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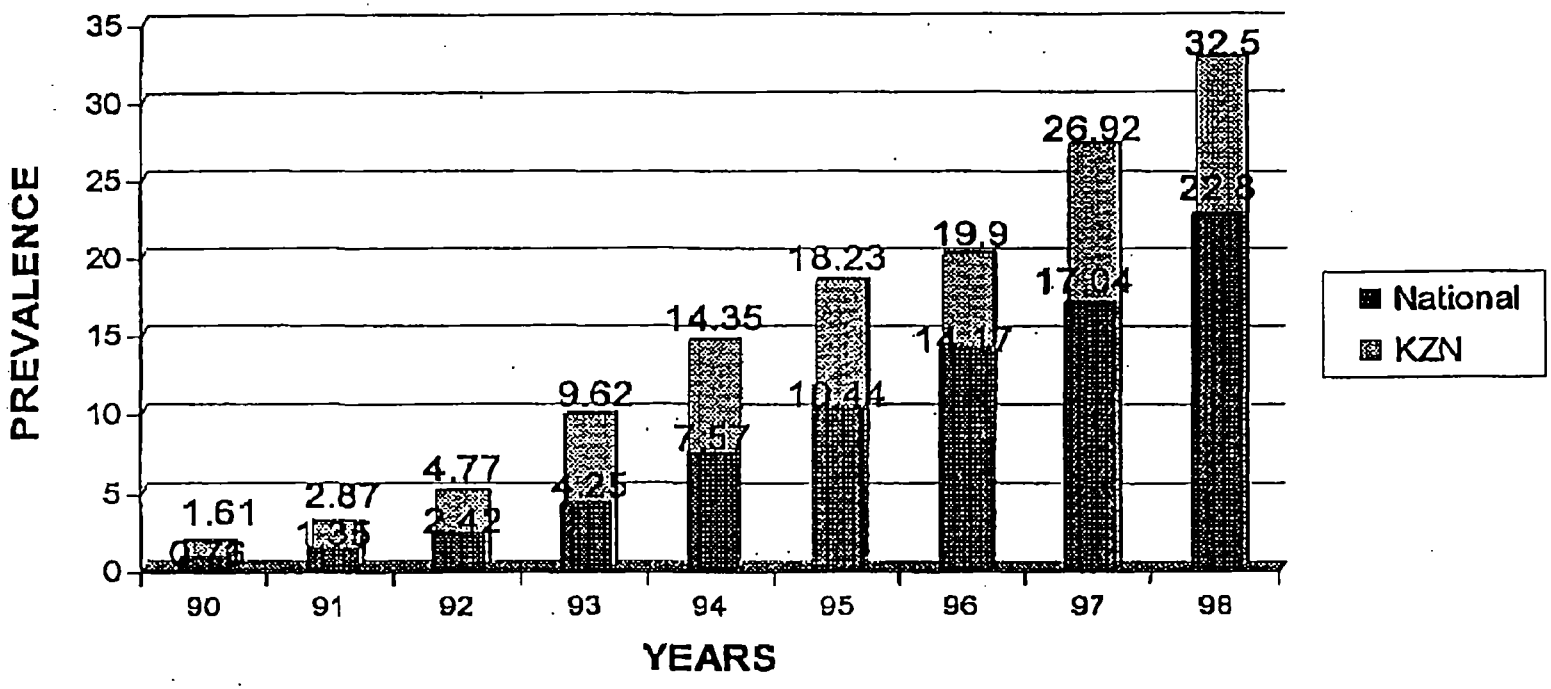

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Extent to which low-level use of antiretroviral treatment could curb the AIDS epidemic in sub-Saharan Africa

Lancet 2000; **355:** 2095 - 2100 Download PDF (99 Kb)

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Summary

Background Despite growing international pressure to provide HIV-1 treatment to less-developed countries, potential demographic and epidemiological impacts have yet to be characterised. We modelled the future impact of antiretroviral use in South Africa from 2000 to 2005.

Methods We produced a population projection model that assumed zero antiretroviral use to estimate the future demographic impacts of the HIV-1 epidemic. We also constructed four antiretroviral-adjusted scenarios to estimate the potential effect of antiretroviral use. We modelled total drug cost, cost per life-year gained, and the proportion of per-person health-care expenditure required to finance antiretroviral treatment in each scenario.

Findings With no antiretroviral use between 2000 and 2005, there will be about 276 000 cumulative HIV-1-positive births, 2 302 000 cumulative new AIDS cases, and the life expectancy at birth will be 46·6 years by 2005. By contrast, 110 000 HIV-1-positive births could be prevented by short-course

antiretroviral prophylaxis, as well as a decline of up to 1 year of life expectancy. The direct drug costs of universal coverage for this intervention would be US$54 million--less than 0·001% of the per-person health-care expenditure. In comparison, triple-combination treatment for 25% of the HIV-1-positive population could prevent a 3·1-year decline in life expectancy and more than 430 000 incident AIDS cases. The drug costs of this intervention would, however, be more than $19 billion at present prices, and would require 12·5% of the country's per-person health-care expenditure.

Interpretation Although there are barriers to widespread HIV-1 treatment, limited use of antiretrovirals could have an immediate and substantial impact on South Africa's AIDS epidemic.

Lancet 2000; **355:** 2095-100

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Introduction

Antiretroviral treatment suppresses HIV-1 replication, and significantly alters the natural history of the infection.[1,2] In more-developed countries, widespread use of antiretroviral regimens have substantially reduced AIDS-related morbidity and mortality, and the use of antiretroviral prophylaxis among HIV-1-positive pregnant women has almost eliminated perinatal transmission.[3,4] Trials done in Africa among breastfeeding women have shown the effectiveness of short-course antiretroviral regimens for preventing vertical transmission of HIV-1.[5-8] Of all the advances, this finding may be of greatest relevance to less-developed countries, where the cost of antiretrovirals have made triple drug treatment inaccessible to most of those infected.[9]

The most devastating HIV-1 and AIDS epidemic is in sub-Saharan Africa. Already, AIDS mortality has had a severe demographic impact, and population projections suggest that AIDS mortality will lead to further declines in the region's health status.[10] These models have, however, been calculated under the assumption that there will be zero antiretroviral use. It has been suggested that HIV-1 treatment must be provided to help curb Africa's AIDS epidemic, and there has been mounting pressure locally and internationally to make antiretrovirals accessible.[11,12] However, the potential demographic and epidemiological benefits of antiretroviral provision have yet to be characterised for the region.

We undertook this study to model the potential demographic and epidemiological impact of antiretroviral use on South Africa's AIDS epidemic from 2000 to 2005 for different regimens, as well as effects on health-care costs.

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Models

We created models to project future HIV-1-positive births, new AIDS cases, and life expectancy in the Republic of South Africa from 2000 to 2005. The values assigned to model parameters in each scenario were based, if possible, on empirical data. We developed the models with Spectrum software (version 4.0) by standard demographic techniques described previously.[13] Briefly, baseline population numbers, stratified by age and sex, were acquired from the US Census Bureau's international database.[14] We acquired total fertility-rate data from the US Census Bureau's World Population Profile.[15] The age distribution of fertility was estimated from the United Nations sub-Saharan Africa model fertility table. We estimated the current and future mortality rates from life expectancy data and model life tables.[15] These

parameters were constant in all scenarios.

In addition, we used Spectrum's AIDS Impact model to adjust the population projections for current and projected HIV-1-associated mortality. In the first model, scenario zero, annual HIV-1-positive births, new AIDS cases, and life expectancy were estimated with the assumption of negligible antiretroviral use. In this model, the perinatal transmission rate was set at 30%, based on a consensus which suggested that the absolute rate of mother-to-child transmission among breastfeeding women ranges from 25-35%.[12] The duration from HIV-1 infection to AIDS and death among adults and infants was based on previous estimates for sub-Saharan Africa. We assumed that adult elapsed time from HIV-1 infection to AIDS was normally distributed, with a median of 8·0 years (SD 3·5), as was the duration from AIDS to death, with a median of 1 year.[16] 50% of HIV-1-positive infants, infected at birth or during breastfeeding, were assumed to develop AIDS after 2 years, with 95% developing AIDS by 6 years after infection.[16] Future HIV-1-prevalence estimates were derived from the US Census Bureau's World Population Profile.[15] Despite the potential of antiretrovirals to reduce horizontal transmission of HIV-1,[17,18] prevalence was unaffected by their use in all models. Similarly, in all models we kept the non-HIV-1-related mortality constant at baseline levels for the whole study period.

We modelled scenarios in which the HIV-1-specific parameters were antiretroviral adjusted to estimate the impact of low-level antiretroviral use. First, the findings of trials of orally administered short-course antiretroviral regimens to prevent vertical transmission of HIV-1 were used to estimate the reductions in vertical transmission that could be achieved through various degrees of antiretroviral prophylaxis.[5-8]

Those trials have reported reductions in HIV-1 transmission from 37% to 52%[6,8] To allow for reduced efficacy because of poor adherence, subsequent HIV-1 infection attributable to breastfeeding, or both, as well as increased preventive effectiveness because of improved adherence, early weaning from breastmilk and formula substitution, or both, sensitivity analyses were applied to this parameter. We assessed the impact of prophylaxis use, given a reduction in vertical transmission among mothers who access the intervention of 40% with a range of estimates from 30% to 50%. Second, we modelled the epidemiological and demographic impacts of the use of triple-combination treatment among HIV-1-positive non-pregnant adults. Although the survival benefits of antiretroviral treatment have yet to be quantified, an analysis has suggested life expectancy could increase by 7 years among injecting drug users.[13] We applied a sensitivity analysis to this parameter and assessed the impact of treatment, assuming that the lives of adults who access the intervention would be extended by a median of 6 years (range 5-7).

Four antiretroviral-adjusted scenarios were modelled. In scenario one, we assumed that 25% of all HIV-1-positive pregnant women and infants would receive antiretroviral prophylaxis over the whole study period to prevent vertical transmission. In scenario two, 75% would use antiretroviral prophylaxis. In scenario three, 100% prophylaxis would be provided to all pregnant women irrespective of HIV-1 serostatus. Although concerns have been raised about universal treatment without testing or counselling,[19] we modelled this scenario since it has been argued that inability to provide voluntary testing and counselling may translate into no treatment.[20] In the fourth scenario, we modelled the impact of triple-combination antiretroviral treatment of 25% of non-pregnant HIV-1-positive adults. To assess the demographic impact of this intervention, the perinatal transmission rate was kept at 30% in this scenario. For each scenario we calculated HIV-1-positive births, incident AIDS cases, and life expectancy over the study period. We calculated HIV-1-positive births based on a reduction of perinatal transmission from 30% to 50%. Other indices were robust to this parameter, and reported values are based on the assumption of a 40% reduction in perinatal transmission.

We did an economic analysis to estimate the direct drug costs of antiretroviral provision in all scenarios, by methods described previously.[9] Briefly, model-derived total antiretroviral-drug costs were determined by multiplying the average cost of treatment by the estimated number of pregnant women, neonates, and non-pregnant adults eligible for treatment in the projected year of observation. Estimates of drug costs reflect the UN-brokered preferential pricing strategy.[21] By use of Monte Carlo simulations methodology, we did sensitivity analyses by varying the key model parameters. For each Monte Carlo trial, 10 000 iterations were run. For each iteration in a trial, a random number was generated for the cost of short-course antiretroviral prophylaxis, the cost of triple-combination treatment, and the number of individuals eligible for treatment. Each random number conformed to the preset probability distribution that was used to describe the potential uncertainty in each model parameter.

We assumed the cost of short-course prophylaxis had a right-skewed Weibull distribution with a median of US$8 and a 95th percentile of $100 to represent the range of drug costs in reported trials. This probability distribution favoured the low-cost single-dose HIVNET 012 nevirapine regimen,[7] but allowed for the higher-cost multidose zidovudine and lamivudine regimen used in the PETRA study.[8] We used prevalence and fertility estimates to calculate the number of HIV-1-positive pregnant women over the study period. This estimate was assumed to be normally distributed with SD of 20000.

Based on reported annual percentages of people on antiretroviral therapy in Canada and the USA, we assumed that 25% of HIV-1-positive South Africans would access antiretroviral treatment per year.[9] Annual triple-drug cost was estimated to be $2900 per person, and we assumed the annual cost of triple-combination treatment was normally distributed with an SD of $200. This cost represents the high end of the range ($8) of reported estimates for the daily cost of triple-combination treatment with a protease inhibitor, according to the UN preferential pricing strategy.[21] Similarly, we assumed the total number of HIV-1-infected adults in South Africa over the study period was normally distributed and with an SD of 1000000. All dollar figures are expressed in year 2000 US$ currency. Proportion of per-person health-care expenditure was calculated by dividing the per-person cost of antiretrovirals by the per-person health-care expenditure.[22] In addition, we calculated the cost per life-year gained in each scenario, which was estimated by dividing the total costs of antiretrovirals by the number of life-years gained over the 5-year population projection period. Life-years were calculated by comparing scenarios one to four with scenario zero. Model inputs are summarised in table 1.

Parameter	Source	Values used
Demographic and HIV-1-specific data		
Population data	US Census Bureau[14]	Age and sex specific
Baseline life expectancy	UN World Population Prospects[16]	47·5 years
Age distribution of non-HIV-1-related mortality	Coale-Demeny South model life table	Age-specific distribution
Total fertility rate	US Census Bureau[15]	3·0 in 2000; 2·7 by 2005
Bseline and projected adult HIV-1 prevalence	US Census Bureau[15]	12% in 2000; 16% by 2005
Perinatal transmission rate among breastfeeding women	De Cock et al[12]	30%
Median HIV-1 to AIDS	UN World Population Prospects[16]	8 years
Efficacy of short-course prophylaxis	Dabis, Wiktor, Guay, Saba[6-8]	30-50% reduction
Efficacy of triple-combination treatment	Wood et al[13]	5-7 years
Economic analysis		
Antiretroviral prophylaxis	UNAIDS Press release 11/05/00[24]	US$4-100
Triple-combination treatment	UNAIDS Press release 11/05/00[24]	US$2900 annual cost
Health-care expenditure per person	World Bank[25]	US$571

Table 1: **Model parameters, data sources, and values used in models**

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Results

An estimated 22186700 women and 21975000 men live in the Republic of South Africa in the year 2000; it is estimated that around 12·0% are infected with HIV-1 and that 16·0% will be infected by 2005.[14,15] If the situation of negligible antiretroviral use (scenario zero) persists, there will be 2 302 000 incident AIDS cases and 276 000 HIV-1-positive births between 2000 and 2005, and the life expectancy at birth will be 46·6 years by 2005. The life expectancy projected in this scenario is similar to the US Census Bureau and the UN projections for 2005.[15,16]

Estimates of the total number of HIV-1-positive births, new AIDS cases, and life expectancy at birth for each scenario are presented in table 2. In scenario one (25% prophylaxis in pregnant women), 230000 HIV-1-positive pregnant women and neonates would use antiretroviral prophylaxis over the study period, the cumulative number of HIV-1-positive births would be 248000 (range 241000-255000), there would be 2271000 cumulative AIDS cases, and the life expectancy at birth would be 46·8 years by 2005. In scenario

two (75%), 689000 HIV-1-positive pregnant women and neonates would use antiretroviral prophylaxis over the study period, the cumulative number of HIV-1-positive births would be 193000 (172000-213000), there would be 2208000 cumulative AIDS cases, and the life expectancy at birth would be 47·2 by 2005. If antiretroviral prophylaxis were provided to all of the 6500000 women projected to give birth over the study period (scenario three), the cumulative number of HIV-1-positive births would be 166000 (138000-193 000), there would be 2177000 cumulative AIDS cases, and the life expectancy at birth would be 47·5 years by 2005. In scenario four (triple-combination treatment in 25% of HIV-1-positive adults), there would be 1871000 (1583000-2190000) AIDS cases over the study period and the life expectancy would be 49·7 years (47·4-51·9) at birth in 2005. Scenario four would have the most substantial epidemiological impact over the study period, and would prevent 431000 new AIDS cases. The estimate of at least 140000 AIDS cases prevented by the use of antiretroviral prophylaxis modelled in scenario three would, however, be because of prevented HIV-1 infections, and would not represent a delay in the onset of AIDS, as would occur in scenario four.

Antiretroviral use	Cumulative HIV-1 and HIV-1-positive births (in thousands)	Cumulative new AIDS cases (in thousands)	Projected life expectancy in in 2005
Scenario zero	276	2302	46·6
Scenario one			
25% prophylactic use*	248 (241-255)	2271	46·8
Scenario two			
75% prophylactic use*	193 (172-213)	2208	47·2
Scenario three			
Universal prophylactic use*	166 (138-193)	2177	47·5
Scenario four			
25% triple-combination treatment use†	276	1871 (1583-2190)	49·7 (47·4-51·9)

*Prophylactic use refers to proportion of HIV-1-positive pregnant women using antiretroviral prophylaxis. Values reflect a 40% (30-50) reduction in vertical transmission. Reported AIDS cases and life expectancy reflect 40% reduction.

†Treatment use refers to proportion of HIV-1-positive adults using triple-combination treatment for duration of their lives. Values reflect an additional 6 years (5-7) of life among people on treatment.

Table 2: **Cumulative new AIDS cases and HIV-positive births, and life expectancy in 2005**

Unless a more effective short-course prophylaxis is developed, annual HIV-1-positive births will increase over the study period, irrespective of antiretroviral use, because of the increasing HIV-1 prevalence and limited efficacy of the regimens we have modelled (figure 1). Steep declines in HIV-1-positive births in each year would, however, result from increasing prophylaxis use, and the HIV-1-positive births in 2000 in scenario zero would still exceed the HIV-1-positive births in 2005 in scenario three (figure 1).

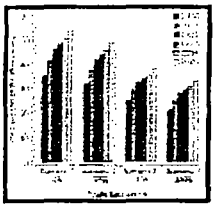

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Figure 1: **Annual HIV-1-positive births projected in scenarios zero to three, with the assumption of 40% reduction**

The use of triple-combination treatment would have the most striking demographic impact, resulting in a life-expectancy gain of 3·1 years that would be sustained for the entire study period. In comparison, short-course antiretroviral prophylaxis could improve life expectancy by 1 year over the study period (figure 2). Although increasing prevalence will result in declining life expectancy in all scenarios of prophylactic treatment, the life expectancy in 2005 modelled in scenario three would still be higher than that for the 2000 in scenario zero. Non-HIV-1-related mortality was fixed at baseline rates in all models, and changes in life expectancy would be due solely to reductions in AIDS deaths.

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Figure 2: **Annual life expectancy projected in scenarios zero to four**

For each scenario, the direct drug costs, proportion of per-person health-care expenditure, and cost per life-year gained for the whole study period would be: scenario one $1838000, less than 0·001%, and $19; scenario two, $5514000, less than 0·001%, and $19; scenario three, $52160000, less than 0·001%, and $133; and scenario four, $19 billion, 12·5%, and $15 000 (table 3). Since the costs and benefits of targeted prophylaxis are directly related, irrespective of the degree of coverage, the cost per life-year gained is the same in scenarios one and two.

	Total drug cost (95% CI*, in US$ thousands)	Proportion of per-person health-care expenditure	Cost per life-year gained (95% CI*, in US$ thousands)
Scenario one			
25% prophylactic use	1838 (1094-3141)	<0·001%	19 (11-32)
Scenario two			
75% prophylactic use	5514 (3293-9408)	<0·001%	19 (11-32)
Scenario three			
Universal prophylactic use	52160 (31087-88645)	<0·001%	133 (79-226)
Scenario four			
25% triple-combination treatment use	19074 750 (16189525-22033718)	12·5%	15000 (12700-17300)

*Each Monte Carlo trial was based on 10000 iterations. Cost per life year in scenario four rounded to nearest $100.

Table 3: **Modelled total costs, proportion per person health-care expenditure, and cost per life-year gained required to finance antiretroviral use, by scenario**

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Discussion

Short-course antiretroviral prophylaxis that would reduce perinatal transmission by 40% could prevent up to 110 000 cumulative infant HIV-1-infections by 2005. This reduction was seen in the universal prophylaxis model, but targeted provision to as few as 25% of HIV-1-positive women could prevent 28000 HIV-1-infections in infants. The direct drug cost for antiretroviral prophylaxis would be less than 0·001% of the per-person health expenditure. The triple-combination treatment for 25% of HIV-1-positive adults could increase life expectancy by 3·1 years and prevent more than 430000 AIDS cases over the study period, but with greatly disproportionate costs and expenditure. Clearly, the cost of antiretrovirals will have to be further reduced before antiretroviral treatment becomes cost-effective in this context.

The 1-year life expectancy gained in scenario three represents a substantial demographic effect. In Canada, for example, all lung-cancer deaths lead to 0·9 years of life expectancy lost among men, and breast cancer to 0·5 years among all women.[23] Provision of short-course antiretrovirals could, therefore, have a demographic impact similar to that from elimination of all lung-cancer deaths in Canada, after adjustment for competing risks. Although model four suggests that 15% treatment coverage could gain more than 3 years of life-expectancy, the scale of drug provision is not comparable, since fertility and prevalence estimates suggest that 919000 HIV-1-positive women will become pregnant between 2000 and 2005, whereas coverage with 25% antiretroviral treatment would represent more than 6·5 million person-years of daily combination treatment over the study period.

Short-course antiretrovirals can effectively reduce rates of vertical transmission,[7,8] but the regimens tested

in less-developed countries are of an inferior standard to those used in more-developed countries and have less effect on vertical-transmission rates. Although we did not assess cost effectiveness, short-course regimens were shown to be cost effective in Africa before the preferential pricing strategy announcement.[24-26]

Feasibility must, however, be taken into account, as well as cost effectiveness, in health-policy decisions. Although primary-health-care clinics and hospitals in urban and rural South Africa may have the capacity to do rapid testing and administer short-course treatment,[26] further investment and education might be required to reach the number of pregnant women who make antenatal-clinic visits modelled in scenario two. Only around 50% of HIV-1-positive women return to get their test results, which makes reaching the women most in need difficult.[27] Furthermore, it is doubtful whether the human resources and infrastructure are in place to provide the amount of triple-combination treatment that we modelled in scenario four. In addition to the medical staff and laboratory equipment that would be required to ensure the success of this programme, additional infrastructure will be required to ensure confidentiality, security, and adequate drug distribution.

Given the limited resources and competing health concerns in sub-Saharan Africa, priority must be given to interventions that can be most easily administered and have the greatest cost effectiveness. Our analyses show that, despite price reductions, interventions other than triple-combination treatment will probably be more cost effective, such as treatment of symptomatic sexually transmitted diseases among prostitutes to prevent horizontal HIV-1 transmission,[28] and public-health interventions such as expanded immunisation coverage.

Currently, the most cost effective, preventatively effective, and most easily administered antiretroviral agent is probably single-dose nevirapine.[7] A report of fatal side-effects has, however, cast doubt on the safety of nevirapine prophylaxis in South Africa,[29] but extensive surveillance of this drug in more-developed and less-developed countries has confirmed the overall safety profile seen in the original clinical trials,[30] and safety data from about 700 mother-infant pairs has shown no important adverse reactions with single-dose nevirapine.[7,31,32] Although confirmation of the HIVNET 012 findings is necessary, nevirapine may reduce transmission rates by more than the estimates we have modelled, since the reported 47% reduction was compared with the 14-dose intrapartum-postpartum zidovudine group.

The additional life expectancy associated with triple-combination treatment is not yet known. Two studies that outlined potential future scenarios attempted to model the potential epidemiological and demographic impacts of antiretroviral treatment. In the first study, which assessed the use of antiretrovirals among homosexual and bisexual men, antiretroviral treatment was estimated to provide an additional 6-24 years to an individual's life expectancy after infection, and the researchers concluded that the use of antiretrovirals could substantially lower the incidence of infection.[33] In the second study, which assessed antiretroviral use among injecting drug users, modern antiretrovirals were estimated to increase the median duration from HIV-1 infection to death by 7 years.[13] In these two analyses, even if HIV-1 prevalence increased, antiretrovirals could substantially reduce the burden of morbidity and mortality. The conclusions of the two studies were not attributable to reduced perinatal transmission.

In HIV-1 endemic areas of more-developed countries, such as Vancouver, Canada, and San Francisco, USA, combination antiretroviral treatment is used by around 50% of HIV-1-infected people (BC Centre for Excellence in HIV/AIDS, unpublished data).[33] Striking improvements have been reported in health status and life expectancy and coincide with the widespread availability of antiretroviral therapy.[34,35] Health-status improvements attributed to antiretroviral therapy have occurred despite growing HIV-1

prevalence. By contrast, almost no triple-combination HIV-1 treatment is used in sub-Saharan Africa. Although short-course antiretroviral prophylaxis could prevent thousands of neonatal HIV-1 infections, more complex prophylaxis regimens and the use of triple-combination antiretroviral therapy would lead to greater demographic benefits. Such treatment might, however, cost as much as $10000 dollars per life-year saved after adjustment for disability,[36] and our findings suggest that the drug cost of treating 25% of HIV-1-positive South Africans would be more than $19 billion. Clearly, drug cost remains a key barrier to the implementation of widespread antiretroviral provision. Although price reductions will probably increase the use of antiretrovirals in less-developed countries, major concerns must be addressed--for example, resistant viral strains emerge quickly in non-adherent individuals, which has implications for future treatment options and the transmission of resistant virus.[37] The long-term benefits of expanded antiretroviral use in less-developed countries will rely on improvements in health-care infrastructure in addition to the availability of antiretroviral drugs.

Several additional benefits may accrue from the use of antiretroviral treatments that were not accounted for in our models. HIV-1 testing and counselling that should accompany the targeted provision of antiretrovirals might provide secondary benefits, such as reduced sexual transmission. HIV-1 viral load is the main predictor of the risk of heterosexual transmission of HIV-1, and transmission is rare among people who have viral loads of less than 1500 copies/mL of HIV-1 RNA.[18] Since the benefits of triple-combination treatment are directly attributable to the degree of viral-load suppression they can induce,[3] such regimens could result in reduced horizontal HIV-1 transmission. Our models may, therefore, underestimate the benefits of antiretroviral use. Achievement of the degree of antiretroviral coverage that we have modelled will require investments in health-care infrastructure that we did not model. Non-drug costs associated with the delivery of the interventions we modelled might be as high as drug costs, but will depend on many factors, including one-time infrastructure costs, as well as the degree of centralisation of services.

When population projections are developed, several parameters, such as future HIV-1 prevalence, must be estimated, and output values are, therefore, estimates. The scenarios we developed were hypothetical and some assumptions could have introduced certain biases. Most importantly, we assumed that HIV-1 prevalence in South Africa would increase substantially over the study period in all models. A widespread educational campaign could lower HIV-1 incidence and invalidate our models. We assumed also that short-course antiretrovirals could lower infant HIV-1 infections by 30-50% among breastfeeding women. These estimates were based on several clinical trials in which overall compliance with the short-course regimen was quite poor.[5,6] For this and other reasons noted, this range might be a conservative estimate of the potential reductions in HIV-1 transmission that could be attained through the use of short-course antiretrovirals, especially if early weaning and formula substitution are a safe alternative to breastfeeding.[38]

At present, there are major barriers to the widespread provision of antiretroviral therapy in South Africa, including limited health-care infrastructure and drug costs. Our estimates suggest that the drug cost of antiretroviral prophylaxis is low and that low-level prophylaxis use could have a substantial demographic and epidemiological impact.

Contributors

Evan Wood designed the study and took primary responsibility for data analysis and writing of the paper. Paula Braitstein advised on study design and analysis and helped coordinate the study. Co-investigators Julio Montaner, Martin Schechter, Mark Tyndall, and Michael O'Shaughnessy assisted in the design of the study. Robert Hogg was the principal investigator and advised and oversaw study design and data analyses.

All investigators contributed to the writing of the paper.

Acknowledgments

This work was supported by the National Health Research Development Program of Health Canada through a National Health Research Scholar Award to RSH and by the Medical Research Council through a Senior Scientist award to MTS. EW and PB are supported through the British Columbia Health Research Foundation and the Canadian Health Services Research Foundation. We thank Peter Vann, Bonnie Devlin, and Kelly Hsu for the administrative and research assistance, and the students in Health Care and Epidemiology 528 for their comments and advice during the development of this study.

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Table 1: HIV prevalence by province, comparing 1997 and 1998 antenatal survey findings

PROVINCE	Est (HIV+) 95% CI	Est (HIV+) 95% CI
	1998	1997
KwaZulu/Natal (KZN)	32.5 (29.3 - 35.7)	26.9 (24.9 - 29.0)
Mpumalanga (MP)	30.0 (24.3 - 35.8)	22.6 (20.6 - 24.8)
Free State (FS)	22.8 (20.2 - 25.3)	20.0 (17.1 - 22.2)
Gauteng (GP)	22.5 (19.2 - 25.7)	17.1 (15.1 - 19.2)
North West (NW)	21.3 (19.1 - 23.4)	18.1 (16.2 - 20.1)
Northern Province (NP)	11.5 (9.2 - 13.7)	8.2 (6.9 - 9.7)
Eastern Cape (EC)	15.9 (11.8 - 20.0)	12.6 (11.0 - 14.4)
Northern Cape (NC)	9.9 (6.4 - 13.4)	8.6 (6.4 - 11.3)
Western Cape (WC)	5.2 (3.2 - 7.2)	6.3 (5.2 - 7.5)
National	*22.8*	*17.04*

NB: The true value is estimated to fall within the two confidence limits, thus the confidence interval is important to refer to when interpreting data.

Table 2: HIV prevalence by age comparing 1997 and 1998 antenatal survey findings.

AGE GROUP	Est (HIV+) 95% CI	Est (HIV+) 95% CI
	1998	1997
<20	21.0 (18.4 - 23.8)	12.7 (11.3 - 14.2)
20-24	26.1 (24.1 - 28.1)	19.7 (18.4 - 21.0)
25-29	26.9 (24.7 - 29.0)	18.2 (16.8 - 19.6)
30-34	19.1 (17.1 - 21.1)	14.5 (12.9 - 16.2)
35-39	13.4 (11.2 - 15.6)	9.5 (7.7 - 11.5)
40-44*	10.5 (6.8 - 14.1)	7.5 (4.4 - 11.8)
45-49*	10.2 (0.4 - 20.0)	8.8 (1.9 - 23.7)

* Note that the wide confidence intervals (CI) are a result of the smaller numbers of women who participated in the study.

Country Brief

SOUTH AFRICA
06/01/00

Socio-Economic Data

Total population (thousands), 1997	43,336	UNPOP
% of population urbanized, 1996	51	UNPOP
Annual population growth rate, 1980-1995	2.3	UNPOP
Infant mortality rate (per 1,000 live births), 1996	50	UNICEF/UNPOP
Maternal mortality rate (per 100,000 births), 1990	230	WHO/UNICEF
Life expectancy, 1996	65	UNPOP
Adult literacy rate, 1995	M 82, F 82	UNESCO
Per capita GNP (US$), 1995	3,160	World Bank

Status of the Epidemic

Prevalence – Year	Trend
16.7 – 1998	Rapid growth with all age groups in surveillance sites showing between 15 and 65 percent growth between 1997 and 1998. Highest growth rate was in the under 20 age group.

National Response

National AIDS Programme

- The HIV/AIDS and STD Directorate is located within the Ministry of Health which is the lead ministry in the response to the epidemic;
- An Inter-Ministerial Committee on AIDS was established in 1998 to provide political direction and policy guidance to the national AIDS programme;

National Strategic Planning

- The development of the national strategic plan occurred during the months of July- November 1999;
- The plan, still in draft form, is a five-year plan;
- The priority areas include prevention, human rights, care and support, research monitoring and evaluation, youth and policy implementation.

Political Commitment

- The President launched the Partnership against AIDS in 1998 to broaden and formalise the participation by all sectors in the response to the epidemic;
- The President also launched the South African National AIDS Council on 1 December 1999. It is a multisectoral body that will oversee the national response to the epidemic and the implementation of the Strategic Plan.
- The current Minister of Health initiated the development of the strategic plan;

Country Brief

- It was in response to the statement by the newly elected President calling all South Africans to action in the fight against AIDS. He challenged all sectors of society to be actively involved in the response to HIV/AIDS.

Multisectoral Involvement

- Initial efforts in the South African response to HIV/AIDS were implemented mainly by non-governmental organizations and the Ministry of Health;
- There has been gradual involvement by other government departments and civil society;
- Participants in the recent national strategic planning process included representatives from faith based organisations, people living with HIV/AIDS, non-governmental organizations, human rights organisations, academic institutions, the civil military alliance, the media, organised labour, organised sports, business, insurance companies, women's organisations, youth organisations, international donors, medical and health professionals, medical and health consulting organisations, political parties and other relevant government departments;
- The Response Analysis calls for all provincial authorities to designate co-ordinators responsible for STD/HIV/AIDS at the province and district levels.

UN Theme Group on HIV/AIDS

Chair:
UNICEF Representative

Members: UNDP, WHO, UNFPA, UNICEF, UNESCO, World Bank

Participants: ILO, UNHCR, UNIC, IOM and UAIDS/ICT

Support from UN System Agencies for HIV/AIDS activities in 1998-1999

Organization	*Amount US$*
WHO	80 000
UNDP	200 000
UNFPA	10 000
UNESCO	5 000
UNAIDS	683 450
Total	**978 450**

USAID

PLAN TO ADDRESS MOTHER (PARENT) TO CHILD TRANSMISSION OF HIV/AIDS IN AFRICA

DRAFT

KEY ISSUES

1. Choice of drugs and related safety and efficacy.
2. Lack of knowledge of women's HIV status → VCT availability.
3. Quality and availability of counseling.
4. Preparation and sensitization of community.
5. STIGMA issues.
6. Breastfeeding issues not only for affected women (MTCT) but spillover effects for the entire community.
7. Ethical issues concerning availability of care for women post-MTCT intervention.
8. Social support for orphans.
9. Health care system preparation.
10. Costs and financing.
11. Monitoring and evaluation.
12. Additional research: e.g., breastfeeding options (by type), safety/efficacy of drugs; community mobilization/sensitization strategies; counseling techniques, stigma reduction, treatment of infants with ARV.
13. If effective, licensure of nevirapine in African countries.

APPROACH

Prevention of parent/mother to child transmission of HIV must include an entire array of services and consideration of issues (beyond just a formulaic VCT + Nevirapine + Infant formula). A variety of "companion" interventions and activities are necessary to reduce maternal mortality, improve antenatal clinic standards, provide community based AIDS prevention especially for HIV negative mothers, provide AIDS care to mothers and infants that are HIV+, enhance infant nutrition programs, assure access to family planning information and commodities, provide for succession planning for children and spouses, and engage with communities in an effort to overcome the stigma of HIV. M/PTCT programs could serve as a potent catalyst.

Before launching a major effort in this area, a degree of international consensus on sone pivotal issues is required.

PLAN

USAID is supporting many of the critical HIV prevention and care components necessary to ensure success for an MTCT intervention: a broader primary prevention system, VCT, training of health workers, breastfeeding, maternal health improvements, family planning and reproductive health services, as well as direct MTCT efforts. USAID is working

closely with CDC to expand the MTCT and related activities in the LIFE initiative emphasis countries, as well as coordinating with UNICEF on their MTCT pilot sites. USAID is also supporting research into questions of MTCT and breastfeeding, community responses, and other aspects of MTCT.

1. USAID will work with UNAIDS, WHO, UNICEF and USG agencies to meet with key experts to strive to reach consensus, as well as to identify major needs for priority research, on as many of the key issues involving MTCT, breastfeeding, community and health system preparation and related issues. UNAIDS is organizing a meeting for September. TIME: Over the next 4 months.

2. With consensus, USAID, working with CDC, will plan and implement a series of major MTCT intervention sites in several countries. These will represent a holistic approach including the essential program elements: VCT, community preparation and sensitization, training of health workers, development of appropriate breastfeeding strategies, and monitoring and evaluation.

   These sites will lead to further scaling up in the respective countries once key issues are resolved and lessons are learned about the implementation of M/PTCT interventions in the country.

   Limiting factors: time required to work with the respective nation to prepare for these interventions; cost issues; and resolution of key issues related to MTCT approaches. Time: Over the next year.

3. As these initial sites are underway, prepare for the future in terms of sensitizing communities, families, and training health providers (maybe other sectors too) about MTCT, basic facts). This will be important to facilitate introduction of other interventions too.

USAID will also:

4. Seek to Integrate HIV VCT into maternal and reproductive health programs so that HIV+ women can receive whatever interventions become available, and prevention during pregnancy/lactation can be offered.

5. Emphasize the importance of counseling. Not just post-test but also bereavement, psycho-social, etc. Persons living with HIV/AIDS at Durban stressed that counseling helped them to deal with their test results and make positive changes in their lives. Good counseling may also encourage others to go for testing because they will know that there is someone there to help them with fallout of a positive test result, etc.. Support training of peer counselors on all HIV issues including MTCT/infant feeding. Don't think that everything must fall to the health system.

6. Strengthen breastfeeding/infant feeding counseling skills among healthproviders and community groups. This is not only for HIV-infected women but for all

women/families. (Health providers need to be able to support women who are HIV+ and choose to breastfeed or to replacement feed. They must also be comfortable counseling/advising women who are status unknown (the majority) or who are HIV-negative. There is much confusion on the ground about HIV/BF among health workers. Support for breastfeeding programs has eroded significantly in A frica. Preliminary reports suggest that there is some spillover to non-infected women also who think they may be infected and are stopping breastfeeding or weaning early. This needs to be reversed.

7. Support research on ways to make breastfeeding safer for HIV-infected women.

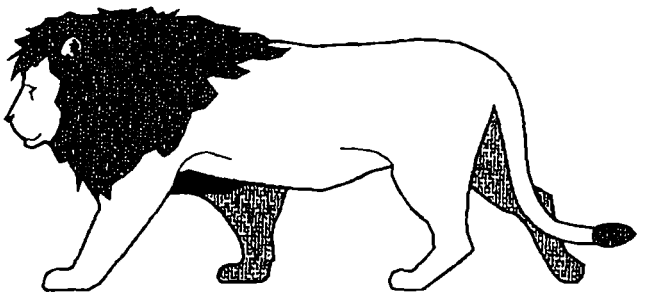
8. Monitor and evaluate all aspects of these activities.

9. Continue research into aspects of M/PTCT.

U.S. Department of State
Office of Southern African Affairs

FACSIMILE

DATE: Wednesday, April 12, 2000



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TO:

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C. Reintsma	AID/AFR	712-4018	216-3233

SUBJECT: Fact Sheet for Clearance

Attached is a draft unclassified fact sheet (for press/public use) on Health and HIV/AIDS in South Africa for President Mbeki's state visit.

Please provide comments/changes/clearance by **COB Thursday April 13.**

Thanks

FACT SHEET: HEALTH AND HIV/AIDS

A major priority for the South African government is providing adequate health care to the South African people, particularly the formerly disadvantaged majority woefully underserved during the apartheid era. Social services account for the bulk of the government's discretionary spending and has continued to grow in real terms under Mbeki. The government has budgeted over 53 billion rand ($8 billion) for social services for this fiscal year.

Most of South Africa's people lack access to basic medical services, including primary health care. The Mbeki government is responding by strengthening hospital management, rehabilitating hospitals, and developing tertiary medical services in under-served provinces. Well over one thousand clinics have been built or upgraded since the end of apartheid in 1994. Over three-quarters of urban South Africans now have adequate sanitation and almost two-thirds enjoy access to safe water.

South Africa has one of the fastest growing HIV/AIDS epidemics in the world; 1,700 new infections occur each day. One out of twelve South Africans is infected. AIDS mortality is also accelerating - since the beginning of the epidemic, over 350,000 persons have died of AIDS. Based on recent UNAIDS estimates, 2.8 million adults and 80,000 children are living with HIV/AIDS in South Africa.

Tuberculosis (TB) kills one thousand South Africans each month. TB is the most common opportunistic infection (and primary cause of death) among HIV-positive South Africans. Over 1.5 million South Africans contract TB each year. Less than one quarter have access to adequate treatment.

The Mbeki government has committed to allocate over 500 million rand ($75 million) over the next three years to the crisis. The SAG has established an inter-ministerial Committee on AIDS which has launched a public awareness campaign against HIV/AIDS and it has announced the national "Partnerships Against AIDS" plan of action that raises HIV/AIDS from a health issue to a broader development issue. To build broad public support and awareness, government ministers consult with all sectors of society including leaders in religion, the media, education, business, government, non-governmental and women's organizations, art, entertainment and sport.

Mbeki Visit - Factsheet - Health and HIV/AIDS

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U.S. Department of State
Office of Southern African Affairs

FACSIMILE

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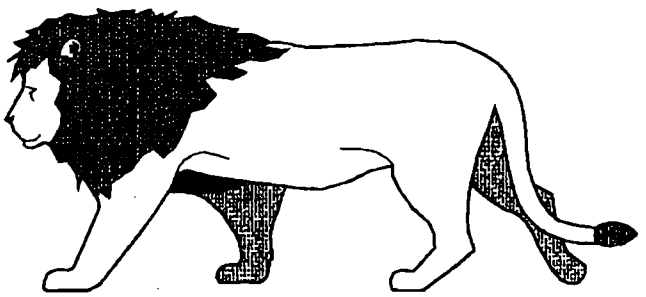

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SUBJECT: Qs and As for Clearance

Attached are draft press **Qs and As** for POTUS use during South African President Mbeki's state visit. Please review and provide comments/changes/clearance by **Noon on Friday April 14.**

Thank you.

Qs AND As

Q: Describe the U.S.-South African relationship.

- Our relations with South Africa are excellent. With much hard work, the U.S. and South Africa have developed a strong and productive friendship since the end of apartheid in 1994. Our contacts across all sectors have multiplied exponentially, and our cooperation on issues of mutual interest has expanded considerably.

- The U.S.-South Africa Binational Commission (BNC), which is one of only five BNCs chaired by the Vice President, reflects the priority both sides place on strengthening our ties and enhancing our cooperation. We profoundly thank President Mbeki for his untiring efforts to strengthen ties between our governments and our people.

Q: What has President Mbeki's visit to Washington accomplished?

- This is another significant step in the process of establishing a firm, lasting friendship between the United States and South Africa, a friendship based on mutual respect, common interests, and a shared vision of a peaceful, democratic, and prosperous world.

Q: In terms of the international community, how does the U.S. perceive South Africa and its role?

- South Africa is a leading and influential actor in the international community. As chair of the Non-Aligned Movement, South Africa serves as a strong, persuasive voice for the views of the developing countries. On many critical issues, South Africa is an important bridge between the U.S. and its G-7 partners and the developing world. South Africa also plays an active and influential role in other regional and multilateral institutions, including the OAU and the UN. We want to maximize our cooperation with South Africa on issues of mutual interest.

Q: What is the status of the Africa Growth and Opportunity Act? Does South Africa support the Act?

- The bill is currently in House-Senate Conference. We expect congressional action before the next recess. We continue to

work hard to secure early passage of this bill, which will be an important step in strengthening our trade relations with Africa and promoting Africa's integration with the global community.

- South Africa has been a strong public supporter of the act since 1998.

Q: What is the U.S. view of South Africa's friendly relations with pariah states like Libya and Cuba?

- South Africa, like all nations, must set its own foreign policy priorities. As current chair of the Non-Aligned Movement (NAM), the South African government believes it is important to maintain friendly relations with other NAM states. South Africa is well aware of our views on Libya, Cuba, Iraq, and other pariah states. As friends, we are able to engage in frank discussions on these issues. South Africa's commitment to democracy, human rights, and a peaceful international order is an example these states should follow.

Q: Senior South African officials - including their UN Ambassador - have criticized the U.S. for not paying its UN arrears while seeking to change the peacekeeping scale of assessments. How do you respond to this criticism?

- Achieving benchmarks included in the November 1999 Helms-Biden legislation is necessary to allow the U.S. to make payments toward our arrears. Reform of the peacekeeping scale of assessment is critical to this effort, and is one of the Administration's top priorities at the UN this year. The peacekeeping scale is in urgent need of review. It was negotiated in just eight days to fund a single peacekeeping mission in 1973, yet has not been updated since. The scale concentrates 98% of the responsibility for peacekeeping finance in the hands of just 30 member states, while the rest pay only token amounts, regardless of their current economic circumstances.

- Africa has everything to gain and nothing to lose from this reform - no African countries would pay more as a result of our current proposals, and South Africa would pay substantially less. Furthermore, we believe reform of the peacekeeping budget will substantially strengthen the UN's peacekeeping capacity.

Q: Are the U.S. and South Africa working to get a new WTO round launched?

- We have both demonstrated a firm commitment and expressed a strong desire for the successful launch of a new round of multilateral trade talks. Ambassador Barshefsky and Minister Erwin (have been/will be) sharing ideas for developing an effective strategy to achieve this goal.

Q: Can you comment on President Mbeki's views on HIV/AIDS? How, if at all, will it affect our assistance in this area?

- The approximately $50 million in development assistance the United States provides to South Africa each year helps solidify its successful transformation to a modern, democratic, and market-oriented system. We are committed to helping South Africa achieve this goal. President Mbeki and I are totally committed to the fight against HIV/AIDS in South Africa and around the world. His government's policies and actions demonstrate a strong commitment to the campaign against the scourge of HIV/AIDS.

Q: What is the U.S. view of the high rate of violence against women - especially rape - in South Africa?

- Obviously we abhor all violence against women or anyone else. It is clear that President Mbeki and his government take the problem of violence very seriously. The South African government has passed legislation to protect women and children from violence and has sought to strengthen the judicial system as a deterrent to those who would inflict violence on others. Our justice and anti-crime cooperation assists the South African government in that effort.

Q: What are the highlights of the U.S. assistance program in South Africa?

- The United States provides considerable assistance to South Africa to further our shared goal of achieving an inclusive, pluralistic, market-oriented, and economically sustainable democracy in South Africa. USAID, the Defense Department, Peace Corps, USIS, the State Department, law enforcement agencies, and other agencies provide assistance or training.

- The largest component of our assistance is USAID's longstanding effort to promote economic, social, and political development. In FY 2000, USAID is providing approximately $50 million in assistance. The U.S. assistance strategy for South Africa, developed in close cooperation with the government, civil society, academia and the private sector, supports the objectives of the government's reform program.

- The USAID program focuses on six strategic objectives: democratic consolidation (particularly administration of justice), education, health (particularly HIV/AIDS), economic policymaking capacity, job creation, and housing.

Q: Is the pharmaceutical patent dispute between the U.S. and South Africa resolved?

- In September 1999 we reached an understanding that allowed us to remove this issue from our bilateral agenda. We reaffirmed our shared objective of fully protecting intellectual property rights as set out in the WTO, while addressing South Africa's health issues.

Q: Will the U.S. take South Africa to the WTO over AT&T's complaint against Telkom?

- We take AT&T's allegations very seriously. We expect South Africa, as we expect all our WTO partners, to fulfill its obligations and commitments under the WTO agreement. That said, a constructive and cooperative dialogue to resolve this issue is underway. I am confident we will soon reach an amicable arrangement that addresses AT&T's and South Africa's concerns.

Q: Crime in South Africa is reportedly spiraling out of control. What is the U.S. view and what are we doing to help?

- The high rate of violent crime in South Africa is cause for concern because it could impede the country's transformation. President Mbeki has made the fight against crime one of his top priorities, and we are committed to assisting him in that fight. We have vastly expanded our anti-crime cooperation with South Africa in the last few years.

- Most notably, we established within the BNC a new anti-crime committee, chaired by Attorney General Reno. The committee works year-round to develop and implement anti-crime training

and assistance programs. In FY 1999, the State Department funded $2.2 million in anti-crime training and assistance. USAID also has a $16.5 million multi-year program aimed at strengthening the justice system in South Africa.

Q: But South Africa's police kill hundreds of suspects each year. Aren't you concerned about the human rights aspects of this assistance?

- Yes, we are concerned, and we know that President Mbeki's government is deeply concerned as well. The South African government is making strenuous efforts to reform the police force and build professionalism and capacity. These efforts are beginning to bear fruit.

- Our assistance and growing bilateral cooperation in this area is designed to strengthen the overburdened judicial system and, principally through training, to help improve the performance and professionalism of the police.

Q: Why is the U.S. training 50 South African police officers at the FBI Academy in Quantico?

- President Mbeki has made the fight against crime one of his top priorities, and we are committed to assisting South Africa in that fight. As part of our anti-crime cooperation, we agreed to train 50 recruits to South Africa's new elite investigating unit, the Directorate of Special Operations (DSO). These agents are not police officers but rather are under the authority of the National Director of Public Prosecutions. They are charged with investigating high-profile crimes and crime syndicates. Attorney General Reno, who chairs the BNC committee on anti-crime cooperation, and FBI Director Freeh strongly support this training program.

Q: Will the U.S.-South Africa Binational Commission continue to function?

- Yes. The Commission has been instrumental in strengthening the U.S.-South Africa partnership, and we have agreed that the BNC's nine committees should continue their valuable joint efforts.

- The BNC has accomplished a great deal -- including the signing of a Civil Aviation Agreement, Tax Treaty, and Trade

and Investment Agreement (TIFA); improved defense cooperation; vastly expanded anti-crime cooperation; and the establishment of a Fulbright Commission (the only one of its kind in sub-Saharan Africa).

- In the period ahead we will undoubtedly consult on the BNC's structure - particularly leadership modalities - and we are confident that the BNC process will continue to make an invaluable contribution strengthening our relations.

Q: What is the U.S. view on a permanent seat for South Africa in the U.N. Security Council?

- I would not want to comment specifically on that question. We strongly support Security Council enlargement that does not impede the effective functioning of the Council. We support additional permanent seats for countries from the Africa, Asia, and Latin America/Caribbean regions. The U.S. would defer to the regional groups on the selection modalities for regional permanent seats.

Q: President Mbeki has declared that an African Renaissance is underway. Yet the continent is wracked by war, poverty, and disease. How does the U.S. perceive this so-called renaissance?

- Despite today's headlines, there is considerable reason for optimism about Africa's future, and the United States is committed to working with Africans to resolve conflicts, promote democracy and sustainable development, and help the continent integrate into the global economy.

- African economies that were growing at less than 2% ten years ago are registering growth at more than twice that level. Some countries are recording double-digit growth rates. The number of democracies has more than quadrupled in less than a decade. From the demise of apartheid in South Africa to the rebirth of democracy in Nigeria, there is reason for hope.

- Clearly, this progress has not been universal, and Africans themselves must address their own problems. But the United States will not stand on the sidelines. Working with partners like President Mbeki, we will act upon our growing interest in a thriving Africa that can take its rightful place on the world stage.

Q: Why was the U.S. so slow in responding to the southern African floods in February/March?

- Let me first express my thanks to President Mbeki and his government for its decision to allow our military forces providing flood relief assistance to Mozambique to operate from South African territory. The cooperation between our two militaries was exemplary, and we are deeply appreciative.

- As the crisis unfolded the U.S. response was timely and appropriate. The U.S. Ambassador in Mozambique declared a disaster and invoked his authority to render immediate assistance on February 7, as soon as the dimensions of the disaster were becoming apparent. Our Ambassadors in Botswana, South Africa, and Zimbabwe declared disasters on February 16, 17, and 28.

- We gradually increased our assistance throughout February and, after the devastating effects of Cyclone Eline, authorized drawdown authority on March 1 to mobilize Operation Atlas Response. To date the U.S. has committed over $50 million for southern African flood relief.

Q: What is the U.S. response to President Mbeki's call for comprehensive debt relief?

- We recognize that many African countries labor under enormous debt burdens. Paying their creditors can steal resources away from pressing development needs.

- But debt relief alone is no panacea. Solid macroeconomic frameworks, market-oriented reforms, robust financial sectors, poverty reduction strategies, and stable democratic traditions are critical to economic success.

- The U.S. has already committed to 100 percent relief under the enhanced heavily indebted poor country initiative (HIPC). Most HIPC beneficiaries are African nations. Mozambique, Uganda, and Mauritania, for example, are well on their way to receiving enhanced HIPC debt forgiveness. Others can seek rescheduling of their debt obligations through the Paris Club.

Q: What is your assessment of the strengths and weaknesses of South Africa's transition?

- I would leave it to President Mbeki to comment on that question. Let me just say that all Americans continue to be enormously impressed by the progress South Africa has made - and in only six short years - building a nation and a society grounded in freedom, equality, and justice. It is one of the extraordinary achievements of the last century, and we are confident that President Mbeki, his government, and South Africa's people will continue to surmount the problems they face and succeed in realizing the promise of the great South African nation.

Q: How do you respond to former President Mandela's comments in April that the U.S. and Britain are causing "chaos" in the world?

- I have not seen those comments and would only say that I - and all Americans - hold former President Mandela in the highest regard and will always remember his selfless, wise service to South Africa and to the world. Among his many continuing activities, Mr. Mandela is now facilitating an end to Burundi's civil conflict, and in March I was pleased to participate by video in a Burundi peace conference he hosted. We wish him well in all his endeavors.

Q: South Africa opposes U.S. policy in key hotspots like Kosovo and Iraq. How does this affect our bilateral relations?

- As friends, we can discuss our differences openly and constructively, and, on occasion, agree to disagree. On many issues, such as Kosovo and Iraq, South Africa does not categorically oppose U.S. policy but rather disagrees with certain aspects of it. On Kosovo, for example, I understand that South Africa shared our concerns about the gross human rights abuses perpetrated by Serbia. However, South Africa also believed military action should not have been taken without a UN Security Council Resolution. We respect South Africa's views and believe it is important to maintain an open dialogue on key issues such as these.

Q: Can you give us any more details on when the U.S. and South Africa will begin talks on a Bilateral Investment Treaty and a Free Trade Area?

- As I said during my 1998 visit to South Africa, we are prepared to begin free trade talks with South Africa at an appropriate time. Although we are putting our efforts into launching a new WTO round, and South Africa is implementing

its SADC trade protocol, there is no reason we could not soon begin preliminary consideration of a U.S.-South Africa free trade agreement.

- As a signal of South Africa's commitment to make itself attractive to U.S. direct investors, I believe a bilateral investment treaty would be invaluable. It would encourage more U.S. investors to consider South Africa when making foreign direct investment decisions. I would welcome the initiation of negotiations of a bilateral investment treaty.

Q: What is the U.S. view of South Africa's position on the African Crisis Response Initiative (ACRI)?

- The U.S. has and will remain in close consultation with South Africa on ACRI. I understand that South Africa believes this kind of program should be implemented under regional auspices (through the OAU, for example), rather than on a bilateral basis. We respect South Africa's views but continue to believe that ACRI is of tremendous value to our peacekeeping partners on the continent.

Mbeki State Visit: Q's and A's

Drafted by: South Africa Deskoffs, 7-9838
I:SF docs/Mbeki State Visit/Q's and A's

Cleared by:
AF:SERice
AF:WSchneidman
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D:KDoherty
S/P:PByers
PA:LPisar
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IO/UNP:GOlson
NEA/ENA:JLapenn
EB/OMA:JMullinax/CWalker
EB/TPP/BTA:DAckerman
EB/TPP/MTA:RFrisbie
EB/OIA:DRenz
EB/CIP:SMiller
EB/TPP/IPC:SCronin
OES/EID:EBarth
AID/AFR:CReintsma
Treasury/OASIA: ???
USTR:Bschwartz
USDOC/ITA: ARobinson
ONAP:SThurman
OVP:JBabbitt
AF/ACRI:SFisher
DRL/BA:PHiggins
OSD/ISA/AF:AGrissom

THE PRESIDENCY: REPUBLIC OF SOUTH AFRICA
Private Bag X1000, Pretoria, 0001

(Embargoed till 20h00 – check against delivery)

SPEECH OF THE PRESIDENT OF SOUTH AFRICA, THABO MBEKI, AT THE OPENING SESSION OF THE 13TH INTERNATIONAL AIDS CONFERENCE: DURBAN, JULY 9, 2000.

Chairperson,
Participants at the 13th International AIDS Conference;
Comrades, ladies and gentlemen:

On behalf of our government and the people of South Africa, I am happy to welcome you to Durban and to our country.

You are in Africa for the first time in the history of the International AIDS Conferences.

We are pleased that you are here because we count you as a critical component part of the global forces mobilised to engage in struggle against the AIDS epidemic confronting our Continent.

The peoples of our Continent will therefore be closely interested in your work. They expect that out of this extraordinary gathering will come a message and a programme of action that will assist them to disperse the menacing and frightening clouds that hang over all of us as a result of the AIDS epidemic.

You meet in a country to whose citizens freedom and democracy are but very new gifts. For us, freedom and democracy are only six years old.

The certainty that we will achieve a better life for all our people, whatever the difficulties, is only half-a-dozen years old.

Because the possibility to determine our own future together, both black and white, is such a fresh and vibrant reality, perhaps we often overestimate what can be achieved within each passing day.

Perhaps, in thinking that your Conference will help us to overcome our problems as Africans, we overestimate what the 13th International AIDS Conference can do.

Nevertheless, that overestimation must also convey a message to you. That message is that we are a country and a Continent driven by hope, and not despair and resignation to a cruel fate.

Those who have nothing would perish if the forces that govern our universe deprived them of the capacity to hope for a better tomorrow.

Once more I welcome you all, delegates at the 13th International AIDS Conference, to Durban, to South Africa and to Africa, convinced that you would not have come here, unless you were to us, messengers of hope, deployed against the spectre of the death of millions from disease.

You will spend a few days among a people that has a deep understanding of human and international solidarity.

I am certain that there are many among you who joined in the international struggle for the destruction of the anti-human apartheid system.

You are therefore as much midwives of the new, democratic, non-racial and non-sexist South Africa as are the millions of our people who fought for the emancipation of all humanity from the racist yoke of the apartheid crime against humanity.

We welcome you warmly to South Africa also for this reason.

Let me tell you a story that the World Health Organisation told the world in 1995. I will tell this story in the words used by the World Health Organisation.

This is the story:

" The world's biggest killer and the greatest cause of ill-health and suffering across the globe is listed almost at the end of the International Classification of Diseases. It is given the code Z59.5 – extreme poverty.

"Poverty is the main reason why babies are not vaccinated, why clean water and sanitation are not provided, why curative drugs and other treatments are unavailable and why mothers die in childbirth. It is the underlying cause of reduced life expectancy, handicap, disability and starvation. Poverty is a major contributor to mental illness, stress, suicide, family disintegration and substance abuse. Every year in the developing world 12.2 million children under 5 years die, most of them from causes which could be prevented for just a few US cents per

child. They die largely because of world indifference, but most of all they die because they are poor ..

"Beneath the heartening facts about decreased mortality and increasing life expectancy, and many other undoubted health advances, lie unacceptable disparities in wealth. The gaps between rich and poor, between one population group and another, between ages and between sexes, are widening. For most people in the world today every step of life, from infancy to old age, is taken under the twin shadows of poverty and inequity, and under the double burden of suffering and disease.

"For many, the prospect of longer life may seem more like a punishment than a gift. Yet by the end of the century we could be living in a world without poliomyelitis, a world without new cases of leprosy, a world without deaths from neonatal tetanus and measles. But today the money that some developing countries have to spend per person on health care over an entire year is just US $4 – less than the amount of small change carried in the pockets and purses of many people in the developed countries.

"A person in one of the least developed countries in the world has a life expectancy of 43 years according to 1993 calculations. A person in one of the most developed countries has a life expectancy of 78 – a difference of more than a third of a century. This means a rich, healthy man can live twice as long as a poor, sick man.

"That inequity alone should stir the conscience of the world – but in some of the poorest countries the life expectancy picture is getting worse. In five countries life expectancy at birth is expected to decrease by the year 2000, whereas everywhere else it is increasing. In the richest countries life expectancy in the year 2000 will reach 79 years. In some of the poorest it will go backwards to 42 years. Thus the gap continues to widen between rich and poor, and by the year 2000 at least 45 countries are expected to have a life expectancy at birth of under 60 years.

"In the space of a day passengers flying from Japan to Uganda leave the country with the world's highest life expectancy – almost 79 years – and land in one with the world's lowest – barely 42 years. A day away by plane, but half a lifetime's difference on the ground. A flight between France and Cote d'Ivoire takes only a few hours, but it spans almost 26 years of life expectancy. A short air trip between Florida in the USA and Haiti represents a life expectancy gap of over 19 years...

"...HIV and AIDS are having a devastating effect on young people. In many countries in the developing world, up to two-thirds of all new infections are among people aged 15-24. Overall it is estimated that half the global HIV infections have been in people under 25 years – with 60% of infections of

females occurring by the age of 20. Thus the hopes and lives of a generation, the breadwinners, providers and parents of the future, are in jeopardy. Many of the most talented and industrious citizens, who could build a better world and shape the destinies of the countries they live in, face tragically early death as a result of HIV infection."

(World Health Report 1995: Executive Summary, WHO.)

This is part of the story that the World Health Organisation told in its World Health Report in 1995.
Five years later, the essential elements of this story have not changed. In some cases, the situation will have become worse.

You will have noticed that when the WHO used air travel to illustrate the import of the message of the story it told, it spoke of a journey from Japan to Uganda, another from France to the Cote d'Ivoire and yet another from the United States to Haiti.

From developed Asia, Europe and North America, two of these journeys were to Africa and the third to the African Diaspora.

Once again, I welcome you to Africa, recognising the fact that the majority of the delegates to the 13th International AIDS Conference come from outside our Continent.

Because of your heavy programme and the limited time you will spend with us, what you will see of this city, and therefore of our country, is the more developed world of which the WHO spoke when it told the story of world health in 1995.

You will not see the South African and African world of the poverty of which the WHO spoke, in which AIDS thrives - a partner with poverty, suffering, social disadvantage and inequity.

As an African, speaking at a Conference such as this, convened to discuss a grave human problem such as the acquired human deficiency syndrome, I believe that we should speak to one another honestly and frankly, with sufficient tolerance to respect everybody's point of view, with sufficient tolerance to allow all voices to be heard.

Had we, as a people, turned our backs on these basic civilised precepts, we would never have achieved the much-acclaimed South African miracle of which all humanity is justly proud.

Some in our common world consider the questions I and the rest of our government have raised around the HIV-AIDS issue, the subject of the

Conference you are attending, as akin to grave criminal and genocidal misconduct.

What I hear being said repeatedly, stridently, angrily, is - do not ask any questions!

The particular twists of South African history and the will of the great majority of our people, freely expressed, have placed me in the situation in which I carry the title of President of the Republic of South Africa.

As I sat in this position, I listened attentively to the story that was told by the World Health Organisation.

What I heard as that story was told, was that extreme poverty is the world's biggest killer and the greatest cause of ill health and suffering across the globe.

As I listened longer, I heard stories being told about malaria, tuberculosis, hepatitis B, HIV-AIDS and other diseases.

I heard also about micronutrient malnutrition, iodine and vitamin A deficiency. I heard of syphilis, gonorrhoea, genital herpes and other sexually transmitted diseases as well as teenage pregnancies.

I also heard of cholera, respiratory infections, anaemia, bilharzia, river blindness, guinea worms and other illnesses with complicated Latin names.

As I listened even longer to this tale of human woe, I heard the name recur with frightening frequency – Africa, Africa, Africa!

And so, in the end, I came to the conclusion that as Africans we are confronted by a health crisis of enormous proportions.

One of the consequences of this crisis is the deeply disturbing phenomenon of the collapse of immune systems among millions of our people, such that their bodies have no natural defence against attack by many viruses and bacteria.

Clearly, if we, as African countries, had the level of development to enable us to gather accurate statistics about our own countries, our morbidity and mortality figures would tell a story that would truly be too frightening to contemplate.

As I listened and heard the whole story told about our own country, it seemed to me that we could not blame everything on a single virus.

It seemed to me also that every living African, whether in good or ill health, is prey to many enemies of health that would interact one upon the other in many ways, within one human body.

And thus I came to conclude that we have a desperate and pressing need to wage a war on all fronts to guarantee and realise the human right of all our people to good health.

And so, being insufficiently educated, and therefore ill prepared to answer this question, I started to ask the question, expecting an answer from others – what is to be done, particularly about HIV-AIDS!

One of the questions I have asked is – are safe sex, condoms and anti-retroviral drugs a sufficient response to the health catastrophe we face!

I am pleased to inform you that some eminent scientists decided to respond to our humble request to use their expertise to provide us with answers to certain questions.

Some of these have specialised on the issue of HIV-AIDS for many years and differed bitterly among themselves about various matters. Yet, they graciously agreed to join together to help us find answers to some outstanding questions.

I thank them most sincerely for their positive response, inspired by a common resolve more effectively to confront the AIDS epidemic.

They have agreed to report back by the end of this year having worked together, among other things, on the reliability of and the information communicated by our current HIV tests and the improvement of our disease surveillance system.

We look forward to the results of this important work, which will help us to ensure that we achieve better results in terms of saving the lives of our people and improving the lives of millions.

In the meantime, we will continue to intensify our own campaign against AIDS, including:

- a sustained public awareness campaign encouraging safe sex and the use of condoms;
- a better focused programme targeted at the reduction and elimination of poverty and the improvement of the nutritional standards of our people;
- a concerted fight against the so-called opportunistic diseases, including TB and all sexually transmitted diseases;
- a humane response to people living with HIV and AIDS as well as the orphans in our society;
- contributing to the international effort to develop an AIDS vaccine; and,
- further research on anti-retroviral drugs.

You will find all of this in our country's AIDS action plan which I hope has been or will be distributed among you.

You will see from that plan, together with the work that has been going on, that there is no substance to the allegation that there is any hesitation on the part of our government to confront the challenge of HIV-AIDS.

However, we remain convinced of the need for us better to understand the essence of what would constitute a comprehensive response in a context such as ours which is characterised by the high levels of poverty and disease to which I have referred.

As I visit the areas of this city and country that most of you will not see because of your heavy programme and your time limitations, areas that are representative of the conditions of life of the overwhelming majority of the people of our common world, the story told by the World Health Organisation always forces itself back into my consciousness.

The world's biggest killer and the greatest cause of ill health and suffering across the globe, including South Africa, is extreme poverty.

Is there more that all of us should do together, assuming that in a world driven by a value system based on financial profit and individual material reward, the notion of human solidarity remains a valid precept governing human behaviour!

On behalf of our government and people, I wish the 13th International AIDS Conference success, confident that you have come to these African shores as messengers of hope and hopeful that when you conclude your important work, we, as Africans, will be able to say that you who came to this city, which occupies a fond place in our hearts, came here because you care. Thank you for your attention.

OFFICE OF NATIONAL AIDS POLICY

EXECUTIVE OFFICE OF THE PRESIDENT

THE WHITE HOUSE

FACSIMILE TRANSMITTAL SHEET

TO: Ken Bernard	FROM: Sarah Holewinski
COMPANY:	DATE: July 10, 2000
FAX NUMBER: 456-9390	TOTAL NO. OF PAGES INCLUDING COVER: 8
PHONE NUMBER: 456-9391	
RE:	

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

Sandy wanted to make sure that this got to you from South Africa. Please feel free to call me at 456-2959 with any questions or concerns!

736 Jackson Place
Washington, DC 20503
(202) 456-2437
(202) 456-2438 (fax)

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*** ERROR TX REPORT ***
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TX FUNCTION WAS NOT COMPLETED

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OFFICE OF NATIONAL AIDS POLICY

EXECUTIVE OFFICE OF THE PRESIDENT
THE WHITE HOUSE

FACSIMILE TRANSMITTAL SHEET

TO: Jim Babbitt
FROM: Sarah Holewinski
COMPANY:
DATE: July 10, 2000
FAX NUMBER: 456-9500
TOTAL NO. OF PAGES INCLUDING COVER: 8
PHONE NUMBER: 456-9511
RE:

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NOTES/COMMENTS:

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OFFICE OF NATIONAL AIDS POLICY

EXECUTIVE OFFICE OF THE PRESIDENT

THE WHITE HOUSE

FACSIMILE TRANSMITTAL SHEET

TO: Jim Babbitt	FROM: Sarah Holewinski
COMPANY:	DATE: July 10, 2000
FAX NUMBER: 456-9500	TOTAL NO. OF PAGES INCLUDING COVER: 8
PHONE NUMBER: 456-9511	
RE:	

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(202) 456-2438 (fax)

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OFFICE OF NATIONAL AIDS POLICY

EXECUTIVE OFFICE OF THE PRESIDENT
THE WHITE HOUSE

FACSIMILE TRANSMITTAL SHEET

TO: Noca Dempsey
FROM: Sarah Holewinski
COMPANY:
DATE: July 10, 2000
FAX NUMBER: 456-9260
TOTAL NO. OF PAGES INCLUDING COVER: 8
PHONE NUMBER: 456-9261
RE:

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THE WHITE HOUSE

FACSIMILE TRANSMITTAL SHEET

TO: Nora Dempsey	FROM: Sarah Holewinski
COMPANY:	DATE: July 10, 2000
FAX NUMBER: 456-9260	TOTAL NO. OF PAGES INCLUDING COVER: 8
PHONE NUMBER: 456-9261	
RE:	

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DEPARTMENT OF HEALTH

PRESS BRIEFING BY MINISTER OF HEALTH – SA.

- Yesterday, President Mbeki opened this Conference and reaffirmed our government's commitment to respond to the HIV/AIDS epidemic.

- He also referred to our 5-year HIV/AIDS/STD Strategic Plan released on the 19th of June 2000 containing the key elements of our national response to the epidemic. It also represents the collective wisdom of many South Africans from across a wide range of sectors who participated in its formulation. It has the full endorsement of our government, as well as the South African National AIDS Council (SANAC) chaired by our Deputy President, Jacob Zuma. SANAC is the concrete manifestation of this country's partnership against AIDS and has representatives from an array of civil society structures.

- This 5-year Strategic Plan is premised on the common understanding that there is a causal link between HIV and AIDS. **The President of this country has never denied either the existence of AIDS nor this causal connection between HIV and AIDS**. In this regard, we would like to quote the editorial of the Sunday Times of yesterday, 9 July 2000. "*Neither he nor Tshabalala-Msimang have ever denied the link between HIV and AIDS, and nor have they ever denied that AIDS represents a public health crisis that demands a special response from the government. On the contrary, in a television insert that has been run repeatedly over the past year, Mbeki has pleaded with the youth to use condoms and take the Aids crisis seriously. He should not be begrudged this because he has overzealously demanded a re-examination of sientific orthodoxy.*"

- It is precisely those who have decided to make this allegation and then cynically expect the President to respond to distortions of their own making, who should reflect on their own consciences.

- In any event, the statement of President Mbeki during the opening ceremony was unequivocal on this matter.

- A key element of our plan is the escalation of prevention efforts. This is focused particularly at the youth and includes the introduction of life skills programmes in schools as a compulsory part of our curriculum. It also includes peer education and broader social mobilisation.

  This effort is linked to public awareness on the dominant heterosexual modality of transmission in our context and therefore puts emphasis on condom usage and adequate treatment of sexually transmitted infections. We are strengthening all of these programmes and the President is unequivocal about our commitment to escalate our response on these elements.

- We are unapologetic about the fact that the focus on primary prevention remains the core of our response to this epidemic.

- A related issue is that of mother-to-child HIV transmission (MTCT). Again we have supported ongoing research in South Africa both on AZT and Niverapine. We have indicated clearly some of the concerns that are well known about side effects of these drugs, including the development of resistance. We also recognise that Niverapine, if it were to be proven to have a positive benefit/risk profile, would present a better option for developing countries like ours. This is because of its ease of administration as well as a relatively more favourable cost profile.

  As previously stated, we have therefore supported ongoing research on this. We look forward to the discussions in this Conference which will focus on the results of these trials and link them to the challenges of breastfeeding options given the evidence of reversal of benefits with continued breastfeeding. We have, in discussion with our scientists, agreed to discuss this matter once the relevant results are available. We also shall be looking at the recommendations from the WHO on this matter.

- Meanwhile, early this year we released our guidelines on the obstetric care of those who are HIV positive.

  It is important for us to remember that there are other basic interventions that are critical in preventing MTCT apart from the use of antiretrovirals.

- We reiterate our view that it is inappropriate to blame everything around this epidemic on the HI virus. Clearly the relationship between HIV and other social ills afflicting our society such as poverty and disease, particularly TB and STDs, is complex. We reaffirm unapologetically our view that a comprehensive response in our country needs to recognise this reality.

  It is clear to us that this reality is part of the elements that define the striking differences in response to this epidemic in developing countries as compared to developed countries. President Mbeki articulated this comprehensively in his address yesterday.

  We leave those who have the comfort to ignore this reality to continue deluding themselves. Our task is not to respond to narrow sectoral agendas and interests, but to intervene in a comprehensive, sustainable manner in the interests of our country, particularly those previously marginalised.

- Flowing from this understanding, earlier this year we released guidelines for the treatment of opportunistic infections. We have also strengthened our STD and TB programmes. We are also strengthening our national response to other public health challenges such as poverty and the provision of adequate safe water and sanitation.

  We do so because we believe that the presence of these infections accelerates viral replication and therefore increases the rate of transmission. It seems eminently evident to us that countries that are resource-constrained like ours, need to begin with these interventions both because this is good in itself but secondly because an effective response in this regard is an effective response against HIV and AIDS.

availability of all treatment of proven efficacy and benefit to deal with the epidemic of HIV and AIDS.

We are encouraged by the growing support for such interventions as parallel importing, compulsory licensing and local manufacturing, and we support these initiatives fully.

- Our Strategic Plan also places a lot of emphasis on the need to prevent all forms of discrimination against those infected and affected. This is central to the realisation of the theme of this Conference, namely "Breaking the Silence".

- We wish to reiterate our backing of this Conference and the robust debates it hosts.

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OFFICE OF NATIONAL AIDS POLICY

EXECUTIVE OFFICE OF THE PRESIDENT
THE WHITE HOUSE

FACSIMILE TRANSMITTAL SHEET

TO: Jim Boesiff
FROM: SARAH for STHEMAN
COMPANY:
DATE:
FAX NUMBER: 456-9500
TOTAL NO. OF PAGES INCLUDING COVER: 4
PHONE NUMBER: 456-9511
RE: SA Minister of Health

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NOTES/COMMENTS:

Not as BAD as MBeki's remarks
But....

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FACSIMILE TRANSMITTAL SHEET

TO: Jim Bobbitt
COMPANY:

FROM: SARAH for STHUEMAN
DATE:

FAX NUMBER: 456-9500

TOTAL NO. OF PAGES INCLUDING COVER: 4

PHONE NUMBER: 456-9511

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RESULT	OK

OFFICE OF NATIONAL AIDS POLICY

EXECUTIVE OFFICE OF THE PRESIDENT
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FACSIMILE TRANSMITTAL SHEET

TO: Nora Dempsey
FROM: SARAH for S. Thurman
COMPANY:
DATE:
FAX NUMBER: 456-9260
TOTAL NO. OF PAGES INCLUDING COVER: 4
PHONE NUMBER: 456-9261
RE: SA Minister of Health

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TO: Nora Dempsey

FROM: SARAH for S. Thurman

COMPANY:

DATE:

FAX NUMBER: 456-9260

TOTAL NO. OF PAGES INCLUDING COVER: 4

PHONE NUMBER: 456-9261

RE: SA Minister of Health

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RESULT	OK

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FACSIMILE TRANSMITTAL SHEET

TO: Ken Bernard
FROM: SARAH for S. THURMAN
COMPANY:
DATE:

FAX NUMBER: 456-9390
TOTAL NO. OF PAGES INCLUDING COVER: 4

PHONE NUMBER: 456-9391

RE: SA Minister of Health Briefing

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SOUTH AFRICA

U.S. Agency for International Development (USAID)
Population, Health, and Nutrition Briefing Sheet

Country Profile

Richly endowed with human and natural resources, South Africa is the fourth most populous nation and has the largest and most developed economy in sub-Saharan Africa. Still recovering from a legacy of social and political inequities, South Africa faces the challenges of pervasive poverty and the need to improve services for the disadvantaged.

USAID Strategy

USAID's program in South Africa began in 1995, the country's first full year of a democratically elected government with a constitution, bill of rights, and policy of transformation to foster equity among all its citizens. The South Africa mission has launched a 10-year program (1996–2005) that supports the development objectives of the Republic of South Africa, USAID, and the U.S.-South Africa Binational Commission. USAID's health activities are addressing inequities in access to primary health care (PHC) among South Africans. The strategy includes

- Expanding PHC services to all South Africans under a unified system,
- Improving management of the health care delivery system, and
- Increasing the capacity to deliver prevention and treatment services for HIV/AIDS and sexually transmitted infections (STIs).

Major Program Areas

Primary Health Care System Strengthening. The "Equity Project," a seven-year initiative of health training and sector reform activities, is USAID's main activity for strengthening PHC. Initial activities are designed to strengthen PHC management and service delivery systems in the Eastern Cape Province; the intention is to formulate successful activities into models for nationwide replication. In addition to technical emphases on improving the quality of reproductive and child health care and nutrition, the initiative includes support to develop effective health information and referral systems.

HIV/AIDS Prevention Activities. USAID supports a number of nongovernmental organizations (NGOs) and the national Department of Health with training of staff and community leaders in HIV/AIDS prevention. Workshops and group presentations focus on HIV/AIDS prevention messages and emphasize educating adolescents and other high-risk groups. A major new initiative is designed to help build capacity to plan and implement HIV/AIDS programs in the national Department of Health and at provincial and district levels.

Demographic Health Survey (DHS). Working with the Government of South Africa, USAID will help implement and disseminate the findings of the 1998 South Africa DHS. The DHS will establish baseline data for health sector planning and monitoring.

Results

- Publication and provincewide introduction of a standardized national PHC package in the Eastern Cape Province; this is the only province where the national policy has been interpreted and realized. With USAID assistance, 43 percent of clinic professional nurses in the Eastern Cape were trained in PHC clinical skills, and by 1997, 46 percent of clinics had at least one staff member who was trained in management skills.
- A National AIDS Strategy that resulted from a USAID-supported National AIDS Convention. A National STI/HIV/AIDS Review will guide the strategy's implementation through regional coalitions among policy and civic leaders.
- A USAID-supported NGO developed a legal charter to prevent discrimination against persons living with AIDS.
- More than 220 nurses were trained in the "syndromic approach" to HIV/AIDS diagnosis, a cost-effective method based on diagnosing by symptom rather than by running clinical tests.

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SOUTH AFRICA

Success Stories

USAID has supported extensive policy dialogue and an exploration of enhanced cost-recovery methods to improve PHC services' financial sustainability in South Africa. A USAID-funded study of the Uitenhage Hospital contract with a private provider group showed that public/private partnerships can result in improved quality for all patients and generate increased resources that can be used in under-funded facilities. USAID plans to provide technical assistance to replicate such partnerships elsewhere.

With USAID technical assistance, Eastern Cape Province developed and established clear guidelines for referrals to reduce the burden on hospitals. As a result, hospital outpatient load diminished significantly. For example, the Umtata General Hospital, the largest hospital in the province's poorest region, closed its outpatient department for general walk-in services, reducing the patient load in the hospital by nearly 40,000 patients per month. Meanwhile, with assistance from the Kellogg Foundation, the Eastern Cape Department of Health created four community-based rural health centers serving the catchment area around the town of Umtata, resulting in significant financial savings and reducing the hospital's burden.

USAID-assisted NGOs have been providing a substantial contribution to community outreach and HIV/AIDS awareness activities in rural and informal settlement areas. Interventions designed and implemented by community members target the general population and individuals at increased risk for HIV infection, such as adolescents. Peer-led prevention education programs have been successful in creating a nonjudgemental environment for the exchange of ideas on issues such as sexuality, STIs, reproductive health, values clarification, and decision-making skills. The USAID-funded AIDSCAP Project played a pivotal role in connecting these NGOs to a variety of information, technology, and resources that not only facilitate their understanding of HIV/AIDS issues, but also help in project implementation.

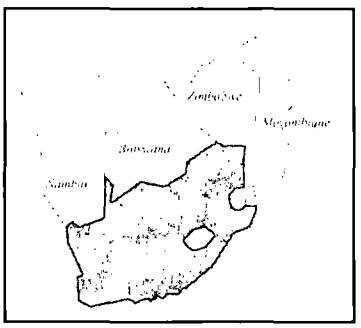
Continuing Challenges

South Africa's major health care challenge is to achieve an equitable distribution of basic health care. Unifying two vastly different health systems in South Africa requires that USAID's technical assistance promote appropriate health systems management and development. In addition, USAID's integrated PHC project must integrate HIV/AIDS/STI information and counseling into basic community-level health services.

Prepared by Center for International Health Information, Arlington, Virginia 22209, October 1998

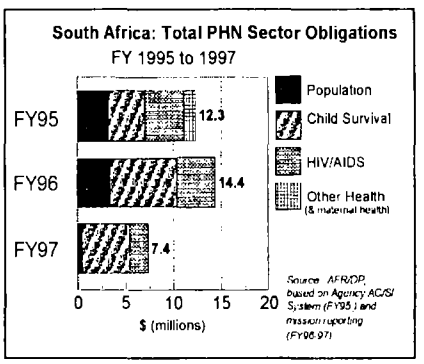
USAID Country Program Brief, October 1998
Health Development Activities in

South Africa



Population:	40.6 million (1996 Census)
Infant mortality rate:	48 deaths per 1,000 births (UN est. for 1997)
Adequate nutritional status:	not available
Total fertility rate:	3.8 children per woman (UN est. for 1997)
Contraceptive prevalence rate:	60% (all women/modern methods, 1994)
Demographic and Health Survey:	1998 (planned)

The South Africa mission has launched a 10-year program (1996–2005) to support the development objectives of the Republic of South Africa and USAID as well as the U.S.-South Africa Binational Commission. The mission submitted a revised country strategic plan in March 1997 specifying a goal of support for sustainable transformation and a subgoal of political, social, and economic empowerment. The program of assistance is assessed on an annual basis in a joint, bilateral exercise with the government of South Africa. Agencywide funding trends for health development activities in South Africa in 1995–97 are summarized in the figure to the right. The mission's results framework includes one strategic objective (SO) and five intermediate results (IRs) in health development. Activities under this objective are complemented by efforts under other SOs to strengthen local government (SO1) and to improve municipal service delivery (SO6).



Strategic Objective 3: More equitable, unified, and sustainable systems delivering integrated primary health care (PHC) services to all South Africans.

IR 3.1: Increase access to integrated package of PHC services.

IR 3.2: Effective health care referral systems are operational first in the pilot province (Eastern Cape) and then nationally.

IR 3.3: Improve management of integrated PHC [including human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) and sexually transmitted infection (STI)] delivery systems at the provincial level.

IR 3.4: PHC training program is strengthened and institutionalized at the provincial level initially in the pilot province (Eastern Cape).

IR 3.5: Increase capacity of the PHC system to deliver appropriate HIV, STI, and tuberculosis (TB) prevention and treatment.

Activities in Health Development

The EQUITY Project. This seven-year bilateral program, nearing its first full year of implementation, is the centerpiece of the mission's program for integrated primary health care. The initial activities focus on strengthening management, financial, and service delivery systems for primary health care in the Eastern Cape Province. Successful activities will serve as lessons, pilots, and models for replication on a nationwide basis. After one full year of implementation, a number of results are already evident:

- A unified drug logistics system has been fully implemented and is being scaled up to the national level.
- The health information system, developed under Equity, is being implemented in the Eastern Cape Province and will be scaled up nationally.
- Implementation of the health care referral system has started in the Eastern Cape.
- The DOTS methodology for tuberculosis diagnosis and treatment is being implemented for the first time in ten locations in the Eastern Cape.
- Condoms are widely and freely available in health clinics throughout the Eastern Cape Province, without the need for consultation with health personnel.

- Public/private partnerships involving the administration and management of small hospitals has been successfully initiated in the Eastern Cape.

The HIV/AIDS Project. This new, five-year program follows mission support in the area of HIV/AIDS since 1991, and is in response to the government of South Africa's recently launched "Partnerships Against AIDS" campaign. The main areas of support will include awareness raising and capacity strengthening, support for the establishment of a national STI reference center, and collaboration with ongoing South African initiatives for vaccine development. These activities will be carried out in close collaboration with the US Centers for Disease Control, the US National Institutes of Health, and USAID/Global Bureau Cooperating Agencies.

To date, mission initiatives in HIV/AIDS have focused on training, community outreach, and institutional capacity building. These have been carried out with the assistance of CDC and Global Bureau Cooperating Agencies. Key results with USAID funding include:

- The National AIDS Convention prepared a national AIDS strategy plan, which has been the backbone of the country's response to the epidemic.
- Work by a local NGO led to the development of a legal charter to prevent discrimination against people living with AIDS.
- A pilot program in a mining community to address STIs has led to the mining company picking up costs of the service delivery, with replications likely in other mining communities.
- The major labor unions have drafted a consensus position document on workplace policies and guidelines on AIDS.

The Amy Biehl Foundation. This foundation is a community-based NGO that focuses on integrated health and community development in key townships surrounding Cape Town. Established shortly after the killing of Amy Biehl in 1993, the Foundation's activities include youth-centered reproductive health and HIV/AIDS education, community development, outreach, and training. Virtually all of the Foundation's programs are carried out in close collaboration with the public sector and with specialized local NGOs.

The Binational Commission (BNC). The Gore-Mbeki Binational Commission establishes a framework for the collaborative relationship between the US and South Africa in all matters, including development assistance. USAID forms part of the health working group of the BNC and, as such, looks for collaborative opportunities that are consistent with USAID and USG priorities. USAID partners closely with the US Centers for Disease Control and the US National Institutes for Health in identifying and implementing joint programs. USAID has also been in discussions with the Medical University of South Africa (MEDUNSA), School of Public Health, in identifying further areas of collaboration.

USAID/Global Bureau and USAID/South Africa - Joint Programming Activities

Demographic and Health Surveys (DHS), working with the government of South Africa, will help implement the 1998 South Africa DHS and to disseminate the survey's findings. While developing baseline data for health sector planning and monitoring, the DHS will also increase local capacity to replicate these efforts in the future with little or no USAID assistance.

Environmental Health Project

POLICY Project has been assisting with AIDS awareness raising activities, and with technical projections. Staff from the Policy Project have facilitated capacity building workshops and seminars with provincial and community-based organizations to strengthen their capacity to raise awareness amongst their target populations. The Project has also assisted in analyzing, estimating, and projecting the pattern of the epidemic into the future. This last activity is an excellent example of donor coordination, as the European Union, DfID, and USAID all participate and share the costs of the technical meetings.

Other Collaborative Efforts. A number of Global Bureau Cooperating Agencies are working in the area of linkages between reproductive health and HIV/AIDS, including FHI, AVSC, and Pathfinder; the QAP project is coordinating with the Council for Health Service Accreditation of Southern Africa to experiment accreditation processes for clinic and other lower level facilities; ILSI and OMNI are working closely with the National Department of Health in implementing the Department's Micronutrient Fortification Strategy.

USAID/Bureau for Humanitarian Response, Office of Private & Voluntary Cooperation
Child Survival Grantees as of 1998

Medical Care Development, Inc. is focusing on the prevention and control of common childhood illnesses, maternal and newborn care, and improved immunization coverage in KwaZulu/ Natal Province.

World Vision Relief and Development, Inc. has a four-year project (through August 1999) focusing on nutrition, HIV/AIDS, childhood diseases, immunization, family planning, and maternal and newborn care in KwaZulu/Natal Province.

This USAID Country Program Brief was prepared for the Human Resources Division, Office of Sustainable Development, USAID Africa Bureau (AFR/SD/HRD), by the Center for International Health Information (CIHI). Questions and comments can be directed to CIHI (info@cihi.com).

South Africa failing to tackle AIDS, warns bank

By Steven Swindells

JOHANNESBURG, April 10 (Reuters) - South Africa, with one of the world's highest HIV infection rates, is failing to act quickly enough to keep AIDS from ravaging the country, a leading investment bank warned on Monday.

The criticism by bankers ING Barings was the latest assault on Pretoria, which has been criticised for questioning the causal link between the Human Immuno-deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

``The government really needs to formulate an AIDS strategy. It doesn't help when the government debates whether HIV causes AIDS. We can't waste any time," Kristina Quattek, chief economist at bankers ING Barings told Reuters after the bank presented a study of the future economic impact of AIDS.

South Africa's government has incensed the scientific world by inviting AIDS dissidents – scientists who question the link between HIV and AIDS – to an international AIDS conference in July and allowing them on a panel of international experts.

Pretoria also attracted controversy by refusing to give the AIDs-retardant drug AZT to HIV-infected pregnant women or rape victims, citing conflicting scientific reports and its cost.

President Thabo Mbeki, who succeeded Nelson Mandela last June, questioned the efficacy of AZT in preventing infection and reducing the likelihood of transmission in the womb.

The country's health minister has also fanned the flames by accusing the scientific community of using South Africa as a dumping ground where drugs could be tried but most people would never benefit from them because they were unaffordable.

The need for a clear policy was made all the more pressing by the estimated 1,700 South Africans who become infected each day with HIV.

According to government statistics, about 12 percent of the country's 40 million people are HIV positive.

ING Barings' report, a year in the making, forecast that HIV infection rates would peak at almost 17 percent by 2006 and AIDS related deaths top off five years later at 256 AIDS deaths per 100 normal deaths.

AZT treatment could significantly change the future growth of HIV-AIDS, the bank said.

``The fact that there is a lack of policy response means that the AIDS epidemic is a dark cloud on the horizon," said Quattek.

The ING-Barings study showed that the population growth rate would stagnate by 2010, by which time 2.5 times as many South Africans would die of AIDS than any other causes.

16:03 04-10-00

AIDS to hit S.African growth and investment -Barings

JOHANNESBURG, April 10 (Reuters) - South Africa's escalating AIDS epidemic is set to dampen economic growth, exacerbate a skills shortage, increase inflation and squeeze savings and investment, ING Barings said on Monday.

In a report entitled "The economic impact of AIDS in South Africa – a dark cloud on the horizon," the investment bank predicted that the epidemic would reduce gross domestic product (GDP) growth by 0.3 to 0.4 percentage points.

"The lower growth and higher risk profile for South Africa will not bode well for financial markets and may well deter foreign investors," it said.

South Africa has one of the highest rates of HIV infection in the world. An estimated 1,700 people are infected every day and according to government statistics, about 12 percent of the 40 million population are HIV-positive.

ING Barings forecast that the infection rate would peak at almost 17 percent by 2006 for the overall population – but said it could reach 26 percent among the economically active population and 30 percent for the unskilled and semi-skilled.

Using a model constructed by the Actuarial Society of South Africa, ING Barings predicted that the total population would be 23 percent lower by 2015 than without AIDS.

"South Africa is already battling with a skills shortage which will be further exacerbated by the AIDS epidemic raising remuneration and replacement costs for companies," it said.

These costs would be passed onto consumers and increase consumer price inflation, the report said, exerting upward pressure on interest rates. ING Barings also predicted the epidemic would shave two percentage points off domestic savings as a percentage of GDP, forcing South Africa to rely even more heavily on foreign inflows that it already does.

"Should foreign inflows not materialise, a savings-investment crunch will ensue, pushing interest rates markedly higher and further slowing GDP growth," it said.

The report said transport and storage and catering and accommodation were the sectors most exposed to the AIDS risk, given their reliance on skilled workers with a high infection risk who were expensive to replace.

The bank, which said it believed this was the first time such in-depth macro-economic modelling had been done on the impact of AIDS in South Africa, also said the fiscal deficit would increase due to higher health spending and lower revenue.

ING Barings urged both business and government to formulate better AIDS strategies. The government recently became embroiled in controversy after it invited scientists who question the link between HIV and AIDS to take part in an expert panel.

"So far, no clear strategies have been forthcoming from either, but they are urgently needed in order to mitigate the destructive effect of the epidemic on all parts of the economy and society," the report said.

12:35 04-10-00

Monday May 22 1:43 PM ET

S. Africa Asks U.S. Help With AIDS

By SONYA ROSS, Associated Press Writer

WASHINGTON (AP) - President Clinton met today with South African President Thabo Mbeki, who appealed for U.S. support, ``whatever our differences'' over how best to combat AIDS on the African continent.

Clinton greeted Mbeki, successor to the storied Nelson Mandela, at a formal ceremony in the White House East Room. The two leaders were cordial as they headed off to take up the thorny matter of obtaining low-cost AIDS drugs in South Africa and halting the spread of the virus through better prevention methods.

Mbeki denied that he said the drug AZT, a common treatment for AIDS, is ineffective. South Africa has contacts with scientists who argue that AZT does not work and that the human immunodeficiency virus does not cause AIDS.

``I never said that. Pure invention. Pure invention,'' Mbeki said.

Arguing that it cannot afford AIDS drugs at current prices, South Africa has been embroiled in a protracted fight with pharmaceutical companies over plans to import generic versions of drugs for which the companies have patents. Five companies said last week they would cut the price of treatments for HIV and AIDS, an offer South Africa said it could not accept if it also had to give up the right to seek cheaper generic drugs.

Clinton said he was sympathetic to Mbeki's goal of obtaining cheaper AIDS drugs and would do what he could to resolve the drug dispute.

``We've got to get them to him. He's got to be able to afford them,'' Clinton said. ``You've got these five big pharmaceutical companies now that say they're going to help. The next couple months we'll see if we really can get a victory.''

While not directly referring to the AIDS dispute, Mbeki praised Clinton for consistently prodding other industrial powers to take a greater interest in fighting the problems that plague Africa - such as disease,

interest in fighting the problems that plague Africa - such as disease, famine and war.

``You and your administration have treated us with dignity, whatever our differences on specific matters, with sensitivity to our problems in an unwavering commitment to help us resolve these," Mbeki said.

Later, in a toast with Vice President Al Gore (news - web sites) at the State Department, Mbeki thanked the United States for its help of a continent ``that has been marginalized."

Gore praised Mbeki's vision for Africa and added, ``We want you to know, Mr. President, America shares that dream."

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the African - special series on the African AIDS epidemic From the Boston Globe, October, 1999
• AIDS in Africa: Heartbreak and Hope - includes facts and figures, news and views, and a look at children affected by AIDS/HIV. From the General Board of Global Ministries United Methodist Church
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Opinion & Editorials

• "Africans Must Solve AIDS Crisis" - Africa News Online (May 15, 2000)
• Cheaper Drugs to Combat AIDS - NY Times (registration req'd) (May 15, 2000)
• Some inroads against AIDS - Milwaukee Journal Sentinel (May 14, 2000)
• Price of fighting aids - Miami Herald (May 12, 2000)
• Politics add to suffering - (May 12, 2000)

Magazine Articles

• The dream and the coming disaster - Salon (May 18, 2000)
• South Africa's Aids Agony: An Explosion in Slow Motion - National Geographic (May 2, 2000)
• Care for a Dying Continent - Scientific American (Apr 21, 2000)
• Flirting With Strange Ideas - Newsweek (Apr 10, 2000)
• Giving It Away - Village Voice (Apr 4, 2000)

Audio

• Presidential spokesman Parks Mankahlana "What is being done in the Western world [about AIDS]... to a large extent is not relevant to us" - BBC (Apr 20, 2000)
• The issues facing the conference - BBC (Sep 13, 1999)
• AIDS activists confront Gore, protesting policies on HIV in Africa - Democracy NOW (Jun 29, 1999)
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Video

• Slashed treatment prices - BBC (May 11, 2000)
• "The price of failure is high" - BBC (Sep 13, 1999)

Mbeki appeals for U.S. support on AIDS in Africa

May 22, 2000
Web posted at: 1:34 p.m. EDT (2034 GMT)


South African President Thabo Mbeki is greeted by President Clinton at the White House Monday

WASHINGTON (AP) -- President Bill Clinton met Monday with South African President Thabo Mbeki, who appealed for U.S. support "whatever our differences" over how best to combat AIDS on the African continent.

Making his first U.S. visit since succeeding Nelson Mandela, Mbeki was greeted by Clinton at a formal ceremony in the White House East Room. The two leaders were cordial as they headed off to take up the thorny matter of obtaining low-cost AIDS drugs in South Africa and halting the spread of the virus through better prevention methods.

Mbeki flatly denied that he said the drug AZT, a common treatment for AIDS, is ineffective. South Africa has contacts with scientists who argue that AZT does not work, and the human immunodeficiency virus does not cause AIDS.

"I never said that. Pure invention. Pure invention," Mbeki said.

Arguing that it cannot afford AIDS drugs at current prices, South Africa has been embroiled in a protracted fight with pharmaceutical companies over plans to import generic versions of drugs for which the companies have patents.

Five companies said last week they would cut the price of treatments for HIV and AIDS, an offer South Africa said it could not accept if it also had to give up the right to seek cheaper generic drugs.

Clinton said he was sympathetic to Mbeki's goal of obtaining cheaper AIDS drugs and would do what he could to resolve the drug dispute.

AIDS: Africa in Peril
- AIDS in Africa: Dying by the numbers
- AIDS leaves Africa's economic future in doubt
- Image gallery: pictures from the front line
- AIDS statistics

MESSAGE BOARD
AIDS in Africa

"We've got to get them to him. He's got to be able to afford them," Clinton said. "You've got these five big pharmaceutical companies now that say they're going to help. The next couple months we'll see if we really can get a victory."

While not directly referring to the AIDS dispute, Mbeki praised Clinton for consistently prodding other industrial powers to take a greater interest in fighting the problems that plague Africa -- such as disease, famine and war.

"You and your administration have treated us with dignity, whatever our differences on specific matters, with sensitivity to our problems in an unwavering commitment to help us resolve these," Mbeki said.

Other topics on Mbeki's agenda are likely to be the seizure of white farms in neighboring Zimbabwe and debt relief for poor nations, most of them in Africa.

VIDEO

CNN's Charlayne Hunter-Gault explains the forces acting on Mbeki's presidency.

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Watch Mbeki's speech upon arriving in the U.S.

QuickTime Play
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After meeting Clinton, Mbeki went to the State Department and was a guest of Vice President Al Gore for lunch. He returns to the White House Monday night for a state dinner.

On Tuesday he will meet with congressional leaders, deliver a lecture at Georgetown University and receive an honorary degree from Howard University. He will spend the rest of the week visiting U.S. cities in search of investment.

RELATED STORIES:

World - Pharmaceutical firms to slash cost of AIDS drugs for Africa
May 11, 2000
AIDS meeting in South Africa stirs up hornet's nest
May 6, 2000
Clinton administration declares AIDS a security threat
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Best course to stop spread of AIDS in Africa debated
February 17, 2000
Gore to announce major initiative on AIDS in Africa
January 9, 2000

RELATED SITES:

Unwembi's Resource of South African Government Information
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- UNAIDS The Joint UN Programme on HIV/AIDS

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Monday May 22 1:12 PM ET

Mbeki Says Africa Woes Require Extraordinary Steps


Reuters Photo

By Randall Mikkelsen

WASHINGTON (Reuters) - South African President Thabo Mbeki told President Clinton on Monday ``urgent and extraordinary'' measures were required to fight poverty, war and diseases including AIDS in Africa.

Wearing a red AIDS awareness pin on the lapel of his dark blue suit, Mbeki brought his crusade against the disease -- which has included questioning conventional AIDS treatments and scientific explanations of the disease -- to a White House state-visit arrival ceremony.

Mbeki urged a search for ``the best possible ways'' for Africans to extricate themselves from war, poverty and disease, and said the continent was falling further behind as technological development raced ahead in developed nations.

``These challenges require of us not just standard responses, but urgent and extraordinary interventions that will ensure that the benefits of the current scientific and technological advances are shared by everyone, including those in the most remote and isolated villages of the world,'' Mbeki said.

While ``most of humanity'' grapples with the sort of problems afflicting Africa, ``we witness on the other side of the same universe an abundance of resources and an unprecedented economic prosperity occasioned in great measure by vast technological advances,'' he said.

Clinton pledged solidarity and described Mbeki, who succeeded Nelson Mandela as president last June, as a leader of his continent.

He described as Africa's ``terrible problems'' renewed war between Ethiopia and Eritrea, wars in the Congo, Zimbabwe, Sierra Leone and Angola, excessive national debt, and the diseases AIDS, tuberculosis and malaria.

Full Coverage

See a Yahoo! special report on South Africa

Related News Stories

- Mbeki's Visit to U.S. Puts AIDS Activists in a Quandary - NY Times (registration req'd) (May 21, 2000)
- Mbeki heads for US - BBC (May 20, 2000)
- Color line defines South African opinion Mugabe's actions - Boston Globe (May 19, 2000)
- Queen honours Mbeki - BBC (May 18, 2000)
- African Politicians Take HIV Test - AP (May 16, 2000)

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Related Web Sites

- South Africa: An Overview - government-produces primer that includes sections on the country's history, arts, culture, and religion, economy and foreign relations.
- Thabo Mbeki: South Africa's President - profile of Mbeki from Infoplease.com
- South African Government - includes information on the president, the National Assembly, and government departments.
- New South African Constitution - adopted by the Constitutional Assembly on May 8, 1996
- Nkosi Sikelel' iAfrica - South Africa's National Anthem - a brief history and lyrics.

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Opinion & Editorials

- When culture, medicine don't quite cooperate - Chicago Tribune (May 10, 2000)
- No longer a president, Mandela remains a tower of leadership - Philadelphia Inquirer (May 10, 2000)

malaria.

``These are hard challenges without easy answers. And they will test our partnership, but that is what partners are for -- to solve big problems together," Clinton said.

He told Mbeki, ``You are leading your nation and an entire continent forward."

Mbeki has expressed frustration and alarm at the rampant spread of AIDS through his country -- where one in 10 are infected with the HIV virus that virtually all scientists agree causes AIDS -- and the high costs of conventional drugs used to fight the disease.

Arguing that all avenues to fighting AIDS in Africa must be explored, Mbeki appointed to an AIDS advisory panel three U.S. members of a group which argues that AIDS is not always caused by HIV and that conventional drugs may be ineffective.


Reuters Photo

Mbeki has denied AZT to pregnant mothers and rape victims, arguing the drug is too toxic and too expensive for South Africa. Mbeki on Monday dismissed as ``pure invention" reports that he questioned the effectiveness of AZT, the most common AIDS-fighting drug, ``I never said that," he told a reporter.

He added that his government was discussing ways to distribute AIDS medicines with officials of the World Health Organization.

``We need to be able to cope with dispensing" the drugs, Mbeki said on Monday. ``WHO says when you dispense them, you've got to have a strong enough medical infrastructure because of the potential toxicities and contraindications."

Clinton told reporters he hoped South Africa would be helped by a decision earlier this month by five major drug makers to cut prices for AIDS drugs, and by his own executive order that effectively gives the country more leeway to pursue cheaper, generic versions of patented anti-AIDS drugs.

He also urged Congress to pass a tax credit for vaccine development.

``There are some drugs out there now; we need to get them out there at affordable prices, and then we need to develop the vaccines," Clinton said.

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Earlier Stories

- South Africa's Mbeki Visits United States (May 21)
- S.Africa's Mbeki Makes First State Visit to U.S. (May 21)

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- Interview with a South African Volkswagen worker - World Socialist Web Site (Apr 29, 2000)
- In South Africa, AIDS and a Dangerous Denial - Washington Post (Apr 20, 2000)
- Pseudo-Science in South Africa - Washington Post (Apr 18, 2000)

Magazine Articles
- The return of Miriam Makeba - Salon (May 15, 2000)
- The Mantle of Mandela - Time Europe (May 15, 2000)
- The Netherlands and the Early Years of Apartheid - Radio Netherlands (May 11, 2000)
- White? Mandela cannot help you now - The Times (UK) (May 9, 2000)
- South Africa's Aids Agony: 'An Explosion in Slow Motion' - National Geographic (May 2, 2000)

Audio
- South African President Opens Debate On Cause Of AIDS - Democracy NOW (Apr 26, 2000)
- Presidential spokesman Parks Mankahlana "What is being done in the Western world [about AIDS]...to a large extent is not relevant to us" - BBC (Apr 20, 2000)
- Afrikaner extremist Eugene Terreblanche surrenders - BBC (Mar 30, 2000)

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Wednesday May 24 1:45 PM ET

Mbeki Tries to Puts AIDS Controversy Behind Him

By Sue Pleming

WASHINGTON (Reuters) - Trying once and for all to end controversy over his views on AIDS, South African President Thabo Mbeki said on Tuesday his past comments had been misinterpreted and that he had never questioned the link between HIV and AIDS.

But Mbeki was quick to stress that the world's focus should not only be on the AIDS epidemic sweeping across Africa and that the mosquito-borne disease malaria deserved equal treatment.

Reports that Mbeki questioned whether HIV causes AIDS--the view of most scientists--and his decision not to give pregnant women the antiviral drug AZT, has clouded the South African president's first state visit to the United States.

``Clearly there has been some misunderstanding of what we have said...We have never said there is no connection between HIV and AIDS. I don't know where that report came from," Mbeki told reporters after receiving an honorary degree at Howard University in Washington.

AIDS activists say Mbeki's government has been slow to respond to the AIDS epidemic in his country where one in 10 South Africans, or about 4.2 million people, are infected with HIV, the human immune-deficiency virus. They are also outraged by the inclusion on a presidential panel of three US researchers who contend AIDS is not always caused by HIV and that conventional drugs may be ineffective.

Mbeki, who discussed the AIDS issue with President Bill Clinton on Monday, said questions remained over the use of antiviral drugs such as AZT for pregnant women with AIDS.

Even with recently announced price reductions for drugs by five large pharmaceutical companies, prescribing AZT to all pregnant women with HIV would take up his country's entire health budget, he said.

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- South African president meets with Clinton on fighting AIDS - Baltimore Sun (May 23, 2000)

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- AIDS in Africa - briefing that highlights the threat to youth, cultural, and other factors related to the epidemic. From UNAIDS, November 1998. Also get country-by-country fact sheets.
- 11th International Conference on AIDS and STDs in Afric - theme is "Setting Priorities for HIV/AIDS in Africa". Held September 12-16, 1999 in Lusaka, Zambia.
- Children Orphaned By AIDS in Sub-Saharan Africa - report that investigates the extent of the AIDS crisis particularly as it relates to children orphaned by AIDS, and attempts to identify interventions. From the U.S. National Office of AIDS policy.
- A Continent's Crisis: AIDS and the African - special series on the African AIDS epidemic. From the Boston Globe, October, 1999.

with HIV would take up his country's entire health budget, he said. ``We would not even be able to afford an aspirin," he said, adding that South Africa's medical infrastructure was not sufficient to monitor the use of AZT, which can be toxic.

Clinton said Monday he hoped South Africa would be helped by the decision earlier this month by five big drug makers to cut prices for AIDS drugs in Africa, and by his executive order that effectively gives African countries more leeway to pursue cheaper, generic versions of patented anti-AIDS drugs.

South African Foreign Minister Nkosazana Dlamini-Zuma, a former health minister, said she did not believe prescribing AZT was an efficient use of her government's resources. It was also not clear, she said, whether prescribing vitamins and supplementing a mother's diet would have the same effect as using AZT. ``There is a lot of scientific work that still needs to be done, despite the fact that it would cost so much without a very good result in the end."

Mbeki said one of the biggest killers in Africa was malaria, but no one wanted to talk about this issue and instead focused solely on AIDS. ``I think we have to deal with this AIDS issue as effectively as possible, and so on, but I think that it would be incorrect for us as Africans to just focus on this and leave these other major issues- malaria, tuberculosis," he said.

The emergence of HIV/AIDS since the 1980s as an epidemic across Africa has overshadowed the fight against malaria, which affects over 400 million people each year and causes a million deaths. Most of those deaths are African children.

Mbeki said he could understand that malaria was not a serious problem in the United States and so this might be difficult for people to understand.

``No one asks and no one wants to come in and say, 'What can we do to assist with dealing with malaria' because of this exclusive focus. It's an important focus but it must not mean we should close our eyes to other realities," Mbeki said.

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- S.Africa's Mbeki to Take AIDS Row to US (May 16)

the Boston Globe, October, 1999
- AIDS in Africa: Heartbreak and Hope - includes facts and figures, news and views, and a look at children affected by AIDS/HIV. From the General Board of Global Ministries United Methodist Church

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- South Africa's Mbeki must make AIDS a top priority - Star Tribune (May 26, 2000)
- A Dissenting View on AIDS Policy - San Francisco Chronicle (May 24, 2000)
- South Africa's Silent Tragedy - Washington Post (May 23, 2000)
- Africans Must Solve AIDS Crisis - Africa News Online (May 15, 2000)
- Some inroads against AIDS - Milwaukee Journal Sentinel (May 14, 2000)

Magazine Articles

- The dream and the coming disaster - Salon (May 18, 2000)
- South Africa's Aids Agony: 'An Explosion in Slow Motion' - National Geographic (May 2, 2000)
- Care for a Dying Continent - Scientific American (Apr 21, 2000)
- Flirting With Strange Ideas - Newsweek (Apr 10, 2000)
- Giving It Away - Village Voice (Apr 4, 2000)

Audio

- Presidential spokesman Parks Mankahlana: "What is being done in the Western world [about AIDS] ... to a large extent is not relevant to us." - BBC (Apr 20, 2000)
- The issues facing the conference - BBC (Sep 13, 1999)
- AIDS activists confront Gore, protesting policies on HIV in Africa - Democracy NOW (Jun 29, 1999)

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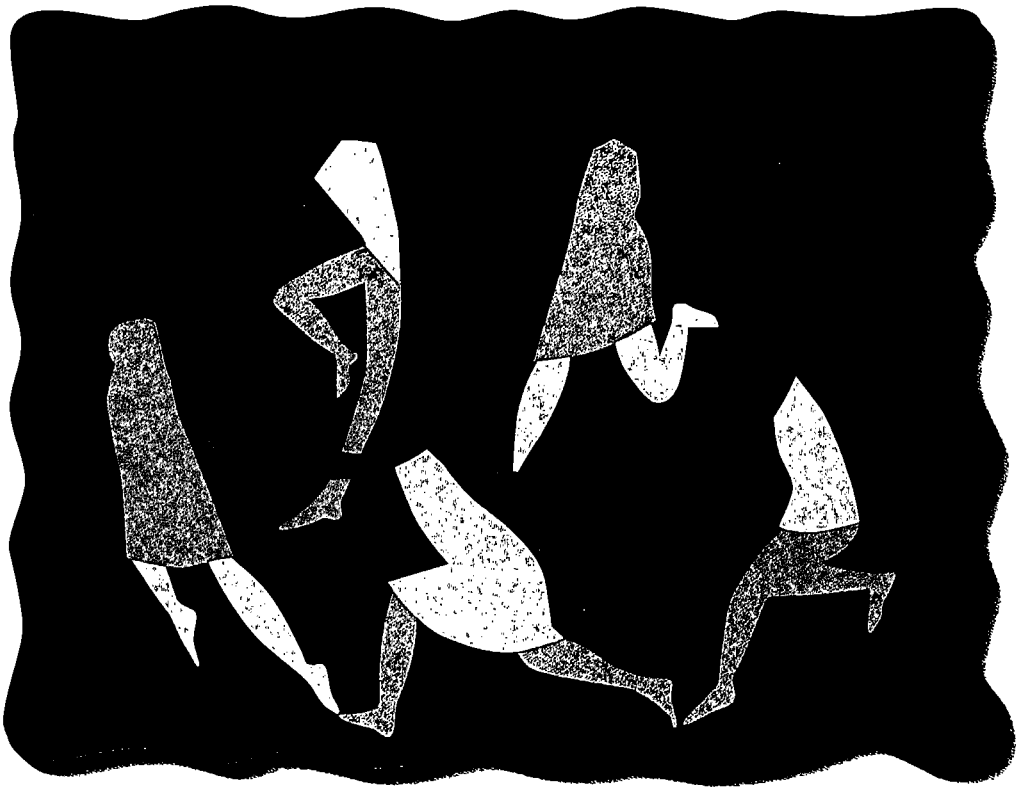

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