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**PRESENTATION ON
HIV/AIDS IN AFRICA**

Background Material

ALEX ROSS, MSPH
Senior Public Health Advisor
USAID Bureau for Africa
Office of Sustainable Development

December 2, 1998



AIDS
epidemic
update:
December 1998



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



**World Health
Organization**

Global summary of the HIV/AIDS epidemic, December 1998

People newly infected with HIV in 1998	Total	5.8 million
	Adults	5.2 million
	<i>Women</i>	<i>2.1 million</i>
	Children <15 years	590 000
No. of people living with HIV/AIDS	Total	33.4 million
	Adults	32.2 million
	<i>Women</i>	<i>13.8 million</i>
	Children <15 years	1.2 million
AIDS deaths in 1998	Total	2.5 million
	Adults	2.0 million
	<i>Women</i>	<i>900 000</i>
	Children <15 years	510 000
Total no. of AIDS deaths since the beginning of the epidemic	Total	13.9 million
	Adults	10.7 million
	<i>Women</i>	<i>4.7 million</i>
	Children <15 years	3.2 million

Original text

From: Todd_A._Summers@opd.eop.gov, on 11/2/98 11:56 AM:

To: <ncih aids@ncih aids.org>, <aross@usaid.gov>, <pdelay@usaid.gov>

Here is the text of the letter sent by Vice President Gore to Deputy President Mbeki (dated October 20, 1998). Please disseminate this to those who might have interest.

Thanks!

Todd Summers
Deputy Director
Office of National AIDS Policy

October 20, 1998

His Excellency
Thabo Mkeki
Executive Deputy President
of the Republic of South Africa
Pretoria

Dear Thabo:

I read with great interest and a sense of shared concern your declaration on the occasion of the launching of the Partnership Against AIDS. Your call to attention is not only important for South Africa, but also as an inspiration for all of Africa.

Over the last fifteen years, our nation has worked diligently to stop the spread of this devastating disease, to support research for effective HIV therapeutics and a preventative vaccine, and to remind all citizens that, together, we must combat this epidemic. Educators and activists, members of religious and civic groups, business and labor organizations, and tens of thousands of other men and women with a shared concern have all been a part of our response to this disease. I am confident that your address to the people of South Africa helped to generate the same broad societal support that has been essential to our own advances.

As you recall, in July 1997, within the framework of the Binational Commission, we announced a \$10 million USAID funded project to support the Ministry of Health's AIDS program. It is our hope that this project will significantly contribute to the attainment of the goals of your finalized national AIDS strategy. In addition, the President recently asked Sandra Thurman, our National AIDS Policy Coordinator, to travel to South Africa, at your government's convenience, to discuss the manner in which the United States can further support South Africa's efforts.

I join with you in mourning the lives of so many who have already been lost and look forward to our continued work together to protect those who remain at risk.

Sincerely,

Al Gore

Everyday every night - wherever we are - we shall let our families, friends and peers know that they can save themselves and save the nation, by changing the way we live and how we love. We shall use every opportunity openly to discuss the issue of AIDS.

As Partners Against AIDS, together we pledge to care!

We shall work together to care for those living with HIV/AIDS and for the orphans. They must not be subjected to discrimination of any kind. They can live productive lives for many years.

They are human beings like you and me. When we lend a hand, we build our own humanity, and when we remind ourselves that, like them, each one of us can become infected.

As Partners Against AIDS, together we pledge to pool our resources and to commit our brain power!

There is still no cure for HIV and AIDS. Nothing can prevent infection except our own behaviour.

We shall work together to support medical institutions to search for a vaccine and a cure. We shall mobilise all possible resources to spread the message of prevention, to offer support to those infected and affected, to destigmatise HIV and AIDS and to continue our search for a medical solution.

And so today we join hands in the Partnership, fully aware that our unity is our strength. The simple but practical action that we take today is tomorrow's insurance for our nation.

Accordingly, we pledge that wherever we meet and study, work and sing, play and enjoy one another's company, we will protect ourselves and our partners against HIV and AIDS.

Together, as Partners Against HIV/AIDS, we can and shall win.

I have asked for your time to listen to this urgent message because there is no other moment but the present, to take action.

I thank you for your attention and urge you to act NOW!

9 October, 1998

ADDRESS BY DEPUTY PRESIDENT THABO MBEKI DECLARATION OF
PARTNERSHIP AGAINST AIDS

President Mandela has asked me to address you on his behalf. I am honoured to be able to do so.

DECLARATION

HIV/AIDS is among us. It is real. It is spreading.

We can only win against HIV/AIDS if we join hands to save our nation.

For too long we have closed our eyes as a nation, hoping the truth was not so real.

For many years, we have allowed the HI Virus to spread, and at a rate in our country which is one of the fastest in the world.

Every single day a further 1 500 people in South Africa get infected. To date, more than 3 million people have been infected.

THE DANGER IS REAL

Many more face the danger of being affected by HIV/AIDS.

Because it is carried and communicated by other human beings, it is with us in our work places, in our classrooms and our lecture halls.

It is there in our church gatherings and other religious functions.

HIV/AIDS walks with us. It travels with us wherever we go. It is there when we play sport. It is there when we sing and dance.

Many of us have grieved for orphans left with no one to fend for them. We have experienced AIDS in the groans of wasting lives. We have carried it in small and big coffins to many graveyards.

At times we did not know that we were burying AIDS victims. At other time we knew, but chose to remain silent.

And when the time comes for each one of us to make a personal precautionary decision, we fall prey to doubt and false confidence.

We hope that HIV/AIDS is someone else's problem.

CHANGING OUR WAY OF LIFE

HIV/AIDS is not someone else's problem. It is my problem. It is your problem.

By allowing it to spread, we face the danger that half of our youth will not reach adulthood. Their education will be wasted. The economy will shrink. There will be a large number of sick people whom the healthy will not be able to maintain. Our dreams as a people will be shattered.

HIV spreads mainly through sex.

You have the right to live your life the way you want to.

But I appeal to the young people, who represent our country's future, to abstain from sex for as long as possible. If you decide to engage in sex, use a condom.

In the same way, I appeal to both men and women to be faithful to each other, but otherwise to use condoms.

PARTNERSHIP

The power to defeat the spread of HIV and AIDS lies in our Partnership - as youth, as women and men, as business people, as workers, as religious people, as parents and teachers, as students, as healers, as farmers and farm workers, at the unemployed and the professionals, as the rich and the poor - in fact, all of us.

Today, we join hands in this Partnership Against HIV/AIDS, united in our resolve to save the nation.

As Partners Against AIDS, together we pledge to spread the message!

uching all nationalities, all genders, and all ages. It preys hardest on those least able to meet economic costs, and in the case of HIV/AIDS, on those in their most productive stage of life—between the ages of 20 and 45.

The one-world nature of life as we know it, where people change address and transportation routes, and exchange goods and services over vast distances, links us all in this battle. We must approach the solutions to our collective dilemma in a universal and collaborative way. Only then can we bring to bear the most fervent action and the most specialized resources we each have to offer.

We look forward to each nation joining this initiative at the highest levels, bringing sustainable commitments to see this fight through to its successful conclusion. Our tools are effective, multisectoral national policies and programs, underpinned by strong public health infrastructures with effective preventative healthcare as a global priority.

The target audience of this strategy includes governments of both developing and developed nations, international organizations, non-governmental organizations, industry, and the public at large. We at the State Department will take the charge by initiating high-level foreign policy discussions by our ambassadors and other embassy representatives with host country counterparts. We will disseminate and discuss the strategies and encourage leaders to expand HIV/AIDS prevention and mitigation programs.

We will continue to work with international organizations, governments, non-governmental organizations, industry, and others in the private sector to effect this goal as a global priority to reduce human suffering and to safeguard all peoples from the devastation of HIV/AIDS.

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Executive Summary

The 1999 U.S. International Response to HIV/AIDS (human immunodeficiency virus/acquired immune deficiency syndrome) is part of a continuing effort by the U.S. Government to create positive change in the international fight against HIV/AIDS. It is designed to foster political commitment, develop international partnerships, and provide a directory of public programs that can serve as a model of government policy and resource investments to more effectively meet the challenges posed by the global HIV/AIDS pandemic.

The 1999 report, like its 1995 predecessor, is the product of an interagency effort and provides a framework of effective programs and strategies. It can be used to guide future efforts in the continual battle against HIV/AIDS. It contains a set of U.S. Government priorities for combating the worldwide spread of HIV/AIDS. Participating agencies include the White House Office of National AIDS Policy, the U.S. Department of State, the U.S. Agency for International Development, the U.S. Information Agency, the U.S. Peace Corps, the U.S. Department of Health and Human Services (National Institutes of Health, Centers for Disease Control and Prevention, and the Food and Drug Administration), the U.S. Department of Commerce, the U.S. Department of Defense, the National Intelligence Council, and the U.S. Department of Justice.

The 1999 report reviews the objectives of the 1995 strategy and the accomplishments and difficulties in meeting those objectives. It then examines the remaining challenges confronting the United States and other members of the international community in meeting the many facets of the HIV/AIDS epidemic. And finally, the report includes an action strategy that identifies specific objectives to effectively address HIV/AIDS issues. The action strategy's programs, policies, and activities represent commitments by each agency and have been adopted at the highest level of agency authority. The goals of the 1999 U.S. International Response to HIV/AIDS are to:

- Raise awareness of the issue of international HIV/AIDS;
- Raise the level of priority accorded to stemming the spread of HIV/AIDS by all governments;
- Promote collaboration between governments, international organizations, and the private sector in developing international partnerships to leverage investments of capital and expertise into sustainable programs to fight HIV/AIDS;
- Encourage and support the efforts of UNAIDS and other international organizations;
- Promote respect of human rights for those afflicted with HIV/AIDS; and
- Highlight the special and growing needs of women and children infected with HIV/AIDS.

The 1999 report should not be viewed as a funding directory or as a manual for eradicating the HIV/AIDS epidemic, for this would be an oversimplification of the problem and its solution. Rather, we provide this compilation of government policies, programs, and priorities to further coordinate and share our collective expertise. Through successful, responsible partnerships at home and abroad, we can expand the benefits of the lessons learned and accomplish greater goals.

No member of the global community can afford, either in terms of human suffering or economic costs, to fail to recognize and act to forestall the impending devastation that has already begun to ravage national economies, security, and social infrastructure. It threatens the very fabric of society, regardless of race, creed, or spiritual belief. Disease is the equalizer,

U.S. INTERNATIONAL RESPONSE TO HIV/AIDS

1999



DEPARTMENT OF STATE PUBLICATION 10589
Bureau of Oceans and International Environmental and Scientific Affairs
Emerging Infectious Diseases and HIV/AIDS Program

Released December 1998

THE AIDS EPIDEMIC IN UGANDA

AIDS has now become a central fact of social, economic, and political life in Uganda. The AIDS epidemic in Uganda has occurred in a country with other serious health conditions as well. The current health care system is characterized by shortages of drugs and hospital beds, and few trained health workers. The catastrophic impact of AIDS in Uganda jeopardizes the many positive strides in development that Uganda has recently achieved. It is now estimated that over 1.5 million Ugandans are already infected with the AIDS virus (HIV). Data from health facilities suggest that nearly half of the beds in medical wards in many hospitals are occupied by patients with HIV infection and AIDS.

The United States of America, through the Agency for International Development (USAID) and research projects funded by the National Institutes of Health, is a major partner with the Government of Uganda in the efforts to respond to the epidemic, and to prevent the further spread of HIV infection in Uganda. A wide range of projects designed to prevent new HIV infections, and to respond to the social and family level impact of the epidemic have been implemented with USAID funding. Since 1989, USAID has provided funding for the AIDS Information Center, which has now provided voluntary and confidential HIV testing and counseling to over 350,000 clients. In 1997, about 80% of clients learned that they are not yet infected with the AIDS virus, and they received intensive prevention counseling to help them adopt safer behaviors. For those who tested positive, AIDS support groups have been established. USAID has also funded the AIDS Support Organization, TASO, Africa's leading agency serving people living with AIDS. TASO has now served over 40,000 individuals and their families.

Recent Ministry of Health reports based on HIV sentinel surveillance in urban antenatal clinics suggest since 1993, there has been a decline in HIV prevalence in pregnant women, the first hopeful trend in Uganda's decade-long experience with AIDS. Declines are particularly pronounced among younger pregnant women, aged 15 to 19, but are also observed in women 20 to 24. For example, in one site in Kampala, 15 to 19 year old pregnant women had an HIV prevalence rate of 26% in 1992 but this has declined to 8% by 1997.

These trends are consistent with a 50% reduction in incidence, or new cases of HIV infection in young women these ages. At the same time, behavioral surveys strongly indicate an increase in the age of first sex; a reduction in casual sexual partners, an increase in general condom use, and especially increases in condom use with casual sexual partners. Beginning in 1987, USAID funded projects have emphasized increased knowledge of risk factors, reduction in high risk behaviors, and condom promotion and distribution.

These encouraging trends have occurred in a context in which the burden of disease and premature death of young adults continues to be overwhelming. Because of the declining trends in new infections and Uganda's track record in developing innovative and effective projects, Uganda is increasingly confronting the epidemic and preventing the further spread of HIV infection.

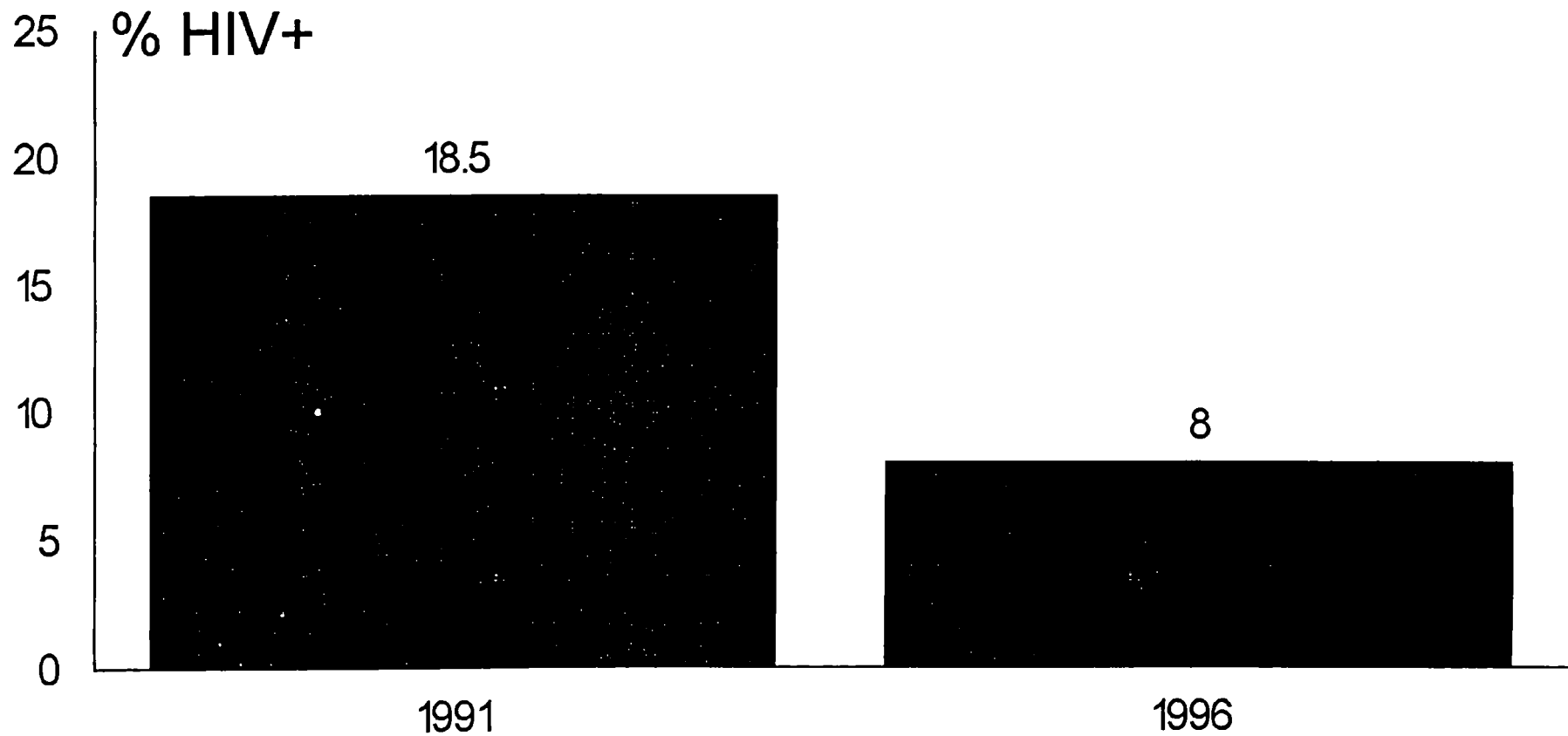
Prepared by: Elizabeth Marum, Ph.D.
Technical Advisor in HIV/AIDS
February, 1998

Cleared by: William Lyerly
AFR/SD
Paul De Lay
G/PHN/HN/HIV-AIDS

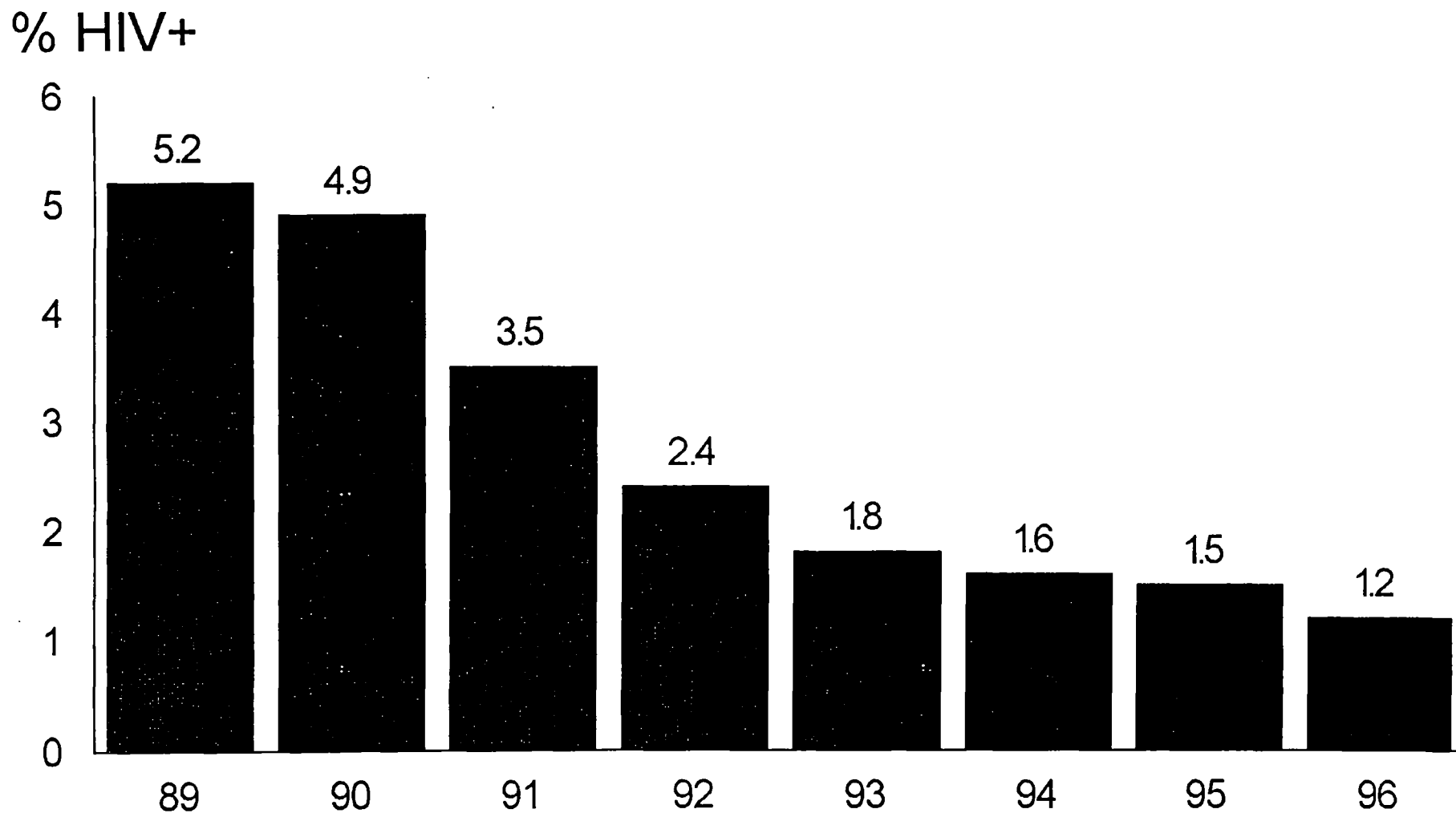
Conclusion

- intense response to the AIDS epidemic can achieve measureable results
- sustained and extensive collaboration between the national government, non-governmental organizations, USG agencies (USAID, NIH, CDC), and American scientists can significantly enhance a nation's response to the AIDS epidemic

HIV Prevalence in young men aged 19-22 entering the army (Gov't of Uganda data)

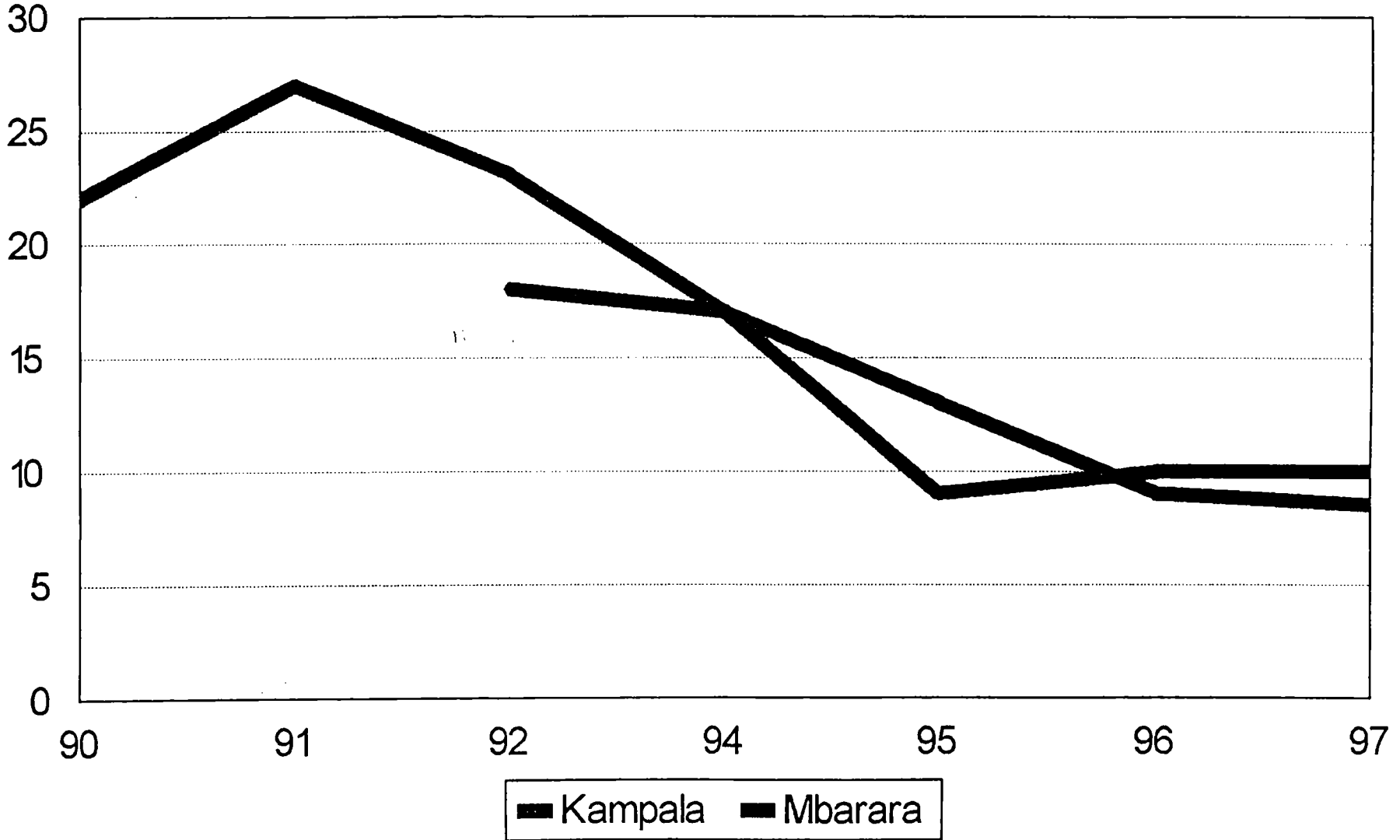


HIV Prevalence in Secondary School Blood Donors (Ministry of Health Data)



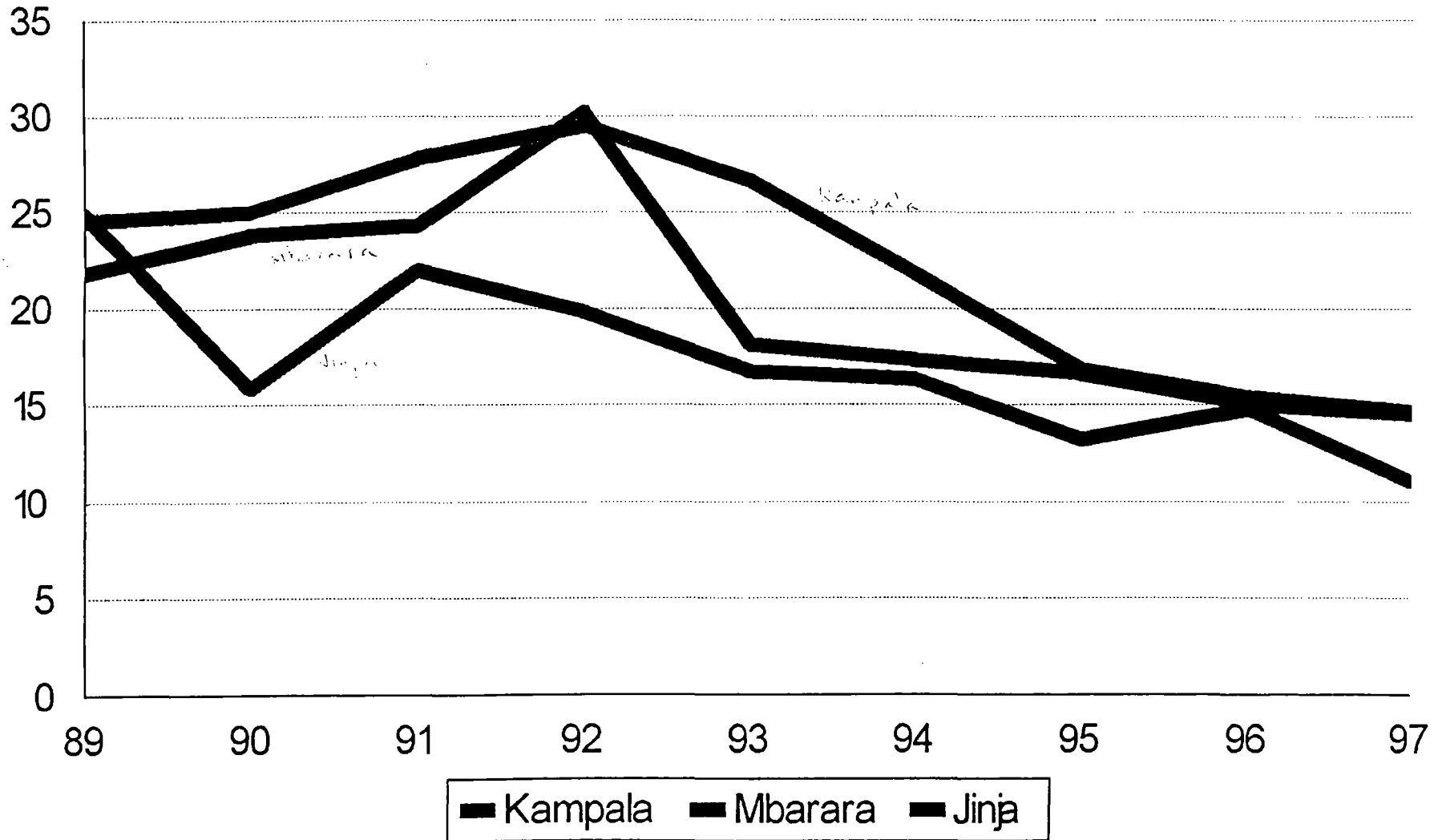
HIV Rates in 15-19 year old pregnant women (Ministry of Health Data)

% HIV+



HIV Infection Rates in antenatal clinics in Uganda

Ministry of Health Data



Impact of Uganda's Intense Response to the AIDS Epidemic

- almost 100% level of awareness of AIDS
- changing social norms, esp discouraging multiple partners and casual sex
- evidence for behavioral changes, esp increasing condom use and age at first sex and decreasing rates of unsafe sex
- evidence of declining trends since 1993, esp in rate of new infections in young people

Indirect Results of Uganda's Response to AIDS

- non-governmental organizations have increased public respect and role of private groups in all sectors of life has been strengthened
citizens have observed the power of a candid and collaborative approach to national problems
hope for the future of Uganda has been restored
other African nations now have successful model of positive response to the AIDS epidemic

USAID funded Activities

- AIDS education in the workplace, military, local communities, religious groups, and mass media
condom promotion and distribution
Voluntary counseling and testing (VCT)
AIDS care and support
detection and treatment of other STDs
capacity building and technical training

Results of USG efforts

- greater understanding of the epidemic in Africa
 - research on therapeutic interventions in Africa
 - feasibility of projects demonstrated
 - over 40,000 persons with AIDS served by TASO
 - over 380,000 clients for HIV counseling & testing
- behavioral impact of interventions documented, esp for HIV counseling and testing, AIDS care & support, and community education at the local level
- Hundreds of Ugandan scientists, physicians, social workers, health educators, and program managers have been trained and developed skills

Response of the USG

- NIH funding for numerous research projects
 - CDC technical assistance for health information systems, rapid testing, counseling, and evaluation of interventions; research on variant strains of HIV
- since 1988, USAID has provided very generous and sustained funding for multi-faceted, intense and extensive AIDS prevention activities
- USAID funding for AIDS activities has now exceeded \$40 million

Response of U.S. Universities

- US Universities active in Uganda include Case Western Reserve University, Columbia University, Johns Hopkins Univ
- with NIH funding, long term biomedical research projects began in 1988 in the areas of:
 - pediatric AIDS
 - mother to child transmission
 - HIV and TB
 - community epidemiology
 - STDs, Kaposi's sarcoma & HIV
 - Vitamin A for HIV+ children
 - preparation for AIDS vaccine trials
 - social and anthropological aspects of the epidemic

Response of Non-Governmental Organizations in Uganda

- Mission hospitals began AIDS care programs in 86
- The AIDS Support Organization (TASO) established in 1987 by 16 Ugandans affected by the epidemic
- The AIDS Information Centre (AIC) began providing HIV counseling and testing in 1990
- Numerous smaller NGOs established to provide care to persons with AIDS and support for orphans
- Associations of PWAs (People with AIDS) organized for education, mutual support

Response of Religious Communities in Uganda

- with USAID funding, Church of Uganda (Protestant) and the Islamic Medical Association of Uganda initiated active programs of AIDS education for religious leaders and lay workers at the community and parish level
these groups have had documented contacts with over 1.5 million individuals
Catholic church active in AIDS care and orphans programs

Uganda's Response to the AIDS Epidemic: Results and Impact

Presentation by:

Elizabeth Marum, Ph.D.

Technical Advisor in HIV/AIDS

Centers for Disease Control & Prevention/USAID Uganda

Government of Uganda Response

- President Museveni spoke openly and widely about AIDS as early as 1986
 - AIDS Control Programme established in 1986; educational programs, mass media and blood safety efforts began
- Intense public information efforts have continued to the present
- International AIDS researchers encouraged to work in Uganda; President Museveni requested vaccine trials
- 1991: multisectoral Uganda AIDS Commission established

8. **Do not maintain false hope for a vaccine.** The development of an effective vaccine is many years, if not decades, away. A social and behavioral response is the only and best thing we have.

Traditional healers and other practitioners who make false claims of an AIDS "cure" do a lot of damage to the AIDS program, and many are just profiteering, leaving many people more impoverished than need be. The "Mocrea" issue in Zimbabwe is a good case in point. However, it is important to remember that there are many positive elements to traditional medicine, and in fact the pressures that AIDS will put on the modern medical services will mean that more and more people will be forced to rely on traditional practitioners for either part or all of the medical care and support.

9. **We must pay particular attention to children and adolescents.** Sex education does **not** lead to earlier or increased sexual activity. Quite the contrary: it leads to delayed initiation, better communication, and more responsible decision-making and behavior.

10. **Each leader must deal with AIDS at a personal level, and must use their platform to warn youth about the scourge of AIDS.** We can see from the reported AIDS cases and from the prevalence data that many of our young people are infected during their teenage years. While there is a sensitivity of discussing these personal issues with our children, we must overcome this reluctance to talk about sexuality in order to warn them about this disease which was unknown to the previous generation. **TEACH YOUR CHILDREN ABOUT SEX, SEXUALITY, HIV/AIDS, and RESPONSIBLE BEHAVIOR.**

Briefing for the U.S. Ambassador to Zimbabwe, Mr. Tom McDonald

Wednesday, March 25th, 1998

Prepared by

Alan G. Johnston
The POLICY Project

Ten Important Messages on HIV/AIDS

These are meant to serve as a starting-off point for brainstorming on the ten most important messages on HIV/AIDS for leadership audiences in Zimbabwe. They are listed in order of priority:

1. The response to the AIDS epidemic cannot be externally driven. Societies and communities must develop their own responses for preventing the spread of HIV, providing care and support for those with AIDS and reducing stigma and discrimination, and mitigating the social and economic impact of AIDS.

Therefore we need to **listen** to what leaders are thinking about AIDS. Everyone knows that AIDS is a big problem. But how do they see the issue of AIDS? What do they **think** can and should be done? Getting people to articulate their ideas also helps to reinforce those ideas.

2. It is important to build on the base of existing activities. Many activities are already underway in the public sector, the private sector, and the NGO sector. Much has been learned from the implementation of these activities. We need to carefully study these lessons learned if we are to **scale-up the successful activities** to have a larger impact, and if we are to do so in a **cost-effective manner**.

The United States is an important donor, but is not the largest sponsor of HIV/AIDS activities in Zimbabwe, and must work in collaboration with the many other donor and implementing agencies.

3. We need to give leadership groups in Zimbabwe a clear indication of the major areas of U.S. assistance in the area of HIV/AIDS. We should also make it clear that the selected areas of focus are based on solid experience and on the comparative advantage of the U.S. in these focus areas.

4. The whole southern African region has experienced explosive growth of the AIDS epidemic during the past ten years. HIV prevalence among the adult population (15 years and over) has reached 20 percent in Zambia, Zimbabwe, Malawi and Botswana, and is increasing most rapidly in South Africa (16 percent in 1997) and Namibia. The AIDS epidemic is a long-term problem that will require sustained attention.

5. There is strong and clear evidence (Uganda, Thailand) that prevention works and that BEHAVIOR IS CHANGING. We must learn and apply these success stories. In addition, it is important to point out that 80 percent of the adult population are not infected, and there are hardly any children in the age group 5-14 who have been infected. They can and must be protected.

6. The epidemic in Africa is still silent. Political leaders must provide personal support to raise awareness, make it possible to discuss the problem, and motivate all sectors of society to take responsibility and action.

Also, personal risk assessment in Zimbabwe is just not getting through. Inconsistent use of condoms is a function of poor risk assessment. The percentage of survey respondents who say that they feel personally at risk is low, although it has increased somewhat in the last few years. It is important to remember that there is also an epidemic of other sexually transmitted diseases, and that the presence of another STD is an important factor in facilitating the transmission of HIV. Many people are not aware of this important link.

7. AIDS can not and must not be defined as the "problem" of the Ministry of Health. It demands a true multi-sectoral approach that involves government, the private sector, NGO/CBOs, churches, and community groups. AIDS cannot be "someone else's problem" or the problem will continue to grow. It is clear that AIDS will have a major economic impact, at the household level, for private sector businesses large and small, and for the economy as a whole. For business leaders, one important message is that with proactive management, the costs of HIV/AIDS can be mitigated through effective prevention and management strategies.

There are also many important legal and ethical issues around HIV/AIDS, involving issues of confidentiality, avoiding discrimination, and the values, rights and responsibilities of all segments of the society. However, there are no easy answers, and leaders must be involved in the discussion of these important policy issues.

HIV/AIDS Prevention and Mitigation in Africa

RECOMMENDATIONS

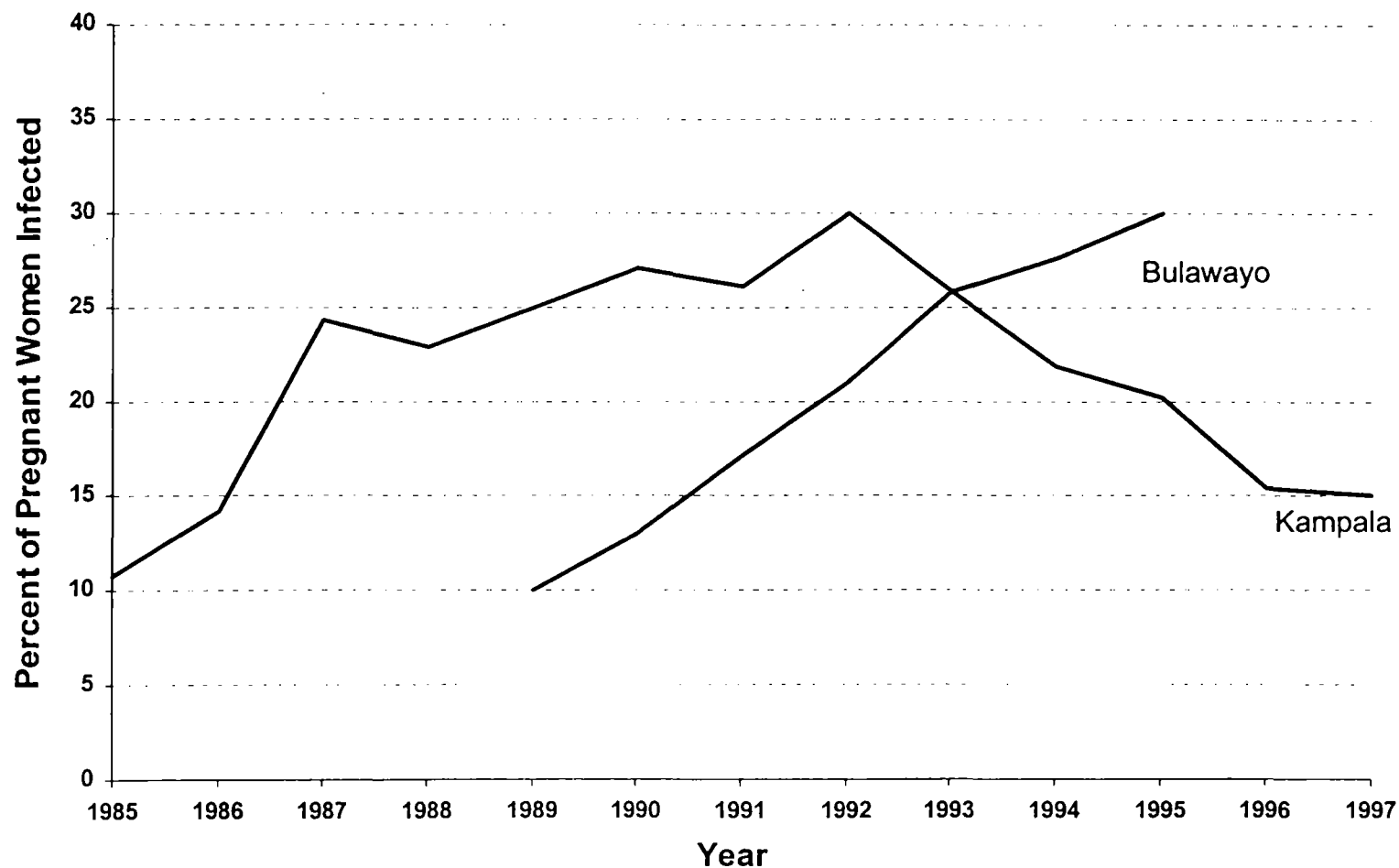
- **Help re-mobilize leadership and political will in HIV/AIDS**
- **Take a leadership role in addressing AIDS-related stigma**
- **Increase the strategic focus on adolescents**
- **Develop and use more effective evaluation methods and strategies**

HIV/AIDS Prevention and Mitigation in Africa

ACTIONS

- **Work with our development partners, especially UNAIDS, to ensure that USAID incorporates these lessons into current and future programs at the country and regional levels.**
- **Assist all development sectors to include an "AIDS Impact Assessment" in their strategy and program design.**
 - How will this program impact the HIV/AIDS epidemic?
 - How will HIV/AIDS affect the success of this program?

Lessons Learned From Uganda: Decreasing HIV Seroprevalence Rate for Pregnant Women in Kampala, Compared to Bulawayo, 1985 - 1997

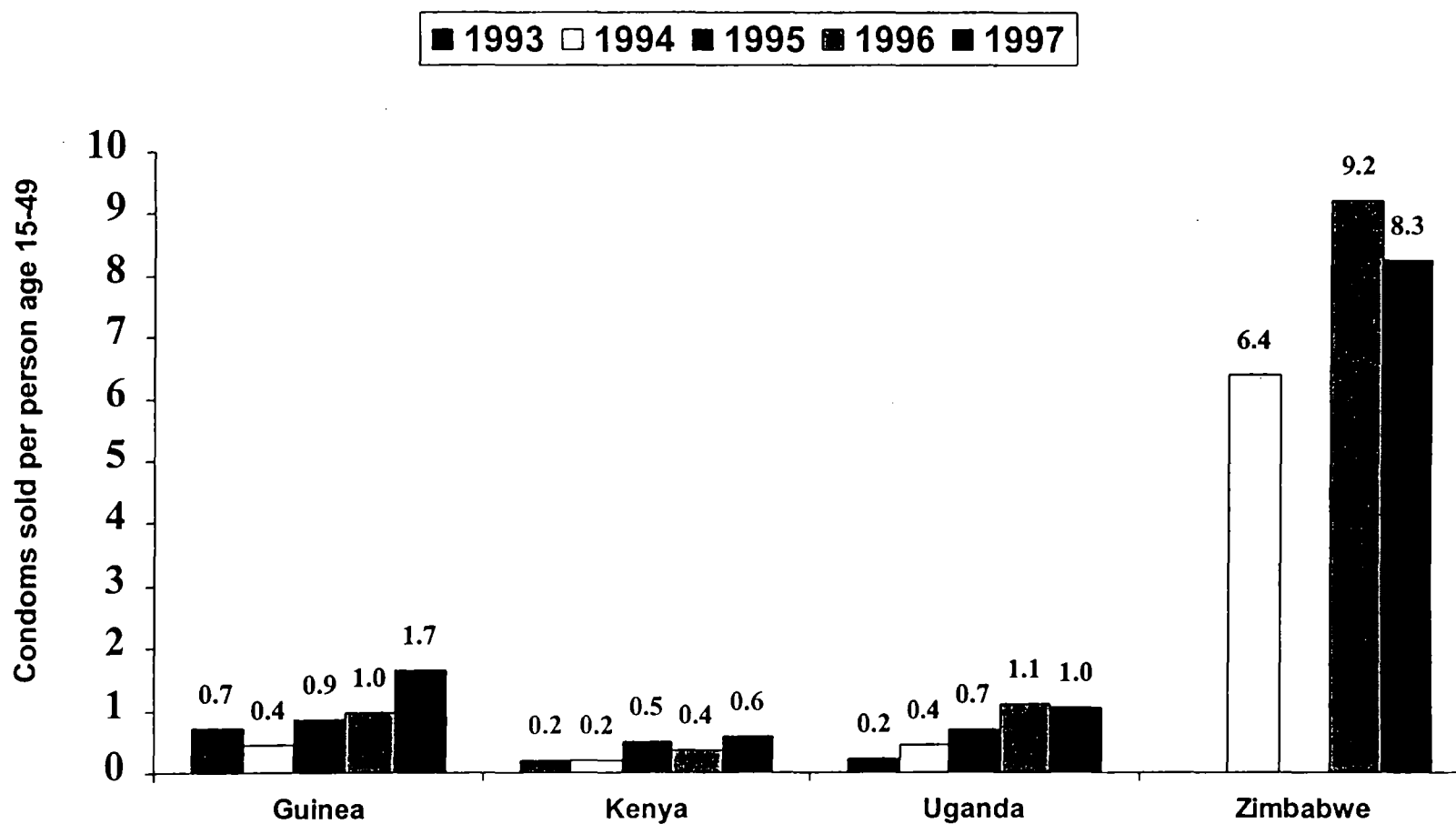


HIV/AIDS Prevention and Mitigation in Africa

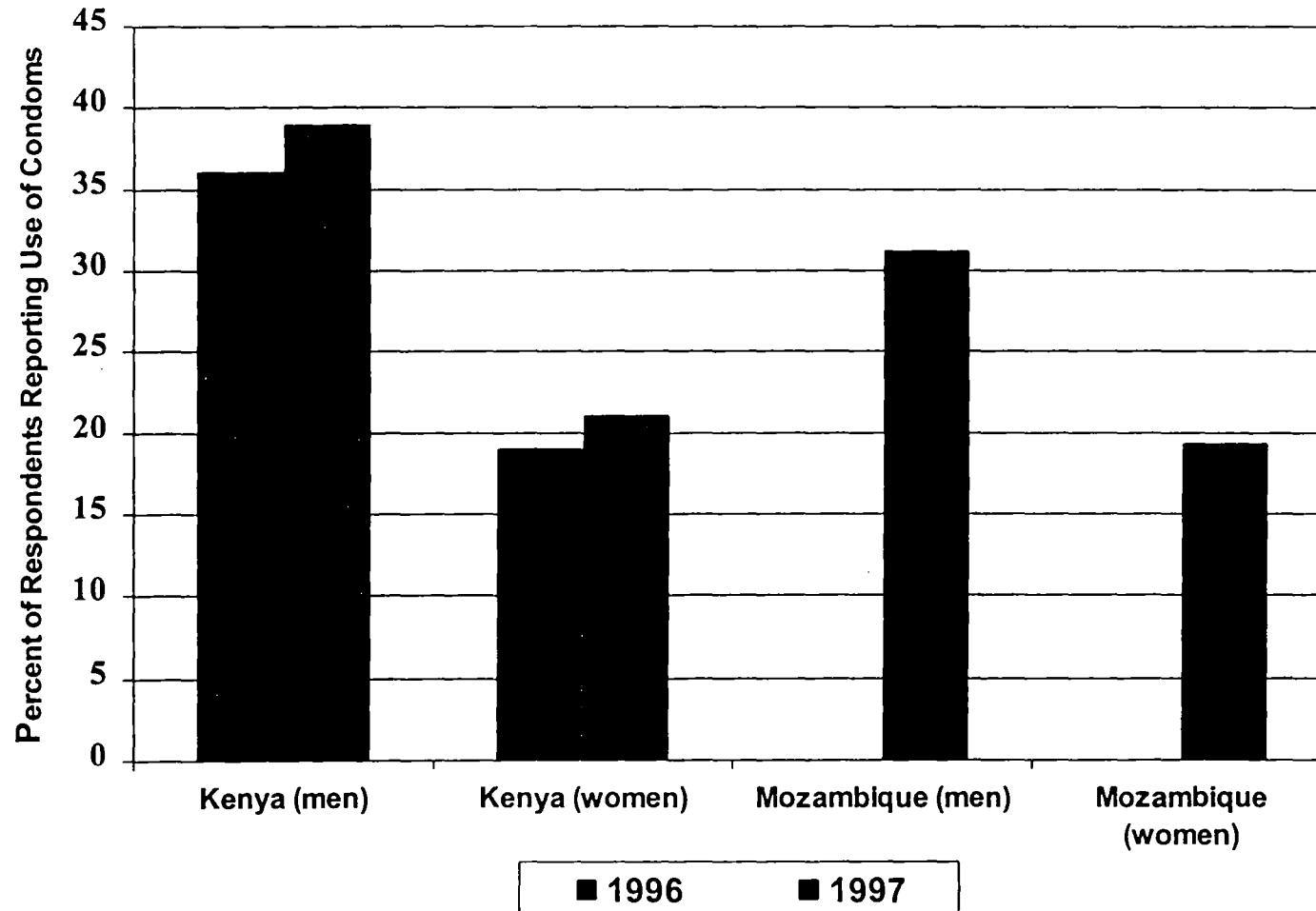
KEY ISSUES

- **Mitigation is Essential to Prevention**
- **HIV/AIDS is Still Being Compartmentalized**
- **Stigma and Silence Lead to Inaction**
- **Lack of Leadership and Political Will**
- **Current Monitoring & Evaluation Methods are Insufficient for Decision-Making**

Condom Social Marketing: Annual Sales per Adult of Reproductive Age



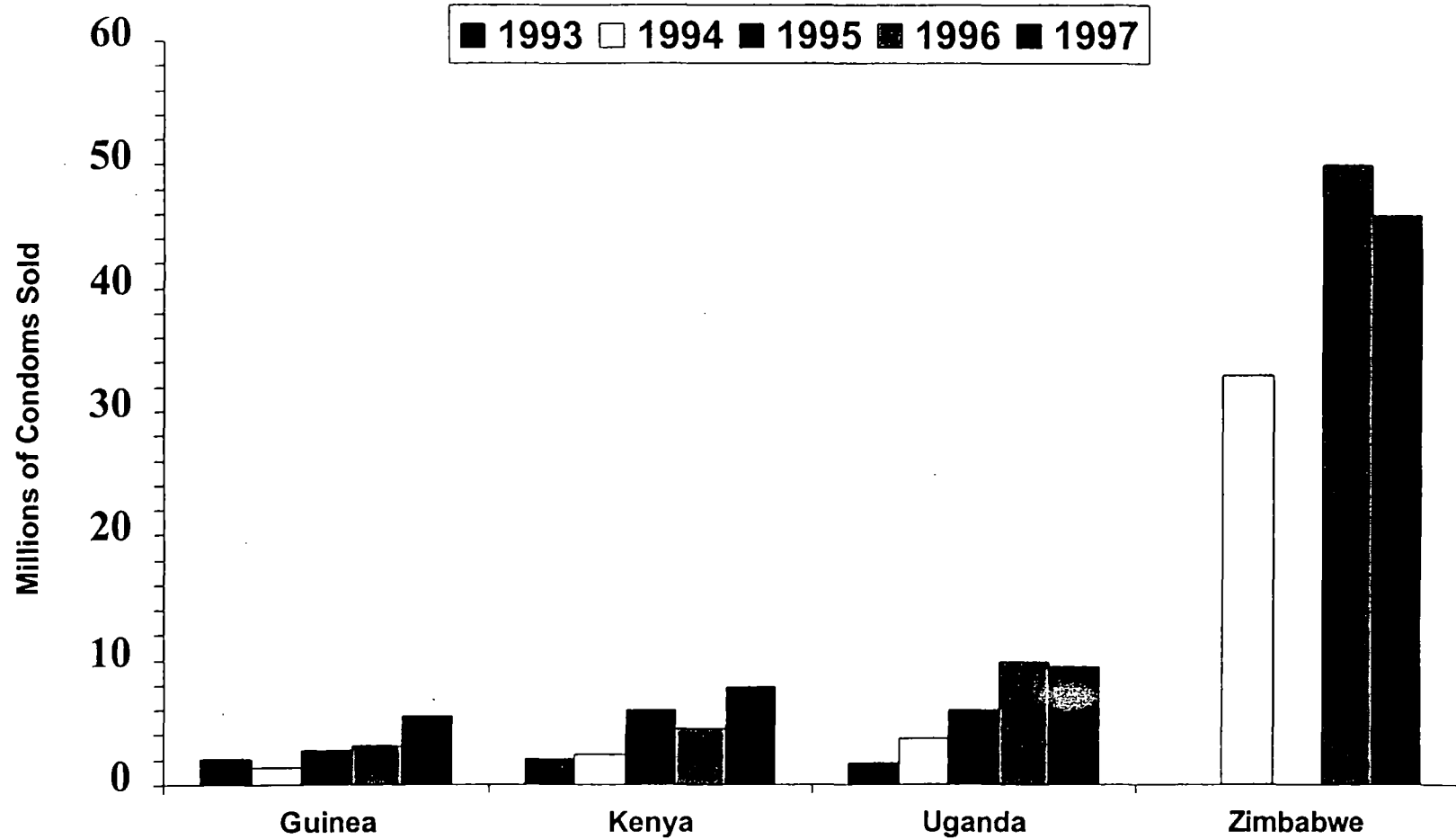
Percent of Respondents Reporting Use of Condoms in Most Recent Act of Sexual Intercourse with Non-Regular Partner



HIV/AIDS Prevention and Mitigation: Inventory of Program Indicators Reported in Africa

- **HIV Seroprevalence**
 - Sentinel Surveillance
 - Special Studies
- **Behavioral Indicators**
 - Reported condom use
 - Reported partner reduction
- **Indicators of Knowledge and Attitudes**
 - Knowledge of two means to prevent HIV transmission
 - Knowledge of condoms as means of prevention
- **Service Supply Indicators**
 - Condom Supply: social marketing
 - Access to HIV testing and counseling
 - Quality of HIV/STD services
 - Number of new HIV positive individuals counseled

Condom Social Marketing: Annual Sales



HIV/AIDS Prevention and Mitigation in Africa

SOCIETAL IMPACT OF HIV/AIDS

- **Human Toll: Morbidity & Mortality**
- **Economic Impact**
- **Social Disruption (Civil Unrest)**
- **Political Destabilization**

Countries Reporting H V/A DS Activities in Sub-Saharan Africa

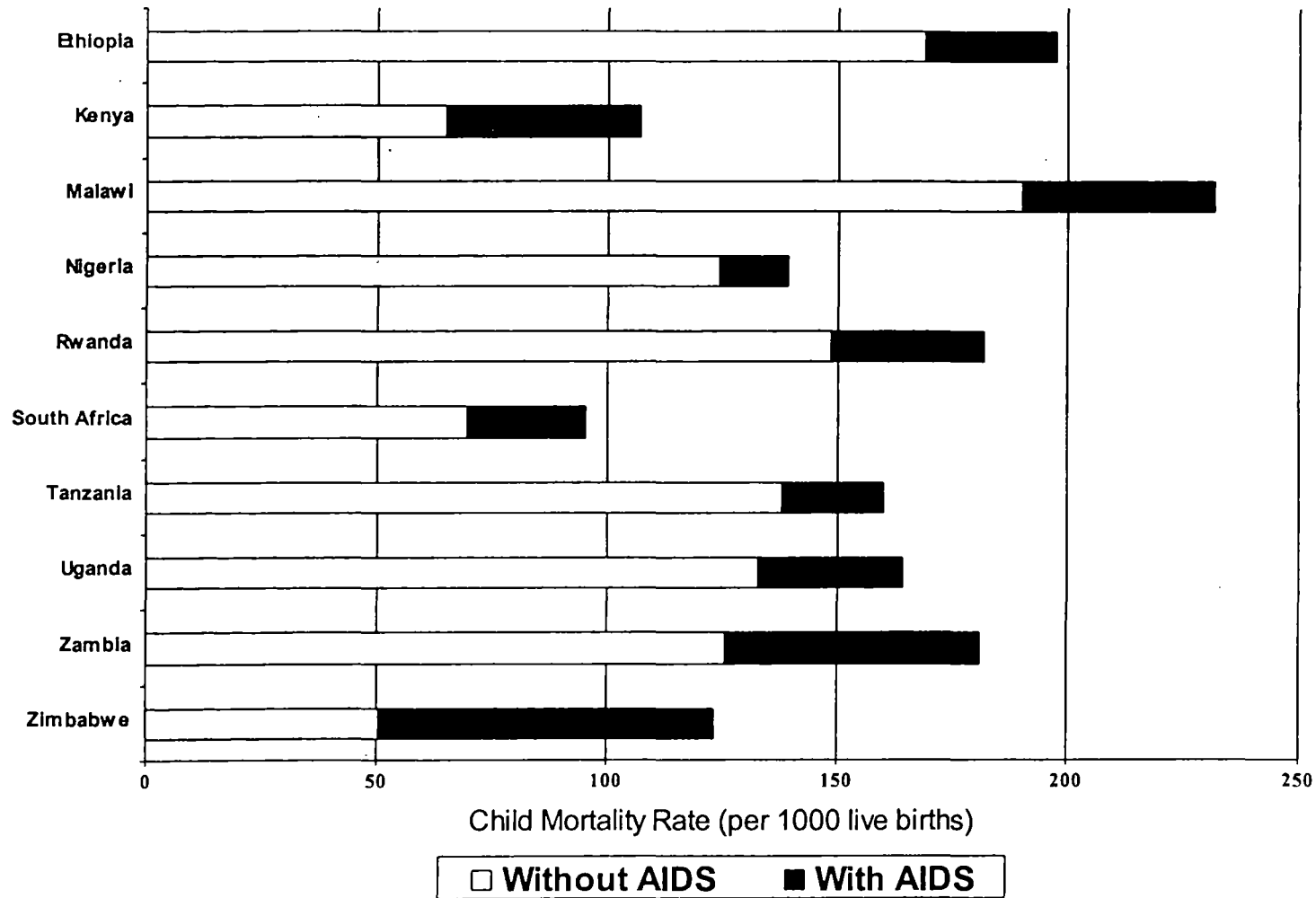


■ **East Africa**
REDSO/ESA
Eritrea
Ethiopia
Kenya
Uganda

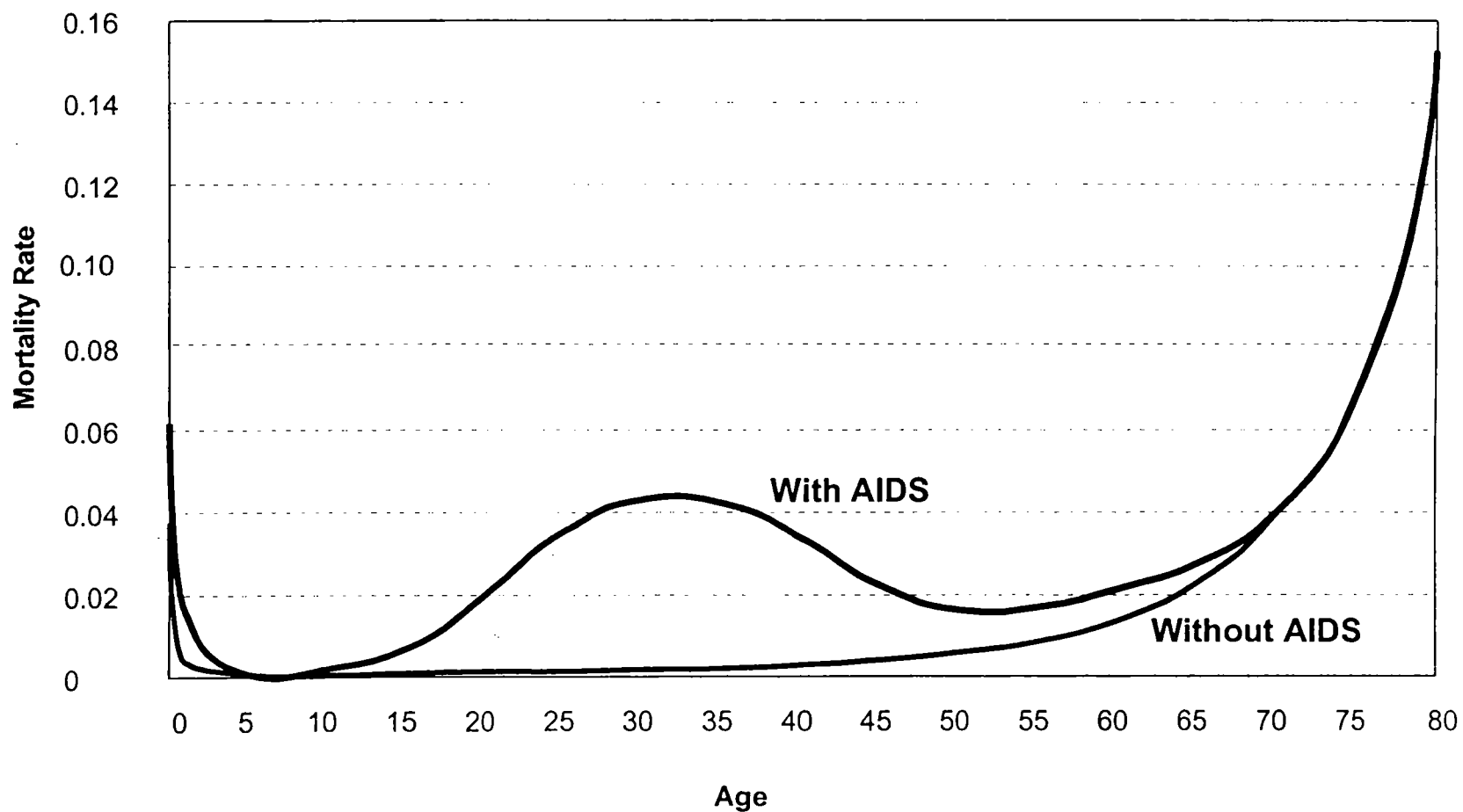
■ **Southern Africa**
Madagascar
Malawi
Mozambique
Tanzania
South Africa
Zambia
Zimbabwe

■ **West Africa**
REDSO/WCA
Burkina Faso
Cameroon
Cote d'Ivoire
Togo
Benin
Ghana
Guinea
Mali
Nigeria
Senegal

Child Mortality Rates with and Without AIDS, for Selected Countries, 1998



Impact of HIV on Age-Specific Mortality Rates at Approximately 20% Adult Prevalence

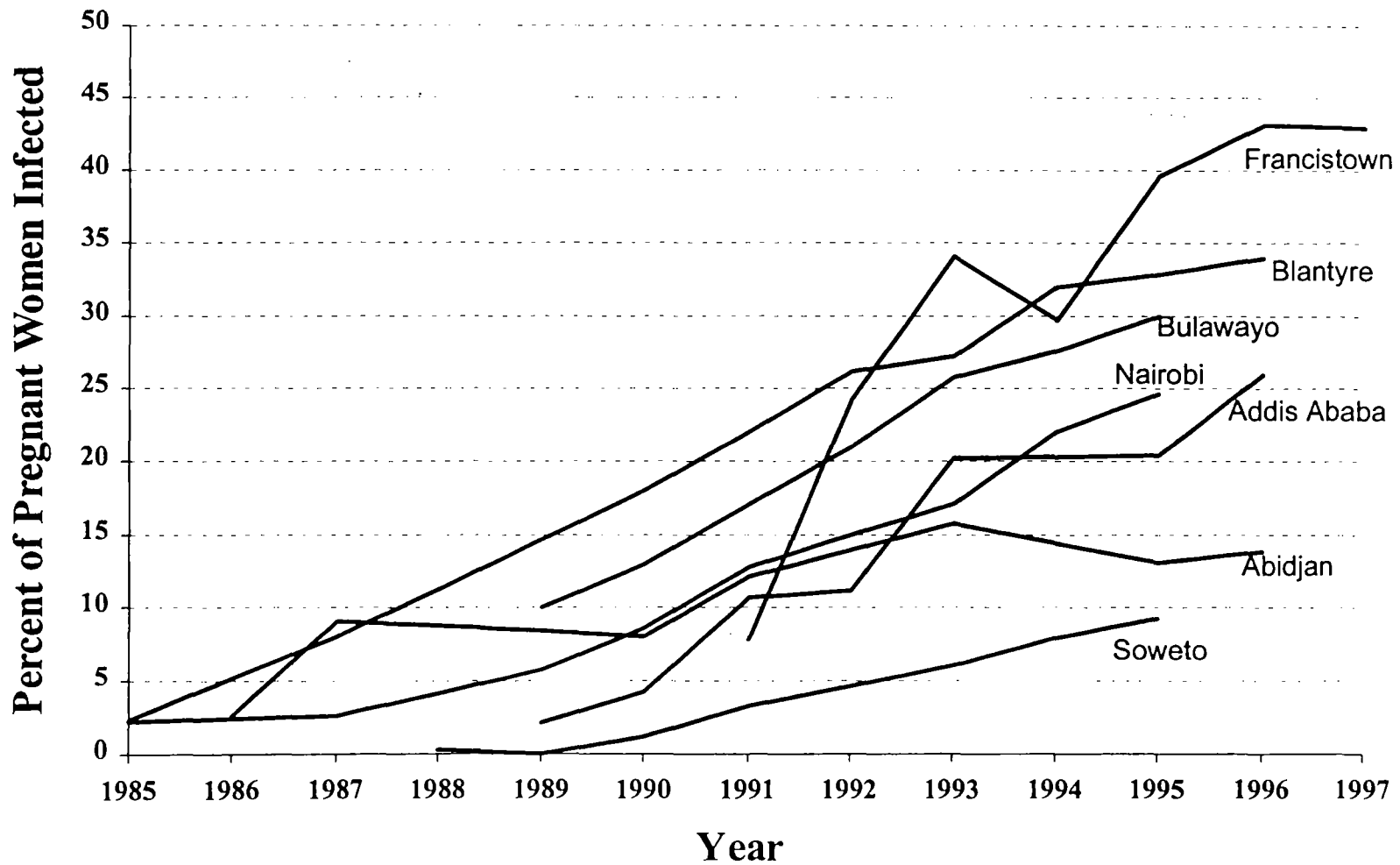


HIV/AIDS Prevention and Mitigation in Africa

- **Overview of HIV/AIDS Epidemic**
 - **Overview of USAID Results in Africa**
 - **Emerging Issues**
 - **Recommendations**
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AFR R4 FY 2000 Wrap-Up

HIV Seroprevalence Rate for Pregnant Women in Selected Urban Areas of Africa, 1985 - 1997



- In order to know "what works" under what circumstances, HIV/AIDS and STI programs have two jobs to do: establishing the effectiveness of particular interventions (e.g. do some forms of voluntary counseling and testing reduce subsequent high risk sexual behavior?); improving the delivery of established interventions (e.g. what is the best way to treat and prevent asymptomatic STIs in women?). Thus the M&E agenda is broader than in some more established development fields.
- To improve the fit between data gathering strategies and the needs of decision-makers, players at all levels require increased awareness and training in the interpretation of M&E.

Recommendations

To approach the above mentioned issues the recommendations of USAID are as follows:

Take a leadership role in addressing AIDS-related stigma.

- Create a forum for discussion of HIV/AIDS stigma by and for Africans. Assist African partners to develop anti-stigma strategies which build upon lessons learned from the previous public health campaigns that have reduced stigma (e.g. mental illness, adoption, TB).

Help re-mobilize leadership and political will in HIV/AIDS.

- Step up efforts within all development sectors to engage a wider array of African leaders in solutions to their countries' HIV/AIDS problems.
- Strengthen linkages with the US domestic HIV/AIDS community to develop better models of political leadership and policy makers.
- Engage other "critical agents of change" (community, business and foreign policy partners) in this effort.

Increase the strategic focus on adolescents.

- Increase programming on HIV/AIDS and reproductive health designed for and with adolescents.
- Leverage adults' concerns about their youth to motivate behavior change and support.

Develop and use more effective evaluation methods and strategies.

- Continue collaboration of USAID Africa and Global Bureaus with UNAIDS, US Bureau of the Census, CDC and other key partners to define and disseminate second generation sentinel surveillance methods.
- Finalize field test and refine common indicators for HIV/STI programs including measures for care and support and other new intervention strategies.
- Promote standardization for improved comparability across programs and across sources.

erved every day, especially in the comprehensive multi-faceted programs implemented in countries such as Zambia and Uganda, these measures assist in monitoring programs and optimizing the potential for success.

Key Issues

Mitigation is Essential to HIV Prevention

- Since the outset of the epidemic, USAID and other donors have focused their resources on HIV prevention as the most cost-effective strategy to control the epidemic. But as the numbers of people living with HIV/AIDS (PLWHA) have increased (to an estimated 20.8 million Africans by the end of 1997), this position is no longer wise:
- Mitigation efforts are desperately needed, including care and support for individuals and communities; and structural interventions to reduce the economic, political and other societal-level barriers that create HIV risk and impede prevention programs.
- As a customer focused Agency, USAID must respond to the expressed needs of communities and governments that are struggling with overburdened health systems and escalating demands for HIV-related medical care.
- In addition, PLWHA are the most important clients for prevention interventions, and the most effective agents of behavior change communications. HIV/AIDS programs are strengthened by the participation of PLWHA, and lose credibility when the needs of this important audience for care and support are ignored.

HIV/AIDS still is being compartmentalized

- Despite rhetoric of "multi-sectorality" in state of the art policies and many African national HIV/AIDS strategies, the reality is that HIV is still too often approached at the government level as the responsibility of Ministries of Health alone. A recent World Bank situation analysis in Malawi, where nearly a third of adults in urban areas are believed to be HIV seropositive, likened the threat of AIDS to a military threat - and called for a full-scale mobilization, as though the country was facing a war. Any other threat that threatened to take out a tenth to a third of the adult population would surely evoke the kind of concerted, cross-sectoral mobilization we have seen in response to major military and natural disasters. Yet the equally lethal threat of HIV/AIDS languishes in the under-funded and under-staffed ministries of health; where it is often ignored by public and private sector leaders alike.

Stigma and Silence lead to Inaction

- HIV/AIDS makes people uncomfortable - both because of its health consequences, and also because early in the epidemic, it became associated with behaviors and populations that violate social norms.

- Silence about HIV/AIDS and the stigma and discrimination societies have heaped upon it, is not neutral, it actually makes the stigma worse. Things that people don't talk about are perceived as "bad."
- These associations and feelings have caused and been used to rationalize serious discrimination and harm to people who do or are suspected of having HIV: at their jobs, in their homes, in their relationships and communities. The stigma of HIV/AIDS thus greatly increases the practical as well as the emotional burdens on PLWHA and their families.
- Fear of those consequences, and fear of being identified or associated with HIV/AIDS, leads people to fear learning their own serostatus, and to conceal their fear and their serostatus from others. This has complex and devastating effects on prevention programs. Fear of being thought to have HIV/AIDS, or to be practicing risky behavior, is a common reason men give for not using condoms. Fear of being associated with HIV/AIDS makes leaders ignore it in their policy documents and speeches.

Lack of Leadership and Political Will

- Mobilizing support of political and other key leaders has been a continuing challenge since the outset of the epidemic, due to a complex of factors including HIV/AIDS stigma and the competition for their attention and scarce resources from other serious health and development challenges. This problem is not unique to African countries, nor to the developing world.
- Lack of visible public engagement about HIV/AIDS by respected community and national leaders reinforces HIV/AIDS stigma, and creates the false impression that the problem is not sufficiently grave to warrant policy-makers' attention. In such an environment it is impossible to mobilize the kinds of broad social and economic support required to provide services for prevention and care.
- On the other hand, involvement by key policy-makers and public opinion leaders creates a supportive environment for HIV/AIDS programs, makes it easier to provide accurate HIV and STI information and services, stimulates creative thinking across sectors about how their activities could become "part of the solution," and conveys the message to ordinary people that responsible citizens are or should be involved with HIV/AIDS prevention, care and support.

Current Monitoring and Evaluation (M&E) Methods are Insufficient for Decision-making

- Although results-based programming has improved rational strategy and program design, the R4 process has reaffirmed the awareness that:
 - available monitoring and evaluation methods are incomplete
 - some desired data are expensive to collect, and are not appropriate for annual reporting (e.g. some outcomes change more slowly than others)
 - quality control on data collection, reporting, and analysis and dissemination has been relatively neglected

3) Social Disruption

Not only do persons with HIV suffer as they get sick with AIDS and prematurely die; their family members, friends and colleagues bear immense burdens of care and social stigma that exacerbate the direct impact of HIV. Hard won gains in girls' education are threatened when families withdraw their daughters from school in order to work or care for the sick. The pernicious effects of AIDS stigma jeopardize social relationships, employment and even access to health care - not only for people living with HIV/AIDS (PLWHA) but also for people thought or assumed to have the infection.

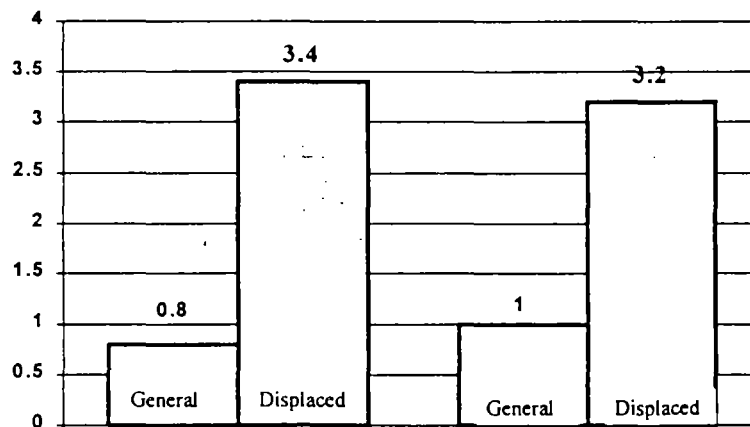
HIV/AIDS also stresses already vulnerable systems in health care, and community life. Some communities in high prevalence areas have already exceeded their abilities to absorb destabilized families, orphans and dependents. However, we have not yet seen the peak number of orphans who will require additional support. In Sub-Saharan countries, orphanhood is expected to rise to 13.5 percent of children under age 15 by the year 2010. The sharp increase in orphanhood will reduce enrollment in schools and increase child labor.

4) Political Destabilization

Just as civil conflict increases the opportunities for HIV to enter new environments, AIDS itself also threatens political stability revealing the fault lines of communities and nations. The military is one of the most affected sectors in East and Southern Africa. In the aftermath of conflict, HIV can be spread by decommissioned personnel return home. Tanzania's 1992 invasion into Uganda and the 1994 genocide in Rwanda, for example, are partially blamed for the surge in AIDS in those regions. Similarly, the difference in the HIV prevalence among the general and displaced population has been noted. For example, in Mozambique there is a threefold difference in HIV prevalence between the general and displaced populations (Figure 3, below).

Figure 3: Conflict, War, and HIV/AIDS

HIV Seroprevalence Rates among General and Displaced Populations in Mozambique 1987/1992



"Consequences of political and civil unrest and subsequent population displacement have led to an increased spread of HIV transmission." International Conference on AIDS, 1996

Source: U.S. Bureau of the Census, International Programs Center, 1998.

Overview of USAID's Efforts in Africa

Since the international epidemic was recognized, USAID has been a global leader in bilateral and multilateral support for HIV/AIDS prevention. USAID was one of the key advocates for developing a UN system-wide response to the epidemic, and since 1996 has also been the lead sponsor of UNAIDS. USAID, other donors, UNAIDS, and national governments work together at the country level, so while it is difficult to fully isolate the contribution of a single donor's efforts in Africa, several nationwide and targeted programs have had a significant impact in achieving results.

USAID has focused on preventing the heterosexual transmission of HIV in over twenty countries. Significant progress has been made via programs that:

- increase knowledge about HIV among the population ;
- change risky sexual behavior, through education, motivation and innovation; promote condom use;
- increase the availability of condoms and access to quality STI and other reproductive health services;
- conduct research to improve the cost-effectiveness of programs.

Recently USAID has responded to the escalating call to help countries develop effective and affordable approaches to HIV care and support.

Mission programs have had very different experience with the epidemic; coordination among Ministries of Health, NGOs, other donors; and the scale and scope of their programs. Missions have responded with single interventions such as adding condom social marketing to an existing child survival or reproductive health portfolio, to comprehensive programs including behavior change communication, condom social marketing, the control of sexually transmitted infections (STI), policy dialogue, and research. Mission programs are at different levels of achieving their objective of HIV/AIDS prevention and mitigation. A variety of indicators to measure the performance of HIV/AIDS related programs are used and only a few missions are able to determine seroprevalence rates. Figure 4 summarizes the indicators used by USAID programs in Africa to measure the results (with the number of missions using the indicator).

While a small number of quantitative indicators can never capture the success and synergies that are being

Figure 4: Program Indicators
(Number of Missions Using)

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- **HIV Seroprevalence (4)**
 - Few countries are able to determine seroprevalence trends.
 - Seroprevalence changes in Uganda are being further analyzed for programmatic implications.
 - **Behavioral Indicators**
 - Condom use (6)
 - **Indicators of Knowledge and Attitudes**
 - Knowledge of two means to prevent HIV transmission (4)
 - Knowledge of condoms as means of prevention (2)
 - **Service Supply Indicators**
 - Condom supply: social marketing (11)
 - Access to HIV testing and counseling (4)
 - Quality of HIV/STD services (1)
 - Number of new HIV positive individuals counseled (1)

HIV/AIDS Prevention and Mitigation in Africa

Africa R4 2000 Wrap-Up

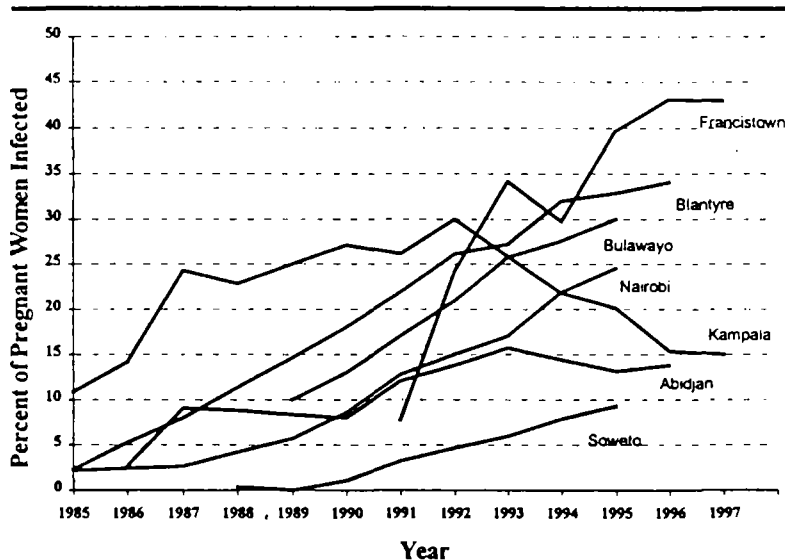
June 17, 1998

Overview:

During the past twenty years, since the HIV/AIDS epidemic was first recognized, there has been significant effort and progress in containing the spread of the disease. However, the spread of the infection continues, fuelled by economic and political challenges that strain health budgets and household coping mechanisms. Since the early 80's an estimated 30 million people worldwide have been infected with the virus, of which nearly seventy percent live in Sub-Saharan Africa.

In Sub-Saharan Africa, 7.4% of all individuals 15 to 49 years of age are infected with HIV. There are significant regional variations in levels of HIV infection among countries, between urban and rural areas and between populations. The estimated seroprevalence ranges between 2 to 12 percent in urban areas and can be as high as 40 percent among groups engaged in sexual risk taking. Heterosexual transmission accounts for most infections, with 50% of these in women and with over 400,000 infants infected in 1997 alone. The best available source of information about rates of HIV is sentinel surveillance systems tracking HIV rates of pregnant women at antenatal care centers. Figure 1 shows different levels of HIV seroprevalence amongst pregnant women in selected urban areas. The rate of increase of prevalence varies also.

Figure 1: HIV Seroprevalence Rate for Pregnant Women in Selected Urban Areas of Africa, 1985 - 1997



Source: U.S. Bureau of the Census, International Programs Center and ICMH.

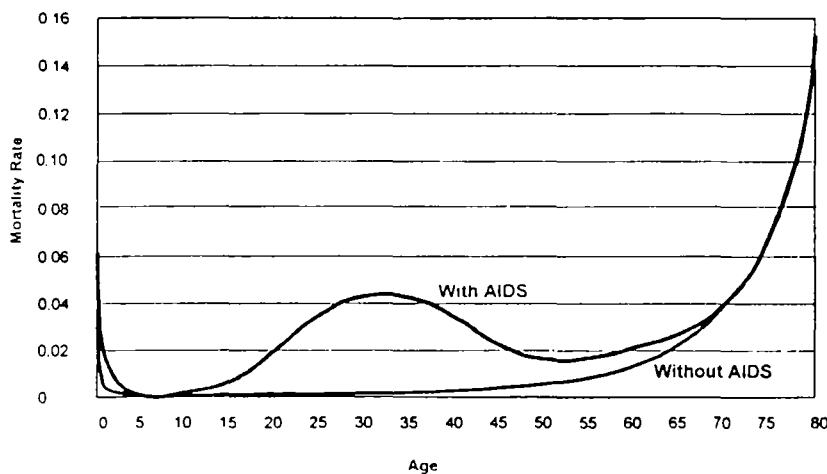
At national levels, there is a high variation. In South Africa, nearly 20% of pregnant women are infected, in Zambia the HIV prevalence is 15 percent among pregnant women (aged 15 - 16 years), whereas in Senegal the estimate is as low as 2% among pregnant women.

Societal Impact of HIV/AIDS

1) Human Toll: Morbidity & Mortality

Apart from the high rates of morbidity in the Africa, mortality rates are rising drastically reducing life expectancy by as much as thirty years. Figure 2 shows the "death gap," the difference between death rates with and without AIDS by age group. The greatest losses to HIV/AIDS are between the ages of

Figure 2: Impact of HIV on Age-Specific Mortality Rates at Approximately 20% Adult Prevalence



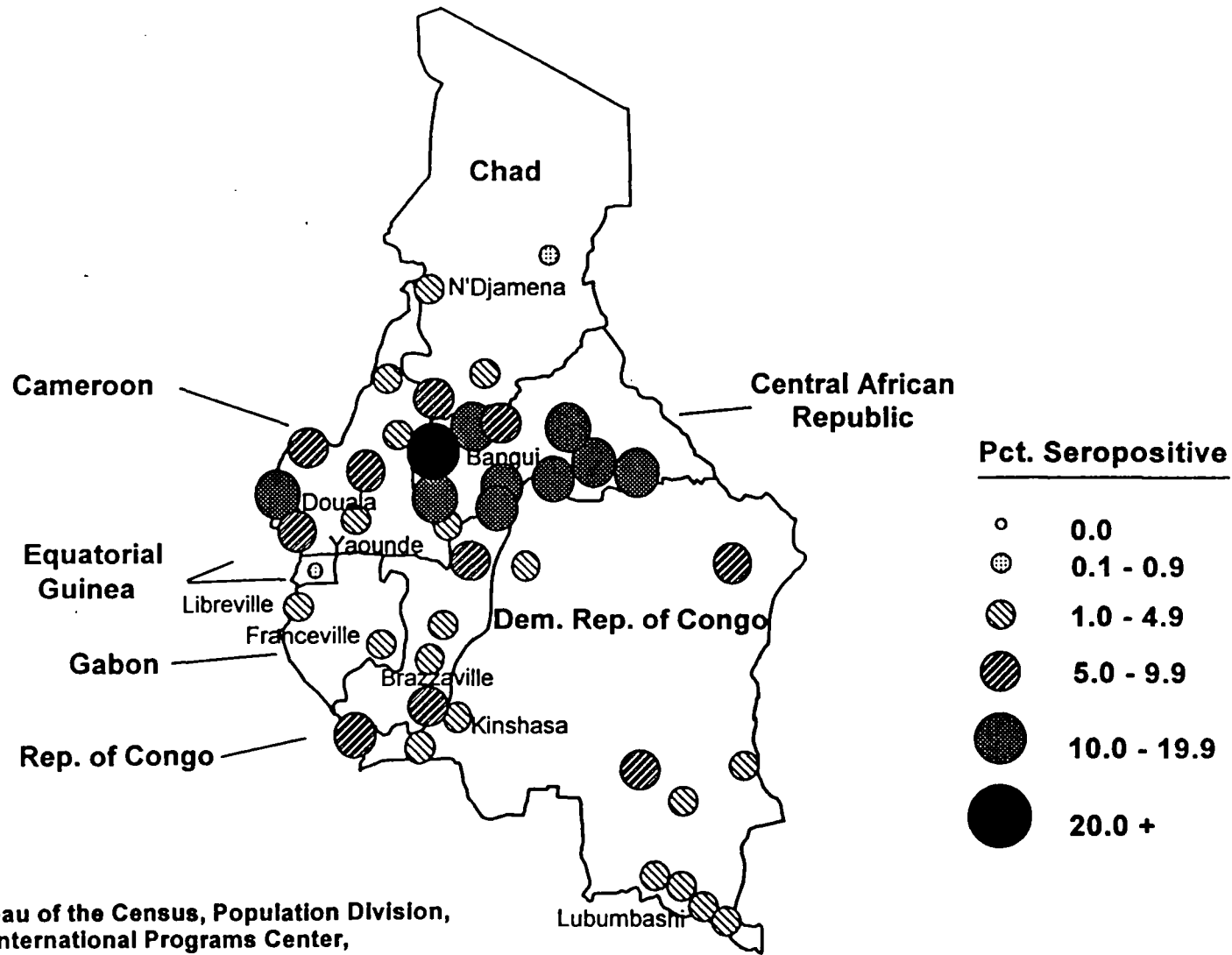
Source: U.S. Bureau of the Census, International Programs Center, 1998.

20 and 45 during which an individual is economically most productive and supportive to the family. Also, HIV/AIDS has a profound effect on mortality of infants and children below the age of five due to intrauterine infection and perinatal transmission. In countries like Zambia and Zimbabwe infant mortality rates have doubled and child mortality rates may triple by the year 2010. Yet because of population momentum at the national level, population growth will continue to rise even in the worst hit countries.

2) Economic Impact

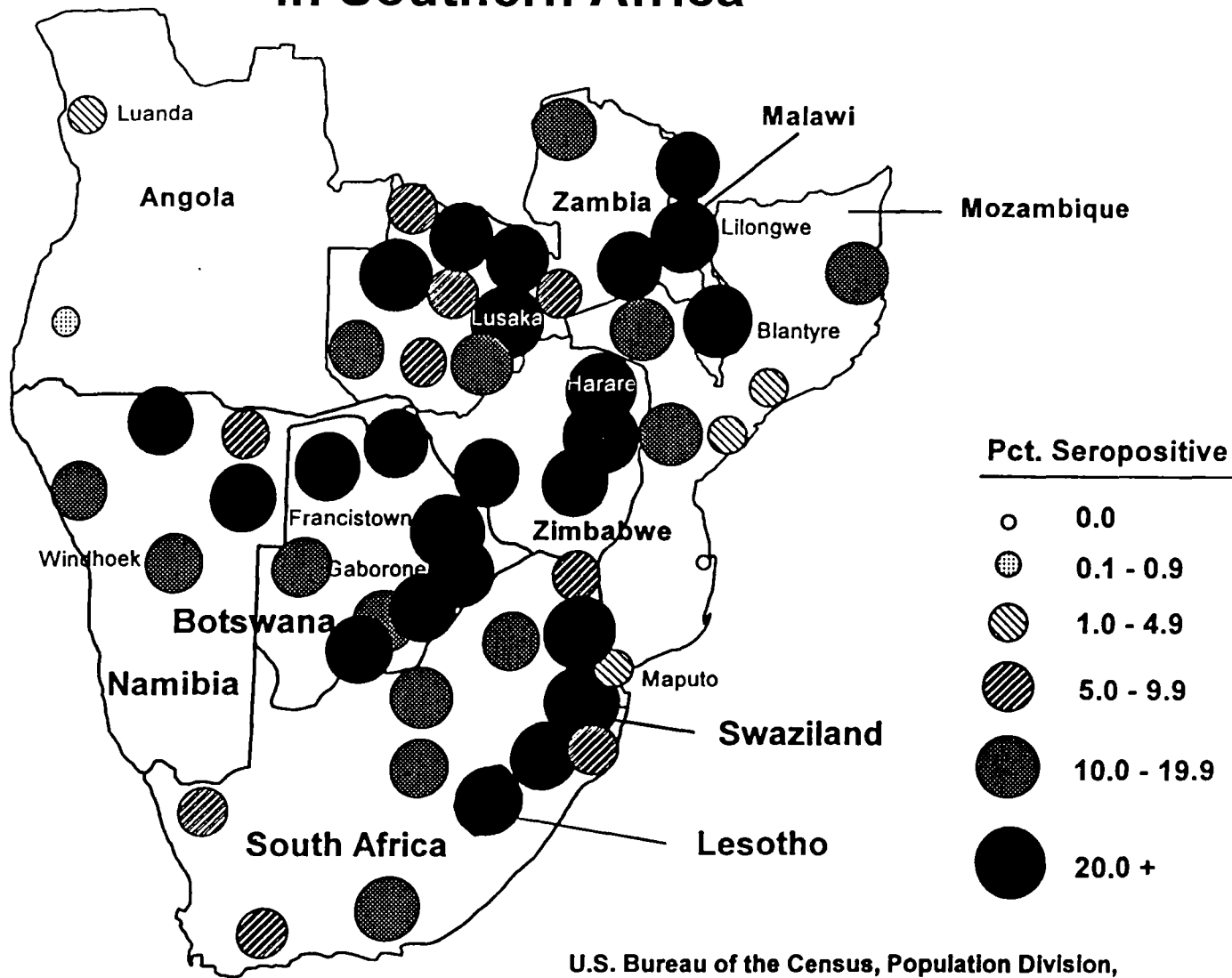
Thus far, the economic impact of HIV has been observed at the family and community level. Not surprisingly, the poorest are most severely affected. A household with a member infected with AIDS will bear expenditure increases due to medical care, special diet, etc. and loss of income due to lower agricultural production, absenteeism caused by illness, or death of friends and relatives. In industry and commerce, as well as other sectors the epidemic is expected to have a further impact due to workforce inefficiency, loss of trained staff and the costs of searching for and training of replacements. All these causes, plus diversion of government expenditures to fight the epidemic are predicted to add up to have macro-economic effects. Attempts to model economic impact estimate economic growth to be 25 percent lower than it would have been otherwise.

Seroprevalence of HIV-1 for Low-Risk Populations in Central Africa



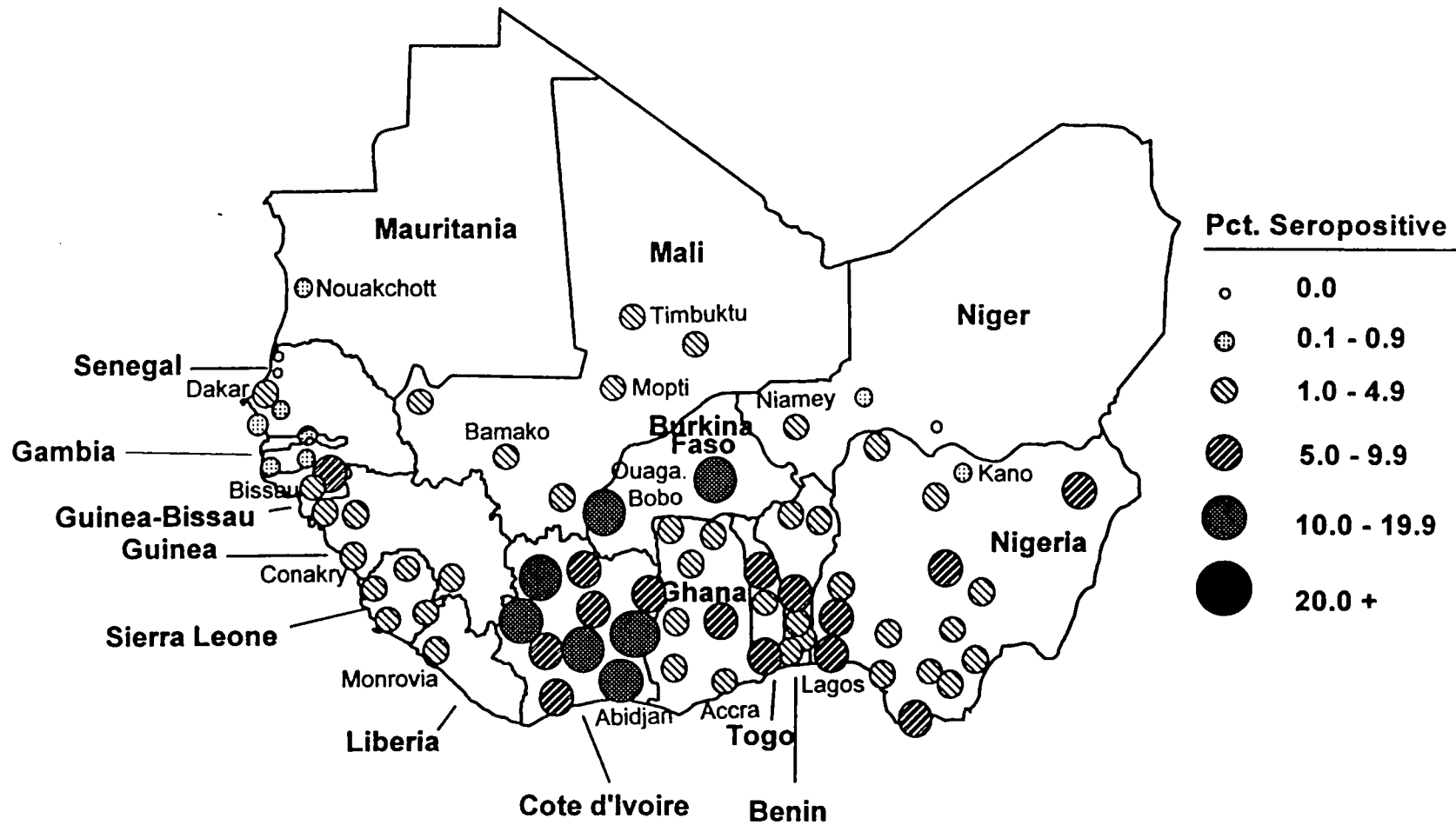
U.S. Bureau of the Census, Population Division,
International Programs Center,
HIV/AIDS Surveillance Data Base, July 1998.

Seroprevalence of HIV-1 for Low-Risk Populations in Southern Africa



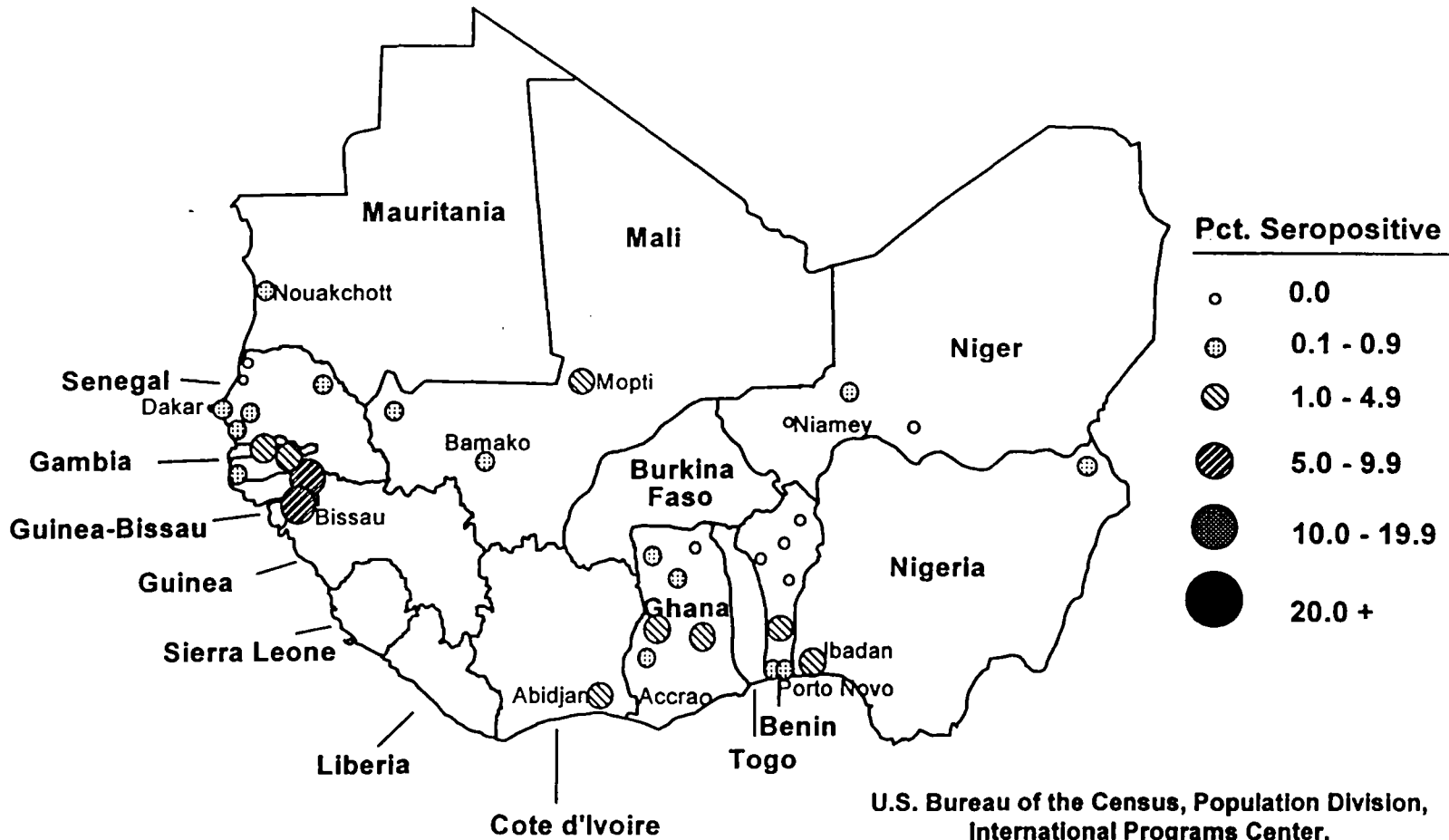
U.S. Bureau of the Census, Population Division,
International Programs Center,
HIV/AIDS Surveillance Data Base, July 1998.

Seroprevalence of HIV-1 for Low-Risk Populations in West Africa



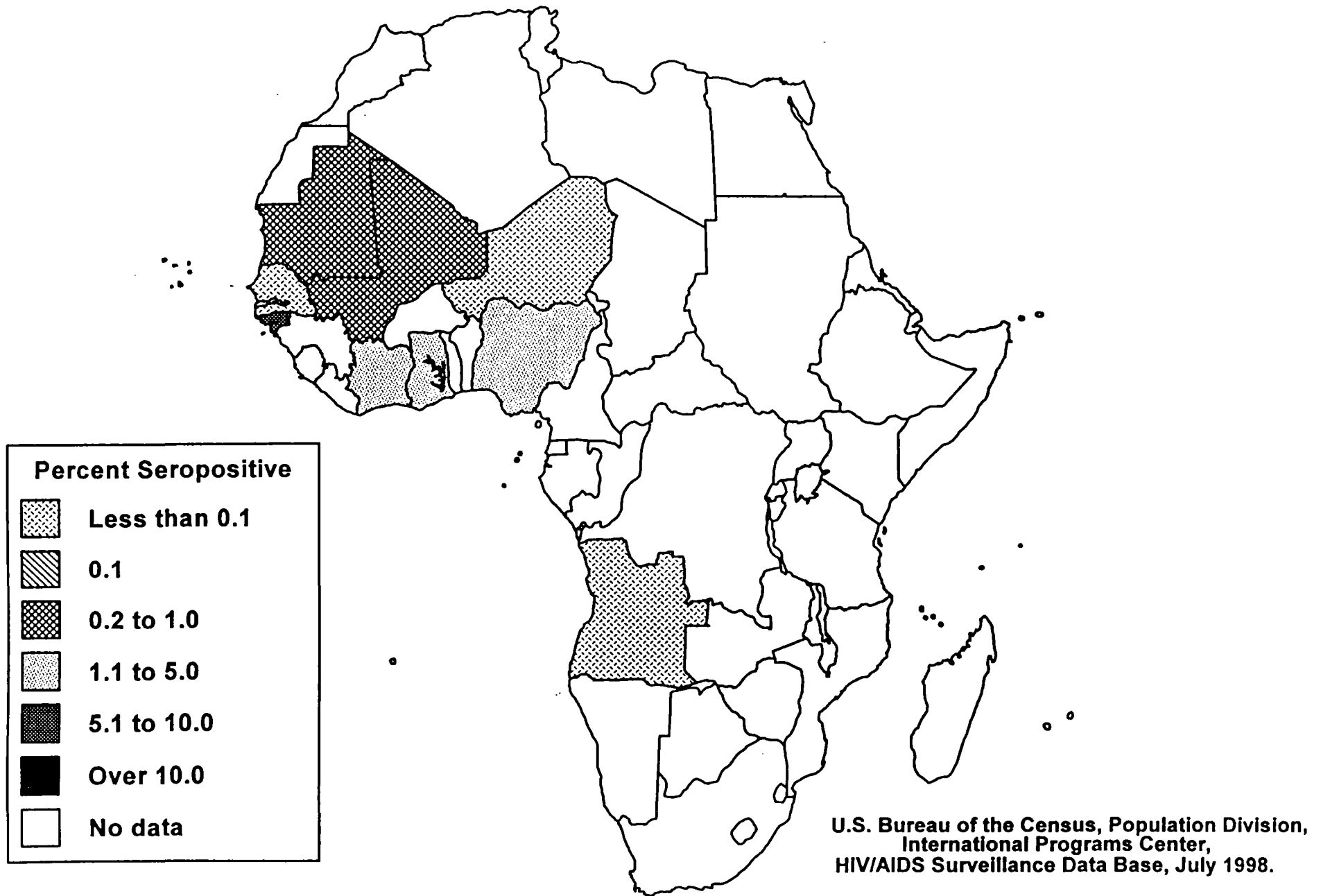
U.S. Bureau of the Census, Population Division,
 International Programs Center,
 HIV/AIDS Surveillance Data Base, July 1998.

Seroprevalence of HIV-2 for Low-Risk Populations in West Africa



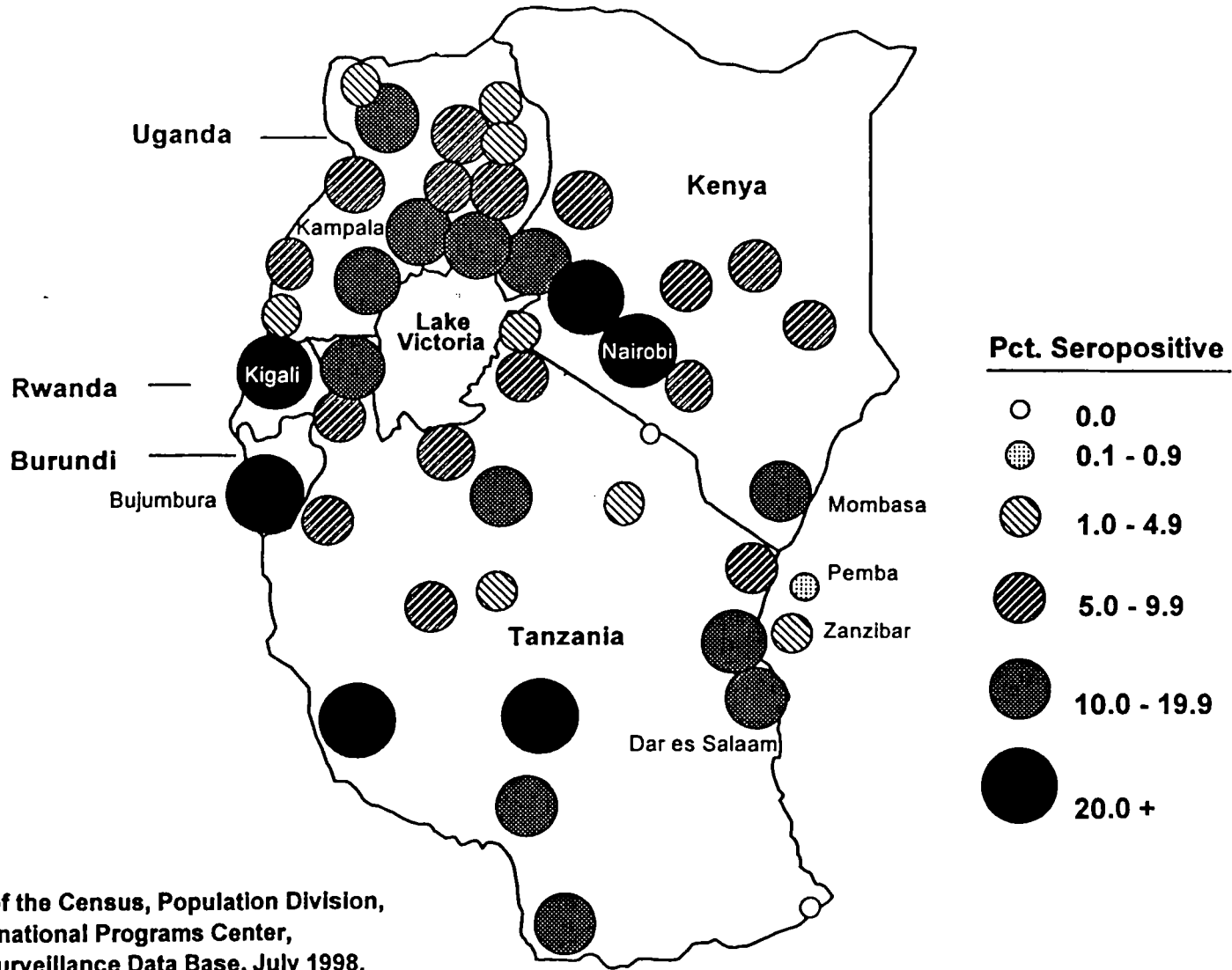
U.S. Bureau of the Census, Population Division,
International Programs Center,
HIV/AIDS Surveillance Data Base, July 1998.

African HIV-2 Seroprevalence in Low-Risk Urban Populations



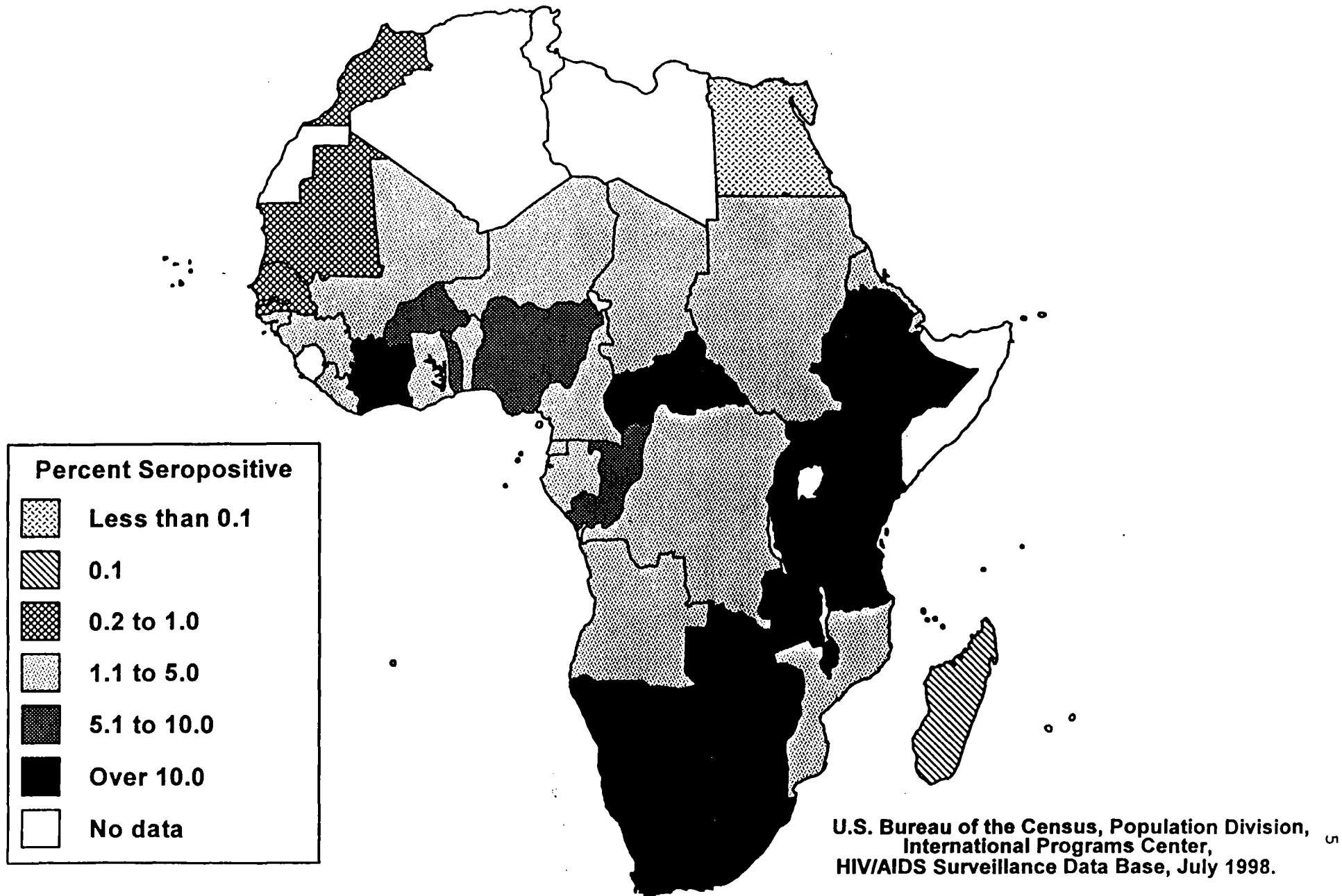
U.S. Bureau of the Census, Population Division,
International Programs Center,
HIV/AIDS Surveillance Data Base, July 1998.

Seroprevalence of HIV-1 for Low-Risk Populations in East Africa

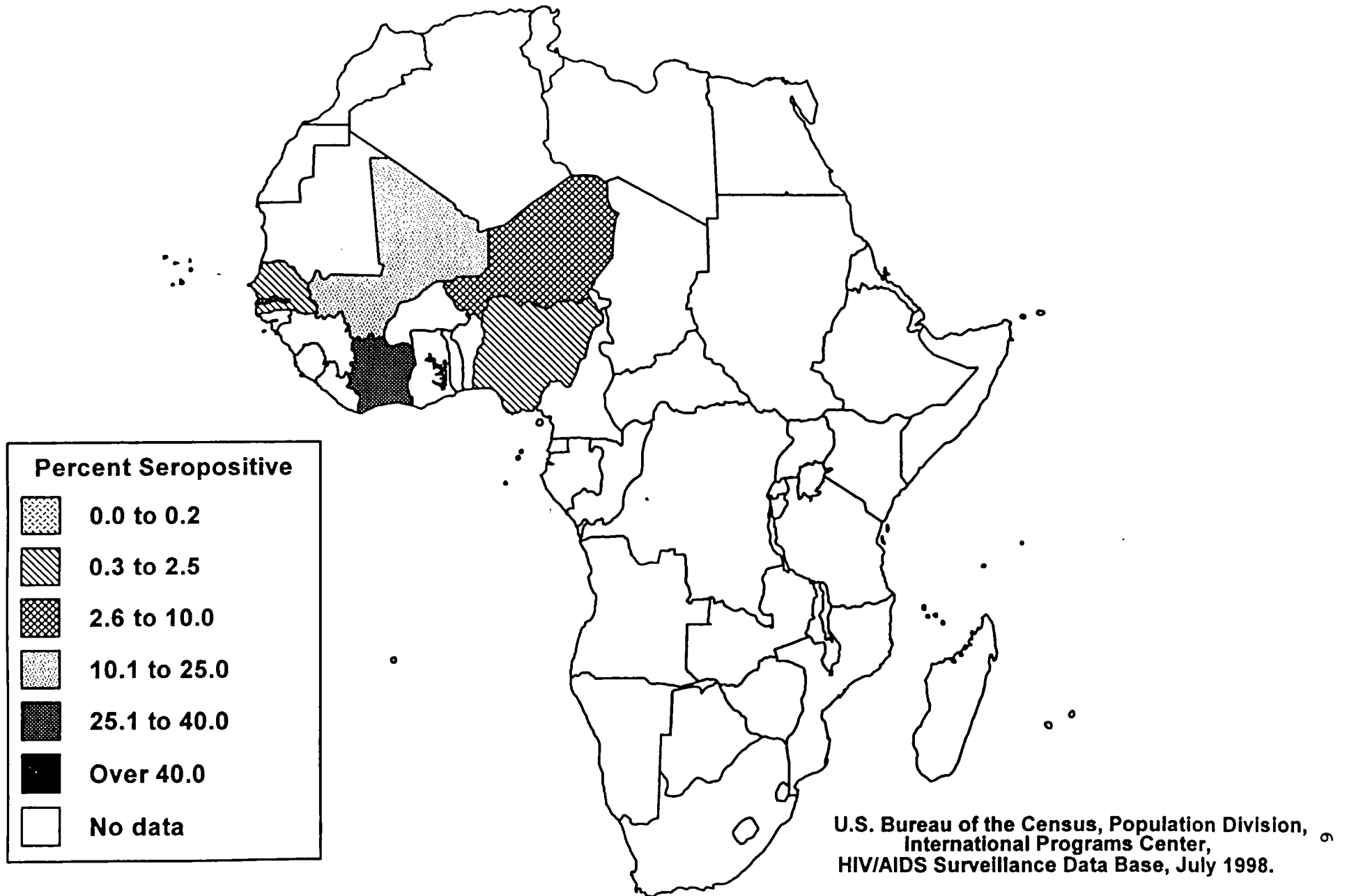


U.S Bureau of the Census, Population Division,
International Programs Center,
HIV/AIDS Surveillance Data Base, July 1998.

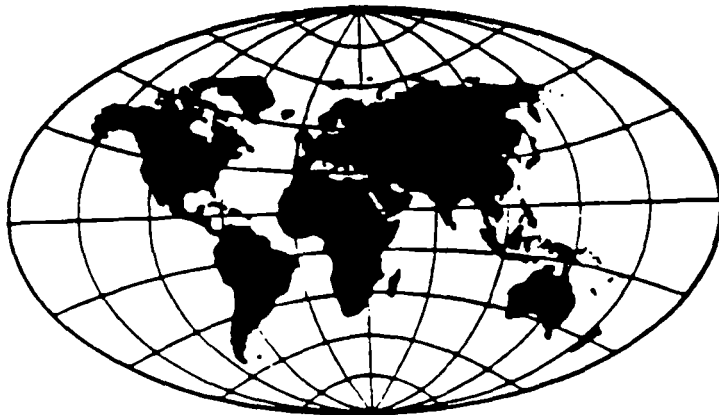
African HIV-1 Seroprevalence for Low-Risk Urban Populations



African HIV-2 Seroprevalence for High-Risk Urban Populations



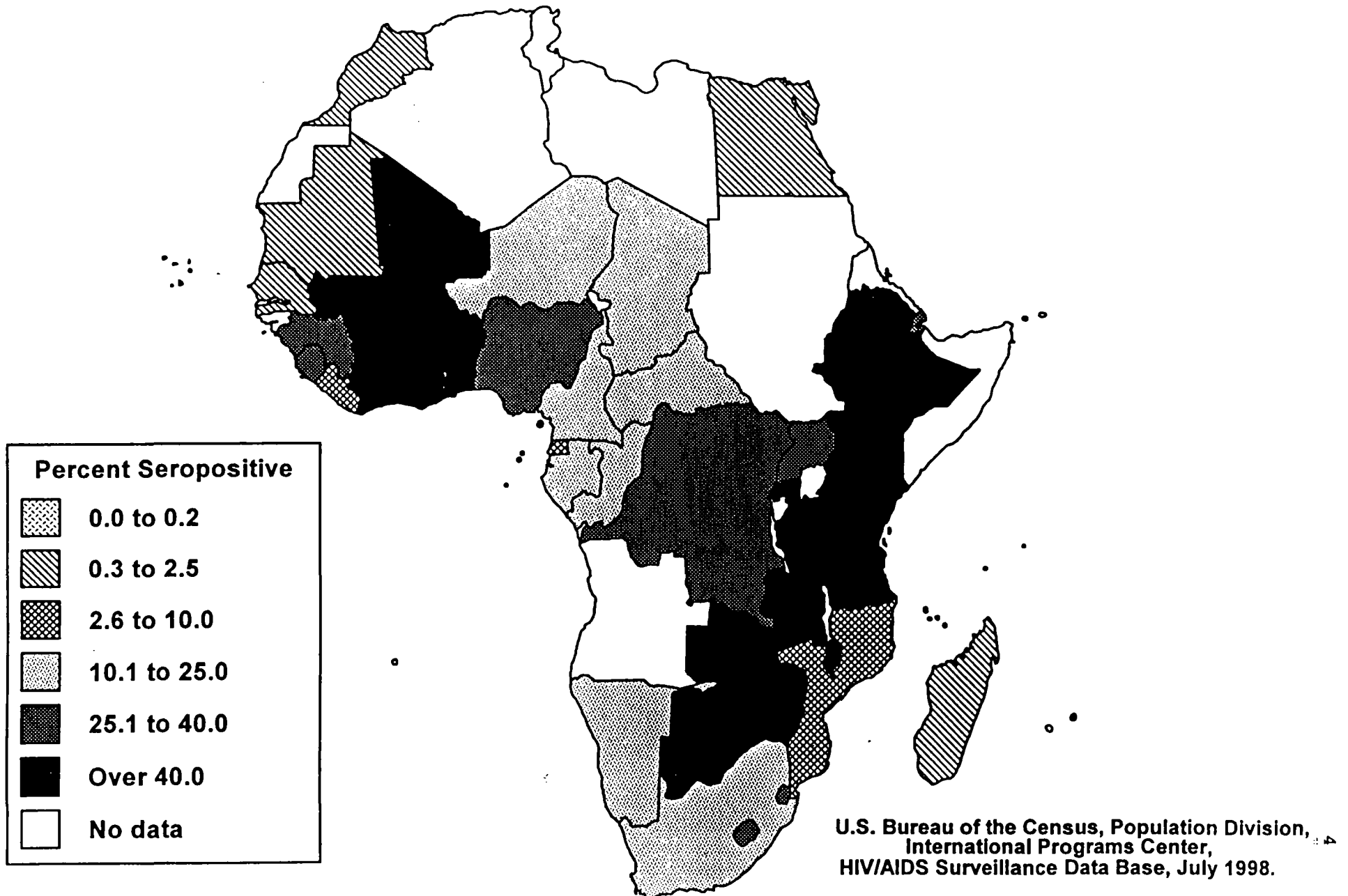
**RECENT HIV SEROPREVALENCE LEVELS
BY COUNTRY: JULY 1998**



**Health Studies Branch
International Programs Center
Population Division
U.S. Bureau of the Census**

**Research Note
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African HIV-1 Seroprevalence for High-Risk Urban Populations



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learning their HIV status.

There is evidence that the fear and denial provoked by AIDS extends even to people working in the health sector. One study in southern Africa sought to record the number of needlestick injuries in primary health care clinics. Researchers found almost none—an unlikely scenario in overworked clinics with poor facilities. Senior staff then explained that, under clinic policy, anyone who reported a needlestick injury had to undergo HIV testing to measure the danger of sero-conversion through exposure to infected needles. Nurses did not report needlestick injuries because they did not want to be tested.

Silence can continue to reign even when people with HIV are ill and dying. Because AIDS is just the name for a cluster of diseases that immunodeficient people develop, patients and their carers can choose to view the illness as just tuberculosis, or diarrhoea, or pneumonia. An example from southern Africa is telling. In one study of home-based care schemes, fewer than 1 in 10 people who were caring for an HIV-infected patient at home acknowledged that their relative was suffering from AIDS. Patients themselves were only slightly more likely to acknowledge their status.

"For too long we have closed our eyes as a nation, hoping the truth was not so real," South African Deputy President Thabo Mbeki told South Africans in October. "At times we did not know that we were burying people who had died from AIDS. At other times we knew, but chose to remain silent."

With this major speech, South Africa's leadership joined those who have spoken out loudly and clearly about AIDS, have sought to demystify it, and have encouraged discussion about safe sex everywhere from the classroom to the boardroom. It is in such countries—of which Uganda is probably the best known example in the developing world—that most progress has been made not just in putting a brake on new infections but in ensuring the wellbeing of those people who are already living with the virus.

Act before it is too late

In Madagascar, an island of 16 million people, HIV is just beginning to raise its head. Surveillance among pregnant women shows exceptionally low levels of infection—perhaps 1 in 5000 (as compared with 1 in 4 in some countries in sub-Saharan Africa, off whose south-eastern coast Madagascar lies). Even among sex workers and patients with other sexually transmitted infections, HIV rates are negligible. An island nation with no need for HIV prevention programmes? Far from it. Madagascar may have been protected by its relative isolation from an early onslaught of HIV, but the high levels of risk in the population are sending alarm bells ringing. The time to act is now.

According to behavioural surveys, sex starts young (at around 15 for the majority of women) and premarital pregnancy is common. Some 14% of pregnant women in a recent survey reported casual partners, and over 9 out of 10 never used condoms in those encounters. Most patients at STD clinics were married, but 16% reported regular extramarital partners and another 14% reported casual partners. Fewer than 10% consistently use condoms in any of these relationships.

STD microbes are already finding plenty of scope for spread. Some 10% of pregnant woman tested positive for syphilis in the most recent round of surveillance—an unusually high rate. Around 15% of STD clinic patients had syphilis. Among sex workers syphilis prevalence ranged up to 28%—not surprising, considering that 35% of sex workers say they never use condoms with any type of clients, and nearly two-thirds never use them with regular partners. Only 14% report using condoms with all of their sex work clients. The potential scope for both STD and HIV spread is alarming.

The government and nongovernmental partners are responding actively. For example, special reproductive health services for 10 to 24-year-olds have been set up in youth centres around the country. The aim is to use these special youth-friendly clinics to spread the word about HIV and to instil a norm of safe behaviour quickly, before the virus can take hold.

reported in 1995 that its costs from AIDS illness and death exceeded its total profits for the year. There is a similar report from a large Tanzanian company.

Prevention programmes for workers have been shown to cut costs as well as infections in Africa. While costs vary significantly between countries, it is estimated that a worker with AIDS costs a business in southern Africa around US\$ 200 a year in lost productivity, treatment, benefits and replacement training. The costs for senior and skilled staff will be far higher. And yet a study in Tanzania has demonstrated that treatment of other sexually transmitted diseases costing as little as US\$ 2.11 per case can cut the number of people getting HIV by over 40%. New HIV infections in Zimbabwean factories with worker-driven prevention campaigns were a third lower than in factories without such campaigns. The campaigns cost US\$ 6.00 per worker-less, in other words, than a single set of protective overalls.

Caring for orphans on Zimbabwe's commercial farms

Some 2 million people-a fifth of the nation's population-live on Zimbabwe's commercial farms. Many are immigrants or the children of immigrants, and many more are Zimbabweans who have moved there from their native villages. Because the majority no longer have any regular contact with their extended families back home, this leaves children with no one to take them in if their parents should die-an increasingly frequent occurrence. A survey at the beginning of 1996 estimated 2.1 orphans per farm. Now a new registration system shows that numbers have climbed to around 10 orphans per farm. The average age of these children is 10.

That is the downside. The upside is that many farm owners are increasingly concerned about the welfare of farm workers and their families, and are supporting initiatives to care for these orphans on their farms. Most of these initiatives centre on finding other farm families to foster abandoned children and orphans. This is more difficult than it sounds, since many people believe orphaned children will bring bad luck.

"After two months my husband wanted me to turn the children away," recounted Monica Kamombe, who, with limited support from the farmer who employs her, provides a home for four orphaned brothers. "Everyone in the village came knocking at the door to say if we kept these unlucky children the ngozi, the bad spirits, would get us". She persisted and now others in the village have followed her example.

The country will need many, many more caring foster parents like Mrs Kamombe. In two years' time, because of AIDS the country will be burying some 350 people a day, and by the year 2005 the government estimates there will be over 900 000 children under 15 struggling to survive without a mother.

A hard-to-break silence

For all the palpable effects of AIDS, a silence born of shame and blame continues to shroud the epidemic in many of even the hardest-hit countries.

A recent study of voluntary counselling and testing offered to pregnant women in developing countries found that in many places with extremely high HIV prevalence, women refused testing or did not return for their test results. This was the case even when interventions that might help them give birth to a healthy baby were being offered to those who tested HIV-positive. In Côte d'Ivoire, for instance, fewer than half of more than 13 000 pregnant women in two study sites accepted to be tested and then came back for their results. More worrying still, in a majority of sites it was the HIV-positive women who were less likely to return. This correlation was seen in South Africa's Soweto, too, where almost all pregnant women in the study agreed to be tested, four-fifths overall came back for their test results, but only half of those who were HIV-positive sought out their results. These systematic differences suggest that women who may be aware that they have been exposed to infection, or who have taken risks, shrink from

infections were occurring in younger women.

People continue to be at risk for HIV throughout their sexually active lives, and all should benefit from services and information that allow them to reduce their risk of infection. However, efforts to promote safer behaviour are especially crucial for young people, who in mature epidemics are those at greatest risk. Prevention efforts also seem to have a greater chance of success among younger people than among people whose sexual habits are well ingrained. For example, following active condom promotion and education campaigns in school and among youth groups, dramatic declines have been recorded in infection rates among teenagers in Uganda and Tanzania.

HIV and AIDS -making themselves felt

HIV can spread silently for many years before the infection develops into symptomatic AIDS and becomes a cause of recurring illness and, finally, death. During 1998 Africa held 5 500 funerals a day for people dying of AIDS, but the death rate is set to increase. Countries where the epidemic is rather recent, such as South Africa, are still far from feeling the major impact of AIDS, despite already high levels of HIV in the general population. But South Africans can anticipate the likely impact by looking at countries where the epidemic has been longer established-Uganda in East Africa, Zambia and Zimbabwe in southern Africa. Millions of adults are dying young or in early middle age. They leave behind children grieving and struggling to survive without a parent's care. Many of those dying have surviving partners who are themselves infected and in need of care. Their families have to find money to pay for their funerals, and their employers-schools, factories, hospitals-have to train other staff to replace them at the workplace.

Children on the brink

Africa is experiencing a growing tide of children living in AIDS-affected households or attempting to survive after the death of their mother, or both parents, to AIDS. Often, the extended family-itself decimated by AIDS-can or will no longer cope. But institutions are not the answer either, not to a problem of this scale. Solutions have to be found in the community.

In Zimbabwe, people are rising to the challenge. Many village heads have designated land to be cultivated by all villagers to feed orphans and families of those suffering from debilitating illness, usually AIDS-related. In some areas, church groups have begun orphan-visiting programmes. Women are trained to identify the neediest orphan households in their area; they then visit them on a regular basis, providing all-important guidance and emotional support and helping with basic necessities. Because these programmes work from within the community they are affordable, costing an average of just 68 US cents per child per month-a small price to pay for a service that will help keep orphans woven into the fabric of society. Fostering initiatives have also begun on commercial farms.

The challenge to business

Since many economies in the region are in flux, it is hard to determine exactly what the impact of HIV is on national economies as a whole. However it is clear that businesses are already beginning to suffer. In Zimbabwe, for instance, life insurance premiums quadrupled in just two years because of AIDS deaths. Some companies report a doubling of their health bills. In Botswana, companies estimate that AIDS-related costs will soar from under one percent of the wage bill now to five percent in six years' time, because of the rapid rise in infection in the last few years. In Zambia, one large company

elsewhere, where far less has been done to encourage safer sex, the reasons for the relative stability remain obscure. Research is under way to explain differences between epidemics in various countries. Factors that may play a role include patterns of sexual networking, levels of condom use with different partners, and promptness in diagnosing and curing other sexually transmitted diseases (which if left untreated can magnify the risk of HIV transmission through sex as much as 20-fold).

Young people in danger

In the worst-affected countries, young people are especially at risk. In sub-Saharan Africa, as in many countries in the industrialized world and elsewhere, people embark on their sexual lives when they are in their teens—often in their early or mid-teens. In Kenya, for example, one study of nearly 10 000 schoolgirls between the ages of 12 and 24 reported that on average, girls lose their virginity when they are between 14 and 15 years old. And yet to date, there is no reproductive health education in schools that would prepare girls to avoid early sex or to adopt safer sexual practices.

The Population Reference Bureau estimates that every year babies are born to 14% of young women aged 15-19 in sub-Saharan Africa, compared with 6% of young women in other less developed countries and just 3% in the industrialized world. Many of these births are outside of marriage. A recent study in Namibia showed that close to 40% of births were to unmarried women. Single motherhood was not associated with ignorance or marginalization—over a third of single mothers were educated to secondary level or beyond, compared with just over a quarter of married mothers.

High levels of teen pregnancy, and pregnancy outside of marriage, do tell us two things: young people are very sexually active, and few of them use condoms. If young people are having unprotected sex with several partners, or if their

single partner has ever had other partners, they are exposed not just to pregnancy but to infection with sexually transmitted diseases, including the one that can kill them: HIV.

Recent HIV surveillance data show how early this exposure can occur and how devastating its consequences can be. In Rwanda, over 4% of both boys and girls aged 12-14 in one community study already tested positive for HIV. In South Africa, the number of pregnant girls under 15 tested for HIV in 1997 was relatively small, but a distressing 9.5% of them were found to be infected with the virus. Among the far greater number of pregnant South Africans tested in their late teens, nearly 13% were HIV-positive.

Often, girls become infected at younger ages than boys. A recent community-based study in one area of Kenya showed that 22% of 15-19-year-old girls in the general population were already infected with HIV, compared with just 4% of boys of the same age. In a Zambian study of young city-dwellers in the same age group, HIV infection was reported in 12.3% of the girls and 4.5% of the boys. In the next-higher age bracket, 20-24 years, a study in Ethiopia found that 35.4% of young women were infected—three times higher than the 10.7% rate among the men.

This age gap at infection indicates that young girls are getting infected through sex with older men. Many girls may choose such relationships because they come with gifts, money or other favours attached. But some will simply have been powerless to resist. In Kenya, one young woman in four said she lost her virginity because she had been forced to. In the Democratic Republic of Congo, the proportion was close to a third. Unwilling sex with an infected partner carries a high risk of HIV infection for girls. When the vagina is dry or when force is used, abrasions and cuts are more likely and the virus can more easily find its way into the bloodstream. What's more, condom use is unlikely in such situations.

(Source: Taha et al. AIDS 1998 12:197-203)

As infection rises in the general population, so does the likelihood of encountering an infected partner (especially an older partner) early in one's sexual career. Over time, then, new infections become increasingly concentrated in the youngest age groups. In a recent study in Malawi, HIV prevalence had built up to high levels in older age groups, but the bulk of new

Johannesburg, 30 November 1998

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AIDS in Africa

Africa continues to dwarf the rest of the world on the AIDS balance sheet. According to UNAIDS and WHO estimates, 7 out of 10 people newly infected with HIV in 1998 live in sub-Saharan Africa; among children under 15, the proportion is 9 out of 10. Of all AIDS deaths since the epidemic started, 83% have been in the region. At least 95% of all AIDS orphans have been African.* Yet only one-tenth of the world's population lives in Africa south of the Sahara.

The sheer number of Africans affected by the epidemic is overwhelming. Since the start of the epidemic, an estimated 34 million people living in sub-Saharan Africa have been infected with HIV. Some 11.5 million of those people have already died, a quarter of them children. In the course of 1998, AIDS will have been responsible for an estimated two million funerals in Africa.

By the end of 1998, there will be an estimated 21.5 million men and women living with HIV in Africa, plus another 1 million children. Some 4 million of these people will have contracted the infection in 1998 alone.

Hot-spots
of infection

No country in Africa has escaped the virus, and yet some are far worse affected than others. The bulk of new infections continue to be concentrated in East Africa and especially in the southern part of the continent.

The southern African region in fact holds the majority of the world's hard-hit countries:

- In Botswana, Namibia, Swaziland and Zimbabwe, current estimates show that over one person in five between the ages of 15 and 49 is living with HIV or AIDS.
- Zimbabwe is especially hard-hit. There are 25 surveillance sites in the country where blood taken from pregnant women is tested anonymously as a way of tracking HIV infection. The most recent data, from 1997, show that HIV prevalence remained below 10% in just two of these sites. In the remaining 23 sites, between a fifth and half of all pregnant women were found to be infected with HIV. At least a third are likely to pass the infection on to their baby.
- South Africa trailed behind some of its neighbours in HIV infection levels at the start of the 1990s. Unfortunately, it is catching up fast. This year, just over 50% of all new infections in southern Africa occurred in this one country.
- In South Africa, as in Malawi, Mozambique, Rwanda and Zambia, between one in seven and one in nine adults live with HIV infection.
- In Central African Republic, Côte d'Ivoire, Djibouti and Kenya, at least one in ten adults are HIV-infected.

(Source: Department of Health, South Africa)

In general, West Africa is less affected by HIV than southern or East Africa. Some countries in central Africa have also seen HIV remain relatively stable, while in neighbouring countries rates have continued to climb.

Early and sustained prevention efforts can be credited with these lower rates in some places—Senegal provides a good example. But

Secrecy can persist even in the face of sickness and death, which in immunodeficient people is often caused by tuberculosis or other common illnesses. In one study of home-based care schemes in southern Africa, fewer than 1 in 10 people who were caring for HIV-infected relatives at home acknowledged that they were suffering from AIDS, and the patients themselves were barely more open.

"One might think that in a country with a quarter or third of the population infected, people would become more open about the epidemic. Experience teaches us that this doesn't happen automatically," said Dr Piot. "The silence needs to be broken, publicly and courageously, by leaders who encourage their people to face the truth about AIDS."

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Tamil Nadu (population: 25 million), a new survey reveals that almost half a million people are already infected with HIV and that the infection rate is three times higher in villages than in the cities.

In Latin America, while infections are concentrated in men who have sex with men and drug injectors, transmission through sex between men and women is on the rise.

Development gains being **wiped out**

In the worst-affected countries the AIDS epidemic is now making significant inroads into precious development gains that have been built up over the past decades.

In nine countries where at least 10% of the adult population is HIV-positive, it has been estimated that AIDS will soon be costing an average of 17 years of life expectancy, compared with what these countries could look forward to in the absence of the epidemic. These dismal declines are not only due to adult deaths. Over half a million children -- most of whom acquired the infection before or at birth, or through breastfeeding - died in 1998 alone. By 2005-2010, the infant mortality rate in, for example, Namibia, is expected to reach 72 per 1000 live births as opposed to 45 per 1000 without AIDS.

The onslaught of AIDS is also denting the prospects for economic development in hard-hit countries. In Zimbabwe, some companies have reported that AIDS costs are now absorbing as much as one-fifth of company earnings and, for instance, in Tanzania and Zambia, other firms estimate that AIDS illness and death cost them more than their total profits for the year.

Says David Heymann, Executive Director, Communicable Diseases Cluster, WHO, "AIDS is a deadly serious public health threat. But as the epidemic continues to spin out of control,

countries face more than just a health crisis. They face a growing threat to human development and to economic and social stability."

Forces that **fuel** the epidemic

Some of the reasons behind HIV's spread remain undetermined. It is not fully understood why, for instance, HIV infection rates take off in some countries while remaining stable in neighbouring countries over many years. What is known is that a number of factors clearly influence the shape and scope of the epidemic in different parts of the world.

Wars and armed conflicts generate fertile conditions for the spread of HIV. The UNAIDS/WHO report notes that in Rwanda, before the political turmoil of the mid-1990s, infection rates were approximately 10% in cities and towns and around 1% in the countryside, where most people lived. Yet by 1997, both urban and rural rates were just over 11%. A revealing fact is that HIV infection rates rose sixfold among the mostly rural people who had fled to refugee camps.

In many places people have no access to voluntary HIV testing and counselling. Yet even when these services are offered, many do not want to know or acknowledge their HIV status because of the blame and shame attached to AIDS. For example, in Côte d'Ivoire, where more than 13 000 pregnant women were offered interventions to increase their chances of having a healthy baby, fewer than half accepted testing and returned for the results.


In Zimbabwe's city of Mutare, surveillance data indicate that close to 40% of pregnant women are HIV-infected and probably 30 000 adults are living with HIV. Yet the sole HIV support group in the city has just 70 members, leaving thousands of others to struggle alone with the implications of their infection, including the dilemma of how to explain the sudden need for condom use with a spouse or other stable partner.

London, 24 November 1998

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**New World AIDS Day report finds
Global HIV Infections increased 10% in 1998
- Half of all new Infections now in 15-24 year olds -**

- Development gains being wiped out
- Sub-Saharan African countries hardest-hit - already 34 million infections and almost 12 million deaths
- Fewer deaths in North America, Western Europe, but no progress in prevention;
HIV infection rates unchanged for a decade

 According to a report issued today by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO), the AIDS epidemic update - December 1998, during the past year a further 5.8 million people were infected with HIV - approximately 11 men, women and children every minute - and the total number of people living with the virus rose by one-tenth, to 33.4 million worldwide. Half of all new infections are now occurring among young people aged 15 to 24. This year's World AIDS Campaign "Young People: Force for Change" was prompted in part by the epidemic's threat to those under 25 years old, for as HIV rates rise in the general population, new infections are increasingly concentrated in the younger age groups.

The global epicentre of AIDS continues to be sub-Saharan Africa. Since the epidemic began, 34 million Africans have been infected, and almost 12 million of them have already died. In 1998 the region experienced four million new infections and rising AIDS death tolls, seen in an estimated 5,500 funerals per day. In the southernmost countries of the continent, where HIV spread

took on epidemic proportions only recently, infection rates continued to rise dramatically during the past year. Four countries now estimate that 20% to 26% of adults are living with HIV, and South Africa alone accounts for one out of every seven new infections on the continent. In contrast, a number of countries in West Africa remain relatively less affected, in part as a result of early and sustained prevention efforts.

In the regions of North America and Western Europe, the availability of new more potent anti-HIV drug combinations has helped people with HIV live longer, healthier lives. In the United States, for example, the number of people dying from AIDS dropped by two-thirds between 1995 and 1997, when these antiretroviral combinations came into wide use. Alongside this undoubted therapeutic success, there is a disturbing lack of progress in prevention. Every year for the past decade, the numbers of new HIV infections have remained stagnant in North America and Western Europe, with close to 75 000 people acquiring the virus in 1998 alone.

"Two decades into the AIDS epidemic, we know better than ever before about prevention --- how to persuade people to protect themselves, make sure they have the necessary skills and back-up services, and remove social and economic barriers to effective prevention," said Dr Peter Piot, Executive Director of UNAIDS. "Yet almost six million people became infected this year. Every one of these new HIV infections represents a prevention failure -- our collective failure."

In many Asian and Eastern European countries, where the epidemic started later than in other regions, HIV is rapidly gaining new footholds. In India, for example, recent research shows that HIV is now firmly embedded in the general population and is spreading into rural areas that were previously thought to be relatively spared. In the state of

End-1998 global estimates Adults and children

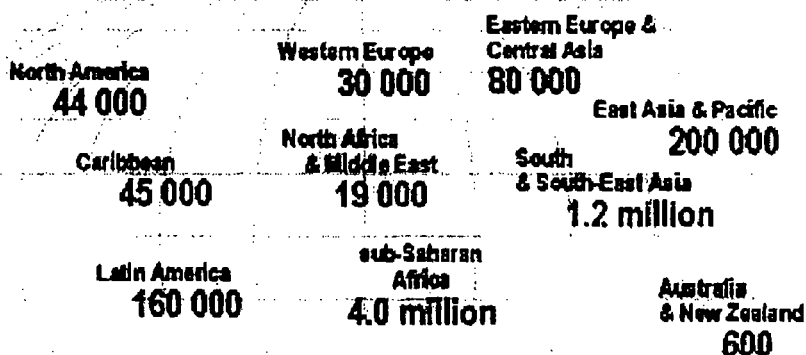
- People living with HIV/AIDS 33.4 million
- New HIV infections in 1998 5.8 million
- Deaths due to HIV/AIDS in 1998 2.5 million
- Cumulative number of deaths due to HIV/AIDS 13.9 million



WORLDWIDE



Estimated number of adults and children newly infected with HIV during 1998



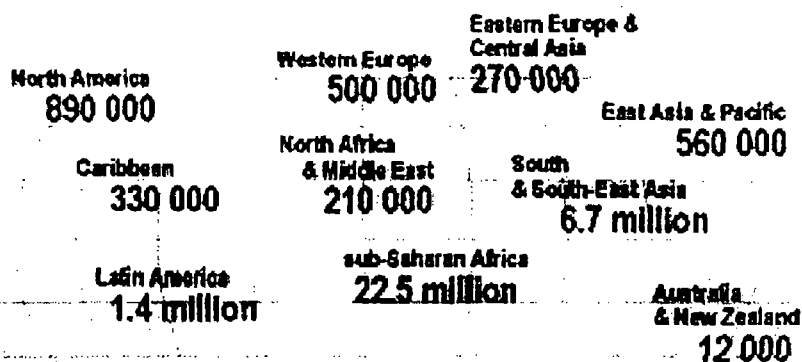
Total: 5.8 million



WORLDWIDE



Adults and children estimated to be living with HIV/AIDS as of end 1998



Total: 33.4 million



UNAIDS



AIDS Control Programme

Estimated number of new HIV infections in young people

- About 7 000 young people aged 10–24 get infected with HIV every day, that is five young persons every minute
- About 1.7 million young people in Africa get infected with HIV every year
- Close to 700 000 young people get infected with HIV every year in Asia and the Pacific



UNAIDS



AIDS Control Programme

In places where shame and stigma are the rule, many people simply do not want to know if they are HIV-infected, even when counselling and testing are offered. And the small minority of people who know their HIV status rarely share it with others, even in confidential support groups. In Zimbabwe's city of Mutare, for example, surveillance data show that close to 40% of pregnant women are HIV-infected, and infection levels in men are likely to be similarly high. There are probably 30 000 adults living with HIV in Mutare. Yet there is just one HIV support group in the city, and it has just 70 members. Many more people know or fear they are HIV infected: some will find support in their partners or families but many will struggle alone with the implications of their infection.

"HIV/AIDS is among us"

South Africa, which in 1998 accounted for nearly 1 in 10 of the new HIV infections estimated to have occurred worldwide, is the latest country in the ranks of those seeking to break through the shroud of stigma and shine a light on the human disaster of AIDS.

"For too long we have closed our eyes as a nation, hoping the truth was not so real," South African Deputy President Thabo Mbeki told South Africans in October 1998. "For many years, we have allowed the human immunodeficiency virus to spread... At times we did not know that we were burying people who had died from AIDS. At other times we knew, but chose to remain silent.

"[Now] we face the danger that half of our youth will not reach adulthood. Their education will be wasted," Mbeki said. "The economy will shrink. There will be a large number of sick people whom the healthy will not be able to maintain. Our dreams as a people will be shattered."

Appealing to South Africans to change "the way we live and how we love", Mbeki called for abstinence, fidelity and condom use, and urged a caring, non-discriminatory attitude to those already infected with or affected by HIV. The speech was nationally televised, and the whole nation was urged to stop work to listen to it. Many private companies gave workers a day off. Flags flew at half mast on government buildings and religious leaders, youth, trade unionists, women's organizations and business leaders committed themselves to the President's Partnership Against AIDS.

Silence can continue to reign even when people with HIV are ill and dying. Because AIDS is just the name for a cluster of diseases that immunodeficient people develop, patients and their carers can choose to view the illness as just tuberculosis, or diarrhoea, or pneumonia. An example from southern Africa is telling. In one study of home-based care schemes, fewer than 1 in 10 people who were caring for HIV-infected patients at home acknowledged that their charges were suffering from AIDS. Patients themselves were only slightly more likely to acknowledge their status, and several told researchers that they had not disclosed their HIV-positivity to anyone, including the person caring for them. This self-imposed silence is hard on the patient. It can also be hard on the carers, particularly when they are children or adolescents. If they do not know that their parent or loved one is suffering from a fatal disease, they cannot prepare themselves for the death or acknowledge that it will inevitably come no matter how much effort they put into care. So carers risk compounding their feelings of grief and loss with feelings of failure.

In some countries, leaders have spoken out loudly, clearly and repeatedly about AIDS, have sought to demystify it, and have encouraged discussion about safe sex everywhere from the classroom to the boardroom. It is in such countries—of which Uganda is probably the best-known example in the developing world—that most progress has been made not just in putting a brake on new infections but in ensuring the well-being of those people who are already living with the virus.

Note about UNAIDS/WHO estimates

The estimates concerning HIV and AIDS in this document are based on the information available to UNAIDS and WHO at the current time. They are provisional. WHO and UNAIDS, together with experts from national AIDS programmes and research institutions, keep these estimates under constant review with a view to updating them as improved knowledge about the epidemic becomes available and as advances are made in the methods used for deriving estimates.

For example, knowledge about the epidemic improves not only as better information becomes available about HIV spread (for example, through more representative sentinel surveillance), but also as more is learnt about the factors that help or hinder the spread of the virus (for example, the natural history of HIV infection in different parts of the world, the impact of HIV infection on fertility, and the effects of improved treatment). This improved knowledge together with methodological advances together provide the basis for updated estimates of HIV incidence, prevalence and mortality.

Because of these factors, the 1998 estimates cannot be directly compared with those for 1997 or earlier years, nor with those that may be published subsequently. While they are largely based on the country-specific models prepared for last year's estimates and published in the joint UNAIDS/WHO publication *Report on the global HIV/AIDS epidemic—June 1998*, the December 1998 estimates reflect upward or downward adjustments that were made for a number of countries in the light of updated information.

The purpose of publishing these estimates is to help governments, nongovernmental organizations and others who have a stake in bringing AIDS under control to gauge the status of the epidemic in their country and to monitor the effectiveness of the considerable efforts at prevention and care being made by all partners.

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carrying infection back to their wives and their home communities. In Hlabisa, a rural district of KwaZulu/Natal, some 60% of households are estimated to have one or more male migrants. One study here found that sex outside the primary relationship is accepted as almost inevitable in separated families, for both men and women. In this community, HIV rates are rising dramatically, with the prevalence among pregnant women shooting up to 26% in 1997 from 4% just five years earlier. A study in 1995 found that of women whose partners were at home less than a third of the time, 13% were infected. No infections were recorded among women who spent more than two-thirds of the time with their husbands or regular partners.

□ Driven by conflict: Survivors in Rwanda

Before the political turmoil of the mid-1990s, more studies had been done to understand the HIV epidemic in Rwanda than in most developing countries. The pattern of infection recorded there was a familiar one: high rates in urban areas (more than 10% of pregnant women infected) but far lower rates in the rural areas that were home to the bulk of the population (just over 1%).

The political difficulties of recent years not only interrupted HIV surveillance; they changed the shape of the epidemic. By 1997, when a well-designed survey of HIV was carried out in the general population, little difference remained between urban and rural rates. Both were just over 11%. Among teenagers, infection was actually higher in rural areas than in cities. And it was appallingly high at the youngest ages: among 12, 13 and 14 year olds, a full 4% were already HIV-infected.

Many of the changes can be ascribed to the huge population movements during and after the years of ethnic conflict. Nearly three-quarters of the 4700 people surveyed in 1997 had lived elsewhere in the preceding three years—an astonishingly high turnover for this largely rural country. Migrants who had spent the years of conflict outside Rwanda had lower rates of HIV infection than those who endured the troubles inside the country. Most of these people are recently returned from Uganda and Tanzania, countries where HIV prevention campaigns are relatively strong.

HIV prevalence among people who said they had spent the conflict years in refugee camps was 8.5%. Most of these people had fled from rural areas where pre-conflict HIV prevalence was just 1.3%. That suggests a six-fold increase in HIV infection among refugees in the camps. Overcrowding, violence, rape, despair and the need to sell or give away sex to survive are all likely to have contributed to this huge leap in infection.

Wars and armed conflicts generate fertile conditions for the spread of HIV. Rape—inside or outside refugee camps—has doubtless played a part in spreading the virus in Rwanda. Some 3.2% of women surveyed reported being raped, over half of them during the conflict itself. Two-fifths of them were teenagers. Among women who had been raped 17% were HIV-positive, compared with 11% of those who had not. Women who reported rape were three times as likely as those who were not raped to have suffered from genital sores, another STD.

□ Driven by danger: Soldiers in Cambodia

Decades of political turmoil and civil war have left much of Cambodia's infrastructure in tatters. Education, health care, the transport network—all are being rebuilt more or less from scratch as peace gradually returns to the country. In the meantime Cambodian soldiers, many of them teenagers with no schooling, continue to battle Khmer Rouge rebels in the northwest of the country. For them, risk is a way of life, whether from combat, malaria or land mines.

It is understandable that many of these young men view sex as a source of comfort, not of special danger. The risk of HIV infection, which will not in any case kill them for at least a decade, can seem negligible. "The regular troops are there at the front because they have no education and nothing to eat at home," says a military doctor. "They have no idea of the future. They first think day by day."

But the HIV risks are not negligible at all. Behavioural research shows that over a third of Cambodian soldiers have visited a brothel just in the last month, including many of the married men in the army and the police force who are separated for long periods from their wives and children. Some 43% of sex workers tested positive in Cambodia's brothels in 1998, while HIV prevalence in the military was around 7%.

One in five soldiers say that besides visiting prostitutes, they also have girlfriends—often waitresses or "beer girls" who promote various brands of the beverage in restaurants or nightclubs. Both the beer girls and their soldier partners make a distinction between their relationship and an act of commercial sex in a brothel, for condom use with these girlfriends is abysmally low—just 8%. Yet over 20% of beer girls tested positive for HIV in 1998.

To decrease risky behaviour and new infections, Cambodia's military has trained a number of soldiers about HIV and other STDs and given them support in spreading the prevention message to other soldiers. This system, known as peer education, works well in the military because, as one officer said, "Soldiers live and fight and die together. They have the same problems and the same habits. They are not intellectuals but are very pragmatic and can follow others' example".

While it is still early days in the peer education programme, there is already evidence that Cambodian soldiers are reducing their risk of HIV infection. Condom use by soldiers in brothels is now 63%—16% more than in 1997—and visits to brothels in the month preceding the survey fell by 40%, a remarkable change in a single year.

□ Driven by stigma: Shame, silence and denial

It is hard to measure stigma—people with HIV see it in a scornful look in the marketplace, in the refusal of family and friends to visit, care for or even touch them, in the maltreatment of their children or the loss of their job on a flimsy pretext. But stigma is a very real obstacle to both prevention and care. In many of the hardest-hit countries, government officials and ordinary citizens—including those most affected by the epidemic—often continue to look the other way because of the rejection, discrimination and shame attached to AIDS.

Stigma and the fear it engenders both fuel the spread of HIV, since those with risky behaviour in the past may be reluctant to change that behaviour in case the change is interpreted as an admission of infection. Fear of acknowledging HIV infection can stop a married man from raising the subject of condom use with his wife. Fear of advertising her HIV status may prevent an infected woman from giving her baby replacement feeding to avoid transmitting the virus through breastmilk.

The stigma attached to HIV affects both sexes. However, the consequences may be more severe for women, who risk being beaten and even thrown out of the house by their husband if their status is revealed. This is true even when the husband was the source of the woman's infection. An HIV-infected woman may be blamed for the death of her children, and deprived of care.

Young escapees on Brazil's streets

Brazil is a country of contrasts, of great wealth and of crushing poverty from which young people find it hard to escape. Around a third of the 31 million Brazilians aged between 15 and 24 come from families living below the poverty line. Only one adolescent in 12 completes high school, and many of the rest—half of the boys and as many as three-quarters of the girls—remain jobless. Across the country, some two million people aged 15–19 neither work nor go to school.

Undereducated and underemployed, these young people are easy targets for adults selling drugs or buying sex. In fact, they are easy targets for adults wanting sex but unwilling to pay for it. Research in São Paulo, Brazil's largest city, indicates that one girl in five has been sexually abused in her own home or in the surrounding community.

Girls who have lived through sexual abuse are more likely than others to drift onto the streets, into prostitution, and onto the waiting list for HIV infection. In Brazil's impoverished northeast, communities are trying to head off this danger by identifying girls who are at risk of violence or abuse in the home. These girls are invited to join support groups that teach them skills that will help them make a living as well as defend themselves against violence and unwanted sex. Of 850 girls who have been helped by one such programme, so far there are no reports of any of them ending up in prostitution or in a street gang. With HIV rates running as high as 17% among poorer sex workers in some cities, supporting young women with alternatives to a life on the streets is an important way of protecting them from HIV infection.

However, much remains to be done. In the USA, for example, 3 million adolescents a year contract a sexually transmitted disease, a clear indicator of unsafe sex. In developing countries, where the likelihood of encountering a partner infected with a sexually transmitted disease is high, STD infection rates in young people are often much higher.

Young people are vulnerable to HIV for many reasons—they do not know about HIV or STDs, or they know about them but do not know how to avoid infection. Those with the information may be unable to get hold of condoms, or may feel unable to discuss condom use with their partner. Young people, and especially girls, may be unable to defend themselves against unwanted sex. In the Democratic Republic of Congo, nearly a third of young women in a large study reported that they had been forced by their partners into first sex. Similar statistics on coerced sex are reported from many parts of the world.

What is more, adolescence is a time when many people experiment—not only with different forms of sex but with drugs. Apart from the HIV risk connected with needle-sharing, it is known that alcohol and other drugs can affect sexual behaviour and increase young people's risk of becoming infected with HIV or the other STDs. Excessive drinking, for example, diminishes inhibitions, increases aggression, diminishes the ability to use important information learnt about AIDS prevention, and impairs the capacity to make decisions about protection.

Whether or not young people's drug-using habits change over time, the consequences of risk behaviour at this age can be irrevocable, as can be seen in data from places as far apart as Asia and Europe. In Myanmar over 60% of teenage drug injectors are infected with HIV—indeed teenagers are the *only* group of drug users in which HIV prevalence has continued to climb steadily since the early 1990s. In Belarus, over four-fifths of registered HIV infections are in drug users in their teens and twenties. In Lithuania, over half of HIV infections registered in injecting drug users are in people under 25. Regardless of whether these young people continue their drug use or abstain, they will carry HIV with them till their premature death.

What drives the epidemic?

The AIDS epidemic has unfolded very differently in different parts of the world, and among different populations. It is not always clear why HIV infection takes off in some places while rates in neighbouring countries remain stable over many years. However, there are several factors which clearly influence the shape of the epidemic. People on the move—escaping from abuse, or even just leaving their families in search of work—are especially likely to be exposed to infection. People whose daily existence is stressful and dangerous may not care about the long-term risks posed by HIV. People in conflict and refugee situations may have little control over their exposure to HIV, indeed even to sex. And the stigma that still attaches to HIV hinders people from protecting themselves and others from infection, or from seeking out care and support.

The different faces of AIDS can be seen in the following country situations, which illustrate some of the factors driving the epidemic.

□ Driven by loneliness: Migrant labourers in South Africa

The world's population is becoming more and more mobile. People are on the move for all sorts of reasons, but probably the most common reason for people to leave their homes (and often their families) is to seek work.

Nowhere is this more true than in South Africa. Thriving mining industries attract workers not just from rural areas of the nation, but from neighbouring economies where job opportunities are limited and wages are lower. It is hard to know how many people move into and around South Africa in search of work. More than a decade ago 2.5 million South Africans were registered as migrant workers, and that number is likely to have increased. This year, over half a million people will join the country's growing urban population.

Carltonville, at the heart of South Africa's gold mining industry, is home to 88 000 mine workers, 60% of them migrants from other parts of South Africa or from nearby countries: Lesotho, Malawi and Mozambique. With the miners come wages. Some US\$ 18 million is paid out to workers every month in Carltonville. With the wages come all manner of goods and services, including, of course, drugs and sex. Some 400–500 sex workers service the Carltonville mines. And with drugs and sex comes HIV.

The city has become the HIV hot spot of Gauteng Province. Around 22% of adults in Carltonville are infected with HIV, a rate over two-thirds higher than the national average. A small survey of sex workers found HIV in three-quarters of them, while one mineworker in five is thought to be infected. That count is probably an underestimate because it does not include the men who have dropped out of the mines because they are too sick to work.

Why are infection levels so high in miners? Most men live lonely lives in single-sex dormitories, often hundreds of miles from their families. They also have a dangerous job. A gold-miner in South Africa has a one in forty chance of being killed by a rock-fall underground and a one in three chance of serious injury. Compared with that, the dangers associated with a long, slow infection like HIV might seem remote.

Of course, the HIV dangers are not just to the mineworkers themselves, or to their sex partners around the mining sites. Most migrant workers return home periodically. Increasingly, they are

Deteriorating child survival

The dismal decline in life expectancy is due not only to deaths of adults—most of them young or in early middle age—but also to child deaths. HIV is contributing substantially to rising child mortality rates in many areas of sub-Saharan Africa, reversing years of hard-won gains in child survival.

By 2005–2010, for example, 61 of every 1000 infants born in South Africa are expected to die before the age of one year. In the absence of AIDS, infant mortality would have been as low as 38 per 1000. With AIDS in the picture, the infant mortality rate in Namibia is projected to be 72 per 1000; without the epidemic the country could have expected a far lower rate of 45 per 1000.

Children on the brink

Zimbabwe offers a frightening window onto orphanhood, another aspect of the epidemic's development impact. In this nation, where over a quarter of the 5.5 million adults are HIV-infected, AIDS is already pushing hundreds of thousands of children to the brink.

The government estimates that in two years' time 2400 Zimbabweans a week will be dying of AIDS. Most of those deaths will be in adults, and they will be concentrated in the young adult ages when people are building up their families. What is more, they may be disproportionately concentrated among single women whose death would leave a child with no parent at all: one recent study in a farming area showed that single mothers, many of them widowed by AIDS, were twice as likely to be HIV-infected as married women.

As early as 1992, a study in Zimbabwe's third largest city, Mutare, recorded that over 10% of children in the study area were orphaned, and that nearly one household in five had taken in orphans. By 1995, an enumeration in the same area showed that the proportion of children who were orphaned had grown to nearly 15%.

The number of children in need of care is rising just as AIDS is cutting into the number of intact families able to provide such care. Some 45% of those caring for orphans are grandparents; often they have no income of their own, and there is a limit to how many children they can take on without outside help. One orphan-support programme reports helping an 80-year-old grandmother who lives with 12 children in a single room. Another has received a request for help from a widower with 9 dependants who has just inherited another 3 grandchildren to care for. A study of households headed by adolescents and children (some as young as 11) showed that while the overwhelming majority had lost both parents, most did have surviving relatives. However, in 88% of those cases, the relatives reported that they did not want to care for the orphans.

Children themselves are beginning to worry about orphanhood and to recognize the importance of supporting needy children. A majority of children interviewed in one study said that if orphans' needs were not met they would become delinquent. Many said the children would drift into prostitution and onto the streets. They also worried about abuse and exploitation of orphans by relatives. With reason. Reports of sexual abuse of girls have risen rapidly in recent years in Zimbabwe, prompting the establishment of a special clinic at a major Harare hospital and an initiative to promote child-friendly courts. In a single rural district of Zimbabwe one study recorded nearly 400 cases of child sexual abuse, at least a quarter of them girls under the age of 12, and at least 10% of them orphans.

AIDS and business: the bottom line suffers

The onslaught of AIDS is denting the prospects for economic development too. In the hard-hit countries of Africa, the epidemic is decimating a limited pool of skilled workers and managers and eating away at the economy. With many economies in the region in flux, it is hard to determine exactly what the impact of HIV is on national economies as a whole. However, it is clear that businesses are already beginning to suffer.

In Zimbabwe, for instance, life insurance premiums quadrupled in just two years because of AIDS deaths. Some companies say that their health bills have doubled. Several report that AIDS costs absorb as much as one-fifth of company earnings. In Tanzania and Zambia, large companies have reported that AIDS illness and death cost more than their total profits for the year. In Botswana, companies estimate that AIDS-related costs will soar from under 1% of the wage bill now to 5% in six years' time, because of the rapid rise in infection in the last few years.

HIV—a threat to the world's young people

This year's World AIDS Campaign—"Young people: Force for change"—was prompted in part by the epidemic's threat to those under 25 years old. Young people are disproportionately affected by HIV and AIDS. Around half of new HIV infections are in people aged 15–24, the range in which most people start their sexual lives. In 1998, nearly 3 million young people became infected with the virus, equivalent to more than five young men and women every minute of the day, every day of the year. And as HIV rates rise in the general population, new infections are increasingly concentrated in the younger age groups. A recent study in Malawi, for instance, found the annual rate of new HIV infections to be as high as 6% in teenage women, compared with under 1% in women over 35.

But the Campaign also highlights the power of young people. The future of the HIV epidemic lies in their hands. The behaviours they adopt now and those they maintain throughout their sexual lives will determine the course of the epidemic for decades to come. Young people will continue to learn from one another, but their behaviour will depend largely on the information, skills and services that the current generation of adults choose to equip their children with.

Research shows that young people adopt safer sexual behaviour provided they have the information, skills and means to do so. In Senegal, 40% of women under 25 and 65% of men used condoms with non-regular partners in 1997, compared with less than 5% for both sexes at the start of the decade. In fact, given the chance, young people are more likely to protect themselves than adults. In Chile, a 1996 study showed that condom use is highest among 15–18-year-olds, and similar patterns have been found in Brazil and Mexico.

Safer sexual behaviour is becoming the norm among young people in developed countries, too. In several studies in Western Europe, some 60% of young people are now using condoms the very first time they ever have sex—a six-fold increase since the early 1990s. Among young people in the United States, abstinence is becoming more common and condom use is rising significantly. Among high school students in 1997, 63% of boys reported that they had used a condom the last time they had sex, up from 55% six years earlier. For girls, condom use rose to 51% from 38% over the same period.

drug-user communities, the potential for continued spread through drugs and sex is undeniable given the known overlap between drug-injecting and sex-worker populations and the dramatic rises in other STDs. In the Russian Federation, for example, syphilis rates have shot up from around 10 cases per 100 000 people in the late 1980s to over 260 cases per 100 000 a decade later.

In **North America and Western Europe**, new combinations of anti-HIV drugs continue to reduce AIDS deaths significantly. For example, recently-published figures show that in 1997 the death rate for AIDS in the United States was the lowest in a decade—almost two-thirds below rates recorded just two years earlier, before combination therapy came into widespread use. However, because new infections continue to occur while antiretroviral drug cocktails keep already-infected people alive, the proportion of the population living with HIV has actually grown. This obviously increases the demands for care. In a number of less obvious ways, it adds to countries' prevention challenges.

During 1998, North America and Western Europe recorded no progress in reducing the number of new infections. The early dramatic rises in HIV were successfully reversed by the mid-to-late 1980s thanks to prevention campaigns that raised condom use among gay men from virtually zero to well over 50%. But over the last decade, the rate of new infections has remained stable instead of continuing to decrease. During 1998 alone, nearly 75 000 people became infected with HIV, bringing the total number of North Americans and Western Europeans living with HIV to almost 1.4 million.

Clearly, the epidemic is no longer out of control in these countries. Just as clearly, it has not been stopped. And at this stage the prevention challenges are greater than ever. One reason is that prevention efforts have already reached the easier-to-reach groups, such as the largely well-educated and well-organized white gay communities. Another reason is that HIV infections are increasingly concentrated in the poorer sectors of the population. In the USA, to take one example, HIV has become a disproportionate threat to US citizens of African origin. Although African-Americans represent only 13% of the total US population, they bear an undue share of American poverty, underemployment and inadequate health care access. African-Americans are now more than 8 times as likely as whites to have HIV. According to the Centers for Disease Control and Prevention (CDC), among black males national HIV prevalence is estimated to have reached 2% and AIDS has become the leading killer in the 25–44 age group. For black women in the same age group, AIDS takes second place as cause of death. The US administration has just announced a new \$156 million federal effort for minority communities to help curb HIV spread through drug injecting and sex, and to help ensure access to antiretroviral drug therapy for those already living with HIV.

*

Further details about regional patterns of HIV infection, together with end-1997 estimates of HIV infection and AIDS deaths for 170 individual countries, can be found in the UNAIDS/WHO publication *Report on the global HIV/AIDS epidemic—June 1998*.⁴ These country-specific estimates are the most recent ones available.

⁴ The report is available on the Internet at <http://www.unaids.org/unaids/document/epidemio/june98/global%5Freport/index.html>

A health crisis and beyond

□ Invisible no longer

For many years, AIDS was referred to as "the invisible epidemic". HIV makes its silent way through a population for many years before infections develop into symptomatic AIDS and become a cause of recurring illness and, finally, death. The virus thus spread stealthily for years before AIDS deaths were registered in any significant numbers.

In industrialized countries AIDS activists succeeded in raising the profile of the epidemic early on. But in the developing world where most men and women with HIV live, it is only now, two decades after the virus first started spreading, that the repercussions of AIDS are stripping off its cloak of invisibility.

In countries with mature epidemics—Uganda in East Africa, Zambia and Zimbabwe in Southern Africa, for example—AIDS is leaving highly-visible damage in its wake. Some doctors report that three-quarters of beds on hospital paediatric wards are occupied by children ill from HIV. Millions of adults have died. Most have left behind orphaned children. Many have left surviving partners who are infected and in need of care. Their families struggle to find money to pay for their funerals, and their employers must now train other staff to replace them.

□ Wiping out the gains of development

Together, the epidemic's visible and less-visible consequences constitute an urgent and massive threat to development.

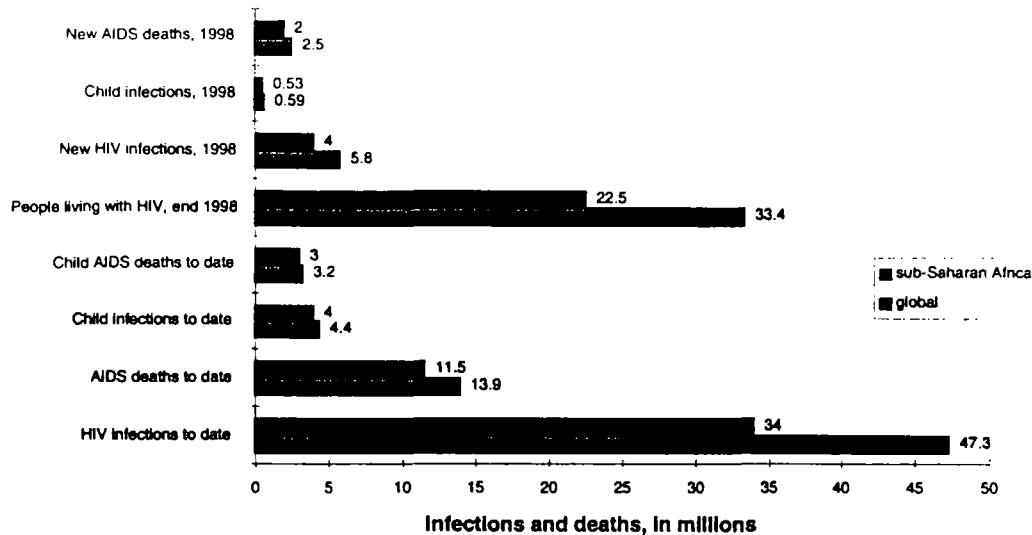
Life expectancy crumbles

Life expectancy at birth is one of the key measures that policy-makers look at to assess human development. Because of the extra deaths from AIDS in children and young adults, this indicator is giving off alarm signals. According to a just-released report prepared by the United Nations Population Division in collaboration with UNAIDS and WHO, the epidemic will wipe out precious development gains by slashing life expectancy.

The impact on life expectancy is proportional to the severity of the local epidemic. In Botswana, for example, where more than 25% of adults are infected, children born early next decade can expect to live just past their 40th birthday. Had AIDS not been in the picture, they could have expected to live to the age of 70. Not surprisingly, between 1996 and 1997 Botswana dropped 26 places down the Human Development Index, a ranking of countries that takes into account wealth, literacy and life expectancy.

Taking the nine countries with an adult HIV prevalence of 10% or more (Botswana, Kenya, Malawi, Mozambique, Namibia, Rwanda, South Africa, Zambia and Zimbabwe), calculations show that AIDS will on average cost them 17 years of life expectancy. Instead of rising and reaching 64 years by 2010–2015, a gain which would be expected in the absence of AIDS, life expectancy will regress on average to 47 years.

HIV and AIDS estimates, global and sub-Saharan Africa



Other areas of the continent are far from immune. One in ten adults or more are HIV-infected in Central African Republic, Côte d'Ivoire, Djibouti and Kenya. In general, however, West Africa is less affected by HIV than Southern or East Africa, and some countries in Central Africa have also seen HIV remain relatively stable. Early and sustained prevention efforts can be credited with these lower rates in some cases—Senegal provides a good example. But elsewhere, where far less has been done to encourage safer sex, the reasons for the relative stability remain obscure. Research is under way to explain the differences between epidemics in various countries. These studies are looking into factors that may play some role, such as patterns of sexual networking, levels of condom use with different partners, and treatment of other sexually transmitted diseases (STDs), which if left untreated make it easier for HIV to pass through sexual intercourse.

Increasingly, the spotlight is on the spread of HIV through the **Asian continent**, especially in South Asia and East Asia. While rates remain low relative to some other regions, well over 7 million Asians are already infected and HIV is clearly beginning to spread in earnest through the vast populations of India and China.

India provides an interesting example of the shifting patterns of HIV.

- Until recently, it was commonly assumed that HIV infection in the world's second most populous nation was concentrated in urban sex workers and their clients and in drug injectors living in a few states. The last round of sentinel surveillance in antenatal clinics shows that in at least in five states, more than 1% of pregnant women in urban areas are now infected.
- India's rural areas—home to 73% of the country's 930 million people—were thought to be relatively spared by the epidemic. Again, new studies show that at least in some areas, HIV has become worryingly common in villages as well as cities. A recent survey of randomly selected households in Tamil Nadu found that 2.1% of the adult population living in the countryside had HIV, as compared with 0.7% of the urban population. For this small state, with its population of 25 million, the study findings suggest that there are close to half a million people already infected with HIV in Tamil Nadu. Considering that nearly 10% of the people surveyed had gonorrhoea, syphilis or another sexually transmitted disease, HIV clearly has fertile ground for further spread.

Regional HIV/AIDS statistics and features, December 1998

Region	Epidemic started	Adults & children living with HIV/AIDS	Adults & children newly infected with HIV	Adult prevalence rate ²	Percent of HIV-positive adults who are women	Main mode(s) of transmission ³ for adults living with HIV/AIDS
Sub-Saharan Africa	late '70s - early '80s	22.5 million	4.0 million	8.0%	50%	Hetero
North Africa & Middle East	late '80s	210 000	19 000	0.13%	20%	IDU, Hetero
South & South-East Asia	late '80s	6.7 million	1.2 million	0.69%	25%	Hetero
East Asia & Pacific	late '80s	560 000	200 000	0.068%	15%	IDU, Hetero, MSM
Latin America	late '70s - early '80s	1.4 million	160 000	0.57%	20%	MSM, IDU, Hetero
Caribbean	late '70s - early '80s	330 000	45 000	1.96%	35%	Hetero, MSM
Eastern Europe & Central Asia	early '90s	270 000	80 000	0.14%	20%	IDU, MSM
Western Europe	late '70s - early '80s	500 000	30 000	0.25%	20%	MSM, IDU
North America	late '70s - early '80s	890 000	44 000	0.56%	20%	MSM, IDU, Hetero
Australia & New Zealand	late '70s - early '80s	12 000	600	0.1%	5%	MSM, IDU
TOTAL		33.4 million	5.8 million	1.1%	43%	

- The virus is firmly embedded in the general population, among women whose only risk behaviour is having sex with their own husbands. In a study of nearly 400 women attending STD clinics in Pune, 93% were married and 91% had never had sex with anyone but their husband. All of these women were infected with a sexually transmitted disease, and a shocking 13.6% of them tested positive for HIV.

In **Eastern Europe** and in **Latin America and the Caribbean**, infections are concentrated in marginalized groups though clearly not limited to them.

In Latin America the pattern of HIV spread is much the same as in industrialized countries. Men who have unprotected sex with other men and drug injectors who share needles are the focal points of infection. In Mexico studies suggest that up to 30% of men who have sex with men may be infected; among drug injectors in Argentina and Brazil the proportion may be close to half. While transmission through sex between men and women is on the rise, especially in Brazil, heterosexual HIV spread is especially prominent in the Caribbean. Prevalence rates of 8% among pregnant women have been reported from Haiti and one surveillance site in the Dominican Republic.

HIV continues to gallop through drug-injecting communities in **Eastern Europe and Central Asia**. A region which until the mid-1990s appeared to have been spared the worst of the epidemic, it now holds an estimated 270 000 people living with HIV. For the moment Ukraine remains the worst-affected country, though the Russian Federation, Belarus and Moldova have all registered enormous increases in the past few years. With HIV gaining new footholds as it penetrates new

² The proportion of adults (15 to 49 years of age) living with HIV/AIDS in 1998, using 1997 population numbers.

³ MSM (sexual transmission among men who have sex with men), IDU (transmission through injecting drug use), Hetero (heterosexual transmission).

Anatomy of the epidemic

□ Global summary

By the end of 1998, according to new estimates from the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO), the number of people living with HIV (the virus that causes AIDS) will have grown to 33.4 million, 10% more than just one year ago. The epidemic has not been overcome anywhere. Virtually every country in the world has seen new infections in 1998 and the epidemic is frankly out of control in many places.

More than 95% of all HIV-infected people now live in the developing world, which has likewise experienced 95% of all deaths to date from AIDS, largely among young adults who would normally be in their peak productive and reproductive years. The multiple repercussions of these deaths are reaching crisis level in some parts of the world. Whether measured against the yardstick of deteriorating child survival, crumbling life expectancy, overburdened health care systems, increasing orphanhood, or bottom-line losses to business, AIDS has never posed a bigger threat to development.

According to new UNAIDS/WHO estimates, 11 men, women and children around the world were infected per minute during 1998—close to 6 million people in all. One-tenth of newly-infected people were under age 15, which brings the number of children now alive with HIV to 1.2 million. Most of them are thought to have acquired their infection from their mother before or at birth, or through breastfeeding.

While mother-to-child transmission can be reduced by providing pregnant HIV-positive women with antiretroviral drugs and alternatives to breastmilk, the ultimate aim must be effective prevention for young women so that they can avoid becoming infected in the first place. Unfortunately, when it comes to HIV infection, women appear to be heading for an unwelcome equality with men. While they accounted for 41% of infected adults worldwide in 1997, women now represent 43% of all people over 15 living with HIV and AIDS. There are no indications that this equalizing trend will reverse.

Altogether, since the start of the epidemic around two decades ago, HIV has infected more than 47 million people. And though it is a slow-acting virus that can take a decade or more to cause severe illness and death, HIV has already cost the lives of nearly 14 million adults and children.

An estimated 2.5 million of these deaths occurred during 1998, more than ever before in a single year.

□ AIDS and the infectious disease picture

According to recent WHO estimates, malaria causes over 1 million deaths a year. In 1998, AIDS deaths totalled some 2.5 million. Both diseases are among the five top killers worldwide. However, it is important not to overlook the dynamics in this picture. Already in 1954, millions of people were dying annually of malaria. AIDS is a still-emerging epidemic whose death toll rises every year, while the ranks of the newly infected swell by some 16 000 a day.

Tuberculosis, the second biggest infectious killer, is also on the rise, driven in large part by the HIV epidemic. People whose immune defences are weakened by HIV infection become an easy prey for other microbes, including the bacillus that causes tuberculosis. The resulting infections

(along with some cancers) are responsible for the recurring illnesses which in their late stages are called "AIDS", and which ultimately lead to death. Around 30% of all AIDS deaths result directly from tuberculosis.

While people undermined by HIV infection are more easily infected with the TB bacillus, many already harbour it from childhood. In either case, individuals with dual HIV/TB infection run a far greater risk than TB carriers who are HIV-negative that their tuberculosis will become active and potentially lethal. Worldwide, millions of people are already infected with both HIV and the tuberculosis bacillus, and the potential for further growth of co-infection in the developing countries is vast, given the crushing prevalence of TB carriers in the general population (some 30%) and the almost 6 million new HIV infections a year. Tackling the dual epidemics calls for stronger TB casefinding and treatment—tuberculosis can be cured with antibiotics regardless of whether the person is HIV-infected or not—in parallel with stronger AIDS prevention programmes to avert new HIV infections.

□ Regional roundup

Sub-Saharan Africa is home to 70% of the people who became infected with HIV this year. It is also the region in which four-fifths of all AIDS deaths occurred in 1998.

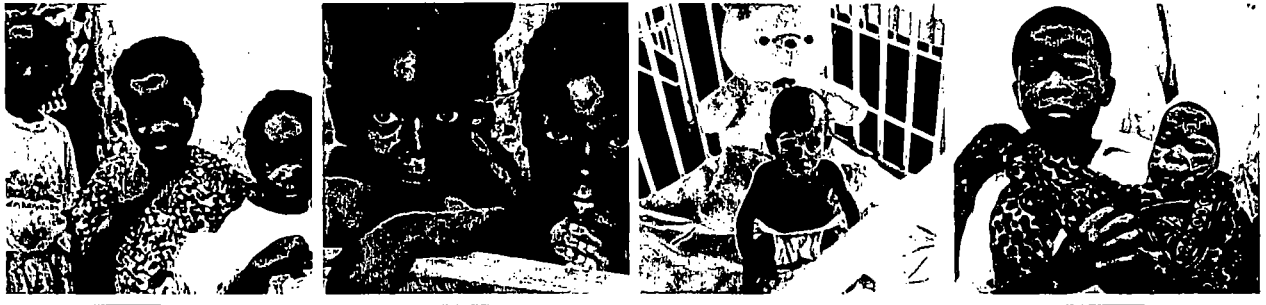
Africa, the global epicentre, continues to dwarf the rest of the world on the AIDS balance sheet. Since the start of the epidemic, 83% of all AIDS deaths so far have been in the region. Among children under 15, Africa's share of new 1998 infections was 9 out of 10. At least 95% of all AIDS orphans have been African.¹ Yet only a tenth of the world's population lives in Africa south of the Sahara.

The sheer number of Africans affected by the epidemic is overwhelming. Since HIV began spreading, an estimated 34 million people living in sub-Saharan Africa have been infected with the virus. Some 11.5 million of those people have already died, a quarter of them children. In the course of 1998, AIDS will have been responsible for an estimated 2 million African deaths—5500 funerals a day. And despite the scale of death, today there are more Africans living with HIV than ever before: 21.5 million adults and a further 1 million children.

While no country in Africa has escaped the virus, some are far more severely affected than others. The bulk of new infections continue to be concentrated in East and especially in Southern Africa.

The southern part of the African continent holds the majority of the world's hard-hit countries. In Botswana, Namibia, Swaziland and Zimbabwe, current estimates show that between 20% and 26% of people aged 15–49 are living with HIV or AIDS. South Africa, which trailed behind some of its neighbours in HIV infection levels at the start of the 1990s, is unfortunately catching up fast: one in seven new infections on the continent this year are believed to be in this one country. Zimbabwe is especially hard-hit. There are 25 surveillance sites in the country where blood taken from pregnant women is tested anonymously as a way of tracking HIV infection. The most recent data, from 1997, show that in only 2 of these sites did HIV prevalence remain below 10%. In the remaining 23 sites, some 20–50% of all pregnant women were found to be infected. At least one-third of these women are likely to pass the infection on to their baby.

¹ UNAIDS defines AIDS orphans as people who lost their mother or both their parents to AIDS when they were under the age of 15.



Report on the Presidential Mission on Children Orphaned by
AIDS in Sub-Saharan Africa: **Findings and Plan of Action**

The White House

July 19, 1999



**HIV/AIDS is not someone else's problem. It is my problem.
It is your problem.**

For too long we have closed our eyes as a nation, hoping the truth was not so real. For many years, we have allowed the human immunodeficiency virus to spread...at times we did not know that we were burying people who had died from AIDS. At other times we knew, but chose to remain silent.

Now we face the danger that half of our youth will not reach adulthood. Their education will be wasted. The economy will shrink. There will be a large number of sick people whom the healthy will not be able to maintain. Our dreams as a people will be shattered.

South African President Thabo Mbeki

(Remarks delivered as Deputy President, launching the South African Partnership Against AIDS, October 1998)

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Summary

1. AIDS is the leading cause of death in Africa. In the next decade, 40 million children will become orphans – by losing one or both parents to AIDS.
2. AIDS is wiping out decades of progress on a variety of development fronts, including per capita GNP, infant mortality, and life expectancy.
3. AIDS is not just taking lives, it is threatening economies, stability, and civil society.
4. As goes Africa, so will go India, South-East Asia, and the Newly Independent States of the former Soviet Union, and by 2005, more than 100 million people worldwide will be living with HIV.
5. We know what works. Scaling up these proven interventions to meet the magnitude of this crisis is essential.
6. Leadership and resources are desperately needed if we are to turn the tide.



Background

On December 1, 1998, World AIDS Day, President Clinton highlighted the growing global tragedy of children orphaned by AIDS in sub-Saharan Africa. At that time, he directed Sandra Thurman, Director of the Office of National AIDS Policy, to lead a fact-finding mission to the region and to report back to him with recommendations for productive action. From March 27 through April 5, Director Thurman led a Presidential Mission to Zambia, Uganda, and South Africa. Director Thurman was accompanied by Representatives Jackson-Lee, Kilpatrick, and Lee, and senior staff from the offices of Senators Hatch, Helms, and Kennedy, and Representative Pelosi. Also joining the Mission was a group of community leaders from outside of government including Mayor David Dinkins, Bishop Felton May, and William Harris. [Attachment A: Trip Manifest]

The goals of the trip were to:

- investigate the extent of the AIDS crisis in sub-Saharan Africa particularly as it relates to children orphaned by AIDS;
- identify proven and promising interventions; and,
- promote leadership both at home and abroad.

I believe that if we could reach to the heart of people, we would always do better in dealing with problems, for our mind always conjures a million excuses. We cannot restore to [these children] all they have lost, but we can give them a future - a foster family, enough food to eat, medical care, a chance to make the most of their lives by helping them to stay in school."

President Clinton, World AIDS Day 1998

Information for this report was gathered from meetings with African presidents, government ministers, donors, experts, providers, children, parents, and community leaders. In addition, site visits were made to a wide variety of community-based programs serving children and families affected by AIDS. Both the meetings and the visits provided an important perspective on the problem regarding actions taken, lessons learned, and further progress needed. [Attachment B: Groups Visited]

Findings

The Problem:

AIDS in sub-Saharan Africa is a plague of biblical proportions.

AIDS in sub-Saharan Africa, notes The United Nations, is the “worst infectious disease catastrophe since the bubonic plague.” Deaths due to AIDS in the region will soon surpass the 20 million people in Europe who died in the plague of 1347 and the more than 20 million people worldwide who died in the influenza epidemic of 1917. Over the next decade, AIDS will kill more people in sub-Saharan Africa than the total number of casualties lost in all wars of the 20th century combined.

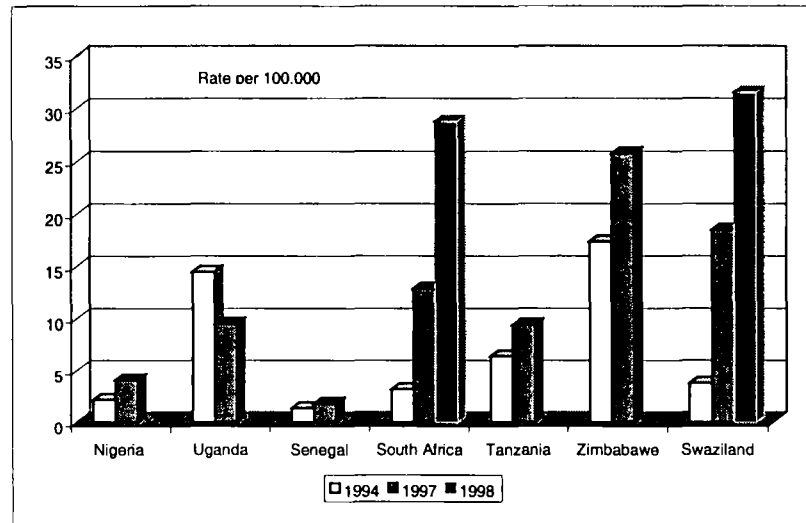
While sub-Saharan Africa accounts for only one-tenth of the global population, it currently carries the burden of more than 80% of AIDS deaths worldwide:

- In the past decade, 12 million people in sub-Saharan Africa have died of AIDS – one-quarter of them children – and each day AIDS buries another 5,500 men, women and children.
- In 1998, AIDS was the largest killer and accounted for 1.8 million deaths in sub-Saharan Africa, nearly double the 1 million deaths from malaria and eight times the 209,000 deaths from tuberculosis.
- By 2005, the daily death toll will reach 13,000 people with, nearly 5 million AIDS deaths in that year alone.

And yet, the pandemic rages on:

- In sub-Saharan Africa, more than 22 million adults and 1 million children are currently living with HIV.
- Every day, 11,000 additional people are infected – one every 8 seconds.
- Since the Administration launched this effort on World AIDS Day (December 1, 1998), more than 2.5 million people in sub-Saharan Africa have been infected with HIV, 368,000 in South Africa alone.
- Half of all new infections in southern Africa, and 10% of new infections worldwide, occur in South Africa, now experiencing the fastest growing AIDS disaster.

HIV Prevalence Trends in Selected African Countries



Source: UNAIDS

Fragile health care systems are already buckling beneath the weight of the rapidly growing number of people with AIDS and the growing loss of health personnel as a result of AIDS. For example, The World Bank estimates that in Zimbabwe, Zambia, and Cote d'Ivoire, people with AIDS already occupy 50-80% of all beds in urban hospitals. In addition, the escalating incidence of tuberculosis (TB), the most common opportunistic infection associated with AIDS, now accounts for between one-third and one-half of all AIDS deaths in Africa.

AIDS in sub-Saharan Africa is stalking women and young people, shattering families, and placing extraordinary burdens on the extended family and village systems that have been the backbone of African child-rearing tradition.

While AIDS in sub-Saharan Africa is an equal opportunity killer, women, children, and young people are increasingly caught in the path of this relentless pandemic.

All too often, cultural norms place women at heightened risk of HIV. In many parts of sub-Saharan Africa, and around the world, discrimination against women begins early and continues throughout life. Girls are far less likely to have access to education, information, and skill training. And in turn, women are far less likely to have access to essential health care and income generating opportunities. These realities increase their vulnerability to both poverty and HIV.

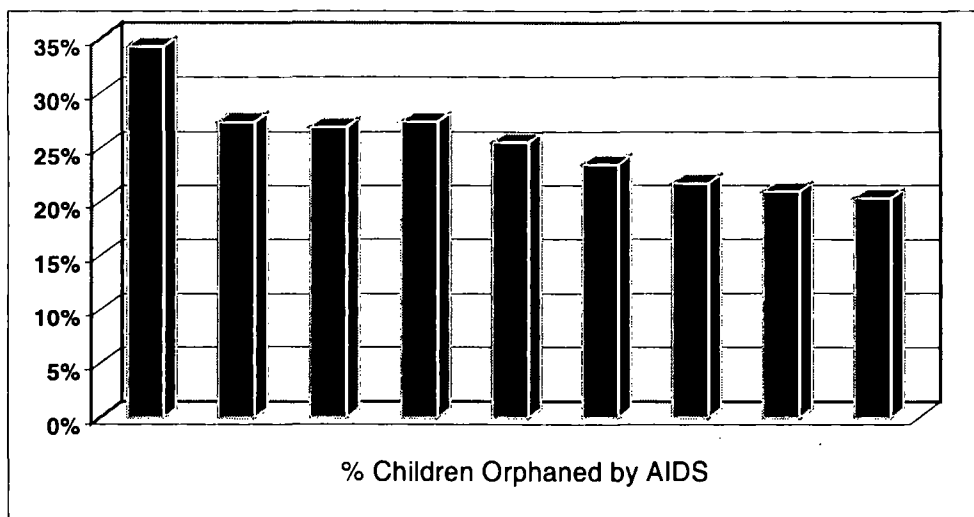
The low status of women in sub-Saharan Africa severely restricts their power to make informed and safe choices. As a result, more than half of all new HIV infections in sub-Saharan Africa are among women and 80% of the 14 million HIV-positive women of childbearing age worldwide reside in sub-Saharan Africa.

In many areas throughout the region, pregnant women have astronomically high rates of HIV infection including 73% in Beit Bridge, Zimbabwe and 43% in Francistown, Botswana. Nine out of every ten infants infected with HIV at birth and through breastfeeding live in sub-Saharan Africa – with nearly 600,000 new infections each year among babies.

There are many places throughout the region where up to one-quarter of all children are already living with an HIV-positive parent. And in nine sub-Saharan African countries, between one-fifth and one-third of all children will be orphaned by AIDS by the end of this year. In human terms, the AIDS orphan emergency is causing unprecedented threats to child welfare. This vulnerability includes decreased access to life-sustaining food, education, health care, housing, and clothing, and increased psychosocial distress brought on by the death of a parent, isolation, and stigma. These children are also at extraordinary risk of physical and sexual abuse as well as child labor exploitation. And while most of these orphans were born HIV-negative – this vulnerability leaves them at seriously increased risk of becoming HIV infected themselves.

Tragically, the worst is yet to come. During the next decade, more than 40 million children will be orphaned by AIDS, and this "slow burn disaster" is not expected to peak until at least 2030. According to UNICEF, the AIDS pandemic in sub-Saharan Africa is having and will continue to have a more significant impact on child survival and maternal mortality than all other emergencies on the continent combined. Without a doubt, AIDS has placed an entire generation of Africa's children in jeopardy.

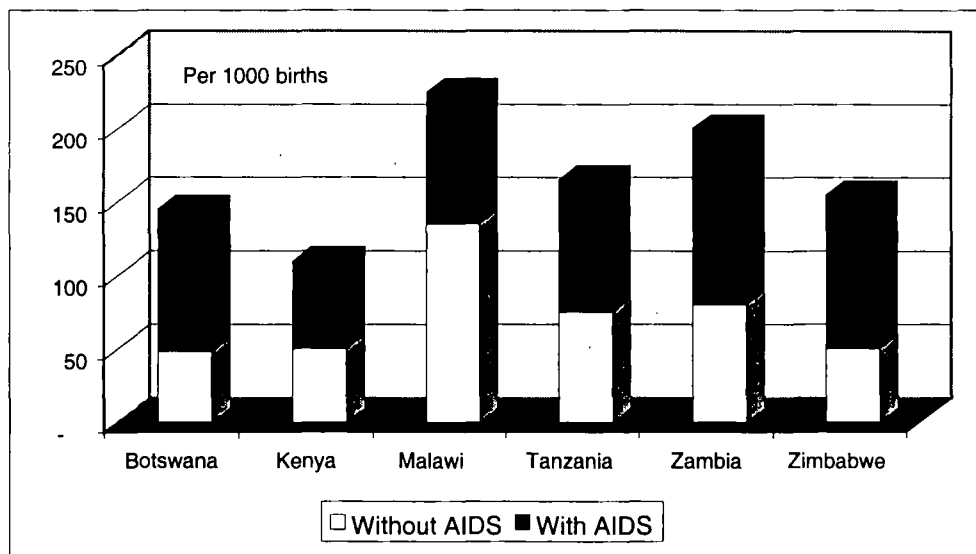
In 9 sub-Saharan African countries, one-fifth to one-third of all children under the age of 15 will be orphaned by the year 2000



Source: USAID

AIDS is wiping out decades of progress on a host of development objectives. After hundreds of millions of dollars of donor investment and well-documented results, AIDS is now turning back the development clock to the 1960s. In the coming decade in many areas of sub-Saharan Africa, infant mortality (those less than one year old) will double and child mortality (those under age five) will triple. In addition, despite steady advances in access to education, a rapidly increasing number of children (particularly girls) are now dropping out of school to act as substitute labor or as caregivers for their dying parents. Far too few are finding their way back to school. Finally, according to the US Census Bureau, AIDS has already reduced life expectancy in Zimbabwe by 25 years and in Zambia from 56 years old to 37. In the next few years, AIDS will reduce life expectancy in South Africa by a third, from 60 years old to 40.

**Projected Under-5 Mortality Rates in 2010
for Selected African Countries**



Source: US Census Bureau

AIDS is not only causing unfathomable human suffering, it is jeopardizing economic growth, political stability, and civil society in many sub-Saharan African nations.

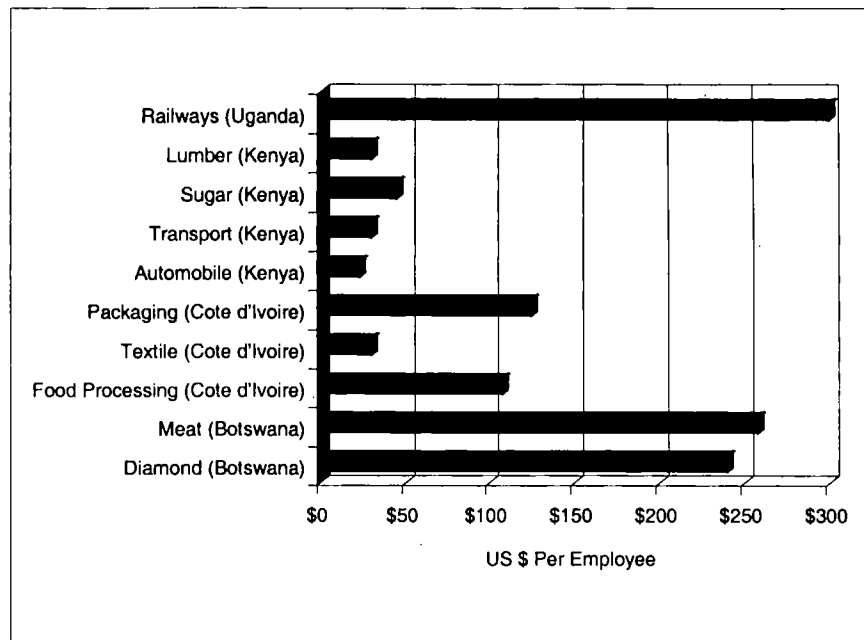
AIDS is a trade and investment issue. The *Blueprint for a US/Africa Partnership for the 21st Century*, adopted at the US/Africa Ministerial Meeting states: "African-US economic ties continue to grow. For example, US exports to Africa grew more rapidly in 1998 than did US exports to most other regions and are now 45% greater than its exports to all countries of the former Soviet Union combined. As a source of crude oil, Africa is as important to the United States as the Persian Gulf. On a balance of payment basis, American private investment consistently produces a higher rate of return in Africa than in any other region."

According to Professor Jeffrey Sachs, Director of the Harvard Institute for International Development, "a frontal attack on AIDS in Africa may now be the single most important strategy for economic development." This is true because as the Southern Africa AIDS Information Dissemination Service estimates, over the next 20 years AIDS will reduce by a fourth the economies of sub-Saharan Africa. In fact, this AIDS related economic impact has already begun. According to the *Economist*, a recent study in Namibia estimated that AIDS costs the country almost 8% of GNP in 1996 and by 2005, Kenya's GNP will be 14.5% smaller than it would have been without AIDS. In Tanzania, The World Bank predicts that GNP will be 15-25% lower as a result of AIDS. The South African government estimates that AIDS costs the country 2% of GNP each year.

AIDS has hit professionals hard in sub-Saharan Africa, particularly civil servants, engineers, teachers, miners, and military personnel. In Malawi and Zambia, 30% of teachers are HIV-positive, and in Zambia, 1,500 teachers died of AIDS in 1998 alone. In South Africa, 1 in 5 miners is currently infected with HIV. Uganda Railways has already lost 5,600 employees (10% of its workforce) to AIDS and now has an AIDS-related labor turnover rate of 15% annually. And in Zimbabwe, a major transportation company employing 12,000 workers found that by 1996 more than one-third were already HIV positive. According to a World Bank study in Kigali, Rwanda, 34% of people with post-secondary education were HIV positive, compared to 18% of those with primary education, and civil servants were more than three times more likely to be HIV-positive than farmers.

Increased benefits and training costs, and the disruption to regular production due to sick and bereavement leave, are seriously affecting both the private and public sectors. A study in South Africa found that at current levels of benefits per employee, the total cost of benefits would rise from 7% of salaries in 1995 to 19% by 2005 due to AIDS. Companies like British Petroleum and Barclays Bank have stated that they are now hiring two employees for every one skilled job, assuming that one will die of AIDS. The Indeni Petroleum Refinery in Zambia reportedly spent more on AIDS-related costs than it declared in profits.

**Annual Costs of AIDS Per Employee in
Various Industries in Selected Sub-Saharan African Countries**

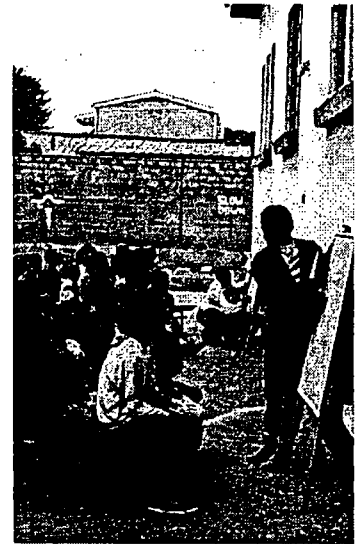


Source: Futures Group International, USAID Policy Project, 1999.

AIDS is a security and stability issue. According to the *Economist*, "the estimated HIV prevalence in the seven armies embroiled in the Congo range from 50% to 80%." Recent reports project that the South African military and police are also already heavily infected by HIV. Moreover, as these troops participate in an increasing number of regional interventions and peacekeeping operations, the pace of the epidemic is likely to accelerate. Extremely high levels of HIV infection among senior officers could lead to rapid turnover in those positions. In countries where the military plays a central or strong role in government, such rapid turnover could weaken the central government's authority. For those countries in political transition, instability in the military and security forces could slow or even reverse the transition process. This dynamic merits attention, not only in Africa where the pandemic is already entrenched, but also in India and the Newly Independent States where the pandemic is intensifying its grip.

AIDS is a crime issue. The South African Institute for Security Studies has linked the growing number of children orphaned by AIDS to future increases in crime and civil unrest. The assumption is that as the number of disaffected, troubled, and undereducated young people increases, many sub-Saharan African countries may face serious threats to their social stability. Without appropriate intervention, many of the two million children projected to be orphaned by AIDS in South Africa alone will raise themselves on the streets, often turning to crime, drugs, commercial sex, and gangs to survive. This seriously affects stability and promotes the spread of HIV among these highly vulnerable young people.

In Lusaka, Zambia alone, 100,000 children are estimated to be living on the streets. Most have been orphaned by AIDS. By the year 2000, one million children in Zambia, or one out of every three children, will be orphaned by AIDS. Hundreds and hundreds of these children spend their nights on Cairo Road, sleeping in gutters and in trees, hoping to remain out of the "line of fire". Some are new to the streets, others have called it home for years. The longer they stay, the harder they get. In an effort to survive, too many are forced into crime, sex, and drug operations. While none would actually "choose" this life, once they "belong to the streets" it is difficult to turn back. Though good data are lacking, it is likely that HIV infection is spreading like wildfire among these children. Given their grim reality, it is amazing that as the dawn breaks, so many of them gather at the gate of the Fountain of Hope to attend school. While this school is simply a collection of wooden benches around outdoor blackboards, the desire to learn among these hungry, homeless children gives us hope.



As goes Africa, so will go India, South-East Asia, and the Newly Independent States, and by 2005, more than 100 million people worldwide will be HIV-positive.

According to current projections, by 2005, AIDS deaths in Asia will mirror those in Africa. As the world's most populous continent, Asia will soon come to dominate the HIV picture accounting for one out of every four infections worldwide by the end of the year. Already, trends suggest that Asia may surpass Africa with the highest number of new infections.

India is increasingly at the center of the global epidemic, with more HIV infected people than any other country in the world – an estimated 5 million. While the current death rate remains low in comparison to sub-Saharan Africa, infection rates are increasing rapidly and are expected to double every 14 months. Surveillance of the disease is particularly difficult in India as cultural norms, gender inequities, and stigma continue to drive the epidemic underground. As a result, AIDS cases in India are thought to be under-diagnosed, and therefore, poorly treated. By 2000, AIDS will cost India \$11 billion or 5% of GNP.

According to Surgeon General Satcher, "It was only a few years ago that epidemiologists offered projections of disease prevalence for sub-Saharan Africa that were met with disbelief. If the present warnings go unheeded, South Asia, Southeast Asia, and, perhaps, China will follow the disastrous course of sub-Saharan Africa."

The Newly Independent States have also registered astronomical growth in HIV infection rates over the past few years. In the last four years alone, Eastern Europe and Central Asia have seen six-fold increases in HIV infections.

In the Russian Federation, HIV infections have increased 27-fold between 1994-1997. And in the Ukraine, HIV infections have increased 70-fold. Injection drug use now accounts for 80% of new infections in the Russian Federation and the increasing number of new users signals a growing dual epidemic of AIDS and drugs.

Region	Epidemic Started	Adults & Children Living With HIV/AIDS	Adults & Children Newly Infected With HIV
Sub-Saharan Africa	Late 70's - Early 80's	22,500,000	4,000,000
South & South-East Asia	Late 80's	7,260,000	1,400,000
Eastern Europe & Central Asia	Early 90's	270,000	80,000

Source: UNAIDS

The Response:

Determined leadership and sustained investment have made, and can continue to make, an extraordinary difference and will save millions of lives.

Leadership matters. Amidst the tragedy of AIDS, there is hope. Uganda has shown that even a country with limited resources and a low literacy level can turn the tide on this burgeoning epidemic. President Museveni demonstrated bold leadership early in the epidemic by making every government ministry take the problem seriously, requiring them to develop and implement a plan to reduce AIDS stigma and HIV transmission, and to support those who became sick. In so doing, Uganda created an “enabling environment” for donors to assist in this effort. Over the past decade, the US has invested \$46 million (26% of the donor contributions to AIDS in Uganda) in partnership with the Ugandan government, other donors, and non-governmental organizations (NGOs) to provide HIV prevention, care and support. As a result, HIV rates in urban Uganda have been cut in half.

Effective solutions for children orphaned by AIDS are community-based and multi-sectoral. Families and communities not only bear the brunt of the impact of AIDS, they form the frontline of an effective response. In the long-standing African tradition, communities across the continent are searching for creative ways to support the village in its efforts to raise its children. Unfortunately, the growing number of young deaths and orphaned children is beginning to overwhelm many of these small villages. Nevertheless, when residents are brought together to organize in the face of seemingly insurmountable odds. These community partnerships are making the difference by helping to strengthen the capacity of those on the frontline to cope with this ever unfolding crisis.

Through village banks and micro-finance programs, women are receiving loans, starting small businesses, and with increased household incomes, are taking in children orphaned by AIDS. With support, communities are mobilizing to deal with school fees, food assistance, counseling, material support, immunizations and basic healthcare, and the range of other services orphaned and other vulnerable children desperately need.

These efforts are low cost strategies designed to empower women (many of whom are HIV-positive), protect children, and support extended families and communities in caring for their own. Community mobilization and micro-finance programs are affordable, mutually reinforcing ways to build the capacity of families and communities to cope with the impact of AIDS. This approach is universally preferred to the use of orphanages, a solution that can never keep pace with this burgeoning pandemic. For a small fraction of the cost of one orphanage bed, many more vulnerable children can receive care in a family setting. The problem is, only a very tiny fraction of those children in need actually receive even this modest level of support.

Bernadette Nakayima is a remarkable woman from a small village called Kyahusome outside of Maskaka, 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 fish, 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 5 who are now 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, Janet Museveni - linking in solidarity thousands of women allied in this same great struggle.



A focus on children orphaned by AIDS can and should be a catalyst for a more comprehensive fight against AIDS. It is almost impossible to consider the issues surrounding the care and protection of children orphaned by AIDS without also considering HIV prevention and AIDS treatment. It is certainly true that the only way to slow the number of children orphaned by AIDS is to reduce the transmission of HIV infection among parents and prospective parents. Yet today, young people under the age of 25 represent at least 60% of all new infections in sub-Saharan Africa. Until there is an available vaccine, more aggressive prevention efforts, particularly programs targeted to youth, are essential to stem this rising tide of devastation.

Community action to save orphans can help to facilitate effective prevention efforts by reducing stigma, denial, and fatalism in the face of AIDS. Planning for children orphaned by AIDS brings home the very real consequences of HIV – death and orphanhood. These grim realities are all too often denied due to the "conspiracy of silence" that surrounds this illness and its long latency period. But this is a matter of life and death and more. Once denial fades, community mobilization enables those involved to believe that they can change their circumstances for the better. This sense of possibility is a powerful behavior change tool.

Helping keep parents alive assures a better future for their children. The number of children being orphaned by AIDS in Africa is staggering, and those children orphaned are at greater social, economic and health risk than their non-orphaned peers. Parents, guardians, and extended families are best able to provide the nurturing environment for these children. Basic care and psycho-social support can make a huge difference. The delivery of low cost treatments for opportunistic infections (especially TB), and the provision of psycho-social support, helps people with HIV and AIDS live longer and better lives, and

enables them to plan for the future of their children. In addition, the availability of care and support gives increased credibility to prevention efforts by demonstrating the merits of pursuing HIV testing and counseling.

Ultimately, it is important to remember that children and families caught in the crossfire of this epidemic do not segment their lives into pieces that follow programmatic or budgetary line items. Therefore, the more holistic and integrated the approach to this complex problem – the more effective the result.

Preventing Mother-to-Child Transmission

Ten percent of all new HIV infections in Africa occur through mother-to-child transmission, with nearly 600,000 infants becoming infected per year. In Africa today, for every ten children born to HIV-positive mothers, two become infected during delivery and one becomes infected through breastfeeding.

Developing methods to reduce mother-to-child transmission of HIV that are feasible in Africa is a high priority. For the past three years, multiple studies have been initiated to find proven interventions that could be workable in poor countries. In February 1998, data from the first of these studies were released from Thailand, which demonstrated that a short course of AZT (Zidovudine) could reduce mother-to-infant HIV transmission by nearly 40% in non-breastfeeding infants. Even more recently, on July 14, 1999, the National Institutes of Health announced a joint Uganda-US study breakthrough identifying a low cost drug, nevirapine (NVP) that can reduce mother-to-child transmission of HIV at birth by an additional 50% as compared to the short course of AZT regimen. These drug regimens are far simpler and less expensive than the antiretroviral regimens used in the United States, and potentially just as effective. These new interventions will give pregnant women an incentive to seek HIV testing and counseling, and if infected, to receive treatment where it is available.



These new developments are extremely encouraging and provide hope for being able to save the lives of hundreds of thousands of babies a year – most of whom will live in sub-Saharan Africa. However, a host of additional issues need to be explored and addressed before this knowledge can be effectively translated into productive action. For example, to receive maximum benefit from AZT and perhaps NVP, mothers should not breastfeed. In many areas of sub-Saharan Africa, infant formula is unaffordable and lack of clean water often makes it unworkable. In some cases, babies are as likely to die from diarrhea resulting from incorrect use of formula as they are from AIDS.

The lack of health care infrastructure is also a serious issue. At least 95% of pregnant women do not know they are HIV-positive and currently lack access to the testing and counseling services needed to find out. In many areas, most women deliver their children with the assistance of midwives in their homes, or in makeshift clinics currently unequipped for complex interventions. In the poorest parts of Africa, nearly 80% of women lack access to any kind of health care at all.

Further, the stigma of AIDS is often so great that fear of discrimination, violence and abandonment dramatically restrict the ability of women to make safe choices. In cultures where breastfeeding is the norm, women who choose not to breastfeed are assumed to be HIV-positive, often with dire consequences. Recently, an HIV-positive woman in South Africa went public with her status and was stoned to death by her neighbors. Countless other women and children have been left destitute after their husbands discovered, or decided, they were HIV-positive.

These technical and ethical challenges deserve our immediate and urgent attention, so that the promise of these exciting new technologies can become a reality for as many women and children as possible.

The Challenge:

It's time to bring effective interventions to scale. We know what works. Unfortunately, these proven interventions currently fail to reach the overwhelming majority of those in need. Successful small scale efforts must be dramatically expanded. While the magnitude of the global AIDS pandemic is far too extensive for any donor, host government, or multilateral institution to ignore, it is also too great for any single entity to address adequately by itself. To make a real difference, an effective response must mobilize and coordinate the commitment and resources of the full range of key stakeholders, including governments, bi-lateral and multi-lateral development bodies, international organizations, religious networks, the private sector, NGOs, families and communities, and people living with HIV/AIDS. AIDS is everyone's problem and everyone must be a part of the solution.



These are the faces of children and families living in a world with AIDS. Their spirit, their determination, and their resilience inspire all of us to join the fight. We are one world, and these children are our children. Their destiny is our destiny. Each of us can make a difference. Each of us can help save lives. Let us wage this holy war together. And for the sake of our children, we will win.

Archbishop Desmond Tutu

Plan of Action

The Background:

Throughout the Mission's travel in Africa, it was clear that President Clinton's "Partnership with Africa" is making hope a reality, even at the village level. From Kampala to Cape Town, people across Africa know of this historic initiative. Unfortunately, AIDS threatens to decimate the progress of this partnership and everything else in its path. To protect and defend the legacy of growth and opportunity we have built with Africa, and the children and families who depend on it, an aggressive AIDS initiative, involving concrete action both at home and abroad, is essential.

Given the magnitude of the AIDS pandemic and its devastating impact on child survival, economic development, trade, regional stability, and civil society in Africa today, and in India tomorrow, the President established a Global AIDS Emergency Working Group. Included were the National Security Council, Office of Management and Budget, Office of the Vice President, USAID, and the Departments of Defense, State, Treasury, Commerce, and HHS. The Office of National AIDS Policy coordinated this effort, and together the Working Group and the members of the Presidential Mission made specific recommendations. These recommendations form the basis of the Plan of Action now put forward by the Administration.

The Goals:

UNAIDS, in cooperation with its bi-lateral and multi-lateral partners, has laid out a series of goals for the next five years as described below. The Administration seeks to further these goals through an initiative entitled "Joining Forces for LIFE": Leadership and Investment in Fighting an Epidemic.

- The incidence of HIV infection will be reduced by 25% among 15-24 year olds by 2005. (Currently 2 million young adults are infected each year in sub-Saharan Africa.)
- At least 75% of HIV infected persons will have access to basic care and support services at the home and community levels, including drugs for common opportunistic infections (TB, pneumonia, and diarrhea). (Currently, less than 1% of HIV infected persons have such access.)
- Orphans will have access to education and food on an equal basis with their non-orphaned peers.

- By 2001, domestic and external resources available for HIV/AIDS efforts in Africa will have doubled to \$300 million per year. (Currently, approximately \$150 million per year is spent on HIV/AIDS prevention in sub-Saharan Africa.)
- By 2005, 50% of HIV infected pregnant women will have access to interventions to reduce mother-to-child HIV transmission. (Currently, less than 1% of HIV infected pregnant women have access to such services in sub-Saharan Africa.)

The Initiative:

Joining Forces for LIFE:
Leadership and Investment in Fighting an Epidemic
A Global AIDS Initiative

I. **Increasing the US Government investment in the global battle against AIDS to begin to reflect the magnitude of this rapidly escalating pandemic.**

Making a difference in Africa and in other highly impacted areas requires broader political commitment, enhanced community mobilization, and, most urgently, increased resources. In 1998, spending on AIDS in Africa totaled only \$165 million. Compared to the ever-escalating need and other health programs, this amount is woefully inadequate. For example, in 1998, over \$500 million was spent for basic childhood immunization programs in Africa. Based on our experience in those countries that are starting to demonstrate success, such as Uganda and Senegal, UNAIDS and donors now agree that a minimum of \$600 million is needed in sub-Saharan Africa per year for HIV prevention alone (\$2 per adult per year).

While we acknowledge the leadership role that the US plays globally and the urgent need to act, clearly an effort to combat AIDS must be driven by many actors including host countries, multi-lateral organizations, and bi-lateral donors, to be successful. In FY1999, the US Government spent \$74 million in USAID prevention and care in Africa and \$38 million in HHS research and surveillance/prevention. But more remains to be done in sub-Saharan Africa and in other seriously affected parts of the world.

The Administration proposes to commit an additional \$100 million in FY2000 to the global battle against AIDS. This initiative will enable us to move forward on four critically important and interconnected fronts including:

- **Containing the AIDS Pandemic (\$48 million)** Implement a variety of prevention and stigma reduction strategies, especially for women and youth, including: HIV education, engagement of political, religious, and other leaders; voluntary counseling and testing; interventions to reduce mother-to-child transmission (MTCT); and enhance training and technical assistance efforts, including Department of Defense efforts with African militaries.
- **Providing Home and Community-Based Care (\$23 million)** Deliver counseling, support, palliative and basic medical care including treatment for sexually transmitted diseases, opportunistic infections (OIs), and tuberculosis (TB) through community-based clinics and home-based care workers. Enhance training and technical assistance efforts.
- **Caring for Children Orphaned by AIDS (\$10 million)** Assist families, extended families, and communities in caring for their children through nutritional assistance, education, training, health, and counseling support, in coordination with micro-finance programs.
- **Strengthening Prevention and Treatment by Augmenting Planning, Infrastructure, and Capacity Development (\$19 million)** Strengthen host country ability to plan and implement effective interventions. Strengthen the capacity for effective partnerships and the ability of community based organizations to deliver essential services. Strengthen surveillance systems to track the epidemic and target HIV/AIDS programs.

This US Government assistance would be provided through AID (\$55 million), HHS (\$35 million), and DoD (\$10 million). The focus of this funding is HIV prevention, and AIDS care and treatment. In those areas, this initiative represents nearly a doubling of funding in Africa from current levels (\$81 million in FY99, which excludes research). The Administration recognizes the fight against AIDS must be sustained to keep pace with this burgeoning epidemic, and is committed to a multi-year effort in this critical area.

II. Building partnerships with other key stakeholders to maximize our impact on the rapidly expanding pandemic.

Increasing US investment in the global battle against AIDS is critical, but is not sufficient to achieve the outcomes needed. The commitment of in-country political leaders and of various segments of civil society are key to success. Moreover, resources provided by the US Government need to help leverage, and to be coordinated with, those of other donors, the private sector, and national governments to ensure synergy and to maximize impact. Building partnerships with key stakeholders in support of effective action at the community level is our greatest hope for progress.

This initiative will pursue a variety of strategic opportunities for challenging other partners to join in an enhanced effort, including:

- **Leadership Meeting** On September 7, 1999, First Lady Hillary Rodham Clinton will convene a meeting of key US officials, The World Bank, UNAIDS, as well as heads of foundations, corporate CEOs, and others to discuss how best to enhance AIDS prevention and treatment efforts in Africa and around the world. The meeting will focus not only on leveraging additional resources, but also on establishing priorities, identifying effective public/private partnerships, and identifying targets for action to combat the crisis of HIV/AIDS.
- **African Leaders Summit** We propose hosting a high-level meeting with Africa government and community leaders within the next ten months. This meeting will highlight the critical role of leadership in arresting the epidemic and will work to encourage increased leadership efforts. Topics will include the economic impact of HIV/AIDS, examination of models of success in reducing the transmission of HIV, and addressing the need for increased investment in health programs. Additional topics will include AIDS care and treatment and support for children orphaned by AIDS.
- **UN Conference on Children Orphaned by AIDS** On December 1, 1999 (World AIDS Day), the United Nations in conjunction with the National Black Leadership Commission on AIDS, The White House Office of National AIDS Policy, The Magic Johnson Foundation and a variety of NGOs, will organize a conference to focus attention on the growing number of children orphaned by AIDS worldwide. Special emphasis will be placed on assessing the needs of orphaned children in sub-Saharan Africa and the Americas. Participants will include noted experts on the priority issues identified by UNAIDS, UNICEF, and other UN agencies.
- **Business** 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. Given the impact that AIDS is having on businesses as well as the overall economic-impact on African countries, such a meeting will seek enhanced business commitment and involvement in AIDS programs.

The Commerce Department will work with American Chambers of Commerce abroad and other business organizations to publicize the successful AIDS efforts of US firms in Africa and to support others taking similar action. In addition, the Department will direct work to promote closer coordination in Africa between Commercial Service Offices, other USG agencies, the business community, and African NGOs in a united effort to promote corporate partnership in AIDS programs.

- **Labor** The Secretary of Labor will facilitate a meeting of US and African labor leaders, and will be co-chaired by the AFL-CIO. The success of the AFL-CIO and its Solidarity Center in South Africa (supported by USAID) in working with the South African Trade Union Federations to include AIDS as a key labor outreach and policy issue provides a model for similar action elsewhere. Outcomes include assisting labor organizations in educating their members and securing commitments to develop workplace-based AIDS education and prevention programs, including outreach to youth.

- **Religious Leaders Summit** The US government 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. In Uganda and Senegal, the involvement of religious communities and leaders had a dramatic impact on the ability of these two countries to reduce HIV incidence and to maintain it at low levels over time. The outcome of such a meeting would be to increase attention to the need for involving religious communities, to mobilize these organizations and leaders in the fight against AIDS, and to identify ways to support their efforts.

- **Diplomatic Initiatives** The Department of State, NSC, and ONAP will work with US and African ambassadors to increase attention to AIDS within the diplomatic community. The NSC, the Department of State, and USAID will work with G-8 and other donors, and challenge them to match the increased investment put forward in this initiative.

Conclusion

Nelson Mandela, in accepting the Congressional Medal of Honor, said:

“Though the challenges of the present time for our country, our continent and the world are greater than those we have already overcome, we face the future with confidence. We do so because despite the difficulties and the tensions that confront us, there is in all of us the capacity to touch one another’s hearts across oceans and continents.”

We are living in wartime and the stakes are high. Tragically, we know the severity of the horror that lies ahead. Fortunately, we also know a great deal about what can be done to protect children and to support families and communities in their battle against AIDS. Across Africa, valiant efforts are being made to stem the rising tide of HIV infection, to prolong the lives of those who are sick and to stitch together a tapestry of family or family-like support systems for the growing millions of children orphaned by AIDS. Partnerships between our government and other donors, host governments, non-governmental organizations, consumer groups, and communities are generating hope and demonstrating promising results.

But the battle against AIDS has just begun, and the worst is yet to come. We need to continue to promote and reward leadership, and to remove barriers that impede a cooperative multi-sectoral response. We need to expand our vision, our capacity, and our resource base – in the face of an ever expanding nightmare that just won't take no for an answer. Living in wartime means pushing forward on several fronts at the same time.

As we seek to keep pace and even gain ground, the magnitude of this challenge looms large. Nevertheless, the faces of the children and families crying out for our help beckon us all to find ways to do better, to be smarter, to move faster, and to develop whatever capacity and partnerships we lack, as we gear up for the long haul.

Attachment A

Trip Manifest

PRESIDENTIAL MISSION TO AFRICA MARCH 27, 1999 – APRIL 5, 1999

MEMBERS OF CONGRESS

Representative Carolyn Kilpatrick
*Foreign Operations Subcommittee, Appropriations, and
Congressional Black Caucus*

Representative Barbara Lee
*Africa Subcommittee, International Relations, and
Congressional Black Caucus*

Representative Sheila Jackson Lee
*Founder and Chair, Congressional Children's Caucus, and
Congressional Black Caucus*

CONGRESSIONAL STAFF

Bruce Artim, Health Staff, Senator Hatch
Mary Lynn Qurnell, Legislative Assistant, Senator Helms
Stephanie Robinson, General Counsel, Senator Kennedy
Carolyn Bartholomew, Legislative Director, Representative Pelosi,
Minority Staff, Foreign Operations Subcommittee, Appropriations

NON-GOVERNMENTAL PARTICIPANTS

William Harris, President, Children's Education and Research Institute
Bishop Felton May, General Board of Global Ministries, United Methodist Church
David Dinkins, Chair, Black Leadership Commission on AIDS
Dr. Jacob Gayle, UNAIDS Technical Advisor and Liaison to The World Bank
Rory Kennedy, Documentary filmmaker, Moxie Films
Nick Doob, Documentary filmmaker, Moxie Films

ADMINISTRATION OFFICIALS

Sandra L. Thurman, Director, Office of National AIDS Policy
Michael Iskowitz, Consultant, USAID
Dr. Paul DeLay, Director, HIV/AIDS Programs, USAID
Maria Sotiropoulos, Protocol Officer, State Department
Phil Drouin, Desk Officer, Bureau of African Affairs, State Department

Attachment B

Groups Visited

	Community Organizations	Government Officials
Zambia	<ul style="list-style-type: none">▪ Bwanfano▪ CHIN▪ Christian Council of Zambia▪ Evangelical Fellowship of Zambia▪ Family Health Trust▪ Fountain of Hope▪ McKinney Islamic Center▪ Mulenga Compound▪ National AIDS Network▪ Ndeke House▪ Project Concern International▪ Society of Women Against HIV/AIDS▪ St. Anthony's Compound▪ Twapia Windows Group	<ul style="list-style-type: none">▪ President Jacob Titus Chiluba▪ Dr. Nkandu Luao, Minister of Health▪ Peter McDermott, UNICEF Country Representative▪ Vincent Malambo, Minister of Legal Affairs▪ Edith Z. Nawakwi, Minister of Finance and Economic Development▪ Abel Chambeshi, Minister of Youth, Sports and Child Health▪ Keli Walubita, Minister of Foreign Affairs▪ Dawson Lupunga, Minister of Community Development▪ Dr. Moses Sichone, HIV/AIDS Coordinator, GRZ▪ GRZ public-private orphan task force▪ Ambassador Arlene Render
Uganda	<ul style="list-style-type: none">▪ AIDS Development Foundation▪ AIDS Information Center▪ The AIDS Support Organization (TASO)▪ Foundation for International Community Assistance (FINCA)▪ Joint Clinical Research Centre▪ Makerere University▪ National Community of Women Living with AIDS▪ Save the Children (UK)▪ Uganda AIDS Commission▪ Uganda Cancer Institute▪ Uganda Virus Research Institute▪ United Women's Effort to Save Orphans	<ul style="list-style-type: none">▪ President Yoweri Kaguta Museveni▪ First Lady Janet Museveni▪ Dr. Crispus Kiyonga, Minister of Health▪ Hajat Janat Mukwaya, Minister of Gender, Labor and Development▪ Dr. Elizabeth Madraa, AIDS/STD Control Program, Ministry of Health▪ Rafina Ochago, Commissioner for Child Care and Protection, Ministry of Gender, Labor and Development▪ Ambassador Nancy J. Powell

**Community
Organizations**

**Government
Officials**

South Africa

- Bethesda House
 - CINDI Coalition (Children in Distress)
 - Don McKenzie TB Hospital
 - Edendale Hospital
 - Edith Benson Babies Home
 - Ethembeni Centre
 - Grey's Hospital
 - Highway Hospice
 - Hope Worldwide-Jabavu Clinic
 - King Edward Hospital
 - Lilly of the Valley
 - Makaphuthu Children's Home
 - Project Gateway
 - Streetwise Shelter
- Nkosa Zana Zuma, Minister of Health
 - GJ Fraser-Moleketi, Minister of Welfare and Population Development
 - Dr. Ben S. Ngubane, Premier, KZN
 - Dr. Zweli Mkhize, Minister of Health, KZN
 - Sipiwe Gwala, Mayor, KZN
 - Ambassador James Joseph

Attachment C

US Government Agencies Engaged

Office of National AIDS Policy

Sandra Thurman, Director
Todd Summers, Deputy Director
(202) 456-2437
Web: www.whitehouse.gov/ONAP

U.S. Department of State

Frank Loy, Under Secretary for Global Affairs
(202) 647-6240
Web: www.state.gov

*Bureau of Oceans and International Environmental and Scientific Affairs --
Emerging Infectious Diseases and HIV/AIDS Program*

Nancy Carter-Foster, Director
(202) 647-2435
Email: ncarterf@state.gov
Web: www.state.gov/www/global/oes/health

U.S. Agency for International Development

Web: www.info.usaid.gov

*Bureau for Global Programs, Field Support and Research -- Center for
Population, Health and Nutrition*

Duff Gillespie, Deputy Assistant Administrator
(202) 712-4120

HIV/AIDS Division

Paul DeLay, Division Chief
(202) 712-0683

*Bureau for Africa, Office of Sustainable Development, Human Resources
Division*

Alex Ross, Deputy Chief
(202) 219-0476

U.S. Information Agency

Joseph D. Duffey, Director
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National Institutes of Health

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Office of AIDS Research
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Attachment D

Key Reference Documents

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FACT SHEET: HIV/AIDS IN AFRICA

Scope of Crisis

Of the 33 million people living with HIV/AIDS worldwide, 22 million – or 2/3 – live in sub-Saharan Africa. AIDS is now the number one cause of death in Africa, killing approximately 5,000 people per day, 175,000 per month – 1.9 million per year.

According to UNAIDS, one in five adults in Botswana, Namibia, Swaziland and Zimbabwe are infected. In South Africa alone, 3 million are HIV positive, and it is estimated that 1,500 new infections occur daily.

In some countries in Africa, it is predicted that life expectancy will fall by up to 1/3 in the next 10 years due to AIDS. And by the year 2010, USAID estimates that there will be 40 million AIDS orphans worldwide – more than ½ of them in Africa.

In a recent article, The Economist estimated that South Africa – the most robust economy in sub-Saharan Africa – has a reduction in its GDP by nearly 1% per year due to AIDS.

What the U.S. is doing to respond

The U.S. is the world's leading donor for the prevention and control of HIV/AIDS in the developing world. In FY99 USAID will spend \$125 million worldwide on HIV/AIDS prevention and control, \$74 million of that in Africa.

Since 1986, USAID has committed nearly \$1 billion worldwide on programs aimed at prevention of HIV/AIDS and other sexually transmitted diseases. In FY98 USAID also launched a new \$50 million initiative against infectious diseases, including HIV/AIDS, laying a foundation in Africa, Asia and Latin America for a global effort to combat infectious diseases.

Our international programs primarily are aimed at combating heterosexual transmission (the most common means of transmission in the developing world). Programs focus on education, changing high risk behavior, promoting condom use, controlling other sexually transmitted diseases, improving the policy environment to reduce transmission of HIV, conducting research and promoting advocacy, monitoring and evaluation, care and support activities, including community-based orphan care and voluntary counseling and testing programs.

Although the U.S. is spending \$200 million this year alone on the development of a vaccine, we are a long way from having an effective product. And while new anti-HIV drugs dramatically improve and extend life, they are not a cure. Prevention based on behavior change remains the primary intervention at this time.

USAID and HIV/AIDS in Africa

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

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

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

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

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

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

- In Uganda, HIV prevalence has declined by 35% in young women aged 15-24.
- Knowledge of several modes of transmission among adults has increased to 70-80% levels in Senegal, based approaches and interventions. Ghana and Uganda.
- In Kenya, studies have indicated that through condom promotion alone over 10,000 HIV infections and over 1.3 million other sexually transmitted diseases were averted from 1991-94. Increased use of condoms is reported in other countries such as Malawi and Benin.
- USAID supported development of low-cost 'dipsticks' for detecting HIV antibodies and they are now being produced in Cameroon and Zimbabwe.
- Successful community care approaches for the orphans have been established in Malawi, Zambia and Uganda.

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

In terms of influencing the donors USAID was one of the key advocates for developing a UN system-wide response to the epidemic and since 1996 has been the lead sponsor of UNAIDS. UNAIDS as well as the World Bank are in the process of developing strategies to intensify their programs in Africa. USAID has supported these

efforts and provided a synthesis of its experiences to them to influence these strategies. USAID is taking an active role in the preparation of forthcoming donors meeting on International Partnership on HIV/AIDS in April. The deliberations of the meeting are expected to lead to new approaches to deal with the epidemic, better coordination of resources and enhanced finding from other donors.



USAID'S HIV/AIDS ASSISTED COUNTRIES

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

HIV-AIDS Funding for FY 1999 and FY 2000

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

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

PRESIDENT CLINTON COMMEMORATES WORLD AIDS DAY
BY UNVEILING NEW STEPS TO ADDRESS THE
GROWING CRISIS OF CHILDREN ORPHANED BY AIDS

December 1, 1998

Today, President Clinton will join Secretary of State Madeleine Albright and Brian Atwood, Administrator of the U.S. Agency for International Development (USAID), to commemorate World AIDS Day by launching a series of new initiatives to address the growing crisis of HIV/AIDS around the world, particularly the millions of children orphaned by AIDS. The President will unveil historic increases in funding for research at the National Institutes of Health (NIH) designed to develop an effective AIDS vaccine and prevention strategies to help address the problem of HIV/AIDS throughout the world. He will announce new emergency funding from USAID to support international AIDS orphan programs. In addition, he will direct his AIDS policy advisor, Sandra Thurman, to lead a delegation to Sub-Saharan Africa to assess the growing problem of AIDS orphans and recommend new strategies for responding to the crisis.

USAID projects that up to 40 million children will be orphaned by HIV/AIDS by the year 2010, over 90 percent of whom live in developing countries with few resources to provide for their care and support. Over 33 million people around the world are now living with HIV or AIDS, with another 5.8 million becoming infected every year. As with so many epidemics, children and young people bear much of the terrible burden of AIDS. In the United States, as many as 80,000 children already have been orphaned by AIDS.

Increases in funding by the National Institutes of Health for research to prevent and treat HIV around the world. The National Institutes of Health will undertake the largest single public investment in AIDS research in the world by supporting a comprehensive program of basic, clinical, and behavioral research on HIV infection and its related illnesses. This program will include:

\$200 million -- a 33 percent increase from last year's funding -- for research on AIDS vaccines to prevent transmission around the world. The development of a safe and effective AIDS vaccine is critical to stemming the growing problem of HIV/AIDS and AIDS orphans internationally. The President will announce that NIH will dedicate \$200 million to vaccine research in Fiscal Year (FY) 1999, a \$47 million or 33 percent increase over FY 1998 and an 100 percent increase over FY 1995. This investment is critical in meeting the President's challenge to develop an effective AIDS vaccine.

\$164 million for other research critical to addressing the HIV/AIDS epidemic around the world. The President also will announce that NIH will invest \$164 million in FY1999, a \$38 million increase over last year, in critical research projects aimed at reducing the number of AIDS orphans by preventing and treating HIV/AIDS internationally. These projects will include: a new prevention trials network to reduce adult and perinatal transmission of HIV/AIDS; new strategies to prevent and treat

HIV infection in children; funding to train more foreign scientists to collaborate on this epidemic; research on the prevention and treatment of the opportunistic infections, such as tuberculosis, that commonly kill people with HIV/AIDS; and research on topical microbicides and other female-controlled barrier methods of HIV prevention.

\$10 million in USAID emergency relief funding to provide support for AIDS orphans. USAID will make available \$10 million in emergency funding to support community-based efforts for orphans in the countries most affected by this problem. These efforts will include training and support for foster families, initiatives to keep children in school, vocational training, and nutritional enhancements. In addition, USAID will take steps to help prevent the spread of HIV from mothers to children and to improve medical care for children already infected with HIV.

AIDS Policy Advisor Sandra Thurman to lead fact-finding delegation to raise awareness and make recommendations to address growing problem of AIDS orphans. President Clinton will ask Sandra Thurman, Director of the Office of National AIDS Policy, to lead a fact-finding delegation early next year to Sub-Saharan Africa, where 90 percent of AIDS orphans reside. The delegation will include representatives from key Congressional offices. Its goal will be to raise awareness of this emerging problem and to develop recommendations for action.

New steps to address the continued needs of those living with HIV/AIDS in the United States. While the problem of HIV/AIDS is particularly acute internationally, the President will underscore the impact of HIV/AIDS on families in this country as well. The President will highlight an announcement today by Vice President Gore of more than \$200 million in funds this year for the Housing Opportunities for People With AIDS (HOPWA) program to prevent individuals affected by HIV/AIDS and their families from becoming homeless. The Vice President will announce these grants at a meeting with local community leaders who provide housing and other support services for people living with HIV/AIDS and with several individuals and families who have benefited from these services.

A solid record of achievement in HIV/AIDS. Today's announcements build on a deep and ongoing commitment by the Clinton Administration to respond to the AIDS crisis both in the United States and across the world. The Administration has fought for other critical investments in HIV/AIDS. This year alone, the President:

Declared HIV/AIDS in racial and ethnic minority communities to be a severe and ongoing health care crisis and unveiled a new \$156 million initiative to address this problem. This initiative included crisis response teams, enhanced prevention efforts, and assistance in accessing state-of-the-art therapies.

Worked with Congress to secure historic increases in a wide range of effective HIV/AIDS programs. Increases this year alone include: a \$262 million increase in the Ryan White CARE Act; a 12 percent increase in AIDS research funding at the NIH, totaling nearly \$1.8 billion; a \$32 million increase for HIV prevention programs at the Centers for Disease Control and Prevention; and a \$21 million increase in the Housing Opportunities for People With AIDS (HOPWA) program at HUD.

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HIV/AIDS

Some in Congress and in the NGO community have said that this bill (the AGOA) will contribute to the spread of HIV/AIDS in Africa. Is this true? What is the Administration doing on HIV/AIDS?

- No, this is absolutely false.
- Those who are making these claims say that this bill and/or this Administration are or will hamper access to drugs used to treat HIV/AIDS for Africans.
- This bill says nothing at all about HIV/AIDS or pharmaceuticals.
- I do, however, want to set the record straight on what this Administration is doing on HIV/AIDS.
- The United States government, particularly the President, the First Lady and the Vice President have taken an active role in publicizing the AIDS crisis in Africa, and in ensuring that the U.S. strongly supports African efforts to combat the disease. As a matter of fact, the Vice President and then-Deputy President Mbeki highlighted the HIV/AIDS crisis during the Vice President's last visit to South Africa in February.
- This Administration has done more than any previous Administration to fight the scourge of HIV/AIDS both here at home and abroad. We have accomplished much, but much more still needs to be done.
- This is especially important as 70% (23 million) of the 33 million people living with HIV/AIDS live in sub-Saharan Africa, and 12 million out of the 14 million deaths (83%) caused by HIV/AIDS have occurred in sub-Saharan Africa.
- The U.S. is by far the world's leading donor for the prevention and control of HIV/AIDS in the developing world. This year (FY99) USAID will spend \$125 million worldwide on HIV/AIDS prevention and control, \$74 million of that in sub-Saharan Africa - including \$7 million alone for AIDS orphans and infected children.
- This is a continuation of our long-term efforts. Since 1986, the United States has funded HIV/AIDS education, treatment, and prevention programs across Africa, spending nearly \$1 billion (BILLION) on these programs, reaching people in 38 countries in sub-Saharan Africa.
- The United States continues to be a leading donor in the fight against HIV/AIDS in some of the worst hit countries on the continent. For example, from 1986-1998, through USAID funding, the U.S. government contributed over \$46 million to fund counseling, testing, education, prevention, and treatment programs in Uganda. This is more than ¼ of the total donor contributions to Uganda's aggressive and successful effort – the only example outside of Thailand in the developing world – to halt the increase in HIV infection rates.

- Our international programs primarily are aimed at combating HIV transmission (more than 70% of infections worldwide are from heterosexual contact). Programs focus on education, changing high risk behavior, promoting condom use, controlling other sexually transmitted diseases, improving the policy environment to reduce transmission of HIV, conducting research and promoting advocacy, monitoring and evaluation, care and support activities, including community-based orphan care and voluntary counseling and testing programs.
- Although the U.S. is spending \$200 million this year alone on the development of a vaccine, we are a long way from having an effective product. And while new anti-HIV drugs dramatically improve and extend life, they are not a cure. Prevention based on behavior change remains the primary intervention at this time.

(Use only if pressed hard on the South Africa/pharmaceuticals issue)

- We applaud recent efforts by many of Africa's leaders, including those of President Mandela, South Africa's Deputy President Mbeki, Ghana's President Rawlings, Namibia's President Nujoma, and many others to publicize the dangers of HIV/AIDS and the need for a united and concerted effort by communities to prevent its further spread and support those already infected.
- In South Africa, we share a mutual goal with the government to bring better health care to the people of South Africa, including those suffering as a result of HIV/AIDS. We believe this goal can be achieved while promoting effective and adequate patent protections for pharmaceutical products. Our goal is to chart a course that assists in improving access to affordable medicines, while not freezing the financial incentives that fuel continued research and production of new drugs. With a shared commitment to improve health care and provide intellectual property protections we are continuing our efforts to find common ground on our differences.
- That said, we do have concerns with some provisions of South Africa's Medicines Act. The lack of definition in the Act makes it unclear whether it is compliant with TRIPs.
- The U.S. government does not generally support compulsory licensing, but the WTO TRIPs agreement does provide for the practice - a patent holder may be compelled to grant a license, but only on a case-by-case basis, normally only after the proper user of the patent has been unable to obtain a license on a voluntary basis on reasonable commercial terms. This requirement may be waived in a "national emergency" but in the case of an emergency, other conditions apply.
- While we do not believe that compromising IPR protections is the solution to the greater problems, contrary to our general approach, we raise no objection to compulsory licensing and parallel importation of pharmaceuticals by South Africa in response to their situation, as long as it is done in a way that is compliant with TRIPs.

- Globally we continue to have concerns about parallel importing both for reasons of safety and efficacy of drugs and for the possibility it presents for patent infringement. That said, this policy is consistent with our position on TRIPs.
- We continue to assist South Africa in addressing the AIDS crisis through a variety of means, including:
 - ✓ a \$10 million five-year program to support the South African government and local NGOs efforts to fight HIV/AIDS.
 - ✓ work with the South African National Youth Commission, which has identified HIV/AIDS as a priority activity
 - ✓ ongoing discussions in our Binational Commission's Health Working Group on ways to enhance our cooperative efforts to fight AIDS, and
 - ✓ expanding available resources through public-private partnerships

Does this represent a change in U.S. policy?

- This position is consistent with U.S. policy.
- It is also responsive to the raging health crisis in South Africa.

LEADERSHIP AND INVESTMENT IN FIGHTING AN EPIDEMIC (LIFE):

A Global AIDS Initiative

SUMMARY

On July 19, 1999, the Administration announced a new Initiative to address the global AIDS pandemic. This Initiative is supported by an amendment to the Fiscal Year 2000 budget proposal signed by the President and submitted to Congress for its consideration. A central feature of this *LIFE* Initiative is a \$100 million increase in US support for sub-Saharan African countries and India, which are working to prevent the further spread of HIV and to care for those affected by this devastating disease. This additional funding is a critical step by the United States Government in recognizing the impact that AIDS continues to have on individuals, families, communities and nations—responding to the imperative to do more. It is our hope that other nations and institutions will match this action.

This plan contains a framework of interventions, grounded in a series of goals and objectives consistent with those already established for the international community in collaboration with the Joint United Nations Programme on AIDS (UNAIDS). Specific activities and outcomes will be added after dialogue with those African nations that partner with the United States, as well as with the multinational and community-based non-governmental organizations that support the front line fight against AIDS.

The Initiative builds on the existing investment by the US in HIV/AIDS programs in Africa and India and involves an unprecedented collaboration between the United States Agency for International Development (USAID), the Department of Health and Human Services (HHS), and the Department of Defense (DoD). USAID will have lead responsibility to facilitate coordinated action. The Initiative is a significant turning point in the United States Government fight against AIDS and will contribute to broad global targets over the next 3 to 5 years which seek to reduce the transmission of HIV by 25% and provide basic care and support services to at least 30% of infected persons.

The Initiative focuses on sub-Saharan Africa and India, which will be complemented by regional activities in western and southern Africa. The countries targeted represent those with the most severe epidemic, the highest number of new infections, where the potential for impact is greatest, and where USG agencies are already active.

At the present time, the UNAIDS has estimated that resource needs for *prevention alone* for sub-Saharan Africa total exceeds \$1 billion per year. The Initiative will contribute to this goal and to the global partnership necessary to bring effective programs to adequate scale. Curtailing this epidemic is not just the responsibility of the U.S. Government. US partners involved in this Initiative will collaborate with UNAIDS and other international and local agencies to leverage additional host country, multilateral, bilateral, and private resources.

LIFE INITIATIVE'S GUIDING PRINCIPLES

US agencies will apply the following principles to the design and implementation of *LIFE*:

- ✓ Country ownership of the activities is essential.
- ✓ Initiative funding and activities are in addition to existing USG HIV/AIDS programs and activities conducted abroad. The net total of new and expansion of existing activities will yield expected results in the target countries and programs.
- ✓ Initiative activities will be coordinated with other donors and will seek to leverage other donors' efforts and resources.
- ✓ Increase the number of collaborating USG agencies and other partners in the fight against AIDS, as well as use of new approaches.
- ✓ Support for African/Indian expertise and institutions in implementing program elements are emphasized.
- ✓ *LIFE* offers opportunities to learn about new models that will assist US-based HIV programs, as well as to share US experiences abroad.

Program Elements

The Initiative addresses four key program elements critical to fighting the AIDS pandemic: primary prevention, improving community and home based care and treatment, caring for children affected by AIDS, and capacity and infrastructure development. Although the Initiative will not support all elements in every country, all program funding must be coordinated and integrated within an overall comprehensive response. Country programs will be tailored to their needs and existing efforts underway.

Primary Prevention: The initiative focuses primarily on prevention to slow—and hopefully reverse—the trend of rising HIV rates in developing countries. The goal of primary prevention is to reduce the incidence of new HIV infections. Ninety percent of new infections in the developing world are known to derive from either sexual transmission (80%) or mother to child transmission (10%), and another 5% from contaminated blood transfusions and infected needles. The prevention component of this initiative seeks to reduce these means of transmission through a package of activities. These include voluntary counseling and HIV testing, mother to child transmission prevention, STD treatment, social marketing of barrier methods, behavior change interventions, and blood safety. USG agencies will work with civilian and military populations.

Improving Community and Home Based Care and Treatment: Currently in Sub-Saharan Africa and India, care and treatment for HIV infected persons and support to their families is minimal. Less than 5% of persons know their HIV status and health care providers lack the resources to diagnose and treat HIV and the associated opportunistic infections, let alone to use of the latest "state of the art" antiviral treatment regimens. Ideally, there should be a continuum between in-patient and community outpatient treatment, combined with psychosocial support services utilizing a wide range of community workers, including traditional healers. Even in the absence of antiretroviral drugs, there is much that can be done to improve the quality and duration of life for persons living with HIV/AIDS and their families within the developing country setting. For instance, while the leading killer of AIDS patients in the developing world is TB, through use of directly observed therapy regimens (DOTS), TB can be cured in HIV infected persons, increasing both the quality and duration of a person's life. The initiative will support basic medical, social, and home and community based care to greatly expand the availability of these services.

Caring for Children Affected by AIDS: By the year 2000, there will be close to 24 million children who will have lost one or both parents in 19 of the African countries where HIV/AIDS is found in epidemic proportions. By the end of the next decade, this number will increase to over 40 million. Despite the magnitude of this crisis, services in developing countries for children orphaned by AIDS are extremely limited or non-existent. This initiative will support USAID to take primary responsibility for activities to assist children affected by AIDS and for their families, primarily through the use of Title II, Food for Peace programs. These efforts will supplement existing efforts to strengthen the capacities of families and communities in the geographic areas where HIV/AIDS has made them especially vulnerable.

Capacity and Infrastructure Development: Within the target countries, it is critical that political commitment is increased and host country capacity to implement effective interventions is strengthened, focusing on government, private sector, NGOs and research institution capabilities. Key activities are to increase the use of accurate HIV surveillance data to inform decisions on targeting of HIV/AIDS prevention and care interventions, to measure the impact of these interventions, and to build new capabilities for the delivery of treatment and support services.

Managing and Monitoring the LIFE Initiative: A coordinating task force will be convened under the auspices of the White House Office of National AIDS Policy, with secretariat support provided by USAID to develop joint management and monitoring plans. Multiple partners will be engaged in a collaborative effort to leverage new resources, identify areas for cooperative efforts and areas for complementary programs, and achieve consensus on measurements of performance.

Annex

Program Element	Investment
Primary Prevention	
1) Program Delivery and Other Activities	USAID: \$25M
2) Technical Assistance and Training	HHS: \$13M
3) Prevention activities for African military and uniformed services	DoD: \$10M
	Subtotal: \$48M
Improving Community and Home Based Care and Treatment	
1) Program Delivery	USAID: \$14M
2) Technical Assistance and Training	HHS: \$9M
	Subtotal: \$23M
Caring for Children Affected by AIDS	USAID: \$10M
Capacity & Infrastructure Development	
1) Increasing political commitment and strengthening AIDS programs	USAID: \$6M
2) Surveillance	HHS: \$13M
	Subtotal: \$19M

Annex**WORLDWIDE HIV/AIDS GOALS**

UNAIDS, in cooperation with USAID and other bilateral and multi-lateral partners, has laid out a series of international goals for the next five years as described below. These goals represent the result of the total worldwide contribution of resources and effort. The Administration seeks to further these goals through *LIFE Initiative*.

- ✓ The incidence of HIV infection will be reduced by 25% among 15-24 year olds by 2005. (Currently 2 million young adults are infected each year in sub-Saharan Africa.)
- ✓ At least 75% of HIV infected persons will have access to basic care and support services at the home and community levels, including drugs for common opportunistic infections (TB, pneumonia, and diarrhea). (Currently, less than 1% of HIV infected persons have such access.)
- ✓ Orphans will have access to education and food on an equal basis with their non-orphaned peers.
- ✓ By 2002, domestic and external resources available for HIV/AIDS efforts in Africa will have doubled to \$300 million per year. (Currently, approximately \$150 million per year is spent on HIV/AIDS prevention in sub-Saharan Africa.)
- ✓ By 2005, 50% of HIV infected pregnant women will have access to interventions to reduce mother-to-child HIV transmission. (Currently, less than 1% of HIV infected pregnant women have access to such services in sub-Saharan Africa.)

HIV/AIDS

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release

December 1, 1998

REMARKS BY THE PRESIDENT
AT WORLD AIDS DAY EVENT

Room 450
Old Executive Office Building

1:15 P.M. EST

THE PRESIDENT: Thank you, Amy, for your magnificent remarks and the power of your example. Thank you, Cynthia, for coming to this big, scary crowd. (Laughter.) She was nervous. I said, well, look at the bright side -- at least you got out of school for a day. (Laughter.)

I thank the other children who are here with us. And I want to thank all the members of our administration who have helped so much in this cause -- Secretary Albright; Brian Atwood; Dr. Satcher; our AIDS Policy Director, Sandy Thurman; members of the Council on HIV and AIDS. We're glad to have Nafis Sadik here, the Director of the U.N. Population Fund. Richard Socarides from the White House, I thank you and all the other members of the administration. And I, too, want to join in expressing my appreciation to the members of Congress who Brian mentioned for their support for AIDS funding.

But I especially want to thank Amy for being here and reminding us of what this is all about. When she was speaking my mind wandered back to an incident that occurred when I was running for President in 1992. Some of you have heard me say this before, but I was in Cedar Rapids, Iowa, a place largely known for its enormous percentage of Czech and Slovak citizens. And there was in the crowd at this rally where I was speaking a woman who was either Czech or Slovak, probably, holding an African American baby. And I said, whose baby is this? She said, this is my baby. And I said, where is this baby from? She said, Florida, I got her from Florida. (Laughter.)

And it was October in Cedar Rapids and she should have been in Florida, probably. (Laughter.) She said, this baby was born with AIDS and abandoned and no one would take this baby. This woman had her marriage had dissolved, she was raising her own children alone. But because she heard about children like this wonderful little girl, she adopted this baby.

And every year since, about once a year, I see this young child. I've watched her grow up now and I'm happy to tell you that six years later she's still alive and doing pretty well. She comes to the NIH for regular check-ups and she comes by the White House to see her friend. And every time I see Jimiya I am reminded of what this whole thing is about.

And I think I should tell you one other thing. When Amy was standing up here with me and I was telling her what a fine job she did, she said, I'm so glad that Cynthia could be here, and that I could say Carla's name in your presence.

This is, I think, very important for people who have not been touched in some personal way -- who have never been at the bedside of a dying friend, who have never looked into the eyes of a child orphaned by AIDS or infected with HIV -- to understand. And I believe, always, that if somehow we could reach to the heart of people, we would always do better in dealing with problems, for our mind always conjures a million excuses in dealing with any great difficulty.

Let me begin, even in this traumatic moment, to say we have a lot to celebrate on this AIDS Day. We celebrate the example of Amy and Cynthia. Just think, a decade ago people really believed that AIDS was unstoppable; the diagnosis was a virtual death sentence; there was an enormous amount of ignorance and prejudice and fear about HIV transmission. Most of us knew people who couldn't get into apartment houses or were being kicked out or otherwise -- their children couldn't be in school because of fears that people had about it.

Every day, for people who had HIV or AIDS and their families -- every day was a struggle a decade ago. A struggle for basic information, for treatment, for funding, and all too often, for simple compassion.

For six years, thanks to many of you, we have worked hard to change this picture -- and so have tens of thousands of other people across our country and across the globe. We've worked

hard to draw attention to AIDS and to better direct our resources by creating the Office of National AIDS Policy and the President's Council on HIV and AIDS. We had the first ever White House conference on AIDS. We helped to ensure that people with HIV and AIDS cannot be denied health benefits for preexisting conditions. We accelerated the approval of more than a dozen new AIDS drugs, helping hundreds of thousands of people with AIDS to live longer and more productive lives.

Working together with members of both parties in the Congress, we increased our investment in AIDS research to an historic \$1.8 billion. This year we secured \$262 million in new funding for the Ryan White CARE Act, providing medical treatment, medication, even transportation to families coping with AIDS. This October we declared that AIDS had reached crisis proportions in the African American, Hispanic American and other minority communities, and fought for \$156 million initiative to address that. Today the Vice President is announcing \$200 million in new grants for communities around the country to provide housing for people with AIDS.

The results of these and other efforts have been remarkable. For the first time since the epidemic began, the number of Americans diagnosed with AIDS has begun to decline. For the first time, deaths due to AIDS in the United States have declined. For the first time, therefore, there is hope that we can actually defeat AIDS.

But all around us there is, as we have heard from all the previous speakers, fresh evidence that the epidemic is far from over, our work is far from finished, that there are rising numbers of AIDS in countries like Zimbabwe, where 11 men, women, and children become infected every minute of every day. There are still too many children orphaned by AIDS, tens of thousands here in America, tens of millions in developing nations around the world.

And when so many people are suffering, and with HIV transmission disproportionately high, still, among our own young people here in America, it's all right to celebrate our progress, but we cannot rest until we have actually put a stop to AIDS. I believe we can do it -- by developing a vaccine, by increasing our investment in other forms of research, by improving our care for those who are infected and our support for their families.

Last year at Morgan State University, I declared that we should redouble our efforts to develop an AIDS vaccine within a decade. Today I am pleased to announce a \$200 million investment in cutting edge research at the NIH to develop a vaccine. That's a 33 percent increase over last year. With this historic investment, we are one step closer to putting an end to the epidemic for all people.

I'm also pleased to say that there will be more than \$160 million for other new research critical to fighting AIDS around the world, from new strategies to prevent and treat AIDS in children, to new clinical trials to reduce transmission.

And as hard as we are working to stop the spread of AIDS we cannot forget our profound obligation for the heartbreaking youngest victims of the disease -- the orphaned children left in its wake. Around the world, as we have heard, millions of children have lost their parents. Their number is expected to rise to 40 million over the next 10 to 15 years. Some of them are free of AIDS, others are not. But sick or well, too many are left without parents to protect them, to teach them right from wrong, to guide them through life and make them believe that they can live their lives to the fullest.

We cannot restore to them all they have lost, but we can give them a future -- a foster family, enough food to eat, medical care, a chance to make the most of their lives by helping them to stay in school. Today, through Mr. Atwood's agency, we are committing another \$10 million in emergency relief that will, though seemingly a small amount, actually make a huge difference for many thousands of children in need around the world.

I'm also directing Sandy Thurman to lead a fact-finding mission to Africa, where 90 percent of the AIDS orphans live. Following the mission she will report back to me with recommendations on what more we can do to help these children and give them something not only to live for, but to hope for.

Eleven years ago, on the first World AIDS Day, we vowed to put an end to the AIDS epidemic. Eleven years from now, I hope we can say that the steps we took today made that end come about. If it happens, it will be in no small measure because of people like you in this room, by your unfailing, passionate devotion to this cause -- a cause we see most clearly expressed in the two people sitting right behind me.

Thank you all, and God bless you. (Applause.)

END

1:26 P.M. EST