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Women and HIV/AIDS
“Global Leadership Network and Dialogue on HIV/AIDS”
12th World AIDS Conference, Geneva

Satellite Session Sponsored by
U.S. Department of Health and Human Services

Co-hosted by
UNAIDS (Switzerland) and The National AIDS Fund (USA)

Tuesday, June 30, 1998 – Thursday, July 2, 1998

Draft Meeting Summary

Part I:

Tuesday, June 30, 1998

Women and HIV/AIDS: An Update

Co-chairs:

Eka Esu-Williams, Senegal
Purnima Mane, Switzerland

Speakers:

Helene Gayle, USA
Geeta Rao Gupta, USA
Joanne Manchester, United Kingdom
Annelise De Salazar, Guatemala

Speakers raised a number of urgent issues that impact women who are infected with and affected by HIV/AIDS. They also identified and provided participants with specific issues that need to be addressed in order to advance the agenda on women and HIV/AIDS.

These included:

Social and Cultural Issues

1. Lower socioeconomic status and sociocultural norms that result in the subordinate status of women
2. Domestic violence and attendant stigmatization
3. Overarching poverty, gender inequity and the additional burden that the HIV/AIDS pandemic places on women.

4. Protection of basic human rights

Prevention and Care Issues

1. Lack of woman controlled methods for prevention
2. Role and responsibility of men in preventing HIV infection among women
3. Lack of culturally sensitive and culturally appropriate information about HIV/AIDS.
4. Lack of reproductive health care and services, including STD prevention and treatment

Support for HIV Positive Women

1. Lack of safe peer support opportunities for positive women
2. Need to enhance community based treatment and support services for women

Speakers provided updates on women and HIV/AIDS in North America, Latin-America, Europe, Asia and Africa. It was noted that around the world, the nature and impact of HIV infection has dramatically altered the context for women's lives. The new context requires that women inevitably must be caregivers for their partners,

children, friends, other family members and, lastly, themselves. Of all recent HIV infections worldwide, 41% are women. As women become increasingly infected with and affected by HIV/AIDS, the question that must be asked is "Who will take care of the woman when she gets sick? Women will move mountains for their children and loved ones. But who will move it for them when they are sick and dying?"

Issues Raised

- Low socioeconomic status across all societies
- Lack or limited education and knowledge of rights
- Limited access to care, particularly health and mental health
- Social norms that limit women's discussion regarding sex and ability to negotiate with partners
- Low self-esteem issues
- Limited access to information due to isolation within relationship or/and geographical location
- Subordination of women's concerns and opinions within heterosexual relationships
- Heightened vulnerability to STDs
- Focus on pregnancy, child-rearing issues and children's health at the expense of women's health needs
- Lack of sensitivity to women's health needs by medical professionals in the role as a pre-HIV caregiver and reluctance to provide positive women with comprehensive information and care
- The medical professionals often provide medications to men and children first and women last.
- Young women are increasingly infected and lack negotiation skills with partners especially, older men

Part II:

Wednesday, July 1, 1998

Women and HIV/AIDS: Public Health Interventions

Co-chairs:

Suki Ports, USA

Noerine Kaleeba, Switzerland

Speakers:

Beri Hull, USA

Edith White, USA

Zeda Rosenberg, USA

Marina Mahathier, Malaysia

Speakers provided insight into three specific issue areas. These included: substance use including alcohol and drugs, breastfeeding, and the critical need for woman controlled prevention methods. Additionally, the unique role that culture plays in the capacity of women, specifically in Asia, to speak for themselves and on behalf of women infected by HIV was highlighted. Several participants raised similar issues for Africa, Latin and South America.

Issues Raised

Substance Use

- Under certain circumstances, some women who use drugs may trade sex for drugs. Drugs may increase the likelihood of seroconversion.
- How do HIV medications impact other illnesses? For example, does antiretroviral therapy affect the progression of Hepatitis C?

Breastfeeding

- The best way to prevent transmission of HIV to infants is to prevent HIV infection in women and to keep women safe from infection. However, there are many pregnant women and mothers living with HIV/AIDS and

therefore careful consideration must be given to supporting their ability to feed and care for their children.

- The 1992 European Collaboration study compared bottle-fed infants to breast fed infants born to HIV positive mothers. Fourteen (14%) percent of bottle-fed infants were found to be HIV infected while 32% of breast fed infants were infected.
- A similar study in Brazil found that 19% of bottle-fed babies were infected, whereas, 49% of breast-fed babies were infected.
- Concerns have been raised which suggest that bottle-feeding is not safe. Yet a study in Soweto demonstrated that there were few adverse effects on bottle-fed babies, including no change in weight, increase in diarrhea or amount of hospitalizations.
- Breastfeeding issues in the United States must be explored in the context of HIV/AIDS.

Microbicides:

Topical microbicides are chemical barriers that women can apply topically to inhibit HIV infection.

- Although none have been shown to be effective now, microbicides are needed due to the high prevalence of non-consensual sex, lack of condom use and need for reproductive choices.
- A new formulation of nonoxynol-9 (a potential microbicide which is spermicidal) is in later stages of efficacy testing against HIV while other products are still in early development and testing. It is unlikely that a new product will be available for women to use in the next 3-5 years even if after products now being tested are demonstrated to be safe and effective.
- Women need products, which can be formulated to allow conception,

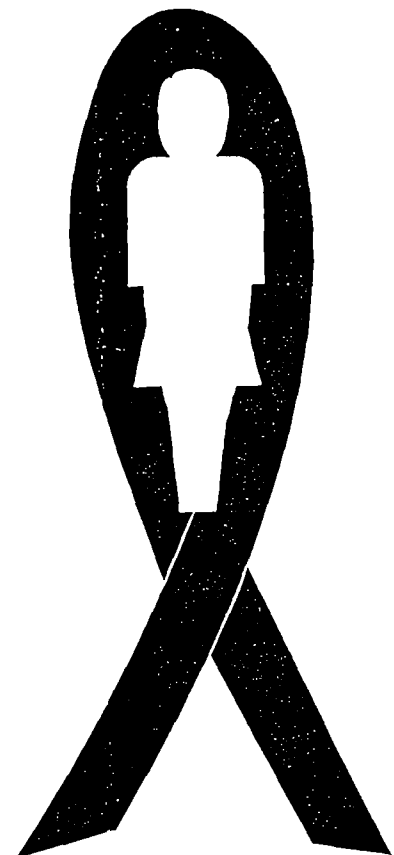
while preventing infection with HIV and other STDs.

- Other female controlled methods are needed. A comprehensive prevention strategy to reduce HIV or other STDs should include how the female condom or cervical cap might be utilized.

Women and Asia

The voices of Asian women are not always heard. Many Asian women face cultural barriers, which limit their ability to speak openly about HIV/AIDS, STDs and sexuality in general. These problems are compounded when women are poor, lack education and are culturally socialized to place others' needs above their own.

- Due to the vast differences and distances between peoples of Asia, situations vary greatly within and between each country. Therefore, individualized national strategic approaches will be necessary to address specific population needs.



Part 3:**Thursday, July 2, 1998****Women and HIV/AIDS: Clinical Strategies and Community Interventions****Co-Chairs:**

Miguelina Maldonado, USA

Awa Coll-Seck, Switzerland

Speakers:

Mercy Makhaemmer, South Africa

Sophia Mukaso Monico, Uganda

Bai Bagasao, Switzerland,

Mabel Bianco, Argentina

The discussion focused on clinical strategies and intervention for positive women and women who are affected by HIV/AIDS. The session highlighted issues that prevent countries from designing effective policies to improve the lives of women who are infected with and affected by HIV/AIDS. Speakers discussed model programs within their countries that are working to address this pandemic. In addition, issues such as religion, machismo, cultural norms and the challenge of providing information in the various languages were discussed.

Issues Raised

- In most parts of the developing world, especially in sub-Saharan Africa, women must travel long hours to receive care, sometimes when they arrive at the clinic or hospital is already closed and they must return home untreated. In addition, economic crises place a greater burden on local public health care systems. Consequently, women may not receive necessary care because of scarce resources or long waiting times.
- Women have limited access to gynecologic care and often have to wait long periods to receive routine

gynecologic care, including regular Pap smears.

- Women in rural areas are not benefiting from results of clinical trials and studies. Participants in trials do not have access to care or antiretroviral therapy after trials have been completed. Ethical issues raised by women in these trials must be considered.
- Many women give birth at home and many die because of lack of hospital obstetric services.
- Rape, physical abuse and everyday dangers unfortunately continue to be an ever-existing part of women's lives.
- Older women are increasingly becoming infected and their issues are often ignored.
- Many women are denied basic health care by providers if it is known that they are HIV positive.
- The epidemic started later in Asia but is rapidly spreading. It is estimated that by 2000, 50% of new HIV infections will be in this region. Asia has one-half of the world's population. Therefore, even small percentage increases in rates of HIV infection have a great impact on the number of persons infected and, therefore, on demands for available services.
- Triple combination therapies are the gold standard, and this is not available for women in many places in the world. Even when women have access to triple therapy, challenges for continuing therapy persist. They included:
 1. Women are not socialized to place their health care needs before that of their partners and children
 2. Lack of urgency and commitment on women's health issues
 3. Structural issues, including human rights, economic development and gender

inequities impede the promotion of women's health

4. The political, social and health systems are male dominated and may not be responsive to women's special needs.
- Globally, women lack of basic health care, especially prenatal care and family planning services, leads to many preventable maternal deaths.
- Societal norms which promote the sexual subordination of women and limit access to basic sexual information increase women's vulnerability to HIV infection. This vulnerability is pronounced among young women because they are not yet aware of these issues.
- Lack of family planning results in unintended pregnancies, and thereby increasing the number of unsafe abortions. Such abortions are especially problematic for HIV positive women.
- Women face multiple layers of discrimination, based on gender, class and HIV status.
- There are vast unmet needs for prenatal care, beyond the need for antiretroviral therapy among pregnant women.
- Adolescent male and females may lack skills to discuss their sexuality, sexual roles and expectations of society
- Meeting basic needs including clean water for women must be addressed with alternatives to breastfeeding for positive women.
- Adolescent women are at increased risk of HIV infection because of biology and older male partners. Young people in general need to be the focus on special prevention efforts.

Part 4:

Building the Bridge over the Gap

Thursday, July 2, 1998

Opening remarks:

Marsha Martin, USA

Helene Gayle, USA

B.J. Stiles, USA

Co-chairs:

Susan F. Wood, USA

Sally Cowal, Switzerland

Speakers:

Judith Billings, USA

Marj Plumb, USA

Elaine M. Daniels, USA

Elba Montalvo, USA

Griselda Hernandez Tepichin, Mexico

Suzana Murni, Indonesia

Sandra Thurman, USA

Nkandu Luo, Zambia

Countess Albina Du Boisrouvray

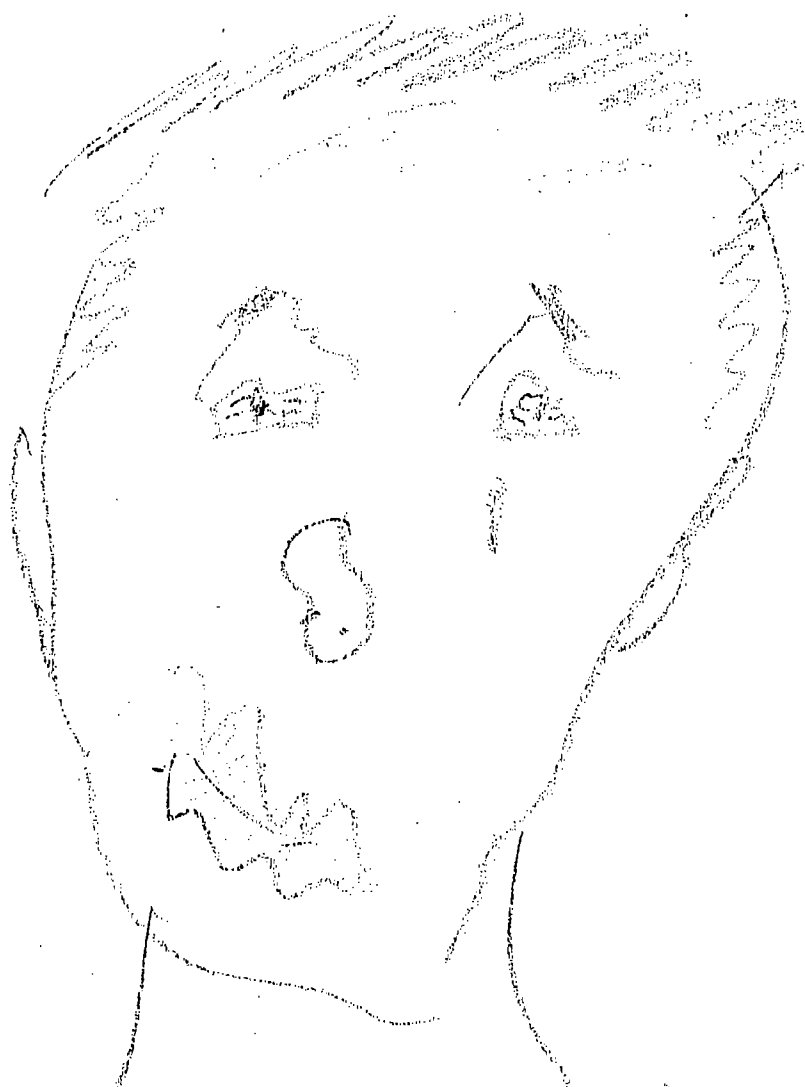
Kate Shindle, USA

Eric Goosby, USA

Collaboration is important in addressing both common and individualized concerns for women when addressing HIV/AIDS issues. Such collaborations should include the public and private sectors, the media, non-governmental organizations, decision-makers and positive women. The speakers raised a number of new issues. These included:

- The need for high level governmental leadership on women and HIV/AIDS issues
- Strategic plans can address specialized concerns for countries. Such plans can include a multi-sectoral response to women and HIV/AIDS issues.
- The resources and long-term commitment of the private sectors are essential in order to adequately address HIV/AIDS issues among women.
- Special populations of women should not be ignored when addressing women and HIV/AIDS issues. This includes rural women, older women, lesbians and other women who have sex with women.

End Notes and Recommendations



***Ad hoc thematic meeting of the
Programme Coordinating Board
Nairobi, 16-18 November 1997***



UNAIDS

UNICEF • UNDP • UNFPA
UNESCO • WHO • WORLD BANK

**Joint United Nations
Programme on HIV/AIDS**

20, avenue Appia
CH-1211 Geneva 27 • Switzerland
Tel: (+4122) 791.3666
Fax: (+4122) 791.4187
e-mail: UNAIDS@UNAIDS.ORG
<http://www.unaids.org>

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DISCOVER THE AFRICAN
PARADISE



**Safari Park Hotel
& Casino**

Nairobi

■ INTERNATIONAL JAMBO CONFERENCE CENTRE

State of the art equipment and multilingual
Translation facilities.

■ CAPACITY

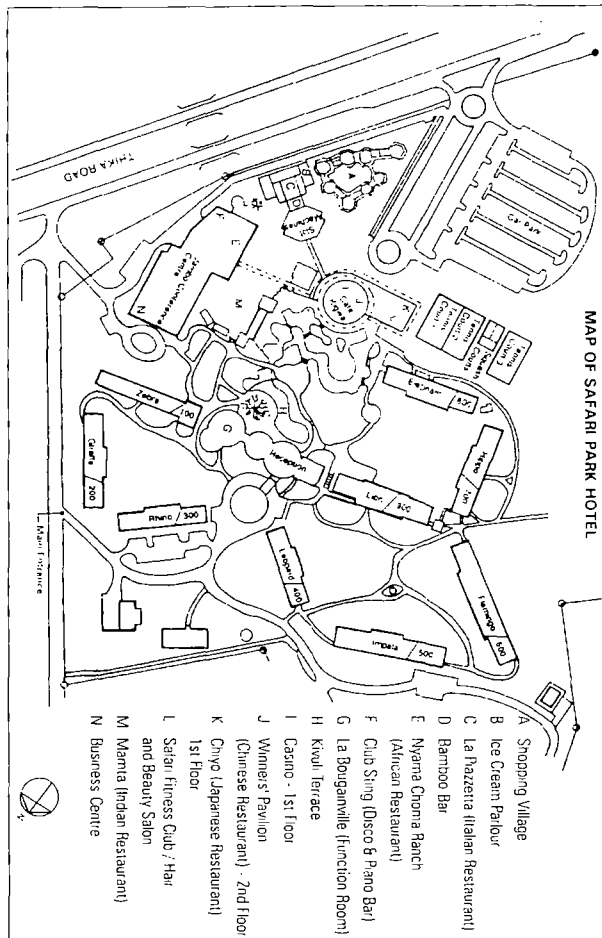
Reception	upto	1500 persons
Theatre Style	upto	1000 persons
Class Room	upto	700 persons
Banquet-Round		
Tables	upto	550 persons
Lion Club		20 persons
Cub Room		20 persons
Mt. Kenya, A,B,C & D Meeting Rooms		
Reception		30
Theatre Style		30
Class Room		20

OPEN AIR THEATRES

Nyama Choma Ranch 3000 persons

■ BUSINESS FACILITIES

Fully equipped; Business centre with
Secretarial services.



**Safari Park Hotel
& Casino**
Nairobi

P.O. Box 45038, Nairobi, Kenya
Tel: 254 - 2 - 802493; 862222 Fax: 254 - 2 - 802477
Tlx: 22114 SAFAROK

Town Office at Kimathi House
Tel: 254 - 2 - 216070; Fax: 254 - 2 - 217677

FACT SHEET



**Safari Park Hotel
& Casino**
Nairobi

■ LOCATION

Nairobi, Thika Road. 15 minutes from City Centre, 30 minutes by car from Nairobi's National Park and 20 minutes from Jomo Kenyatta International Airport.

■ GENERAL INFORMATION

INTERNATIONAL RATING

Five Star Deluxe of two storey buildings beautifully spread over 64 acres of landscaped gardens.

OWNING COMPANY

Paradise Group International, Inc.

■ ACCOMMODATION

204 Rooms consisting of:

- 83 Luxury ensuite twin/double rooms
- 85 Luxury ensuite double rooms
- 19 Deluxe Suites
- 8 Business Suites
- 6 Executive Suites
- 1 Japanese Suite
- 1 Korean Suite
- 1 Presidential Suite

All rooms with individual balcony overlooking the gardens

■ CHECK - OUT TIME

10.00 a.m.

■ TRANSPORT

Free Shuttle bus to and from the city centre.

■ RESTAURANTS & BARS

Café Kigwa	International	24 hours
Nyama Choma		
Ranch	African	1930 - 2300
Chiyo	Japanese	1930 - 2300
Winner's		
Pavilion	Chinese	1930 - 2300
La Piazzetta	Italian	1200 - 1500
		1930 - 2300
Mamta	Indian	1930 - 2300
Hemingways	Cocktail Bar	1100 - 2300
Bamboo Bar		1200 - 0300
Piano Bar		1900 - 0200
Swimming Pool		
Deck	Snacks	0900 - 1800

(Restaurants open 7 days a week)

■ ROOM SERVICE

24 hours

■ IN-ROOM AMENITIES

Refrigerated minibar
Television with CNN, Super Sport, MNET,
Movie Magic, KTN, KBC and inhouse video
Same day laundry service, 7 days a week

■ NIGHT LIFE

- Club Sting Discothèque
- Casino Paradise — American Roulette, Black Jack, Pontoon
- King Solomon's Mine
200 Computerised Slot Machines

■ HEALTH

Safari Fitness Club - Jacuzzis, Saunas, Steam Baths, Gymnasium, Aerobics Studio

■ RECREATION

- 2000 sq mt tropical swimming pool (the largest in Africa)
- One other swimming pool
- 3 tennis courts - 2 flood lit
- 2 squash courts
- 5 top quality, 18 hole golf courses nearby (10 mins by car)
- Horse riding

■ SHOPS

A total of 14 shops such as bookshops, African Carvings, Jewellers, Curio Shop, Boutique, Children's Handcrafted Toys, Gift Items

■ GUEST SERVICES

- Guest Relations Desk • Safari Car Rental / Sightseeing tours • 24 hour taxi service • Parking for over 300 cars

USAIDU.S. Agency For International Development
Washington, D.C. 20523

FACSIMILE TRANSMITTAL COVER SHEET

DATE: 1/7

TO:

ATTENTION:

Alex Ross

ORGANIZATION:

AFR/SO

FAX PHONE:

703 235 4466

OFFICE PHONE:

FROM:

ORIGINATOR:

Paul Delay

ORGANIZATION: USAID/WASHINGTON

G/PHN/HN/HIV-AIDS HIV-AIDS

FAX PHONE:

(202) 216-3045
(202) 216-3404

OFFICE PHONE:

SUBJECT:

BNC

NUMBER OF PAGES (including this cover sheet):

7

COMMENTS:

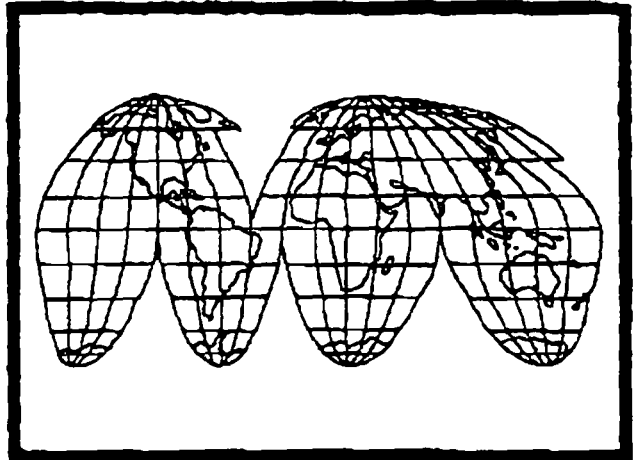
For Alex Ross

703 235 4466

FROM:

Isabel Ellis
Program Analyst
Health & Human Resources
Analysis for Africa
(HRRAA) Program
Office of International
& Refugee Health

Office of Public Health
and Science
Office of the Secretary
Department of Health & Human
Services



OFFICE OF INTERNATIONAL HEALTH

Room 18-75 Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20857

Adminis. Assist. (Ms. Jeffers) 301.443.4010
After Hours Voice Mail 301.443.7304
Email: iellis@osophs.dhhs.gov

TO: Dr. P. DelayFAX NUMBER: 202 216 3046DATE: 01/06/99 NUMBER OF PAGES: 1 includes fax cover

- "attached documents" in Nov. 5 memo refer to what was submitted ~~is~~ to our office for the July 97 briefing booklet
- specifically need update on activities since July 97 BNC, as well as what you'd like to bring to the table for upcoming health component for BNC, Feb 25 '98 in SAfr.



DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of the Secretary

Office of Public Health and Science
Office of International and Refugee Health

Memorandum

NOV 5 1997

To: Addressees

From: Associate Director for Development Support and African Affairs

Subject: Next U.S.-S.A. Binational Commission Meeting

The Office of International and Refugee Health (OIRH) is in the planning stages of the next U.S.-SA Binational Commission (BNC) meeting for the Health Working Group (HWG) which is tentatively scheduled to take place during February-March 1998 in Pretoria. Therefore, we would like to be duly prepared in advance of the holiday season and the possibility of a meeting date change.

As a first step in this process, it is requested that the attached documents be updated to reflect recent activities in your area of participation, as well as proposed activities that will be part of the continuing dialogue with our South African counterparts. It would be most helpful if your inclusions are detailed and succinct given the tremendous amount of reading materials we anticipate in HWG pre-meeting preparation and meeting discussions.

It is suggested that these documents be forwarded back with corrections and additions by December 1, 1997. If there are considerable document changes, your assistance in providing documents on either on a WordPerfect compatible diskette or by e-mail would hasten the work ahead.

Please forward documents to Isabel Ellis, Program Analyst, in OIRH. Ms. Ellis can be reached at phone # 301-443-4010; FAX 301-443-4549. Her e-mail address is: IELLIS@OSOPHS.DHHS.GOV. Thank you for your early cooperation in this important process. Do not hesitate to share and circulate these documents among you colleagues for possible additional comments.

A handwritten signature in black ink, appearing to read "Roscoe M. Moore, Jr.", is written over a horizontal line.

Roscoe M. Moore, Jr., D.V.M., Ph.D., D.Sc.

cc: Linda Vogel

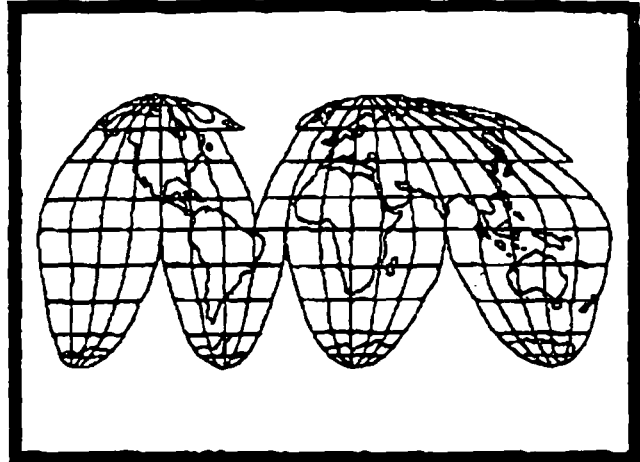
Addressees:

Ms. Michele Chang
Dr. Lloyd Kolbe
Dr. Faye Calhoun
Dr. Pat Needle
Dr. Kenneth Lutterman
Mr. Ted Meinhardt
Ms. Linda Staheli
Dr. Paul Delay
Dr. Jim LeDuc
Dr. Karl Western
Dr. Helene Gayle
Dr. Rodney Hammond
Dr. Dena Puskin
Dr. Elliot Siegel
Dr. Ed Baker

FROM:

Isabel Ellis
Program Analyst
Health & Human Resources
Analysis for Africa
(HRRAA) Program
Office of International
& Refugee Health

Office of Public Health
and Science
Office of the Secretary
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After Hours Voice Mail 301.443.7304
Email: iellis@osophs.dhhs.gov

TO: _____

FAX NUMBER: (202) 216 3046

DATE: _____ NUMBER OF PAGES: _____ : includes fax cover

TO: Dr. Paul DeLay
re: Faxed info re: HIV/AIDS
(from CDC)

Isabel please find below additions to your document which should be inserted after the paragraph on HIV/AIDS Prevention Activities:

HIV/AIDS AND STDs

The south African side made a presentation on the current situation in the country. Based on the results of the antenatal surveys the highest rate of HIV infection is among the 20-29 year old population. There has been a predictable exponential growth in the epidemic.

A contract has just been awarded to MRC to establish a national surveillance program for HIV. Mother-to-child transmission is a serious problem. It has been estimated that South Africa will have 2.75 million infected people and 250,000 AIDS orphans by the year 2000. Additional, the problem is exacerbated by 4 million episodes of STDs each year.

Recent Activities/Progress:

- The joint review of the HIV/AIDS/ STDs program was just completed.
- USAID has committed \$10 million for a five year project. This will be announced at the BNC Meeting

Future Activities:

Activity areas were identified from amongst the preliminary recommendations from the National STD/HIV/AIDS Review. These are:

- Capacity building at a number of levels, including training of health workers in the public and private sectors.
- Facilitate the integration of TB and HIV/AIDS programmes.
- Improve public and private sector management of major risk factors for HIV transmission such as STD treatment, partner notification, promotion of the use of barrier methods and counseling.
- Support for advocacy activities to promote a multi sectoral response to the epidemic.
- Establish a programmes of community mobilization.

Recognizing the USAID support for the foregoing might not be available for several months, the following potential bridging activities were suggested.

- Expansion of the periodic presumptive treatment of STDs in women at high risk

in the Welkom area of the Free State Province.

- Technical assistance to the policy development process in the areas of confidentiality, testing and counseling and infection control/universal precautions.
- Support for the surveillance contract with the Medical Research Council.



United States Department of State

*Bureau of Oceans and International
Environmental and Scientific Affairs*

Washington, D.C. 20520

March 30, 1999

TO: President's Advisory Council on HIV/AIDS

FROM: OES/EID - Nancy -Foster

SUBJECT: Release of the 1999 U.S. International Response to HIV/AIDS

I apologize that I was unable to appear at the PACHA meeting in Washington on March 15. I had looked forward to the opportunity to meet with you and apprise you of our activities on international HIV/AIDS at the Department of State.

I am pleased to tell you that on Tuesday, March 16 Secretary of State Madeleine Albright released the 1999 U.S. International Response to HIV/AIDS at the plenary session of the U.S.-Africa Partnership Ministerial. The document has been distributed to all U.S. Diplomatic and Consular Posts. Shortly, appropriate cables will be sent to each post with tailored regional and universal talking points on HIV/AIDS and instructions to deliver the report and engage in discussion on HIV/AIDS with heads of state, foreign, economic, labor and finance ministers, and other high level officials as appropriate.

We truly thank you for your help in producing the 1999 U.S. International Response to HIV/AIDS. Your input and attention were critical to its completion.

Please contact Erika Barth (647-4542) in my office if you need additional copies of the document. The document can also be accessed on the Internet at <http://www.state.gov>.

Again thank you for your help in making this effort a success.

Global Religious Organizations Roundtable

a concept paper

COPY

Submitted by:
Rev. Kenneth T. South
AIDS National Interfaith Network
1400 I Street, NW ste 1220
Washington, D.C. 20005
(202) 842-0010

December 18, 1998

orgs -
AIDS net
interfaith
network

The AIDS National Interfaith Network, is the only organization dedicated to mobilizing the vast volunteer resources of America's faith community in the battle against HIV/AIDS. We have taken the lead in forging partnerships between local AIDS ministries, other local AIDS service organizations (ASOs), national religious denominations, national AIDS organizations and public health agencies. ANIN is also the primary national technical assistance and training resource for the 1,300 AIDS ministries across the nation.

This past month ANIN co-sponsored with the Carter Presidential Center, The American Academy of Religion, the Interdenominational Theological Center and the Centers for Disease Control and Prevention a historic meeting of religious scholars, media, national leaders and local AIDS ministries in a Convocation entitled AIDS & Religion in America. One of the strong themes that emerged in that event was the recognition of those present that the religious community in America has a very special role to play in the pandemic world wide. The organizing committees for the event also anticipated this interest and made sure that one of the plenary portions of the Convocation was dedicated to international issues. Dr. Paul Delay was asked to speak to the group at a luncheon entitled "AIDS Around The World".

One of the unique aspects of the religious community is that many of our national denominations are, in fact, either multinational in structure or are organized in multinational partnerships with others of their faith group around the world. Second, unlike the mission of local AIDS service organizations, the faith imperative that is at the core of the passion of religious organizations compels them to see the entire world as one community. Third, almost all religions see service and charity for their fellow human beings as an essential part of their mission and give to this service time, talent and resources.

In addition numerous religious groups in the United States have banded together to form cooperative ventures across the world to seek to relieve suffering, poverty and disease. The theology of some religious institutions compels them to seek new believers. Over the course of the last two hundred years especially, missionaries from the United States have established schools, hospitals and other centers for care of the local people as a part of their outreach to stir their souls as well. In many developing countries it is the religious community that provides a large share of the medical care for the local population.

The religious community is well organized for collaboration and communication. While there are very clear distinctions made between and among various faith groups for a variety of theological and political reasons, there are also very active, sophisticated and powerful religious based associations of world wide care and compassion.

The AIDS National Interfaith Network has a clear mission to provide technical assistance and services to AIDS ministries and denominations in the United States. Our membership and board of directors, however is well ware of the crying need for a better approach to the 90% of the persons with AIDS who are found outside our borders. While we do not have the expertise nor resources to provide direct services outside the boundaries of the United States we do feel we can make a significant difference in a convening/coordinating role, with global religious organizations housed in the U.S. similar to our efforts with the recent Carter Center Convocation.

This concept paper is presented to suggest the following:

ANIN would like to partner with the Centers for Disease Control and Prevention and the HIV/AIDS program of USAID to convene a meeting of Global Religious Organizations to focus on the global religious response to HIV/AIDS.

The goals for such a meeting:

- To encourage those global religious organizations who have not as yet seen HIV/AIDS as a priority, to add it to their agenda.
- To provide an assessment of the current status of HIV/AIDS programs currently in progress and supported by the invited organizations.
- To establish a level of cooperation and trust that may encourage future collaboration and sharing of information and resources.
- To explore new and innovative partnerships between and among these global religious organizations and the U.S. Government.

Structure:

A one day meeting (with possibility of follow-up meeting in the near future) to be held in New York City. The meeting should be held at a "neutral site" like a corporation that has been helpful with HIV/AIDS programs.

The meeting would start in the am, include a luncheon, and end by the close of business. An agenda would be prepared by a small steering committee and sent out to all participants. Participants would be asked to be prepared to present an overview of their current programs and specifically any AIDS related programs.

A tentative list of guest would include:

United Church of Christ

United Church Board for World Ministries
New York, NY
David Hirano

Episcopal Church

Presiding Bishops Fund Grants
Program for World Relief
New York, New York
Nancy Marvel

United Methodist Church

Global Board
New York, New York
Rev. Robert Howerton

Lutheran World Relief

New York, NY
Kathryn Wolford

Presbyterian Church in America

Mission to the World
Atlanta, Georgia
Dr. Paul Kooustra

Presbyterian Church, (USA)

Louisville, KY
Global Services & Witness
Dan Rift

American Baptist

World Relief Director
Valley Forge, PA
Rev. Charles Sydnor

Salvation Army, World Service Office

New York, New York
Major Dr. Herbert Rader

World Vision, Relief & Development

Seattle, WA
Dir of Institute of Global Engagement
Tim Dearborn:

Association of Evangelical Relief and Development (AERDO)

Washington, DC
Dennis Stuessi

Baptist General Conference

Arlington Heights, IL
Board of World Mission
Rev. Ronald Larson

Catholic Relief Services

Baltimore, MD
Sr. Ann Duggan

Christian Children's Fund

Richmond, VA
Margaret C. McCullough

Church World Service

(National Council of Churches)
New York, New York
Dr. Rodney Page

Seventh Day Adventist Church

Silver Spring, MD
Africa Bureau Director
William Jenson

Southern Baptist Convention

Nashville, TN
Foreign Mission Board
Rev. Bill Cashion

Christian Reformed World Relief Committee

Richmond, VA
Shepard Harder

Global Religious Organizations Roundtable

Proposed Budget

Meeting Expenses:

(Based on assumption of 20 (non government) persons attending)

Travel: \$10,500.00

14 persons @ \$500 airfare = \$7,000

14 persons @ 1 night hotel @ \$250.00 = \$3,500

Luncheon and Breaks \$0 (Donated by the host company)

Staffing: \$3,450.00

It is estimated that the Executive Director will devote 4% of his professional time (@ \$2,400) to the effort and the Program Director will devote 3% of his time (@ \$1,050).

Office supplies, packets, telephone, conference calls,
reproduction, faxing, etc \$650.00

Sub total: \$14,600.00

G&A: (is calculated as a percentage of specific programmatic effort as it relates to the overall operative expenses of the agency and includes: board expenses, advertizing, membership fees, subscriptions, conference fees, office supplies, insurance, occupancy, equipment, accounting, & miscellaneous)=13%

\$1,898.00

TOTAL REQUEST: \$16,498.00

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LANET Newsletter

Lutheran AIDS Network

"Linking a caring community"

Editor: Joyce Lindh Moore

Volume VIII 1998, Issue 3 Autumn 1998

From the President:

A Force for Change

The theme of the 1998 World AIDS Day is "Be a Force for Change." This message is a wonderful complement to the Lutheran AIDS Network's key phrase "Linking a Caring Community." Why link the community if not to support change?

Changes at all levels are needed in the face of the continuing global pandemic of HIV infection. We need to support individuals as they make changes in the face of living with HIV infection or decided whether or not to risk behaviors that might lead to exposure of the virus. We need to be a force for change in our communities to assure that services are available to all who need them, whether for treatment or prevention. We need to be a force for change that assures all concerned about the epidemic that there are safe places to come to learn, to grow, to grieve. We need to be a force of change within our churches, so that we do not miss opportunities for ministry. In sustaining the force for change it is the linkage among those who care that can sustain energy, sharpen focus and assure the energy to persevere as the struggle goes on and on.

The recent meeting of the LANET board was marked by thoughtful consideration of how our resources can be most effectively invested to serve as a point of linkage and as a source for change. We pursue dialogue with youth within the church regarding the best ways to support HIV prevention and support services.

We anticipate being a presence at major church gatherings. Through this newsletter and other avenues, we seek to provide support for regional and more local networks.

We have begun to plan for the 1999 national meeting, an opportunity for face-to-face linkages.

A force for change can only be effective if the force is continually renewed. LANET needs your prayers, your ideas, your energy, your continuing local efforts and your sustaining LANET membership to maintain and extend our caring community and support the changes required by HIV and AIDS.

Kristine Gebbie, DrPH, RN
President

YOUTH CONSULTATION

A consultation for young people, youth leaders and at risk groups most affected by HIV/AIDS will be held in San Bernardino, California on February 26, 27 and 28, 1999.

Lutheran AIDS Network has been awarded a grant for \$15,000 by Aid Association for Lutherans. The funds will enable LANET to consult with the participants on ways to provide more effective HIV prevention and HIV/AIDS support education within the Lutheran community. The consultation will incorporate training on the use of an HIV prevention curriculum developed by Lutheran AIDS Network, "From Brokenness to Wholeness." This consultation will help the organization to expand its national resource network by the addition of 65 people in Lutheran churches and organizations who can serve as peer educators or group leaders at national, district and local levels.

The Rev. David Kalke, Pastor of Central City Lutheran Mission, will chair the event. If you are interested in the Youth and At Risk Consultation, please contact Pastor Kalke at (909) 381-6921. The mailing address of Central City Lutheran Mission is 1354 North "G" Street in San Bernardino, CA. 92405.



Public Health as Part of the Strategy of African Economic Growth

Professor Jeffrey Sachs¹

Harvard Institute for International Development

March 10, 1999

¹Jeffrey D. Sachs is the Director of the Harvard Institute for International Development, the Center for International Development at Harvard University, and the Galen L. Stone Professor of International Trade at Harvard University. This report was prepared for a meeting of African ministers in Washington, D.C., March 17-18, 1999.

Public Health as Part of the Strategy of African Economic Growth

Every finance minister in Africa knows that Africa's poverty makes it difficult to attend to the health of the population. Budgets are scarce; doctors are few; and health systems are strained by the constant fiscal crisis facing every country on the continent. Fewer ministers and development specialists fully appreciate the converse proposition: that Africa's poor health is a fundamental obstacle to economic development. Both formal statistical analysis and detailed case studies demonstrate that poor health is as much a *cause* as an effect of poverty. A frontal attack on poor Africa's health status may now be the most important single strategy for economic development for the continent.

Healthy populations contribute to economic development in several ways, including:

- higher individual productivity
- greater investments in human capital by healthy individuals
- reduced losses of work time and schooling due to illness
- longer life expectancy, allowing a greater accumulation of work skills and expertise
- easier interface with the world economy through increased trade, travel, and investments

Africa's health situation is nothing short of alarming. At the top of the crisis list, of course, is HIV/AIDS, which according to UNAIDS now affects an estimated 22.5 million Africans, and which took 2 million lives last year. As described in the accompanying paper, AIDS is particularly pernicious, hitting educated, mobile, prime-age workers. War and displacement are a second fundamental feature of the continuing health crisis. The third category includes a host of infectious diseases, ranging from respiratory diseases to vector-borne diseases such as malaria and schistosomiasis. As discussed below, one feature of the African health scene is the paucity of data to make even rudimentary estimates of the extent and economic burden of these various public health crises.

The Macroeconomic Evidence on Health and Economic Growth

Africa's health crisis would be worthy of dire concern even if it had no further repercussions on African economic performance. Alas, the evidence suggests that poor health is not only a direct social burden, but also a major cause of slow economic growth. This section discusses the macroeconomic analysis that demonstrates the linkage from health to economic growth.

In recent years economists have sought to uncover the basic determinants of success and failure in macroeconomic performance, most importantly the success or failure in achieving sustained economic growth. According to economic theory and to empirical studies, there are several basic factors that help to explain why some countries and regions have sustained rapid growth and others have not:

(1) physical geography. Countries that are landlocked, or that are remote from world markets,

generally have a harder time achieving export-led growth than coastal economies and economies close to major world markets. While there are exceptions to this proposition, the overall tendency is very clear in the data,

(2) trade policy. Countries that are closed to international trade have consistently grown more slowly than countries that are open to international trade. For these purposes, openness is characterized by: a convertible currency; low tariffs; low quota protection on imported goods; and low barriers to export;

(3) fiscal policy. Countries that run large budget deficits grow less rapidly than countries that run small budget deficits or budget surpluses. Large budget deficits tend to lower national saving rates (and hence national investment rates), and to cause macroeconomic destabilization;

(4) quality of governance. Countries that are characterized by the rule of law, low levels of corruption, a rule-abiding civil service, and protection of physical and intellectual property rights, tend to grow more rapidly than countries which lack one or more of these attributes;

(5) demographic change. Economists describe the “dependency ratio” as the proportion of the population under the age of 15 or over the age of 65. Countries with a consistently high dependency ratio tend to grow less rapidly in per capita terms than countries with a consistently lower dependency ratio. In simplest terms, the gross domestic product is produced mainly by working-age individuals. When the share of such individuals rises, gross domestic product tends to rise relative to the overall population.

(6) public health. Countries with low levels of life expectancy tend to grow more slowly than countries with a long life expectancy, holding constant all of the other factors of economic growth. Thus, if there are two countries with identical geography, economic policy, and demographic change (dependency ratios), but one has a longer life expectancy than the other, the country with the longer-lived population tends to grow more rapidly.

(7) initial income. Countries with a low level of income -- holding constant all of the other factors -- tend to grow more rapidly than countries with a high level of income. This “convergence” property reflects the ability of poorer countries to achieve “catch-up” growth with the richer countries through the importation of technology, capital, and ideas. Of course, many poor countries do not grow rapidly, but this is the result of other problems facing the economy (such as poor geography, poor economic policies, poor public health, etc.).

In a recent study, my colleague David Bloom and I (Bloom and Sachs, 1998) tried to determine the causes of Africa’s poor economic growth. We looked at the growth of GDP per working-age population during the period 1965-90. Over those years, Africa grew 3.6 percentage points per year less rapidly than East Asia, 0.4 percentage points less rapidly than Latin America (which had its own growth crisis), and 1.7 percentage points less rapidly than the average of all non-African developing countries. Since Africa started out poorer than these other regions, we might have expected Africa to grow faster, because of the forces of “convergence.”

Instead, Africa grew more slowly. What were the relative factors behind that shortfall in growth?

Using a statistical model linking economic growth to factors listed above, we created a quantitative allocation of Africa's growth shortfall according to the various factors. While details must be found in the original paper (Table 7, p. 261), we reproduce the basic table here and give a summary account of the finding (table 1). If we compare Africa with East Asia for example (the first two columns of the table), we find that Geography, demography, and health account for 73 percent of the overall shortfall in African growth, or 3.23 percentage points per year. The two biggest factors are demographic change (listed in the table as "difference in population growth") and life expectancy in 1965. The demographic factor accounts for 1.14 percentage points per year of the growth shortfall, while the life expectancy variable accounts for 1.19 percentage points per year.

The demographic (population) variable reflects the fact that Asia benefited from a "demographic transition" while Africa did not. By the 1960s and 1970s in Asia, women had begun to have many fewer children. (Technically, the Total Fertility Rate, or TFR, went down). As a result, there were fewer children born in Asia per adult population, and the dependency ratio declined. This provided a boost to GDP per capita. In Africa, by contrast, the TFR remained very high throughout the 1970s and 1980s, and as a result, Africa's youth dependency ratio remained very high.

The life expectancy variable reflects the fact that African life expectancy in 1965 averaged around 42.6 years, while life expectancy at birth in Asia in 1965 averaged around 58.7 years (these are unweighted averages across countries in the respective regions). This difference in life expectancies, according to the statistical evidence, accounts for more than 1 percentage point of annual economic growth!

 If one looks at the rest of the table, there are two major findings that are worthy of emphasis. First, the "geography, demography, and health" variables explain most of Africa's growth shortfall with respect to each counterpart group (Asia, Latin America, Non-Africa). Thus, the reasons for Africa's poor growth apparently have more to do with Africa's geography, population dynamics and public health than with economic policy and governance. This is not the usual view of the matter in official discussions. Second, economic policy does matter, but has explained less than half of the shortfall in African performance. The major source of policy problem, it seems clear from the data, has been Africa's relative closure to international trade. Africa remained a closed economy (through high tariffs and licenses, currency inconvertibility, export monopolies which depressed export growth, and other barriers to trade) at a time when other parts of the developing world were benefiting from rapid export-led growth. Thus, export industries such as apparel, textiles, and electronics assembly, which could have come to Africa, instead went to East Asia and the Caribbean, thus limiting Africa's chances for export-led growth.

The gap in life expectancy between Africa and the rest of the world accounts for a great deal of the growth shortfall, but we still lack a deep understanding of the precise channels by which one affects the other. As mentioned earlier, low life expectancy and related higher disease-

associated morbidity imposes direct costs on productivity (less time in the workplace, lower work capacity, higher medical costs) as well as indirect costs (lower accumulation of skills, lower investments in education because of a shorter life span, and so on), each of which contributes to the shortfall in growth. Also, bad health imposes a direct burden on foreign investment and international travel, as Africa is avoided for foreign investments because of fears of greater disease burdens. Much serious research work remains to test these various channels for their practical importance.

Unfortunately, the gap in life expectancy between Africa remains large, and is actually increasing once again because of the AIDS epidemic. As discussed in an accompanying paper, the economic growth implications of HIV/AIDS are serious. As of 1996, Sub-Saharan Africa's life expectancy at birth was 51 for males and 54 for females, compared with 67 for males and 70 for females in the low and middle income countries of East Asia and the Pacific. This gap in life expectancy, of 16 years, would account for around 1.1 percentage points in economic growth per year using the same statistical model as was used to make Table 1. Thus, the health burden remains huge. Africa's life expectancy is a decade lower than in South Asia (which is 61 for males, 63 for females).

There is considerable debate and uncertainty, of course, about the reasons for Africa's particularly poor health status. It is partly a result of poverty. It is also, no doubt, partly a result of specific failures of public health systems to use existing technologies to best advantage. Many deaths in Africa are due to easily treatable diseases, but these cases go unattended because of ignorance, lack of supplies, breakdowns of local health systems, and so on. Part of the disease burden, however, is a result of Africa's special geographical and ecological conditions. As a tropical region, Africa has a special burden of infectious diseases that thrive in the tropics and that are easily controlled in the temperate climates. Moreover, some of these diseases, as well as the vectors which transmit them, may have coevolved with humankind in Africa, and are therefore even more difficult to control in Africa than in other tropical regions, to which they were imported more recently. Also, many parts of Africa face severe limitations on agricultural productivity. As a result of the widespread malnutrition in communities which face these limitations, diseases take a much higher toll in terms of morbidity and mortality.

and
cultural
traditions
practices

The tropical burden in African Health: the example of malaria

This short note can't go into the details of tropical disease ecology in any depth. Instead, it is illuminating to illustrate the general problem by focusing on one disease, *malaria*, which is the vector-borne disease with the greatest prevalence and highest disease burden in the tropical world. It is also a disease that hits Africa especially hard. Sub-Saharan Africa has an estimated 90 percent of the world's clinical malaria cases each. Nobody knows for sure, however, since the record keeping and data systems for malaria in Africa and other tropical regions are notoriously deficient.

Because of the underlying biology of the disease -- in particular, the way in which malaria is transmitted by *Anopheles* mosquitoes, which require warm temperatures to be effective vectors of the disease -- malaria tends to be holoendemic (or "stably transmitted") in perennially hot

climates; epidemic (or “unstably transmitted”) in seasonally warm but not hot climates such as the subtropics or lower tropical highlands, and absent in cool climates (such as above the 2000m level in the tropics, or in most temperate zones). This crucial ecological point helps to explain the critical facts of Figure 1, which describe the prevalence of malaria in three years of observation, 1946, 1966, and 1996, based on maps of the World Health Organization. In 1946, malaria extended to many sub-tropical regions, such as Southern Spain and Italy, the Levant, and Central Asia. The U.S. Government and the World Health Organization spearheaded a global eradication campaign, with various phases, during the 1960s and 1970s. The campaign an “attack phase” during which indoor DDT spraying was designed to kill recently blood-fed mosquitoes before they became infective, followed by a “consolidation phase,” which involved intensified case management for infected individuals. The campaign was a failure relative to its initial bold goal of malaria eradication, but as the figure shows clearly, it did succeed in a limited range of areas, mainly the areas of the sub-tropics where malaria was still prevalent in 1946, such as Southern Europe. Other regions where malaria was successfully controlled included Hong Kong, Singapore, and Mauritius (which were greatly advantaged by their island geography), and parts of Malaysia, where mosquito prevalence was easier to control for other reasons. It is important to note that Africa was excluded from this program, with the exceptions of South Africa, Lesotho, and Mauritius, which were among the last countries in the world to be permitted to join.

The lesson of Figure 1 is quite dramatic. Malaria was controlled in the sub-tropics rather than the tropics. *The failure of Africa to control the disease is not mainly the result of poor public health measures, or unresponsive governments, or the poverty of Africa, but rather of the natural environment.* Actually, Africa's malaria problem is the world's worst for additional ecological reasons. It turns out that *Anopheles gambiae* is indigenous to Sub-Saharan Africa, and is observed only focally in those few tropical regions outside of Africa where it has been imported. For a variety of species-specific reasons, *Anopheles gambiae* is by far the most competent vector of falciparum malaria.

Sachs and Gallup (1998) have found in cross-country growth regressions that falciparum malaria is associated with a substantial reduction in annual GDP growth, perhaps of more than one percentage point per year, even after controlling for other standard variables. We surmise that these high costs of malaria come not only through the direct effects (lost work time, lower worker productivity) but also by raising barriers against technical diffusion and foreign investment into endemic malarial regions. Historical accounts of Africa's interactions with the rest of the world in the past 500 years repeatedly stress that malaria was a major barrier, perhaps the major barrier, to Africa's normal integration into the world economy. Malaria continues to present serious obstacles to foreign investment and tourism in many parts of Africa. Foreign businessmen lack the partial immunity to malaria acquired by African adults who have experienced repeated bouts of the disease since early childhood. Prevention via existing medicines is imperfect, and not feasible for prolonged stays beyond a few weeks. Similarly, malaria presents an obstacle to Africans traveling abroad for a prolonged stay, since the acquired immunity of adult Africans who have been exposed to malaria since infancy is quickly lost in the absence of chronic re-infection. There may be other indirect costs of malaria endemicity. For example, among the clinical outcomes attendant on chronic malaria infection are lung and kidney problems, impaired motor function, and iron deficiency anemia. Such syndromes and diseases are detrimental to the

economic potential of the communities in which they occur.

A New Focus on African Health and Development

In the past twenty years, African economic development has focussed almost entirely on issues of economic policy (such as opening the economy, budget deficit reduction, and improved governance), rather than on issues of poor public health and other geographical barriers to development. Of course, these other issues have not been completely neglected, but they have been overshadowed by the economic reform agenda during the era of structural adjustment programs. It is time to restore a balance to the vision of Africa's development strategy, by putting due weight -- that is, increased emphasis -- on issues of tropical public health, care of the natural environment, and improved agricultural productivity through scientific research. This would be true even if Africa were not now succumbing to an HIV/AIDS epidemic that is unrivaled in modern history in its destructive force. But in view of that epidemic, the case for shifting our attention to critical issues of public health is of course even greater.

We have explained one of the major reasons why finance ministers, economy ministers, and trade ministers need to care about the health crisis. Improving public health is a basic part of the economic strategy, not just the social strategy. Finance ministers need to understand health issues in order to allocate domestic and foreign aid resources appropriately in national spending. Economy ministers need to work closely with public health colleagues to formulate a health strategy as part of the overall development strategy. And trade ministers need to understand that poor public health, including high prevalence of malaria, HIV/AIDS, and even tainted blood supplies used for transfusions, pose major barriers to attracting foreign direct investment and export diversification.

A companion paper discusses some of the options for improving public health systems in Africa. Without duplicating that material, I should like to close with a strong plea to policy makers in Africa and the United States. Public health challenges in Africa tend to have two characteristics that are very different from many other development issues. *First, advances will require an improved base of science and technology.* The barriers to overcoming malaria, for example, are more a question of science (e.g. the availability of an effective vaccine) than of governance (e.g. the functioning of local health clinics). *Second, advances will require regional cooperation rather than simply national programs.* This is obviously true of scientific advances (we don't need separate national vaccines!), but also true of many crucial public health interventions, such as HIV/AIDS control, since diseases like HIV/AIDS are spread especially through travel and cross-border migrations. Thus, as we design appropriate policies to address African public health, special attention needs to be put on international and regional programs, in contrast to the usual approach of country-level programs.

Underlying all of these considerations is the dearth of reliable data regarding health issues of special interest to Africa. For example, data on the incidence of tropical diseases such as malaria or schistosomiasis rely on rough approximations. There are no virtually long-term, longitudinal studies on the interactions between diseases and nutritional status, for example, or on

the social and community impact of long-term disease exposure. Such information is essential to inform effective development policies for the future. African governments together with multilateral organizations like the WHO, UNDP, and the World Bank must encourage such long-term data collection and research, and should sponsor the efforts of African and international scientists, clinicians, and epidemiologists. Today, health issues pose enormous obstacles to African growth, but often some of the most fundamental issues are barely understood.

As for spurring the needed scientific advances, we will need to think in innovative ways. Almost all scientific advances in biotechnology in recent years, whether in pharmaceuticals or in agricultural production, have involved joint actions of the public and the private sectors. Africa's health challenges must engage not only the research laboratories of national governments, but also the world's major pharmaceutical companies. Yet those companies have almost wholly neglected Africa in recent years (with notable exceptions, such as Merck's development and promotion of Ivermectin, to cure onchocerciasis), mainly because they perceive the market to be too small and far too risky to engage in expensive, long-term research and development. Even if they succeed in developing a malaria vaccine, for example, an initiative that would cost several hundred million dollars at least in risky R&D expenditures, they believe that they would reap precious few commercial benefits at the end.

The result is painfully clear. Malaria vaccine research is currently carried out mainly in government research institutes, all suffering from under-funding and hugely competing claims on scarce budgets. The Wellcome Trust estimated recently that the worldwide total malaria vaccine research effort amounted to around \$60 million, or perhaps \$65 per annual case fatality due to the disease. This compares, for example, with annual research funding of around \$140 million for asthma, a disease which is common in the "rich" temperate zones, amounting to around \$790 annual spending per fatality. In short, the 2.4 billion people in the tropics that are vulnerable to malaria provoke remarkably little research effort on their behalf, since the "market demand" is so extremely weak.

We need a dramatic new approach in such cases, using new and creative ways to link market incentives with social goals. In the case of malaria, for example, the key action is to create incentives for private pharmaceutical companies and biotechnology firms to invest heavily in a malaria vaccine. Several researchers at Harvard and MIT are examining the possibility that foreign aid funds be used to *guarantee a market for malaria vaccine at the end of the vaccine development process*. The leading governments would pledge today that they will purchase, for mass distribution, an effective malaria vaccine whenever such a vaccine is successfully developed. For example, the U.S., Europe, and Japan, on behalf of the World Health Organization, would pledge that they will form the relevant market for buying the vaccine. These governments could establish a Malaria Vaccine Trust Fund, capitalized with the needed funding, to prove that they stand ready to "make the market" when and if an effective vaccine arrives.

No money would be expended until an effective vaccine is proved. No large bureaucracy would choose among scientific approaches, or would subsidize research. No government agency would decide in advance who is worthy to lead the anti-malaria campaign. We believe in the urgent need for a decentralized approach, in which the smallest to the largest private

biotechnology and pharmaceutical companies are energized in the search for an effective virus. Market forces, rather than unwieldy public agencies, would be harnessed to tackle the key steps in vaccine development.

We can even put a little flesh on the proposal, though very speculative and rudimentary. Suppose that the leading governments commit to purchase enough vaccine to immunize all of the newborn children in Africa each year. There are, throughout the region, around 25 million births per year. A very rough estimate of the starting price for an effective vaccine, based on comparable cases for other diseases, might be around \$40. A price in this range would likely be enough to cover development costs plus the marginal costs of vaccine production and distribution. In effect, the Trust Fund would be guaranteeing a market of around \$1 billion per year to immunize all of Africa's newborns (\$25 per case times 25 million regimens per year). A global Malaria Vaccine Board, under the auspices of the World Health Organization, would administer the fund, confirming for example the efficacy of all vaccines purchased by the Fund. Would such an effort be worth it? Almost surely. Foreign aid to Africa now totals around \$16 billion per year, so a \$1 billion per year anti-malaria vaccine effort would amount to around 6 percent of total aid, and would be spent only when an effective vaccine is actually developed.

This is just one example of the kind of thinking that will be needed to push forward a major initiative on African health. This new focus will require partnerships all around -- between the U.S. and Africa, among African government, between Finance Ministers and Health Ministers, and between governments and international agencies. The effort will be strongly repaid, not only in a healthy population but also in accelerated economic development.

Table 1. Explaining Africa's Growth Gap

Geography, Demography, and Health	East/SE Asia		Latin America		World	
	Gap	Impact	Gap	Impact	Gap	Impact
Portion land area in geographical tropics	7%	-0.30	7%	-0.16	16%	-0.57
Log population density w/100km coast	14%	-0.61	9%	-0.19	8%	-0.31
Log population density inland	0%	0.01	3%	-0.06	0%	0.00
gpopdiff ^a	26%	-1.14	33%	-0.72	19%	-0.68
Log of life expectancy at birth, 1965	27%	-1.19	52%	-1.12	35%	-1.26
<i>Sub-total</i>	<i>73%</i>	<i>-3.23</i>	<i>103%</i>	<i>-2.24</i>	<i>78%</i>	<i>-2.82</i>
Economic Policy and Governance						
Trade openness	32%	-1.40	13%	-0.27	24%	-0.89
Quality of government institutions ^b	5%	-0.22	-1%	0.02	5%	-0.20
Central government budget deficit ^c	1%	-0.03	-9%	0.20	-7%	0.25
<i>Sub-total</i>	<i>37%</i>	<i>-1.65</i>	<i>2%</i>	<i>-0.05</i>	<i>23%</i>	<i>-0.84</i>
<i>Total Gap explained</i>	<i>110%</i>		<i>105%</i>		<i>101%</i>	

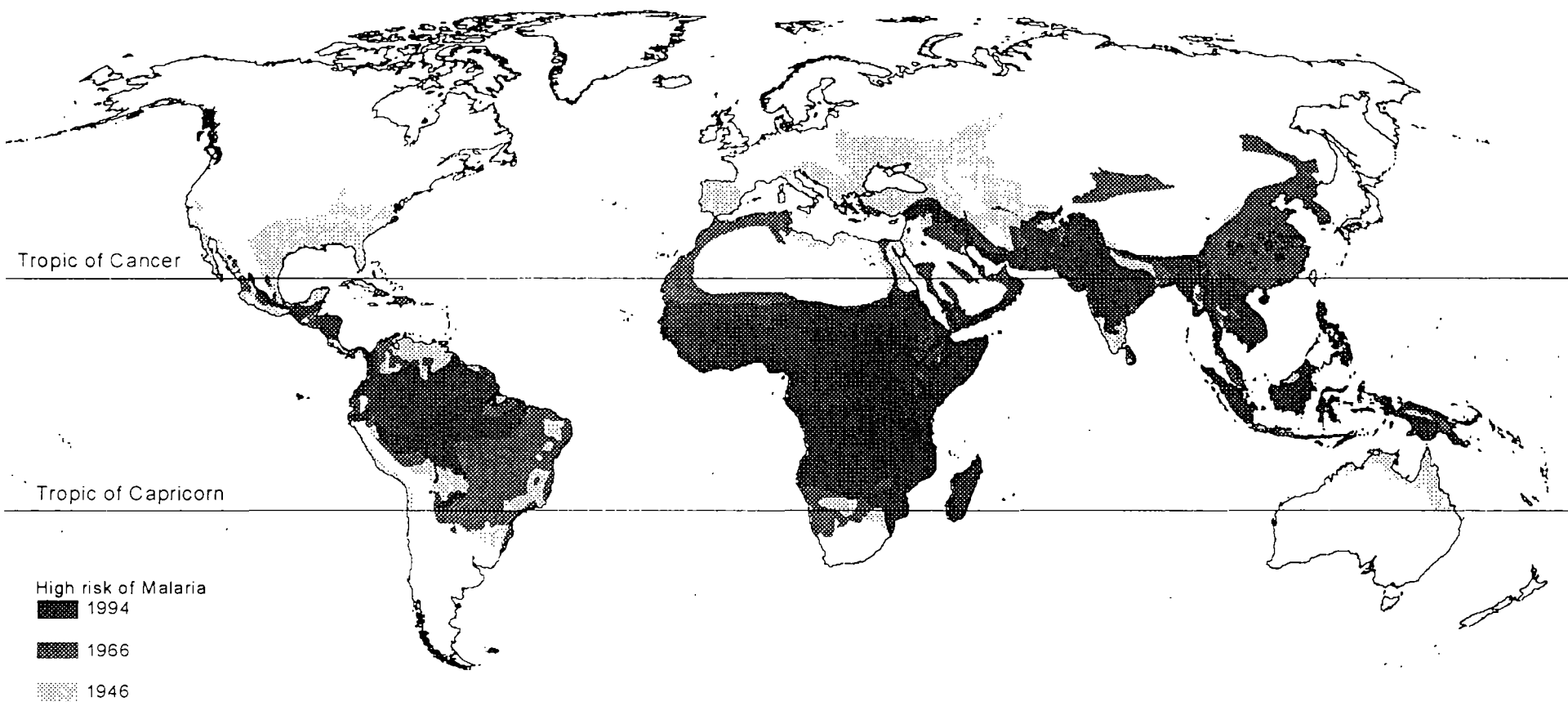
Notes: The observed growth gaps were: Africa-East/Southeast Asia: -3.6%, Africa-Latin America: -0.38%, Africa-Non-Africa: -1.7%. These gaps were then adjusted to reflect differences in the expected rate of convergence. Since Africa is the relatively poorer region, this adjustment "widened" the effective gaps to: Africa-East/Southeast Asia: -4.4%, Africa-Latin America: -2.2%, Africa-Non-Africa: -3.6%.

a Difference of average growth rate of working-age population, 1965-1990 and average growth rate of total population over the same period.

b Unweighted average of 5 sub-indices developed from data by Political Risk Services, measuring the following. The *rule of law index* "reflects the degree to which the citizens of a country are willing to accept the established institutions to make and implement laws and adjudicate disputes." The *bureaucratic quality index* measures "autonomy from political pressure", and "strength and expertise to govern without drastic changes in policy or interruptions in government services." The *corruption in government index* measures whether "illegal payments are generally expected throughout ... government", in the form of "bribes connected with import and export licenses, exchange controls, tax assessments, police protection, or loans." The *risk of expropriation index* measures high risk of "outright confiscation" or "forced nationalization." The *government repudiation of contracts index* measures the "risk of a modification in a contract taking the form of a repudiation, postponement or scaling down." See Sachs and Warner (1997) for details.

c Average over the period 1970-1990, as proportion of GDP

Figure 1.
Malaria risk - 1946, 1966, 1994



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UNAIDS



GENERAL INFORMATION

Programme Coordinating Board
Ad hoc thematic meeting
16-18 November 1997
Nairobi

For the guidance of participants who may not be too familiar with Nairobi, and also to inform everyone of some arrangements and events which have been planned around the meeting, here are a few points to remember.

- On 15 and 16 November, all incoming international flights will be met by a UNAIDS representative at Kenyatta Airport. Transport to the Safari Park Hotel (about 20 minutes ride) has been arranged for delegates. Participants should look for a UNAIDS banner in the arrival lobby of the airport.
- Anyone who arrives before 15 November should be aware that when taking a taxi from the airport to the hotel, it is strongly recommended to select either a Kenatco taxi or one of the black London cabs.
- The meeting will start with registration from 15h00 and the opening session at 16h00 on Sunday, 16 November. Transport has been arranged to take participants from the hotel to the UN Centre in Gigiri where the meeting will be held.
- On the evening of 16 November, a welcome reception is being organized by UNAIDS for all participants. This will take place at the Safari Park Hotel in the Bougainville room, from 19h30 to 21h00.
- The Zebra room at the Safari Park Hotel has been set up as the UNAIDS' secretariat office.
- The current US dollar exchange rate to the Kenyan Shilling is 63.5 (US\$1 = 63.5 Kenyan Shillings).
- While we cannot always anticipate climatic conditions we are informed that, at the present time, the area is experiencing heavy rainfall and even floodings. However, this is not expected to interfere with the field visit.



ONUSIDA

INFORMATION GENERALE

Conseil de Coordination du Programme
Réunion thématique *ad hoc*
16-18 novembre 1997
Nairobi

Pour tous les participants qui ne connaissent pas bien Nairobi et afin de mettre chacun au courant de certains arrangements qui ont été pris ainsi que des événements qui auront lieu au cours de la réunion, voici quelques points à retenir:

- Les 15 et 16 novembre, tous les participants arrivants sur des vols internationaux seront accueillis par un représentant de l'ONUSIDA à l'aéroport de Kenyatta de Nairobi. Le transfert de l'aéroport à l'hôtel Safari Park (un trajet de 20 minutes environ) sera assuré pour tous les délégués. Les participants sont invités à se diriger vers le stand "ONUSIDA" dans le hall d'arrivée de l'aéroport;
- Il est fortement recommandé aux participants arrivant avant le 15 novembre, et désirant prendre un taxi de l'aéroport à l'hôtel de choisir un taxi "Kenatco" ou un des taxis noirs londoniens;
- La réunion s'ouvrira avec l'inscription des participants à partir de 15h 00 et la session d'ouverture à 16h 00 le dimanche 16 novembre. Veuillez noter qu'un transport de l'hôtel au Centre des Nations Unies à Gigiri où la réunion se tiendra sera mis à la disposition de tous les participants;
- Une réception de bienvenue sera organisée par l'ONUSIDA pour accueillir tous les participants dans la soirée du dimanche 16 novembre. Elle aura lieu dans la salle "Bougainville" de l'hôtel Safari Park de 19h 30 à 21h 00.
- La salle "Zebra" de l'hôtel Safari Park a été mise à la disposition du secrétariat de l'ONUSIDA.
- Le taux de change actuel du dollar américain en Shilling kenyan est de 63.5 (US\$ 1 = 63.5 Shillings kenyan).
- Alors qu'il nous est difficile d'anticiper les conditions climatiques, il semblerait que la région de Nairobi expérimente à l'heure actuelle de fortes pluies causant parfois des inondations. Ceci ne devrait cependant pas avoir de conséquences gênant le déplacement sur le terrain.



UNAIDS
UNICEF • UNDP • UNFPA
UNESCO • WHO • WORLD BANK

UNAIDS/PCB(5)/97.1
17 September 1997

Joint United Nations Programme on HIV/AIDS

***Ad hoc thematic meeting of the
Programme Coordinating Board
Nairobi, 16-18 November 1997***

Place of meeting: Conference Room N° 1, United Nations, Gigiri, Nairobi

Provisional Agenda

Sunday, 16 November 1997

Opening Session (16.00 - 18.30)

- Opening of the meeting and adoption of provisional agenda
- Report of the Executive Director
- Report by the Chairperson of the Committee of Cosponsoring Organizations
- Report by the NGO representative

Reference documents

UNAIDS/PCB(5)/97.1

UNAIDS/PCB(5)/97.2

Monday, 17 November 1997

Session 1 (8.30 - 12.30 and 13.30 - 14.30)

Item 1: Access to drugs for HIV/AIDS

UNAIDS/PCB(5)/97.3

Session 2 (15.00 - 17.30)

Item 2: Support to country-level response to HIV/AIDS

- 2(a) National strategic planning
- 2(b) UN Theme Groups on HIV/AIDS

UNAIDS/PCB(5)/97.4

UNAIDS/PCB(5)/97.5

Tuesday, 18 November 1997

Session 3 (morning)

Field visit

Session 4 (13.30 - 15.30)

Item 2 (continued)

Closing session (16.00 - 18.00)

- Next PCB meeting
- Other business
- Conclusions of the meeting



ONUSIDA

UNICEF • PNUD • FNUAP

UNESCO • OMS • BANQUE MONDIALE

UNAIDS/PCB(5)/97.1

17 septembre 1997

Programme commun des Nations Unies sur le VIH/SIDA

**Réunion thématique *ad hoc* du
Conseil de Coordination du Programme
Nairobi, 16-18 novembre 1997**

Lieu de la réunion: Salle de conférence N°1, Nations Unies, Gigiri, Nairobi

Ordre du jour provisoire

Dimanche 16 novembre 1997

Documents de référence

Séance d'ouverture (16h00-18h30)

- Ouverture de la réunion et adoption de l'ordre du jour provisoire
- Rapport du Directeur exécutif
- Rapport du Président du Comité des Organismes coparrainants
- Rapport du Représentant des ONG

UNAIDS/PCB(5)/97.1

UNAIDS/PCB(5)/97.2

Lundi 17 novembre 1997

Séance 1 (8h30-12h30 et 13h30-14h30)

Point 1: Accès aux médicaments pour la prise en charge du VIH/SIDA UNAIDS/PCB(5)/97.3

Séance 2 (15h00-17h30)

Point 2: Appui à l'action contre le VIH/SIDA menée à l'échelon pays

2(a) Planification stratégique nationale

UNAIDS/PCB(5)/97.4

2(b) Groupes thématiques onusiens sur le VIH/SIDA

UNAIDS/PCB(5)/97.5

Mardi 18 novembre 1997

Séance 3 (matin)

Déplacement sur le terrain

Séance 4 (13h30-15h30)

Point 2 (suite)

Séance de clôture (16h00-18h00)

- Prochaine réunion du CCP
- Autres questions
- Conclusions de la réunion

United Nations Organizations - Gigiri

IAAD (B2) - International Audit Division (Nairobi Unit)

ICAO (I) - International Civil Aviation Organization

ADM(11)- Administration
DEPREP(12)- Office of the Deputy Regional Representative
ICAOREP(12)- Office of the Regional Representative
TC(12)- Technical Cooperation
TCO(12)- Technical Cooperation Officer

UNCHS (MNP) - United Nations Centre for Human Settlements (Habitat)

ADM/CB.1/M.1.N.1.P.1- Administration Division
HABITAT II/M3: United Nations Conference on Human Settlements
HHSF/M3: HABITAT and Human Settlements Foundation
IAVD/P.1.N.3: Information, Audio-Visual and Documentation Division
OED & SP/M3.N.3.Q.1.3: Office of the Executive Director and Special Programmes
OPC /M3.P.3: Office of the Programme Coordination and Administration
RDD/M2.N.2.1.Q2: Research and Development Division
TCD/P.1.2.3.J: Technical Cooperation Division

UNCS (HG) - United Nations Common Services

BGMU(G1.2)- Building and Ground Management Unit
SEC(G2)- Security and Safety Unit

UNEP (A,B,CB,CW,DP,F,G,H,LB,Q,R,S,T,U,V,W,X) United Nations Environment Programme

ADMIN(W3): Administrative Service
AMCEN: Secretariat of the African Ministerial Conference on the Environment
CS/CW1,DP,Q3,R1,2,S1): Conference Services
CLH(W3): Cleaning-House
COU(G1): Cable Operations Unit
CPAS(T3): Corporate Planning & Accountability Services
DC/PAC (Q3): Desertification Control Programme Activity Centre
DO(DP): Documents Reproduction and Distribution Unit
EDPU(W1): Electronic Data Processing Unit
OAE(D73): Environment Fund and Administration
EETU(R2,U3): Environment Education and Training Unit
EUE(U3): Environment and Economics Unit
ELUPAC(T1): Environment Law and Institutions Unit Programme Activity Centre
FIN(V2): Finance and Budget Section
FPMB(V3 W3): Fund Programme Management Branch
FUES(R2): Follow-up and Evaluation Section
GFEST/PA(W3): Global Environment Facility/Scientific & Technical Advisory Panel
GEMS/PA(C3): Global Environment Monitoring System Programme Activity Centre
GRID/PA(C2): Global Resource Information Database Programme Activity Centre
GSS(CB1,H1,LB,W2,3): General Services Section
HRMS(V1): Human Resources Management Services
INFOTR(U2): Intertera Programme Activity Centre
IPA(S2,T2): Information and Public Affairs
JMS(F1): Joint Medical Service
LIB(LB1,2): Library and Documentation Centre
MIS(W1): Management Information Systems Unit

OAE/D/EP(S3,K3): Office of the Assistant Executive Director/Environment Programme
 OCA/PAC(A1,2): Oceans and Coastal Areas Programme Activity Centre
 ODED(R3): Office of the Deputy Executive Director
 OED/R2,3(U3): Office of the Executive Director
 OFA/OAED(T3): Office of the Environment Fund and Administration/Office of the AED
 OZONE(U3): Ozone Secretariat
 PCU(T3): Programme Coordination Unit
 PERS(U1,V1): Personnel Section
 REG (A1,H1,CB1): Registry, Mail and Pouch Unit
 ROA(S3): Regional Office for Africa
 TAEB(T2): Technology and Environment Branch
 TEB(O1,2): Terrestrial Ecosystem Branch
 TSC(W1): Telecommunication & Electronic Services
 OGU(A1): Ombudsman and Staff Counsellors' Unit

UNAMIR(G1,J2,Q2) 2

UNESCO (B,C) - United Nations Educational, Scientific and Cultural Organization

ROSTA(B2C1.2)- Regional Office for Science and Technology in Africa
TSBF(B1)- Tropical Soil Biology and Fertility Programme

UNICEF (DEFJ) · United Nations Children's Fund

KCO(D1,3,E1,2)- Kenya Country Office
OLS(J1)- Operation Lifeline Sudan
RO(E1,2)- Regional Office

UNSO (A1) : United Nations Sudano-Sahelian Office

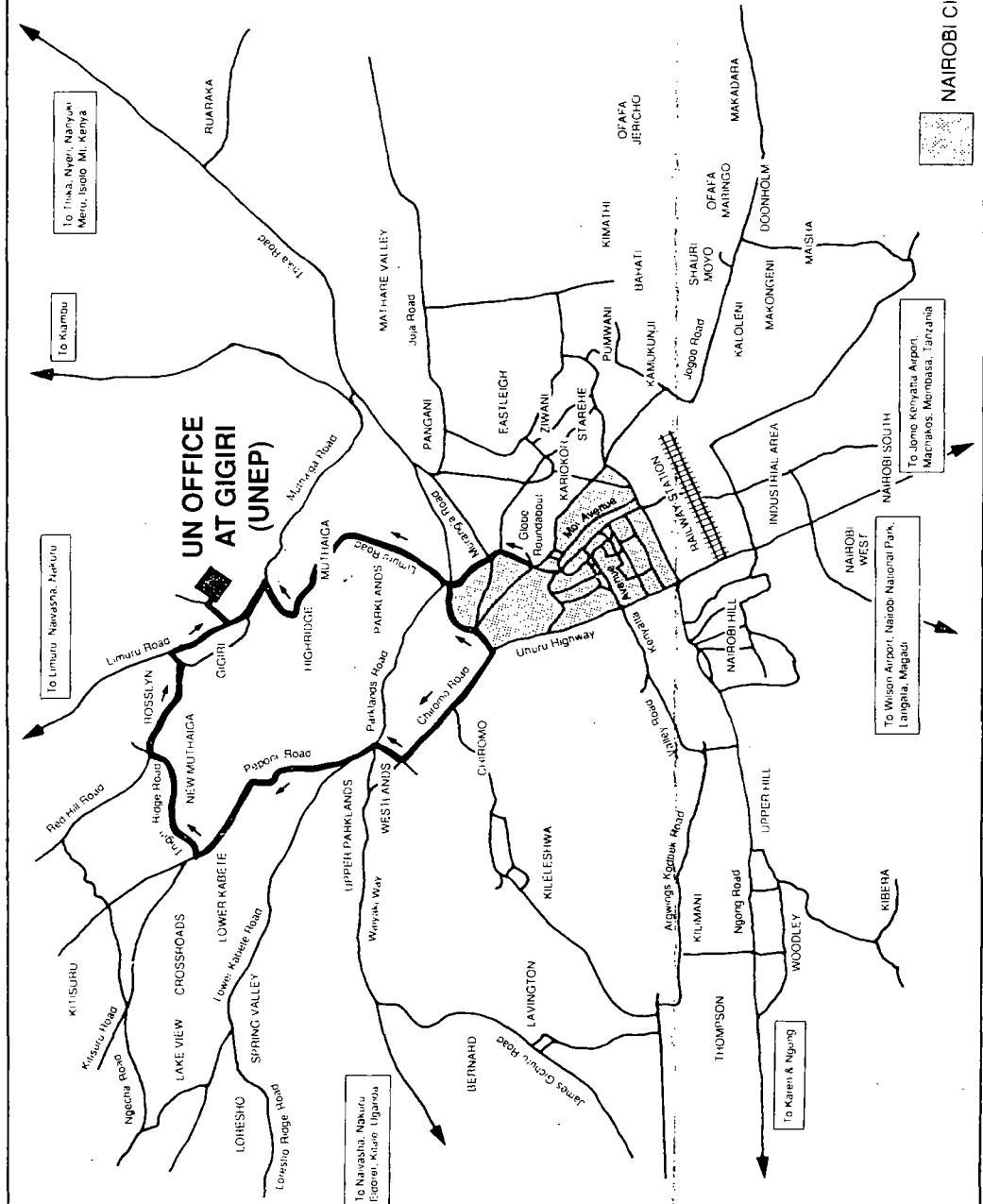
UNOSOM(F2) - United Nations Operation In Somalia .

UNU (G1) : United Nations University

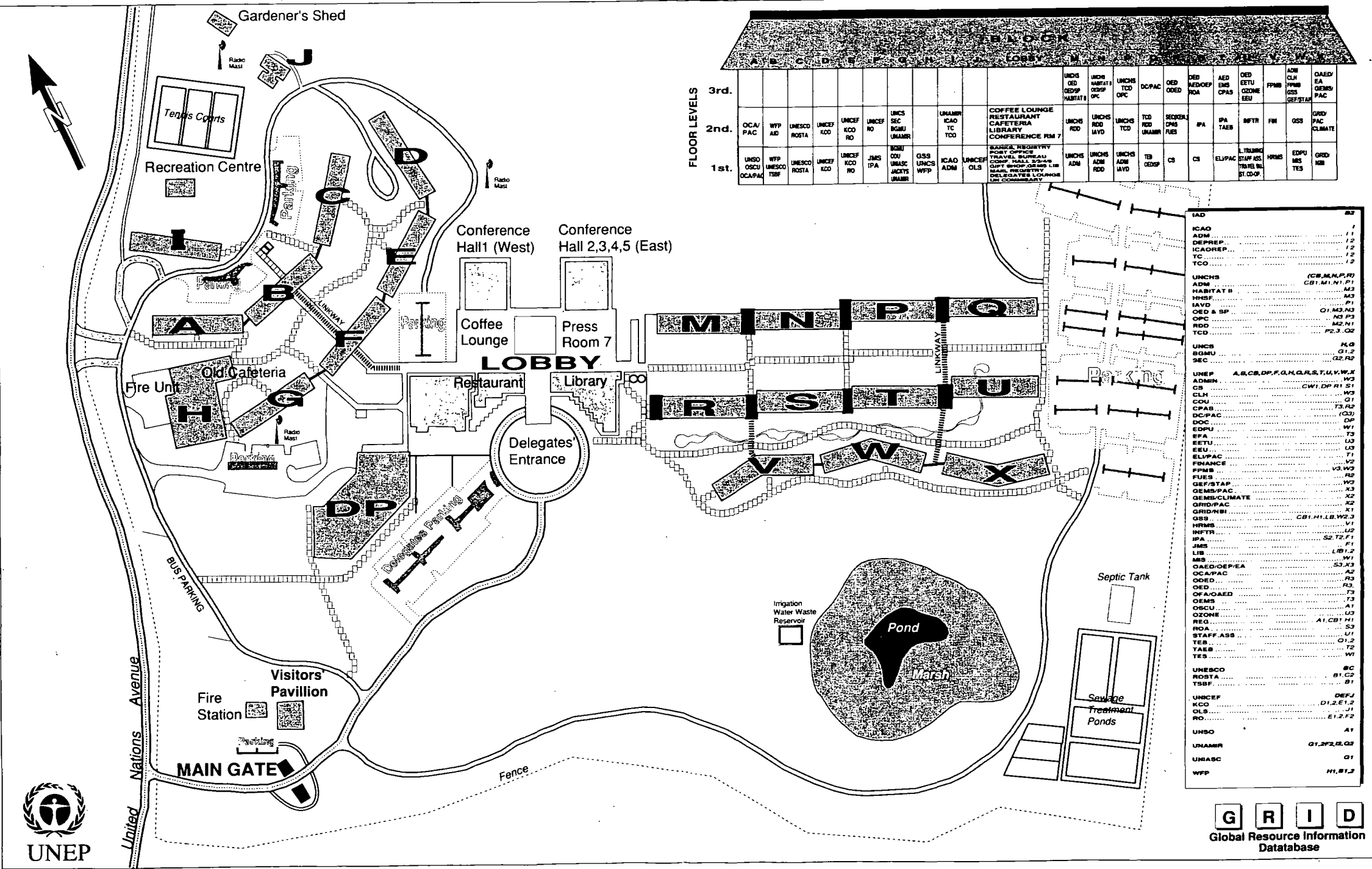
Other UN Organizations in Nairobi

WFP (H.B.) : World Food Programme
FAO (Mamuka Rd.) : Food and Agriculture Organization
UNDP (Harambee Ave.) : United Nations Development Programme
UNFPA (Harambee Ave.) : United Nations Population Fund
UNHCR (Chirimo Rd.) : Office of the United Nations High Commissioner for Refugees
UNIDO (Harambee Ave.) : United Nations Industrial Development Organization
WFP (Harambee Ave.) : World Food Programme
WHO (Cathedral Rd.) : World Health Organization
UNIC (Harambee Ave.) : United Nations Information Centre

The information within brackets indicate the office block and the floor number



UN E) NA) NS - GIGIRI (NA ROBI)



FLOOR LEVELS		BLOCK																											
		A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB
3rd.																													
2nd.		OCA/PAC	WFP AD	UNESCO ROSTA	UNICEF KCO	UNICEF KCO RO	UNICEF NO	UNICEF NO	UNICEF NO	UNICEF NO	UNICEF NO	UNICEF NO	UNICEF NO	UNICEF NO	UNICEF NO	UNICEF NO	UNICEF NO	UNICEF NO	UNICEF NO	UNICEF NO	UNICEF NO	UNICEF NO	UNICEF NO	UNICEF NO	UNICEF NO	UNICEF NO	UNICEF NO	UNICEF NO	UNICEF NO
1st.		UNESCO OSCU	UNESCO TSBF	UNESCO ROSTA	UNICEF KCO	UNICEF KCO RO	JMS IPA	JMS IPA	JMS IPA	JMS IPA	JMS IPA	JMS IPA	JMS IPA	JMS IPA	JMS IPA	JMS IPA	JMS IPA	JMS IPA	JMS IPA	JMS IPA	JMS IPA	JMS IPA	JMS IPA	JMS IPA	JMS IPA	JMS IPA	JMS IPA	JMS IPA	JMS IPA

IAD	1
ICAO	11
ADM	12
DEPREP	12
ICAO/REP	12
TC	12
TCO	12
UNCHS	(CB, M, N, P, R)
ADM	CB1, M1, N1, P1
HABITAT II	M3
HRMS	M3
IAD	P1
OE & SP	Q1, M3, N3
OPC	N3, P3
ROD	M2, N1
TCO	P2, 3, Q2
UNCS	M, Q
BGMU	G1, 2
SEC	Q2, R2
UNEP	A, B, C, D, F, G, H, Q, R, S, T, U, V, W, X
ADMIN	W3
CS	CB1, DP, R1, S1
CLH	W3
COU	G1
CPAS	T3, R2
DC/PAC	(Q3)
DOC	DP
EDPU	W1
EPA	T3
ETU	U3
EEU	U3
EL/PAC	T1
FINANCE	V2
FRMS	V3, W3
FUES	R2
GEF/STAP	W3
GEMS/PAC	X3
GEMS/CLIMATE	X2
GRID/PAC	X2
GRID/NBI	X1
GSS	CB1, H1, L3, W2, 3
HRMS	V1
INFTR	U2
IPA	S2, T2, F1
JMS	F1
LIB	L3, B1, 2
MS	W1
OAED/OEP/EA	S3, X3
OCA/PAC	A2
ODD	R3
OD	R3
OFA/OAED	T3
OEMS	T3
OSCU	A1
OZONE	U3
REG	A1, CB1, H1
RDA	S3
STAFF ASS	U1
TES	Q1, 2
TAEB	T2
TES	W1
UNESCO	B1, C2
ROSTA	B1
TSBF	B1
UNICEF	DEFJ
KCO	D1, 2, E1, 2
OLS	J1
RO	E1, 2, F2
UNSO	A1
UNAMR	G1, 2, 3, R, Q3
UNASC	G1
WFP	H1, B1, 3

GRID
Global Resource Information
Database