yearly for care depending on the estimate used for the cost per person of HAART.

   In the intervening years (when the programmes are being scaled up) the programme costs would be lower, but this reduced cost would be offset by the need to invest resources in increasing capacity of the system to implement the programmes at the target level.

Summary Table, Estimated cost of care for people with HIV/AIDS, 2000 & 20005

		Commodity Costs							Adjusted Labor Costs		Total Costs			
Country Classification	Population	HAART Lab costs	Cost for HAART at $1400/pt	Cost for palliative care	Cost for treatment for OI	Testing costs	Cost for prophylaxis for OI	Total commodity costs for all interventions	Total personel costs for in-patients & outpatient visits	Personnel costs for lab	Cost for HAART at $1400/pt	Cost for HAART at $2800/pt	Cost for HAART at $4200/pt	HAART cost for covering all ADULTS
ESTIMATED COSTS FOR 2000														
Low-income	Adults	1,318,893	23,080,833	9,397,115	46,161,266	410,506	659,447	81,027,859	123,646,248	2,637,787	207,311,894	230,392,527	253,473,160	7,012,292,904
Low-income	Children	307,563	1,794,117	730,462	3,588,234	95,729	51,260	6,567,365	28,834,022	615,126	36,016,512	37,810,629	39,604,746	
Low-income	Total	1,626,456	24,874,750	10,127,577	49,749,500	506,234	710,707	87,595,224	152,480,270	3,252,912	243,328,406	268,203,156	293,077,906	
Low-middle income	Adults	873,545	15,287,045	2,074,670	12,229,636	131,032	436,773	31,032,700	54,596,588	3,494,182	89,123,469	104,410,514	119,697,558	619,622,150
Low-middle income	Children	96,150	560,873	76,118	448,898	14,422	16,025	1,212,287	6,009,353	384,599	7,606,238	8,167,111	8,727,984	
Low-middle income	Total	969,695	15,847,917	2,150,789	12,678,334	145,454	452,798	32,244,987	60,605,940	3,878,780	96,729,707	112,577,625	128,425,542	
Upper-middle income	Adults	5,451,306	95,397,852	6,457,774	33,588,421	479,835	2,239,228	143,614,414	254,912,121	32,707,835	431,234,370	526,632,221	622,030,073	1,453,788,180
Upper-middle income	Children	1,125,702	6,566,593	489,118	2,544,019	109,029	169,601	11,004,062	57,921,854	6,754,210	75,680,126	82,246,720	88,813,313	
Upper-middle income	Total	6,577,008	101,964,445	6,946,892	36,132,439	588,864	2,408,829	154,618,477	312,833,975	39,462,045	506,914,496	608,878,941	710,843,386	
GLOBAL 2000	Adults	7,643,745	133,765,529	17,929,559	91,979,322	1,021,372	3,335,447	255,674,974	433,154,956	38,839,803	727,669,733	861,435,262	995,200,791	9,085,703,234
GLOBAL 2000	Children	1,529,414	8,921,583	1,295,698	6,580,951	219,181	236,887	18,783,714	92,765,228	7,753,935	119,302,876	128,224,460	137,146,043	
GLOBAL 2000	TOTAL	9,173,159	142,687,112	19,225,257	98,560,273	1,240,553	3,572,334	274,458,688	525,920,184	46,593,738	846,972,609	989,659,721	1,132,346,834	
ESTIMATED COSTS FOR 2005														
Low-income	Adults	13,188,933	230,806,330	21,926,601	92,322,532	1,978,340	8,243,083	368,465,819	288,507,912	26,377,866	683,351,597	914,157,927	1,144,964,256	
Low-income	Children	3,075,629	17,941,169	1,704,411	7,176,468	461,344	640,756	30,999,777	67,279,384	6,151,258	104,430,418	122,371,587	140,312,756	
Low-income	Total	16,264,562	248,747,499	23,631,012	99,498,999	2,439,684	8,883,839	399,465,596	355,787,296	32,529,124	787,782,016	1,036,529,514	1,285,277,013	
Low-middle income	Adults	4,367,727	76,435,223	3,319,473	16,344,453	393,095	1,965,477	104,825,448	87,354,540	17,470,908	209,650,896	286,086,119	362,521,341	
Low-middle income	Children	480,748	2,804,365	121,790	673,047	43,267	72,112	4,195,329	9,614,984	1,922,993	15,733,286	18,537,651	21,342,015	
Low-middle income	Total	4,848,475	79,239,587	3,441,262	19,017,501	436,363	2,037,589	109,020,777	96,969,504	19,393,901	225,384,182	304,623,769	383,863,356	
Upper-middle income	Adults	15,994,486	279,903,505	6,837,843	44,784,561	959,669	5,198,208	353,678,072	269,906,951	95,966,916	719,551,939	999,455,444	1,279,358,949	
Upper-middle income	Children	3,634,312	21,200,156	517,890	3,392,025	218,059	383,717	29,356,158	61,329,022	21,805,874	112,491,055	133,691,210	154,891,366	
Upper-middle income	Total	19,628,798	301,103,661	7,355,532	48,176,586	1,177,728	5,591,925	383,034,230	331,235,973	117,772,790	832,042,993	1,133,146,654	1,434,250,315	
GLOBAL 2005	Adults	33,551,146	587,145,057	32,083,717	155,451,546	3,331,105	15,406,768	826,969,339	645,769,403	139,815,690	1,612,554,432	2,199,699,489	2,786,844,546	
GLOBAL 2005	Children	7,190,690	41,945,689	2,344,090	11,241,540	722,670	1,106,585	64,551,265	138,223,369	29,880,125	232,654,759	274,600,448	316,546,137	
GLOBAL 2005	TOTAL	40,741,836	629,090,746	34,427,807	166,693,086	4,053,775	16,513,354	891,520,603	783,992,773	169,695,815	1,845,209,191	2,474,299,937	3,103,390,684	

Briefing notes for spreadsheet on treatment costs for HIV/AIDS in developing countries.

This is a crude model that was primarily designed to explore the relative importance of the different deteminants of the cost of care (access, drug costs, labour costs, etc.) rather than generate global totals.

The outputs of the model depend critically on five classes of inputs :

1. Per-capita estimates of GNP and PPP-adjusted GNP taken from the World Bank (used to adjust labour costs)
2. HIV prevalence and HIV/AIDS mortality estimates from UNAIDS/WHO
3. Estimates of current coverage for (a) attended births, (b) EPI coverage and (c) DOTS therapy for patients for active TB (used to estimate the ceiling for access to care for HIV/AIDS)
4. Estimates of the costs for commodities and labour/infrastructure for providing HIV testing and care. These are expressed as average annual costs for the last two years of life, assume that all costs of care are incurred in those two years, and differentiatially estimate costs for four different categories of care (OI prophylaxis, OI treatment, palliative care. HAART) .
5. Estimates of the proportion of people currently symptomatic with HIV/AIDS who know they are infected with HIV, receive prophylactic therapy for OI's, receive treatment for OI's, receive palliative care and receive HAART.

- **Inputs 1 & 2 :** These are based on data which have been progressively improved over many years and which, while not perfect, have well known strengths and limitations.

- **Inputs 3 :** The use of these inputs to estimate a ceiling for access to care for HIV/AIDS has never been done before and the methodology has not been validated except for seeking the opinion of a small number of knowledgeable persons as to the appropriateness of the resulting estimate. It is intended to estimate a ceiling for access only in the *public*-sector health system, as the inputs predominantly reflect the coverage of existing public-sector programmes. Although the model outputs are sensitive to these inputs and to the intermediate estimate of a ceiling for access to care, there is great uncertainty associated with this estimate. Subsequent work will need to both validate the methodology and perform sensitivity analyses to explore how the uncertainty is reflected in the model's outputs. The advantage of this new approach is that it is empirically based and captures a substantial portion of the likely variation among countries in access to care.

- **Inputs 4 :** The unit costs for commodities and labour/infrastructure are uncertain because relatively few data are available on variability in drug costs, infrastructure costs and labour costs. However, far less is known about the variation in clinical practice patterns (prescribing patterns, frequency of visits, probability of hospitalization, etc.) with resulting uncertainty regarding the estimated average cost of care per patient. The labour/infrastructure cost estimates were adjusted to reflect differences in cost of labour across countries. Commodity costs were assumed to be constant across countries. This last assumption may be a

reasonable approximation for generic drugs for which there is a competitive international market. If patent protected drugs, especially HAART, are differentially priced by region or by a country's level of development (as is currently the case and likely to increasingly be the case in the future), then the assumption of a uniform global price is not appropriate. The only way this was addressed in the current exercise was to model three different scenarios using three different annual costs for HAART. No adjustment was made to anticipate changes in prices between the year 2000 and 2005 with the justification that while the price for first-line therapy is likely to continue to fall, the proportion of people receiving therapy who are receiving second-line therapy will increase over the same period.

- **Inputs 5 :** Virtually no data were available to inform the setting of parameter values for the fifth class of inputs with the exception of isolated reports from countries known to be outliers regarding provision of care for people with HIV/AIDS (e.g. Brazil). The parameter estimates reflect only 'best-guess' estimates by the modelers with an attempt to insure internal consistency (e.g. the proportion pf people receiving prophylactic therapy must be smaller than the proportion who know they are infected, coverage increases in wealthier countries, etc.). As a result, this class of inputs represents the largest sources of uncertainty regarding estimates of current costs. As these estimates are expressed as 'goals' in the model for 2005, the issue is no longer the accuracy of the estimate, but rather the reasonableness of the goal.

Description of the spreadsheets

In the Excel spreadsheets, there are four different models: Adults, in years 2000 and 2005; Children in the years 2000 and 2005. For the models of different years, the only differences are in the goals for coverage of services provided. Costs were done separately both adults and children as there are differences in costs for treatment. In general we assumed that drug costs for children would be 1/3 of the same drugs for adults. In addition, there is a fifth worksheet which contains the summary estimates of care costs.

In organizing the spreadsheets, columns represent inputs or variables. We have tried to organize the spreadsheet so that that all variables, both those input and derived as intermediate steps, are explicitly listed in a column. Also we have placed variables/columns into conceptual groups, for example "Economic Indicators", "Target Coverage Indicators". In the explanation below, the conceptual groups are described (listed in Bold), including the variables contained in each group (listed in Italics). Also you can check the comment boxes at the head of the columns for information.

Region

Geographic region codes 1 = SS Africa, 2= Asia, 3=Latin America & Caribbean, 4=Eastern Europe & Central Asia, 5 = North Africa & Middle East

Country Name

Estimates of Prevalence and Mortality

Includes estimates of prevalence, mortality for adults, women, children, and 1999 population figures.

Economic Indicators

GNP per capita (constant 1995 US$), GNP per capita, PPP (current international $), Economic Classification of country from World Bank CODE 1 = low-income countries; 2 = lower-middle income countries; and, 3 = upper-middle income countries.

Target Coverage Indicators

Births attended by health staff (% of total), *Immunization, DPT* (% of children under 12 months), *DOTS detection*, and *Measure of health care access*. The measure of health care access is the median value of the three indicators. It is used as the measure of access to health care. This only applies to public sector health care providers. SOURCES: World Development Indicators, 1999 for Births attended and Immunization; Global Tuberculosis Control, WHO Report 2000 for DOTS detection rate. NOTE: the Dots detection is the number of cases treated by DOTS over all TB cases (estimated), therefore a measure of coverage of the DOTS programme.

Treatment Population Estimates

People needing care, this is defined for adults as 2 times the number of adult deaths in 1999, for children it is 1.5 times the number of child deaths in 1999.
People needing care with access this is defined as the number of *people needing care* times *measure of health care access*.

Goals for Coverage of People with Access to Health Care (2000 and 2005)

There are five coverage variables one for each broad class of care/treatment. For each of these we have set coverage values.

Coverage for HAART
Coverage for palliative
Coverage for OI treatment
Knowing status of symptomatic
Coverage of prophylaxis of OI

For these five variables coverage values are set for 1999, and goal for coverage are set for 2005. These levels increase with economic classification of the country, with higher 1999 coverage rates and higher goals for 2005. **Please note**: The coverage rates apply to the *People needing care with*

access. For example if, coverage goal is set at 50%, this does not mean 50% of the people needing this treatment get treatment. It is 50% of the people who need treatment **and** have access to health care (as measured by *Measure of health care access*).

Number of People Getting Services

For the five variables: *People getting HAART; People getting palliative care; People getting treatment for OI People knowing status; and People getting prophylaxis for OI* all values are a product of coverage of the variable and *People needing care with access*

UNIT COSTS - Fixed

Lab costs is based on testing cost (minus labor) for tests required for HAART
Cost for HAART is based on an average cost for first and second line treatment. Here the assumption is that second line treatment is more expensive (2,200) while first line treatment should cost 1,000.
Cost for palliative care is based on figures reported in "Confronting AIDS".
Cost for treatment for OI is based on figures in "Confronting AIDS".
Testing costs is based on studies in Uganda (4.00) with an assumption that it is a minimum value.
Cost for prophylaxis for OI is based on figures reported in "Confronting AIDS".

UNIT COSTS - Country variable costs

Staff costs for in-patients & outpatient visits is based on the assumption of 24 visits per year at a cost of US$ 10 per visit in low-income countries (category 1)
Personnel costs for lab is based on lab personnel costs for doing testing for HAART

Country Adjustment Factor

Country Multiplier : The above *country variable costs* for low income countries are assumed to be 100% greater in lower-middle income countries (category 2) and 200% greater in upper-middle income countries (category 3).

National Costs (non-labor)

The first five variables are the product of Unit Costs – Fixed and Number of People Getting Services: *Cost for HAART*; *Cost for palliative care*; *Cost for treatment for OI*; *Testing costs*; and *Cost for prophylaxis for OI*
The six variable (*Total costs for all interventions*) is a sum of the first five.

Adjusted National Labor Costs

These two factors adjust labor costs by a measure of country labor costs..
Total personnel costs for in-patients & outpatient visits is the product of the unit cost of *Personnel costs for lab*, *People getting HAART* and the *Country Multiplier*
Personnel costs for lab is the product of the unit cost of *Personnel costs for lab, People getting palliative car,* and the *Country Multiplier*

Total National Costs, Services and Labor

This is the sum of Adjusted National Labor Cost and *Total costs for all intervention.*

National Cost if HAART costs are 2,800

This column presents the regional totals for cost of care if the costs of arv drugs for HAART are double the estimate we used.

National Cost if HAART costs are 4,200

This column presents the regional totals for cost of care if the costs of arv drugs for HAART are triple the estimate we used.

Also please note that there is a calculation of costs for providing HAART to all adults who need it in the last column on the sheet for adult 2000.

Preliminary Estimates of the Cost of HIV/AIDS Prevention
For Sub-Saharan Africa

The cost figures reflect the estimated costs of improving the coverage of programme activities at a national scale. The following prevention strategies are costed:

Prevention:
1. Youth-focused interventions
2. Sex Worker interventions
3. Strengthening of public sector condom distribution
4. Condom social marketing, male condom only
5. Strengthening STI services
6. Voluntary counselling and testing (VCT)
7. Workplace interventions
8. Strengthening blood transfusion services
9. Interventions to reduce mother-to-child transmission (MTCT), including VCT
10. Mass media campaigns
11. Start up capacity building (for weakest countries)

The figures presented are given in US $ (2000 value). These costs give an idea of the magnitude of resources which need to be spent next year, if one hopes to reach the scale of the target coverage levels in 2005. It is important to note that resources that are necessary to keep programmes at current levels are not included. Such resources do include national and to some extent international resources.

Table 1. Grouping of Countries by Existing Strength of HIV/AIDS Programme Activities

Estimated Programme Strength			
Very Low	**Low**	**Medium**	**Strong**
Angola	Benin	Botswana	Cote d'Ivoire
Congo	Burkina Faso	Burundi	Senegal
Djibouti	Burundi	Cameroon	Uganda
Eritrea	*Chad*	Central African Rep.	
Ethiopia	*Equatorial Guinea*	Kenya	
Liberia	***Gabon***	Lesotho	
Nigeria	Gambia	Malawi	
Sierra Leone	Ghana	Mozambique	
Somalia	Guinea	Tanzania	
Zaire	*Guinea Bissau*	*Namibia*	
	Madagascar	South Africa	
	Mali	*Swaziland*	
	Mauritius	Zambia	
	Niger	Zimbabwe	
	Rwanda		
	Togo		

Note: Figures for countries in italics extrapolated from other countries within same group

Table 2: Baseline and target coverage assumptions for 2005

Coverage assumptions										
			Very Low		Low		Medium		Strong	
Form of intervention	Potential target group	Measure of coverage	Baseline	Target	Baseline	Target	Baseline	Target	Baseline	Target
Youth focused interventions In school youth	Male and female youth enrolled in school. 6 – 11 12 – 16	Proportion 6 – 11 receiving HIV education Proportion 12 – 16 receiving HIV education	5% 20%	50 % 80%	5% 20%	50% 80%	10% 30%	50% 80%	20% 50%	50% 80%
Youth focused interventions Out of school youth	Males and females 12 – 16	Proportion 12 – 16 receiving HIV education	5%	50%	5%	50%	10%	50%	20%	50%
Sex worker interventions	4% urban women aged 15 – 49. Average 2 sex acts per week	Proportion total reached Proportion using condoms often	20% 10%	60% 70%	20% 10%	60% 70%	40% 20%	60% 70%	50% 30%	60% 70%
Strengthening public sector condom distribution	All sex acts with non-regular partners 20% sex acts in regular partners	Proportion using condoms often in non-regular partnerships Proportion using condoms in regular partnerships	10% 2%	70 % 2%	10% 1%	70% 2%	20% 2%	70% 2%	40% 2%	70% 2%
Condom social marketing	All sex acts with non-regular partners 20% sex acts in regular partners	Proportion using condoms often in non-regular partnerships Proportion using condoms in regular partnerships	10% 2%	70% 2%	10% 2%	70% 2%	20% 2%	70% 2%	40% 2%	70% 2%
Strengthening STI services	Men and women with curable STIs and access to health services	Among those with access to health services, proportion of curable STIs treated by health service	5%	30%	5%	30%	15%	30%	20%	40%
Voluntary counselling and testing	Current sexually active population	Proportion receiving VCT urban Proportion receiving VCT rural	1% 0 %	5% 5% (including MTCT testing)	1% 0%	5% 5% (including MTCT testing)	1% 0 %	5% 5% (including MTCT testing)	1% 1%	5% 5% (including MTCT testing)
Strengthening blood transfusion services	Blood for transfusion	Proportion units of blood for transfusions tested Urban Rural	 70% 70%	 100% 100%	 70% 70%	 100% 100%	 90% 75%	 100% 100%	 90% 90%	 100% 100%
Mother to child transmission	Pregnant women aged 15 – 49	Proportion pregnant women tested HIV Urban Rural	 0.5% 0%	 10% 5%	 0.5% 0%	 10% 5%	 0.5% 0%	 10% 5%	 0.5% 0%	 10% 5%
IEC / mass media	National campaigns for entire country	Number campaigns per year	2	6	2	6	2	6	2	6

TABLE 3: Low and high cost estimates for sub-Saharan Africa

BILLIONS US$ (2000 value)

	LOW	HIGH
PREVENTION		
Youth focused interventions	.226	.335
Interventions focused on sex worker interventions	.105	.199
Increased public sector condom provision	.013	.037
Condom social marketing	.076	.149
Strengthening STI services	.467	.554
Voluntary counselling and testing	.044	.160
Workplace interventions	.082	.100
Strengthening blood transfusion services	.003	.011
MTCT	.005	.014
Mass media	.099	.105
Start-up capacity development (very low only)	.003	.012
TOTAL PREVENTION (billions US$ 2000)	**1.120**	**1.664**