South Africa	**Zimbabwe**	**Nigeria** 4-7%	**Ghana** 4%
49.2 million people	11.9 million people	147 million people -- most populated country in Africa;	low but increasing incidence
3.6 million adults HIV+ (16%)	more than 3 million adults already HIV+ (26%) -- highest country-wide prevalence in the world	full of new opportunity -- need to ensure that opportunity by learning more about the extent of the epidemic and vigorously preventing further spread	talked with President Rawlings when he was here and he is very open and committed to ensuring that Ghana learning from Senegal and Uganda and effectively manage HIV
twice 3 yrs. ago fastest growing epidemic in the world	AIDS has decreased life expectancy by 26 years already -- from 65 to 39		
1,500 new infections per day (1 in every 10 new infections worldwide)	1.5 million children under 15 will be orphaned by 2010 (more than 1 in 3)	a Nigerian epidemic like that which has hit Southern Africa would be a huge catastrophe -- affecting tens of millions of people	
more than 3 million children under age 15 will be orphaned by 2010 (1 in 5)	100% increase in infant mortality and 200% increase in child mortality		
growing number of prohaned linked to crime and civil unrest and children raise themselves on the street	negative population growth by 2010		
losing 1-2% of GNP per year as a result of AIDS	AIDS orphans here are the "largest and fastest category of children in difficult circumstances" according to UNICEF		
life expectancy will drop by one-third from 60 to 40	In ante-natal clinics, up to 50% of women test HIV+		

Development of a Strategic Plan for Treatment of HIV Disease in Southern Africa

Sponsored by:
The National School of Public Health at the Medical University of South Africa
and
The Forum for Collaborative HIV Research
at the George Washington University SPHHS
Center for Health Services Research and Policy

Goal: Through a dialogue of leaders from government, industry, research, health care delivery, and community, the project will develop short-term and long-term goals for the treatment of HIV disease and its complications in southern Africa.

Southern Africa represents one of the fastest growing segments of the HIV/AIDS epidemic in the world. In many areas throughout the region, pregnant women have astronomically high rates of infection, for example, 73% in Beit Bridge, Zimbabwe and 43% in Francistown, Botswana. There are an estimated 1500 new infections each day in South Africa. An estimated 3.5 million people within South Africa alone are HIV-infected. Within the next five years, that number will rise to 5.6 million, 2.1 million will have died and 18% of the workforce will be infected. South Africa is faced with the possibility of over 1 million orphans and an overall decrease in life expectancy of 10 – 15 years because of HIV disease. Confronting the HIV epidemic in southern Africa requires battle on many fronts including prevention, appropriate surveillance, and research to develop a vaccine. However, for the millions already infected with HIV, development of a feasible and effective course of treatment is essential. Treatment for HIV and its related illnesses can provide hope for those living with AIDS. It will provide incentive for individuals to come forward and learn their HIV status, thus impacting on prevention efforts and reducing the stigma associated with the disease.

The National School of Public Health at the Medical University of South Africa (MEDUNSA) and the Forum for Collaborative HIV Research (the Forum) propose the development of a policy initiative to engage in strategic planning for HIV treatment intervention in southern Africa. Drawing on expertise and leadership from southern Africa, the United States and Europe, the initiative would bring together government officials, public health experts, researchers, health care providers, patient advocates, employers, unions, and pharmaceutical company representatives to develop short- and long-term objectives for treatment of HIV in southern Africa. The dialogue would address such questions as:

- What is the scope of available treatment options that could have the greatest immediate impact on morbidity, mortality, and quality of life?
- What is the prevalence of opportunistic infections? What are the best options for prophylaxis and treatment?

- Given limited resources and infrastructure, what are the feasible treatment priorities that can be implemented over the short-term?
- What is needed to increase the availability of additional treatment options and improve the health care infrastructure over time?
- How can the effects of treatment interventions be evaluated?

The dialogue would provide an important opportunity for all the relevant stakeholders to assess the viable treatment options and the abilities of the health care infrastructure in southern Africa to provide care for people with HIV now and in the future. It is essential that the strategic plan be developed by leadership within southern Africa, who can best represent the needs of the epidemic there and provide the most comprehensive understanding of the region's capabilities in providing health care and support for people with HIV. Leaders in government, health care provision and industry from outside of southern Africa can best participate in the process by helping to determine how to implement the agenda. The project would be coordinated by the National School of Public Health at MEDUNSA and the Forum.

Project planning and implementation will take place over the next nine months. Key steps include:

- Development of the group of participants for the project, which will include meeting with individuals and group essential to the success of the project to discuss their views and ensure their participation;
- Develop an infrastructure for communications within and beyond southern Africa for the group;
- Create a workplan for project, including staffing needs within southern Africa and in Washington, DC, budgets, and a schedule for meetings;
- Prepare a report for release at the International AIDS Conference in Durban, South Africa, with the necessary background information needed to inform the group's discussions. Examples of information to be included in the report:
    a) Epidemiology of opportunistic infections in the region;
    b) The cost of different treatment options;
    c) The current capabilities of health care infrastructures in the region;
    d) A compilation of current programs that provide support and care in the area.
- Hold the first meeting of the full group to agree on the project's scope and mission, the groundrules for discussion, and to prepare a presentation for the conference in Durban announcing the policy initiative.
- Announcement of the project through a presentation at the Durban conference.

The School of Public Health at MEDUNSA is uniquely qualified to undertake this initiative within southern Africa. With schools of medicine, dentistry, basic sciences, pharmacy and public health, Pretoria-based MEDUNSA is the largest health sciences academic institution in Africa. MEDUNSA's mission is to empower the educationally disadvantaged community of southern Africa by providing excellent community-oriented tertiary education, training and research in health and related sciences, and to promote services at all levels of health care in the community.

The Forum for Collaborative HIV Research at the School of Public Health and Health Services at George Washington University provides an important model for the development of the proposed policy initiative in southern Africa. The Forum is a public/private partnership created at the request of Vice-President Al Gore in 1997. The Forum is made up of representatives from government agencies, clinical researchers, patient advocates, pharmaceutical company representatives, and health care providers. The Forum facilitates discussion about emerging issues in HIV clinical research and the transfer of research results into care. The Forum seeks to identify gaps and impediments in furthering knowledge about HIV treatment, develop recommendations to fill those gaps, and then catalyze its membership to implement those recommendations.

Thinking big: scaling-up HIV-1 interventions in sub-Saharan Africa

HIV-1 infection and AIDS continue to have a devastating impact in sub-Saharan Africa, where they accounted for 1·8 million deaths in 1998, almost double the number of deaths from malaria and eight times that from tuberculosis.[1] Yet resources to address HIV-1 infection have been limited compared with those for other priority areas. In 1998, external spending on HIV-1 infection in Africa was about US$165 million, less than a third of the $650 million spent on childhood immunisation programmes.[2] Thus, although there are strong HIV-1/AIDS interventions across Africa, few are implemented nationally. The experiences of Uganda and Senegal indicate the importance of a national and coordinated response. Hence, a key priority should be the rapid expansion of activities.

Some funds will be available for such expansion. Under the USA's LIFE initiative (Leadership in Investment in Fighting an Epidemic) now undergoing congresssional approval, an additional $100 million will be allocated for HIV-1/AIDS in the year 2000.[3] The bulk of this sum is earmarked for Africa, with defined targets for increasing national coverage of specific activities.

The task ahead is complex. There is a patchwork of, mostly small-scale, prevention and care activities being implemented across Africa by public-sector and private for-profit and non-profit organisations. There is little experience of replication and expansion, so strategic and creative thinking is needed. Current experience must be built upon, the burden that HIV-1 infection already poses recognised, and lessons from future successes quickly shared.

In the short term, effective activities that can be scaled-up quickly need to be identified. For rapid scaling-up, the potential to use the existing infrastructure to achieve widespread coverage must be maximised. For example, with current enrolment rates, a quarter of youths aged 12-16 years could potentially be reached each year through interventions based on secondary schooling. However, an additional 10% (who do not go on to secondary school) could be reached if HIV-1 education was also provided in the last year of primary school. The substantial potential to use private-sector and informal networks must also not be overlooked. Already in some countries condoms are transported to rural areas through food-and-beverage distribution systems. More generally, the widespread involvement of different organisations and networks (such as workplaces, unions, and religious and community networks) could help increase the access of different social and geographical groups to specific activities.

Among countries most affected, strategies to reduce the significant burden that HIV-1 infection is placing on existing infrastructure and capacity will be required. About 50-70% of medical beds for adults in large hospitals are taken up by patients with HIV-1-related illnesses.[4] Likewise, the attrition of skilled people (such as teachers and nurses) due to death from HIV-1 infection or AIDS may be substantial. It is estimated that each year 2-4% of workers will die of HIV-1-related causes in a country with a 20% prevalence of HIV-1 infection among adults.[5] Coping mechanisms, such as complementary home-based care to reduce the load on hospitals, need to be identified and strengthened.

During implementation, key gaps in information need to be addressed--for example, because of limited data on costs, even identification of the resources required to scale-up and sustain different interventions is difficult.[6] Knowledge is lacking about how the relative quality, efficiency, and cost-effectiveness of various interventions change as their implementation is scaled up. Although the incorporation of HIV education into school curricula may have high start-up costs (to develop the curriculum and print materials), implementation costs may be relatively low, so the intervention becomes increasingly efficient with increasing scale.

Although it is important to focus on rapid action, sustainability must not be ignored, otherwise the overall impact of efforts to increase intervention coverage will be undermined. In the longer term, too, there will be inherent limits on the extent to which interventions can be scaled-up and supported with current levels of infrastructure. Consequently, complementary actions to invest in broader development and economic progress are required. Ultimately, it is important not only to strengthen capacity to respond to the epidemic, but also to pursue the fundamental changes needed to break the cycle of poverty and HIV infection.

Charlotte Watts, Lilani Kumaranayake

Health Policy Unit, London School of Hygiene and Tropical Medicine, London WC1E 7HT, UK

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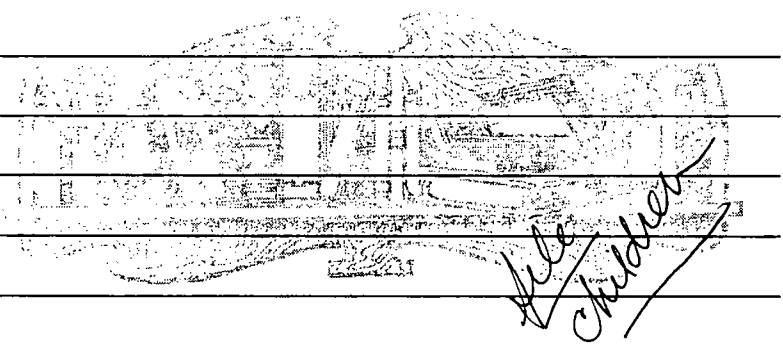

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HIV/AIDS in African Children: A Major Calamity That Deserves Urgent Global Action

Chinua Akukwe

ABSTRACT. According to the United Nations Global Program on HIV/AIDS (UNAIDS), Africans account for 70% of all global HIV infection despite representing only 10% of the world population. More than 80% of all 1998 global AIDS deaths occurred in Africa. However, the fate that awaits children in Africa is even more ominous: in 1998, 9 out of 10 new global HIV infections among children, 15 years or below, occurred in Africa and more than 95% of all AIDS orphans worldwide are African children. Nearly 2.9 million African children have died of AIDS related illnesses since the beginning of the pandemic. This article discusses the HIV/AIDS calamity among African children and concludes with recommendations on how to organize an urgent global action to save these children. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-342-9678. E-mail address: getinfo@haworthpressinc.com <Website: http://www.haworthpressinc.com>]*

KEYWORDS. HIV/AIDS, Africa, children, global action

INTRODUCTION

The United Nations Joint Program of HIV/AIDS (UNAIDS) recently announced its 1998 report on the Human Immunodeficiency Virus

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AIDS in Africa is a Serious Crisis

But Opportunities Exist for Helping to Save Millions of Lives

AIDS IN SUB-SAHARAN AFRICA IS SHATTERING FAMILIES AND COMMUNITIES.

- About 24 million Africans south of the Sahara are HIV infected -- almost 70% of the world's total number infected in a region that accounts for only 10% of the world's population.
- In seven countries in southern Africa, including South Africa, 20% of the adult population (ages 15 to 49) is already infected.
- UNAIDS has declared HIV/AIDS in Africa "the worst infectious disease catastrophe since the bubonic plague."
- In sub-Saharan Africa, each and every day more than 11,000 additional people become HIV+. In South Africa alone, at least 1,600 people a day become HIV+.
- AIDS is now the leading killer in sub-Saharan Africa with 84% (13.7 million) of the 16.3 million AIDS deaths to date.
- There are over 5,500 AIDS related funerals a day in Africa. That number will rise to 13,000 a day by 2005.
- In 1998 in Africa, 200,000 people died as a result of war -- AIDS killed 2.2 million.
- By 2010, more than 40 million children in Africa will be orphaned by AIDS.

AIDS IS WIPING OUT DECADES OF PROGRESS ON A HOST OF DEVELOPMENT OBJECTIVES IN SUB-SAHARAN AFRICA.

- According to US Census Bureau, AIDS has already reduced life expectancy Zimbabwe from 65 to 39 years, in Uganda from 54 to 43 years, and in Zambia from 56 to 37years. In the next few years, AIDS will reduce life expectancy in South Africa by a third, from 68 to 45 years.
- In the coming decade, AIDS will double infant mortality (infants under the age of 1) in many sub-Saharan Africa countries and triple child mortality (children ages 1 to 5).

AIDS IS NOT ONLY CAUSING UNFATHOMABLE HUMAN SUFFERING IT IS JEOPARDIZING THE ECONOMIES, THE STABILITY, AND CIVIL SOCIETY OF MANY SUB-SAHARAN AFRICAN NATIONS.

- AIDS is a trade and investment issue. At the recent meeting with African trade and finance ministers, Professor Jeffrey Sachs, director of the Harvard Institute for International Development, stated that, "a frontal attack on AIDS in Africa may now be the single most important strategy for economic development."
- According to *The Economist*, a recent study in Namibia estimated that AIDS cost the country almost 8% of GNP in 1996. Another analysis predicts that Kenya's GNP will be 14.5% smaller in 2005 than it would have been without AIDS, and the per capita income will be 10% lower.

- A report released by the World Bank last week states: "The question is, will this pandemic destroy the developing nations' hard earned economic gains or will governments get their act together in time? Clearly time is running out."
- AIDS has hit professionals hard in sub-Saharan Africa, particularly civil servants, engineers, teachers, miners, and military personnel. According to one study in Kigali, Rwanda, 34% of people with post-secondary education were HIV positive, compared to 18% of those with primary education, and civil servants were more than three times more likely to be HIV positive than farmers. Increased benefits and training costs, and disruption due to sick and bereavement leave are seriously affecting both the private and public sectors. Companies like British Petroleum and Barclay Bank told us that they are now hiring two employees for every one skilled job, assuming that one will die of AIDS.
- AIDS is a security issue. According to the Economist, "the estimated HIV prevalence in the seven armies embroiled in the Congo range from 50% for the Angolans to 80% in Zimbabweans". Recent reports confirm that 40% of the South African military is already HIV positive. US military officials have raised this as a serious stability concern.
- A South African anti-crime institute has linked the growing number of children orphaned by AIDS to future increases in crime and civil unrest. Without appropriate intervention, many of the 2 million children projected to be orphaned by AIDS in South Africa will raise themselves on the streets, often turning to crime, drugs, commercial sex, and gangs for survival. This not only effects social stability but also dramatically increases their risk of HIV.

DETERMINED LEADERSHIP AND PARTNERSHIPS HAVE MADE, AND ARE CONTINUING TO MAKE, AN EXTRAORDINARY DIFFERENCE, SAVING MILLIONS OF LIVES.

- Uganda has been the world leader in demonstrating that even a country with limited resources and low levels of literacy could turn the tide on a burgeoning epidemic. President Museveni demonstrated bold leadership early on, making every government ministry take the problem seriously, and develop and implement its own plan for reducing stigma and transmission, and caring for those who become sick.
- Uganda has created an enabling environment for donors, such as the US, to be active partners in the battle against AIDS. The US has invested $46 million in HIV prevention and care in Uganda (26% of all donor AIDS funding), and as a result, HIV rates have been slashed by more than half. Through stigma reduction, education, HIV counseling and testing, treatment of STDs, and community based HIV care and support, Uganda has begun to turn the tide.
- Countries such as Zambia, Malawi, Uganda, and Kenya have begun to develop initiatives to respond to the growing number of children orphaned by AIDS. In the longstanding African tradition, communities are finding creative ways to support the village in its efforts to raise its children, but the growing number of orphaned children already overwhelms many of these villages.
- Through micro-finance programs like FINCA (Foundation for International Community Assistance), women are receiving loans, starting small businesses, and with increased household incomes, taking in children orphaned by AIDS. With support of non-governmental organizations, communities are coming together to deal with school fees, nutritional assistance, immunization and oral hydration, counseling, and the range of other needs that arise for orphaned children. These efforts are low cost strategies designed to empower women, protect children, and support extended families and communities in carrying for their own. For a small fraction of the cost of one orphanage bed an entire community of vulnerable children can receive care. The problem is that only a very small number of children receive even this modest level of support.

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Sandra L. Thurman
National AIDS Policy Director

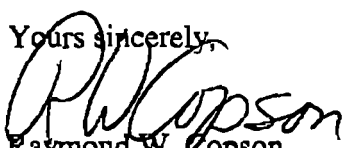
Dear Ms. Thurman:

Alex Ross at USAID suggested I let you know that I will be attending the AIDS2000 meeting in Durban in my capacity as a specialist in African affairs at the Congressional Research Service. I have been working on the HIV/AIDS issue for several months at CRS, and I believe that the conference will deepen my understanding of all aspects of the disease – and of its consequences for African societies. I maintain an issue brief on AIDS in Africa at CRS, and am including a copy with this fax. I expect to complete an update in the next couple of days.

On my way to Durban, I will be stopping in Malawi and Zambia to talk with U.S. officials and others involved in efforts to combat the disease. I hope to visit some AIDS projects.

I look forward to meeting you one day, perhaps in Durban. I have always found your testimony at hearings most informative.

Yours sincerely,



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CRS Issue Brief for Congress

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AIDS in Africa

Updated May 11, 2000

Raymond W. Copson
Foreign Affairs, Defense, and Trade Division

CONTENTS

AIDS in Africa

SUMMARY

Sub-Saharan Africa has been far more severely affected by AIDS than any other part of the world. The UN reports that 23.3 million adults and children are infected with the HIV virus in Africa, which has about 10% of the world's population but nearly 70% of the worldwide total of infected people. The overall rate of infection among adults in sub-Saharan Africa is about 8%, compared with a 1.1% infection rate worldwide. In some countries of southern Africa 20% to 26% of adults are infected. An estimated 13.7 million Africans have lost their lives to AIDS, including 2.2 million who died in 1998. AIDS has surpassed malaria as the leading cause of death in Africa, and it kills many times more Africans than war.

In Africa, HIV is spread primarily by heterosexual contact. Sub-Saharan Africa is the only region of the world where women are infected at a higher rate than men, and young women suffer a particularly high rate of infection.

Experts relate the severity of the African AIDS epidemic to the region's poverty. Health systems are ill-equipped for prevention, diagnosis, and treatment. Poverty forces many men to become migrant workers in urban areas, where they may have multiple sex partners; and poverty forces many women to become commercial sex workers, vastly increasing their risk of infection. Cultural and behavior patterns, such as low rates of male circumcision, may also play a role.

AIDS is having severe social and economic consequences, depriving Africa of skilled workers and teachers, while reducing life expectancy by decades in some countries. The disease has created 7.8 million "AIDS orphans," who face increased risk of malnutrition and reduced prospects for education. AIDS is being blamed for declines in agricultural output in Zimbabwe and Kenya.

Donor governments, non-governmental organizations, and African governments have responded primarily by attempting to reduce the number of new HIV infections, and by trying ameliorate the damage done by AIDS to families, societies, and economies. A third possible response – treatment of AIDS sufferers with medicines that can result in long-term survival – has not been widely used in Africa. Advocates of treatment argue that it would reduce damage to African economies and keep parents alive. They believe that ways can be found to reduce the cost of AIDS medications. Skeptics argue that treatment would require not only expensive drugs but also costly improvements in Africa's health infrastructure.

U.S. concern over AIDS in Africa grew during the 1980s, as the severity of the epidemic became apparent. Congress earmarked funds for a worldwide campaign against the disease in 1987. According to the U.S. Agency for International Development, the U.S. has been the global leader in the international response to AIDS since 1986. The Administration launched an AIDS initiative in July 1999, and spending on AIDS in Africa is projected to reach $169 million in FY2000.

Many are urging that more be done, and bills have been introduced to support a wide range of Africa AIDS initiatives. Nonetheless, some observers argue that competing budget priorities work against a massive U.S. Africa AIDS program.

MOST RECENT DEVELOPMENTS

On May 11, 2000, five major pharmaceutical companies announced sharp reductions in the price of AIDS drugs sold in Africa. President Clinton, on May 10, issued an executive order stating that the United States would not seek to prevent sub-Saharan countries from promoting access to HIV/AIDS pharmaceuticals or medical technologies consistent with the World Trade Organization's TRIPS agreement. (See AIDS Treatment Issues.*) The order resembled Section 116 (known as the Feingold/Feinstein amendment) of the Senate-passed version of the Africa trade bill (H.R. 434), which had been dropped in conference with the House.*

The Foreign Operations Appropriations bill (S. 2522), reported to the Senate on May 9, earmarks $225 million in Development Assistance for worldwide HIV/AIDS programs; the Administration had requested $244 million under this account. (Aadditional AIDS spending is proposed through other programs; see U.S. Policy.*) According to press reports on April 30, the White House was treating HIV/AIDS in Africa and other regions as a national security threat and had ordered the National Security Council to prepare a study of enhanced responses.*

BACKGROUND AND ANALYSIS

Sub-Saharan Africa has been far more severely affected by AIDS than any other part of the world. According to December 1999 United Nations data, some 23.3 million adults and children are infected with the HIV virus in the region, which has about 10% of the world's population but nearly 70% of the worldwide total of infected people. The overall rate of infection among adults in sub-Saharan Africa is about 8%, compared with a 1.1% infection rate worldwide. An estimated 13.7 million Africans have lost their lives to AIDS, including 2.2 million who died in 1998. AIDS has surpassed malaria as the leading cause of death in sub-Saharan Africa, and it kills many times more people than Africa's armed conflicts.

Leading Causes of Death in Sub-Saharan Africa, 1998

	% of Deaths
HIV/AIDS	19.0
Malaria	10.0
Lower respiratory infections	8.2
Diarrheal diseases	7.6
Perinatal conditions	5.5
Cerebrovascular disease	4.7
Heart disease	2.9
Tuberculosis	2.2
Traffic accidents	1.8
Chronic obstructive pulmonary disease	1.1

Source: World Health Organization, *World Health Report, 1999.*

Characteristics of the African Epidemic

In addition to its severity, the sub-Saharan AIDS epidemic is defined by a number of other unusual characteristics.

- HIV, the human immunodeficiency virus that causes AIDS, is spread in Africa primarily by heterosexual contact, rather than primarily by contact among gay males or through intravenous drug use.

- Sub-Saharan Africa is the only region in which women are infected with HIV at a higher rate than men. According to UNAIDS, women make up an estimated 55% of the HIV-positive adult population in sub-Saharan Africa, as compared with 35% in the Caribbean, the next highest-ranking region, and 20% in North America.

- Young women are particularly at risk. A U.N. study found girls aged 15-19 to be infected at a rate of 15% to 23%, while infection rates among boys of the same age were 3% to 4%.

- To date, eastern and southern Africa have been far more severely affected than West Africa, but infection rates in a number of West African countries are starting to escalate. In Botswana, Namibia, Zambia, and Zimbabwe, all southern African countries, an estimated 20% to 26% of adults are infected with HIV, and 13% of adults in South Africa were infected at the end of 1997. In Senegal, a West African country, the 1997 adult infection rate was 2%. However, adult infection rates now exceed 10% in Ivory Coast and Burkina Faso, two other West African states, and the infection rate is increasing in populous Nigeria as well.

- The African AIDS epidemic is having a much greater impact on children than is the case in other parts of the world. An estimated 600,000 African infants become infected with HIV each year through mother to child transmission, either at birth or through breast-feeding. (White House, *Report on the Presidential Mission on Children Orphaned by AIDS in Sub-Saharan Africa: Findings and Plan of Action.* Washington, July 19, 1999. p.14.)

- An estimated 7.8 million African children have lost either their mother or both parents to AIDS, and thus are regarded by UNAIDS as "AIDS orphans." South Africa is expected to have one million AIDS orphans by 2004, and in some of Africa's worst-affected cities, orphans already comprise 15% of all children. (World Bank, *Intensifying Action Against HIV/AIDS in Africa.* See also, U.S. Agency for International Development (USAID), *Children on the Brink*, 1997.) In its January 17, 2000 issue, *Newsweek* projected that there will be 10.4 million African AIDS orphans by the end of 2000. UNAIDS reports that AIDS orphans, suspected of carrying the disease, generally run a greater risk of being malnourished and of being denied an education.

Explaining the African Epidemic

AIDS experts offer a number of explanations for the severity of the AIDS epidemic in Africa and for its unusual characteristics. Some experts believe that the explanation may be partly medical: AIDS in Africa is generally caused by a virus known to specialists as HIV I-Subtype C, which may spread more easily through heterosexual contact than Subtype B, common in the United States. If this is the case, then the entire sexually active population is more vulnerable to infection than in countries where Subtype B is dominant.

Most analysts, however, emphasize a variety of economic and social factors to explain Africa's AIDS epidemic, placing primary blame on the region's poverty. Poverty has deprived Africa, for example, of effective systems of health information, health education, and health care. Thus, Africans suffer from a high rate of untreated sexually-transmitted infections (STIs) other than AIDS, and these are believed to open the way to infection by HIV. African health care systems are typically unable to provide AIDS counseling, which could help slow the spread of the disease, and even HIV testing is difficult for many Africans to obtain. AIDS treatment is generally available only to the elite.

Poverty forces large numbers of African men to migrate long distances in search of work, and while away from home they may have multiple sex partners, increasing their risk of infection. Some of these partners may be women who have been forced to become commercial sex workers because of poverty, and they too are highly vulnerable to infection. Migrant workers can become a conduit for spreading the disease from urban to rural areas; when they return home, they commonly infect their wives. Long distance truck drivers and drivers of "taxis," who transport Africans long distances by car, are also believed to be key agents in spreading AIDS

Adult HIV Infection Rates, end of 1997 (%)

Zimbabwe	25.84	
Botswana	25.10	
Namibia	19.94	
Zambia	19.07	
Swaziland	18.50	
Malawi	14.92	
Mozambique	14.17	
South Africa	12.91	
Rwanda	12.75	
Kenya	11.64	
Cent. Af. Republic	10.77	
Djibouti	10.30	
Cote d'Ivoire	10.06	
Uganda	9.51	
Tanzania	9.42	
Ethiopia	9.31	
Togo	8.52	
Lesotho	8.35	
Burundi	8.30	
Congo Brazzaville	7.78	
Burkina Faso	7.17	
Cameroon	4.89	
Congo Kinshasa	4.35	
Gabon	4.25	
Nigeria	4.12	
Liberia	3.65	
Sierra Leone	3.17	
Eritrea	3.17	
Chad	2.72	
Ghana	2.38	
Guinea Bissau	2.25	
Gambia	2.24	
Angola	2.12	
Guinea	2.09	
Benin		2.06
Senegal	1.77	
Mali	1.67	
Equatorial Guinea	1.21	
Sudan	.99	
Mauritania	.52	
Somalia	.25	
Madagascar	.12	

Source: UNAIDS Epidemiological Fact Sheets

Some behavior patterns in Africa may also be affecting the epidemic. In explaining the fact that young women are infected at a higher rate than young men, Peter Piot, the Executive Director UNAIDS, has commented that "the unavoidable conclusion is that girls are getting

infected not by boys but by older men," who are more likely than young men to carry the disease. (UNAIDS press release, September 14, 1999.) A researcher in a UNAIDS project studying the differential rate of infection added that "Young (women's) lives are being cut short through sex which is all too often forced, coerced, or 'bought' with sugar-daddy gifts." Many believe that the infection rate among women generally would be far lower if women's rights were more widely respected in Africa and if women exercised more power in political and economic affairs. (For more on these issues, see Carol Ezzell, "Care for a Dying Continent," *Scientific American*, May 2000.) Other cultural factors may also be playing a role in the African epidemic. Male circumcision, for example, is reportedly more common in West Africa than in eastern and southern Africa, and some scientists are beginning to suspect that this helps to explain the comparatively lower rate of infection in West Africa. (*Boston Globe*, November 5, 1999; *Sunday Times*, London, March 26, 2000)

The breakdown in social order and social norms caused by armed conflict could also be contributing to the African epidemic. Conflict, which has afflicted many sub-Saharan countries for years, is typically accompanied by numerous incidents of violence against women, including rape, carried out by soldiers and guerrillas. Such men are also more likely to resort to commercial sex workers than those living in a settled environment.

Some observers believe that the spread of AIDS in Africa could have been slowed if African leaders had been more engaged and outspoken in the struggle against the disease. President Yoweri Museveni of Uganda, in particular, has won wide recognition for leading a successful campaign against AIDS in his country. But many other African leaders have said or done comparatively little about the epidemic. In September 1999, the United Nations convened a major conference on AIDS in Africa in Lusaka, the capital of Zambia, but none of the 15 invited African heads of state attended. Even the host-country president, Frederick Chiluba, claimed a conflict and sent his vice president to read his opening remarks.

President Daniel arap Moi of Kenya, where 13.5% of adults are infected and 760,000 have died from AIDS, did not endorse the use of condoms as a preventive until December 1999. (*Africa News Service*, December 23, 1999.) South Africa has a large AIDS program launched by the former president, Nelson Mandela, but some critics question whether the current president, Thabo Mbeki, is treating the disease with sufficient urgency. President Mbeki's stance is particularly worrisome to many AIDS experts because he is an influential leader not only in heavily-infected southern Africa but also among developing countries generally. Mbeki has challenged the safety and effectiveness of AIDS medications useful in preventing mother-to-child transmission of the disease. On April 19, 2000 the press reported that he had sent a letter to President Clinton and other heads of state asserting that Africa would not copy foreign approaches to dealing with AIDS and defending dissident scientists who maintain that AIDS is not caused by the HIV virus. Dissident scientists from several countries make up more than half of a commission Mbeki convened in May to study and report on the disease. According to press reports, $6.2 million of South Africa's $17 million AIDS budget was unspent during 1999.

Social and Economic Consequences

AIDS is having severe social and economic consequences in Africa, and these negative effects are expected to continue for many years. A Central Intelligence Agency *National*

Intelligence Estimate report on the infectious disease threat, made public in an unclassified version, forecasts grave problems over the next 20 years.

> At least some of the hardest-hit countries, initially in sub-Saharan Africa and later in other regions, will face a demographic catastrophe as HIV/AIDS and associated diseases reduce human life expectancy dramatically and kill up to a quarter of their populations over the period of this Estimate. This will further impoverish the poor, and often the middle class, and produce a huge and impoverished orphan cohort unable to cope and vulnerable to exploitation and radicalization. (CIA, *The Global Infectious Disease Threat and Its Implications for the United States* [http://www.odci.gov].)

Report estimates predicted increased political instability and slower democratic development as a result of AIDS.

According to the World Bank,

> The illness and impending death of up to 25% of all adults in some countries will have an enormous impact on national productivity and earnings. Labor productivity is likely to drop. the benefits of education will be lost, and resources that would have been used for investments will be used for health care, orphan care, and funerals. Savings rates will decline, and the loss of human capital will affect production and the quality of life for years to come. (World Bank, *Intensifying Action Against HIV/AIDS in Africa.*)

USAID estimates that Kenya's GNP will be 14.4% smaller in 2005 than it would have been without AIDS. The disease is expected to hinder growth prospects in South Africa, Tanzania, Namibia, and other countries in eastern and southern Africa as well. *(Report on the Presidential Mission on Children Orphaned by AIDS.)*

In the most severely affected countries, sharp drops in life expectancy are occurring, and these will reverse major gains achieved in recent decades. UNAIDS reports that life expectancy at birth in southern Africa, which stood at 44 years in the early 1950s, reached 59 in the early 1990s, but will fall to 45 by 2015. (UNAIDS, *AIDS Epidemic Update: December 1999.*) The Kenyan minister of public health said on December 10, 1999 that life expectancy in his country had already dropped from 60 years to 45.

According to many reports, AIDS has devastating effects on rural families. The father is typically the first to fall ill, and when this occurs, farm tools and animals may be sold to pay for his care. As he grows weaker, he will become unable to farm at all; nor will his wife be able to farm, since she will be devoting her time to nursing him. The family will be unable to pay school fees, and in any event, children will likely be kept out of school to perform added chores at home. Should the mother also become ill, children may be forced to shoulder responsibility for the full time care of their parents, particularly since rural clinics in some countries are reportedly short-staffed because of AIDS.

The economic consequences of the disruption of rural life can be severe. For example, sharp declines in the production of maize, cotton, and other crops in Zimbabwe have been blamed on widespread illness and death from AIDS among peasant farmers and among workers at small commercial farms. (*Washington Post*, December 12, 1999.) A decline in agricultural activity in Kenya has also been attributed to AIDS.

AIDS is also being blamed for shortages of skilled workers and teachers in several countries. Although unemployment is generally high in Africa, such trained personnel are not readily replaced. Teachers are reportedly dying more rapidly than replacements can be found in parts of western Kenya. In Ivory Coast, five teachers reportedly die from AIDS during each week of the school year. According to USAID, the Ministry of Education in Zambia found that 1,300 teachers had died in 1999, mostly from AIDS, and that only 700 new teachers were trained. AIDS is believed responsible for high rates of absenteeism and labor turnover in eastern and southern Africa, and the resulting increased costs are believed to be discouraging new investment. The disease is also claiming many lives at middle and upper levels of management in both business and government.

AIDS may have serious security consequences for much of Africa, since HIV infection rates in many armies are extremely high. South African soldiers have been widely expected to play an important peacekeeping role in the Democratic Republic of the Congo (DRC, formerly Zaire) and perhaps other countries in coming months and years, but the infection rate in the South Africa army is 40% according to one insurance company survey (*Mail and Guardian* (Johannesburg), October 19, 1999), and other estimates are higher. Infection rates among the seven armies currently embroiled in the conflict in the DRC have been estimated at 50% to 80%. (*Report on the Presidential Mission on Children Orphaned by AIDS.*) The ability of such armies to conduct effective operations and behave professionally is a source of concern to analysts. Domestic political stability could also be threatened in African countries if the security forces become unable to perform their duties due to AIDS. (For more on this issue, see the CIA Estimate, noted above.)

Responses to the AIDS Epidemic

Donor governments, non-governmental organizations (NGOs) working in Africa, and African governments have responded to the AIDS epidemic primarily by attempting to reduce the number of new HIV infections, and to some degree, by trying ameliorate the damage done by AIDS to families, societies, and economies. A third possible response – treatment of AIDS sufferers with medicines that can result in long-term survival – has not been widely used in Africa, largely due to cost and the lack of effective health care infrastructure. However, demands for large-scale treatment are mounting in Africa, and are drawing support from outside the continent among AIDS activists and others concerned for the region's future. An effective vaccine could offer a permanent solution to the African AIDS crisis, but progress in vaccine development has been slow.

Efforts to reduce the number of AIDS infections have focused on increasing AIDS awareness among Africans. Programs and projects aimed at combating the disease typically provide information on how the disease is spread – and on how it can be avoided – through the media, posters, lectures, and skits. AIDS awareness programs can be found in many African schools and increasingly in the workplace, where employers are recognizing their interest in reducing the infection rate among their employees. Many projects aim at making condoms readily available – USAID reports that it has shipped more than 2 billion condoms to Africa since 1986 – and on providing instruction in condom use. Some recent pilot projects have had success in reducing mother-to-child transmission by administering the anti-HIV drug AZT, or a less expensive medicine, nevirapine, during birth and early childhood. HIV testing has also received support on grounds that people will exercise greater care in

their sexual conduct if they are aware of their HIV status. In December 1999, for example, the government of Norway announced that it would help Uganda establish voluntary HIV testing centers in every district of the country. USAID is currently supporting HIV testing centers in 10 African countries.

Church groups and humanitarian organizations have helped Africa deal with the consequences of AIDS by setting up programs to provide care and education to orphans. The Farm Orphan Support Trust in Zimbabwe tries to keep sibling orphans together and in a family living situation; the Salvation Army sponsors a pilot, community-based, orphan support program in Zambia, providing education and health care to vulnerable children. (*Report on the Presidential Mission on Children Orphaned by AIDS.*) A United Nations study has found that community-based organizations, sometimes with the support of NGOs, have emerged to supply additional labor, home care for the sick, house repair, and other services to AIDS-afflicted families. (UNAIDS, *A Review of Household and Community Responses to the HIV/AIDS Epidemic in Rural Areas of Sub-Saharan Africa*, 1999.)

Further information on the response to AIDS in Africa may be found at the following websites:

CDC [http://www.cdc.gov/nchstp/od/nchstp.html]
European Union: [http://europa.eu.int/comm/development/aids/]
International Association of Physicians in AIDS Care: [http://www.japac.org/]
Journal of the American Medical Association HIV/AIDS Information Center:
[http://www.ama-assn.org/special/hiv/]
UNAIDS: [http://www.us.unaids.org/]
USAID: [http://www.info.usaid.gov/pop_health/aids/aidshome.htm]
World Bank: [http://www.worldbank.org/aids/].

Effectiveness of the Response

The response to AIDS in Africa has had some successes, most notably in Senegal, mentioned above, and in Uganda, where the rate of infection has been cut in half – to approximately 9.5% – by an active AIDS awareness program that openly advocates the use of condoms. Despite these success stories, however, available evidence indicates that the epidemic is deepening in most of the region. Even the head of the Ugandan AIDS program is worried that Ugandans are letting down their guard with respect to the disease. (*Africa News Service*, December 10, 1999). In the West African nation of Nigeria, Africa's most populous country with 111 million people, the rate of adult HIV infection has increased from 4.5% in 1995 to 5.4% in 1999, adding to a large pool of infected people who could be a source of a much more rapid increase in coming years.

Experts note that there are a number of barriers to a more effective AIDS response in Africa, such as cultural norms that make it difficult for many government, religious, and community leaders to acknowledge or discuss sexual matters, including sex practices, prostitution, and the use of condoms. However, experts continue to advocate AIDS awareness and AIDS amelioration as essential components of the response to the epidemic. Indeed, there is strong support for an intensification of awareness and amelioration efforts, as well as adaptations to make such efforts more effective. Some advocate, for example,

awareness campaigns that include intensive, interpersonal communication strategies targeted at those most likely to acquire or transmit HIV.

A World Bank report, among other proposals, recommends that the Bank create teams of well-known African elders, former statesmen, friends of Africa, and celebrities who would visit afflicted countries to help mobilize civil society against the epidemic. (*Intensifying Action Against HIV/AIDS in Africa: Responding to a Development Crisis.)* With respect to amelioration, UNAIDS has recommended that donors find ways to strengthen those indigenous support institutions that are already helping AIDS victims and their families. (*A Review of Household and Community Responses.)* There is also support for a stronger focus on treatment of non-HIV STIs, which can dramatically lower the rate of HIV transmission.

The lives of infected people could be significantly prolonged and improved, some maintain, if more were done to identify and treat the opportunistic infections, particularly tuberculosis, that typically accompany AIDS. Millions of Africans suffer dual infections of HIV and TB, and the combined infection dramatically shortens life. The U.S. Ambassador to Botswana, Robert Krueger, recently pointed out that "Botswana has perhaps the highest degree of HIV/AIDS infection in the world and 44 per cent of all its people who are affected receive their death stroke by contracting tuberculosis." (*Africa News Service*, November 3, 1999. Krueger was speaking at the opening of a U.S.-funded TB laboratory in Botswana.) Tuberculosis can be cured by treatment with a combination of medications over several months, even in HIV-infected patients. However, according to the World Health Organization, Africans often delay seeking treatment for TB or do not complete the course of medication (*Global Tuberculosis Control: WHO Report 1999*, Key Findings), contributing to the high incidence of death among those with dual infections.

AIDS experts strongly believe that more funding needs to be devoted to fighting the epidemic. The July 1999 White House report on children orphaned by AIDS stated that $150 million per year was then being spent on combating AIDS in Africa from all sources, including donor spending and spending by African governments. Approximately half of this amount was being contributed by USAID, and the great bulk of the rest was coming from other donors. According to UNAIDS, in 1996-1997, only Botswana, Kenya, Malawi, and Uganda were spending more than $1 million of their own resources on AIDS.

World Bank President James Wolfensohn said in January 2000 that according to Bank estimates, $1 billion to $2.3 billion was needed to fight AIDS in Africa, and he estimated current HIV/AIDS official assistance for Africa from all sources at $160 million. On April 17, the World Bank's Development Committee pledged increased spending to combat AIDS, and Wolfensohn said he had told African clients that with respect to AIDS, "if you have programs, we will fund them. No sensible project will be stopped for lack of funding."

AIDS Treatment Issues

Access for poor Africans to costly combinations of AIDS medications or "antiretrovirals" is perhaps the most contentious issue surrounding the response to the African epidemic today. Administered in a treatment regimen known as HAART – highly active antiretroviral therapy – these drugs can return AIDS victims to normal life and lead to long-term survival rather than early death. Such treatment has proven highly effective in developed countries, including the United States, where AIDS, which had been the eighth

leading cause of death in 1996 no longer ranked among the 15 leading causes by 1998. (U.S. Department of Health and Human Services Press Release, October 5, 1999.)

Advocates of making HAART widely available in Africa argue that the therapy would keep parents alive, slowing the growth in the number of AIDS orphans; and keep workers, teachers, civil servants, and managers alive as well, thus reducing the economic impact of the epidemic. Some also see a moral obligation to try to save lives when the medications for doing so exist.

The high cost of HAART treatments, however, has been regarded as the principal obstacle to offering the therapy on a large scale in Africa, where most victims are poor and lack health insurance. Varying figures – some as high as $20,000 – have been published as estimates of the annual cost of combination drug therapies in Africa (*Washington Post* editorial, January 6, 1999). Yet other estimates are considerably lower. In October 1999, the cost of combination therapy in South Africa was estimated at $334 per month (*The Christian Century*, October 20, 1999), or $4,000 per year. UNAIDS reports that Brazil treated 75,000 victims with antiretrovirals in 1999 at a cost of $300 million – or, again, $4,000 per person. Variations in treatment cost estimates may reflect differences in the prices of drugs chosen for the combination therapy and the degree to which other costs, such as physician visits and specialized laboratory tests, are included.

Even at $4,000 per year per person, however, combination therapy would be far beyond the means of most victims and governments in sub-Saharan Africa, where GNP per capita averages $308 per year. (World Bank 1997 data, excluding South Africa. With South Africa included, the figure would be $503.) According to the World Bank, no sub-Saharan country spent more than $400 per person per year on health during 1990-1995, the latest period for which data are available. (*African Development Indicators, 1998/1999.)*

As long as combination drug therapy continues to cost several thousand dollars per year per patient, the total cost of treating a significant portion of Africa's more than 23 million HIV-infected people would be many billions of dollars per year. Skeptics of the possibility of administering combination drug therapy widely in Africa argue that meeting such costs would require assistance from developed countries at an unprecedented level – one which their taxpayers would be unlikely to accept. They also note that early diagnosis and regular monitoring are required if the combination drugs are to be used effectively. This would be difficult for most African health infrastructure systems to achieve without additional foreign assistance.

Advocates of helping to provide combination antiretroviral therapies in Africa maintain that the alternative is to see much of the continent sink into an economic and political decline that will require decades to reverse. They favor subsidies to make the drugs affordable as well as donor action to strengthen African health care systems so that drug therapies can be effectively administered. In addition, advocates of treating HIV-infected Africans argue that it should be possible for African governments and donor agencies to achieve sharp reductions in the cost of antiretrovirals for Africa, perhaps partly through negotiated agreements with drug manufacturers. The British pharmaceutical firm Glaxo Wellcome, a major producer of antiretrovirals, has already stated that it is committed to "differential pricing," which would lower the cost of AIDS drugs in Africa.

Many also advocate "parallel imports" of drugs and "compulsory licensing" by African governments to lower the price of patented medications. Through parallel importing, patented pharmaceuticals could be purchased from the cheapest source, rather than from the manufacturer; while under "compulsory licensing," an African government could order a local firm to produce a drug and pay a negotiated royalty to the patent holder.

Although both parallel imports and compulsory licensing are permitted under Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS agreement) of the World Trade Organization agreement for countries facing health emergencies, pharmaceutical manufacturers and U.S. officials have strongly opposed such measures on grounds that they could lead to infringements of intellectual property rights. Moreover, some argue, the profits of drug companies might be reduced by parallel importing and compulsory licensing, and this would hinder the ability of manufacturers to conduct research on new drugs, including drugs that might be even more effective against HIV. A third view is that some combination of subsidization, price reduction, and local manufacturing might be found that would make the drugs much more widely available while maintaining drug company revenues through the sheer volume of African sales.

On April 5, 2000, UNAIDS and the World Health Organization recommended that Africans infected with HIV be treated with an antibiotic known by the trade name Bactrim to help prevent fatal opportunistic infections. Preliminary studies indicate that the drug could reduce the AIDS death rate at a cost of between $8 and $17 per year per patient.

U.S. Policy

U.S. concern over AIDS in Africa grew during the 1980s, as the severity of the epidemic became apparent. In 1987, in acting on the FY1998 foreign operations appropriations legislation, Congress earmarked funds for fighting AIDS worldwide, and House appropriators noted that in Africa, AIDS had the potential for "undermining all development efforts" to date. (H.Rept. 100-283). In subsequent years, Congress supported AIDS spending at or above levels requested by the executive branch, either through earmarks or report language.

Appropriators in 1987 also commended USAID, together with the World Health Organization, for "timely efforts to begin an international attack on the AIDS pandemic." And indeed, USAID states that it has been the global leader in the international response to AIDS since 1986, not only by supporting multilateral efforts but also by directly sponsoring regional and bilateral programs aimed at combating the disease. (See various documents available on the Internet at the USAID world wide web site, particularly [http://www.info.usaid.gov/pop_health/aids/aidsaccomplish.htm].) The Agency has sponsored AIDS education programs; trained AIDS educators, counselors, and clinicians; supported condom distribution; and sponsored AIDS research. USAID claims several successes in Africa, such as helping to reduce HIV prevalence among young Ugandans and to prevent an outbreak of the epidemic in Senegal; reducing the frequency of sexually transmitted infections in several African countries; sharply increasing condom availability in Kenya and elsewhere; assisting children orphaned by AIDS; and sponsoring the development of useful new technologies, including the female condom. USAID reports that it spent a total of $67 million on fighting AIDS in Africa in FY1998 and $81 million in FY1999. USAID's spending on the epidemic worldwide, including Africa, was $121 million in FY1998 and $135 million in

FY1999. In addition, some spending by the Department of Health and Human Services was going toward HIV surveillance in Africa and other Africa AIDS-related efforts.

As the severity of the epidemic continued to deepen in recent years, many of those concerned for Africa's future, both inside and outside government, came to feel that more should be done. On July 19, 1999, Vice President Gore proposed $100 million in additional spending for a global AIDS initiative to begin in FY2000, with a heavy focus on Africa. The LIFE (Leadership and Investment in Fighting an Epidemic) initiative called for:

- $35 million for AIDS surveillance and technical assistance for prevention, care, and support activities of the Centers for Disease Control,
- $10 million for AIDS education in African militaries through the Department of Defense,
- $45 million in additional AIDS for USAID under the Child Survival and Disease Programs fund (CSD), and
- a reprogramming of $10 million in food assistance to help families and communities affected by AIDS.

Funds approved during the FY2000 appropriations process will support most of this initiative, although the $10 million requested for AIDS education in African militaries was not appropriated. H.R. 3422, the Foreign Operations Appropriation bill which became part of the consolidated appropriations (P.L. 106-113), earmarks $35 million under the Child Survival and Disease Programs Fund exclusively for AIDS programs worldwide, and lists AIDS programs among those that can be supported from general Child Survival Funds. According to the conference report on the consolidated appropriations (H.Rept. 106-479) "at least $10,000,000 additionally is designated for children affected by the HIV/AIDS epidemic." The Health and Human Service Appropriation (H.R. 3424, also included in P.L. 106-113) provides $35 million for international AIDS programs, and under current plans this money will be used by the Centers for Disease Control and will be available for Africa. Table 1 indicates projected U.S. spending on fighting AIDS in sub-Saharan African in FY2000.

Table 1. Projected FY2000 U.S. Spending on Fighting AIDS in Africa
($ millions)

U.S. Agency for International Development	133.82
Dept. of Health and Human Services	35.00
Total	168.82

Many observers of the African AIDS epidemic, although supporting the LIFE initiative, believe that U.S. spending should be sharply increased. Former House Member Ron Dellums, who now heads the Washington-based Constituency for Africa, advocates a $1 billion program. He has given a number of speeches, particularly in African-American churches, to build political support for his proposal (*Boston Globe*, October 13, 1999). There have also been proposals for accelerated efforts to develop an AIDS vaccine and to pressure pharmaceutical companies to make AIDS medications widely available at affordable prices.

On January 10, 2000, Vice President Al Gore, chairing a session of the United Nations Security Council, announced a new U.S. initiative to combat AIDS overseas, particularly in Africa. The Vice President said that as part of its FY2001 budget, the Administration would request that Congress appropriate an additional $100 million for AIDS education, prevention, and treatment in Africa, India, and other areas. This increase would bring total U.S. international AIDS spending to $325 million, according to the Vice President.

The $100 million increase proposed by Vice President Gore is expected to be allocated as follows: $54 million to the Child Survival and Disease Programs Fund of the U.S. Agency for International Development (USAID), $26 million to the Centers for Disease Control and Prevention (CDC) of the Department of Health and Human Services (HHS); $10 million for Department of Labor workplace prevention programs; and $10 million for a Department of Defense program to slow the spread of AIDS in African militaries.

President Clinton's December 1, 1999 speech at the World Trade Organization summit in Seattle has been interpreted as heralding an easing of Administration policy with respect to intellectual property rights and AIDS pharmaceuticals. According to the President,

> And today, the USTR, our trade representative, and the Department of Health and Human Services are announcing that they are committed to working together to make sure that our intellectual property policy is flexible enough to respond to legitimate public health crises.
>
> Intellectual property protections are very important to a modern economy, but when HIV and AIDS epidemics are involved ... the United States will henceforward implement its health care and trade policies in a manner that ensures that the poorest countries won't have to go without medicine they so desperately need. I hope this will help South Africa and many other countries that we are committed to support in this regard.

LEGISLATION

H.R. 434 (Crane)

Africa Growth and Opportunity Act. Section 19 of the House-passed version and Section 129 of the conference version state the sense of the Congress that addressing the HIV/AIDS crisis in sub-Saharan Africa should be a central component of U.S. Africa policy; that significant progress needs to be made in preventing and treating HIV/AIDS in order to sustain a mutually beneficial trade relationship; and that the AIDS crisis merits greatly expanded public, private, and joint public-private efforts, and appropriate legislation. Section 116 of the Senate-passed version(Feingold/Feinstein amendment) included sense of the Congress language supporting the development of new pharmaceuticals, vaccines, and therapies; and prohibited the executive branch from using funds to seek revocation or change in any African law or policy on intellectual property grounds if the purpose of the law or policy promotes access to AIDS pharmaceuticals and provides adequate intellectual property protection. Passed House, July 16, 1999; passed Senate November 3; conference report (H.Rept. 106-606) filed May 4, not including Feingold/Feinstein provisions. Conference report passed House May 4, 309-110; passed Senate May 11, 77-19.

H.R. 772 (Jackson)/S. 1636 (Feingold)

Human Rights, Opportunity, Partnership, and Empowerment for Africa Act or HOPE for Africa Act. Both bills add language to the Development Fund for Africa legislation to specifically mention HIV/AIDS (on the DFA, see CRS Issue Brief 95052, *Africa: U.S. Foreign Assistance Issues*); Section 602 of the Senate version, on pharmaceuticals and intellectual property rights, is similar to Section 116 of the Senate-passed version of H.R. 434. H.R. 772 was introduced on February 23, 1999 and referred to the House Committees on International Relations, Banking, and Ways and Means; S. 1636 was introduced on September 24, 1999 and referred to the Committee on Finance.

H.R. 1095 (Leach)

Debt Relief for Poverty Reduction Act of 1999. As reported by the House Committee on Banking and Financial Services, Sec. 902 requires countries receiving debt relief to establish a Human Development Fund, which will receive all savings generated by debt relief and include monitorable poverty reduction goals, such as lowering the incidence of AIDS. Introduced March 11, 1999; referred to the House Committees on International Relations and on Banking and Financial Services. Reported by the Committee on Banking and Financial Services (H.Rept. 106-483), November 18, 1999.

H.R. 2765 (Lee)

AIDS Marshall Plan Fund for Africa Act. Establishes the AIDS Marshall Plan Fund for Africa Corporation to provide assistance for HIV/AIDS research, prevention, and treatment activities in Africa. The corporation shall make grants to African governments and NGOs for HIV/AIDS projects and solicit contributions from private sources and foreign governments; an annual appropriation of $200 million is authorized for FY2001 through FY2005. Introduced August 5, 1999; referred to the Committee on International Relations.

H.R. 3519 (Leach)/S. 2033 (Kerry)

World Bank AIDS Prevention Trust Fund Act. States that the Secretary of the Treasury should enter into negotiations with the World Bank or the International Development Association (IDA), t he World Bank affiliate that makes low-interest loans to poor countries, and other interested parties for the establishment of a trust fund. The fund would accept contributions from the governments and the private sector, and use these contributions to address the AIDS epidemic in IDA-eligible countries. Authorizes a U.S. contribution to the trust fund of $100 million per year through FY2005. Requires the Secretary of the Treasury to report within three years on the effectiveness of the fund. H.R. 3519 introduced January 4, 2000; referred to the Committee on Banking and Financial Services; hearing held March 8; committee consideration and markup, March 15; reported, amended, (H.Rept. 106-548) March 28. S. 2033 introduced February 3, 2000; referred to the Committee on Foreign Relations.

Passed the House, May 16

H.R. 3812 (Pelosi)

Vaccines for the New Millennium Act of 2000. Amends Section 104(c)(3) of the Foreign Assistance Act of 1961 (P.L. 87-195) to state the expectation of Congress that USAID will set as an objective the universal protection of children from immunizable diseases by the end of 2009; authorizes an appropriation of not to exceed $50 million in FY2001 and $100 million in FY2002 for contributions to the Global Alliance for Vaccines and Immunizations, an international partnership to expand access to existing safe and cost-effective vaccines, and requires the President to report on the effectiveness of the alliance;

in addition to amounts otherwise available, authorizes $10 million in FY2001 and $20 million in FY2002 for the U.S. contribution to the International AIDS Vaccine Initiative, which provides financing to industry in exchange for international access to any vaccine; provides additional tax credits to private sector firms to promote research on vaccines against HIV, malaria, tuberculosis, and other infectious diseases; provides a tax credit to promote sales of lifesaving vaccines in developing countries; establishes the Lifesaving Vaccine Purchase Fund to authorize and advance appropriate from any unappropriated funds in the Treasury up to $100 million per year for 10 years from the first appropriation for the purchase and distribution in developing countries of any newly developed vaccine against HIV, malaria, and tuberculosis, and other infectious diseases; states that the President should enter into negotiations with other governments on establishing an international vaccine purchase fund and report to Congress on the status of negotiations; establishes a 12-member Lifesaving Vaccine Advisory Commission to oversee and promote public private efforts, both national and international, to develop vaccines; states the sense of Congress that flexible and differential pricing for vaccines is a valid strategy to accelerate the introduction of vaccines in developing countries. Introduced March 1, 2000; referred to the Committees on Ways and Means, International Relations, and Commerce. See S. 2132, below.

H.R. 3826 (Crowley)/S. 2387 (Leahy)

Global Health Act of 2000. For FY2001, authorizes an additional $1 billion over FY2000 spending for foreign assistance under the Population and Health program, with $225 million to go toward the health and survival of children, $100 million for the health and nutrition of pregnant women and mothers, $200 million for voluntary family planning, $275 million for combating HIV/AIDS, and $200 million for the prevention and control of infectious diseases other than HIV/AIDS; states the sense of Congress that the President should coordinate among agencies to ensure funds are used effectively. H.R. 3826 introduced on March 2, 2000; referred to the Committee on International Relations. S. 2387 introduced on April 11; referred to the Committee on Foreign Relations.

H.R. 4140 (Millender-McDonald)

International HIV/AIDS Partnership Prevention Act of 2000. Amends Section 104(c) of the Foreign Assistance Act of 1961 (P.L. 87-195) to state that USAID shall undertake a comprehensive, coordinated effort to combat HIV/AIDS through effective partnerships with international organizations, donors, national and local governments, and nongovernmental organizations; authorizes $150 million in FY2001, rising through $25 million increments to $250 million in FY2005, for testing, prevention, care, and other AIDS programs and initiatives, with $10 million to be used annually for vaccine research. Introduced on March 30, 2000; referred to the Committee on International Relations.

S. 2026 (Boxer)

Global AIDS Prevention Act of 2000. Amends Section 104(c) of the Foreign Assistance Act of 1961 (P.L. 87-195) to state that Congress expects USAID to make HIV/AIDS a priority and to undertake a comprehensive, coordinated effort, including primary prevention and education, voluntary testing and counseling, medications to prevent mother to child transmission, and care for those living with HIV/AIDS; authorizes $2 billion over 5 years, starting with $300 million in FY2001, for this purpose; states that not less than half of these funds be used in sub-Saharan Africa. Introduced February 2, 2000; referred to the Committee on Foreign Relations.

S. 2030 (Durbin)/H.R. 4039 (Jackson)

AIDS Orphans Relief Act of 2000. Adds a section to the Foreign Assistance Act of 1961 (P.L. 87-195) authorizing an annual appropriation of $50 million to assist microcredit programs that serve the very poor, especially women, in communities heavily affected by AIDS; adds a section to the Agricultural Trade and Development Assistance Act of 1954 (P.L. 83-480) authorizing $50 million annually in food assistance to address the nutritional needs of individuals in communities affected by AIDS, for assistance to households affected by AIDS, and to create or restore sustainable livelihood strategies in communities affected by AIDS. S. 2030 was introduced February 3, 2000; referred to the Committee on Foreign Relations. H.R. 4039 was introduced on March 21; referred to the Committees on International Relations and on Agriculture.

S. 2032 (Moynihan)/H.R. 4038 (Jackson)

Mother-to-Child HIV Prevention Act of 2000. Amends Section 104(c) of the Foreign Assistance Act of 1961 (P.L. 87-195) to require USAID to coordinate with international health agencies and local governments to expand programs to prevent mother-to-child transmission of AIDS; authorizes $25 million per year through FY2005, for this purpose. S. 2032 introduced on February 3, 2000; referred to the Committee on Foreign Relations. H.R. 4038 introduced on March 21; referred to the Committee on International Relations.

S. 2132 (Kerry)

Vaccines for the New Millenium Act of 2000. Similar to H.R. 3812 but does not include the Lifesaving Vaccine Advisory Commission. Introduced in the Senate on March 1, 2000; referred to the Committee on Foreign Relations.

S. 2382 (Helms)

Technical Assistance, Trade Promotion, and Anti-Corruption Act of 2000. Subtitle D Amends Section 104(c) of the Foreign Assistance Act of 1961 (P.L. 87-195) to authorize $300 million for FY2001 for the development and implementation, in cooperation with international agencies, of strategies to prevent mother-to-child transmission of HIV. The authorization is to be in addition to funds otherwise available, and a formula specifies among other provisions that not less than 65% shall be provided through non-governmental organizations. Authorizes $50 million in addition to amounts otherwise available for an FY2001 contribution to the Global Alliance for Vaccines and Immunizations, an international partnership, and $10 million for the International AIDS Vaccine Initiative, which provides financing for private sector vaccine research in exchange for assured poor-country access to any vaccine that is developed; requires the President to report on the effectiveness of the two programs and urges him to begin negotiations on a multilateral fund to buy and distribute vaccines for poor countries; authorizes $100 million in FY2001 for the U.S. contribution to a World Bank Trust Fund, to be established through negotiations, for AIDS prevention and eradication; $50 million in FY2001 for the U.S. contribution to a World Bank Trust Fund, to be established through negotiations, for the education of orphans in sub-Saharan Africa; requires the President to coordinate the development a multi-donor strategy for supporting and educating African AIDS orphans; ensures AIDS education for African armed forces through the U.S. Africa Crisis Response Initiative, which provides training to potential African peacekeeping troops. Reported to the Senate (S.Rept. 106-257) from the Committee on Foreign Relations on April 7, 2000; referred to the Committee on Banking on April 11.

Kaiser Media Fellowship Event
AIDS In Africa

- AIDS is a plague of biblical proportion – and it is killing more people than all of the armed conflict on the continent – combined.

- AIDS is now the leading cause of death among all people of all ages in Africa. The progression of this pandemic has outpaced all of our projections. In 1991 the World Health Organization predicted that by 1999 there would be 9 million infected and nearly 5 million deaths in Africa due to AIDS. The resulting numbers are *two to three times* higher with nearly 24 million infected and 14 million deaths.

- Each and every day Africa buries 5,500 men women and children as a result of AIDS – and by 2005, Africa will bury nearly 13,000 every day.

- 11,000 new infections each day -- one every 8 seconds.

- In some countries, between one-fifth and one-third of all children have already been orphaned by AIDS. And the worst is yet come. Within the next decade more than 40 million children will be orphaned by AIDS – 95% of whom will live in sub-Saharan Africa – and this tragedy will continue to grow for at least another 30 years.

- In just a few short years, AIDS has wiped out decades of hard work and steady progress in development – and will soon double infant mortality, triple child mortality, and slash life expectancy by 20 years or more. And AIDS has had a devastating impact on economic growth – striking down skilled workers in their prime and forcing many companies to hire two employees for every one job – assuming that one will die of AIDS.

- Not since the bubonic plague of the Middle Ages has the world witnessed such devastation from a single disease, and the worst is yet to come. The sad truth is that we are at the beginning of an epidemic – what we see in Africa is just the tip of the iceberg. A report recently released by the National Intelligence Council indicates that in the next 15 years the epicenter of the epidemic will be

in India, and the Newly Independent States of the Former Soviet Union are not far behind.

- AIDS is not an African or an American issue – it is truly a global issue.

- Yet my message to you today is not one of hopelessness and desolation.

- The good news is we know what works.

- The United States has been engaged in the fight against AIDS here at home since the early 1980s. But increasingly we have come to realize that when it comes to AIDS – both the crisis and the opportunity have no borders. We have much to learn from the experiences of other countries, and the suffering of citizens in our global village touches us all.

- We have done much, but there remains much more that the United States and other developed nations can and must do.

- The Administration has launched a broad new initiative, the centerpiece of which is a $100 million investment in the FY2000 budget.

- In January, Vice President Gore opened the first-ever United Nations Security Council session on a health issue by addressing the AIDS crisis in Africa. He announced the Administration's request to Congress for an additional $100 million to further enhance our efforts against AIDS in Africa and around the globe.

- But bilateral donors cannot - and should not - do this alone.

- Luckily, painful experience here at home has taught us some valuable lessons.
  1) Leadership
  2) Resources

- Together, we must find ways to affirm that we are a global community and our battle against AIDS in America, in Africa, and around the world is a shared responsibility.

AIDS in Africa is a Serious Crisis

But Opportunities Exist for Helping to Save Millions of Lives

AIDS IN SUB-SAHARAN AFRICA IS SHATTERING FAMILIES AND COMMUNITIES.

- About 24 million Africans south of the Sahara are HIV infected -- almost 70% of the world's total number infected in a region that accounts for only 10% of the world's population.
- In seven countries in southern Africa, including South Africa, 20% of the adult population (ages 15 to 49) is already infected.
- UNAIDS has declared HIV/AIDS in Africa "the worst infectious disease catastrophe since the bubonic plague."
- In sub-Saharan Africa, each and every day more than 11,000 additional people become HIV+. In South Africa alone, at least 1,600 people a day become HIV+.
- AIDS is now the leading killer in sub-Saharan Africa with 84% (13.7 million) of the 16.3 million AIDS deaths to date.
- There are over 5,500 AIDS related funerals a day in Africa. That number will rise to 13,000 a day by 2005.
- In 1998 in Africa, 200,000 people died as a result of war -- AIDS killed 2.2 million.
- By 2010, more than 40 million children in Africa will be orphaned by AIDS.

AIDS IS WIPING OUT DECADES OF PROGRESS ON A HOST OF DEVELOPMENT OBJECTIVES IN SUB-SAHARAN AFRICA.

- According to US Census Bureau, AIDS has already reduced life expectancy Zimbabwe from 65 to 39 years, in Uganda from 54 to 43 years, and in Zambia from 56 to 37years. In the next few years, AIDS will reduce life expectancy in South Africa by a third, from 68 to 45 years.
- In the coming decade, AIDS will double infant mortality (infants under the age of 1) in many sub-Saharan Africa countries and triple child mortality (children ages 1 to 5).

AIDS IS NOT ONLY CAUSING UNFATHOMABLE HUMAN SUFFERING IT IS JEOPARDIZING THE ECONOMIES, THE STABILITY, AND CIVIL SOCIETY OF MANY SUB-SAHARAN AFRICAN NATIONS.

- AIDS is a trade and investment issue. At the recent meeting with African trade and finance ministers, Professor Jeffrey Sachs, director of the Harvard Institute for International Development, stated that, "a frontal attack on AIDS in Africa may now be the single most important strategy for economic development."
- According to *The Economist*, a recent study in Namibia estimated that AIDS cost the country almost 8% of GNP in 1996. Another analysis predicts that Kenya's GNP will be 14.5% smaller in 2005 than it would have been without AIDS, and the per capita income will be 10% lower.

- A report released by the World Bank last week states: "The question is, will this pandemic destroy the developing nations' hard earned economic gains or will governments get their act together in time? Clearly time is running out."
- AIDS has hit professionals hard in sub-Saharan Africa, particularly civil servants, engineers, teachers, miners, and military personnel. According to one study in Kigali, Rwanda, 34% of people with post-secondary education were HIV positive, compared to 18% of those with primary education, and civil servants were more than three times more likely to be HIV positive than farmers. Increased benefits and training costs, and disruption due to sick and bereavement leave are seriously affecting both the private and public sectors. Companies like British Petroleum and Barclay Bank told us that they are now hiring two employees for every one skilled job, assuming that one will die of AIDS.
- AIDS is a security issue. According to the Economist, "the estimated HIV prevalence in the seven armies embroiled in the Congo range from 50% for the Angolans to 80% in Zimbabweans". Recent reports confirm that 40% of the South African military is already HIV positive. US military officials have raised this as a serious stability concern.
- A South African anti-crime institute has linked the growing number of children orphaned by AIDS to future increases in crime and civil unrest. Without appropriate intervention, many of the 2 million children projected to be orphaned by AIDS in South Africa will raise themselves on the streets, often turning to crime, drugs, commercial sex, and gangs for survival. This not only effects social stability but also dramatically increases their risk of HIV.

DETERMINED LEADERSHIP AND PARTNERSHIPS HAVE MADE, AND ARE CONTINUING TO MAKE, AN EXTRAORDINARY DIFFERENCE, SAVING MILLIONS OF LIVES.

- Uganda has been the world leader in demonstrating that even a country with limited resources and low levels of literacy could turn the tide on a burgeoning epidemic. President Museveni demonstrated bold leadership early on, making every government ministry take the problem seriously, and develop and implement its own plan for reducing stigma and transmission, and caring for those who become sick.
- Uganda has created an enabling environment for donors, such as the US, to be active partners in the battle against AIDS. The US has invested $46 million in HIV prevention and care in Uganda (26% of all donor AIDS funding), and as a result, HIV rates have been slashed by more than half. Through stigma reduction, education, HIV counseling and testing, treatment of STDs, and community based HIV care and support, Uganda has begun to turn the tide.
- Countries such as Zambia, Malawi, Uganda, and Kenya have begun to develop initiatives to respond to the growing number of children orphaned by AIDS. In the longstanding African tradition, communities are finding creative ways to support the village in its efforts to raise its children, but the growing number of orphaned children already overwhelms many of these villages.
- Through micro-finance programs like FINCA (Foundation for International Community Assistance), women are receiving loans, starting small businesses, and with increased household incomes, taking in children orphaned by AIDS. With support of non-governmental organizations, communities are coming together to deal with school fees, nutritional assistance, immunization and oral hydration, counseling, and the range of other needs that arise for orphaned children. These efforts are low cost strategies designed to empower women, protect children, and support extended families and communities in carrying for their own. For a small fraction of the cost of one orphanage bed an entire community of vulnerable children can receive care. The problem is that only a very small number of children receive even this modest level of support.

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UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT

USAID Mission to South Africa

THE REGIONAL HIV/AIDS PROGRAM FOR SOUTHERN AFRICA

➢ *Background on HIV/AIDS in the Southern Africa Region*

Africa is the global epicentre for HIV/AIDS. The sheer number of Africans affected by the epidemic is overwhelming -- approximately 22 million adults and 1 million children were living with HIV by the end of 1998. Since the epidemic began, 83% of all AIDS related deaths have been in Africa - over 12 million people have already died, a quarter of them children. Among children under 15 years of age, 9 out of 10 new infections in 1998 occurred in Africa and at least 95% of all AIDS orphans are in Africa.

While no country in Africa has escaped the virus, some are far more severely affected than others. Although only a tenth of the world's population lives in Africa south of the Sahara, 70% of all the people infected with HIV in 1998 and four-fifths of all AIDS-related deaths occurred in sub-Saharan Africa. In 1999 in Botswana, Malawi, Namibia, South Africa, Swaziland and Zimbabwe, estimates showed that 20% - 26% of people aged 15-49 were living with HIV or AIDS.

Life expectancy at birth is one of the key measures used to assess human development. As a result of the extra deaths caused by HIV infection in children and young adults, the epidemic will wipe out previous development gains by slashing life expectancy, thus reversing years of hard-won gains in child survival. By 2005-2010, for example, 61 of every 1000 infants born in South Africa are expected to die before the age of one. The current infant mortality rate is 52 per 1000 and in the absence of HIV/AIDS it has been projected that infant mortality would have been as low as 38 per 1000.

➢ *The Regional HIV/AIDS Program for Southern Africa*

In the light of these devastating statistics, the USG has responded with increased support to the countries in the Southern Africa region through its regional LIFE Initiative (Leaders in the Fight Against the Epidemic). This regional response to the HIV/AIDS pandemic complements specific country focused activities. In particular, the regional program is intended to provide support to those countries in Southern Africa where there are no USAID Missions, specifically Botswana, Lesotho and Swaziland (BLS).

1. Southern Africa Development Community (SADC)

In April 1999, the US-SADC Forum was held in Gaborone, Botswana. At this meeting, the United States pledged $2 million in Economic Support Funds (ESF) funds to support programming in a number of areas, to be managed by the USAID Regional Centre for Southern Africa (RCSA). Of this amount, approximately $315,000 was devoted to HIV/AIDS. On the SADC side, the Botswana based secretariat has delegated responsibility for programming these funds to the SADC Health Desk based in Pretoria. The SADC Desk has proposed that the US assist in certain policy and programming areas. The proposal scope of work for the HIV/AIDS policy environment is currently being finalised. (This scope of work is attached.)

2. USAID Regional Program

In response to the strong recommendations of a number of Ambassadors at the US-SADC Forum held in April 1999, USAID is developing a broad Southern African Regional HIV/AIDS program. To assist in this process, USAID/Washington in FY 1999 made available $1 million to support both programming and the hiring of the regional program manager/advisor. This figure has risen to $1.5 million for FY2000 and will

rise to approximately $4.0 million in FY2001. The field based regional USAID program will address the following areas:

1. ***Transport Corridors***: One of the defining characteristics of the HIV/AIDS epidemic in Southern Africa is the excellent transport system and the resultant mobility of people within and across countries. As a result, migration and the poverty of women exacerbate the epidemic. This mobility results in an exceptionally efficient carrier system for the spread of the epidemic. Transportation corridors that range from Durban to Lusaka, from Maputo to Pretoria, from Johannesburg to Francistown and Bulawayo, can all be considered prime routes through which the epidemic can spread. Within these corridors, the border crossings are particularly vulnerable sites. The USG through USAID will establish pilot programs in key border crossings.
2. ***HIV/AIDS Surveillance***: The quality of data varies widely across countries of the region. USAID together with CDC will work with countries and with SADC to improve data collection and analysis.
3. ***Policy***: While policies are the responsibilities of each country, there are many experiences that represent "best practice". USAID will work with SADC and with countries in sharing these experiences. In relation to the transport corridors program, USAID will identify critical policy impediments to services and programs at border crossings. Specific interventions will be carried out to address selected policy constraints.
4. ***Regional Coordinator:*** The regional program is located at USAID/South Africa. In order to manage all aspects of this program, a Regional Coordinator has been hired.

USAID REGIONAL PROGRAM PROGRESS TO DATE

➢ *Transport Corridors*

The first corridor for intervention is the Durban to Lusaka transport corridor. An assessment has been carried out at the border sites of Messina (South Africa), Beitbridge (Zimbabwe), Churundu (Zimbabwe) and Churundu (Zambia). As suspected, all indications are that HIV rates are much higher at these locations than in the countries as a whole. There are also a number of policy constraints to services being effectively delivered. One such example is that a national from one country cannot receive health services in another country.

A second corridor for intervention is the Maputo to Maseru to Pretoria corridor. This triangle, encompassing the southeastern corner of South Africa, bordering Mozambique and Swaziland, is a major transit point for migrant labourers. A third corridor for intervention is the Pretoria to Francistown to Bulawayo corridor.

Each of the corridors will be phased in over time.

➢ *Regional Co-ordinator*

Ms. Michelle Russell

In January 2000 a regional co-ordinator, Ms. Michelle Russell was hired. Ms. Russell has spent the past four months travelling the region to get an overview of the HIV/AIDS epidemic in each country. Among her critical activities:

- Strategic planning on how to include BLS (Botswana, Lesotho, Swaziland) countries where USAID does not have programs. The plan is for USAID to work closely with the Embassies, especially PAS and the Self-Help program, to develop programs and to provide resources from the regional initiative funds. It is envisioned that an Inter Agency Agreement (IAA) will be developed to enable the BLS countries to participate in the regional initiative.
- Consultation with each of the countries, to determine how best the Regional Program can respond to specific country needs.

UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT
USAID Mission to South Africa

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UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT
USAID Mission to South Africa

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➢ *Background on HIV/AIDS in the Southern Africa Region*

Africa is the global epicentre for HIV/AIDS. The sheer number of Africans affected by the epidemic is overwhelming -- approximately 22 million adults and 1 million children were living with HIV by the end of 1998. Since the epidemic began, 83% of all AIDS related deaths have been in Africa - over 12 million people have already died, a quarter of them children. Among children under 15 years of age, 9 out of 10 new infections in 1998 occurred in Africa and at least 95% of all AIDS orphans are in Africa.

While no country in Africa has escaped the virus, some are far more severely affected than others. Although only a tenth of the world's population lives in Africa south of the Sahara, 70% of all the people infected with HIV in 1998 and four-fifths of all AIDS-related deaths occurred in sub-Saharan Africa. In 1999 in Botswana, Malawi, Namibia, South Africa, Swaziland and Zimbabwe, estimates showed that 20% - 26% of people aged 15-49 were living with HIV or AIDS.

Life expectancy at birth is one of the key measures used to assess human development. As a result of the extra deaths caused by HIV infection in children and young adults, the epidemic will wipe out previous development gains by slashing life expectancy, thus reversing years of hard-won gains in child survival. By 2005-2010, for example, 61 of every 1000 infants born in South Africa are expected to die before the age of one. The current infant mortality rate is 52 per 1000 and in the absence of HIV/AIDS it has been projected that infant mortality would have been as low as 38 per 1000.

➢ *The Regional HIV/AIDS Program for Southern Africa*

In the light of these devastating statistics, the USG has responded with increased support to the countries in the Southern Africa region through its regional LIFE Initiative (Leaders in the Fight Against the Epidemic). This regional response to the HIV/AIDS pandemic complements specific country focused activities. In particular, the regional program is intended to provide support to those countries in Southern Africa where there are no USAID Missions, specifically Botswana, Lesotho and Swaziland (BLS).

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Global AIDS 1981–1999: the response

G. Slutkin

Epidemiology and International Health, School of Public Health, University of Illinois at Chicago, Chicago, Illinois, USA

A tribute to Jonathan Mann, and
A plea for leadership and action

I'D LIKE FIRST to take this opportunity to thank the IUATLD for this opportunity to participate in this conference and present at this distinguished lectureship.

I am here today because Jon Mann, who was scheduled to provide this talk, has died. Jon, as many of you know, was the founding director of the World Health Organization's Global Programme on AIDS, the founder of World AIDS Day, and a bold visionary, idealist, and fighter for human rights and equity. Jon was a friend of mine, and I also had the pleasure and honor of working for him during his years at the World Health Organization. As many of you know Jon died in the Swiss Air 111 plane crash of September 1998.

The discussion today will be on Global AIDS—the response. This discussion is relevant to the TB situation, because, as all of you know, the AIDS epidemic is rapidly fueling massive increases in global TB. I always have TB in mind and in heart; it was my initial training in public health, and the field includes my longest lasting professional friends and colleagues. At the same time, like many of you, I have interfaced between the two diseases for nearly 20 years now, and it is a special privilege and joy to see so many old friends here, and an honor to be giving my thoughts at this forum.

My intention today is to achieve three things: 1) to describe the current situation of AIDS in the world, which is a total disaster in Africa, and increasingly in India—worse than most of the worst predictions previously made; 2) to describe very briefly the history of the response, highlighting the years from 1987 to 1990, when Jon Mann and his extremely capable lieutenant Daniel Tarantola led the program; and 3) to describe what we have learned from the successes of Uganda and Thailand, and what we have learned from Jon that is most urgent and pertinent to the situation today.

AIDS NOW

It is hard to believe that it is nearly 20 years since the first cases of AIDS, when a handful of primarily homosexual men began appearing in emergency rooms with unusual infections, and how this has evolved to the current situation. The current situation is described in Table 1.

From out of nowhere and these few unusual cases, there have now been over 40 million infections, and 12 million persons have died. Now, 6 million new infections occur every year.[1]

The situation is particularly devastating in Africa, where there are now over 20 million infected persons, which includes 10 to 15% of all of the adults in Cote d'Ivoire, Central African Republic, Djibouti, Ethiopia, Kenya, Malawi, Mozambique, Rwanda, and now nearly 15% of all South African adults. We are at the 20% mark in Zambia, and 25% of the whole population of Zimbabwe is infected. Four million persons are estimated to be infected with HIV in India, and this number continues to grow steadily.

In the above African countries hospital beds are totally full of patients with AIDS and AIDS-related tuberculosis, funeral drums play constantly, villages have long ago run out of nails for coffins, and the traditional funeral ceremony itself has been shortened from days to just hours, to allow time for the work force to have time at work. African life expectancy, following decades of steady gain, made an abrupt reversal in the late 1980s and is now back to the low levels of over 30 years ago.[2,3]

India is the main country to watch for further impending catastrophe. India already has over 4 million persons infected with HIV—more infected persons than any other country in the world—and this

Dr Slutkin was the medical director for TB control in San Francisco in the early 1980s. His career kept him bounding between the two partner problems of HIV and TB for two decades. While at San Francisco General Hospital, he saw some of the first cases of AIDS in SF. He moved to East Africa in the mid 1980s to work on TB in refugees in Somalia and joined WHO Global Programme on AIDS (GPA) in 1987, 4 months after the founding of the program, and stayed with the WHO from 1987 to 1994. His responsibilities included supporting the 15 countries in the center of the epidemic in central and east Africa. He worked with Jon Mann until his resignation in 1990 and stayed on with GPA until 1994. He was also responsible for the development of the joint HIV-TB agenda, which was a tripartite arrangement between WHO/GPA, WHO/TUB and the IUATLD.

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Table 1 HIV infections and AIDS deaths (global) to date

HIV infection	
No. of persons currently infected with HIV	30.6 million
New HIV infections in 1998*[1]	5.8 million
AIDS deaths	
AIDS deaths 1981–1998	11.7 million[1]
New deaths in 1998[1]	2.0–2.5 million[3]

Source UNAIDS, 1998.
* Number of new infections and new deaths increases every year.
[1] Approximately two-thirds of infections and deaths are occurring in Africa every year.
[1] Over 8 million children have become orphans because of their parents' death.
[3] USAID estimates 2.5 million deaths/year.

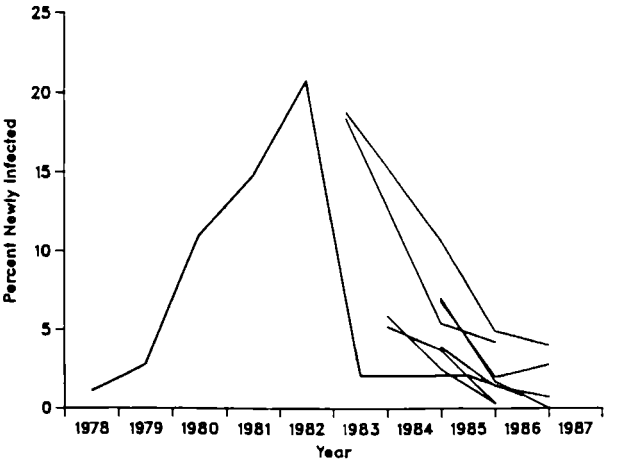

Figure 1 HIV incidence among homosexual men in eight US cities, 1978–1987. Source. Morbidity and Mortality Report, Centers for Disease Control, December 18, 1987

number is growing steadily. Rates of HIV infection in sex workers in several cities in India (up to 50%) and in antenatal clinics (a median figure of 4.3%) bode poorly for the long term, as these are the types of surveillance figures that were seen 5 to 10 years ago in many African countries, and which preceded spread into not only the highest risk populations, but also into the general public. The general public in India includes over one billion persons; every 1% increase in the general population infected in India represents over 10 million persons. The catastrophe of AIDS in India is unthinkable, but the likelihood of such a catastrophe is unfortunately very high, as steps being taken by the government and non-governmental organisations to combat AIDS in India are not at the levels that are needed.

Vietnam, Cambodia, and Myanamar have growing HIV/AIDS situations as well, with nearly half a million persons infected in Myanamar.

In the 14th century 20 million persons died of the plague worldwide. In the great influenza epidemic of 1918, 20 million persons died worldwide.[4,5] AIDS now rates with these greatest epidemics of all times. This is not an exaggeration. For the moment, 12 million persons have died, 8 million children have been orphaned, and 6 million new infections are occurring every year. Added to this is the fact that the whole problem is still growing very rapidly.[1,2,6]

THE RESPONSE

1981–1986

A quick overview of how all this began returns us to the emergency rooms of San Francisco, New York City and Los Angeles, USA, in the early 1980s. It is here that homosexual men who had for a few years been presenting with an unexplained lymphadenopathy began to show up with otherwise unheard of (but lethal) problems among young healthy persons, including Kaposi's sarcoma, toxoplasmosis of the brain, pneumocystis lung disease, cytomegalovirus (CMV) retinitis, and others.

This was of course a devastating problem for these individuals and in these cities. However, looking back on it, responses in terms of changing behavior occurred, and occurred fast. It did not seem fast then, but in contrast to the developing world, the risk behaviors practically shut down within 2 to 3 years of people becoming aware of the problem. Certainly the number of cases and deaths continued, but retrospectively reviewing the serologic data from previously collected blood, we see that risk behaviors did change quickly (Figure 1).

These local responses occurred throughout the US—first in San Francisco, and then in other US cities, and the same pattern was subsequently found in homosexual populations in Western Europe.

Two lessons were learned that had much lasting benefit to the global effort that was yet to come—that sexual behavior can be changed, and that a supportive social environment should be part of the strategy.

However, while much attention was being paid to the epidemic among homosexuals, silent spread was simultaneously occurring in several other parts of the world, most notably Africa. Little was actually known about the problem in most developing countries in the early 1980s, however data were emerging primarily from research efforts in two countries, Kenya and Zaire. Jonathan Mann was generating the Zaire data. Dr Mann was a CDC State epidemiologist in New Mexico who had been writing articles on the plague in the Western Journal of Medicine. Jim Curran had selected Jon for the assignment of running Project SIDA in Kinshasa, realizing that we (the world) would have to learn fast what was going on in Africa.

The world, including the World Health Organization (WHO), was very slow to recognize that spread was occurring in Africa and elsewhere. For one thing the blood test for HIV had only been available since 1985. Although deaths were occurring among adults at a perceptibly increased rate in African countries

there was not a lot known, and much of what was known was not being shared.

There was not a real wake-up call outside of the US and Europe until 1986, when, at the World Health Assembly, the Minister of Health of Uganda declared that his country had an enormous problem with AIDS, and needed help. The Minister and the Assembly called on the WHO to act.

In September 1986, Dr Mann was recruited to Geneva to form a WHO program for prevention and control of AIDS, and in February 1987 the Special Programme on AIDS was formed.

Hafden Mahler, one of the greatest visionaries around, then Director General of the WHO—and himself a TB specialist—confessed that he had needed to be 'converted to the idea that AIDS was a problem which would affect the developing world'. This view was considered 'not surprising, given the enormity of other threats . . . such as malaria, TB and diarrhoeal diseases', and with the rest of the world not admitting to the problem.[7]

1987–1990

Within months of the 1986 World Health Assembly, the Special Programme on AIDS was founded and Jonathan Mann was recruited to head it up. This program grew from two persons to 400 and from half a million dollars to 100 million over the next 3 years. These funds were put in what was called a Global Programme on AIDS (GPA) trust fund account. Over 80% of these funds were used for country support. For example, the 1987 emergency (short-term) plan for Uganda received 1 million dollars, the 1988 short-term plan 4 million dollars, and approximately 10 million dollars went to the more comprehensive program of work developed in 1989 following the program review.

By January 1990, the GPA, now less than 3 years old, had helped 123 countries develop short term plans to begin activities, and had mobilized funds for 65 countries (Figure 2). Funds additional to the global budget were mobilized at in-country donor meetings.[8]

These national programs emphasized public education and information on how HIV is, and is not, transmitted, and encouraged persons to avoid unprotected sex. This was the main function of these first programs—urgent public education. The programs also emphasized HIV surveillance to monitor trends and estimate effectiveness at national level.[9,10] Other elements of these first programs included blood screening, urgently demanded by the governments, guidance on care and counseling, and management strengthening. Getting condom programming going was very difficult in the first few years, and STD case manage-

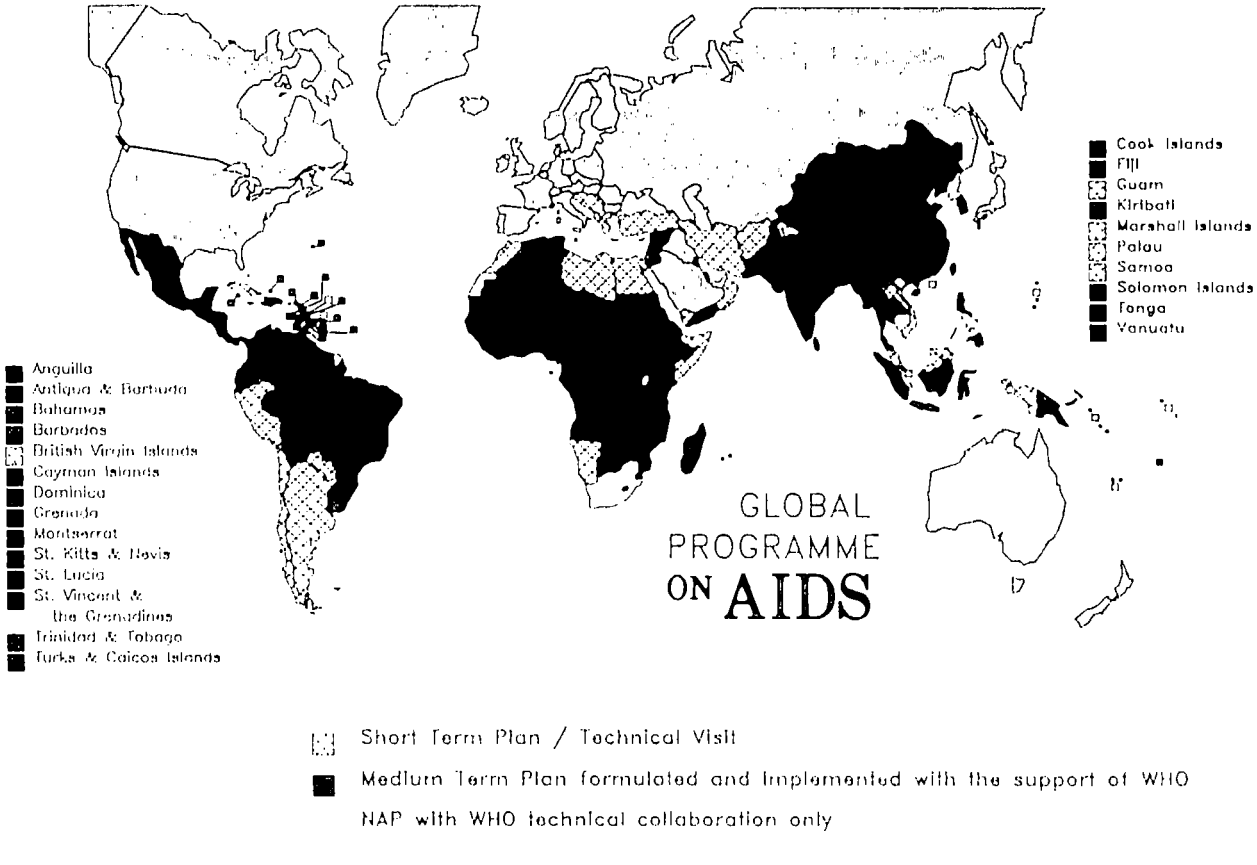

Figure 2 National AIDS programme development in 120 countries by the Global Programme on AIDS, 1987–1990 (status as of 1 June 1990).

ment unfortunately remains elusive for many developing countries.

Country program reviews were a critical part of the international effort. These were 2-week exercises preceded by weeks of preparation, during which a summary of accomplishments were made, barriers noted and recommendations made—in particular to refocus strategy and strengthen management. Country replanning directly followed program reviews.[11] In the case of Uganda, this plan,[12] written in 1989 (Figure 3), was the plan from which a major increase in efforts followed, including a major infusion of resources.

The period from 1987 to 1990, in which Dr Mann led this effort, was a period of tremendous energy, inspiration and accomplishment. Five main themes are stressed about this period in the External Review of the WHO Program (1987–1990).[7]

1 *Farsightedness and vision*—[it] "signaled the scale of the problem, which was totally unknown, presented it as a global issue . . . and defined it as a global problem which requires international solidarity". Jon used the word solidarity like no other. He spoke of the need to break down barriers and produce solidarity.
2 *Public education and information*—to dispel myths, to build up media interest. Media interest has waned since the late 1980s, although the epidemic has continued to increase. Public information of sufficient intensity is one of the main reasons why there was a reversal in Uganda.
3 *Avoidance of discrimination and promotion of human rights*—"The WHO played a critical role in placing discrimination, stigmatization and the promotion of human rights on the HIV prevention agenda . . . discrimination [was] opposed on both ethical and public health grounds. The GPA worked behind the scenes and on center stage to promote a more tolerant and rational approach to AIDS control."
4 The perception of *AIDS as a multi-dimensional problem*, requiring a multisectoral response, highly *dependent on social factors*, a topic that was to carry Dr Mann into the direction of human rights.
5 *A rapid and massive operational response*—the mounting of a serious response to a serious problem, a response which brought over 1500 consultant missions to help form over 160 country programs, and a response which brought a few countries to the *tipping point* of the epidemic, but for many other countries did not.

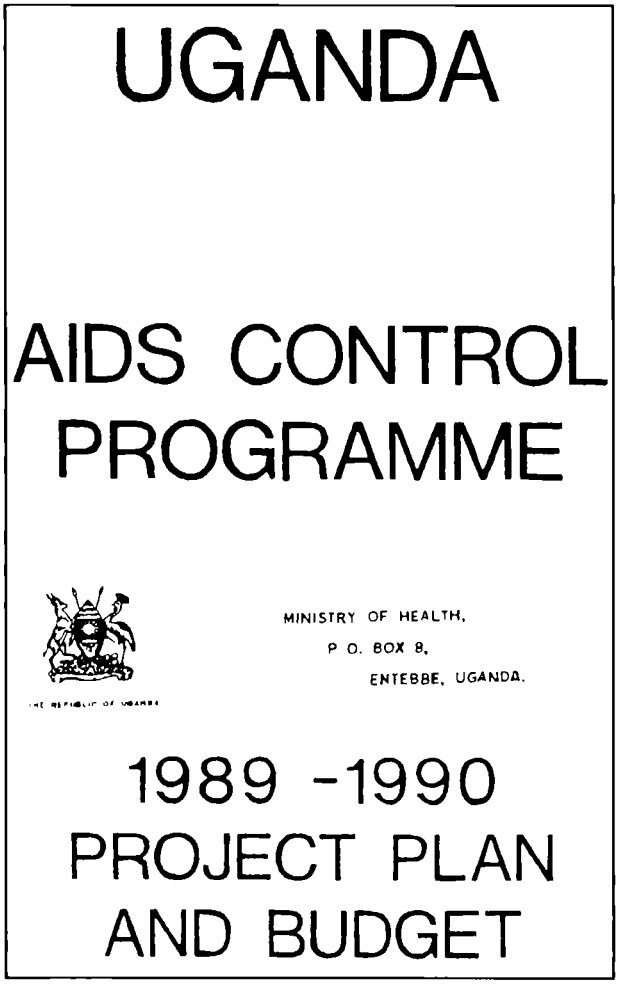

Figure 3 Cover page of the National AIDS Programme of Uganda. The implementation of this plan resulted in the reversal of the epidemic in Uganda.

THE MAIN SUCCESSES—UGANDA AND THAILAND

Uganda and Thailand are the two clearest and most impressive examples of reversals of the epidemic in the developing world so far. Lessons from these two countries need to be heeded and known. There is nothing that happened in these two countries that could not happen elsewhere.

I will provide only a very brief summary of these experiences. I saw these country reversals at close range. I supported the Uganda program directly, and led the program reviews of Uganda (December 1988) and Thailand (March 1990), and visited each country multiple times in the course of the years 1987–1994.

In Uganda, the seroprevalence of HIV in five cities decreased by 30–50% in different cities (Figure 4).[13–15] This was a result of several different types of behavioral changes, including a decrease in numbers of partners, an increase in condom use, a delay in median age of first intercourse, and for some, abstinence (Stoneburner R et al, unpublished). Different persons tried different, but safer, sexual practices. Information provided persons with choices as to how they could best modify their own lifestyle. The changes made added up to a massive saving of lives.

Notably, the Uganda program itself emphasized sticking to one partner ('zero grazing'), and in fact condom promotion was not a big part of the program,

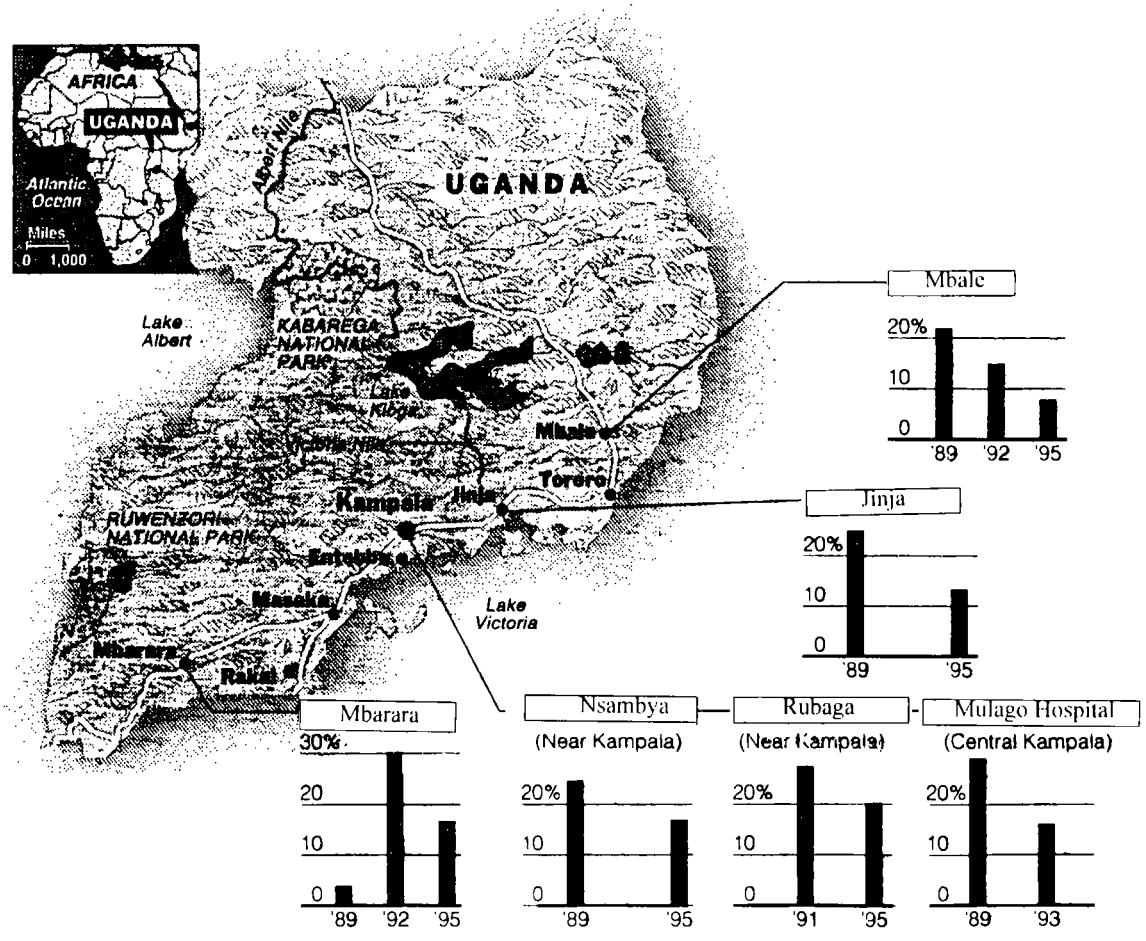

Figure 4 Decreases in HIV infection among pregnant women in six cities in Uganda, as reported in the *New York Times*, 1996.

although condom distribution was occurring despite objections of the church and other organizations. Complaints were even made about there being too many condoms floating around in Lake Victoria . . .

Referring back to the Uganda Program Review Report of 1988 summarized in the Uganda Plan,[12] several key changes in the program took place at this juncture. These included accepting the review recommendations and modifying the plan to: 1) changing the program to a much higher overall level of effort, 2) decentralization of the information, education and communication (IEC) activities to involve all sectors and communities, 3) much stronger district and community based efforts, 4) less reliance on the government to be the sole implementor, but at the same time strengthening of the government role to coordinate and manage, and 5) increasing materials for illiterate populations. It was essential that the national government take on a stronger role in technical planning, coordination and monitoring. Special efforts to identify and deal with the problem of low remuneration of staff were also recommended, recognizing the unusual nature of this problem in terms of magnitude and urgency. All of these factors created knowledge and commitment throughout the country, and a sense of urgency and purpose.

The revised plan was for a greatly strengthened program, with a budget that went from 1 to 4 to 18 million dollars in external support. Over 35 full-time Ugandan staff were involved, and the WHO posted six full-time staff, including a full-time administrator, a very active health educator and a full-time person just to run a printing press to disseminate information on AIDS. Major budget items included training and the importation of paper for the printing press for educational materials.

In the case of Thailand, it was during the program review of March 1990 that the Ministry of Health and the Review Team recognized that the epidemic was no longer a principally homosexual and drug user problem, on which current public education efforts were still being focused. The government of Thailand had translated the WHO sentinel surveillance guidelines,[9,10] which had been available at the time in only draft form, and had already performed a series of training courses on their use and had made HIV surveillance the policy in all 33 provinces of the country. At the time of the review, therefore, data were already available showing the greatly changing pattern and extent of the problem. And the Thai government was prepared to respond.

A rapidly expanding epidemic was revealed, with

high rates of HIV and a gradient of transmission from sex workers to clients to the general population (as shown largely in antenatal populations). The epidemic was occurring countrywide. The national program had not yet revealed these findings, and was probably ready to address it, but the data were much worse than was being discussed in the country.

At this program review, the estimated numbers of HIV-infected persons were revised upward from 1700 to 150 000! (This number was an epidemiological compromise on the calculation made by WHO epidemiologists of 225 000 infected persons, which was considerably higher than the Ministry was prepared to acknowledge at that time.) The review became the occasion for announcing these findings, and the Thai government took them seriously.

WHO epidemiologists and planners stayed back after the review, extending their visit, and helped develop a rapid rewrite of the new plan. The new plan and program emphasized mass education, and a 100% condom policy in the brothels—a negotiated settlement with the brothel industry in which there was to be enforcement of condom use.[16,17] There were several other important factors of this program, including active involvement of the private advertising sector (a sector very active in Asia, but not in Africa). The results of the program included almost immediate decreases in commercial sex, increases in condom use, and reductions in rates of STDs and HIV (Figure 5). This structural policy change had an almost immediate impact. The policy was being enforced, and visits to this country months later revealed used condoms by the dozens and hundreds in brothel effluent. Rates of HIV and STDs plummeted. The country was serious about surveillance, used the data, and reversed its epidemic. The response was characterized by leadership which faced the problem, practicality in the interests of the population, and a very high intensity of program effort.

To this day these are the two developing country programs in which large scale success has been accomplished. They share the factors of having commitment

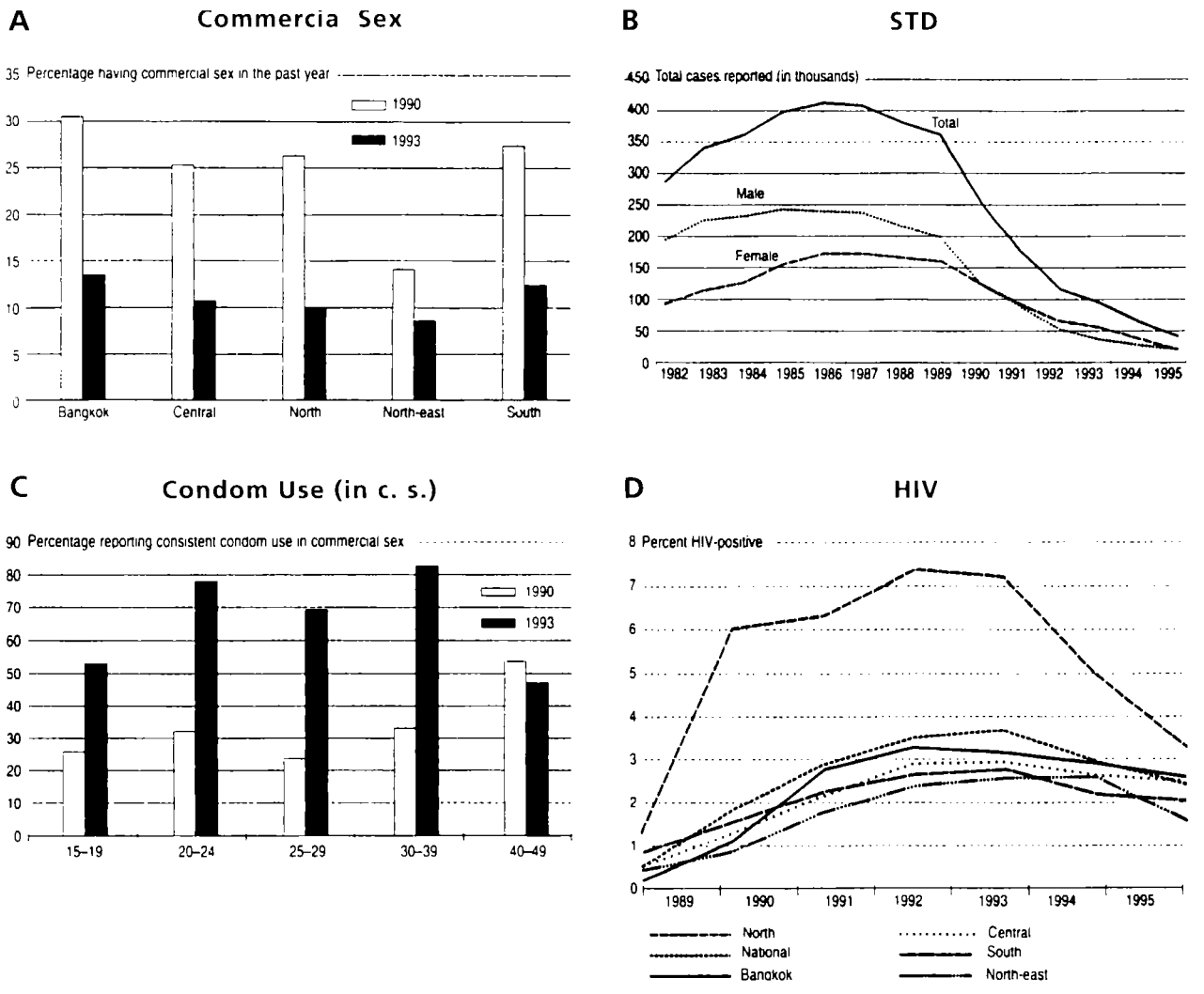

Figure 5 Changes in sexual behavior, sexually transmitted diseases (STDs) and HIV infection in Thailand in response to the active Thai AIDS Control Programme. c.s. = commercial sex; HIV = human immunodeficiency virus.

at the top (President and Prime Minister), very visible spokespersons (Sam Okware and Mechai), and high intensity of effort. They were also programs into which the WHO put an unusually large amount of resources, in terms of both funds and staff. There was a focus on these two countries for their status in their respective regions, as they are countries of high standing where success would have a lot more meaning to neighboring countries who would look to them as examples.

1990–1998

The years 1987 to 1990 had been years of great inspiration, idealism, hope and action, and were characterized by the leadership of the international effort by Jonathan Mann. They were years of unprecedented operational activity at country levels, intensive support for country programs, and a very high profile given to the problem internationally. Dr Mann resigned in 1990 over difficulties working for the Director General.

A period of great turmoil and confusion followed Dr Mann's resignation.[7] Within the WHO, his administration was criticized for going around the usual WHO mechanisms, and most senior staff were asked to leave. The program during the years that followed Dr Mann had several important accomplishments, however the focus on country level support declined. The accomplishments of the program in the years 1990–1994 include a more complete and more clearly stated strategy, more active condom promotion, and the development of evaluation indicators—essential for monitoring progress and impact more systematically. Additionally, a course for program managers was developed, the cost-effectiveness of the interventions was evaluated, and successful model practices of HIV infection and care were disseminated.

Nevertheless, in the desire to improve management, reorganize, improve strategy, and follow a more normal WHO course, momentum and motivation were lost, and the high level of activity of the technical assistance program was interrupted.

Within 3 months of the departure of Dr Mann and his central management team, effective programmatic contact with the African countries was virtually lost. Within 2 years, all 45 of the WHO African country staff had been removed. International funds became harder for the WHO to raise, in part because of the desire of bilaterals to work in a bilateral fashion. Overall funding levels at country level may have been maintained, although they were less well coordinated, and they never achieved the level of funding or intensity that the Uganda program had realized.

Simultaneously, further events within the UN system—in particular calls for reform—were to be experimented upon within the context of the international AIDS effort. Thousands of hours of staff time went into the policy and programmatic efforts required to develop a UN program, which effectively meant the disappearance of the WHO program. This effort was designed to help coordination within the UN system as other UN organizations became increasingly involved in the global effort, and bilateral donor countries were looking for both more coordinated UN action and possibly less overall UN action in favor of more bilateral funding. UNAIDS was founded in 1994–1995, and has since functioned as the coordinating agency of the UN system, internationally and at the country level. It is a common view that for most heavily affected countries, neither country level activity nor resources have increased much, if at all, since the early 1990s. UNAIDS offered and continues to offer great promise for a UN system working together, and perhaps for increased commitment on the part of the global community, much of which is occurring. However, it is not clear whether this large scale managerial change was, or should have been expected, to result in the greatly enhanced level of activity that is still most urgently needed.

At the same time, the UNAIDS program has accomplished much, including an enormous effort to try to develop equity around international pharmaceutical policies (i.e., the need for drugs to the developing world), an effort that has largely failed throughout history, and one in which the tuberculosis world has experienced many years of frustration. (For decades the anti-tuberculosis community tried and failed to obtain sufficient supplies of anti-tuberculosis drugs for Africa when the cost of curative therapy was $200 a person; it is hard to imagine commitments of $20 000–$25 000 per person coming for AIDS treatment). The UN program also focused on several other important biomedical aspects of HIV/AIDS, including promoting much needed vaccine development, policy development around the use of AZT for pregnant women, and countless other initiatives. Still, efforts to push proven prevention methods have not increased enough. Further, from the very beginning the UN program suffered from the impossibility of this heavily burdened management challenge, while at the same time attempting to recover the momentum, the in-country staffing, and the funding from which the original GPA had benefited.

Many international workers in AIDS, although they are pushing hard, are discouraged that the epidemic is still raging without sufficient support. The massive response, motivation, program activity and funding increases that were seen in the initial period of 1987–1990 have not kept pace and are still needed—even more so now. It is probably worth noting that in 1989 and 1990 several other countries were developing national level efforts which were increasing, and which seemed to be coming to a level of effort near that of Uganda. In particular, efforts in Malawi, Rwanda, Burundi, Tanzania, Zaire, and Cameroon were all expanding, but did not increase enough.

In Africa, the principal difference between the pro-

gram in Uganda and all other countries in those early years was level of commitment and intensity of effort. I would periodically make visits to several of the African countries one after another, to determine needs, support public education efforts, discuss management or money, and would invariably come back to Geneva with the observation that there was simply no comparison between the neighboring countries and Uganda in terms of what was happening. This is totally consistent with the growing literature on public education for behavior change, which is increasingly showing the necessity and primary importance of intensity of effort (e.g., as opposed to perfection of message, perfection of strategy, etc) (Hornick R. Public Health Communication: Making sense of contradictory evidence. Unpublished.).

Much of the regret that many workers in the field have felt is that other countries besides Uganda were also increasing their efforts in the late 1980s and early 1990s, and that the level of activity subsequently decreased, or failed to continue to increase enough over the last decade.

The challenge today, of course, is how to scale up now, to increase efforts now. At this point, there are new opportunities and possibilities that did not exist previously. For example, some hope lies with the new International Partnership on AIDS in Africa, recently convened by UNAIDS in London, as a result of renewed realization at global level of the full scale of the disaster, and the associated discussion about the need to at least triple international resources devoted to this epidemic over the next 5 years. This time scale may not be good enough. Hope also lies with new management at the WHO. However, many are still hoping for a clear statement of priority for this rising epidemic of AIDS—so far only tobacco and malaria have risen to this level of interest, but not AIDS or TB. Hope lies too in a new task force for Africa of the World Bank: it would be greatly beneficial for its senior management to continuously bring up AIDS when speaking to African and Asian leaders in the context of any and all of their work. Hope lies in reports of a heightened interest on the part of the UNICEF East and South African Regional Office (ESARO), which has recently declared AIDS as their main priority. And hope lies in the recent engagement of a few other world leaders, including clergy, who are now speaking out and talking directly with African and other leaders. Heads of state need to know that they are central and essential to this effort and to preventing AIDS among their own country populations.

The most urgent needs are noted in Table 2. What needs to be done is not complicated: what is needed is leadership, money and a focus on youth.[18] First, many country leaders still need to make the decision to mount an open and highly visible national campaign and support the AIDS program themselves by speaking openly, for the benefit of the country. Corporate leaders, spiritual advisors, and others from around the world need to persistently and relentlessly encourage this, and African and other country leaders need to encourage each other.

Table 2 Most urgent needs

Global and country leadership
Leadership in/for Africa, India, possibly other areas; regular engagement of African and other leaders
Reduction of stigma—open talk in country, at every opportunity
Funds to country programs
Focus of programs on 10–20 year olds
Multiple-channel engagement of young people
To protect themselves based on full information of what is and is not safe
Challenging of myths
Providing activities, alternatives
Active outside support to country programs from public, private, health, religious and global leadership groups committed to halting the epidemic

Leadership and open speaking is central to reducing stigma and reversing widespread denial. Ugandan President Musevini in the late 1980s not only spoke out about AIDS, and did so regularly, but instructed the government employees of all Ministries to talk about AIDS at all government and public meetings, i.e., not just those in which AIDS was the topic, but also at agriculture, livestock, or whatever other forum. The stigma still exists, and the continuous dialogue to reverse stigmas is still needed.

The analogy of the frog in hot water is pertinent to the African AIDS situation. A frog in hot water, where the temperature had been increased very gradually, will not feel the water as hot; whereas a frog put suddenly in hot water will jump out. Africans have adjusted to this frequency of early death, disease, newly orphaned children and funerals. It is now normal. It is up to us who are not in that situation to point out the reversible nature of this epidemic, and provide the assistance and support to make this reversal. The awakening of leaders is and will continuously remain a priority.

It is also not at all hard to see what is required in terms of prevention resources. Uganda spends about 18 million dollars a year for a population of roughly 33 million. Uganda has kept up this level of spending and the effort has continued to pay off. Most other countries are not being provided with sufficient aid, or cannot spend at this level. This is not a large amount of funds: for all of Africa it probably amounts to about 550 million dollars a year needed for prevention, which is probably only about three times what is being spent now. Funds are also needed to support care. This amount should be totally achievable; it is not trillions. The impact of an additional 500 to 600 million USD over what is being spent currently, if really devoted to prevention, could have an enormous and long-term impact.

At the same time, we should be wary of gifts, dona-

tions, and announcements of large amounts of moneys that really go toward donor interests, rather than to the country level work needed in prevention or care.

Programmatically, information dissemination and programming for youth are still key. Amazingly enough, myths still need to be dealt with. A recent article in the Washington Post documents beliefs in South Africa that only thin women can transmit AIDS, concerns that persons have injected bananas and oranges with HIV, and questions from an infected woman as to whether she could get rid of the infection by 'passing it back to her boyfriend'.

These are the same types of questions we heard 10 years ago in Uganda, and the program review of 10 years ago encouraged major efforts to dispel myths. These types of concerns reveal ignorance. Ignorance is not stupidity: ignorance is the absence of information, and the absence of a sufficiently active information program.

Most of all, children aged 10–19 need to be reached.[19] We still need to talk very openly to them, providing direct information as to what is safe, what is not safe, provide skills to avoid risk behavior in sex, and a variety of activities to keep young persons busy, motivated and to avoid sexual intercourse or intercourse without a condom. Many program ideas are around, probably all useful; the intensity of the educational and support effort for this current cohort of very young people will determine the level of success.

CONCLUSION

What Dr Mann had accomplished was a mobilization of many countries. Two of these countries, because of their own country leadership and seriousness of concern, turned the corner on the epidemic. In these two countries the corner was turned, not through genius, but through effort.

Today this effort is still not being made to a sufficient scale in most developing countries. The result is a *global level plague that equals the largest epidemics in all of the history of man*. The only difference between this epidemic and the other worst ever epidemics is that this one is due to *total human failing—total, because the technology for control exists*.

Dr Mann is credited with initially mobilizing the world, years ago. In addition to pushing country programs, his advocacy included a summit of all Ministers of Health from around the world. He spoke on AIDS at the UN General Assembly—the first time ever that one disease was discussed at this forum. He raised the level of interest to where it was needed in the international community. He founded World AIDS Day, still on the global calendar. He facilitated the passage of a World Health Resolution in every country in the world to avoid discrimination in relation to HIV infection and AIDS, and the development of a human rights agenda.[8] He discussed the *marginalization* of populations, and their resultant *vulnerability* to HIV, and the need for *solidarity* with these peoples. He popularized these words—still extremely relevant today.[8,19]

The need today is for a *few real leaders to get together and make a decision to use their time on this planet at this moment to this cause*. This cause is one that reveals how some of us are more marginalized, more vulnerable, and in need of more solidarity from those who can see it clearly and help.

Africa is itself the continent of marginalization; the vulnerability of its people is clear, and the need for help urgent. There are several candidate leaders who I think must meet about this regularly and develop a program of work that engages African and other leaders regularly to focus on active HIV/AIDS prevention in a way that is several times the current level of effort. This group should report regularly to each other on a few very easy to measure indicators of level of activity. Some of the persons who I would hope would become engaged in this are already engaged—it just needs to get a little more organized. The situation of India should also be on the agenda.

Some of today's leaders in health, human rights and equal opportunity, who have expressed solidarity with other peoples, have begun to speak out more and more. This group should work both independently and in cooperation with some of the current leadership of UNAIDS, WHO, UNICEF, the World Bank, USAID, and others to call African leadership together to limit the damage, and also to meet with this leadership at other opportunities. In 1990, we were engaged in describing an urgent situation, since over 1.5 million persons were being infected each year. Now nearly 6 million new infections occur per year and the numbers are still rising. It is hard to imagine so many more funerals, and still *such limited help from the outside*. It is hard to imagine how many more deaths will occur (Table 3). The cumulative history of the epidemic and some projections are seen in Table 4. Nobody really knows how much worse this will get. It is already a total disaster, and without the full response needed.

The recent meetings, strategies, new task forces and verbal commitments provide hope. We all remain eager to see if enough action will follow, and which organizations and leaders will face this real challenge.

Table 3 Current situation: more knowledge on what works, less application, massively spreading epidemic

	No. of persons newly infected per year	State of knowledge	Intensity of programs
1985	0.5 million/year	+	+
1990	1.5 million/year	+ +	+ + +
1998	5.8 million/year	+ + + + +	+ + + − + + +
2000–2010	(?)		(?)

Table 4 Cumulative HIV infections and AIDS: history and projections—global

	1980*	1990†	2000†	2010§¶**
HIV infections	0	10 million	60 million	>100 million
AIDS death	0	1.5 million	18 million	68 million

* HIV infection probably began in the1940s, probably <10 000 before 1980, none known.
† WHO/GPA
‡ Based on estimated 47 million HIV infections and 14 million AIDS deaths at end of 1998 plus rate of current increase of 5–9 million HIV infections/year, 2.0 million AIDS deaths/year. Current annual death estimates vary between 1.8 and 2.5 million/year (C Murray, WHO, P Delay, USAID–personal communications)
§ Current USAIDS estimates are that 100 million infections will have occurred by 2007 based on current rates of increase, assumes no additional increases in rates—which is virtually impossible to imagine, given current response. Deaths are easier to predict, since they follow incident infections. Estimates here are of 0.5 million deaths/year increase until they stabilize at 6 million deaths/year in 2007. These are all probably conservative estimates. (Many epidemiologists prefer not to refer to cumulative estimates, in particular for infections, and prefer to look at incident rates. Current incident rates for HIV infections and deaths are noted above (Table 1)
¶ Assumes no major advances in drug therapy made available to Africa, and no major vaccine advances made available to Africa. Both assumptions are by far the most likely scenario.
** These numbers greatly outdistance all prior epidemics in the history of man, and approximate all deaths from war in the 20th century combined.

This matter is serious enough that it is fair to say that history will judge us—as individuals and organizations—as to who did and who did not respond at this point as well. Leadership, reduction of stigma, funds to country programs and a heavily focused effort toward youth are urgently needed to limit further damage and reverse this course.

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Jonathan Mann
(Photo taken on the day of his resignation)