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HIV/AIDS DIVISION FAX

U.S. AGENCY FOR
INTERNATIONAL
DEVELOPMENT

DATE: 6/25/99

TO: SANDY TAWMAN ORGANIZATION: ONAP

FAX PHONE: 456-2438 OFFICE PHONE: _____

FROM: ALAN OFFICE PHONE: _____

FAX PHONE: 202-216-3046 NUMBER OF PAGES (INCLUDING COVER) 5

COMMENTS:

NSC INFO AS REQUESTED

REGARDS

USAID and HIV/AIDS in Africa

USAID has been a global leader in bilateral and multilateral support for HIV/AIDS prevention and mitigation. USAID strategy in Africa has been to strengthen HIV/AIDS program through:

- Influencing the policies of African countries and other donors.
- Direct support to governments, NGOs and private sector for key intervention expected to prevent the epidemic and mitigate its impact particularly on the orphans.
- Analytical work on the impact of ~HIV/AIDS on various sectors, identification of cutting edge issues and support for operational research.
- Cooperation with Regional organizations such as Southern African Development Community for strengthening bilateral programs through exchange of experiences.

Funding Level: The U.S. Government response to the global pandemic began in 1986 and since then we have contributed \$1.143 billion to the effort. Since the early 1990's, the U.S. has been the lead donor, contributing 25% of the budget for UNAIDS each year (in 1999 = \$15 million) and 48% of overall development assistance devoted to HIV/AIDS prevention and control in the developing world. (\$125 million in 1999) The U.S contributes four times more than the next largest bilateral donor (Netherlands).

Since 1986, USAID has expended in sub-Saharan Africa approximately \$650 million (50% of the total global expenditure). Financial resources, from USAID, for HIV/AIDS in Africa have increased from over \$23 million in 1992 to \$74 millions in 1999. Also, in 1999, an additional \$7 million has been provided for Africa from the Supplemental Fund for Children Affected by HIV.

USAID Programs: To date, USAID has carried out policy dialogue and supported programs in over 38 countries. The activities range from changing risky behavior through education, motivation and innovation, increasing the availability of condoms and access to quality drugs for the treatment of sexually transmitted diseases; providing guidance and counseling services, reducing mother to child transmission of the disease and conducting community based approaches and interventions.

Impact: Specific impact has been made in countries where USAID support has been significant as

In Uganda, HIV prevalence has declined by 35% in young women aged 15-24 identified below:

- Knowledge of several modes of transmission among adults has increased to 70-80% levels in Senegal, Ghana and Uganda.
- In Kenya, studies have indicated that through condom promotion alone over 10,000 HIV infections and over 1.3 million other sexually transmitted diseases were averted from 1991-94. Increased use of condoms is reported in other countries such as Malawi and Benin.
- USAID supported development of low-cost 'dipsticks' for detecting HIV antibodies and they are now being produced in Cameroon and Zimbabwe.
- Successful community care approaches for the orphans have been established in Malawi, Zambia and Uganda.

Future Strategies: The global community and we have learned, from the above experiences, that sufficient knowledge and tools exist to reduce the transmission and mitigate its impact. The challenge, in many countries, is to create strong political will as well as capacity to implement successful efforts on a large scale. HPN officers from Southern Africa have strongly supported a new Southern Africa Regional Initiative called Storm Warning. This includes strengthening programs at the country as well as subregional levels. The new sub-regional programs focus on strengthening sub-regional surveillance, HIV/AIDS cross border programs targeted at high-risk population along the transportation corridor and policy dialogue on a sub-regional level.

In terms of influencing the donors USAID was one of the key advocates for developing a UN system-wide response to the epidemic and since 1996 has been the lead sponsor of UNAIDS. UNAIDS as well as the World Bank are in the process of developing strategies to intensify their programs in Africa. USAID has supported these efforts and provided a synthesis of its experiences to them to influence these strategies. USAID is taking an active role in the preparation of forthcoming donors meeting on International Partnership on HIV/AIDS in April. The deliberations of the meeting are expected to lead to new approaches to deal with the epidemic, better coordination of resources and enhanced finding from other donors.



USAID'S HIV/AIDS ASSISTED COUNTRIES

AFRICA REGIONAL	ANE REGIONAL	LAC REGIONAL
Angola * Benin Botswana Burkina Faso** Cameroon** Congo (DRC) Congo (Brazzaville) Cote d'Ivoire** Eritrea Ethiopia Ghana Guinea Kenya Madagascar Malawi Mali Mozambique Namibia* Nigeria Rwanda Senegal South Africa Tanzania Togo** Uganda Zambia Zimbabwe * New Programs FY00 ** Regional FHA Project	Bangladesh Cambodia Egypt India Indonesia Laos Morocco Nepal Phillipines Vietnam ENI/NIS REGION Russia Ukraine	Bolivia Brazil Dominican Republic El Salvador Guatemala Haiti Honduras Jamaica Mexico Nicaragua Peru

HIV-AIDS Funding for FY 1999 and FY 2000

HIV/AIDS Component	FY 1999	FY2000 (still being finalized)
Total HIV/AIDS appropriation	\$125,000,000	\$127,000,000 (requested)
-Africa	-\$56,000,000	-\$55,100,000
-Latin America/Caribbean	-\$13,000,000	-\$13,200,000
-Asia/Near East	-\$19,000,000	-\$21,350,000
-Global	-\$36,000,000 (50% -\$18 million- of this sum is targeted at Africa)	-\$35,750,000 (50%- \$17 million -of this sum is targeted at Africa)
-Other Central Bureaus	-\$1,000,000	-\$1,600,000
Additional Funding for HIV/AIDS activities (not part of the HIV/AIDS appropriation)		
Eastern Europe/Newly Independent States*	\$1,750,000*	\$1,750,000*
Condom procurement*	\$21,145,833	\$20,907,717
Children Affected by HIV Supplemental Funding*	\$10,000,000*	NA
Africa	-\$7,000,000	NA
Latin America/Caribbean	-\$200,000	NA
Asia/Near East	-\$1,800,000	NA
Global	-\$1,000,000	NA

* These funds are not part of the HIV/AIDS appropriation FY request.



U.S. Agency for International Development

Handwritten: B-2408

Bureau for Africa
Office of Sustainable Development
1325 G St., NW Suite 400
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Date: _____

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From: *Alp*

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Number of Pages Including Cover Sheet

Message

*A hard copy of my edits/suggestions/notes
for draft report (file sent electronically)
A*

Sandy:

The following are comments to the draft report (the version I had from a week ago Friday).

Summary Section.

Add an item 6:

6. We know what works—interventions have succeeded in many locations. Scaling up these efforts, along with commensurate resources, are required.

(Rationale: It is important to convey that we just don't recognize the problem but we know how to deal with it, and thus can use the resources well).

Page 4 – Findings Section

You may wish to add a subheading "The Problem" before launching into the text at the beginning (see later under page 10).

Page 5 – Findings Section

Para beginning "Fragile health care...": At the end of the first sentence, add a new sentence: "TB now accounts for half of all AIDS deaths in Africa, according to a recent study."

Para beginning with "Further, throughout...": Possibly before the sentence beginning "According to UNICEF..." add a new sentence: "Moreover, the enormous numbers of AIDS orphans will have negative effects on African society, particularly on the transmission of traditions, history, values, and norms."

(Rationale: African society, particularly at the village level, relies on oral traditions and history telling. With so many adults dying, the link with the past will be a casualty of the epidemic and its chaotic impacts.)

Page 5 – Graphic. I think it's OK. One minor revision to consider is to amend the graph title to read: "% of All Children Orphaned by AIDS"

(Rationale: this makes it clear that the denominator is all children in the given country).

Page 6 – graphic. Add the source of the data to the graph (in fine print). I believe it is the US Bureau of the Census.

Page 6, bottom, Para beginning with "AIDS is a trade and investment issue": You note that Jeffrey Sachs spoke at the recent meeting with African trade and finance ministers... If that refers to the Ministerial meeting we had in March, Sachs in the end did not speak there. He did prepare some papers for the meeting. As an aside, Treasury and others did not want him there. The quote however is great. The way the statement is currently formulated, it does not refer to *which* meeting he spoke at, so we may be OK. And his thoughts are documented in the papers.

Page 8—Bottom of page, Para that begins "As goes Africa, so will go India, Asia, and the new Soviet...": This is a technicality, but the Soviet Union referred to the old order. I am not sure that it is appropriate to refer to "new Soviet states" as they are now not Soviet and are independent states. One term often used is Newly Independent States, but you may want to check with a State Dept person for the current term.

Page 10 – Add a subheading at the top of the page "The Response". This sets this sub-section apart from the rest of the findings section which discusses the problem.

Perhaps add a new paragraph immediately following such a subheading such as "We know what works. Prevention programs, linked with basic care and support, in several countries have demonstrated success in preventing HIV transmission. But, the scale of these activities is too small. In order to make a lasting

difference, large scale increases in resources are required. Consider that total worldwide spending for AIDS in developing countries (all sources: national, bilateral and multilateral) was \$550 million in 199_ for 34 million cases of AIDS (22 in Africa). Last year, U.S. spending for AIDS was \$6-7 billion for 600,000 cases of AIDS."

p. 13 The special box on MTCT. Numerous typos and missing letters. Para beginning "The lack of health care..." Second sentence, the letter "d" missing from an—should be "and." Para beginning "Further, the AIDS..." Second sentence, the word is "breast". Same sentence, the HIV+ - is confusing, better to spell it out here. Next sentence, women should be singular, woman.

p. 14 – A thought on resources. First, the US is the leader worldwide when it comes to AIDS donor funding (by a large margin, Holland is next at \$30+ million). If the US increases its resources for AIDS, it will send a clear signal to the rest of the donor community to increase their resources as well, thereby leveraging those resources. Increased US funding could also be used as an incentive to leverage important national reforms and resource increases favoring AIDS efforts.

p. 16. Para on "We recommend that the US establish a program... The terms debt forgiveness and debt swaps are used interchangeably in this paragraph—this should be avoided. Rather than saying a "debt swap agreement" I suggest using a "debt relief agreement."

Item 3 – the Headline of the section is unclear: "Other partnerships with African nations (no apostrophe)" is there a word(s) missing here?

Some thoughts on this section. First, there are numerous opportunities where US and African interests intersect. These often occur in established forums such as BNCs, Ministerial meetings, SADC Forums, and so on. Hence, the need for the USG to speak with one voice (a recommendation). A second recommendation involves using the upcoming ICASA and Durban AIDS conferences in Africa to highlight the issue and to send high level US delegations as speakers (particularly multisectoral, not just health).

US Ambassadors to Africa have voiced their tremendous concerns about AIDS in Africa. They have repeatedly asked for more information and action on the part of other USG agencies as well as from their host country counterparts. Moreover, a State Dept cable requiring a demarche on AIDS has been sent out earlier this year. A recommendation could be that the State Department work jointly with other country ambassadors to Africa in a unified diplomatic initiative to apply pressure on host country governments to respond to the AIDS epidemic.

To lead off with this section should be a strong recommendation on either a First Ladies summit or a Presidential summit. To the extent this could be tied down as a possibility (either one) at publication time, the better. It seems that a Presidential Summit would be less likely, but post Kosovo and as we get closer to the end of this Administration, the greater the possibility that it could actually happen. It may depend on the African American community's push as well as any inspiration that could be derived from the example of former President Carter and his efforts surrounding guinea worm and other humanitarian causes. It also begs the question as to what deliverables the US would be able to offer for such an event. But, what an event it could be (and what a workload ☺)

I am not so sure on the AIDS impact statement—more so on the language used. Apparently, the World Bank is already doing something akin to an AIDS impact statement by requiring that their environmental impact assessments include AIDS. For USAID and other USG agencies working in Africa, we could recommend that AIDS impact assessments be considered to see how a given project would affect or be affected by AIDS.

p. 17 Item 4 – Partnerships with other donors. G8 language on debt forgiveness and use of benefits for social sectors and AIDS especially is moving forward. On a broader level, the US can work with other donors in providing leadership in donor coordination, as well as participating in the international Africa Partnership Against AIDS. To be honest, I cannot think of a headline grabbing initiative here. Working closer with the World Bank is a very interesting proposition—particularly as the Bank is launching their

new AIDS strategy and the US (via USAID) can leverage these WB projects by providing technical assistance to countries. The WB provides the money, the US provides the TA and the marriage is done. A meeting between you and Jan Peerce/Wolfensohn could be useful in developing a specialized initiative that increases/formalizes the WB-USAID relationship.

Item 5 – The Private sector. Business investment is directly linked with the President's "Partnership with Africa" (see p. 14) and his trade initiatives. Thus, the real appropriateness of this type of initiative. Dept of Commerce needs to play a role in this. One idea is to have the President issue awards of excellence to those companies that took the leadership to develop AIDS in the workplace programs. Although symbolic, it is something that companies would value i.e., recognition and PR.

As you have indicated, several US companies have taken the lead in developing AIDS programs: Levi Strauss, Ford, Chevron, and others. Another related initiative is to mobilize American Chambers of Commerce to assist with AIDS advocacy. Another idea is to develop Business Councils on AIDS in many countries that provides the forum for business leaders to talk with one another and support each other.

A Cabinet official/White House (i.e. you?) sponsored meeting for foundations on the topic of AIDS in Africa could be useful to mobilize their interest the subject.

Unions. The Solidarity Center experience with COSATU (Council of South African Trade Unions) is very valuable and should be mentioned. By successfully engaging COSATU and obtaining their agreement to place AIDS as a major labor policy issue, the union council reaches millions of South Africans and others from the region. Next steps are to implement the policies and to set up support programs for the membership.

PVOs and NGOs. The not for profit sectors, represented by international PVOs and indigenous NGOs, play a critical and vital role in the fight against AIDS in Africa, particularly at the community level—where it counts. A recommendation to hold some form of meeting, and possibly awards, would be useful. Global Council and others may have others specific ideas in this area.

Item 6 – Partnerships with the religious community. A White House summit of US and African religious leaders would go a very long way in mobilizing African religious leader commitment to the issue of AIDS prevention and care/support. Religion plays a very important role in the lives of Africans. It is where they derive their hope and seek comfort. It is an extremely powerful mobilizing and social support force. But, on AIDS, many religious leaders and institutions have not been supportive. They have not spoken out, and in many cases have shunned the very people that need their help the most—AIDS infected and affected persons. Key issues are stigma and reducing the discrimination that people with AIDS experience in Africa, as well as creating the spiritual home that all those affected require. All faiths would be welcome. Key US leaders such as Rev. Sullivan and Jackson; Bishop Haines, and other denomination leaders would be invited. US models such as NEAC and African models/inspirations such as the Ugandan and Senegalese experiences, as well as many others would be shared. A product of the meeting could be some form of joint statement of principles. A footnote: the World Parliament of Religions is slated to meet in Durban on Dec 1 1999 and this may provide some competition as far as the date is concerned. The Parliament also wishes to have an AIDS program.

Citations

- p. 2 item 1 – USAID report Children at the Brink
item 2 – UNAIDS and USAID
item 3 – Based on economic and security facts (World Bank, DOD)
item 4 – UNAIDS
item 5 – USAID Uganda and other experiences
- p.4 First para. Numbers on bubonic plague and influenza probably gotten from public health book
AIDS vs all wars data from Global Health Council. Remainder of para data from UNAIDS December 1998 report.

Second para. UNAIDS and ONAP derivation of South African numbers since World AIDS Day 98.
Graph from UNAIDS.

- p. 5 First para. World Bank Confronting AIDS book. Next section (shattering families) probably derived from John Williamson (USAID) and UNICEF report.

Graph source: UNICEF?

- p. 6 Life expectancy data and graph derived from US Bureau of Census World Population Reports 1998 report.

AIDS as economic issue. Sachs quote from HIID articles on AIDS (will verify). Economist article from January 1999 I believe.

- p. 7. World Bank data from Confronting AIDS book. Last para of economic section—South African study.. Not sure which one this is, do you all have it?

DOD for military issues.

South African crime institute report—you probably all have it.

- p. 8 bottom and page 9. UNAIDS data

- p. 10 Leadership matters. Uganda story from Elizabeth Marum, USAID technical advisor, Uganda.

Effective solutions based on your interviews and Jon Williamson's input.

- p. 11 bottom. USAID and others as a source.

- p. 12 Four pronged approach. USAID.

Bottom on MTCT – USAID as source.

- p. 14 bottom. Funding stats from USAID.

- p. 15 top. Again, funding from USAID.

Bottom, US Treasury Dept?

FAX TRANSMISSION

Department of the Treasury

Office of International Debt Policy

Office 202-622-0212

Fax 202-622-0218

To: Sandra L. Thurman

Date: 28 May 1999

Fax #: 456-2438

Pages: 1, including this cover sheet.

From: Max Hudgins

Subject: Debt Reduction to Fight AIDS

COMMENTS:

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

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

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

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

THE WORLD BANK GROUP
Headquarters: Washington, D.C. 20433 U.S.A.
Tel. No. (202) 477-1234 • Fax (202) 477-6391 • Telex No. RCA 248423

FACSIMILE COVER SHEET AND MESSAGE

DATE: May 26, 1999 **NO. OF PAGES:** 13 **MESSAGE NO.:**
(including cover sheet)

TO: **FAX NO.:** 456-2439
Title:
Organization:
City/Country:

FROM: Mead Over **FAX NO.:** (202)522-3230
Title: Senior Economist Telephone: (202)473-3451
Dept/Div: Dept./Div. No.:

SUBJECT: The Economic Impact of AIDS

MESSAGE:

Transmission authorized by:

If you experience any problem in receiving this transmission, inform the sender at the telephone or fax no. listed above.

Prepared by John Stone, Policy PROJECT.

Reinforce
into >

The Economic Impact of AIDS

AIDS has the potential to create severe economic impacts in many African countries. It is different from most other diseases because it strikes people in the most productive age groups and is essentially 100 percent fatal. The effects will vary according to the severity of the AIDS epidemic and the structure of the national economies. The two major economic effects are a reduction in the labor supply and increased costs:

Labor Supply

- The loss of young adults in their most productive years will affect overall economic output
- If AIDS is more prevalent among the economic elite, then the impact may be much larger than the absolute number of AIDS deaths indicates

Costs

- The direct costs of AIDS include expenditures for medical care, drugs, and funeral expenses
- Indirect costs include lost time due to illness, recruitment and training costs to replace workers, and care of orphans
- If costs are financed out of savings, then the reduction in investment could lead to a significant reduction in economic growth

A World Bank study of the economic impacts of AIDS in Africa concluded that the macroeconomic impacts of AIDS could be significant.¹ Yet there is still time to mitigate the economic impact of AIDS; over half of Africa's population live in countries where the epidemic is "concentrated," that is, where HIV infection is concentrated in groups with risky behavior and is not yet widespread in the general population.²

The economic effects of AIDS will be felt first by individuals and their families, then ripple outwards to firms and businesses and the macro-economy. This paper will consider each of these levels in turn and provide examples from various African countries to illustrate these impacts.

Economic Impact of AIDS on Households

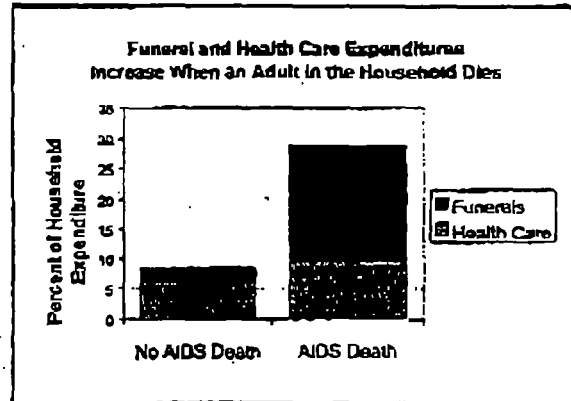
The household impacts begin as soon as a member of the household starts to suffer from HIV-related illnesses:

- Loss of income of the patient (who is frequently the main breadwinner)
- Household expenditures for medical expenses may increase substantially
- Other members of the household, usually daughters and wives, may miss school or work less in order to care for the sick person
- Death results in: a permanent loss of income, from less labor on the farm or from lower remittances; funeral and mourning costs; and the removal of

children from school in order to save on educational expenses and increase household labor, resulting in a severe loss of future earning potential.

Studies in Tanzania, Cote d'Ivoire, Uganda, and Ethiopia have documented the tremendous burden of loss of income, large health care expenditures, and consumption of savings to pay for funeral and mourning costs:

- In Tanzania, a study of adult mortality found that 8 percent of total household expenditure went to medical care and funerals in households that had an adult death in the preceding 12 months. In households with no adult death the figure was only 0.8 percent. In addition to increased expenditures, many households experienced a reduction in remittances if the adult member worked outside the home. In partial compensation for these financial setbacks, many households were forced to remove children from school in order to reduce education-related expenditures and have the children help with household chores.³



graph does not reflect text

- In Cote d'Ivoire, households with an HIV/AIDS patient spent twice as much on medical expenses as other households. Furthermore, 80 percent of the expenditures went to the AIDS patient, rather than to other household members who are ill. When the person with AIDS died or moved away, average consumption fell by as much as 44 percent during the following year.⁴
- In Uganda, the economic impact of HIV-related deaths was stronger than other types of death, as households lost much of their savings in order to pay health care and funeral expenditures. Asset ownership declined when the death of an HIV+ member occurred, but remained stable when the death was of an HIV- member.⁵
- In Ethiopia, a study of 25 AIDS-afflicted rural families found that the average cost of treatment, funeral and mourning expenses amounted to several times the average household income.⁶

Economic Impact of AIDS on Agriculture

Agriculture is the largest sector in most African economies accounting for a large portion of production and a majority of employment. Studies done in Tanzania and other countries have shown that AIDS will have adverse effects on agriculture, including loss of labor supply and remittance income. The loss of a few workers at the crucial periods of planting and harvesting can significantly reduce the size of the harvest. In countries

where food security has been a continuous issue because of drought, any declines in household production can have serious consequences. Additionally, a loss of agricultural labor is likely to cause farmers to switch to less-labor-intensive crops. In many cases this may mean switching from export crops to food crops.⁷ Thus, AIDS could affect the production of cash crops as well as food crops.

- A study done by the Zimbabwe Farmers Union (ZFU) showed that the death of a breadwinner due to AIDS will cut the production of maize in small scale farming and communal areas by 61 percent. Similar results were obtained for other crops (see table at right). The fall in output results from losses of labor and remittances and the need to spend scarce resources on medical expenses.

Reduction in Production Due to AIDS Deaths in Zimbabwe

Crops	Reduction in Output
Maize	61%
Cotton	47%
Vegetables	49%
Groundnuts	37%
Cattle Owned	29%

- In Ethiopia, the male head of the household is responsible for special tasks, such as oxen cultivation, harvesting, threshing and farm management. One study found that the effect of an AIDS death varied by region: it would have the most severe effect on harvesting teff in Nazareth, on digging holes for transplanting enset plants in Atat, on ploughing millet fields in Baherdar, and on picking coffee in Yirgalem. Women are generally responsible for other tasks: leveling, weeding, harvesting minor crops, transporting produce, and household duties. The death of the wife to AIDS can make it difficult for other household members to carry out these tasks, in addition to caring for children. The death of a family member because of AIDS also leads to a reduction in savings and investment. The stock of food grain can be depleted to provide food for mourners and the other expenses were met most often by selling livestock. Such loss of productive assets only makes it harder to survive in the future.⁸
- In Kagabiro village, Tanzania, when a household contained an AIDS patient, the household labor supply was severely affected: on average, 29% of household labor was spent on AIDS-related matters, including care of the patient and funeral duties. If two people were devoted to nursing duties, as occurred in 66% of the cases, the total labor loss was 43%, on average.⁹
- In Malawi, 10% of GDP comes from estate agriculture. A recent study evaluated the costs of HIV/AIDS on a tea estate there (see table at right). The study found that the costs are determined by the levels of both employee benefits and of skilled labor necessary for production. It predicted that, in the longer term,

Cost of HIV/AIDS on a Tea Estate in Malawi

Description	Total Cost (£)	Related to HIV (%)	Cost of HIV (£)
Provision of medical services	22,275	25	5,569
Funeral costs	928	75	696
Death in service benefits	4,691	100	4,691
Absence	14,875	25	3,719
Total	42,769		14,675

the negative impact on the supply of skilled labor will be the strongest effect of HIV/AIDS.¹⁰ It will become increasingly difficult to recruit skilled people, even at the national level.

- Data collected in Uganda indicate that agricultural tasks were frequently disrupted when women needed to care for household members ill with AIDS-related conditions.¹¹

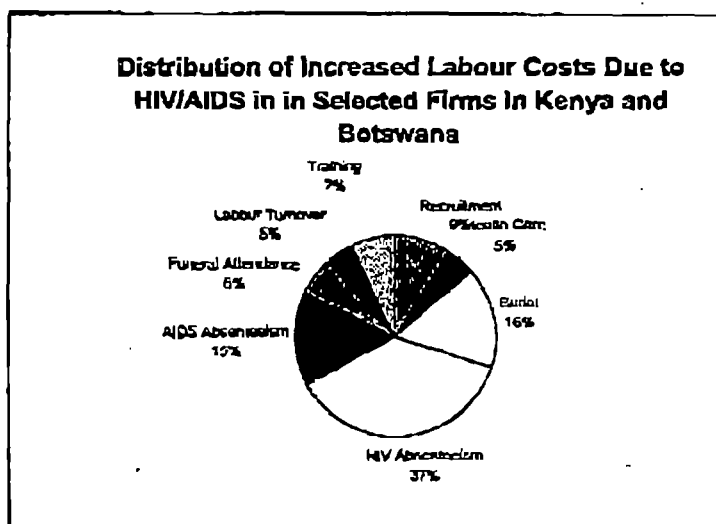
Economic Impact of AIDS on Firms

AIDS may have a significant impact on some firms. AIDS-related illnesses and deaths to employees affect a firm by both increasing expenditures and reducing revenues. Expenditures are increased for health care costs, burial fees and training and recruitment of replacement employees. Revenues may be decreased because of absenteeism due to illness or attendance at funerals and time spent on training. Labor turnover can lead to a less experienced labor force that is less productive.

Factors Leading to Increased Expenditure	Factors Leading to Decreased Revenue
Health care costs	Absenteeism due to illness
Burial fees	Time off to attend funerals
Training and recruitment	Time spent on training
	Labor turnover

The actual distribution of these costs has been calculated as part of various USAID-funded AIDSCAP studies of the private sector impact of AIDS:

- One study examining several firms in Botswana and Kenya showed that the most significant factors in increased labor costs were absenteeism due to HIV or AIDS and increased burial costs as shown in the figure to the right.¹²



- Another study in Zimbabwe found that the major expense was health care costs. The transport company in this study has a large staff of 11,500 workers. Since the company offers significant health benefits to its employees, the cost of AIDS is even higher than for other companies that do not provide such benefits. The study estimated that there are currently more than 3,400 workers who are infected with HIV and 64 who died from AIDS in 1996. The total costs of AIDS to the company in 1996 were estimated at Z\$39 million, equal to about 20 percent of the company's profits. More than half of

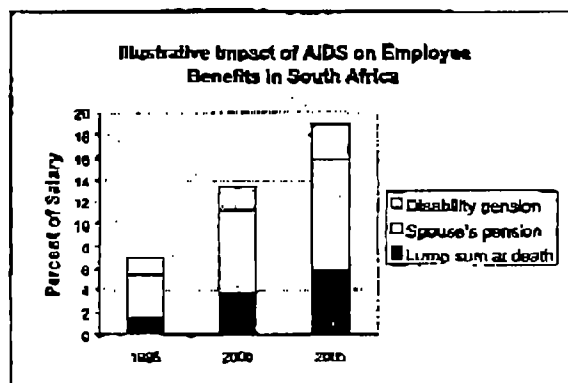
this amount resulted from increased health care costs. By 2005 the cost of AIDS to the company could reach Z\$108 million. There may be indirect costs as well. The report speculates that HIV/AIDS will worsen employee morale and create greater labor-management tensions and cause a labor shortage among skilled positions.¹³

Various studies have also examined the total annual cost of AIDS to different companies, as well as the annual cost of AIDS per employee.¹⁴ These studies found that the annual cost of AIDS per employee varied from US\$17 to US\$300, as shown in the table below:

Company Name	Total Annual Cost of AIDS	Annual Cost of AIDS per Employee
Botswana Diamond Valuing	US\$ 125,941	US\$ 237
Botswana Meat Commission	US\$ 370,200	US\$ 268
Cote d'Ivoire food processing firm	US\$ 33,207	US\$ 120
Cote d'Ivoire textile firm	US\$ 32,667	US\$ 29
Cote d'Ivoire packaging firm	US\$ 10,398	US\$ 125
Kenyan automobile firm	US\$ 21,312	US\$ 17
Kenyan transport firm	US\$ 61,132	US\$ 28
Muhoroni Sugar, Kenya	US\$ 58,303	US\$ 49
Kenyan lumber firm	US\$ 40,630	US\$ 25
Uganda Railway Corporation	US\$ 77,000	US\$ 300

Increased labor costs can reduce the profits necessary for expansion. This impact on profits can be considerable:

- The Indeni Petroleum Refinery in Zambia spent US\$26,400 on AIDS-related costs in 1994, more than its declared profits of US\$25,514 in that year.¹⁵
- A study in South Africa examined the expected impact of AIDS on employee benefits, and thus on corporate profits. It found that at current levels of benefits per employee, the total costs of benefits would rise from 7 percent of salaries in 1995 to 19 percent by 2005. Since these additional costs will have to be paid at the same time that productivity is declining, due to AIDS, the net impact on profits could be significant.¹⁶



Finally, other costs associated with AIDS that firms face include:

- The Uganda Railway Corporation has been hard hit by AIDS among its employees, experiencing a labor turnover rate of 15 percent per year in recent years.¹⁷

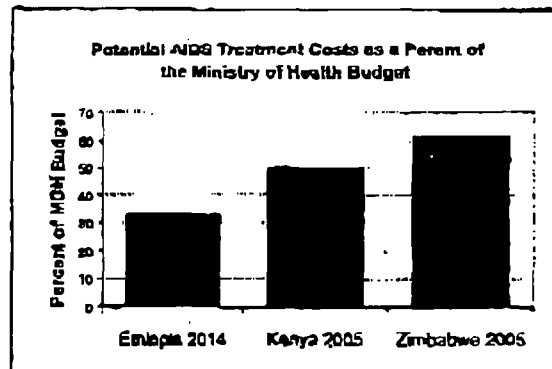
- Medical aid companies in Zimbabwe have estimated that meeting all the claims of just one percent of HIV-infected members could result in a 31 percent increase in insurance rates. Most of this increase would have to be paid by employers.¹⁸

For some smaller firms the loss of one or more key employees could be catastrophic, leading to the collapse of the firm. In others, the impact may be small. Firms in some key sectors, such as transportation and mining, are likely to suffer larger impacts than firms in other sectors. In poorly managed situations the HIV-related costs to companies can be high. However, with proactive management these costs can be mitigated through effective prevention and management strategies.

Impacts on Other Economic Sectors

AIDS will also have significant effects in other key sectors. Among them are health, transport, mining, education and water, *for civil servants and the military.*

- Health. AIDS will affect the health sector for two reasons: (1) it will increase the number of people seeking services and (2) health care for AIDS patients is more expensive than for most other conditions. The number of AIDS patients seeking care is already overwhelming health care systems. In many hospitals in Africa, half of hospital beds are now occupied by AIDS patients. AIDS is also an



(have more access to cash)

expensive disease. The graph shows projected expenditure on AIDS as a percentage of public health spending for three African countries.¹⁹ On average, treating an AIDS patient for one year is about as expensive as educating ten primary school students for one year. Governments will face trade-offs along at least three dimensions: treating AIDS versus preventing HIV infection; treating AIDS versus treating other illnesses; and spending for health versus spending for other objectives. Maintaining a healthy population is an important goal in its own right and is crucial to the development of a productive workforce essential for economic development.

- Transport. The transport sector is especially vulnerable to AIDS and important to AIDS prevention. Building and maintaining transport infrastructure often involves sending teams of men away from their families for extended periods of time, increasing the likelihood of multiple sexual partners. The people who operate transport services (truck drivers, train crews, sailors) spend many days and nights away from their families. A survey of bus and truck drivers in Cameroon found that they spent an average of 14 days away from home on each trip and that 68 percent had sex during the most recent trip and 25 percent had sex every night they were away.²⁰ Most transport managers are highly trained professionals who are hard to

replace if they die. Governments face the dilemma of improving transport as an essential element of national development while protecting the health of the workers and their families.

- **Mining.** The mining sector is a key source of foreign exchange for many countries. Most mining is conducted at sites far from population centers forcing workers to live apart from their families for extended periods of time. They often resort to commercial sex. Many become infected with HIV and spread that infection to their spouses and communities when they return home. Highly trained mining engineers can be very difficult to replace. As a result, a severe AIDS epidemic can seriously threaten mine production.
- **Education.** AIDS affects the education sector in at least three ways: the supply of experienced teachers will be reduced by AIDS-related illness and death; children may be kept out of school if they are needed at home to care for sick family members or to work in the fields; and children may drop out of school if their families can not afford school fees due to reduced household income as a result of an AIDS death. Another problem is that teenage children are especially susceptible to HIV infection. Therefore, the education system also faces a special challenge to educate students about AIDS and equip them to protect themselves.
- **Water.** Developing water resources in arid areas and controlling excess water during rainy periods requires highly skilled water engineers and constant maintenance of wells, dams, embankments, etc. The loss of even a small number of highly trained engineers can place entire water systems and significant investment at risk. These engineers may be especially susceptible to HIV because of the need to spend many nights away from their families.

Some resources spent on education will be lost if kids die of AIDS. The more skilled, the greater the loss.

Macroeconomic Impact of AIDS

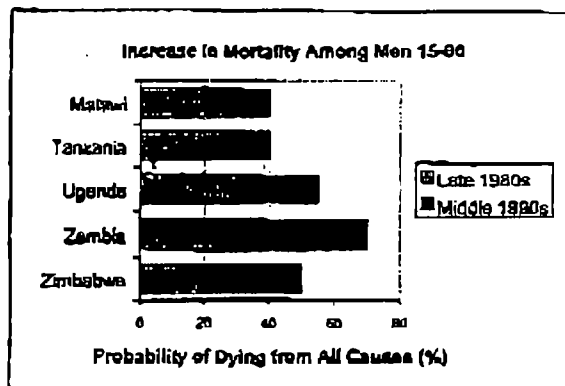
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The macroeconomic impact of AIDS is difficult to assess. Most studies have found that estimates of the macroeconomic impacts are sensitive to assumptions about how AIDS affects savings and investment rates and whether AIDS affects the best-educated employees more than others. Few studies have been able to incorporate the impacts at the household and firm level in macroeconomic projections. Some studies have found that the impacts may be small, especially if there is a plentiful supply of excess labor and worker benefits are small. Other studies have found significant macroeconomic impacts. Studies in Tanzania, Cameroon, Zambia, Swaziland, Kenya and other sub-Saharan African countries have found that the rate of economic growth could be reduced by as much as 25 percent over a 20-year period.

also, macroecon. impact depends on structure of the economy.

There are several mechanisms by which AIDS affects macroeconomic performance.

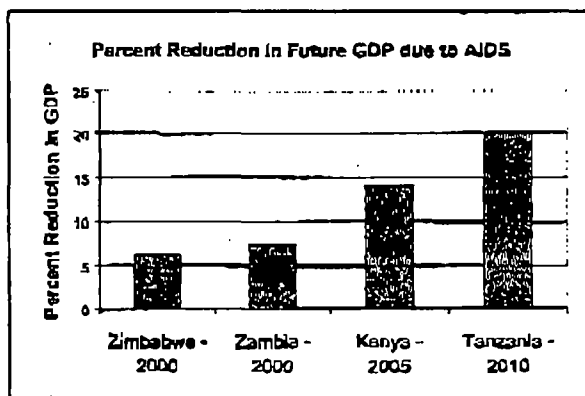
- AIDS deaths lead directly to a reduction in the number of workers available. These deaths occur to workers in their most productive years. As younger, less experienced workers replace these experienced workers, worker productivity is reduced. The graph to the right illustrates the magnitude of the problem in five African countries.²¹ It shows the increase in mortality among men of working age from the late 1980s to the mid-1990s. Most, if not all, of this increase is due to AIDS.



- A shortage of workers leads to higher wages, which leads to higher domestic production costs. Higher production costs lead to a loss of international competitiveness which can cause foreign exchange shortages.
- Lower government revenues and reduced private savings (because of greater health care expenditures and a loss of worker income) can cause a significant drop in savings and capital accumulation. This leads to slower employment creation in the formal sector, which is particularly capital intensive.
- Reduced worker productivity and investment leads to fewer jobs in the formal sector. As a result some workers will be pushed from high paying jobs in the formal sector to lower paying jobs in the informal sector.
- The overall impact of AIDS on the macro-economy is small at first but increases significantly over time.

Several studies have found that these effects could be large in some African countries.

- A World Bank study examined the macroeconomic impact of AIDS in 30 sub-Saharan African countries.²² This study concluded that the net effect is likely to be a reduction of the annual growth rate of GDP of 0.8 to 1.4 percentage points per year and a 0.3 percentage point reduction in the annual growth rate of GDP per capita.



Very Important

- A simulation model of the economy of Cameroon concluded that the annual growth rate of GDP could have been reduced by as much as 2 percentage points during the 1987-1991 period because of AIDS.²³
- A study of the macroeconomic impacts of AIDS in Zambia found that by 2000 the GDP would be 5 to 10 percent lower because of AIDS than it would be if there were no AIDS affecting the population. The authors concluded, "...without unprecedented infusions of free foreign aid to mitigate the effects of AIDS, the economy of Zambia will suffer considerable damage."²⁴
- An assessment of the macroeconomic impacts of AIDS in Tanzania by the Government of Tanzania, the World Bank and the World Health Organization in 1991 found that total GDP will be 15 to 25 percent smaller in 2010 because of the impact of AIDS.²⁵
- A study of the impact of AIDS on the economy of Kenya projected that GDP will be 14 percent lower in 2005 than it would have been without AIDS. GDP per capita will be 10 percent less in 2005.²⁶
- *Effects on savings in country.*
- *Effects on private sector & investment.*
- *What Can Be Done?*

AIDS has the potential to cause severe deterioration in the economic conditions of many countries. However, this is not inevitable. There is much that can be done now to keep the epidemic from getting worse and to mitigate the negative effects. Among the responses that are necessary are:

- *Plan for AIDS in all development sectors.*
- **Prevent new infections.** The most effective response will be to support programs to reduce the number of new infections in the future. After more than a decade of research and pilot programs, we now know how to prevent most new infections. An effective national response should include information, education and communications; voluntary counseling and testing; condom promotion and availability; expanded and improved services to prevent and treat sexually transmitted diseases; and efforts to protect human rights and reduce stigma and discrimination. Governments, NGOs and the commercial sector, working together in a multi-sectoral effort can make a difference. Workplace-based programs can prevent new infections among experienced workers.
- **Design major development projects appropriately.** Some major development activities may inadvertently facilitate the spread of HIV. Major construction projects often require large numbers of male workers to live apart from their families for extended periods of time, leading to increased opportunities for commercial sex. A World Bank-funded pipeline construction project in Cameroon was redesigned to avoid this problem by creating special villages where workers could live with their families. Special prevention programs can be put in place from the very beginning in

projects such as mines or new ports where commercial sex might be expected to flourish.

- **Programs to address specific problems.** Special programs can mitigate the impact of AIDS by addressing some of the most severe problems. Reduced school fees can help children from poor families and AIDS orphans stay in school longer and avoid deterioration in the education level of the workforce. Tax benefits or other incentives for training can encourage firms to maintain worker productivity in spite of the loss of experienced workers.
- **Mitigate the effects of AIDS on poverty.** The impacts of AIDS on households can be reduced to some extent by publicly funded programs to address the most severe problems. Such programs have included home care for people with HIV/AIDS, support for the basic needs of the households coping with AIDS, foster care for AIDS orphans, food programs for children and support for educational expenses. Such programs can help families and particularly children survive some of the consequences of an adult AIDS death that occur when families are poor or become poor as a result of the costs of AIDS. The costs of these programs can vary widely.²⁷

Annual Costs of Programmes to Mitigate the Household Impacts of AIDS, Kagera, Tanzania, 1992

Type of Programme	Annual Cost (US\$)
Home care for people with AIDS	\$227 per patient
Orphanage care	\$1,063 per child
Foster care	\$185 per child
Feeding post	\$69 per child
Basic needs support	\$47 per household
Educational support	\$13 per child

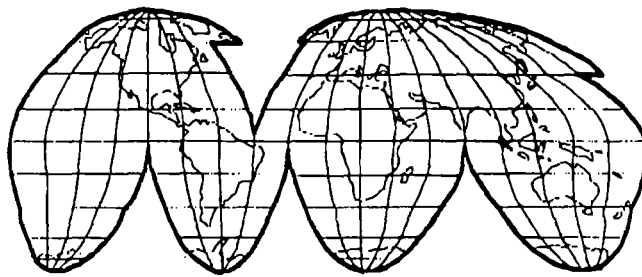
A strong political commitment to the fight against AIDS is crucial. Countries that have shown the most success, such as Uganda, Thailand and Senegal, all have strong support from the top political leaders. This support is critical for several reasons. First, it sets the stage for an open approach to AIDS that helps to reduce the stigma and discrimination that often hamper prevention efforts. Second, it facilitates a multi-sectoral approach by making it clear that the fight against AIDS is a national priority. Third, it signals to individuals and community organizations involved in the AIDS programs that their efforts are appreciated and valued. Finally, it ensures that the program will receive an appropriate share of national and international donor resources to fund important programs.

Perhaps the most important role for the government in the fight against AIDS is to ensure an open and supportive environment for effective programs. Governments need to make AIDS a national priority, not a problem to be avoided. By stimulating and supporting a broad multi-sectoral approach that includes all segments of society, governments can create the conditions in which prevention, care and mitigation programs can succeed and protect the country's future development prospects.

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FAX TRANSMISSION SHEET

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PAGES: 3

DATE: May 25, 1999

☐	FOR YOUR ACTION	☒	FOR YOUR INFORMATION
☒	AS REQUESTED	☐	AS DISCUSSED

MESSAGE: I am sorry for the delay. Secretary Shalala, Assistant Secretary for Health/Surgeon General Satcher, and a large delegation of DHHS officials including myself were in Geneva last week for the World Health Assembly. DHHS will hold a meeting of relevant agencies later in the week to further develop the response to your request. I will be in touch.

ATTACHED: Memorandum with Attachments



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Office of Public Health and Science
Office of International and Refugee Health
Rockville, MD 20857

DATE: May 25, 1999

TO: Director
Office of National AIDS Policy

FROM: Acting Director
Office of International and Refugee Health
Department of Health and Human Services

SUBJECT: Global AIDS Emergency Working Group

The Department of Health and Human Services (DHHS) has been seriously engaged in a response to the growing emergency of HIV/AIDS in many parts of the world. The crisis in sub-Saharan Africa has been of special concern.

The Assistant Secretary for Health and Surgeon General (ASH/SG) has included Emerging and Reemerging Infectious Diseases (ERIDs) in general and HIV/AIDS in particular under his Global Health Priority. Attached is a column on global HIV/AIDS by the ASH/SG from the *Journal of the American Medical Association (JAMA)* (Tab A).

The three most important agencies in the DHHS response to global HIV/AIDS are the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), and the National Institutes of Health (NIH). Attached is a summary of the DHHS response to global HIV/AIDS (Tab B).

DHHS looks forward to its participation in the Global AIDS Emergency Working Group.


Gregory Pappas, M.D., Ph.D.

TAB A



JAMA

The Journal of the American Medical Association

Medical News & Perspectives - April 28, 1999
From the Surgeon General

JAMA

The Global HIV/AIDS Epidemic

An enormous human tragedy is unfolding in many less-developed countries because of the spread of HIV/AIDS. Of the 33.4 million HIV-infected people around the world, there are an estimated 22.5 million in sub-Saharan Africa, 6.7 million in South and Southeast Asia, 1.4 million in Latin America, and 665,000 in the United States. Globally, more than 14 million people have died of the disease, including 2.5 million last year.

In many southern African countries, HIV/AIDS has become an unprecedented emergency, with 20% to 26% of people between the ages of 15 and 49 infected. In Botswana, Kenya, Malawi, Mozambique, Namibia, Rwanda, South Africa, Zambia, and Zimbabwe, HIV/AIDS will reduce life expectancy from 64 to 47 years by 2015. The progress of decades of work immunizing children, controlling diseases, and improving nutrition is being negated by HIV/AIDS.

Conditions in many parts of the world promote rapid spread of the HIV/AIDS epidemic. For example, India, with a population approaching 1 billion, has estimated that 3 million to 5 million of its people are infected, and the number of new infections will double every 14 months.

Social and political issues surrounding sex, injecting drug use, and blood transfusion in many countries have created special circumstances in which the disease has been able to spread unchecked. Some less-developed countries also bear a burden of political and economic instability that makes prevention even more difficult. It was only a few years ago that epidemiologists offered projections of disease prevalence for sub-Saharan Africa that were met with disbelief. If the present warnings go unheeded, South Asia, Southeast Asia, and, perhaps, China will follow the disastrous course of sub-Saharan Africa.

More than a decade of experience has taught us how to control HIV/AIDS—we know what works. Many developed countries have successfully checked the spread of the epidemic. While development of therapy and a vaccine continue, prevention must be emphasized. The basic elements of prevention include education, behavior change, voluntary testing and counseling,

prevention of perinatal transmission, and political commitment. Each country must find the mix of methods appropriate to its particular conditions.

Education about HIV/AIDS is necessary but alone does not change the behavior of populations. Promotion of voluntary testing and counseling must complement education. Testing and counseling break the deadly silence around HIV/AIDS and empower individuals to make informed decisions and change behaviors. Breaking the silence also will begin to diffuse the stigma surrounding the disease. We have seen success with behavioral change in Uganda and Thailand, the only two less-developed countries with extensive capacity for voluntary testing and counseling.

It is known that perinatal transmission of HIV can be reduced by more than 50% by using antiretroviral therapy; however, problems with access to these drugs limit their use in some countries. Transmission of HIV through breast-feeding and poor survival of orphans make the avoidance of disease via treatment for perinatal transmission more complex. We continue to work with international organizations, other governments, and pharmaceutical companies to lower costs and expand access to antiretroviral drugs. Current treatment for perinatal transmission (as well as use of antiretrovirals in general) in less-developed countries is also limited by the fact that very few people have been tested for HIV infection.

Treatment of other sexually transmitted diseases (STDs) is important to control the spread of HIV. One of the reasons HIV has spread so rapidly in Africa is that so many STDs go untreated. Untreated STDs break down natural barriers that prevent transmission. Access to even basic treatment for STDs remains a problem for many less-developed countries.

Perhaps most important in the global battle against HIV/AIDS is political commitment. Leaders at the national, provincial, and local levels of government must speak out about HIV/AIDS and encourage businesses and nongovernmental organizations to commit to work against the disease. I was encouraged by US Vice President Al Gore and Deputy President Thabo Mbeki of South Africa, who put the HIV/AIDS threat at the top of the international agenda at the recent meeting of the United States-South Africa Joint Commission. They set an important example for leaders in developed and less-developed countries.

American medicine and public health have an important role to play in the global battle against HIV/AIDS by supporting international organizations such as the Joint United Nations Program on HIV/AIDS, the World Health Organization, and the World Bank.

HIV/AIDS can be likened to the plague that decimated the population of Europe in the 14th century. While the modern epidemic affects people of all age groups, those of working age are at highest risk, posing potentially dire economic, social, and political consequences for the global community. Unfortunately, the world continues to devote greater attention and resources to traditional national security issues such as wars, postponing notice of an epidemic that, if left to spread unchecked, will kill more people than any of the terrible conflagrations that have so marked this century.

—David Satcher, MD
Surgeon General of the United States and Assistant
Secretary,
Department of Health and Human Services

(JAMA. 1999;281:1479)

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TAB B

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Centers for Disease Control and Prevention

The U.S. Department of Health and Human Services (DHHS) is committed to working in partnership with others to reverse the toll that HIV/AIDS is taking on millions of lives by halting the further spread of HIV and mitigating its effects on those already infected through research, prevention, service delivery and education efforts. Scientists at DHHS have contributed significantly to international progress in understanding how HIV infection is transmitted, how it affects the body, and how to treat and prevent it. As new information becomes available, increased knowledge about this disease and better ways to treat and prevent it should be forthcoming to address this critical health problem.

As the Nation's prevention agency, CDC integrates prevention science, research and practice. Through basic and laboratory research, epidemiologic research, and surveillance, behavioral, communications, and social science research, CDC supports a comprehensive approach to issues which impact prevention. CDC collaborates with governmental and non-governmental organizations, international and domestic, awarding grants to national organizations, state and local health departments, community-based organizations and other institutions to support prevention activities based on science. This integration of science and practice is consistent across all of CDC's Centers, Institutes, and Offices supporting prevention science activities. These include the National Center for HIV, STD and TB Prevention (NCHSTP), the National Center for Infectious Disease (under which falls the Division of AIDS, STD, and TB Laboratory Research), the National Center for Chronic Disease Prevention and Health Promotion (under which falls the Division of Adolescent and School Health and the Division of Reproductive Health), the Office of Women's Health and the Public Health Practice Program Office (which ensures the quality of laboratory testing).

In FY-1998, DHHS received more than \$6.8 billion dollars for HIV/AIDS activities. The majority of these funds (nearly two-thirds) were distributed for care and treatment of Americans through the Health Care Financing Administration (HCFA) authorized under Medicaid and Medicare programs and through the Health Resources and Services Administration (HRSA) authorized under the Ryan White Care Act. Funding for international collaborative HIV/AIDS activities is limited within the offices and agencies within DHHS, with no formal budget allocation for international activities. Therefore, only a tiny percentage of HIV/AIDS funds are allocated for international HIV/AIDS activities.

CDC has two programmatic approaches to international collaboration in HIV/AIDS prevention: field-based research collaborations and limited CDC-based technical assistance, training, and project management.

Field-Based Research

Epidemiology of HIV. Field-based research provides collaborative assistance to Côte d'Ivoire, Uganda, South Africa and Thailand. Studies are designed to increase the

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understanding of the epidemiology of HIV and to evaluate intervention methodologies in the host country and the United States. Because of the variation in the virus itself throughout the world, CDC, through two of its centers in Côte d'Ivoire and Thailand, conducts international surveillance of the genetic diversity of HIV research collaborations in numerous countries throughout the world.

Perinatal Transmission. Earlier this year, researchers from CDC and the Ministry of Public Health in Thailand announced dramatic findings that offer real hope for extending perinatal prevention successes to many developing nations. Researchers found that a short course of AZT given late in pregnancy and during delivery reduced the rate of HIV transmission to infants of infected mothers by half and is safe for use in the developing world. CDC is continuing collaborative research in West Africa to establish the longer term efficacy of short course zidovudine for populations in whom safe alternatives to breast feeding may not be available.

Microbicide Development. CDC has also supported international collaboration on the development of microbicidal products, as well as international studies in acceptability of microbicides in Zimbabwe and Thailand. In addition, a number of domestic and international activities have included research about the potential impact of including information on microbicides, once available, as part of the prevention messages about condoms. CDC participates with NIH and FDA in the International Working Group on Microbicides, which also includes UNAIDS, the Population Council and some industry representatives.

Prophylaxis of Opportunistic Infections. In Côte d'Ivoire, a placebo controlled trial of cotrimoxazole in patients in treatment for tuberculosis showed a significantly reduced mortality in immuno-suppressed patients taking the active drug. The recently completed trial of preventive therapy for tuberculosis in Uganda, conducted by Case Western Reserve University in collaboration with Ugandan colleagues was supported by CDC as well.

Vaccine Research. CDC has a number of research activities related to the development of HIV vaccines. This includes participation in efficacy trials in the United States and Thailand, as well as in the development of novel candidate vaccines in collaboration with academic centers. In addition, behavioral research and communication efforts about vaccine related issues are ongoing. CDC expertise in vaccine implementation will be a valuable resource once candidates become available.

Technical Assistance

In addition, CDC provides both long and short term technical assistance internationally. Long-term technical assistance and management capacity has been established by CDC field assignees to Uganda and South Africa, working in conjunction with USAID, as well as India and Vietnam. In addition to these field-based staff, CDC provides short-term technical assistance and training to numerous countries including Brazil, Russia, The

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Republic of South Africa, and Mali, and to international organizations including UNICEF, UNAIDS, and WHO.

Training

In conjunction with these technical assistance activities, CDC provides training in the areas of epidemiology, evaluation, prevention methodologies and other technical areas through an extensive program of training based in Atlanta as well as at field sites in Thailand and Côte d'Ivoire. CDC has also designed a program, in collaboration with USAID, to link U.S.-based community organizations and their prevention interventions with counterparts in developing countries. This was established in order to provide a mechanism to share relevant experiences, provide materials and resources, and training opportunities across countries. Other activities will support USAID-assisted countries with access to CDC epidemiologic and surveillance expertise.

Other Activities

Although not specific to HIV/AIDS, it is important to note that CDC's international work focuses heavily on strengthening public health infrastructure, and such work can contribute to sustainable HIV/AIDS control. For example, the CDC established field epidemiology training programs in developing countries. Epidemiology is the cornerstone of public health science, and trained epidemiologists are valuable countries to detect, monitor and help control their key public health programs. Secondly, CDC has established a sustainable management development program to provide practical training in management of public health programs in developing countries.

Recognizing the urgency of the epidemic and its impact on many domestic issues, CDC is committed to HIV/AIDS research within, as well as outside of, U.S. borders. To understand HIV/AIDS at a global level, research must address issues and conditions unique to different countries and communities within countries. Many developing countries severely affected by the epidemic lack the research capacity, public health infrastructure, and financial and human resources to respond to the epidemic. CDC's international research underscores the importance of developing and implementing diverse interventions to address issues among varied populations and to do so quickly and cost-effectively.

Food and Drug Administration

The Food and Drug Administration (FDA) is the only agency within the U.S. Public Health Service whose responsibilities are regulatory in nature. Its purview is product-driven and encompasses products worth approximately 25 percent of the U.S. gross national product. FDA activities respond to product applications—the agency reviews what is brought to it.

FDA's level of commitment to prevention, diagnosis, and treatment of HIV/AIDS is broad-based. FDA, like all of its component agencies in the U.S. Public Health Service, is committed to finding more and better ways to prevent, diagnose, and ultimately cure HIV/AIDS. FDA performs research and review involving AIDS therapeutic and diagnostic vaccine products. Major research priorities include: (1) new more sensitive blood safety testing for HIV; and (2) methods, standards, and studies on mechanisms of action of new AIDS therapeutics and vaccines.

Funding

FDA and its budget is organized around the products within its regulatory framework and is not, generally, a grant-making institution nor an entity organized in terms of line items for particular diseases or disease groups. FDA does not have a specific international budget allocation.

Prevention

Medical Devices. FDA has an ongoing responsibility to help ensure the safety and effectiveness of AIDS-related medical devices through its regulatory activities. This includes sampling and testing of medical gloves and latex condoms; reviewing submissions to market devices that reduce the risk of HIV transmission, including donor screening tests; conducting HIV-related regulatory research involving medical devices; and evaluating the role of devices in the transmission of bloodborne infections.

FDA has cleared for marketing over 280 needle and intravenous cannulas with safety features that reduce the risk of sharps injuries to healthcare workers. Among sharps containers FDA has recently cleared for marketing are devices that electrically oxidize all types and sizes of needles immediately after use, further reducing the risk from used needles.

As condoms remain the best means of protection against the transmission of HIV and other sexually-transmitted diseases, FDA must be vigilant in its regulation. FDA is working to develop better tests for condom strength and is investigating the barrier capability of condoms manufactured of different materials.

Blood and Blood Products. FDA is responsible for ensuring the safety of the U.S. blood supply. Regulatory mechanisms designed to ensure blood safety include establishing

policies; approving authority for blood products and establishments; and surveilling and enforcing blood safety standards. The blood safety system FDA has established consists of five layers of overlapping safeguards that start at the blood collection centers and extend to the manufacturers and distributors of the blood products made from donated blood.

The first level of precautions seeks to eliminate high-risk donors by encouraging those whose blood may pose a health hazard to exclude themselves, and by evaluating their behavioral and medical history as a basis for deferral. The second safeguard entails constant updating of a list of unsuitable donors and checking donors' names against the list to prevent using their blood. The third consists of testing the blood for such bloodborne agents as HIV, hepatitis, and syphilis. The fourth safeguard FDA enforces is a quarantine of donated blood until tests and other control procedures establish its safety. Finally, the blood collection centers are obligated to investigate incidents, audit their systems, and correct deficiencies. FDA also sets quality and safety standards for blood-derived products such as viral inactivation of clotting factor concentrates and immune globulins.

Treatment Equity

Therapeutic Agents. FDA is responsible for approving safe and effective drugs and biologics used in the United States for treating HIV infection, AIDS, and AIDS-associated opportunistic infections. FDA is also responsible for regulating the investigation of new drugs. It places special emphasis on ensuring the most timely and efficient premarketing review possible of products that offer promise for diagnosing, treating, or preventing HIV and HIV-related illnesses. FDA has approved 37 applications for products to treat HIV/AIDS. Twelve drugs are antiretroviral agents that are used to treat the virus, and the remaining 25 are used to treat opportunistic infections that can complicate HIV infection. In addition, FDA is responsible for monitoring the safety of the drugs and biologics post marketing and places special emphasis on ensuring that new safety information is disseminated widely and in a timely manner.

Vaccine Research

Within the framework of the Public Health Service-wide vaccine program for prevention and therapy, FDA is continuing its efforts to guarantee that any promising products for immunization against HIV will receive expedited regulatory review, and when appropriate, will be approved in the shortest possible time.

Diagnostic Capability

Diagnostic Reagents and Test Kits. FDA conducts a variety of regulatory, testing, and research activities to approve for marketing satisfactory test methodologies for detection of HIV. FDA has approved 2 HIV-1 Antigen tests; 20 anti-HIV-1 assays; 3 anti-HIV-2 assays; 1 anti-HIV assay on urine; 1 anti-HIV testing service using home collection; 1

anti-HIV-1 oral specimen collection device; and 1 HIV-1 viral load assay. FDA currently is facilitating development of gene-based screening tests.

National Institutes of Health

The National Institutes of Health (NIH) supports a comprehensive program of basic, clinical, and behavioral research on HIV infection and its associated opportunistic infections and malignancies. Each of the 24 NIH Institutes and Centers is involved in some HIV/AIDS-related research activity consistent with its individual mission. NIH is the world's leading biomedical research institution, supporting more than 5,000 individual HIV/AIDS research projects at more than 500 research institutions across the nation and around the world. NIH has played a leadership role in the discovery and characterization of HIV and continues to lead research to determine the pathogenesis of AIDS. Findings from NIH-sponsored studies have resulted in significant advances in the treatment of HIV infection and its related illnesses and prevention of the opportunistic infections that cause morbidity and mortality of HIV-infected individuals.

The NIH AIDS program supports biomedical and behavioral research necessary to identify therapeutic regimens, behavioral interventions, and vaccine candidates to treat and prevent HIV infection and its associated illnesses in the United States and internationally. The global nature of the AIDS epidemic underscores the critical need to identify interventions for developed and developing nations that prevent HIV transmission, disease progression, and mortality. Continued collaboration with international organizations and other nations is required to achieve these priorities. Research capacity-strengthening in foreign countries is a critical element to NIH's efforts to address HIV/AIDS, and in this regard, NIH supports a strong research training program with partners in 100 countries.

The NIH AIDS program includes collaborations with numerous international organizations. Ongoing and planned efforts include collaborations with the following organizations: UNAIDS, in planning for the initiation of international vaccine clinical trials; the Pan American Health Organization (PAHO) for studies on heterosexual transmission of HIV infection and tuberculosis prophylaxis; the World Health Organization (WHO) in the Antibody Serologic Project; WHO as one of three AIDS reagent centers; and WHO for support of several international workshops and conferences.

In addition, since its inception in 1996, NIH has collaborated with UNAIDS through mutual representation on advisory and coordinating bodies, frequent exchange of information, and collaboration on specific efforts, such as vaccine development, ethical issues related to clinical trials, and research training and infrastructure in developing countries. In this regard, the National Institute of Allergy and Infectious Diseases (NIAID) and the Fogarty International Center (FIC) have been designated UNAIDS Collaborating Centers. Additionally, NIAID and the National Institute of Child Health and Human Development (NICHD) have collaborated with UNAIDS on the Working Group on Prevention of Mother to Child Transmission of HIV.

The NIH Office of AIDS Research (OAR) is located within the Office of the Director of NIH and is responsible for the scientific, budgetary, legislative, and policy elements of the NIH AIDS research program. Congress provided in the NIH Revitalization Act of 1993 broad authorities to the OAR to plan, coordinate, evaluate, and fund all NIH AIDS research. The OAR is responsible for developing an annual comprehensive plan and budget for all NIH AIDS research. The OAR supports trans-NIH Coordinating Committees to assist in these efforts in the following areas of program emphasis: Therapeutics, Vaccines, Natural History and Epidemiology, Behavioral and Social Sciences, Etiology and Pathogenesis, Training and Infrastructure, and Information Dissemination.

The OAR promotes collaborative research activities in both domestic and international settings. These research studies are conducted by the Institutes and Centers of the NIH, including the NIAID, National Cancer Institute (NCI), NICHD, National Institute of Mental Health (NIMH), National Institute on Drug Abuse (NIDA), and FIC.

A report by a group of non-government scientists and AIDS community representatives who were convened to evaluate the NIH AIDS research program, has had a significant effect on almost every aspect of the AIDS research program--in setting the scientific agenda, refocusing priorities, and shaping the AIDS research budget. The recommendations in the "Report of the NIH AIDS Research Program Evaluation Working Group of the Office of AIDS Research Advisory Council" (also known as the "Levine Report") helped frame the OAR's final distribution of the NIH AIDS appropriations for fiscal years (FY) 1997 and 1998. In addition, the Levine Report significantly influenced the priority setting that occurred in the development of the FY-1999 NIH Plan for HIV-Related Research and Budget, which the OAR is congressionally mandated to develop in concert with the annual NIH AIDS research budget request. The priorities established by the Levine Report will have an impact not only on government-supported research but on the research agendas of industry and private research organizations in the United States and abroad.

The report articulated the importance of coordinating international HIV/AIDS research efforts with other agencies, international organizations, and other governments. Further, it listed as one of several high priorities "domestic and international studies testing the efficacy of joint behavioral and biomedical strategies for combined control of HIV and other sexually transmitted diseases and combined control of HIV and other adverse health consequences of injection drug use."

The FY-1998 and FY-1999 NIH AIDS research priorities include the following:

- A continued increased emphasis on fundamental science, particularly investigator-initiated research;
- A comprehensive effort, including several important new research initiatives, to develop new vaccine candidates and bring them to clinical trials as soon as

possible, including a refocusing on the importance of international collaboration at the earliest stages of vaccine development and testing;

- An augmentation of research efforts to better understand the human immune system; and
- An emphasis on prevention science research, including enhanced domestic and international studies of risk-taking behavior and the development on strategies to avert infection, such as microbicides, female-controlled barriers, and STD treatment and prevention.

International AIDS Funding (in thousands of dollars)

	FY-1995 Actual	FY-1996 Actual	FY-1997 Actual	FY-1998 Estimate	FY-1999 Estimate
NCI	5,876	3,415	5,641	5,674	5,775
NIDCR	--	--	782	816	901
NINDS	2,103	1,923	973	973	973
NIAID	21,112	21,691	24,892	26,958	29,958
NIGMS	--	--	92	89	84
NICHHD	2,263	3,302	4,151	4,400	4,700
NIMH	4,301	3,894	3,512	3,656	3,912
NIDA	1,839	140	--	500	500
NCRR	677	590	418	499	588
FIC	9,108	9,694	10,312	10,611	11,305
Totals	\$47,279	\$44,649	\$50,773	\$54,176	\$58,696

Prevention

NIH-sponsored programs targeting the development and evaluation of various preventive interventions have resulted in marked changes in sexual and drug-using behaviors associated with HIV transmission among at-risk populations, including difficult-to-reach and socially disenfranchised populations in the U.S. and abroad. NIH programs have

demonstrated that behavioral interventions targeting behaviors can be developed and implemented, including those designed to delay or prevent initiation of sexual activity and drug use. These studies have demonstrated that multifaceted risk-reduction programs, including those providing drug treatment, outreach, and education on HIV risk, and sterile injection equipment, can produce significant and sustained decreases in HIV risk behavior among injection drug users. Prevention research has shown that interventions must be culturally and ethnically directed in order to successfully reach targeted populations. NIH also is studying community-level interventions as an important way to effect behavioral change on a larger scale.

Preventing vertical transmission from HIV-infected mother to child is a priority of NIH intervention research. Implementing the ACTG 076 protocol has significantly reduced the incidence of maternal-fetal HIV transmission in the United States. Ongoing efforts are designed to identify and test other interventions that can effectively and easily be used globally to further reduce the incidence of vertical transmission of HIV. NIH-funded scientists are actively studying the timing and mechanisms by which HIV is transmitted from mother to baby so that more effective interventions can be developed to block mother-to-child transmission.

NIH also has sponsored several international conferences on the prevention of perinatal transmission. The second Global Strategies Conference on Prevention of HIV Transmission from Mother to Infant will be held in September 1999 in Montreal Canada. It will bring investigators from developing countries together with investigators from more developed countries to plan future collaborative strategies for the prevention of mother to infant HIV transmission.

NIH international efforts in prevention research and related training and research capacity-building include the following:

- Studies of the role of viral shedding in infectivity for both sexual transmission and mother to child transmission;
- Studies in several developing countries in Africa, Asia, and Latin America to evaluate interventions for reducing mother-to-child transmission of HIV that may be used in diverse cultural and economic settings, such as the use of short courses of treatment with zidovudine, nutritional supplements, HIV-1 hyperimmune intravenous immune globulin, vaginal cleansing, and studies of breastfeeding;
- Development of safe, effective, and acceptable condoms, microbicides, and other female-controlled barriers;
- Studies in Africa on the efficacy of STD treatment and prophylaxis on reducing sexual transmission of HIV; and
- Development of behavioral interventions to reduce the risk factors associated with HIV transmission, including injection drug use and various sexual behaviors.

In response to the Levine Report recommendation for developing a Prevention Science Agenda that combines behavioral and biomedical intervention research, the NIH sponsored several agenda setting activities, including a 1998 Workshop on International HIV/AIDS Prevention Research Opportunities. The goal of the Workshop was to encourage research that would be feasible and relevant for developing countries with limited resources. Representatives from 37 countries severely affected by the epidemic participated in the workshop to develop a "Basic Prevention Package," a list of HIV prevention interventions that would be important in developing countries, and a listing of "Priorities for International HIV Prevention Research." Another outcome of the workshop was a better understanding of the HIV prevention planning process. More information on this workshop may be found at <http://hivinsite.ucsf.edu/ari>.

Behavioral Research/Behavioral Change Interventions

NIH supports an extensive portfolio of behavioral and social science research on HIV infection and AIDS. These studies have demonstrated the important interaction of biological, psychological, and social factors that contribute to HIV prevention, transmission, and disease progression among individuals and population groups. Findings from these studies have significantly contributed to the understanding of human behaviors that affect HIV transmission risk and to the development of successful interventions to encourage sustained behavioral change. NIH-sponsored behavioral and social science research includes research related to the following goals:

- Developing, implementing, and evaluating behavioral and social interventions to reduce HIV transmission;
- Strengthening the understanding of the determinants, trends, and processes of HIV-related risk behaviors and the consequences of HIV infection;
- Developing and evaluating behavioral strategies for preventing or ameliorating the negative physical, psychological, and social consequences of HIV infection; and
- Improving the research methodologies employed in behavioral and social science research.

NIH-supported studies are ongoing, either independently or linked with biomedical studies, in countries in Africa, Asia, and Latin America.

Vaccine Research

The development of a safe and effective HIV vaccine is of the highest priority for the NIH, and NIH has pledged to work with the other G-8 nations on vaccine efforts. NIH supports a broad program of basic, preclinical, and clinical research on the discovery and development of HIV vaccine candidates. Basic research on HIV and the immune system provides crucial information for developing potential vaccines. Various strategies for

stimulating a protective immune response against HIV infection are being explored through basic research, animal model research, and clinical trials. In recognition of the need to develop vaccines that are efficacious against a variety of strains found around the world, NIH supports studies analyzing genetic and antigenic variation of HIV and targeted toward eliciting cross-reactive immune responses. While the goal of preventive vaccines is to end the HIV pandemic by protecting individuals from HIV infection, vaccines also may serve as immunomodulators to improve immune function and slow disease progression in infected individuals and may prevent them from infecting others.

To accelerate the development of NIH's AIDS vaccine effort, the AIDS Vaccine Research Committee (AVRC), chaired by Dr. David Baltimore, was established. Specific areas of basic research relating to HIV vaccines efforts have been identified by the AVRC and a new, special initiative supporting innovative research in these scientific areas has been funded during the last 2 years to advance this research field. To further HIV vaccine research in the NIH intramural programs, the Vaccine Research Center is being constructed with completion targeted for 2000.

The NIH supports an AIDS Vaccine Evaluation Group (AVEG), which consists of six sites nationwide that are actively evaluating potential HIV vaccines in phase I and II clinical trials. To date, the AVEG has conducted or initiated more than 46 trials with 24 different HIV vaccine candidates. All vaccine candidates to date in AVEG phase I trials have been shown to be safe and well tolerated. In preparation for phase III clinical trials, NIH supports a domestic and international network of sites that are currently identifying the cohorts of populations at risk for HIV infection and building the infrastructure necessary to conduct large-scale efficacy trials of potential HIV vaccine candidates when they become available. These efforts involve strengthening in-country research capacity by training foreign scientists and health professionals. NIH collaborates with UNAIDS, host country governments, and in-country scientists in vaccine development and preparation for efficacy trials. Eleven sites have been established in Africa, Asia, and Latin America.

Treatment Equity

In an effort to identify options for clinical management of HIV-infected patients that would be useful in resource-poor settings, NIH is supporting studies on the use of isoniazid and rifampin to prevent active tuberculosis in PPD-positive, HIV-infected patients in Uganda. In addition, NIH-supported scientists in Thailand are studying risk factors for infection with *Penicillium marneffe*. These NIH-trained scientists also are working with the pharmaceutical industry in Asia on developing therapeutics for *P. marneffe* infection.

Women and Health

NIH supports an extensive portfolio of basic, clinical, and behavioral research focusing on women and HIV/AIDS. HIV-infected women experience some complications of HIV disease that are unique or more prevalent in them than in men, such as vaginal and

esophageal candidiasis, chronic herpes simplex infections, other STDs, and cervical dysplasia. NIH-sponsored programs target studies on the natural history and epidemiology of the disease in women through a number of studies in Africa, Asia, and Latin America.

Studies on the etiology and pathogenesis of HIV infection and disease progression in women are ongoing. These studies focus on the role of STDs and other factors in acquiring HIV infection and the pathogenic mechanisms associated with HIV disease progression. Studies on biologic determinants of infectiousness and susceptibility are important areas under investigation. Specific attention is being given to the possible correlation between the level of cell-free or cell-associated HIV in blood, semen, urine, cervical/vaginal secretions or oral fluids, and the probability of transmission. In addition, NIH-funded researchers are investigating the cellular and molecular aspects of mucosal immunity and other infectious diseases as cofactors, as they impact HIV susceptibility and transmission. Results from these studies are critical to developing safe and efficacious AIDS vaccines and microbicides.

A critical area of concern is the impact of HIV on cervical cancer. Co-infection with human papilloma virus (HPV) is common in HIV-infected women, and HPV has been shown to act synergistically with HIV to increase expression of individual viral genes. A study in Africa is examining the natural history of cervical neoplasia in women infected with HIV-1 and HIV-2 and the role of HPV as a risk factor.

Of similar critical importance is a current NIH-sponsored multi-site international trial to determine any possible increase in risk acquisition of HIV through heterosexual contact by uninfected women who use hormonal contraceptives. Other studies are planned to examine the possible effects of steroidal hormones on early, acute HIV infection and later progression to AIDS among hormonal contraceptive users, and on the possible effect of steroidal hormone use on the infectiousness of HIV-infected women.

NIH-supported behavioral and social science research that relates to or focuses on women include studies on (1) determinants of HIV risk and prevention; (2) specific elements of social and cultural life that contribute to HIV risk and protective behaviors; (3) the development of appropriate interventions to reduce risk behaviors; (4) community-level interventions; (5) acceptability of both biomedical and behavioral interventions among different individuals and communities; (6) the behavioral aspects of the adoption of new HIV prevention technologies, such as microbicides and the female condom; and (7) social and psychological factors influencing treatment adherence and compliance as well as participation in clinical trials.

Microbicide Development

NIH sponsors a comprehensive biomedical and behavioral program for the discovery, development, preclinical testing, and clinical evaluation of topical microbicides and other female-controlled barrier methods for prevention of HIV transmission. Population-based research is essential to ensure both the efficacy and acceptability of these interventions to

decrease or eliminate HIV transmission. It is an NIH priority to develop a safe, inexpensive, reliable, and acceptable microbicide for the prevention of HIV and other STDs.

The development of screening assays to test compounds and agents for their microbicidal/spermicidal activity, as well as developing suitable animal models for safety and efficacy-testing of potential microbicides, are vital parts of the developmental efforts supported by NIH in this field of research. Close collaboration with industry is important in conducting the important phase I through III clinical testing of these agents in various populations and to ensure their eventual availability. While a number of microbicidal substances have been clinically tested in phase I and II studies to date, a safe, effective, and acceptable microbicide has yet to be identified. NIH has placed a high priority on developing an efficacious microbicide and continues to look at new compounds, as well as other barrier interventions. In FY-1999, NIH will establish a Prevention Trials Network that will focus on the testing at U.S. and international sites of various interventions, including microbicides, the expansion of the Topical Microbicide Program Projects involving multidisciplinary research to develop and test new agents and the expansion of programs targeting the developing and clinical testing of spermicidal microbicides and other female-controlled barrier methods.

Other Activities

Basic biomedical and behavioral research has significantly contributed to advances in AIDS research. Findings from basic research have provided the scientific basis for developing potential AIDS drugs, vaccine candidates, and effective behavioral interventions to halt the AIDS epidemic.

The NIH has the primary responsibility for the Federally-supported clinical trials evaluating potential treatment regimens against HIV infection and its associated opportunistic infections and malignancies. NIH supports an extensive network of more than 100 clinical trial sites, including adult and pediatric units in major domestic medical centers and community-based primary care settings. More than 50,000 patients have been enrolled to date in these studies that have involved evaluating more than 200 different drugs. The enrollment and accrual in these clinical trials of women, minorities, children, adolescents, injection drug users, and other populations is a high priority for the NIH.



Department of Health and Human Services

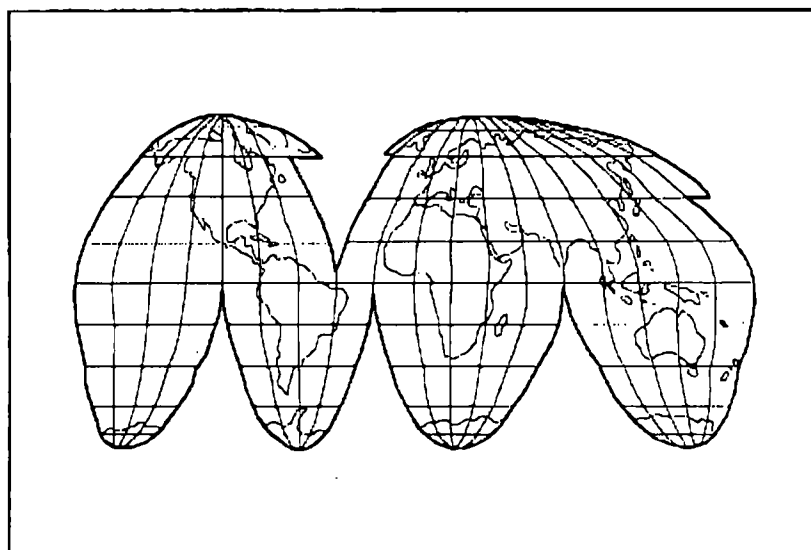
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DATE: 5/14/99

NUMBER OF PAGES: 8

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SENT BY: 5-14-99 : 14:40 : 92024562439.# 2/ 8

Ministerial Roundtable on HIV/AIDS Questions and Answers

The Ministerial Roundtable follows a series of questions grouped in three themes. Below are questions and answers for the three themes followed by questions and answers on other themes which may come up at the roundtable.

Theme 1: The burden of HIV/AIDS on national health systems

- Q. What should a core minimum package of care and support for people living with HIV/AIDS comprise? How much would it cost?
- A. The core minimum package of care and support will differ country by country, and the cost will vary accordingly.
- Q. How can health systems be strengthened so that the package can be provided? What are the minimum requirements for health systems in terms of facilities, equipment and staff?
- A. I think that it would be more appropriate to reframe the questions a bit and discuss how governments should respond to HIV/AIDS. More than a decade of experience has taught us how to control HIV/AIDS-we know what works. Many developed countries have successfully checked the spread of the epidemic. While development of therapies and a vaccine continue, prevention must be emphasized. The basic elements of prevention include education, behavioral change, voluntary testing and counseling, prevention of perinatal transmission, and political commitment. Each country must find the mix of methods appropriate to its particular conditions.
- Q. Is the establishment of voluntary counseling and testing sites the first priority? In the interest of public health, under what conditions should the serostatus of individuals be disclosed to authorities and/or families?
- A. Education about HIV/AIDS is necessary but alone does not change the behavior of populations. Promotion of voluntary testing and counseling must complement education. Testing and counseling break the deadly silence around HIV/AIDS and empower individuals to make informed decisions and change behaviors. Breaking the silence also will begin to diffuse the stigma surrounding the disease. There have been successes in a few less developed countries with extensive capacity for voluntary testing and counseling.

The lack of testing and counseling has been one reason why there has been a limited response to HIV/AIDS in many less developed countries until very recently. Testing

and counseling are important not only for care but also for prevention. Some people ask why should there be testing if there is no available treatment. There should be because knowledge is power. When people know that they are positive, they can change their behavior and stop spreading the disease. When they know they are negative, they can change their behavior to prevent catching the disease. Testing and counseling change behavior in ways that public service announcement cannot.

There are differences of opinion about the disclosure of status to authorities and/or families. Regardless of the system, it is of the utmost importance to maintain strict confidentiality restricted to those to whom status should be disclosed.

Theme 2: The implications of new drug treatments

- Q. Should antiretroviral treatments only be considered when the infrastructure allows adequate clinical and laboratory monitoring, proper medical follow-up and support, and guaranteed supplies of drugs and diagnostics?
- A. From a clinical and public health perspective, it is better not to use antiretroviral treatments if they cannot be administered properly. The development of resistant strains of the disease is a very real possibility. Resistance has both personal and global consequences. When resistance develops, we lose vital drugs from our arsenal of treatments.
- Q. The high cost of antiretroviral treatments means that ability to pay may determine access to these treatments. How can governments ensure or maximize equity of access? How can drug costs be met? Should ARVs be put on national essential drug lists?
- A. Access to drugs is an extremely complex issue. Cost is one of many barriers to access. Diagnostic tools, drug distribution networks, and health care delivery systems are all necessary elements to expand access to drugs. However, there are opportunities for the use of ARV drugs in many less developed countries.

The United States Government seeks to promote public-private partnerships to address access. We must work in partnership with international institutions, governmental agencies, nongovernmental organizations, and pharmaceutical companies. Without such a partnership, we will be unable to get drugs to people who need them.

The issues around trade and public health are very complex. Instead of addressing them in depth at this roundtable, we should build on the consensus represented at this World Health Assembly by the Revised Drug Strategy, an important step in the process of expanding global access. The Revised Drug Strategy is the culmination of the fine work of many partners, and it has near-universal support.

Theme 3: Improving the international response

Q. How can interest and concern in relation to HIV/AIDS be maintained so that an effective international response can be mounted? Can a sense of solidarity be established between countries and continents emphasizing the mutual interest and the need for international action to halt the spread of the epidemic everywhere?

A. Political leadership is essential. We must work with leaders at the highest levels to increase awareness in our international institutions and governmental agencies. President Clinton and I created a Presidential Advisory Council on HIV/AIDS to increase awareness in the United States Government. The Advisory Council includes representatives of the public and private sectors from across the United States.

Included in this political leadership is our responsibility to remove the stigma around HIV/AIDS. As my friends in ACT-UP said early and often, "Silence equals death." We must educate our governments and our publics in order to destigmatize HIV/AIDS. We have had a number of "national conversations" around HIV/AIDS in the United States. One conversation concerned Ryan White, a young boy from Indiana whose friendships with Michael Jackson and Elizabeth Taylor made him famous. Ryan helped teach the American people about HIV/AIDS in the early years of the disease. Another conversation concerned my friend Pedro Zamora, a young man from Florida whose role in the MTV series "The Real World" made him famous. Pedro helped teach the American people how to respond to HIV/AIDS in the middle years of the disease. We owe Ryan, Pedro, and countless others a debt of gratitude for their personal sacrifices to educate the United States and the rest of the world.

Q. How can the health sector contribute to removing or modifying the structural factors (often social and economic constraints) which determine vulnerability to HIV/AIDS? With whom should the health sector collaborate to address these structural problems?

A. We must mobilize all of our governments and all of our peoples to address HIV/AIDS. The United States Government and the Department of Health and Human Services in particular are making special efforts to address the unacceptable rate of new infections among our minority and youth populations. We look forward to continuing to share lessons learned in this area.

We have devised an extensive series of special programs to address barriers to prevention and care. Ryan White has left a lasting legacy with the Ryan White CARE Act, which provides funding for programs which may provide examples to other countries as they address similar barriers. In turn, we look for examples from other countries in areas such as palliative care and alternative medicine.

Additional Questions and Answers

Q. What is the status of HIV/AIDS vaccine research?

- A. The toll of the epidemic in poorer countries where therapeutic and prevention interventions are unavailable or unaffordable, as well as in industrialized parts of the world, dictates the important emphasis on vaccine development.**

In Fiscal Year 1999, the National Institutes of Health (NIH) will spend an estimated \$200 million on HIV/AIDS vaccine research, which represents a 100% increase since Fiscal Year 1995.

Q. What is the President's Vaccine Initiative?

- A. The President has made the discovery of an HIV/AIDS vaccine a national research priority. A safe and effective vaccine is the critical missing element in our armamentarium for the prevention of HIV and ultimate control of the pandemic, and remains one of the highest research priorities. A new Vaccine Research Center has been established at the NIH. A major international vaccine research meeting was held May 3-5 at NIH.**

Q. What is the G-8 Initiative?

- A. At the Summit meetings of the G-8 nations for the past two years, we have agreed to work to devote appropriate resources to the quest for an HIV/AIDS vaccine. NIH has also pledged to work with other G-8 nations on vaccine research efforts.**

In recognition of the need to develop vaccines that are efficacious against a variety of strains found around the world, NIH supports studies analyzing genetic and antigenic variation of HIV and targeted toward eliciting cross-reactive immune responses.

Q. What are the current Vaccine Clinical Trials?

- A. The NIH AIDS Vaccine Evaluation Group, consisting of 6 U.S. sites, is evaluating potential HIV vaccines in phase I and II clinical trials. To date, more than 46 trials with 24 different vaccine candidates and adjuvants have been conducted.**

In preparation for phase III efficacy trials, NIH supports a domestic and international network of sites that are currently identifying the cohorts of populations at risk for HIV infection and building the infrastructure necessary to conduct large-scale efficacy trials of potential HIV vaccine candidates when they become available.

These efforts involve strengthening in-country research capacity. NIH collaborates with UNAIDS, host country governments, and in-country scientists in vaccine development and preparation for efficacy trials. Sites have been established in Uganda, South Africa, Haiti, Malawi, Thailand, India, Zimbabwe, Zambia, Trinidad and Tobago, Brazil, and Kenya.

CDC is providing technical assistance for the first international phase III efficacy trial in Thailand.

Q. What is the New Fiscal Year 1999 Initiative?

- A. NIH has issued a new Request for Applications (RFA) for the HIV Vaccine Trials Network Leadership Group. This group will serve as the executive core to lead the vaccine clinical trial effort to set the scientific agenda for future vaccine clinical trials worldwide. The next step will be the issuance of a second RFA shortly that will solicit investigators to conduct the trials in both domestic and international sites. (Funds for this are included in the overall Vaccine increase.)

The changes that have been implemented in this area over the past few years, and the scientific advances that have been achieved, have enormous potential significance, not only for HIV/AIDS but for other diseases as well, as progress made in the development of an HIV/AIDS vaccine will certainly have implications for vaccines against other life-threatening illnesses.

Q. What is being done in terms of Capacity Building, Training of Scientists, and Information Dissemination?

- A. It is critical to the success of international studies that foreign scientists be full and equal partners in the design and conduct of collaborative studies and that they have full responsibility for the conduct of studies in-country.

To help build capacity in developing countries, the NIH funds the AIDS International Training and Research Program (AITRP). The AITRP provides research training to foreign scientists through grants to U.S. universities. The program has provided training in the United States for more than 1400 scientists from developing countries in Africa, Asia, and Latin America, and over 600 training courses have been conducted in 60 countries. NIH will increase the number of trainees and sites in Fiscal Year 1999.

NIH-supported HIV-related research helps to build laboratory capacity in developing countries where the research is conducted through purchase of laboratory equipment and transfer of research technology.

The translation of research results into effective prevention programs and improved patient care is a high priority. We are working to assure that research results relate to the cultural, social, and economic contexts of developing countries.

Q. What is being done in Research Collaboration?

A. NIH has established the International AIDS Research Collaborating Committee. The goal of the Committee is to assist in:

1. Enhancing and promoting international collaboration in HIV research
2. Developing a coordinated international HIV research effort, including biomedical, behavioral, and social science studies
3. Providing a forum for international exchange. Its membership includes the NIH, other government agencies and departments that conduct and support international research on HIV/AIDS, agencies involved in the implementation and dissemination of the results of such research, and international organizations such as UNAIDS and the World Bank.

The development of international collaborations for tracking the natural history and epidemiology of infectious diseases and for obtaining and identifying variants of infectious agents from different geographic regions helped expedite research on AIDS. This experience, and the collaborations established, will be of great value as new epidemic diseases emerge in the future.

Q. What research is being conducted in international sites?

A. It is important to point out that included in the total investment in international HIV/AIDS research, more than \$62 million in Fiscal Year 1999 is estimated to be research that will be conducted in international sites and involving foreign scientists.

Q. What support has there been from pharmaceutical companies, foundations, and foreign governments?

A. Glaxo Wellcome has made its antiretroviral drugs available at a dramatically reduced price in developing countries.

Bristol-Myers Squibb just announced a donation of \$100 million over 5 years, the largest corporate contribution to bolster HIV/AIDS research and training in sub-Saharan Africa.

The William H. Gates Foundation has announced a donation \$25 million to the International AIDS Vaccine Initiative, a program established by the Rockefeller Foundation.

The French Government has established the French Therapeutics Solidarity Fund to make pharmaceuticals available in developing countries.

- Q. What is the role of HIV-infected individuals and nongovernmental organizations in NIH biomedical research?
- A. HIV-infected individuals and nongovernmental organizations are critical in NIH biomedical research. All NIH research is conducted with the support and participation of HIV-infected individuals and nongovernmental organizations representing them, including assistance in recruitment of study participants.

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URGENT



Joint United Nations Programme on HIV/AIDS

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452-2439

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Pages: 4

Ref.: OED

From: Frances McCaul

Date: 28 May 1999

Subject:

Jacob

Attached as discussed.

Frances

SANDY

THURMAN

for

COMPANIES INVOLVED IN THE GLOBAL BUSINESS COUNCIL

1. Members

COMPANY	CHIEF EXECUTIVE	CONTACT PERSON
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10. THE TATA IRON & STEEL COMPANY LTD.	Dr Jamshed J. Irani Past President and Chairman, CII Social Development Council & Managing Director Jamshedpur - 831 001 Bihar, India Tel. 91 657 431024 Fax: 91 657 431818	

11. POLAROID	Mr Brian Poggi Vice President, Europe Polaroid Europe, Ltd. 3, Furzeground Way Stockley Park Uxbridge, Middlesex UB11 1DW United Kingdom Tel.: 44 181 606 2000	Mr Christophe Valentin European Marketing Manager POLAROID La Clef de Saint Pierre 12 bis avenue Gay-Lussac -BP 7 F-Elancourt Cedex 78996 Tel.: 33 1 30 68 38 23 Fax: 33 1 30683816/30683832 Email: valente@polaroid.com
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2. Partners

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2. PRINCE OF WALES BUSINESS LEADERS' FORUM	Mr Robert Davies Chief Executive 15-16 Cornwall Terrace Regent's Park GB-London NW1 4QP	Mr Julian Parr Regional Manager - South Asia & Middle East The Prince of Wales Business Leaders Forum 15-16 Cornwall Terrace, Regent's Park GB-London NW1 4QP Tel.: 44 171 467 3635 Fax: 44 171 467 3610
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Washington, D.C. 20520

OFFICE OF SOUTHERN AFRICAN AFFAIRS (AF/S)
TELECOPIER TRANSMITTAL



DATE: 5/24/99 NO. OF PAGES (INCLUDING COVER): 4
TO: WH/ONAP - Sandy Thurman

FAX NUMBER: 9-456-2439

FROM: AF/S - Phil Drouin PHONE: 647-9854

COMMENTS: Sandy,

Attached is input from Assistant
Secretary Rice, per your request, for
your HIV/AIDS paper. I'm sure you've
seen USA Today, today! Regards,
Phil

THE FAX NUMBER FOR THE OFFICE OF SOUTHERN AFRICAN AFFAIRS IS
(202) 647-5007.



United States Department of State

Assistant Secretary of State
for African Affairs

Washington, D.C. 20520-3430

UNCLASSIFIED
MEMORANDUM

MAY 24 1999

TO: ONAP - Sandra Thurman

FROM: AF - Susan E. Rice *for*

SUBJECT: Input for the Interagency HIV/AIDS Paper

We appreciate the opportunity to provide input for an interagency paper on HIV/AIDS, which will form the basis for a report with recommendations to the President in June. Specifically, we were asked to comment on: (1) State's activities to respond to the HIV/AIDS epidemic in sub-Saharan Africa; and, (2) suggestions for possible additional funds, and how these new resources could be used to shape a strengthened and more coordinated USG response to the epidemic. When reviewing the HIV/AIDS epidemic in Africa, the option of doing nothing simply is not there. We welcome your efforts to build consensus among key agencies and departments for USG follow-up to your recent trips to Africa.

With regard to State's activities, back in 1995 the Department of State's US International Strategy on HIV/AIDS laid out a strategy of three broad goals: prevent new HIV infections; reduce personal and societal impact; and mobilize national and international efforts. In 1999 AID will spend \$74 million in Africa (out of a worldwide budget of \$125 million) on AIDS programs. A recent multi-agency review of the HIV/AIDS strategy highlighted numerous successes, as well as areas for future action. One of the most significant areas for improvement is "strengthening political commitment by governments to more actively address HIV/AIDS and its impacts." Accordingly, the Secretary of State instructed all ambassadors to urge heads of state, foreign ministers, labor ministers, economic ministers, and others as appropriate to openly address the HIV/AIDS pandemic in their own countries and the adverse economic, social, political and security impacts; urge

other governments to increase spending or to reallocate funds to prevent the spread of HIV/AIDS and to strengthen AIDS research efforts; emphasize the importance of National AIDS Action Plans involving all relevant government agencies, ministries, non-government organizations, and the private sector; and to encourage foreign leaders to support the Joint UN Programme on AIDS.

Thus, the State Department, as the lead US foreign affairs agency, has led efforts to develop bilateral and multilateral partnerships on HIV/AIDS, asking all diplomatic posts to raise awareness with host-government officials. This has resulted in HIV/AIDS now being addressed at the highest levels of government and across the spectrum of political bodies as well. We plan to continue this effort.

Most recently, at the first ever U.S.-Africa Ministerial (March 1999) and U.S.-SADC Forum (April 1999), we held discussions with senior African officials from across the continent on HIV/AIDS. Discussions focused particularly on the impact of HIV/AIDS, and the importance of pursuing solutions that address the social, economic, political and security aspects of HIV/AIDS. We agreed at the Ministerial to deepen our partnership with African countries in the areas of collaborative research on HIV/AIDS, effective and affordable treatment, and also to cooperate on efforts to build African capacity to better monitor the prevalence of the disease. At the SADC Forum, the U.S. and SADC countries agreed to pursue collaborative efforts to develop a unified AIDS policy in southern Africa.

In our view total USAID spending on AIDS in Africa needs to be increased by at least \$20 million (additive to total budget, not an earmark requiring cuts in other important areas.) With these funds AID could undertake a much more aggressive three pronged program of working with youth, adults and children. Infection rates are much lower with young people, where there is still time to change habits to avoid even higher AIDS rates in the future. Programs could be undertaken through schools, youth clubs and the media to educate young people about the risk of AIDS and what they can do to protect themselves. Turning to adults, more voluntary testing would be useful. Experience has shown that after testing, whether the results are positive or negative, behavior changes to a



U.S. Agency for International Development

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

Date:

6/2

To:

Sandy

Phone:

Fax:

From:

Alex For

Phone:

Fax:

Number of Pages Including Cover Sheet

Message

Sandy,
Re communication with Salhe Miller at
Dept of Commerce re: HIV/AIDS (see Paul &
Elizabeth Marum) points
Alex,

re: fwd: Re: cu.s. dept of commerce and aids/malawi - a poss...

Subject: re: fwd: Re: cu.s. dept of commerce and aids/malawi - a poss...**Date:** Tue, 1 Jun 1999 17:18:24 -0400**From:** "Paul Delay" <pdelay@usaid.gov>**To:** "Barbara de Zalduondo" <bzalduondo@usaid.gov>,

"Elizabeth Marum" <Elizabeth=Marum%HPN%LILONGWE@usaid.gov>

CC: <AROSS@AFR-SD.ORG>, "Hope Sukin" <hosukin@usaid.gov>,

<"internet[IHUSAIN@AFR-SD.ORG]"@usaid.gov>, "Joan LaRosa" <jlarosa@usaid.gov>

Elizabeth, great response!! I spoke briefly with Sally this morning. Not sure I gave the big picture but I went through the four areas where we have had dialogue with the drug companies and the pros and cons of each approach. The four areas were:

1. Preferential tiered pricing of drugs (The problems include grossly inequitable access, even with significant preferred pricing, no lab support or training, would lead to suboptimum use and probable resistance, etc),
2. Drug donations (same problems as above but even more so and clearly not sustainable)
3. Drug Company Foundations which support training, community activities and some infrastructure (probably the most benign of the drug company interventions)
4. Compulsory licensing versus continuing to push enforcement of the Treaties on Intellectual Property Rights (TRIPS) This is a hot one now with lots of activist involvement. The pros and cons are fairly complex, and the USG does not have a single policy on this, unfortunately.

Paul R. De Lay, Chief, HIV-AIDS Division
 Tel: 202 712 0683; FAX 202 216 3046;
 Internet: pdelay@usaid.gov

Original Text

From: Barbara de Zalduondo@G.PHN.HN@AIDW, on 06/01/1999 5:10 PM:
 To: Elizabeth Marum@HPN@LILONGWE
 Cc: Alex Ross@AFR.SD.OFF@AIDW, Hope Sukin@AFR.SD@AIDW,
 internet[IHUSAIN@AFR-SD.ORG], Joan LaRosa@HPN@LILONGWE, Paul
 Delay@G.PHN.HN@AIDW

Yay Elizabeth!!! Comprehensive, concrete, compelling, and I especially like the airplane metaphor - another Marum citation to add to briefings up here. Just wanted to say thanks and congrats.
 - Brazey

Barbara O. de Zalduondo, Ph.D.
 (Under Z in the F2 Directory)
 USAID G/PHN/HN/HIV-AIDS
 Tel: 202-712-1325; Fax:

202-216-3046

internet: bzalduondo@usaid.gov

From: Paul Delay@G.PHN.HN@AIDW, on 06/01/1999 1:03 PM:
 To: Alan Getson@G.PHN.HN@AIDW, Amy Bloom@G.PHN.HN@AIDW, Barbara de
 Zalduondo@G.PHN.HN@AIDW, Clifton Cortez@G.PHN.HN@AIDW, David L.
 Piet@G.PHN.HN@AIDW, David Stanton@G.PHN.HN@AIDW, Douglas

cc: fwd: Re: cu.s. dept of commerce and aids/malawi - a poss...

Heisl@G.PHN.HN@AIDW, Jaynell Smith@G.PHN.HN@AIDW, John
Novak@G.PHN.HN@AIDW, Louis Salinas@G.PHN.HN@AIDW, Paurvi
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fyi

Paul R. De Lay, Chief, HIV-AIDS Division
Tel: 202 712 0683; FAX 202 216 3046;
Internet: pdelay@usaid.gov

From: "Elizabeth Marum" <emarum@malawi.net>, on 06/01/1999 11:02 AM:
To: internet["Sally Miller" <Sally_Miller@ita.doc.gov>]
Cc: Joan LaRosa@HPN@LILONGWE, Paul Delay@G.PHN.HN@AIDW

Hello, Sally-- how nice to hear from you. I've heard much about
you and Bruce from Jane, and I hope one day we'll have a chance
to meet.

Let me first tell you that not only have I met with Sandy Thurman,
but also I was the one who did a lot of the planning for the in-
country events relating to her two trips to Uganda.

Now, to respond to your questions: I like option #1 much more
than option #2. Although I am committed to working hard to make
sure that we provide better care to the millions of Africans already
living with HIV infection, our first priority must be prevention of new
infections. Workplace programs can be quite effective, and
anything you can do to encourage this initiative is great.

The problems that I see with the donation of AZT to the very poor
countries in Africa such as Malawi, Zambia, Uganda, etc are the
following:

1. Many people in these countries don't have access to clean
water, enough food, and simple antibiotics for opportunistic
infections. Simple infections such as syphilis remain undiagnosed
and untreated. Even tuberculosis is under-diagnosed and under-
treated. In this environment, to talk of AZT and other anti-retrovirals
is like supplying airplanes to villages with no roads, no bicycles, no
fuel, no mechanics, no pilots...etc. Personally, I believe we have
to work harder to get some basic needs first.
2. Another big barrier is that most people in these very poor
nations who are HIV infected do not know it-- so they don't even
know that they should be on drugs. One of the main projects I'm
working on here in Malawi (and worked on in Uganda) is increasing
the availability of HIV testing and counseling. I was at the largest
hospital in Malawi an hour ago-- they have almost no HIV test kits
in the hospital, and have no idea when more will be delivered. The
few test kits remaining are being saved to test blood before
transfusions. This is another critical need which, in my opinion,
needs attention before drugs are donated. Abbott has a new,
simple, rapid HIV test kit called "Determine". If you could get
Abbott to donate large quantities of these test kits, it would be a
great service to the people of Africa.
3. The third major problem is-- who gets the drugs? In Uganda,
there has been a program supported by UNAIDS for the last six
months, whereby anti-retroviral therapy is available at a slightly
reduced price. Though this sounds great, unfortunately to date the
only people who are benefitting are those who live in the capital city
(Kampala) and who can afford not only the drugs but also the lab

cc: fwd: Re: c.u.s. dept of commerce and aide/malawi - a poss...

work and doctors fees. Even if the drugs were free, the costs of the recommended routine lab tests and the costs of paying a doctor skilled in caring for someone on the drugs is considerable. Gender access is another big problem. Before I left Uganda in April I kept trying to find out what percentage of people benefitting from the program were women. No one would tell me, I think because they are embarrassed, but I heard unofficially that it might be as high as 80% or more of the beneficiaries are men. And yet we know that more than 50% of the people living with HIV infection in Uganda and other poor countries are women. I have Ugandan friends who are getting the drugs through this program, and I'm so glad that they are getting access. But even they are feeling great ambivalences about such a program which benefits only a tiny percentage (and mostly men) of those who desperately need help. The sad truth remains that, even in Uganda which probably has more AIDS home care programs than anywhere else in Africa, most people with AIDS do not even get simple drugs such as antibiotics, creams for rashes, and anti-fungal treatments.

4. A fourth major problem is logistics. In many African countries, systems for distribution of drugs, lab tests, and even condoms are very inadequate. Many health centers and rural hospitals are very poorly supplied with basic needs, while drugs sit on the shelf past their expiry dates in some central warehouse in the capital city. Making sure that the drugs (and required associated lab tests) are stored properly, distributed in a timely fashion, pulled from distribution when expired, etc., is a major task for which many (most?) African countries do not have the systems in place at this time.

Now, having said all of the above, let me emphasize that this is NOT an official response from USAID-- this is my informat response directly to you. For such a potentially large program with high visibility, it would be best to get a more official response from USAID. Also, most of what I have said applies to the very poor countries such as Malawi, Tanzania, Uganda, etc., and may not be completely applicable in South Africa which has more money and more resources. I have copied on my reply the USAID Health Officer in Malawi and the USAID HIV/AIDS coordinator in Washington DC, Dr. Paul DeLay. I'm not sure I have his email address correctly, so you might want to give him a call directly. I don't have his direct phone number but if you call USAID at the Ronald Reagan building, you should be able to track him down.

In addition, as Dr. DeLay will no doubt tell you, USAID is hoping to implement some regional AIDS activities, specific to the Southern Africa region, and something like this might come under this initiative more than a country specific program. Dr. DeLay will be able to give you "the big picture response" whereas mine is more limited to the specific problems I have seen living and working in Uganda and now Malawi.

I hope this is helpful. In spite of my reservations about the drugs, I think it's great that Americans are more aware of the terrible tragedy of AIDS in Africa, and perhaps the most important impact of these initiatives and ideas is simply to increase public awareness and concern about Africa.

Sincerely,
Elizabeth Marum, Ph.D.
Technical Advisor in HIV/AIDS

USAID Malawi and CDC

Date sent: Fri, 28 May 1999 13:30:20 -0400
From: "Sally Miller" <Sally_Miller@ita.doc.gov>
To: emarum@malawi.net
Subject: cu.s. dept of commerce and aids/malawi - a possible link

> let me introduce myself. I am the director of Commerce's Office of Africa.

>

> I know of you through your sister Jane Corwin, who works with my husband, Bruce Miller, in another part of commerce.

>

> The White House AIDS director, Sandra Thurman, approached my political boss, DAS for Africa Ed Casselle, and asked our office to try to link up with the AIDS effort in two ways.

>

> the first was to think up avenues, using Levi Straus and Ford south africa videos regarding AIDS in the workplace, to reach out to other large US employers in the region to adopt similar programs.

>

> the second would involve an outreach by the Secretary to U.S. pharmaceutical firms by which the firms would be asked for a specific amount of anti-AIDS medication dosages over a specific period of time which would be given to specific entity within a specific African country. a hypothetical example, would be WRT drug company, 3 million doses of AZT to the military in country X.

>

> It is in crafting this second option that I ask for assistance. Could you identify specific potential recipient organizations in specific country/countries which could be proposed for such an effort? the thinking was that specific drug companies could thereby be challenged with a discrete request, with a set dollar figure attached - and with a concrete end-user in mind, so that there would be confidence in the medications getting to the afflicted.

>

> As an AIDS professions, how does this initiative strike you? if it needs recrafting, how would you suggest it be reshaped?

>

> I await your suggestions and reaction.

>

> Hope your long weekend is enjoyable.

>