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THE WHITE HOUSE
WASHINGTON

November 17, 2000

Pete Babcock
Vice President, General Manager
Atlanta Hawks
One CNN Center, Suite 405
Atlanta, Georgia 30303

Dear Pete,

As you know, Dikembe Mutombo will be joining me here in Washington, D.C. on Tuesday to discuss AIDS for a satellite program which will be broadcast across sub-Saharan Africa on World AIDS Day 2000.

I know that without your support Mr. Mutombo would not be able to participate in this very important program. I want to take this opportunity to thank you for advocating on our behalf. We all understand that this was a huge favor to ask.

I am confident that Mr. Mutombo's participation will send a strong message to Africa's youth, in particular, and it is indeed a tribute to yourself and the Atlanta Hawks that he is able to effect so many lives in such a positive way.

Thank you again for your support of our continued efforts to fighting AIDS around the world. You are an angel!

Sincerely,

Sandra L. Thurman
Presidential Envoy for AIDS Cooperation, &
Director, Office of National AIDS Policy

THE WHITE HOUSE
WASHINGTON

November 17, 2000

Dikembe Mutombo
Atlanta Hawks
One CNN Center
Suite 405
Atlanta, Georgia 30303

Dear Dikembe,

I wanted to thank you so very much for making time in your hectic schedule to join me here in Washington, D.C. for the AFNET satellite program. I am absolutely delighted!

Your participation and willingness to engage in this form of outreach, in addition to the multitude of other contributions you continue to make in the fight against AIDS, will certainly impact generations to come.

As we seek to move forward in our shared struggle to fight AIDS around the world, your generosity of time and spirit has indeed set a shining example of this year's World AIDS Day theme of "Men Make a Difference".

Thank you for continuing to make a difference to so many. I look forward to seeing you next Tuesday!

Sincerely,

Sandra L. Thurman
Presidential Envoy for AIDS Cooperation, &
Director, Office of National AIDS Policy

DEPARTMENT OF STATE
OFFICE OF LANGUAGE SERVICES

Translating Division

LS No. 143940-A
ALK/HKE/JPM
French

Ministry of Foreign Affairs – Paris

No.314 NUOI/S

The Ministry of Foreign Affairs presents its compliments to the Embassy of the United States of America and, with regard to its note verbale No. 194 concerning the meeting of Heads of Government on International Mobilization against AIDS, has the honor to transmit herewith the agenda of the preparatory meeting of April 8, 1994, to be held in Paris. The Ministry also has the pleasure to inform the Embassy of the invitation to attend this meeting, which is designed to bring together the interministerial-level coordinators who have been appointed to undertake preparations for the November meeting.

The Ministry of Foreign Affairs would be grateful if the Embassy of the United States of America would inform the appropriate authorities that the above-mentioned meeting is to take place, and to provide the Ministry with the name of the coordinator who will be designated to attend the meeting on

April 8, as well as the names of the members of any accompanying delegation.

[Complimentary close]

Paris, March 17, 1994

[Initialed]

[Ministry stamp]

LS No. 143940-B

Meeting of Coordinators Assigned to Prepare for
the Meeting of Prime Ministers
on International Mobilization against AIDS

Paris, April 8, 1994

Centre des Conférences Internationales
[International Conference Center]
19, Avenue Kléber
(Room 3)

Agenda

9:30 a.m. - 11:15 a.m.

Commencement of activities. Opening remarks by Ambassador Michel Lunven, Chairman, Head of the French delegation.

- Outline of the process leading up to the meeting in late November;

. Coordination between the group of coordinators and the Conference of Ministers of Health and Ministers of Cooperation to be held June 17-18;

. Schedule of coordinators' meetings.

- Report by Mr. Jean-Francois Girard, Director General for Health, on the meetings of experts held January 27-28.

11:15 a.m. - 11:30 a.m.

Coffee break

11:30 a.m. - 1:00 p.m.

- Discussion of the priority topics generated by the meeting of the group of experts held January 27-28.

1:00 p.m.

- Luncheon at the Centre de Conférences Internationales hosted by the French delegation.

3:00 p.m.

Resumption of activities:

- Consideration of the draft declaration;

- Consideration of an action program.

4:30 p.m. - 4:45 p.m.

Coffee break

4:45 p.m. - 7:00 p.m.

Resumption of activities

- Continuation of consideration of the text of the declaration;

- Approval of the schedule of future meetings.

For any further information on the organization of the meeting or to communicate items you would like to add to the agenda, please contact:

Ambassador Michel Lunven
Head of the French delegation
Ministry of Foreign Affairs
37, Quai d'Orsay
75007 Paris
Phone: 33 1 47 53 54 77

or

Mr. Nicolas Mettra
Deputy Director for Human Rights and Social Issues
Bureau of United Nations and International
Organization Affairs
Same address as above
Phone: 33 1 47 53 46 71
Fax: 33 1 47 53 51 05

or

Mr. Christophe Guilhou
Office of United Nations and International
Organization Affairs
Same address as above

P.S. Simultaneous interpretation from French to English and from English to French will be provided.

LS No. 143940-C

Draft Declaration

We, the Heads of Government of the 17 industrialized countries most involved in AIDS control efforts, meeting in Paris in November 1994,

Mindful of:

- The seriousness of AIDS, a disease for which, despite medical research efforts, a truly effective treatment or vaccine is still many years away;

- The fact that, the above notwithstanding, everything possible must be done to provide for the broad dissemination of existing medication that mitigates the effects of the disease, at as low a cost as possible;

- The very rapid spread of HIV infection, which respects no borders, spares no continent, and strikes or threatens to strike every country, thus earning the label of "pandemic";

- The vital importance of a firm and bold policy of prevention that calls on every possible means to provide the population with more information about the disease and how to guard against it by implementing various forms of social mobilization, with due regard for cultural diversity;

- The physical, moral, and social suffering that the disease inflicts on individuals and, in particular, the intolerable human rights abuses it too frequently entails;

- The often irreparable damage it causes to the family and to the fabric of society;

- The tragic situation of the many children who suffer from the disease themselves or whose families are affected;

- The toll it takes on societies, at times among the very poorest, affecting their dynamic forces and thereby further hampering economic and social development;

- The particular vulnerability of women to HIV infection, which makes the pandemic even more serious;

- The fact that HIV infection threatens all humankind, its dignity, and its quality of life;

Solemnly affirm:

- Our political responsibility in the struggle against this global scourge, which is now a priority issue under the direct authority of the governments themselves, and which must be dealt with as such, at the highest levels, not only by each one of us, but by all governments as well;

- Our duty to stand behind those countries that are and will be the hardest hit by the epidemic, which are precisely the countries with the greatest needs;

- Our refusal to yield to any fatalism in the struggle against AIDS, and our certainty that by adopting the necessary public health measures and necessary information and prevention policies, the pandemic can be halted and reduced;

- Our conviction that full-scale, sustained, concerted international action will also help to contain the AIDS pandemic;

- Our support for the co-sponsored United Nations Program, under WHO auspices;

- Our admiration for the activities and work carried out by associations, which play an indispensable role that will have to be strengthened in the future;

- Our resolve to uphold the inalienable right, under all circumstances, of all persons who have AIDS or who are infected with HIV to receive the care they need, and our resolve to remind the responsible authorities of their absolute duty to furnish care for affected persons;

Undertake to:

- Implement all measures adopted under the program of action that accompanies this Declaration;

- Combat every form of discrimination against individuals infected with HIV and involve representatives of such individuals in decisions made concerning them;

- Increase, in particular, our aid intended for the most severely affected developing countries, as a direct expression of our solidarity with those countries, and mobilize aid from other donors for the same purposes;

- Agree, in addition, to strengthen the harmonization of our bilateral cooperation programs, as well as to conduct regular evaluations of the actions undertaken;

- To foster genuine access, among the developing countries, to the tools currently available for the prevention and treatment of HIV infection, as well as to the tools to be developed in the future and, in particular, to a possible vaccine.

Draft

O-State

MEMORANDUM

February 2, 2000

To: AF – Susan E. Rice

Through: AF – Nancy Powell

From: AF – Witney Schneidman

Subject: Africa Bureau Strategy to Combat HIV/AIDS

Our response to the HIV/AIDS pandemic must be robust and comprehensive, demonstrate moral leadership, and recognize this issue for what it is – the most significant threat to every one of our long-term policy objectives in Africa. We need a policy response that places this issue on par with our other top priorities in Africa. AIDS in 2000 is like water just beginning to rush through a breach in the dam; while we see part of the problem, the real threat is what remains unseen behind the dam. The Africa Bureau must be in the forefront of USG efforts to change the way AIDS is perceived and responded to in Africa. This is imperative because AIDS continues to spread almost unabated throughout much of sub-Saharan Africa. Death rates from the disease will rise dramatically in the near term and the negative political, economic, and social effects will soon increase to critical levels in many countries. Africa will soon have 40 million AIDS orphans, and that is only part of the picture. In light of these compelling facts, every Embassy in Africa should be tasked with developing a country-specific plan of action to address HIV/AIDS.

This Africa Bureau strategy is presented as two sets of recommendations that together constitute the nucleus of our short-term response to the AIDS pandemic. The list of recommendations is not inclusive and will be expanded as additional suggestions are presented. The recommendations are divided into those for the Africa Bureau in Washington and those for Ambassadors and missions abroad. Some of the recommendations have personnel and resource implications. For AF to reallocate a portion of available resources is consistent with our understanding of the devastating potential of this disease and our recognition that we are gearing up to fight this battle for many years, if not for decades. Our bureaucratic structure and resource priorities should reflect these realities.

Overall Objective:

To devise a substantially more aggressive response to the HIV/AIDS crisis within the Africa Bureau and within the Department. To achieve this, over the next 12 months the Africa Bureau should seek to effectively double the amount of Bureau time, energy and resources used to understand and combat HIV/AIDS in Africa. (Note: While many AF officers in Washington and overseas spend a portion of their time on HIV/AIDS

related activities, our collective effort should be increased and better coordinated. It would help to produce a baseline survey of current HIV/AIDS activities in order to gauge our progress in this regard.)

Recommendations:

Africa Bureau

1) **AF Management Must Lead the Fight on HIV/AIDS:** AF leadership must continually reinforce through directives to the field, public statements, visits and by allocating additional resources, the high priority given to HIV/AIDS. There is a relationship between the attention paid to HIV/AIDS in Washington and the attention it receives in the field. HIV/AIDS issues should be fully reflected in the Bureau Performance Plan.

2) **AF Needs a Larger Bureaucratic Footprint on HIV/AIDS:** AF should enlarge and strengthen its bureaucratic interaction within the Department and as a leader in the USG policy response to HIV/AIDS. This will require deeper engagement with the White House Office of National AIDS Policy (ONAP), NSC, OVP, USAID, G, OES, USUN and other concerned entities. To do this will require additional staff time (see #9 below). AF should have one officer fully dedicated to HIV/AIDS activities. All bureau personnel, from desk officers to, administrative officers, to front office management should be educated on HIV/AIDS issues and prepared to engage effectively with their respective bureaucratic counterparts.

3) **AF Should Identify and Mobilize Knowledgeable Personnel:** AF has a number of officers who are among the USG's most knowledgeable experts on the emergent impact of HIV/AIDS in Africa. These personnel should be woven into in a comprehensive bureaucratic effort to garner additional resources. AF/PD should maintain a personnel resources database to draw on for public speaking engagements. AF/RA and H should make known our willingness to have ambassadors and senior officers posted to highly affected countries brief congressional members, their staffs and other interested groups on the national security and humanitarian implications of HIV/AIDS in Africa.

4) **AF Should Engage on Pharmaceutical IPR Issues:** AF should work with ONAP, USTR and other concerned entities to develop a cooperative approach on health-related intellectual property (IPR) matters that is consistent with our goal of helping poor countries gain access to affordable medicines. However, our policy response recognizes that simple provision of cheap drugs will, in itself, do little to address the HIV/AIDS crisis absent improvements in public health infrastructures in the affected countries. Despite this, a mounting perception among some African governments that big business is failing to play a constructive role in the fight against AIDS is probably not in the best long-term

commercial interest of U.S. pharmaceutical companies in Africa. This is an area where strong executive leadership is required.

5) **Creating Performance Incentives:** AF should create positive incentives to encourage better performance by embassies and individual officers. The Bureau should encourage the Secretary to establish two new Department awards for HIV/AIDS reporting and advocacy. The awards would go to an individual and to an embassy to recognize exceptional performance in HIV/AIDS reporting or advocacy. In addition to, or in advance of, a Department award AF should immediately recognize exceptional efforts through the existing awards program. The Assistant Secretary should present HIV/AIDS related Superior Honor Awards to an individual and to an embassy during the current FY.

6) **Organize Sub-regional HIV/AIDS Meetings:** AF should organize meetings for Ambassadors, USAID Mission Directors, and Public Diplomacy personnel to discuss HIV/AIDS within their respective countries and sub-regions of Africa. These meetings (in East, West and Central Africa) should use as a model the very productive SADC regional HIV/AIDS conference. Senior bureau management should be represented at each of the sub-regional meetings. Other participants might include experts from ONAP, USAID, CDC, DOD, and the intelligence community. Consideration might be given to inviting key Congressional staff to one of the sessions.

7) **Highlight HIV/AIDS at COM Meetings:** A substantial block of time at the annual COM conference should be devoted to HIV/AIDS. In addition, virtually every regional gathering of bureau personnel (Administrative Conference, Econ/Commercial Conference, Consular Conference, etc.) should include an HIV/AIDS component in the presentations.

8) **Strengthen AF/FO Oversight:** A Deputy Assistant Secretary should be given an enhanced mandate to oversee HIV/AIDS activities for the bureau and to represent the bureau at a senior level in the interagency process. All senior personnel should be expected to make HIV/AIDS related activities a significant component of their regular duties and this should be reflected in work requirements statements and in office action plans.

9) **AF Should Establish an HIV/AIDS Response Unit:** Staffing would consist of a Coordinator, to be assisted by interns, PMIs, WAEs, and/or TDY officers from the field. At present HIV/AIDS issues are covered part time by AF/EPS, and on an ad hoc basis by desk officers and bureau management as specific issues arise.

10) **Advocate for a Special Advisory Board on HIV/AIDS:** AF should recommend to the Secretary that she establish a Special Advisory Board within the department on HIV/AIDS. The board would be chaired at the Under Secretary level with senior membership from the geographic and relevant functional bureaus. Among the board's responsibilities would be to devise and monitor the Department's

response to HIV/AIDS and to make recommendations for interagency action. (Note: The recent addition of Dr. Jack Chow as Senior Health Advisor to the G Bureau may be a step in this direction, but we need to ensure that AIDS is treated as a security issue, with important political and economic implications, and not simply a health issue.)

11) **Strengthen Contacts with the Office of National AIDS Policy:** AF should explore establishing a rotational arrangement with the Office of National AIDS Policy to place an officer at ONAP for a period of time prior to follow-on duties in the field, or in the bureau's HIV/AIDS unit.

12) **Press for an Interagency AIDS Crisis Working Group:** AF should recommend that ONAP Director Thurman establish an interagency Africa AIDS Crisis Coordinating Group to better monitor and coordinate activities and programs targeted at the region.

13) **Strengthen our In-House Education Programs:** AF should make greater efforts to educate bureau and department personnel about the facts of HIV/AIDS and about the relationship between the pandemic and our other policy objectives in Africa. Arrangements should be made for ONAP and USAID personnel to provide a comprehensive briefing to all AF staff on the current HIV/AIDS situation in Africa. Working with their counterparts at USAID, each desk officer should maintain an HIV/AIDS situation paper for their respective country to use when drafting briefing papers or in public discussions.

14) **Provide HIV/AIDS Support to African Militaries:** AF, in conjunction with ONAP, should advocate to provide additional humanitarian HIV/AIDS related assistance to African military organizations. Military institutions are important vehicles for information dissemination and social change in many African countries. In addition, the loss due to AIDS of critical skills within African militaries constitutes a vital threat to stability and security in affected countries. Any such assistance could be provided bilaterally, or through regional or sub-regional initiatives. Assistance might be channeled directly to military entities through DOD or other USG programs, or indirectly through NGOs. Assistance to combat HIV/AIDS, as with humanitarian demining programs, is directed at broad social, political, and security concerns and should not be restricted.

15) **Include HIV/AIDS in all Africa Policy Discussions:** AF must ensure that HIV/AIDS assumes a prominent place in all of our public discussions about Africa. In addition, the issue must be factored into every significant policy statement or strategy report issued by the Department. AF/PD should devise a public diplomacy strategy for use overseas and in the U.S. to make maximum use of our substantial in-house HIV/AIDS expertise. AF might consider establishing a web page devoted to HIV/AIDS related materials and events.

16) **Promote Mandatory Counseling for FS Personnel:** AF should push for a directive to all Foreign Affairs agencies mandating HIV/AIDS counseling and education at all State Department posts.

17) **AF Should Carry the AIDS Message to Other Donors:** AF should engage interested donor governments and the IFIs in discussions on HIV/AIDS in Africa in an effort to secure additional donor financial support and to share knowledge and expertise. AF, in conjunction with ONAP, USUN, USAID, and the World Bank might co-host a follow-on donor meeting on HIV/AIDS, building on the January, 2000 AIDS initiative at the UNSC.

18) **Bolster Efforts by African Regional Organizations:** AF should provide political and perhaps financial support to HIV/AIDS related activities sponsored by the OAU, UNECA, SADC, ECOWAS, COMESA, and other regional and sub-regional organizations in Africa. HIV/AIDS should play a prominent role in our policy dialogue within the U.S.-SADC Forum and with emergent mechanisms such as the Nigeria JEPC.

19) **Don't Ignore Areas of Conflict and Instability:** Special attention should be placed on devising creative responses to HIV/AIDS in situations of instability and conflict, notably in southern Sudan, Burundi, Angola and DROC, while recognizing the great difficulties inherent in working in such environments. (Note: Carter Center initiatives to combat Guinea Worm in southern Sudan have continued with mixed results in spite of the ongoing conflict in the region.) Post-conflict governments in each of these regions will emerge from years or decades of war, only to be confronted with the inevitable, and perhaps equally devastating crisis already being created behind the scenes by the AIDS epidemic. Even modest efforts to sensitize governments and key decision makers in these regions now may pay dividends later in post conflict reconstruction. In Rwanda, for example, the post-conflict and post-genocide government must now confront an AIDS epidemic which will kill many more people than either of those earlier tragedies.

20) **AF Should Develop Personnel Guidelines Relating to HIV/AIDS at Missions Abroad:** AF should produce a clear set of guidelines to govern mission hiring practices as they relate to HIV/AIDS issues. For example, should a positive HIV test be deemed a medical reason not to hire a foreign job applicant? Should the bureau maintain uniform standards overseas for hiring/firing and medical benefits as they relate to HIV/AIDS? How would any change in the prevailing practices impact financial operations? How would or will the AIDS epidemic impact our operational capabilities in the most affected embassies? Should the USG seek to set an example for American corporate employers overseas with regard to the issue of HIV/AIDS or should we hold back and continue to mirror "local practice," even when local practice is increasingly out of step with prevailing U.S. domestic employment practices?

OVERSEAS

1) **Every Embassy Needs an Action Plan:** Ambassadors and staff must be aggressive in promoting HIV/AIDS awareness and education with host governments. Every Embassy should develop a comprehensive HIV/AIDS action plan geared to local circumstances and fully reflective of the level of current and future threat.

2) **Every Ambassador in Africa Must be Educated on the Issue of HIV/AIDS:** This process will be furthered by the sub-regional HIV/AIDS gatherings. AF/PD, ONAP, OES and USAID each have roles to play in providing information for education and for distribution on HIV/AIDS.

3) **Build on the SADC Regional HIV/AIDS Experience:** Ambassadors should coordinate effectively with their peers in their respective regions to generate synergy and to learn and share best practices. This includes viewing the HIV/AIDS crisis in regional terms. Each Ambassador should read and be familiar with the "What Ambassador's Can Do" memorandum which resulted from the SADC region HIV/AIDS Meeting in October 1999 (Attached). The practical suggestions included in this memorandum may be incorporated into mission-specific HIV/AIDS action plans.

4) **HIV/AIDS Should be Specifically Discussed in the Post MPP:** HIV/AIDS issues should be included in the MPP, in work requirements statements, and reflected in decisions to allocate Self Help and other resources at post. The post action plan should encourage and seek to reward exceptional individual and group efforts to respond to the AIDS emergency.

5) **Embassies Should Identify and Target Agents of Change:** Each country team should work to identify the most effective agents of change in their respective country, including, where appropriate, military and national security institutions which may have the discipline or organizational capability to disseminate HIV/AIDS related materials and expertise. These agents of change should be targeted for special attention in the mission action plan.

6) **Work to De-stigmatize HIV/AIDS in the Embassy Workplace:** Ambassadors must help de-stigmatize HIV/AIDS in the Embassy workplace and should support efforts to increase AIDS education in the host community.

7) **Consider the Financial and Personnel Implications of the Pandemic on Post Operations:** Posts should ensure that mission personnel policies and budgeting take into account the additional effects, financial and otherwise, likely to result

from the AIDS epidemic. Posts should review health care and survivor benefits for local personnel in light of this new health emergency.

Drafted:AF/EPS:TNiblock
Cleared:AF/EPS:AHolmes
AF/S:ARender
AF/W:SWilkinson
AF/E:JMillington
AF/C:RMeece
AF/RA:CSnyder
AF/EX:RManzanares
AF/PD:MHulbert
ACRI:AHooks
AF:HJeter
AF/SE:RBogosian
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O- Date-

United States Department of State

Bureau of Oceans and International Environmental and Scientific Affairs

Washington, D.C. 20520

To: Ken Bernard (202) 456-9390

From: Jack Chow

Draft plan on global HIV

Comments appreciated -

I can present a synopsis

at the IWG Tuesday -

Jack

UNCLASSIFIED DRAFT MEMORANDUM

TO: U/S Loy
FROM: Jack C. Chow, Senior Advisor for Global Health Policy
RE: Proposed Strategy on Global HIV/AIDS
DATE:

To follow-up on the Vice President's U.N. speech calling upon the world community to recognize and confront the AIDS epidemic as an international security concern, you asked me to develop a plan for the Department to take a pro-active approach in Africa and other vulnerable regions. With the assistance of the staff of OES/EID and the other bureaus of State, I am submitting a proposed framework for action. The Africa Bureau in particular has been very active in contributing suggestions. With your approval, this framework would form the basis of the Department's contribution to the overall USG effort.

PROPOSED DEPARTMENT OF STATE HIV/AIDS ACTION PLAN

US Government Goal: Prevent new HIV infections in regions of the world with high incidence and prevalence rates, particularly in Africa, and to prevent the spread of HIV into other vulnerable areas with weak public health infrastructures.

State Department Goal: In support of combating the epidemic as a both a national security and public health threat, the Department will pursue a leadership role to ensure that a strong, sustainable effort will be originated from the United States, the international community, and those countries strongly impacted by, or vulnerable to, the epidemic. When appropriate, the Department will also assist USG technical agencies pursue their operational objectives in host countries.

Objectives:

1. Strengthen U.S. diplomatic efforts and capabilities to promote active involvement by all governments to more effectively confront the HIV/AIDS pandemic.

2. Persuade foreign leaderships that the global spread of HIV/AIDS has profound implications for national and international security in terms of its impact on economic growth, political stability and civil society, and that national commitment to address HIV/AIDS will help elicit international assistance.

3. Enhance international scientific and health collaboration among the U.S., other nations, and international bodies.

4. Develop innovative policies in partnership with other US agencies and international bodies.

These objectives and supporting actions build upon the framework outlined in the document published by OES/EID, 1999 U.S. International Response to HIV/AIDS. The Department continues to support the recommendations contained in the document.

Taking each objective in turn:

1. Strengthen U.S. diplomatic efforts and capabilities to promote active involvement by all governments to more effectively confront the HIV/AIDS pandemic.

ACTIONS:

In Washington:

- Publicly announce the State Department's and USAID's commitment to address the global HIV/AIDS pandemic. The upcoming address by the Secretary before the American Association for the Advancement of Science (AAAS), for instance, is an opportunity to reinforce the Vice President's message and to articulate State's role. (AID, OES, G)

- Utilize the assets of Public Affairs/Public Diplomacy, in conjunction with regional bureaus, to communicate a compelling USG message to domestic and international audiences on the need to combat global HIV/AIDS. An information kit/package could be produced, including a dedicated Internet site, that would inform the public on the international importance of the epidemic. Highlight

the success of high-level political commitment in countries such as Uganda, Senegal, and Ghana. (PA/PD)

- Continually reinforce the high priority given to HIV/AIDS by top State Department and USAID officials, through directives to the field, public statements, budgeting decisions, and high level visits. Raising the attention devoted to HIV/AIDS in Washington would likewise promote and reinforce the work of the field missions. (Department wide)

- While confronting AIDS in Africa is a top priority, efforts must also be broadened to include other countries and regions with high incidence or with high vulnerability to rapid propagation of HIV, such as India. Ensure that HIV/AIDS issues are fully reflected in Bureau Performance Plans. (G/OES/AF/EAP/SA/EUR)

- Ensure that HIV/AIDS assumes a prominent place in all of our public discussions about Africa (and other affected regions). In addition, the issue should be factored into all key policy statements or strategy reports issued by the Department. (AF/G/OES)

- Intensify efforts to educate bureau and department personnel about basic facts of HIV/AIDS and about the links between the pandemic and our other policy objectives. For example, arrangements could be made for select ONAP, USAID, and HHS personnel to provide a comprehensive briefing to all AF (and other relevant regional bureau) staff on the current HIV/AIDS situation in Africa. Working with their counterparts at USAID, each desk officer could maintain an HIV/AIDS situation paper for their respective country to draw upon when drafting briefing papers or participating in public discussions. (AF/G/OES/Regional Bureaus)

- Identify and analyze common traits from those countries that have been successful in addressing HIV/AIDS. Develop a medium through which to communicate best practices and examples. (G/OES/USAID/PAPD)

At Posts:

- To be more effective in promoting HIV/AIDS awareness and education with host governments, each Ambassador should direct the Embassy to develop a comprehensive HIV/AIDS action plan geared to local circumstances and fully reflective of the level of current and future threat. HIV/AIDS should be specifically discussed in the post MPP, in work requirements statements, and reflected in decisions to allocate Self Help and other resources at post. The post action plan should encourage and seek to reward exceptional individual and group efforts to respond to the AIDS emergency. (AF/POST)

- Dispatch HIV/AIDS expert teams to relevant countries to discuss with Embassies, host nation officials, and NGO's dynamics of infection and prevention strategies.

- Each Ambassador should read and be familiar with the "What Ambassadors Can Do" memorandum which resulted from the SADC region HIV/AIDS meeting in October 1999 (Attachment B). The practical suggestions included in this memorandum may be incorporated into mission-specific HIV/AIDS action plans. Such suggestions might also be incorporated into a brochure for post use. (AF/POST/R)

- Require each U.S. ambassador posted in Africa to be briefed extensively on the status and implications of the epidemic in their assigned country. Such briefings could be held individually or collectively, such as at sub-regional HIV/AIDS gatherings. AF/PD, ONAP, OES and USAID each have distinct roles and information for education and for in-country distribution. (AF/G/OES/USAID/ONAP)

- Ambassadors should coordinate effectively with their peers in their respective regions to generate cooperative ideas and to share best practices of host government actions. This includes viewing the HIV/AIDS crisis from a regional standpoint. (AF/PSOT)

- Devote substantial time at the annual Chiefs of Mission conference to HIV/AIDS. In addition, virtually every regional gathering of bureau personnel (Administrative Conference, Economic/Commercial Conference, Consular Conference etc.) should include an HIV/AIDS component in the presentations. (AF/SA/EAP/EUR/POST)

- Require DCMs and EST officers to attend an AIDS briefing during their consultative stays in Washington. (G/OES)

- Organize sub-regional meetings for Ambassadors, USAID Mission Directors, and Public Diplomacy personnel to discuss HIV/AIDS within their respective countries and regions of Africa. These meetings could use as a model the very productive SADC regional HIV/AIDS conference. Senior DOS management should be represented at each of the sub-regional meetings. Other participants might include experts from ONAP, USAID, CDC, DOD, and the intelligence community. Consideration might be given to inviting key Congressional staff to the sessions. (AF/G/Regional Bureaus/POST/USAID)

- Provide posts with sufficient epidemiological information, both globally and in each particular country and region. This could be done through a dedicated DOS AIDS Information Officer, through USAID missions, or through an information clearinghouse that is internet accessible. In posts without a USAID mission, other means of obtaining and disseminating information may be used. Also actively solicit advice from posts on how best to approach national leaders or key public figures in country. (G/OES/USAID)

- Develop a succinct set of materials for use in host country that clearly defines why AIDS is a high-priority security and foreign policy issue. (AID/PAPD/G/OES/P)

- Regularly provide posts with information on specific USG programs that address HIV/AIDS, including the Vice President's UNSC pronouncement, the Global Alliance for Vaccinations and Immunizations initiative, and the Leadership and Investment in Fighting an Epidemic (LIFE) Initiative. (G/OES)

- Use all available diplomatic venues to advance HIV/AIDS as a topic of discussion and action and to promote the linkages to foreign policy and international security. (i.e. U.S.-SADC Forum, International AIDS Conference in Durban etc., see Attachment A). (G/OES)

- Post/DCM should advise DOS in Washington of what information and resources they need to adequately address AIDS in their host country. (POST)

- Post/DCM should encourage the development of country plans by host country. (POST)

2. Persuade foreign leaderships that the global spread of HIV/AIDS has profound implications for national and international security in terms of its impact on economic growth, political stability and civil society, and that national commitment to address HIV/AIDS will help elicit international assistance.

ACTIONS:

- Post AMB should strongly urge top African leaders - heads of state and ministers in charge of economics, finance, trade and foreign affairs - to make AIDS a high priority on their national agenda, emphasizing the wide impact that an unchecked epidemic would have upon their societies. (AF/POST)

- Use R and former USIA programs to raise host nation public/governmental awareness about HIV/AIDS through trips to the US as well as US experts' trips to affected countries.

- Special attention should be placed on devising responses to HIV/AIDS in situations of instability and conflict, notably in southern Sudan, Burundi, Angola and DROC, while recognizing the great difficulties inherent in working in such environments. Post-conflict governments in each of these regions will emerge from years or decades of war, only to be confronted with the inevitable, and perhaps equally devastating crisis already being created behind the scenes by the AIDS epidemic. Even modest efforts to sensitize national decisionmakers may pay dividends later in post conflict reconstruction. In Rwanda, for example, the post-conflict and post-genocide government must now confront an AIDS epidemic which will kill many more people than either of those earlier conflagrations. (AF/PRM/Regional Bureaus/DOD/USAID)

- Each country team should work to identify the most effective agents of change in their respective country, including, where appropriate, military and national security institutions which may have the discipline or

organizational capability to disseminate HIV/AIDS related materials and expertise. These agents of change should be targeted for special attention in the mission action plan. (AF/POST)

- Provide analyses that clearly defines AIDS as a high-priority foreign policy issue and highlights the non-health implications of the disease - i.e. impact on economic growth, political stability and civil society. (G/OES)

- Issue a demarche (to follow up on the demarche delivered in March 1999) that directs posts to encourage host governments to address AIDS at the highest levels. (G/OES/Regional Bureaus)

- In cooperation with AF regional bureaus and ONAP, State should advocate for the provision of humanitarian HIV/AIDS related assistance to African military organizations. Military institutions are important vehicles for information dissemination and social change in many African countries. In addition, the loss due to AIDS of critical skills within African militaries constitutes a vital threat to stability and security in affected countries. Any such assistance could be provided bilaterally, or through regional or sub-regional initiatives. Assistance might be channeled directly to military entities through DOD or other USG programs, or indirectly through NGOs. Assistance to combat HIV/AIDS, as with humanitarian demining programs, is directed at broad social, political, and security concerns and should not be restricted. (PRM/AF/Regional Bureaus/DOD/USAID)

- Through public diplomacy, implement HIV/AIDS public awareness campaigns internationally. Provide incentives (i.e. awards) for journalistic pieces that address the security and foreign policy implications of HIV/AIDS. (PA/PD)

- Ensure that the UNAIDS Partnership Against AIDS in Africa encourages action by African governments. (G/OES/USAID/POST)

3. Develop innovative, sustainable policies in partnership with other US agencies and international bodies.

- Increase State's involvement with the business community on HIV/AIDS issues, working with ONAP, USTR and other concerned USG entities to develop a cooperative approach on health-related intellectual property (IPR) matters that is consistent with our goal of helping poor countries gain access to affordable medicines. There is a perception among some African governments that the Western pharmaceutical industry is failing to offer assistance or flexibility in its sales of anti-retroviral medications. (AID/G/OES/EB/NGOs)

- The Secretary should consider mandating the provision of HIV/AIDS counseling and education to all U.S. and foreign national employees of posts abroad.

- Pursue creative financing mechanisms, such as debt swaps for HIV/AIDS, working with MDBs, Treasury, OMB. (EB/IO/G/P/OES)

- Although initial efforts center in Africa, where almost 70% of the 33.6 million persons currently living with HIV/AIDS live, State should also accelerate efforts in India, South-East Asia, and the Newly Independent States of the former Soviet Union. (SA/EUR/G/OES)

- Fully participate in Interagency Working Groups convened by the White House and exercise leadership as appropriate on international elements of a coordinated USG plan.

- The Secretary may establish a Department Award for HIV/AIDS Reporting and Advocacy for an individual officer, and a second similar award for a post overseas.

- Devise a transition strategy to ensure the HIV/AIDS challenge will maintain a position of prominence during changeover to a new administration. (AF/G/Department wide)

4. Enhance international scientific and health collaboration among the U.S., other nations, and international bodies.

ACTIONS:

- Share lessons learned and encourage action by national governments at appropriate regional and international

venues (i.e. SADC, Durban, UN Security Council (summer 2000) see VENUES section). (G/OES/POST)

- Use FY '00 OES project funding, through a USG technical agency, to support an innovative project in HIV/AIDS.

- Assist technical agencies in expediting USG personnel placement in host countries.

ATTACHMENT A

VENUES

- U.N. Security Council follow-up session on HIV/AIDS (Summer 2000). (AF should engage interested donor governments and the IFIs in discussions on HIV/AIDS in Africa in an effort to secure additional donor financial support and to share knowledge and expertise. AF, in conjunction with ONAP, USUN, USAID, an the World Bank might co-host a follow-on donor meeting on HIV/AIDS, building on the January, 2000 AIDS initiative at the UNSC.)

- G-8 meeting in Okinawa. It was proposed at the Loy meeting, and adopted by consensus, that the State Department recommend to the USG sherpa through Al Larson that AIDS be broken out of the "health issues" agenda item it is presently included in and made a stand-alone agenda item. Given the seriousness of the issue, the rapidly increasing level of resources being devoted to the fight against it, and the critical need for more resources and top-level attention needed in that fight, making it the topic of a separate discussion seemed very much to fit in with the VP's initiative. AIDS has received such summit attention before, so there is precedent for this as well. Within this, Jim Babbitt highlighted the need to address HIV debt swap for non-HIPC countries.

- U.S.-Japan Common Agenda (February 29). One of the afternoon discussion sessions is being reserved for the U.S. to discuss potential bilateral cooperation in HIV/AIDS.

- President's trip to India (March). With the potential for an acceleration of HIV infections among a huge population base and a fragile public health infrastructure, the President may identify the pandemic as an area for bilateral cooperation and assistance.

- U.S.-SADC Forum (April/May 2000). AIDS is one of three issues to be highlighted (along with regional trade integration and collective security) at the 2nd U.S.-SADC Forum. There will be a planning meeting in Gabarone, Botswana on February 2, 2000.

- Chiefs of Mission Conference in Africa (April/May 2000). This would be an opportunity to bring in senior USG technical experts to present information sessions for Ambassadors, DCM, and perhaps African leaders.

- Durban International AIDS Conference (July 2000). Sandy Thurman may attend. Jim Babbitt suggested a side meeting of SADC heads of state (possibly led by Mbeki). This would serve to encourage head of state attendance at the conference.

- President's Advisory Council on HIV/AIDS (PACHA) meeting (March 19-21). Under Secretary Loy will be invited to brief the council on the Department of State's HIV/AIDS strategy. Other tentative invitees for this session include Sandra Thurman, Director of the Office of National AIDS Policy, and Paul Delay, Chief of the HIV/AIDS Bureau, USAID. (PACHA will be receiving 14 new members this year. The new chair of the Council will be former Congressman Ron Dellums.)

- Labor Meeting (February 3-4): The Secretary of Labor will facilitate a meeting of U.S. and African labor leaders, and will be co-chaired by the AFL-CIO (part of the LIFE Initiative).

- Business Leaders Meeting (tentatively scheduled for a date after the March primaries): The Department of Commerce will facilitate a meeting of business leaders active in Africa to encourage them to increase their efforts to rise to the AIDS challenge (part of the LIFE Initiative).

- Religious Leaders Summit (no date yet): The USG will facilitate a meeting of African, American, and other religious leaders to discuss the important role of communities of faith in the fight against AIDS (part of the LIFE Initiative).

ATTACHMENT B

USG RESPONSE TO THE EPIDEMIC
WHAT CAN AMBASSADORS DO?

Ambassadors can make HIV/AIDS a country team priority, involving all members in strategy and development, by:

- Personally leading and coordinating country team efforts regarding HIV/AIDS;
- Talking about the epidemic in the management team;
- Being the post's senior advocate for obtaining resources from Washington;
- Using the Mission Program Plan (MPP) to flag the importance of HIV/AIDS as a global and regional issue and ensure USG support for HIV/AIDS programs;
- Incorporating HIV/AIDS into public affairs programs by: 1) bringing in high-level HIV/AIDS speakers; 2) establishing a media award program for HIV/AIDS reporting to encourage responsible and sustained local media coverage; 3) incorporating university-based HIV/AIDS awareness campaigns into the programs of Fulbright professors and visiting researchers;
- Discussion the epidemic with the Defense Attache Office to seek ways for the military assistance programs to address HIV/AIDS within the host country security establishment by: 1) working with defense counterparts to incorporate HIV/AIDS messages into demining training and contracts; and 2) encouraging HIV/AIDS education at military installations;
- Instructing the political section to consider using democracy and human rights funds to support human rights groups that perform HIV/AIDS advocacy;
- Instructing the economic section to: 1) emphasize community-based HIV/AIDS activities in the Ambassador's self help program; and 2) include HIV/AIDS issues in discussions with U.S. companies.

- Instructing the RSO to assist local police and security guard companies to develop HIV/AIDS awareness programs; and
- Including HIV/AIDS on the agendas of visiting CODELS and STAFFDELS.

Ambassadors can use their public position to promote HIV/AIDS activism by:

- Being "out in front" and not delegating to staff the opportunity to promote HIV/AIDS activism;

- Seizing their position as the "President's Representative" to ensure that they personally represent presidential initiatives, coordinate access to USG resources and stress that they are also representatives of the American people.

- Raising the profile of the issue by mentioning HIV/AIDS in all meetings with the host country president, cabinet members, and other senior government officials;

- Being proactive in capturing media coverage focusing attention on HIV/AIDS in every public speech, even if it seems unrelated;

- Motivating and mobilizing other Ambassadors and the international community, for example, by hosting forum to discuss HIV/AIDS challenges;

- Using the media to advertise Ambassador's support for persons living with AIDS in HIV/AIDS awareness by attending events and functions hosted by other organizations, and by personally visiting and holding hands of those living with AIDS;

- Urging host governments to provide tax incentives to companies and individuals who support local NGO initiatives; and

- Stressing to local government officials the importance of free public service announcements, rather than using scarce donor funds to purchase media spots.

Ambassadors can engage U.S. and local private sector companies on HIV/AIDS issues by:

- Providing leadership in the American business community through AMCHAM or the local American business associations;

- Demonstrating to companies that HIV/AIDS has a direct impact on bottom line profits, in part by using analyses that show the cost of prevention programs versus the cost of coping with HIV/AIDS in the workplace.

- Helping to establish links between companies interested in developing HIV/AIDS workplace programs and HIV/AIDS NGOs that can assist;

- Creating a private sector forum to share HIV/AIDS prevention best practices;

- Publicly recognizing businesses that have best practices, and encouraging companies to adopt such practices when mergers and acquisitions occur;

- Encouraging local rotary clubs to promote HIV/AIDS awareness and workplace policies;

- Helping the foreign commercial service and Department of Commerce prepare and deliver appropriately balanced messages to potential investors about the impact of HIV/AIDS, including accurate risk assessments; and

- Encouraging private sector social responsibility in three ways: 1) Adopting progressive internal workplace policies; 2) Extramural funding of local HIV/AIDS prevention and care activities; 3) Promoting a public image of a business that cares about its employees and the public.

called TIM
fine - no comments
@ 9/28.

United States Department of State

Bureau of Oceans and International
Environmental and Scientific Affairs
2201 C St., NW, Rm. 5806
Washington, DC 20520

Timothy W. Smith TWS
Office of Emerging Infectious Diseases
OES/EID Room 5806 202-647-4542 (Voice) 202-736-7336 (FAX) Email: tsmith@state.gov

Date: 9/22/00 Number of Pages: 3

To: Sandra Thurman, ONAP _____

Ken Bernard, NSC _____

Office Phone: 456-2959 // 456-9391 _____ FAX: 456-2439 // 456-9390_____

Attached for your clearance is a draft version of the cable we are transmitting to all diplomatic and consular posts announcing the PEAC. Thanks for your attention to this matter.

Domestic OutGoing Cable

Status: Draft

Classification UNCLASSIFIED **Date** 09/22/2000

DRAFTER/APPROVER INFORMATION

Drafter Info:
Office OES/SEID **Name** TWSMITH **Phone** 202-647-4542

Approver Info:
Office OES/PDAS **Name** KBRILL

ADDRESS INFORMATION

DESIRED DISTRIBUTION:
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M/P - APONCE
S/S-O -

MESSAGE/HEADER INFORMATION

Special Handling Captions:

Other Captions:

FreeForm Captions: NSC FOR KEN BERNARD
WHITE HOUSE FOR ONAP

TAGS: KHIV, SENV, PREL

Subject Line: PRESIDENT
APPOINTS PRESIDENTIAL
ENVOY FOR AIDS
COOPERATION

Reference:

Message Text:

1.(U) This telegram has been cleared by M/P(SEP).

2.(U) On August xx, 2000, President Clinton named Sandra L. Thurman as Presidential Envoy for AIDS Cooperation (PEAC.) Prior to and concurrently to her appointment as PEAC, Ms. Thurman has functioned as the Administration's envoy for AIDS issues as the director of the White House Office of National AIDS Policy (ONAP). As PEAC, she will serve as the President's representative for HIV/AIDS to other governments, stressing the need for heightened leadership commitment for increased action and funding for this urgent issue. The PEAC will also help promote continued cooperation and increased collaboration on intensifying the international campaign that will be needed to fight HIV/AIDS effectively.

3.(U) The Department places a very high priority on the fight against HIV/AIDS. The Secretary and other Department principals have raised the issue personally and through our missions abroad with leaders throughout the world. We have encouraged other nations to appoint similar top level representatives to promote international coordination and to work with the U.S. to provide high level support for addressing HIV/AIDS. We also urge increased financial commitment from governments for AIDS prevention, care, and treatment.

4.(U) As an active member of the interagency team that has worked on the issue of HIV/AIDS throughout the life of the administration, the Department will continue to work closely with Ms. Thurman in her new capacity. In cooperation with the PEAC and the interagency community the Department will work to implement the U.S. diplomatic strategy to raise awareness and increase the international commitment to fighting AIDS around the globe.

5.(U) Minimize considered.

O-State

FOR IMMEDIATE ACTION

United States Department of State

Bureau of Oceans and International
Environmental and Scientific Affairs
2201 C St., NW, Rm. 7821
Washington, DC 20520

Timothy W. Smith
Office of Emerging Infectious Diseases
OES/EID Room 5806 202-647-4542 (Voice) 202-736-7336 (FAX) Email: tsmith@state.gov

Date: 9/12/00 Number of Pages: 6

To: Sandy Thurman, ONAP, 456-2439

Dr. Ken Bernard, NSC, 456-9390

Hope Sukin, USAID , 216-3373

Attached is a copy of the final text of the female foreign ministers' letter to Kofi Annan on HIV/AIDS as it was signed in NY last night. Thanks for all your help and support.

Tim

11 September 2000

Mr. Secretary-General:

We are writing as the Foreign Ministers of thirteen nations, and as concerned women, to proclaim our joint resolve to combat the global scourge of HIV/AIDS. We are saddened to note that HIV/AIDS continues to ravage the developing world, where 95 percent of global infections and deaths have occurred. The worldwide HIV/AIDS pandemic, and the continued, associated health challenges of other infectious diseases, such as malaria and tuberculosis, threaten to rob multiple generations of the promises and hope of a new century.

Our governments recognize that the HIV/AIDS pandemic is an urgent foreign policy issue with humanitarian, security, economic, and development implications that threaten decades of hard-won progress, and which extends beyond the means and competence of any one nation or entity to counter. This is especially evident in the pandemic's current epicenter, Africa. We are cognizant, however, of the need to focus international attention on the emerging HIV/AIDS threat in Asia, Russia, the newly independent states, regions of northern Europe, and parts of the Western Hemisphere, especially the Caribbean, as well.

His Excellency
Mr. Kofi Annan,
Secretary-General,
United Nations,
New York.

We welcome the success of the recent HIV/AIDS conference in Durban and the urgency attached to tackling HIV/AIDS by African leaders, donors, international financial institutions and the private sector. We encourage all Heads of State to devote high-level political leadership and direction to the struggle against HIV/AIDS, not only in Africa, but also around the world. Experience has shown that strong national leadership and open discussion of the problem are critically important to the fight against HIV/AIDS, and we call on all national leaders, not only Health Ministers, to join in the public fight against HIV/AIDS.

Mr. Secretary-General, our governments are committed to supporting your call to stop and reverse the spread of HIV/AIDS by 2015, and to provide special assistance to children orphaned by HIV/AIDS. We recognize that support of this goal requires the dedication of significant financial and human resources, and we will strive to identify and dedicate those resources. We especially note the critical need to support UNAIDS, including the promotion of assistance to developing countries in their efforts to treat people infected with HIV/AIDS.

Finally, but by no means the least of our concerns, we as women note the special needs of women in HIV/AIDS prevention, care and treatment. Recognizing the increasing number and growing proportion of women with HIV, we call upon the UN membership to take into account the need for the enhanced availability of education, testing, counseling, care and treatment designed to address the specific needs of women and girls. The destructive forces of the AIDS pandemic pose a fatal threat to young men and women during their productive years, and, in the case of women, in the reproductive process itself. In addition, we call for affordable, enhanced medical interventions aimed at lessening the risk factors associated with mother-to-child transmission of HIV/AIDS, and which address the needs of mothers as well as their newborn.

We thank you, Mr. Secretary-General, for your leadership on this issue of global importance. We look forward to working with you in our common effort to overcome this global plague.

We ask that you circulate this letter as a document of the General Assembly.

Benita Ferrero-Waldner
Foreign Minister
Austria

Nadezhda Mihailova
Foreign Minister
Bulgaria

Maria Eugenia Brizuela de Avila
Foreign Minster
El Salvador

Maria Soledad Alvear Valenzuela
Foreign Minister
Chile

Lydia Polfer
Foreign Minister
Luxembourg

Dr. Andrea Willi
Foreign Minister
Principality of Liechtenstein

Lila Ratsifandrihamanana
Foreign Minister
Republic of Madagascar

Lilian Patel
Foreign Minister
Malawi

Rosario Green
Foreign Secretary
Mexico

Nkosazana Zuma
Foreign Minister
Republic of South Africa

Maria E. Levens
Foreign Minister
Suriname

Anna Lindh
Foreign Minister
Sweden

Madeleine K. Albright
Secretary of State
United States of America

O-State called Erika w/Comments

United States Department of State

Bureau of Oceans and International Environmental and Scientific Affairs

Washington, D.C. 20520

DATE: Sept. 12, 2000

NUMBER OF PAGES TO FOLLOW (Including Cover Sheet): 2

FAX TO: Cheryl Bauerle

TELEPHONE: _____ FAX: 456-2439

OFFICE: ONAP

FROM: Erika Barth

TELEPHONE: 647-4689 FAX: 736-7336

OFFICE: OES/EID

****

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MESSAGE:

Susan Rice is giving a presentation to Congress on these numbers. OES provided the 2001 numbers, and AF simply doubled for the 2002 projections. Do you have any more credible numbers for 2002? AF Bureau has a very tight turnaround on this and needs a reply by 3:30. Sorry!!

Thanks Erika

****

Defending Against Transnational Threats

Strategic Goal:

HE

HIV/AIDS Initiative: Partnership for L.I.F.E.

(Millions)

	2001*	2002 NEEDED
	100	200 (doubled. 2001 #s.)

- Prevention and education
- Home and community-based care
- Caring for AIDS orphans
- Infrastructure/capacity development

USAID HIV/AIDS	244	488
CDC HIV/AIDS	61	122
DOD HIV/AIDS	10	20
[illegible]ROR HIV/AIDS	10	20
TOTAL	425	850 NEEDED

O-State

To: **NSC - Ken Bernard - 456-9390**
NSC - Hoyt Yee - 456-9150
NSC - Nora Dempsey -456-9260
NSC - Laura Efros -456-6023
ONAP - Sandy Thurman - 456-2439
AID - Mary Knox - 216-3394
AID - Alex Ross - 219-0507
AID - Joyce Holfeld - 216-6077

From: EUR/ERA - Ray Walser (647-1605)

Subject: Draft Statement on HIV/AIDS/Infectious Diseases for U.S.-EU Summit

Attached is a revised version of the proposed U.S.-EU statement. I have shared it with my State colleagues and they have made a number of suggestions. If you have comments, suggestions, please provide them by 1 PM on Friday, April 28. I will then share this with the EU. This is of course just a draft. I have reserved the EUR video facility for a possible conference on May 5 from 10AM until 12PM. Please keep this time open. We do not however have a confirmation from the EU on the day or time.

I still need to do the paper on concrete steps and urgently welcome input on specific measures we will propose.

Thanks.

Ray Walser

4/27/00 5:21 PM

U.S.-EU Statement on the Expanding Threat of HIV/AIDS And Other Infectious Diseases, Especially in Africa

Few challenges are more profoundly disturbing or more far-reaching than the threat posed by HIV/AIDS, tuberculosis, malaria, and other infectious diseases. The scope of the infectious disease threat is fundamentally global; yet, Africa today bears the disproportionate brunt. In Africa, AIDS alone annually claims more than 2.6 million victims, while more than a million lives are lost to malaria and tuberculosis. The number of African families devastated by parental loss caused by AIDS runs into the tens of millions. This health crisis in much of Africa deepens the vicious cycle of disease and poverty, erodes security, creates states of national emergency, and robs an entire generation of the hope for future development. The toll of human devastation caused by infectious diseases is also rising in Asia.

At the start of the new millennium, the U.S. and the EU seek to mobilize international opinion, resources, and action to target HIV/AIDS and other infectious diseases. The United Nations Security Council held its first-ever session devoted to HIV/AIDS in Africa during the January 2000 U.S. Presidency. The U.S. committed to provide additional resources in 2000, with much of its new money going to HIV/AIDS programs in Africa. In Cairo in April, leaders of the EU met with their African counterparts and committed to work cooperatively for solutions to the health crisis. The renewal of the Lome Convention in May likewise underscores the EU's enduring commitment to the future development of its African, Caribbean, and Pacific partners, including sounder economic underpinnings for the health sector.

We, the leaders of the United States and the EU, call upon the leaders of threatened nations around the world to redouble their political and financial commitment to fight the spread of infectious diseases. We reiterate our commitment to work with these leaders, their national institutions, and citizens, in Africa and elsewhere, to find ways to develop and sustain successful national prevention and health care strategies.

We agree that cooperation between the U.S. and the EU in the fight against HIV/AIDS and other infectious diseases will become an integral and ongoing part of our global cooperative agenda. At the U.S.-EU Summit, we agreed on the importance of working in tandem to address the challenges of HIV/AIDS and other infectious diseases, particularly in Africa, and to cooperate as partners to advance the following priority objectives:

- To increase public awareness of effective health and prevention measures among at-risk populations and to draw upon the lessons of progress made by a number of developing countries in order to empower civil society and individual citizens with the knowledge needed for improved disease prevention and self-protection, and
  To direct our representatives at the individual country level to work cooperatively and to share relevant information needed to strengthen local capacity for the delivery of necessary health services and cost-effective treatments.

- To explore and implement measures and policies that speed research, development, and field testing of needed drugs and vaccines;
  To support the introduction of new financial and investment incentives designed to make drugs and vaccines more accessible and affordable to countries in need, and,
  To support the Global Alliance for Vaccines and Immunization (GAVI).

- To seek increased governmental and private resources dedicated to supporting the international fight against infectious diseases.

- To maximize our donor coordination efforts in the United Nations, World Bank, and other multilateral organization to encourage the effective use of resources, concessionary loans, and debt relief as weapons in the fight against infectious diseases; and
  To augment multilateral bank lending for health care systems in Africa and elsewhere to promote improved basic health services, build health care infrastructure, and deliver enhanced medicines and prevention services.

The G-8 Summit in Okinawa in July 2000 constitutes a unique opportunity to increase international cooperation and support for the global fight against infectious diseases. U.S.-EU cooperation against HIV/AIDS and infectious diseases is

designed to complement the work of the G-8 and to contribute to a successful outcome at the Okinawa G-8 Summit.

U:\PUBLIC FILES\EU\Portugal\Summit\HIV-AIDS-Infectious Diseases Initiative\4-24 Statement on HIV-AIDS (2).doc

YES O-Stal C

Fax message - this cover plus 5 pages

To: NSC - Ken Bernard - 456-9390
NSC - Hoyt Yee - 456-9150
ONAP - Sandra Thurman -- 456-8439
USAID - Alex Ross - 219-0507
USAID - Mary Knox - 216-3394

From: State, EUR/ERA Ray Walser

Date: April 6, 2000

Subject: HIV/AIDS/Infectious Diseases Cooperation in Africa

You are invited to participate in a meeting to discuss the proposed U.S.-EU initiative on HIV/AIDS/Infectious Diseases in Africa in Room 6519 (EUR/ERA's conference room) at 4PM on April 10. The purpose of the meeting is to script out what we want EUR PDAS Wayne and U/S Pickering to say to the EU at the U.S.-EU Task Force meeting on April 12 and the Senior Level Group Meeting on April 13. I have attached a draft of an incoming cable from Brussels on the topic as well as the letter the Commission proposes to send to U/S Pickering. Please let me know if you can attend. If you need help with clearance let me know. Thanks.

UNCLASSIFIED
PROG 04/06/00
ECON:ADERSE
ECON:CHELMER
POL:SSWANSON
ECON

USEU BRUSSELS
SECSTATE WASHDC PRIORITY
INFO WHITE HOUSE WASHDC PRIORITY
ALL EUROPEAN UNION POST COLLECTIVE

STATE FOR G-J.CHOW, OES/EID-N.CARTER-FOSTER, EUR/ERA-R.WALSER, AF/EPS-T.HOLMES AND PRM/POP
STATE PASS USAID/AF/SD - ALEX ROSS
WHITE HOUSE FOR NSC KEN BERNARD AND ONAP SANDRA THURMAN

E.O. 12958: N/A
TAGS: TBIO, PREL, PREF, EUN
SUBJECT: HIV/AIDS: COMMISSION IS ON BOARD

REF: A) BRUSSELS 0327; B) STATE 61180; C) LISBON 1223

1. SUMMARY: THE EU COMMISSION IS ON BOARD WITH THE IDEA OF LAUNCHING AN HIV/AIDS INITIATIVE AT THE SUMMIT. COMMISSION SERVICES ARE STILL STUDYING THE U.S. PAPER (REF B) AND FORMULATING THEIR RESPONSE, BUT AGREE WITH ITS GENERAL THRUST. A LETTER THAT THE COMMISSION HAS DRAFTED ON SUMMIT IDEAS TAKES A SIMILAR LINE TO OUR PROPOSED APPROACH. EVEN WITH ENTHUSIASM ON BOTH SIDES, WE WILL HAVE TO WORK QUICKLY TO PRODUCE A SUBSTANTIVE PACKAGE IN TIME FOR THE SUMMIT. THE U.S. SHOULD BE PREPARED TO LAY OUT OUR PROPOSAL IN EVEN GREATER DETAIL AT NEXT WEEK'S SLG MEETING, PARTICULARLY WITH REGARD TO THE PUBLIC DIPLOMACY AND IPR ASPECTS WHERE THE COMMISSION APPEARS TO HAVE THE MOST QUESTIONS. END SUMMARY.

2. MISSIONOFFS MET APRIL 6 WITH DG RELEX OFFICER NORA STEHOUWER TO DISCUSS THE U.S. PROPOSAL FOR A U.S.-EU INITIATIVE ON HIV/AIDS IN AFRICA (REF B). STEHOUWER EMPHASIZED THAT SHE COULD ONLY PROVIDE A PRELIMINARY REACTION AS SHE WAS STILL WAITING FOR FEEDBACK ON THE U.S. PAPER FROM OTHER ELEMENTS OF THE COMMISSION, BUT IN PRINCIPLE SHE WAS VERY POSITIVE ABOUT THE PROPOSAL. SHE COMPLIMENTED THE DRAFTING OF THE PAPER AND THE STRATEGY IT LAID OUT FOR ATTACKING THE PROBLEM ON SEVERAL FRONTS.

3. STEHOUWER SAID THAT HER PRELIMINARY SOUNDINGS WITH OTHER COMMISSION SERVICES FOUND GENERAL SUPPORT FOR THE IDEA OF LAUNCHING A HIV/AIDS INITIATIVE AT THE SUMMIT. SPECIFICALLY: DG RESEARCH IS VERY ENTHUSIASTIC; DG

DEVELOPMENT IS SUPPORTIVE TO THE DEGREE THAT IT WOULD COMPLEMENT INITIATIVES BEING TAKEN IN THE G-8 CONTEXT; AND DG TRADE IS NOT OPPOSED, BUT NEEDS TO KNOW MORE ABOUT WHAT THE U.S. WANTS TO DO ON THE TRIPS/IPR FRONT. STEHOUWER PROVIDED MISSIONOFFS WITH A DRAFT LETTER (COPY FAXED TO EUR/ERA) ON SUMMIT IDEAS THAT THE COMMISSION HAD PREPARED PRIOR TO THE RECEIPT OF THE U.S. PAPER. THE SECTION ON HIV/AIDS TAKES A SIMILAR LINE TO OUR PROPOSED APPROACH.

4. FROM HER OWN PERSPECTIVE AT DG RELEX, STEHOUWER SAID SHE PARTICULARLY APPRECIATED THE STEPS PROPOSED IN THE U.S. PAPER WITH REGARD TO "REINFORCING POLITICAL WILL". WHILE SHE SEEMED TO HAVE IN MIND AN EFFORT THAT FOCUSED ON AFRICAN LEADERS, IN RESPONSE TO FURTHER EXPLANATIONS FROM MISSIONOFFS SHE RECOGNIZED THE VALUE OF WORKING WITH ALL SECTORS OF SOCIETY. SHE ASKED IF IT WOULD BE POSSIBLE TO SEE ANY GUIDANCE THAT THE U.S. HAS SENT TO ITS MISSIONS IN AFRICA ON LAUNCHING A PUBLIC DIPLOMACY CAMPAIGN ON HIV/AIDS.

5. LOOKING AT POSSIBLE STUMBLING BLOCKS, STEHOUWER POINTED OUT THE IMPORTANCE OF CRAFTING THE CAMPAIGN SO THAT IT WOULD NOT BE PATRONIZING TO AFRICAN COUNTRIES. SHE ALSO OBSERVED THAT THE IPR ASPECTS OF PROVIDING HIV/AIDS TREATMENTS TO AFRICAN COUNTRIES AT A REASONABLE PRICE WILL BE DIFFICULT TO RESOLVE. IN DEALING WITH THE COMMISSION, SHE URGED THE U.S. TO AVOID LANGUAGE WHICH COULD IMPLY AN OVERLY-RIGID FRAMEWORK FOR COLLABORATION. SHE REMARKED THAT THE ONE WRONG NOTE STRUCK IN THE U.S. PAPER WAS THE USE OF THE TERM "JOINT PROJECT", WHICH SOME COMMISSION OFFICIALS FELT IMPLIED A TIGHTER RELATIONSHIP THAN THEY WOULD BE COMFORTABLE WITH.

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MORNINGSTAR

DRAFT

Brussels, 3 April 2000

Dear Mr Pickering,

We are writing to you to follow up one of the themes Secretary Albright raised in her recent discussions in Lisbon and Brussels with Prime Minister Guterres, President Prodi and Foreign Minister Gama.

In those discussions, Ms Albright flagged the idea of EU-US co-operation on AIDS/communicable diseases in Africa as a potential issue for the EU-US Summit in June. Given the huge human suffering and the effect of this problem on the socio-economic stability of the continent, we consider this a valuable idea and have asked our officials to investigate possibilities for a joint message. The importance of this issue is also recognised by the Africa-Europe Summit, which will take place in Cairo on 3-4 April.

As already indicated by President Prodi in the discussions, the EU proposes to extend the discussion to also include other major poverty diseases, such as tuberculosis and malaria.

Our proposal would be to draft a Summit statement, which should made clear that the impact these diseases have on life and society in Africa puts heavy responsibilities on the (inter) national community. African leaders, as well as the international community of donors, the pharmaceutical industry and civil society will need to redouble efforts to control diseases such as tuberculosis and malaria and join forces to combat HIV/AIDS. The problem of HIV/AIDS is clearly not only a health, education or development issue, but as was shown in the January debates of the UN Security Council is affecting peace and security in Africa.

At the moment we are contemplating the following elements for the draft: strengthening of support of national HIV/AIDS interventions, the notion of recipient country ownership and leadership, priority for effective prevention strategies and awareness campaigns, improvement of health services and the development /strengthening of local capacity, improved access to essential drugs, the promotion of research and development cooperation for HIV/AIDS, malaria and tuberculosis (some promising EU-US high level contacts in this field are taking place). Of course we are open to suggestions from your side.

We suggest that in the context of this draft, we could also highlight the EC-USAID

co-operation on infectious diseases, which is taking place in Africa (and elsewhere).

In short, we want to give visibility to the fact that Africa plays - or should play- an important role in our EU-US relations. There are of course many other important aspects to our respective Africa policies, such as conflict prevention and resolution or trade and development issues, which we should refer to and which we may wish to revert to in the future. But we do think that this time we should focus on communicable diseases. We hope that our joint message will raise the visibility of our co-operation and will contribute to the resolution of these global problems.

We would welcome an early discussion of these initial thoughts in the context of the 12 April Task-Force and the Senior Level Group on 13 April.

Yours sincerely,

Signed by

Joao SALVEIRO
Director General
Political Affairs
Ministry of Foreign Affairs

Guy LEGRAS
Director General for
External Affairs
European Commission

O-State

97. Work for the achievement of education for all, prioritising the attainment of the International Development Target of universal primary education by 2015 and gender equality in schooling by 2005. We are committed to strengthening our co-operation to ensure that sound, costed strategies for the achievement of these key objectives are in place and receive strongly co-ordinated support.

98. Support African governments in their efforts to give high priority to the building of national and regional capacities in the area of science and technology, through the formulation of sound and effective national policies for education and training in science and technology for development, as well as in networking of regional and national institutions and centres of excellence. In this regard, we call upon African governments to devote at least 1% of their GDP to the development of these areas

99. Support the effort of African countries in the creation of a suitable environment for the retention of African experts within the continent, and agree on the need for action to reverse the brain drain.

Health

We agree to:

100. Work towards the eradication of endemic, parasitic and infectious diseases such as malaria, tuberculosis, polio and river blindness, which have retarded the quality, and productivity of Africa's human resources.

101. Increase support to meeting basic needs and to greater protection and priority access for the most vulnerable and disadvantaged. In particular, greater account shall be taken in matters regarding women's health and family planning. Support for the development of systems of social protection and security will be increased.

102. Continue to work towards:

a) greater access to safe water and sanitation;

b) the reduction of maternal mortality;

c) the reduction of the mortality rates of infants and children under the age of five

years;

d) the reduction of the number of malnourished persons.

103. Call on pharmaceutical companies to re-examine their commercial and intellectual property rights in order to reduce the costs of drugs and to allow access to the poorest, in particular for those suffering from HIV/AIDS.

104. Promote formulation of national drug policies and strategies with a view to improve the access to and affordability of essential drugs.

105. Also co-operate in the provision of adequate financial and technical assistance to African countries geared towards the eradication of endemic diseases, such as malaria, tuberculosis, polio and river blindness.

106. Reiterate the devastating nature of the HIV/AIDS pandemic as a national emergency in many African countries (with economic, stability + security implications) (global issue of strategic concern)

107 Recognise the growing burden of HIV on individuals and are committed to reducing the stigma of people with HIV, promoting local solutions such as home-based care, developing programmes to help AIDS orphans to become and remain valued productive members of society, improving health services, promoting and improving access to essential drugs.

108. Promote co-operation in research into new treatment regimes and their registration, as well as in the use of anti-retrovirals in the prevention of mother to child transmission of HIV/AIDS, as contained in the Dakar (1992) and Tunis (1994) Heads of State and Government Declarations on HIV/AIDS.

109. Work together to focus national HIV/AIDS programmes on well known and effective strategies for reducing the spread of the disease. We call on African Governments, EU Partners and external agencies to work with UNAIDS Africa Partnership and civil society to mitigate the devastating impact of the HIV/AIDS pandemic

110. In this respect, call upon governments and other donors to make more resources available for assisting these countries in their fight against the pandemic.

Drugs Abuse and Trafficking

We agree to:

111. Continue to work closely with African partners in combating vigorously drugs trafficking and money laundering, both on a multilateral and bilateral basis. We also agree to combat the demand and supply of illicit drugs, narcotics and psychotropic substances in conformity with the pertinent recommendations of the 20th UNGASS and aim at offering the populations lawful alternatives to the growth of illicit crops.

112 Strengthen our co-operation in developing strategies and capacity building measures to this effect.

113. Assist African countries and organisations in strengthening their capacities to control illicit drugs and trafficking and money laundering.

The Environment

We agree to:

114. Strengthen our co-operation in the field of prevention of natural disasters and set up disaster prevention and preparedness mechanisms, including reduction and early warning systems, taking into account particularly the work accomplished on the International Decade for Natural Disaster Reduction. We also agree to strengthen our co-operation on humanitarian assistance, rehabilitation and reconstruction related to the consequences of such disasters

115. Co-operate in environmental issues as a basis for ensuring sustainable development.

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Political Affairs
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External Affairs
European Commission

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WHITE HOUSE FOR NSC KEN BERNARD AND ONAP SANDRA THURMAN

E.O. 12958: N/A
TAGS: TBIO, PREL, PREF, EUN
SUBJECT: HIV/AIDS: COMMISSION IS ON BOARD

REF: A) BRUSSELS 0327; B) STATE 61180; C) LISBON 1223

1. SUMMARY: THE EU COMMISSION IS ON BOARD WITH THE IDEA OF LAUNCHING AN HIV/AIDS INITIATIVE AT THE SUMMIT. COMMISSION SERVICES ARE STILL STUDYING THE U.S. PAPER (REF B) AND FORMULATING THEIR RESPONSE, BUT AGREE WITH ITS GENERAL THRUST. A LETTER THAT THE COMMISSION HAS DRAFTED ON SUMMIT IDEAS TAKES A SIMILAR LINE TO OUR PROPOSED APPROACH. EVEN WITH ENTHUSIASM ON BOTH SIDES, WE WILL HAVE TO WORK QUICKLY TO PRODUCE A SUBSTANTIVE PACKAGE IN TIME FOR THE SUMMIT. THE U.S. SHOULD BE PREPARED TO LAY OUT OUR PROPOSAL IN EVEN GREATER DETAIL AT NEXT WEEK'S SLG MEETING, PARTICULARLY WITH REGARD TO THE PUBLIC DIPLOMACY AND IPR ASPECTS WHERE THE COMMISSION APPEARS TO HAVE THE MOST QUESTIONS. END SUMMARY.

2. MISSIONOFFS MET APRIL 6 WITH DG RELEX OFFICER NORA STEHOUWER TO DISCUSS THE U.S. PROPOSAL FOR A U.S.-EU INITIATIVE ON HIV/AIDS IN AFRICA (REF B). STEHOUWER EMPHASIZED THAT SHE COULD ONLY PROVIDE A PRELIMINARY REACTION AS SHE WAS STILL WAITING FOR FEEDBACK ON THE U.S. PAPER FROM OTHER ELEMENTS OF THE COMMISSION, BUT IN PRINCIPLE SHE WAS VERY POSITIVE ABOUT THE PROPOSAL. SHE COMPLIMENTED THE DRAFTING OF THE PAPER AND THE STRATEGY IT LAID OUT FOR ATTACKING THE PROBLEM ON SEVERAL FRONTS.

3. STEHOUWER SAID THAT HER PRELIMINARY SOUNDINGS WITH OTHER COMMISSION SERVICES FOUND GENERAL SUPPORT FOR THE IDEA OF LAUNCHING A HIV/AIDS INITIATIVE AT THE SUMMIT. SPECIFICALLY: DG RESEARCH IS VERY ENTHUSIASTIC; DG

DEVELOPMENT IS SUPPORTIVE TO THE DEGREE THAT IT WOULD COMPLEMENT INITIATIVES BEING TAKEN IN THE G-8 CONTEXT; AND DG TRADE IS NOT OPPOSED, BUT NEEDS TO KNOW MORE ABOUT WHAT THE U.S. WANTS TO DO ON THE TRIPS/IPR FRONT. STEHOUWER PROVIDED MISSIONOFFS WITH A DRAFT LETTER (COPY FAXED TO EUR/ERA) ON SUMMIT IDEAS THAT THE COMMISSION HAD PREPARED PRIOR TO THE RECEIPT OF THE U.S. PAPER. THE SECTION ON HIV/AIDS TAKES A SIMILAR LINE TO OUR PROPOSED APPROACH.

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MORNINGSTAR

O - State

United States Department of State

Washington, D.C. 20547
www.state.gov

10 July, 2000

The Honorable Sandra Thurman
Office of National AIDS Policy
The White House

Dear Sandy:

You'll probably get this when you return from Durban where I hope you will have had a number of opportunities to examine our electronic journal on AIDS. We did want you to have a reference copy easily available.

With your assistance, and that or our other contributors, we were able to publish in advance of the meeting so that this compilation of policy and information was available for use in Durban and at our embassies around the world.

Your timely support in developing this product was critical, and we are most grateful. We hope the journal, in both its hard copy format and HTML version, will continue to be useful as you move ahead with your vital work in addressing the U.S. response to this world scourge.

We are also committed to maintaining our active and wide-ranging web page on HIV/AIDS that gives us the opportunity regularly to post the most important and timely material for a wide range of users. Your continued help in assuring that we receive this material will be greatly appreciated.

We look forward to continuing to work with you.

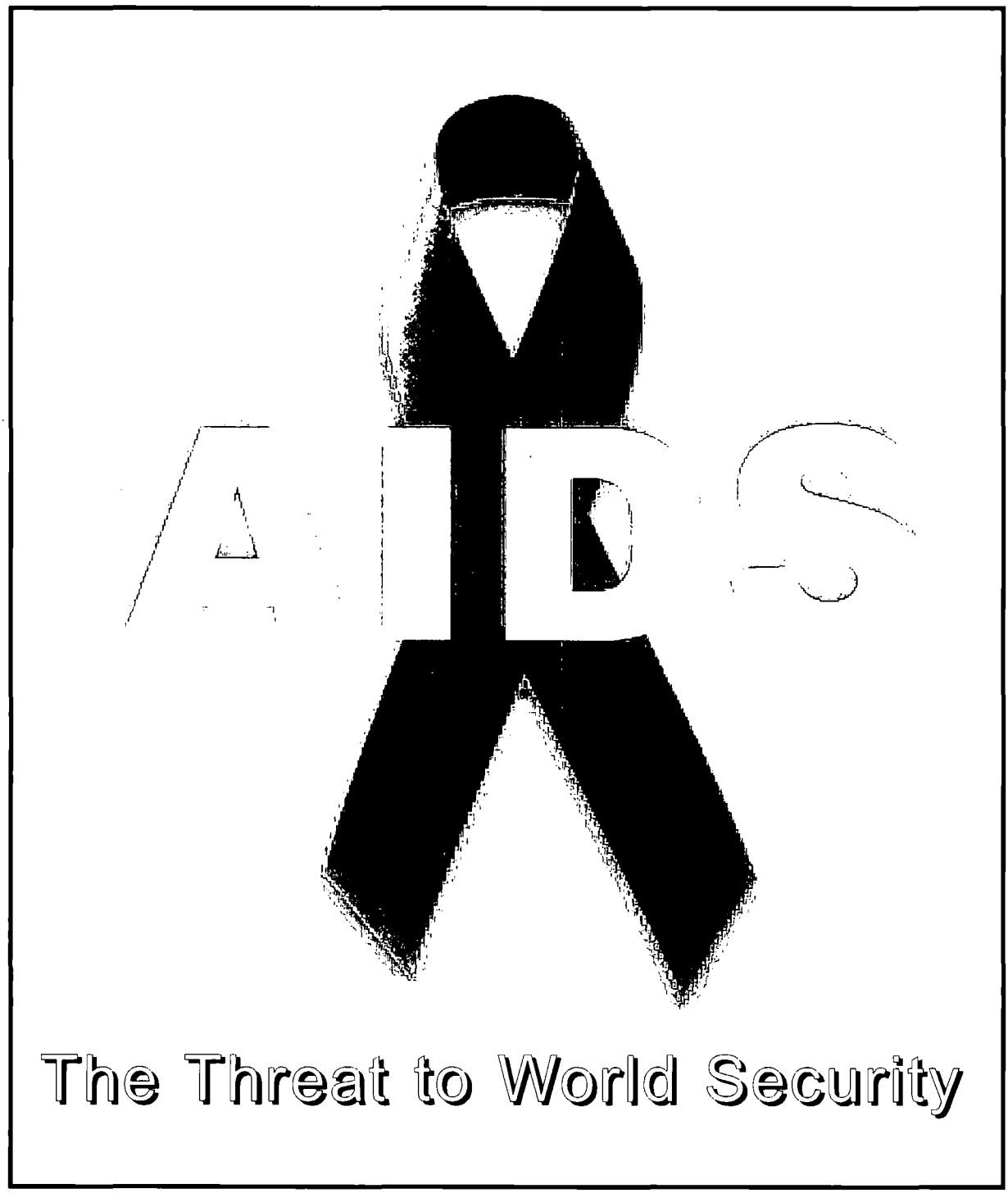
Respectfully yours,

Bill Peters

William Peters
Office of International Information Programs

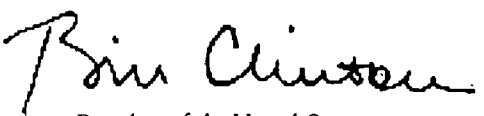
global issues

An Electronic Journal of the U.S. Department of State - July 2000 Volume 5, Number 2



The Threat to World Security

We shouldn't pretend that we can give injections and work our way out of this. We have to change behavior, attitudes, and it has to be done in an organized, disciplined, systematic way.



President of the United States

Keynote Address to the National Summit on Africa
February 17, 2000

From the Editors

This Electronic Journal goes to press at the time that about 10,000 researchers, physicians, activists, care-givers, and government officials prepare to convene at the XIII International AIDS Conference in Durban, South Africa. The meeting is expected to showcase innovative techniques and strategies for care, treatment, and prevention that could offer new directions for those pursuing this vital work.

The weeks before the conference have brought a steady stream of developments in this ongoing story about HIV/AIDS: new statistics on the mounting toll of the disease; initiatives for education and prevention programs; new efforts to encourage the hunt for a vaccine. Perhaps most significant of all, however, is the evolving recognition that a disease, for the first time, presents such an ominous threat to health, prosperity, and development that it deserves the same kind of official attention world leaders have given to more traditional threats to world security. We remain hopeful that this increased attention from around the world will make major contributions as we seek to confront this scourge.

global issues
An Electronic Journal of the U.S. Department of State
July 2000 Volume 5, Number 2

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The Shared Struggle Against AIDS

By Sandra Thurman
Director, Office of National AIDS Policy

The United States, working with other countries, is helping to design model programs based on prevention and community-based care to stem the rising tide of new AIDS infections in Africa and other regions of the world.

I would like to lay out a vivid picture of the scope of the AIDS pandemic—particularly as it impacts the stability of families, communities, and nations. I would like to share with you some of my experiences with the faces behind these shocking facts. And I would like to outline for you some key components of the Clinton administration's enhanced response to this global pandemic.

By any and every measure—AIDS is a plague of Biblical proportion. And it is claiming more lives in Africa than in all of the wars waging on the continent combined. AIDS is now the leading cause of death among all people of all ages in Africa—and 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.

And yet this war rages on. Each and every day Africa buries 5,500 men, women, and children as a result of AIDS—and that count will more than double in the next few years. It is now projected that by 2005 more than 100 million people worldwide will have become HIV infected. And unlike other wars—it is women and children that are increasingly caught in the crossfire of this relentless pandemic.

In Africa, an entire generation of children is in jeopardy. In several sub-Saharan African countries, between one-fifth and one-third of all children have already been orphaned by AIDS. And the worst is yet to come. Within the next decade, more than 40 million children in Africa will have lost one or both parents to AIDS. Forty million. That is about the same number as all children in the United States living east of the Mississippi River.

In just a few short years, AIDS has wiped out decades of hard work and steady progress in improving the lives and health of families throughout the developing world—infant mortality is doubling, child mortality is tripling, and life expectancy is plummeting by 20 years or more.

And AIDS is not just a health issue; it is an economic issue, a fundamental development issue, and a security and stability issue.

AIDS is having a dramatic effect on productivity, trade, and investment—striking down workers in their prime, driving up the cost of doing business, and driving down gross national product (GNP). Many companies are already being forced to hire at least two employees for every one job—assuming one employee will die of AIDS.

AIDS is also affecting stability in the region. The U.N. Security Council recently held a daylong meeting on HIV/AIDS. This historic event highlighted the growing awareness that AIDS is a security threat that requires a global mobilization. This reality was also addressed in a report recently released by the National Intelligence Council, which documents that the impact of this pandemic is far more serious a threat than we thought.

Yet my message to you is not one of hopelessness

and desolation. On the contrary, I hope to share with you a sense of optimism. For amidst all of this tragedy, there is hope. Amidst this terrible crisis, there is opportunity: the opportunity for us—working together—to empower women, to protect children, and to support families and communities throughout the world in our shared struggle against AIDS.

It is important to remember that what we are talking about today is not numbers but names, not facts and figures but faces and families. Let me tell you the story of one inspirational grandmother I met in a small village outside of Masaka, Uganda.

Bernadette has lost 10 of her 11 adult children to AIDS. Today, at age 70, she is caring for her 35 grandchildren. With loans from a village banking system, she has begun growing sweet potatoes, beans, and maize, raising goats and pigs, and trading in sugar and cooking oil.

With the money she earns, she is now able to send 15 of her grandchildren to school, provide modest treatment for the five who are HIV positive, and begin construction on a house big enough to sleep them all. In her spare time, she participates in an organization called "United Women's Effort to Save Orphans"—founded by the first lady of Uganda, Mrs. Janet Museveni—linking in solidarity thousands of women allied in the same great struggle.

And these women are not alone. From the young people doing street theater in Lusaka to educate their peers about HIV to the support groups in Soweto providing home and community-based care for people living with AIDS—communities are mobilizing and creating ripples of hope.

These are the faces of children and families living in a world with AIDS. And their spirit, their determination, and their resilience lead us on.

The good news is, we know what works. With our partners in Africa we have developed useful knowledge and effective tools. Together, we have designed model programs and proven that they work. And today, we know how to stem the rising tide of new infections, how to provide basic care to those who are sick, and how to mobilize communities to support the growing number of children orphaned by AIDS. Uganda has demonstrated that with strong political commitment and sustained nationwide programs, HIV prevalence can be cut in half. And Senegal has shown that HIV can be stopped in its tracks and prevalence can be kept low. But there is more, much more that needs to be done if we are to continue these successes.

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.

During the past year and a half I have made four trips to eight African countries. Together with members and staff from both parties and chambers of Congress we went to witness firsthand both the tragedies and triumphs of AIDS in Africa. In response to the findings of these trips, the administration requested and Congress appropriated an additional $100 million in fiscal year 2000 to enhance our global AIDS efforts.

This initiative provides for a series of steps to increase U.S. leadership through support for some of the extraordinary community-based programs currently being funded through the U.S. Agency for International Development (USAID) and to provide much needed technical assistance to developing nations struggling to respond to the needs of their people infected and affected by AIDS. This effort more than doubles our funding for programs of prevention and care in Africa, and challenges our G-8 (group of seven major industrialized nations plus Russia) and other partners to increase their efforts as well.

The initiative focuses on four key areas:

- Prevention—Particularly stigma reduction strategies, especially for women and young

people, including HIV education, voluntary counseling and testing, and interventions to reduce mother-to-child transmission.

- Home and community-based care—This will help to create and enhance counseling and support systems, and provide some basic medical care, (including treatment for related illnesses like sexually transmitted diseases (STDs) and tuberculosis (TB).

- Care of children orphaned by AIDS—This will be done through nutritional assistance, education, training, health, and counseling support, in coordination with micro-enterprise programs.

- Infrastructure—These funds will help to increase the capacity for the effective delivery of essential services through governments, NGOs, and the private sector.

Some of the other key components of this initiative include an increase in our efforts to make the AIDS epidemic a part of our foreign policy dialogue, to promote the use of resources freed up by debt relief for HIV prevention, and to engage all sectors including business, labor, foundations, the religious community, and other non-governmental organizations in a broad-based mobilization.

While this new initiative greatly strengthens the foundation of a comprehensive response to the pandemic, UNAIDS has estimated that it will take $1,000 million to establish an effective HIV prevention program in sub-Saharan Africa. Currently, all donors combined are contributing less than $350 million to that end. In addition, UNAIDS estimates that it will take a minimum of $1,000 million to begin to deliver basic care and treatment to people with AIDS in the region. We have not even begun to scratch the surface when it comes to delivering even this most basic treatment.

In the face of such tremendous need, the administration has requested, in the president's 2001 budget submission, an additional $100 million increase to enhance and expand our efforts to combat AIDS in Africa and around the world.

These funds will enable us to bolster our efforts already underway at USAID and the Centers for Disease Control (CDC), and to expand our approach to include the Departments of Labor and Defense for efforts to address HIV/AIDS transmission in the workplace and in the military. Let me repeat, however, that the United States cannot and should not do this alone. This crisis will require the active engagement of all segments of all societies working together. Every bilateral donor, every multilateral lending agency, the corporate community, the foundation community, the religious community, and every African government must do its part to provide the leadership and resources necessary to turn this tide. It can and it must be done.

The bottom line is this: we have no vaccine or cure in sight, and we are at the beginning of a global pandemic, not the end. What we see in Africa today, frankly, is just the tip of the iceberg. As goes Africa, so will go India and the Newly Independent States of the former Soviet Union. There must be a sense of urgency to work together with our partners in Africa and around the world, to learn from both our failures and our successes, and to share this experience with those countries that now stand on the brink of disaster. Millions of lives—perhaps hundreds of millions of lives—hang in the balance. AIDS is a devastating human tragedy that cries out to all of us for help.

We are one world, and in many ways, Africa's destiny is our destiny. There is hope on the horizon, but that hope will only be realized if we take constructive action together. Today, let us commit to seize this opportunity. As South Africa's Archbishop Desmond Tutu said: "If we wage this holy war together—we will win."

Battling the AIDS Pandemic

By Richard C. Holbrooke
U.S. Ambassador to the United Nations

The AIDS epidemic, still seen as a taboo and surrounded by cold silence in many cultures, must be talked about publicly at the highest levels.

I first became aware of the intersection between international security issues and HIV/AIDS in 1992, when as a private citizen I traveled to Phnom Penh and had the opportunity to speak with U.S. and U.N. officials then working on U.N.-sponsored elections in Cambodia. I was so alarmed by what I was hearing about transmission of the virus to and by peacekeeping troops that I wrote a letter to the senior U.N. official in Cambodia, noting that 40 different nations contributed to the U.N. peacekeeping force in Phnom Penh. While the peacekeeping troops were committed to the admirable task of bringing peace to that war-torn country, those troops also had a high potential for contributing to the global spread of AIDS, either bringing it into Cambodia or taking it out.

Since that time, predictions by epidemiologists on the global spread of HIV-AIDS have come devastatingly true. While education and new drug therapies have offered much hope for stemming the disease in the West, in the developing world infection rates are exploding. Nowhere is the disease's impact more apparent than in sub-Saharan Africa. Although the crescent of states from Kenya to South Africa has only 10 percent of the world's population, it accounts for over two-thirds of the world's HIV positive people and nearly 85 percent of all AIDS deaths. The disease kills 10 times more people in sub-Saharan Africa annually—more than 2.62 million people last year alone—than all of the continent's armed conflicts combined.

Last December, on a 10-nation trip to Africa, I saw firsthand the ravages of AIDS—from thousands of orphans in Lusaka, Zambia, who were forced to live in a bus depot, many already infected with HIV, to six pregnant women in Windhoek, Namibia, all of whom were infected with AIDS and who had to meet with our delegation secretly because of the stigmatization associated with the disease. These women told us that if they even admitted they had contracted the disease they would lose their husbands, families, and jobs, and be completely ostracized from society. HIV/AIDS—untested and untreated—destroys family and kinship relationships, killing breadwinners, teachers, soldiers, and policemen who are the very hope of the next generation.

In January of this year, the U.N. Security Council marked the new millennium by taking an historic step in making HIV/AIDS the subject of its first-ever session devoted to a health issue. This event symbolized something that many of us have believed for a long time —that AIDS is as destabilizing as any war; that in the post-Cold War world, international security is about more than guns and bombs and the balance of power between sovereign states. Vice President Gore, who chaired that Security Council session, put it eloquently when he said AIDS is "a security crisis because it threatens not just individual citizens but the very institutions that define and defend the character of a society."

In the months since that Security Council session, there has been growing media attention to the issue of AIDS in Africa, including a Pulitzer Prize to the Village Voice's Mark Schoofs for his feature series, "AIDS: The Agony of Africa." There have been many new initiatives by the United Nations,

by the U.S. government, by drug companies, and by nongovernmental organizations (NGOs). And, as long as I am ambassador to the United Nations, the U.S. will never again vote for a peacekeeping resolution that does not require specific action by the U.N.'s Department of Peacekeeping Operations to prevent AIDS from spreading by or to peacekeepers.

But we must do more. First and foremost, we urgently need a greater commitment of resources. It's no secret that the level of international resources dedicated to fighting AIDS is far too low by an order of magnitude. According to World Bank President James Wolfensohn, the current level of official international assistance for AIDS prevention in Africa is only $160 million. In last January's Security Council session, Vice President Gore announced that the administration would ask Congress' support for another $100 million to fight the epidemic, bringing the U.S. total this year to $342 million. We will continue to work through diplomatic channels to energize our G-8 colleagues, UNAIDS, the World Health Organization, the World Bank, and other international organizations, the private sector, and the leaders of every country in the world to improve cooperation and bring more financial and political commitment to this global fight.

Secondly, those nations that are in the throes of the AIDS crisis, as well as those that are on the launch pad to a wider outbreak, must accept their own responsibilities. In too many cultures, HIV/AIDS is still seen as a taboo and is surrounded by cold silence. This epidemic and its causes must be talked about publicly at the highest levels. In addition to financial resources, the battle against AIDS requires political capital and will. For this reason, I welcome the 13th Annual International Conference on AIDS, held in Durban, South Africa, this July. This conference provides an excellent opportunity for government and NGO representatives, donor organizations, and medical experts to have open discussions on effective strategies of prevention, on potential treatments, and on international, national, and community mobilization to battle the pandemic that is AIDS.

For it is clear that no government can fight the scourge of AIDS alone. Only through partnership among the community of nations, and among the public and the private sectors can we make progress in preventing a generation of orphans whose futures have been utterly diminished and who have lost all hope. Surely, we owe the world's children nothing less than our best combined efforts to stop the seemingly inevitable spread of this horrific disease.

Preventing AIDS: An Investment in Global Prosperity

By Lawrence H. Summers
U.S. Secretary of the Treasury

Today's pace of scientific discovery provides an historic opportunity to make progress against deadly diseases like AIDS that exact such a toll on economic development and threaten the prosperity and stability of the global economy.

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

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

I would like to address here the three points that form the basis for the president's initiative. First, the development and delivery of vaccines and treatments for infectious diseases is now one of the most effective investments that we can make in successful economic development in the poorest countries. Second, both the lessons of recent development experience and the advance of scientific discovery have put us in a position to have a real impact on the global spread of these diseases. Third, public-private cooperation, both at the national and international level, is needed to achieve this.

Combating Infectious Diseases as a Moral and an Economic Imperative

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

Today, it does not overstate the case to say that the greatest single obstacle to human development in these countries is the specter of disease, such as HIV/AIDS. The spread of HIV/AIDS in recent years has been swift and particularly brutal.

Fifty million people worldwide have been infected with the HIV virus; more than 16 million have died; and annual AIDS-related fatalities hit a record 2.6 million last year. In sub-Saharan Africa, where 85 percent of all AIDS deaths have occurred, life expectancy is now declining sharply in many countries, reversing decades of hard-won gains. In at least five African countries, more than 20 percent of adults are HIV-positive. In southern Africa, life expectancy is expected to drop from a high of 59 in the early 1990s to 45 within the next 5-10 years—a level not seen since the 1950s. And the highest rates of new infection are often among young women who will soon be mothers.

Women are increasingly bearing the brunt of HIV/AIDS, both as the primary care providers and, among the young, as those who are often most vulnerable to the disease. In many places, HIV/AIDS infection among young women is three-to-five times higher than among boys. And in parts

of South Africa, nearly one-third of pregnant women are testing HIV positive, compared to just 1 percent in 1990. On a continent where women perform an inordinate share of the physical labor and contribute in critical ways to the household economy, the debilitation wrought by AIDS is especially cruel.

Most worrisome is the rate at which HIV/AIDS is spreading, and the very real danger that what is happening in Africa is about to happen elsewhere. Infection rates in Asia are climbing rapidly, with several countries on the brink of a large-scale pandemic and needing to take action immediately to forestall the disaster that Africa has suffered. Parts of Latin America and the Caribbean—our own neighbors—also show high and rising rates of infection. And the former Soviet Union countries and Eastern Europe are vulnerable as well, with Russia experiencing the highest increase in infection rates in the world last year.

At the same time, it bears emphasis that millions of the world's people still fall prey to diseases that are centuries old. For example, tuberculosis (TB) accounts for more than two million deaths annually, and drug-resistant strains are spreading. Indeed, thousands of people who are HIV-positive actually die of TB; their damaged immune systems allow active TB to develop, which then can spread to people who are not HIV-positive.

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

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

If these countries do not develop, they cannot contribute to the broader global growth in which we have such a stake, at a time when more than 40 percent of our exports already go to developing countries. The national economic distress and political instability that inevitably accompany this scale of human loss can cause greater damage to the global system as a whole.

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

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

The Ability to Make a Real Difference

We must deal now with the ongoing and immediate impact of infectious and other diseases of poverty. The record of past international efforts to combat infectious disease suggests that there are no easy, simple solutions to this problem. But we are in a much stronger position today than we were even a few years ago to help countries make concrete progress.

First, there has been rapid growth in relevant scientific understanding. Clearly, one reason for the high incidence of infectious diseases is the remaining gaps in our scientific knowledge about those diseases. The development of vaccines and medicines simply cannot exceed the frontiers of available basic science. But, as one pharmaceutical executive said at a recent meeting on this subject

with President Clinton, this is a "golden age" for research and implementation. Important recent advances are being made on malaria, pneumococcus, and AIDS. We believe that public policy can provide a critical boost to private research efforts in this area.

Second, we have new tools for potentially channeling significant internal and external resources toward this effort. A sheer lack of financial resources relative to the cost of even the most basic investments in health is clearly an even greater obstacle to improving health outcomes in these countries.

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

We cannot hope to eliminate the relative gap in countries' economic resources. But in the Heavily Indebted Poor Countries (HIPC) initiative we do have a tool for increasing the funds they have available—and ensuring that they are channeled to core human development priorities such as basic health care.

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

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

It bears emphasis that educating girls holds the further benefit of helping to prevent the spread of HIV/AIDS. Studies in Zaire, Zimbabwe, and elsewhere all suggest strongly that higher rates of female secondary school enrollment have been associated with a much slower rate of transmission of HIV. And across the developing world, health care data confirm that levels of education are now highly correlated with the probability that women will practice safe sex. That is why the new approach to official lending that is part of the HIPC initiative puts core investments in female education, along with other core social investments, at center stage.

Finally, we have greater understanding of the importance of—and prerequisites for—the effective delivery of vaccines and treatments. Clearly, it does no good to ship vaccines and medicines to the ports of poor nations if they do not end up in the arms or throats of the people who need them. Just as clearly, it does little good to administer vaccines and medicines to people who do not receive basic tools for maintaining health, such as nutritional interventions like vitamin A and iron, or for preventing disease, such as bed nets for malaria and education to prevent the spread of HIV/AIDS. These problems have often been important obstacles to international efforts to combat heart disease in the past. However, the tight linkages between different aspects of health care are now well understood in the development community and are being successfully put into practice.

This is reflected in both the President's Millennium Initiative and plans now being developed by the World Bank, which focus on shifting significant resources to improving the delivery of basic health services, including vaccines and medicines.

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

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

The President's Millennium Vaccine Initiative

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

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

The president's initiative has four basic components. First, mobilizing additional international resources to help the poorest countries purchase existing vaccines for their children. Many poor countries often cannot afford to buy vaccines. To help address this problem, the president's fiscal year 2001 budget proposes a $50 million contribution to the Global Alliance for Vaccines and Immunization (GAVI) to purchase existing vaccines for children. This contribution should help catalyze significant contributions from other countries and foundations. It will also add critical credibility to the international community's commitment to provide a market for new vaccines, including vaccines for AIDS, when they are developed. Further, the president has helped stimulate commitments from the pharmaceutical industry to donate hundreds of millions of dollars worth of existing vaccines.

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

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

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

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

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

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

While important progress is being made, it is widely recognized that the market does not provide sufficient incentive for pharmaceutical companies to develop vaccines and medicines for diseases that disproportionately affect developing nations. Indeed, the World Health Organization estimates that only perhaps 10 percent of the $50,000-$60,000 million spent worldwide each year on health research is directed towards diseases that afflict 90 percent of the world's population.

To start to address this problem, the president is proposing a new tax credit for sales of vaccines against malaria, tuberculosis, HIV/AIDS, or any infectious disease that causes over one million deaths annually worldwide. Under the proposal, the seller of a qualified vaccine could claim a credit equal to 100 percent of the amount paid by a qualifying nonprofit organization (such as UNICEF) that received a credit allocation from the U.S. Agency for International Development (AID). The tax credit would match the purchaser's expenditures dollar-for-dollar, thereby doubling its purchasing power.

For 2002 through 2020, AID could designate up to $1,000 million of vaccine sales as eligible for the credit. This credit would provide a specific and credible commitment to purchase vaccines for the targeted diseases once they become available. The president is calling on other governments to make similar purchase commitments so that we can ensure a future market for these critically needed vaccines.

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

Conclusion

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

However, in Uganda, Thailand, Senegal, and elsewhere we have now seen compelling examples of concrete progress. And we have seen in the past that well-coordinated global efforts can have an enormous impact. One need only consider the eradication of smallpox; the nearly complete campaign against polio; and the remarkable global effort to combat river blindness (onchocerciasis), which has halted the transmission of that disease in 11 African countries and prevented 185,000 who were already infected from going blind.

As I have said, we believe that we now have a historic opportunity to make headway against the other killer diseases that today exact such a toll on the developing economies. What is crucial is that we act now to catalyze a broad international effort to address the problem at its root.

The AIDS Epidemic: Considerations for the 21st Century

By Dr. Anthony S. Fauci
Director of the National Institute of Allergy
and Infectious Diseases

The HIV pandemic, ranking as one of the most destructive microbial scourges in history, can be controlled in both developed and developing countries through such things as education, behavior modification, and the use of antiretroviral drugs.

Humankind has been besieged throughout its evolution by microorganisms that pose a continual challenge to the survival of the species.[1] Although such ancient killers as tuberculosis and malaria persistently take a toll of millions of lives per year, occasionally the emergence or reemergence of a microbe results in an unexpected, catastrophic pandemic with global public health consequences. As we enter a new century, it is worth reflecting on the fact that within the framework of an enormous but constant burden of a variety of infectious diseases, as well as a number of mini-epidemics, the 20th century witnessed two such unexpected cataclysmic events.

One, the influenza A pandemic of 1918 was due to an old, but reemerging microbe. Influenza had been a problem for centuries, but in that one winter of 1918-1919 it was responsible for the deaths of approximately 25 million people worldwide and 550,000 people in the United States.[2]

The other pandemic, the acquired immunodeficiency syndrome (AIDS), is due to a newly recognized microbe, the human immunodeficiency virus (HIV).[3] The world first became aware of this new disease in the summer of 1981, and it has exploded in successive waves in various regions of the world. The catastrophic potential of the pandemic may still not have been fully realized. As this new millennium begins, it is appropriate to reflect on the origins of this epidemic, what has occurred over the past 18 years, what has been accomplished from a scientific and public health perspective, and what the prospects are for the future.

The Origins of HIV

Recent molecular epidemiologic data have clearly indicated that HIV type 1 (HIV-1) evolved with the *Pan troglodytes troglodytes* subspecies of chimpanzee and was present in that subspecies for centuries.[4] The virus apparently does not readily cause disease in the chimpanzee. As is the case with many viruses, HIV at a particular point (or points) in time "jumped" species to infect human beings; hence, it almost certainly originated as a zoonotic infection. HIV type 2, the less prevalent and less virulent species of HIV, is remarkably similar genetically to the simian immunodeficiency virus that is endemic among sooty mangabeys.[5]

The most likely mechanism of transmission of HIV-1 from chimpanzees to humans was by contamination of a person's open wound with the infected blood of a chimpanzee, probably when the chimpanzee was being butchered for the purposes of consumption.[6] Chimpanzees have traditionally served as a source of nutrition for humans in certain parts of sub-Saharan Africa. Any of a number of mutations in the viral genome that would have allowed successful transmission of the virus from chimpanzees to humans probably took place intermittently over the centuries.[4] Indeed, it is likely that sporadic cases of transmission to humans were continually occurring unnoticed over the course of decades, and perhaps centuries.

Only when demographic and social conditions allowed rapid spread of the virus among people did an epidemic actually begin to emerge. These conditions included massive migration from rural areas to urban areas; the breakup of family units due to the migratory nature of employment opportunities, with its attendant sexual promiscuity and extensive frequenting of commercial sex workers; and contamination of the blood supply.[7]

The introduction of the epidemic to developed countries, such as the United States, followed relatively soon after the "gay revolution" that had its origins in the riot at the Stonewall Inn, a bar frequented by homosexual men, in New York City in 1969.[8] The demographic setting of the high-risk homosexual practices that were concentrated in cities such as New York, San Francisco, and Los Angeles in the 1970s and early 1980s unfortunately made this population of predominantly young adults a perfect target for an epidemic of sexually transmitted disease. Similar patterns soon followed in other developed countries, such as Canada, Australia, and those of western Europe.

Scope of the Epidemic

AIDS continues to exact an enormous toll throughout the world, in both human and economic terms. In the United States, an estimated 650,000 to 900,000 people are infected with HIV,[9] of whom more than 200,000 are unaware of their infection.[10] Through 1998 (the latest figures available), 688,200 cumulative cases of AIDS and 410,800 AIDS-related deaths had been reported to the Centers for Disease Control and Prevention (CDC).[11]

The demographic characteristics of those affected by the epidemic have changed dramatically since the first cases were reported in 1981. Unlike the early days of the HIV and AIDS epidemic in the United States, when the affected population consisted overwhelmingly of homosexual men, leading some to assume incorrectly that the epidemic would remain contained within the gay population, today new cases of HIV infection result predominantly from injection-drug use and heterosexual contact, with a disproportionate representation among minority populations.[11] The numbers of cases of AIDS (per 100,000 population) reported in 1998 in the United States were 66.4 for non-Hispanic blacks, 28.1 for Hispanics, 8.2 for non-Hispanic whites, 7.4 for American Indians and Alaska Natives, and 3.8 for Asians and Pacific Islanders. Women are increasingly affected; the proportion of U.S. cases reported among women and adolescent girls more than tripled between 1985 and 1998, from 7 percent to 23 percent.[11]

It is often said that the HIV and AIDS epidemic in the United States and other developed countries has reached a plateau, since the number of new infections per year is no longer on an accelerating trajectory but has leveled off. However, in the United States it is estimated that this plateau has reached an unacceptable level of 40,000 new infections per year, a rate that is believed to have remained relatively constant throughout the 1990s.[12] Of these newly infected people, the CDC estimates that half are younger than 25 years of age and were infected sexually.[13] As the number of new cases per year among homosexual men has decreased dramatically, the number of new infections among heterosexuals, particularly among women, has accelerated greatly, producing a deceptive plateau. In the United States we are in fact seeing new waves of the epidemic among different demographic groups.

The same phenomenon of successive waves is reflected dramatically in the global pattern of the epidemic, with sub-Saharan Africa currently bearing the greatest burden of the epidemic worldwide.[14] In addition, the number of HIV infections in the countries of the former Soviet Union has escalated sharply over the past few years.[14] However, the trajectory of the infection rate in the Indian subcontinent and Southeast Asia indicates that without dramatically successful preventive measures, these regions will bear the greatest burden of the epidemic as we enter the 21st century.[14] The estimated number of infections in China is still relatively low; however, there is potential for an explosive spread of HIV in that nation of more than 1 billion people.

The magnitude of the epidemic is huge. As of the end of 1998, there were more than 33 million people worldwide with HIV infection or AIDS, 43 percent of them female, according to estimates by

the Joint United Nations Program on HIV/AIDS (UNAIDS).[14] An estimated 5.8 million new HIV infections occurred worldwide during 1998—approximately 16,000 each day. More than 95 percent of these new infections occurred in developing countries. In 1998, HIV infection or AIDS was the fourth leading cause of death worldwide, resulting in an estimated 2.3 million deaths.[15] If the current trend in the incidence of HIV infection continues, more than 40 million people will be infected with HIV as we enter the new millennium.

The Successes and Limitations of Antiretroviral Therapy

In the United States and other developed countries, the numbers of new AIDS diagnoses and deaths have fallen substantially during the past three years. The age-adjusted death rate from AIDS declined 48 percent from 1996 to 1997;[16] similar decreases have been noted in western Europe and Australia.[17,18] These trends are due to several factors, including improved prophylaxis against opportunistic infections and improved treatment, the growing experience among health professionals in caring for HIV-infected patients, improved access to health care, and the decrease in the number of new HIV infections due to prevention efforts and to the fact that a substantial proportion of persons with high-risk behavior are already infected.

However, the most influential factor has clearly been the increased use of potent anti-HIV drugs, generally administered in combinations of three or more agents and usually including a protease inhibitor.[17,19-21] Such combinations are known as highly active antiretroviral therapy. The development of therapies for HIV infection has been remarkably successful, reflecting an effective synergy among government, industry, and academia. Sixteen anti-HIV drugs are now licensed by the U.S. Food and Drug Administration. These drugs have had dramatic effects in reversing the extent of illness in many patients with advanced disease, as well as in preventing the progression of disease in those who are relatively healthy.

Consensus guidelines have been developed for the use of highly active antiretroviral therapy in adults and adolescents, as well as in children and in HIV-infected pregnant women.[22-24] These guidelines, when appropriately applied, have greatly improved the prognosis for HIV-infected people and have markedly reduced the risk of HIV transmission from mother to baby.

Despite the enormous beneficial effects of highly active antiretroviral therapy, many HIV-infected people have unfortunately not had adequate responses to the regimens, cannot tolerate the toxic effects, or have difficulty complying with treatment that involves large numbers of pills, myriad interactions with other drugs, and complicated dosing schedules in which intake of food and liquids must be taken into account.[22] Even in patients who are successfully treated with highly active antiretroviral therapy and have extremely low levels of HIV-1 ribonucleic acid (RNA) in plasma, the virus persists in sanctuaries where the drugs cannot reach it or in a latent form on which drugs haveno effect.[25-28] In addition, the emergence of strains of HIV that are resistant to currently available drugs is a widespread and growing problem.[29]

Although there is evidence of improvement in immune-system function in most patients who receive combination antiretroviral therapy, complete normalization of the immune system and complete eradication of the virus from the body appear unlikely with currently available therapies. The persistence of latent HIV despite therapy that successfully suppresses detectable levels of HIV-1 RNA in plasma is particularly problematic and suggests that lifelong treatment may be necessary with drugs that are currently expensive and difficult to tolerate for prolonged periods.[30-34] In patients in whom plasma HIV-1 RNA had been suppressed by highly active antiretroviral therapy to below detectable levels for a median of 390 days, levels invariably rebounded within three weeks after the cessation of therapy.[35]

Therefore, the development of a new generation of therapies remains a major priority. Currently, all licensed antiretroviral medications are directed at one of two viral enzymes, reverse transcriptase or protease. Many new treatment strategies are being developed and tested, including the use of drugs that prevent the virus from entering a cell and those that prevent the integration of the provirus into nuclear DNA. In addition, approaches to

purging the virus from its latent reservoirs in certain cells and tissues are being vigorously pursued, as are methods to boost HIV-specific immune responses.[36]

Prevention of HIV Infection

In developing countries in which the per capita allocation for health care spending may be only a few dollars a year, anti-HIV therapies are invariably beyond the reach of all but the privileged few. This situation underscores the need for effective, low-cost tools for HIV prevention that can be used in these settings as well as in the United States and other developed countries. Even if such therapies were feasible on a global scale, it is clear that treatment is not the solution to the global HIV problem. Unlike microbial scourges, such as malaria and tuberculosis (among many others), for which there is very little that people can do to prevent infection, HIV infection in adults is entirely preventable by behavior modification. Researchers have shown that several approaches to prevention, when properly executed, can be effective. These approaches include education and behavior modification, the promotion and provision of condoms, the treatment of other sexually transmitted diseases, drug-abuse treatment (for example, methadone maintenance for injection-drug users), access to clean needles and syringes for injection-drug users, and the use of antiretroviral drugs to interrupt the transmission of the virus from mother to infant.[37]

The use of antiretroviral drugs in pregnant women with HIV infection and their infants is an extraordinarily successful prevention strategy.[38] The rate of mother-to-child transmission of HIV in the United States has been cut to negligible levels among women and infants treated with an extended regimen of zidovudine therapy. Recent studies by the CDC, the National Institutes of Health (NIH), and others have shown that substantially shorter regimens of antiretroviral drugs, which would be more feasible in poorer countries, can also reduce perinatal HIV transmission dramatically.[39-40] A brief and affordable regimen of therapy administered to the mother around the time of delivery could potentially prevent HIV infection in hundreds of thousands of babies per year. An interim analysis of a study in Uganda indicates that two doses of nevirapine—one given to the mother at the onset of labor and one given to the infant within 72 hours after birth—can markedly reduce the incidence of perinatal transmission of HIV.[41]

Other methods of preventing HIV transmission may also help slow the epidemic of HIV and AIDS. For example, researchers are developing and testing topical microbicides, substances that a woman could use in her vagina before sexual intercourse to prevent the transmission of HIV and other sexually transmitted diseases.[42] UNAIDS and other organizations have also facilitated the widespread use of the female condom in Africa. These interventions may help empower women to protect themselves in situations in which they are unable to avoid sexual relations with HIV-infected partners or cannot persuade their partners to use a condom.

Development of an HIV Vaccine

Historically, vaccines have provided a safe, cost-effective, and efficient means of preventing illness, disability, and death from infectious diseases.[43] The solution to the HIV pandemic is the development and availability of a safe and effective vaccine against the infection. Indeed, such a goal remains the highest priority of AIDS research. A major scientific obstacle to the accomplishment of this goal has been the difficulty in establishing the precise correlates of protective immunity against HIV infection. To speed the pace of discovery, many public and private agencies have dramatically increased the resources devoted to research on HIV vaccines. For example, at the NIH, funding for HIV-vaccine research rose from $100.5 million in fiscal year 1995 to an estimated $194.1 million in fiscal year 1999. To date, more than 3,000 uninfected volunteers have enrolled in more than 50 HIV-vaccine studies sponsored by the NIH (including two phase 2 intermediate-sized trials), involving 27 vaccines.

As part of a broad portfolio of research, recent NIH-supported studies have assessed so-called vectored vaccines: harmless viruses (e.g., canarypox) that are genetically altered to make HIV proteins. These vaccines have been administered to volunteers in combination with a

separate vaccine made of a purified HIV envelope protein. Results have been encouraging. In phase 1 and phase 2 studies, the combination approach has appeared safe and has evoked both cellular and humoral immune responses that may have a role in providing protection from HIV infection.[44] Three vectors, as well as other HIV proteins, are currently being compared to determine which combination produces the most vigorous immune response.

Meanwhile, a large-scale study of a vaccine based on the surface proteins of two strains of HIV was recently undertaken in the United States by a private company, with an additional phase 3 study to be conducted in Thailand.[45] Finally, a phase 1 trial of canarypox-vectored vaccine for HIV infection has been initiated in Uganda in a growing effort to involve scientists from developing countries in the research effort.

Conclusions

The HIV pandemic has posed a formidable challenge to the biomedical-research and public health communities of the world. What began as a handful of recognized cases among homosexual men in the United States has become a global pandemic of such proportions that it clearly ranks as one of the most destructive microbial scourges in history. We are at a pivotal point in the evolution of this historic event. Biomedical research has provided the tools for the development of treatments as well as a still elusive vaccine. It has become apparent over the past few years that minimizing the destructive impact of this epidemic will require partnerships between the public and private sectors as well as a stronger political will among the nations of the world. Unless methods of prevention, with or without a vaccine, are successful, the worst of the global pandemic will occur in the 21st century.

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Reaching a Turning Point

By Peter Piot
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While AIDS in Africa has become a full-blown development catastrophe, an historic line has been crossed in the battle against the deadly disease as political leaders speak out and new international resources are mobilized.

AIDS has become the number one killer in Africa, taking more lives—10 times more—than the wars on that continent in 1998. Since the pandemic began, more than 16 million people have died worldwide and 13.7 million of them have been Africans, according to a global survey on the disease conducted by UNAIDS and the World Health Organization (WHO) at the end of 1999.

These staggering statistics mean that AIDS stands to reverse the developmental progress Africans have made over the last two decades in health care, education, life expectancy, economic growth, and human security. AIDS in Africa has become a full-blown development catastrophe.

The facts emerged starkly from a survey conducted by the United Nations Development Program (UNDP) in late 1999. African nations suffered downward changes this year in the Human Development Index, a ranking based on levels of health, wealth, and education. Almost all of the major changes in rank could be attributed to declining life expectancy as a result of AIDS:

- Average life expectancy at birth in southern Africa, which climbed from 44 in the early 1950s to 59 in the early 1990s, is expected to drop back to 45 sometime between 2005 and 2010.
- The United Nations Development Program estimates that fewer than 50 percent of South Africans currently alive can expect to reach the age of 60, compared with an average of 70 percent for all developing countries and 90 percent for industrialized countries.

Yet even amidst these grim figures I am optimistic. I believe we are now at a turning point in the 20-year history of the AIDS epidemic in Africa. Everywhere I go, I hear top African leaders speaking out about AIDS as the major threat to the continent's development.

In Ghana two months ago, for example, First Lady Nana Konadu Agyeman Rawlings participated in the launch of a new female condom program, calling the introduction of these prophylactics a "long-awaited global dream come true for Ghanaians."

I believe an historic line has been crossed in our battle against this disease as political leaders speak out and new domestic resources are directed to prevention and care programs and new international resources are being mobilized. When governments begin to focus on AIDS as a national priority, tough decisions can be made to create more favorable conditions for those affected by the epidemic, and establish better protections for the poorest and the most vulnerable.

The International Partnership Against AIDS (IPAA) in Africa is working toward those goals in a cooperative effort involving national governments, international organizations, and private sector

groups. African governments are leading broad-based national responses. United Nations organizations are coordinating the global response and providing program and financial support to country-level efforts. Donor governments are also supporting action at all levels, providing input into substantive development of the partnership in addition to financial assistance. The private sector is providing expertise and resources to help turn the epidemic around in the workplace, among organized labor, and in the business community. And, finally, nongovernmental organizations, including groups of people living with HIV, are working to ensure ownership of the partnership within local civil society and to strengthen regional and country networks.

The partnership's mission is as ambitious as it is simple. Over the next decade, it will help reduce the number of new HIV infections in Africa, promote care for those who suffer from the virus, and mobilize society to halt the advance of AIDS. Specific goals promoted by the partnership include:

- giving young people aged 15-24 the information and skills they need to prevent infection;
- providing HIV-positive pregnant women with access to HIV testing and counseling and to drugs that can increase their chances of having healthy babies;
- including people living with HIV/AIDS actively in all aspects of social, economic, and political life;
- furnishing AIDS orphans with the means to grow up and lead meaningful lives;
- providing HIV-positive people with access to care in accordance with locally established standards;
- ensuring that national and international firms operating in Africa are fully involved in the fight against the epidemic;
- encouraging decentralization of HIV/AIDS programs and participation of communities;
- promoting an end to stigma and discrimination by social and legal means.

Governments in a dozen African nations have already accelerated their own actions in order to contain the disease. Burkina Faso and Cote d'Ivoire have established a national solidarity fund, for example.

The African partnership will also better enable these nations to exchange ideas on the "best practices" already emerging in the sub-Saharan region. In Uganda, sex and health education information and in-school HIV prevention programs for teenagers and youth have contributed to a demonstrated reduction in the rate of infection—a decline as high as 40 percent in urban areas.

In Senegal, a rapid, broad-based response to the epidemic, supported by both Islamic and Christian leaders, has kept the rate of HIV infection below 2 percent. Recent behavioral surveys indicate that more than 60 percent of men and 40 percent of women aged 15-24 are now using condoms in casual sexual encounters.

The IPAA and partnerships like it will be the foundation on which to build more effective resistance to this epidemic. Individual sectors can not be successful alone; government, business, educators, and all society's players must be engaged to achieve success. We see it happening not only in these African programs, but elsewhere too—the cooperation between government, nongovernmental organizations, and others is working.

Thailand's government demonstrated the importance of partnership when it launched an impressive program after a 1989 study showed that 44 percent of the sex workers in Chiang Mai were HIV positive. Despite the illegal status of prostitution in Thailand, the government worked with brothel owners to urge 100 percent condom use in brothels. They launched mass media campaigns to encourage respect for women and discourage men from visiting sex workers, and improved access to care for people living with AIDS. As a result, HIV prevalence has declined significantly—especially among young people.

Success stories like these can help other nations

and communities shape future programs. We need to work harder to ensure that "best practices" in the fight against this disease are shared.

We have learned that success in reducing transmission is not random; the most effective HIV prevention programs have key features. They benefit from political commitment and work on many levels at the same time, promoting safe behavior and providing care and support for people affected by HIV. They offer a broad range of prevention measures, including access to cheap and good quality condoms, confidential counseling and testing, prevention of mother-to-child transmission, and early treatment for other sexually transmitted diseases, which multiply the risk of infection with HIV. Other critical elements are long-term education and mass media campaigns to ensure broad public awareness about HIV. Finally, the communities affected and people living with HIV are actively involved in the planning and execution of AIDS programs.

Attention to youth, during their most sexually active and experimental years, is critical. About half of all the new cases of HIV infection involve young people between 15 and 24 years of age. While the young may be the most vulnerable population, we also find that they are the most receptive to prevention messages and will adopt more responsible behaviors.

Besides explanations of what the disease is and how it's transmitted, it is also important to challenge harmful concepts of masculinity, including the way adult men look on risk and sexuality and how boys are socialized to become men. At the same time, young women must be educated to recognize their vulnerability to infection, their responsibility to protect themselves, and their right to insist upon protection in sexual relationships.

Prevention programs will help us contain future HIV infections, but we must not forget the needs of more than 33 million infected people who need our care today. The UNAIDS Secretariat and WHO. are trying to provide well-founded guidance and support to countries to assist in building health systems that can respond to the epidemic.

To that end, together with WHO., UNICEF, the World Bank, and UNFPA, we have opened a new dialogue with five international pharmaceutical companies to explore ways to accelerate and improve the provision of HIV/AIDS-related care and treatment in developing countries. The pharmaceutical companies involved—Boehringer Ingelheim, Bristol-Myers Squibb, Glaxo Wellcome, Merck & Co., and F. Hoffmann-La Roche—have indicated their willingness to work with other stakeholders to find ways to broaden access to care and treatment, while ensuring rational, affordable, safe, and effective use of drugs for HIV/AIDS related illnesses. The companies are offering, individually, to improve access to, and availability of, a range of medicines. Other pharmaceutical companies have also expressed interest in cooperating in this endeavor.

But that's but one step in improving the lives of HIV infected persons. We need to ensure that the lowering of the price of some medicines stimulates the development of more comprehensive care strategies. We recognize that even at heavily discounted prices, the cost of antiretroviral therapies will continue to be beyond the reach of public sector subsidies and therefore unavailable to the majority.

This is a time of great opportunity when it comes to AIDS in the developing world—a time of political opportunity, as exemplified by the strong commitment to respond to AIDS by numerous heads of state, and by the debates on AIDS in Africa at the U.N. Security Council in January 2000, initiated by Ambassador Richard Holbrooke, and at the World Bank/IMF Development Committee last April. It is also a time of opportunity in terms of resources, with the U.S. government, as well as other donors, greatly increasing funding for AIDS programs in the developing world. Africa alone will need $1,600 to $2,600 million per year to ensure effective prevention programs and basic care.

But amidst all this analysis of costs, programs, strategies, and multi-sectoral cooperation, there is one commodity that does not emerge, perhaps the most precious one. That is hope, which is certainly critical to reversing this appalling epidemic. It is my role, and that of all those engaged in this struggle, to keep that hope alive.

reports & documents

A Primer: HIV Infection and AIDS

The following fact sheet, prepared by the National Institute of Allergy and Infectious Diseases (NIAID), a component of the National Institutes of Health, provides basic information about AIDS, including how it is transmitted, diagnosed, treated, and prevented.

Overview

AIDS was first reported in the United States in 1981 and has since become a major worldwide epidemic. AIDS is caused by the human immunodeficiency virus (HIV). By killing or damaging cells of the body's immune system, HIV progressively destroys the body's ability to fight infections and certain cancers. People diagnosed with AIDS may get life-threatening diseases called opportunistic infections, which are caused by microbes such as viruses or bacteria that usually do not make healthy people sick.

More than 700,000 cases of AIDS have been reported in the United States since 1981, and as many as 900,000 Americans may be infected with HIV. The epidemic is growing most rapidly among minority populations and is a leading killer of African American males. According to the U.S. Centers for Disease Control and Prevention (CDC), AIDS affects six times more African Americans than whites and three times more Hispanics than whites.

Transmission

HIV is spread most commonly by having sex with an infected partner. The virus can enter the body through the lining of the vagina, vulva, penis, rectum, or mouth during sex.

HIV also is spread through contact with infected blood. Before blood was screened for evidence of HIV infection and before heat-treating techniques to destroy HIV in blood products were introduced, HIV was transmitted through transfusions of contaminated blood or blood components. Today, because of blood screening and heat treatment, the risk of getting HIV from such transfusions is extremely small.

HIV frequently is spread among injection drug users by the sharing of needles or syringes contaminated with very small quantities of blood from someone infected with the virus. It is rare, however, for a patient to give HIV to a health care worker or vice-versa by accidental sticks with contaminated needles or other medical instruments.

Women can transmit HIV to their babies during pregnancy or birth. Approximately one-quarter to one-third of all untreated pregnant women infected with HIV will pass the infection to their babies. HIV also can be spread to babies through the breast milk of mothers infected with the virus. If the mother takes the drug AZT during pregnancy, she can reduce significantly the chances that her baby will be infected with HIV. If doctors treat mothers with AZT and deliver their babies by cesarean section, the chances of the baby being infected can be reduced to a rate of 1 percent.

A study sponsored by NIAID in Uganda found a highly effective and safe drug regimen for preventing transmission of HIV from an infected mother to her newborn that is more affordable and practical than any other examined to date. Interim results from the study show that a single oral dose of the antiretroviral drug nevirapine (NVP) given to an HIV-infected woman in labor and another to her baby within three days of birth reduces the transmission rate by half compared with a similar short course of AZT.

Although researchers have detected HIV in the saliva of infected individuals, no evidence exists that the virus is spread by contact with saliva. Laboratory studies reveal that saliva has natural properties that limit the power of HIV to infect. Research studies of people infected with HIV have found no evidence that the virus is spread to others through saliva such as by kissing. (Know one knows, however, whether so-called "deep" kissing, involving the exchange of large amounts of saliva, or oral intercourse increase the risk of infection). Scientists also have found no evidence that HIV is spread through sweat, tears, urine, or feces.

Studies of families of HIV-infected people have shown clearly that HIV is not spread through casual contact such as the sharing of food utensils, towels and bedding, swimming pools, telephones, or toilet seats. HIV is not spread by biting insects such as mosquitoes or bedbugs.

HIV can infect anyone who practices risky behaviors such as: sharing drug needles or syringes; having sexual contact with an infected person without using a condom or with someone whose HIV status is unknown.

Having a sexually transmitted disease such as syphilis, genital herpes, chlamydial infection, gonorrhea, or bacterial vaginosis appears to make people more susceptible to acquiring HIV infection during sex with infected partners.

Early Symptoms

Many people do not develop any symptoms when they first become infected with HIV. Some people, however, have a flu-like illness within a month or two after exposure to the virus. This illness may include fever, headache, tiredness, and enlarged lymph nodes (organs of the immune system easily felt in the neck and groin). These symptoms usually disappear within a week to a month and are often mistaken for those of another viral infection.

More persistent or severe symptoms may not surface for a decade or more after HIV first enters the body in adults, or within two years in children born with HIV infection. This period of "asymptomatic" infection is highly individual. Some people may begin to have symptoms as soon as a few months, while others may be symptom-free for more than 10 years. During the asymptomatic period, however, the virus is actively multiplying, infecting, and killing cells of the immune system. HIV's effect is seen most obviously in a decline in the blood levels of CD4+ T cells (also called T4 cells)—the immune system's key infection fighters. At the beginning of its life in the human body, the virus disables or destroys these cells without causing symptoms.

As the immune system deteriorates, a variety of complications start to take over. For many people, their first sign of infection is large lymph nodes or "swollen glands" that may be enlarged for more than three months. Other symptoms, often experienced months to years before the onset of AIDS, include: lack of energy, weight loss, frequent fevers and sweats, persistent or frequent yeast infections (oral or vaginal), persistent skin rashes or flaky skin, pelvic inflammatory disease in women that does not respond to treatment, or short-term memory loss.

Some people develop frequent and severe herpes infections that cause mouth, genital, or anal sores,

or a painful nerve disease called shingles. Children may grow slowly or often be sick.

AIDS

The term AIDS applies to the most advanced stages of HIV infection. Official criteria for the definition of AIDS are developed by CDC in Atlanta, Georgia., which is responsible for tracking the spread of AIDS in the United States.

CDC's definition of AIDS includes all HIV-infected people who have fewer than 200 CD4+ T cells per cubic millimeter of blood. (Healthy adults usually have CD4+ T-cell counts of 1,000 or more.) In addition, the definition includes 26 clinical conditions that affect people with advanced HIV disease. Most of these conditions are opportunistic infections, which rarely cause harm in healthy people. In people with AIDS these infections are often severe and sometimes fatal because the immune system is so ravaged by HIV that the body cannot fight off certain bacteria, viruses, fungi, parasites, and other microbes.

Opportunistic infections common in people with AIDS cause symptoms such as: coughing and shortness of breath, seizures and lack of coordination, difficult or painful swallowing, mental symptoms such as confusion and forgetfulness, severe and persistent diarrhea, vision loss, nausea, abdominal cramps, vomiting, weight loss, extreme fatigue, severe headaches, and coma.

Although children with AIDS may get the same opportunistic infections as adults with the disease, they also experience severe forms of the bacterial infections that all children may get, such as conjunctivitis (pink eye), ear infections, and tonsillitis.

People with AIDS are particularly prone to developing various cancers, especially those caused by viruses such as Kaposi's sarcoma and cervical cancer, or cancers of the immune system known as lymphomas. These cancers are usually more aggressive and difficult to treat in people with AIDS. Signs of Kaposi's sarcoma in light-skinned people are round brown, reddish, or purple spots that develop in the skin or in the mouth. In dark-skinned people, the spots are more pigmented.

Many people are so debilitated by the symptoms of AIDS that they cannot hold steady employment or do household chores. Other people with AIDS may experience phases of intense life-threatening illness followed by phases in which they function normally.

A small number of people (fewer than 50) initially infected with HIV ten or more years ago have not developed symptoms of AIDS. Scientists are trying to determine what factors may account for their lack of progression to AIDS, such as particular characteristics of their immune systems or whether they were infected with a less aggressive strain of the virus or if their genes may protect them from the effects of HIV. Scientists hope that understanding the body's natural method of control may lead to ideas for protective HIV vaccines and use of vaccines to prevent the disease from progressing.

Diagnosis

Because early HIV infection often causes no symptoms, a doctor or other health care worker usually can diagnose it by testing a person's blood for the presence of antibodies (disease-fighting proteins) to HIV. HIV antibodies generally do not reach levels in the blood that the doctor can see until one to three months following infection, and it may take the antibodies as long as six months to be produced in quantities large enough to show up in standard blood tests.

People exposed to the virus should get an HIV test as soon as they are likely to develop antibodies to the virus. By getting tested early, they can get the right treatment at a time when their immune systems are most able to combat HIV and thus prevent the emergence of certain opportunistic infections (see **Treatment** below). Early testing also alerts HIV-infected people to avoid high-risk behaviors that could spread the virus to others.

Doctors diagnose HIV infection by using two different types of antibody tests, ELISA and Western Blot. If a person is highly likely to be infected with HIV and yet both tests are negative, a doctor may look for HIV itself in the blood. The person also may be told to repeat antibody testing at a later date, when antibodies to HIV are more likely to have developed.

Babies born to mothers infected with HIV may or may not be infected with the virus, but all carry their mothers' antibodies to HIV for several months. If these babies lack symptoms, a definitive diagnosis of HIV infection using standard antibody tests cannot be made until after 15 months of age. By then, babies are unlikely to still carry their mothers' antibodies and will have produced their own, if they are infected. New technologies to detect HIV itself are being used to more accurately determine HIV infection in infants between ages 3 months and 15 months. A number of blood tests are being evaluated to determine if they can diagnose HIV infection in babies younger than 3 months.

Treatment

When AIDS first surfaced in the United States, no medicines were available to combat the underlying immune deficiency and few treatments existed for the opportunistic diseases that resulted. Over the past 10 years, however, researchers have developed treatments to fight both HIV infection and its associated infections and cancers.

The Food and Drug Administration has approved a number of drugs for treating HIV infection. The first group of drugs used to treat HIV infection, called nucleoside reverse transcriptase (RT) inhibitors, interrupt an early stage of the virus making copies of itself. Included in this class of drugs (called nucleoside analogs) are AZT (also known as zidovudine or ZDV), ddC (zalcitabine), ddI (dideoxyinosine), d4T (stavudine), and 3TC (lamivudine). These drugs may slow the spread of HIV in the body and delay the onset of opportunistic infections.

More recently, a second class of drugs has been approved for treating HIV infection. These drugs, called protease inhibitors, interrupt virus replication at a later step in its life cycle. They include ritonavir (Norvir), saquinivir (Invirase), indinavir (Crixivan), amprenivir (Agenerase), and nelfinavir (Viracept). Because HIV can become resistant to both classes of drugs, combination treatment using both is necessary to effectively suppress the virus.

The risk of HIV transmission from a pregnant woman to her baby is significantly reduced if she takes AZT during pregnancy, labor, and delivery, and her baby takes it for the first six weeks of life. Currently available antiretroviral drugs do not cure people of HIV infection or AIDS, however, and they all have side effects that can be severe. Some of the nucleoside RT inhibitors may cause a depletion of red or white blood cells, especially when taken in the later stages of the disease. Some may also cause an inflammation of the pancreas and painful nerve damage. Other complications, including lactic acidosis and severe hepatomegaly (enlarged liver) with steatosis (fatty liver) that may result in liver failure and death have also been reported with the use of antiretroviral nucleoside analogs alone or in combination, including AZT, ddI, ddC, 3TC, and abacavir.

The most common side effects associated with protease inhibitors include nausea, diarrhea, and other gastrointestinal symptoms. In addition, protease inhibitors can interact with other drugs resulting in serious side effects.

Researchers have credited highly active antiretroviral therapy, or HAART, as being a major factor in reducing the number of deaths from AIDS in the United States. by 47 percent in 1997. HAART is a combination of several drugs to treat patients. These drugs include reverse transcriptase inhibitors and protease inhibitors. Patients who are newly infected with HIV as well as AIDS patients can take the combination.

HAART is not a cure. The health of HIV and AIDS patients has benefited dramatically by combining protease inhibitors with other AIDS drugs, but there are drawbacks. Also, though HIV may not be found in the patients successfully treated with HAART, researchers know that it is still present, lurking in hiding places such as the lymph nodes, the brain, testes, and the retina of the eye.

A number of drugs are available to help treat opportunistic infections to which people with HIV are especially prone. These drugs include foscarnet and ganciclovir, used to treat cytomegalovirus eye infections, fluconazole to treat yeast and other fungal infections, and rimethopim/sulfamethoxazole (TMP/SMX) or pentamidine to treat *Pneumocystis carinii* pneumeonia (PCP).

In addition to antiretroviral therapy, adults with HIV whose CD4+ T-cell counts drop below 200 are given treatment to prevent the occurrence of PCP, which is one of the most common and deadly opportunistic infections associated with HIV.

Prevention

Because no vaccine for HIV is available, the only way to prevent infection by the virus is to avoid behaviors that put a person at risk of infection, such as sharing needles and having unprotected sex.

Many people infected with HIV have no symptoms. Therefore, there is no way of knowing with certainty whether a sexual partner is infected unless he or she has repeatedly tested negative for the virus and—has not engaged in any risky behavior.

People should either abstain from having sex or use latex condoms, which may offer partial protection, during oral, anal, or vaginal sex. Only condoms made of latex should be used, and water-based lubricants should be used with latex condoms.

Although some laboratory evidence shows that spermicides can kill HIV, researchers have not found that these products can prevent a person from getting HIV.

Research

NIAID-supported investigators are conducting an abundance of research on HIV infection, including the development and testing of HIV vaccines and new therapies for the disease and some of its associated conditions. Twenty-eight HIV vaccines are being tested in people, and many drugs for HIV infection or AIDS-associated opportunistic infections are either being developed or being tested. Researchers also are investigating exactly how HIV damages the immune system. This research is suggesting new and more effective targets for drugs and vaccines. NIAID-supported investigators also continue to trace how the disease progresses in different people.

Scientists are investigating and testing chemical barriers, such as topical microbicides, that people can use in the vagina or in the rectum during sex to prevent HIV transmission. They also are looking at other ways to prevent transmission such as controlling sexually transmitted diseases and modifying people's behavior as well as ways to prevent transmission from mother to child.

Further information is available at http://www.niaid.nih.gov/

The Evidence Linking HIV to AIDS

The following fact sheet, prepared by the U.S National Institute of Allergy and Infectious Diseases(NIAID), a component of the National Institutes of Health, refutes many of the myths surrounding the AIDS epidemic.

MYTH: HIV antibody testing is unreliable.

FACT: Diagnosis of infection using antibody testing is one of the best-established concepts in medicine. HIV antibody tests exceed the performance of most other infectious disease tests in both sensitivity (the ability of the screening test to give a positive finding when the person tested truly has the disease) and specificity (the ability of the test to give a negative finding when the subjects tested are free of the disease under study). Current HIV antibody tests have sensitivity and specificity in excess of 98 percent and are therefore extremely reliable (WHO 1998; Sloand et al. JAMA 1991;266: 2861).

Progress in testing methodology has also enabled detection of viral genetic material, antigens, and the virus itself in body fluids and cells. While not widely used for routine testing due to high cost and requirements in laboratory equipment, these direct testing techniques have confirmed the validity of the antibody tests (Jackson et al. J Clin Microbiol 1990;28:16; Busch et al. NEJM 1991;325:1; Silvester et al. J Acquir Immune Defic Syndr Hum Retrovirol 1995;8:411; Urassa et al. J Clin Virol 1999;14:25; Nkengasong et al. AIDS 1999;13:109; Samdal et al. Clin Diagn Virol 1996;7:55).

MYTH: There is no AIDS in Africa. AIDS is nothing more than a new name for old diseases.

FACT: The diseases that have come to be associated with AIDS in Africa—such as wasting syndrome, diarrheal diseases, and tuberculosis (TB)—have long been severe burdens there. However, high rates of mortality from these diseases, formerly confined to the elderly and malnourished, are now common among HIV-infected young and middle-aged people (UNAIDS, 1999).

For example, in a study in Cote d'Ivoire, HIV-seropositive individuals with pulmonary TB were 17 times more likely to die within six months than HIV-seronegative individuals with pulmonary TB (Ackah et al. Lancet 1995; 345:607). In Malawi, mortality over three years among children who had received recommended childhood immunizations and who survived the first year of life was 9.5 times higher among HIV-seropositive children than among HIV-seronegative children. The leading causes of death were wasting and respiratory conditions (Taha et al. Pediatr Infect Dis J 1999;18:689). Elsewhere in Africa, findings are similar.

MYTH: HIV cannot be the cause of AIDS because researchers are unable to explain precisely how HIV destroys the immune system.

FACT: A great deal is known about the pathogenesis of HIV disease, even though important details remain to be elucidated. However, a complete understanding of the pathogenesis of a disease is not a prerequisite to

knowing its cause. Most infectious agents have been associated with the disease they cause long before their pathogenic mechanisms have been discovered. Because research in pathogenesis is difficult when precise animal models are unavailable, the disease-causing mechanisms in many diseases, including tuberculosis and hepatitis B, are poorly understood. The critics' reasoning would lead to the conclusion that *M. tuberculosis* is not the cause of tuberculosis or that hepatitis B virus is not a cause of liver disease (Evans. Yale J Biol Med 1982;55:193).

MYTH: AZT and other antiretroviral drugs, not HIV, cause AIDS.

FACT: The vast majority of people with AIDS never received antiretroviral drugs, including those in developed countries prior to the licensure of AZT in 1987, and people in developing countries today where very few individuals have access to these medications (UNAIDS, 1999).

As with medications for any serious diseases, antiretroviral drugs can have toxic side effects. However, there is no evidence that antiretroviral drugs cause the severe immunosuppression that typifies AIDS, and abundant evidence that antiretroviral therapy, when used according to established guidelines, can improve the length and quality of life of HIV-infected individuals (Guidelines for the Use of Antiretroviral Agents in HIV-Infected Adults and Adolescents, 2000).

In the 1980s, clinical trials enrolling patients with AIDS found that AZT given as single-drug therapy conferred a modest (and short-lived) survival advantage compared to placebo. Among HIV-infected patients who had not yet developed AIDS, placebo-controlled trials found that AZT given as single-drug therapy delayed, for a year or two, the onset of AIDS-related illnesses. Significantly, long-term follow-up of these trials did not show a prolonged benefit of AZT, but also never indicated that the drug increased disease progression or mortality. The lack of excess AIDS cases and death in the AZT arms of these placebo-controlled trials effectively counters the argument that AZT causes AIDS (NIAID, 1995).

Subsequent clinical trials found that patients receiving two-drug combinations had up to 50 percent increases in time to progression to AIDS and in survival when compared to people receiving single-drug therapy. In more recent years, three-drug combination therapies have produced another 50 percent to 80 percent improvement in progression to AIDS and in survival when compared to two-drug regimens in clinical trials (Deeks, Volberding, 1999). Use of potent anti-HIV combination therapies has contributed to dramatic reductions in the incidence of AIDS and AIDS-related deaths in populations where these drugs are widely available, an effect which clearly would not be seen if antiretroviral drugs caused AIDS (Figure 1; CDC. HIV AIDS Surveillance Report 1999;11[2]:1; CDC MMWR 1999;48:1; Palella et al. NEJM 1998;338:853; Mocroft et al. Lancet 1998;352:1725; Vittinghoff et al. J Infect Dis 1999;179:717; Detels et al. JAMA 1998;280:1497).

MYTH: Behavioral factors such as recreational drug use and multiple sexual partners account for AIDS.

FACT: The proposed behavioral causes of AIDS, such as multiple sexual partners and long-term recreational drug use, have existed for many years. The epidemic of AIDS, characterized by the occurrence of formerly rare opportunistic infections such as Pneumocystis carinii pneumonia (PCP), did not occur in the United States until a previously unknown human retrovirus—HIV—spread through certain communities (NIAID, 1995a; NIAID, 1995b).

Compelling evidence against the hypothesis that behavioral factors cause AIDS comes from recent studies that have followed cohorts of homosexual men for long periods of time and found that only HIV-seropositive men develop AIDS.

In a prospectively studied cohort in Vancouver, 715 homosexual men were followed for a median of 8.6 years. Among 365 HIV-positive individuals, 136 developed AIDS. No AIDS-defining illnesses occurred among 350 seronegative men despite the fact that these men reported appreciable use of inhalable nitrites ("poppers") and other recreational drugs, and frequent receptive anal intercourse (Schechter et al. Lancet 1993;341:658).

Other studies show that among homosexual men and injection-drug users, the specific immune deficit that leads to AIDS—a progressive and sustained loss of CD4+ T cells—is extremely rare in the absence of other immunosuppressive conditions. For example, in the Multicenter AIDS Cohort Study, more than 22,000 T-cell determinations in 2,713 HIV-seronegative homosexual men revealed only one individual with a CD4+ T-cell count persistently lower than 300 cells per cubic millimeter (mm3) of blood, and this individual was receiving immunosuppressive therapy (Vermund et al. NEJM 1993;328:442).

In a survey of 229 HIV-seronegative injection-drug users in New York City, mean CD4+ T-cell counts of the group were consistently more than 1000 cells/mm3 of blood. Only two individuals had two CD4+ T-cell measurements of less than 300/mm3 of blood, one of whom died with cardiac disease and non-Hodgkin's lymphoma listed as the cause of death (Des Jarlais et al. J Acquir Immune Defic Syndr 1993;6:820).

MYTH: AIDS among transfusion recipients is due to underlying diseases that necessitated the transfusion, rather than to HIV.

FACT: This notion is contradicted by a report by the U.S. Transfusion Safety Study Group (TSSG), which compared HIV-negative and HIV-positive blood recipients who had been given transfusions for similar diseases. Approximately three years after the transfusion, the mean CD4+ T-cell count in 64 HIV-negative recipients was 850/mm3 of blood, while 111 HIV-seropositive individuals had average CD4+ T-cell counts of 375/mm3 of blood. By 1993, there were 37 cases of AIDS in the HIV-infected group, but not a single AIDS-defining illness in the HIV-seronegative transfusion recipients (Donegan et al. Ann Intern Med 1990;113:733; Cohen. Science 1994;266:1645).

MYTH: High usage of clotting factor concentrate, not HIV, leads to CD4+ T-cell depletion and AIDS in hemophiliacs.

FACT: This view is contradicted by many studies. For example, among HIV-seronegative patients with hemophilia A enrolled in the Transfusion Safety Study, no significant differences in CD4+ T-cell counts were noted between 79 patients with no or minimal factor treatment and 52 with the largest amount of lifetime treatments. Patients in both groups had CD4+ T cell-counts within the normal range (Hasset et al. Blood 1993;82:1351). In another report from the Transfusion Safety Study, no instances of AIDS-defining illnesses were seen among 402 HIV-seronegative hemophiliacs who had received factor therapy (Aledort et al. NEJM 1993;328:1128).

In a cohort in the United Kingdom, researchers matched 17 HIV-seropositive hemophiliacs with 17 HIV-seronegative hemophiliacs with regard to clotting factor concentrate usage over a 10-year period. During this time, 16 AIDS-defining clinical events occurred in nine patients, all of whom were HIV-seropositive. No AIDS-defining illnesses occurred among the HIV-negative patients. In each pair, the mean CD4+ T cell count during follow-up was, on average, 500 cells/mm3 lower in the HIV-seropositive patient (Sabin et al. BMJ 1996;312:207).

Among HIV-infected hemophiliacs, Transfusion Safety Study investigators found that neither the purity nor the amount of Factor VIII therapy had a deleterious effect on CD4+ T cell counts (Gjerset et al., Blood 1994;84:1666). Similarly, the Multicenter Hemophilia Cohort Study found no association between the cumulative dose of plasma concentrate and incidence of AIDS among HIV-infected hemophiliacs (Goedert et al. NEJM 1989;321:1141).

MYTH: The distribution of AIDS cases casts doubt on HIV as the cause. Viruses are not gender-specific, yet only a small proportion of AIDS cases are among women.

FACT: The distribution of AIDS cases, whether in the United States or elsewhere in the world, invariably mirrors the prevalence of HIV in a population. In the United States, HIV first appeared in populations of homosexual men and injection-drug users, a majority of whom are male. Because HIV is spread primarily through sex or by the exchange of HIV-contaminated needles during injection-drug use, it is not surprising that a majority of U.S. AIDS cases have occurred in men (U.S. Census Bureau, 1999; UNAIDS, 1999).

Increasingly, however, women in the United States are becoming HIV-infected, usually through the exchange of HIV-contaminated needles or sex with an HIV-infected male. The Centers for Disease Control (CDC) estimates that 30 percent of new HIV infections in the United States in 1998 were in women. As the number of HIV-infected women has risen, so too has the number of female AIDS patients in the United States. Approximately 23 percent of U.S. adult/adolescent AIDS cases reported to the CDC in 1998 were among women. In 1998, AIDS was the fifth leading cause of death among women aged 25 to 44 in the United States, and the third leading cause of death among African-American women in that age group (NIAID Fact Sheet: HIV/AIDS Statistics).

In Africa, HIV was first recognized in sexually active heterosexuals, and AIDS cases in Africa have occurred at least as frequently in women as in men. Overall, the worldwide distribution of HIV infection and AIDS between men and women is approximately one to one (U.S. Census Bureau, 1999; UNAIDS, 1999).

MYTH: HIV cannot be the cause of AIDS because the body develops a vigorous antibody response to the virus.

FACT: This reasoning ignores numerous examples of viruses other than HIV that can be pathogenic after evidence of immunity appears. Measles virus may persist for years in brain cells, eventually causing a chronic neurologic disease despite the presence of antibodies. Viruses such as cytomegalovirus, herpes simplex, and varicella zoster may be activated after years of latency even in the presence of abundant antibodies. In animals, viral relatives of HIV with long and variable latency periods, such as visna virus in sheep, cause central nervous system damage even after the production of antibodies (NIAID, 1995).

Also, HIV is well recognized as being able to mutate to avoid the ongoing immune response of the host (Levy. Microbiol Rev 1993;57:183).

MYTH: Only a small number of CD4+ T cells are infected by HIV, not enough to damage the immune system.

FACT: New techniques such as the polymerase chain reaction (PCR) have enabled scientists to demonstrate that a much larger proportion of CD4+ T cells are infected than previously realized, particularly in lymphoid tissues. Macrophages and other cell types are also infected with HIV and serve as reservoirs for the virus. Although the fraction of CD4+ T cells that is infected with HIV at any given time is never extremely high (only a small subset of activated cells serve as ideal targets of infection), several groups have shown that rapid cycles of death of infected cells and infection of new target cells occur throughout the course of disease (Richman J Clin Invest 2000;105:565).

MYTH: HIV is not the cause of AIDS because many individuals with HIV have not developed AIDS.

FACT: HIV disease has a prolonged and variable course. The median period of time between infection with HIV and the onset of clinically apparent disease is approximately 10 years in industrialized countries, according to prospective studies of homosexual men in which dates of seroconversion are known. Similar estimates of asymptomatic periods have been made for HIV-infected blood-transfusion recipients, injection-drug users, and adult hemophiliacs (Alcabes et al. Epidemiol Rev 1993;15:303).

As with many diseases, a number of factors can influence the course of HIV disease. Factors such as age or genetic differences between individuals, the level of virulence of the individual strain of virus, as well as exogenous influences such as co-infection with other microbes may determine the rate and severity of HIV disease expression. Similarly, some people infected with hepatitis B, for example, show no symptoms or only jaundice and clear their infection, while others suffer disease ranging from chronic liver inflammation to cirrhosis and hepatocellular carcinoma. Co-factors probably also determine why some smokers develop lung cancer while others do not (Evans. Yale J Biol Med 1982;55:193; Levy. Microbiol Rev 1993;57:183; Fauci. Nature 1996;384:529).

MYTH: Some people have many symptoms associated with AIDS but do not have HIV infection.

FACT: Most AIDS symptoms result from the development of opportunistic infections and cancers associated with severe immunosuppression secondary to HIV.

However, immunosuppression has many other potential causes. Individuals who take glucocorticoids and/or immunosuppressive drugs to prevent transplant rejection or for autoimmune diseases can have increased susceptibility to unusual infections, as do individuals with certain genetic conditions, severe malnutrition, and certain kinds of cancers. There is no evidence suggesting that the numbers of such cases have risen, while abundant epidemiologic evidence shows a staggering rise in cases of immunosuppression among individuals who share one characteristic: HIV infection (NIAID, 1995; UNAIDS, 1999).

MYTH: The spectrum of AIDS-related infections seen in different populations proves that AIDS is actually many diseases not caused by HIV.

FACT: The diseases associated with AIDS, such as PCP and Mycobacterium avium complex (MAC), are not caused by HIV but rather result from the immunosuppression caused by HIV disease. As the immune system of an HIV-infected individual weakens, he or she becomes susceptible to the particular viral, fungal, and bacterial infections common in the community. For example, HIV-infected people in certain Midwestern and mid-Atlantic regions are much more likely than people in New York City to develop histoplasmosis, which is caused by a fungus. A person in Africa is exposed to different pathogens than is an individual in an American city. Children may be exposed to different infectious agents than adults (AIDS Knowledge Base, 1999a; 1999b).

An expanded version of this fact sheet is available on the NIAID website www.niaid.nih.gov/factsheets/evidhiv.htm

NIAID, a component of the National Institutes of Health (NIH), supports research on AIDS, tuberculosis, malaria, and other infectious diseases, as well as allergies and immunology. NIH is an agency of the U.S. Department of Health and Human Services.

additional resources

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Selected Internet Resources

XIII International AIDS Conference
July 9-July 14, 2000, Durban, South Africa.
http://www.aids2000.com/

AIDS Education Global Information System
The AIDS Education Global Information System (AEGIS) offers news, clinical information, a law library, and other features. Maintained by the Sisters of Saint Elizabeth of Hungary.
http://www.aegis.com/

AIDS Knowledge Base
This 1999 textbook on HIV disease in adults is from the University of California, San Francisco, and the San Francisco General Hospital.
http://hivinsite.ucsf.edu/akb/1997/about.html

Best of the Net
Links to HIV/AIDS programs and organizations in various countries selected by editorial reviewers from "Best of the Net" section of the "Journal of the American Medical Association," HIV/AIDS Information Center.
http://www.ama-assn.org/special/hiv/bestonet/global.htm

The Body: An AIDS and HIV Information Resource
This service of the Body Health Resources Corporation is sponsored in part by several pharmaceutical companies, and provides information in over 250 topical areas.
http://www.thebody.com/

CDC Network
The National Prevention Information Network (NPIN) is a reference, referral, and distribution service for information on HIV/AIDS, sexually transmitted diseases, and tuberculosis, sponsored by the U.S. Centers for Disease Control and Prevention.
http://www.cdcnpin.org/

The Deadliest Epidemic: AIDS in Africa
A collection of news articles and links compiled by the Washington Post.
http://www.washingtonpost.com/wp-dyn/world/issues/aidsinafrica/

Guide to NIH HIV/AIDS Information Services
Prepared by the National Library of Medicine, this is a guide to the many HIV/AIDS programs of the National Institutes of Health, with selected public health service activities.
http://www.sis.nlm.nih.gov/aids/

HIV/AIDS
Information about development programs to combat HIV/AIDS and infectious diseases from the U.S. Agency for International Development (USAID).
http://www.info.usaid.gov/pop_health/aids/

HIV/AIDS
The World Health Organization (W.H.O.) provides information on its work combating HIV/AIDS and sexually transmitted infections.
http://www.who.int/health-topics/hiv.htm

HIV/AIDS—A Guide to Resources
Policy texts and annotated links to U.S. and international resources concerning AIDS and other infectious diseases. From the Office of International Information Programs, U.S. Department of State.
http://usinfo.state.gov/topical/global/hiv/

HIV/AIDS Treatment Information Service (ATIS)
Coordinated by the U.S. Department of Health and Human Services, ATIS provides information in English and Spanish about federally approved treatment guidelines for HIV and AIDS.
http://www.hivatis.org/

HIV/AIDS and the World of Work
Information on the impact of HIV/AIDS on work, productivity, employment, and development. Maintained by the International Labor Organization.
http://www.ilo.org/public/english/protection/trav/aids/

National Institute of Allergy and Infectious Diseases
The Division of Acquired Immunodeficiency Syndrome (DAIDS) provides information on AIDS vaccine research, clinical trials, and DAIDS-supported programs.
http://www.niaid.nih.gov/research/Daids.htm

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The homepage of the Joint United Nations Programme on HIV/AIDS provides documents on the World AIDS Campaign, and information on international conferences on AIDS.
http://www.unaids.org/

White House Office of National AIDS Policy
Information on efforts by the Clinton/Gore administration to address the national and international AIDS pandemic. Provides links to government and non-government sites.
http://www.whitehouse.gov/ONAP/