

Withdrawal/Redaction Sheet

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. calendar	Re: personal (1 page)	09/04/2000	b(6)

COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Irene Bueno
OA/Box Number: 19893

FOLDER TITLE:

Global AIDS

2017-1120-S

ry2204

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

- b(1) National security classified information [(b)(1) of the FOIA]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
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- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

MEMORANDUM

TO: MARIA ECHAVESTE
FROM: IRENE BUENO
RE: INTERNATIONAL AIDS MEETING ON LEGISLATIVE
STRATEGY – Friday, September 14, 2000 at 4:00 PM the Roosevelt
Room

PURPOSE: You are having an internal meeting to discuss further the global AIDS package that we are seeking for FY 2001 and to develop a strategy to get this additional funding while at the same time not undermine our other foreign operations priorities. Also, a new issue – vaccine tax credit – may be discussed as well we are able to get more information from Treasury on this proposal. Attached are the President's recent statements on global AIDS at the U.N. Millennium Assembly.

BACKGROUND: Two weeks ago, the group consensus was to develop a strategy for how we would use additional resources in the Foreign Operations and Labor/HHS budgets under different funding scenarios. The key questions were: (1) what is the absorptive capacity of USAID, HHS, and NGOs; (2) how much should we put into the World Bank Trust Fund; and (3) how would an increase for AIDS impact other international priorities. USAID and ONAP argued that USAID has a significant absorptive capacity, provided that certain administrative measures are put into place to increase FTEs and streamline procurement. OMB questioned this conclusion and will provide its own assessment -- both for USAID and HHS.

\$65-\$75
\$16m
\$10

On the second point, the group consensus was that part of any increase must be allocated for the World Bank Trust Fund, provided that this funding comes through the USAID budget and that there is some conditionality that the funding be used by a certain date or otherwise be transferred back to USAID. The relative proportion of any increase to be allocated to the Trust Fund was left open for discussion.

On the final point -- the need to protect other foreign operations priorities -- OMB will provide guidance for approaching Congress.

- Funding for USAID (this will include funds HHS/CDC and the Peace Corp)

- Funding for preventative and care programs including Orphan Care
- Funding for World Bank Trust Fund
- Funding would be provided to other countries outside of Africa

OMB is preparing talking points on this package.

A new issue – the vaccine tax credit – may also be discussed during this meeting. Treasury has been working with John K. and Pelosi on the vaccine tax credit - and have done so well that they plan to do a roll-out at the end of the week with Summers. They are close to securing support from Republicans including Dunn and Frist. They may try to attach it to the Minimum Wage legislation and Treasury would like to have their language as part of an endgame strategy on appropriations. We hope to get a draft of this language from Treasury soon.

ATTENDEES:

You
 Sylvia Matthews -NT
 Mara Rudman
 Sandy Thurman
 Michael Iskowitz -NT
 Michael Casella, OMB
 Robert Kyle, OMB
 Laura Efros
 Rebecca Walldorff
 Martha Foley -NA
 Miles Lackey -NA
 Mara Rudman
 Chris Jennings -NT

- (1) Absorbability Capacity of ASAD - if drop more than \$3 million in 01 could not ~~absorb~~ obligate the \$ in 01 but exploring options ~~tasked~~ (to E + threat) Kout
- (2) \$30-70 million above the high level to \$305-\$330 (Robert Kyle)
- ~~ASAD~~
 - World Trust Fund (Pelosi's idea) but like this approach so would be ok w/ cabinet
 - AID -
 OMB go to the higher end of the problem. OMB will go to Dems (Pelosi, Litz)
 to say we will support them if they support our overall all Foreign Ops package.
 but need to figure out how not give.
- on the ground - our mission + CBUs are well organized. There countries more difficult
 existing ones OK

World Bank \$10.

Conditions:

- D- \$65 - \$15 - add 10, 110s, Penn Corp. not. 4 single 110
 1 Bill \$10.
 Conditions:
 - they can get it up + running in 12 months (else need to make it work)
 - Matching donors challenge - if w/in 18 months get \$50 m.

OMB draft language triggers

● CDC - \$1B million - Common Lk Initiative - ^{current authority} ~~absorb the capacity~~
~~may~~ would go to AID if ~~request~~. Don't have authorization
 to do work ~~overseas~~ overseas. Prefer is not to get this authority
 work thru AID.
 Have transferred \$6 million to ~~AID~~ AID
 to be used service indigently.

1. then transferred \$6 million to ~~AAA~~ AIO

CDC announced availability of vaccine to replace
but HHS ~~the~~ did not know. HHS - leave a msg.

① Talk to Jerome Lombard or ME - have a copy

● CBC - don't need to do anything at this point. If we are advocating on the
West End... need to meet Simon Lee?
IP - we are working towards

Next time... need to meet Benson Lee?
 Need to coordinate ~~the~~ w/ members on TP - we are working toward
 FY budget proposal & we are working on additional ~~some~~ ~~the~~ fronts - no
 specifics.

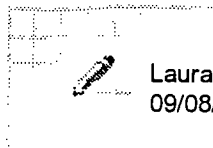
• mty agent - not productive to meet - advise on it

- Internal Vaccine - got an example... now while the \$  Book coming out in Jan. - critical.
- We don't like to give telling NIT what doesn't to do.
- ... (Pelosi & John Kerry).

- International
We don't like to be telling NIH
- Tax Credit Proposal - negotiating a proposal / Pelosi & John Kerry.
headed a ~~pre~~ compromise & looking for a ~~united~~ vehicle.

① - Payan White Call Act - orig ~~not~~ on 9/26/60 possible

9/20/02 Pelosi ~~is~~ introduced a bill ~~to~~ today. Which
tax credit refers to spec - reintroduced.
Industry ~~can~~ support but not actively.
Priority - What should we do.
Summer - what to do.



Laura L. Efos
09/08/2000 10:39:33 AM

Record Type: Record

To: Irene Bueno/WHO/EOP@EOP

cc:

Subject: Remarks at African leaders reception -- lots of unexpected good stuff on the AIDS event we did in Nigeria



THE WHITE HOUSE

Office of the Press Secretary
(New York, New York)

For Immediate Release

September 7, 2000

REMARKS BY THE PRESIDENT
AT RECEPTION FOR LEADERS OF AFRICAN NATIONS

Waldorf Astoria
New York, New York

12:50 P.M. EDT

THE PRESIDENT: Well, first of all, let me thank Congressman Jefferson. This reception was his idea, and I thank him for his work on it -- and all the members of the Congressional Black Caucus who helped him who are detained in Washington for votes this afternoon. I want to thank all the leaders of African nations who are here, and the diplomats and the business leaders who have come.

There's a simple purpose to this event. We want to say that Africa matters to America. Or as Reverend Jackson, my Special Envoy, was just saying, we don't see Africa as a continent of debtor nations, we see Africa as a credit bank for America's future; an opportunity for a real and genuine and lasting partnership.

I just got back from Nigeria and Tanzania, where I was with some of you in Arusha. And that trip reminded me again of all the positive things that are out there to be built in the future. It also enabled me to say something no American President had ever been able to say -- I was glad to go to Africa for the second time. (Applause.)

But I think, and I hope and pray, that no future American President will ever not say that; that we will take it for granted that we should have a broad, comprehensive, in-depth, consistent relationship with Africa. We have a shared interest in making sure that the people of Africa seize their opportunities and work with us to build a common future.

Of course, the governments of Africa have to lay the foundations -- the rule of law, a good climate for investment, open markets and making national investments that broaden the economic base and provide benefits to ordinary people. These things will work.

Last year, the world's fastest-growing economy was Mozambique, and Botswana was second. Nigeria turned the fiscal debt into a surplus. So that will work. But we must also reach out through our Export-Import Bank, our Overseas Private Investment Corporation, our Trade and Development Agency, to encourage more American investment in Africa.

We also should encourage the regional trade blocs to unite smaller economies into bigger economic units in more attractive markets. And as Bill Jefferson said, we're going to do our best to make the most of the Africa Growth and Opportunity Act, the trade act which the Congress passed earlier this year. When we fully implement it, Africa will have much greater access to American markets than any region in the world has to American markets outside North America, and I'm very proud of that. (Applause.)

We are also working to bridge some of the other divides -- helping 20 African countries connect to the Internet, training more than 1,500 government and civic institutions to use it. We know we have to do more in communications in rural Africa. There are some rural areas where there is less than one phone line for every 500 inhabitants.

We don't want a digital divide between Africa and the rest of the world, but neither do we want a digital divide to develop within Africa itself, between cities that are connected and villages that are left out. So we will continue to do what we can for trade and technology. We know that is not enough.

A year ago, I announced that we would support a global effort on debt relief, and that we would completely write off the debts of as many as 27 African nations. Uganda has already used savings on debt payments to double its primary school enrollment -- double. (Applause.) Senegal has used theirs to hire 2,000 teachers. Mozambique has used theirs to buy much needed medicines.

I asked Congressman Jefferson to go back after meeting with all these leaders to influence the Congress to give us the \$435 million we need this year to fully fund our debt relief program this year and to continue to extend debt relief to other deserving countries who will take the savings and invest it in their people and their future. (Applause.)

I also believe we should do more to promote education in Africa. I have launched a \$300-million initiative, which I hope will be nothing more

than a pilot program, to work with developing countries to provide free meals -- nutritious breakfasts or lunches in schools, so that parents will be encouraged to send 9 million more boys and girls to school in countries that desperately need to increase school enrollment.

We estimate that if our friends around the world will join us, and if we can cooperate with countries to deliver the food in an appropriate way, and to make sure we don't interrupt local farm markets -- we don't want to hurt local farmers anywhere -- we estimate that for about \$4 billion worldwide, we could provide a nutritious meal in school to every child in every developing country in the entire world. That could change the face of the future for many African countries and many countries in Asia and Latin America, as well. (Applause.)

Finally, we're trying to do more to fight infectious diseases, especially AIDS. I want to thank Sandy Thurman, my AIDS Coordinator, who is here, for all the work she and others in my administration have done to try to help Americans realize that this is a global crisis. (Applause.) Earlier this year we declared that AIDS was a national security issue for America.

There were some people who made fun of me when I did that -- some people who said, what's the President doing; how can AIDS be a national security crisis? When you think about all the democracies we want to see do well in the 21st century and all the people who will lose their freedom because they can't even keep their people alive, it is quite clear that AIDS is, in fact, a national security challenge for the United States that we have to do more to meet. (Applause.)

Now, what are we doing in America? We, again -- Bill Jefferson is here -- we're trying to get Congress to approve a \$1-billion vaccine tax credit to give tax incentives to our big companies to develop vaccines that they otherwise would not develop because they know most of the people who need the medicine are not able to pay for it. So we are trying to cut the cost of developing it so they will still have a financial incentive to do it, and then, if they develop them, we'll find a way to pay for it and distribute it.

Even as we insist, however, on vaccine research and research for a cure, we should remember that AIDS is 100 percent preventable. We need to do more with education and prevention programs and to break the silence. We have a chance to take on this human challenge together.

One of the most moving experiences I have had as President -- and I have been through a lot of interesting and profoundly emotional experiences the last eight years -- but one of the most moving things that's happened to me happened when we were just in Nigeria and President Obasanjo and I went to this event in an auditorium with a lot of people to talk about what they were doing in Nigeria to try to prevent AIDS. So there were two speakers. The first speaker is a beautiful, 16-year-old Nigerian girl who gets up and talks about what she's doing as a peer counselor to talk to her contemporaries to keep the children out of trouble. That was pretty good.

Then, this young man gets up. I think he must have been about 30.

And he talked about how he fell in love with a woman who was HIV positive, and how his family and her family didn't want them to get married, and about how their priest didn't want them to marry and they were deeply religious people, and how their love was so strong, they finally convinced the priest that they ought to get married, and he finally convinced the parents that it was all right, and so they did. And then he became HIV positive. And then his wife became pregnant. And he had already lost one job because he was HIV positive and he was desperate to find the money to get the medicine for his wife so that there could be a chance that his child would be born without the virus.

And finally, he got the money, his wife took the medicine, the baby was born without the virus. And he basically was affirming the fact that he was glad he followed his heart, even though he contracted the virus. He was glad that he and his wife had had a child who was free of HIV, and he wanted the world to do more to get rid of this illness.

And then, the President of Nigeria brought his wife up on stage and embraced her in front of hundreds of people, and it was all over the press in Nigeria the next day. It changed the whole thinking of a nation about how to approach this disease -- to treat the disease as the enemy, but not the people who are gripped with it. It was an amazing encounter. (Applause.)

So I just say to all of you, we're committed for the long run. We want to take on the great human challenges; we want to take on the great political challenges. There are some things that you will have to do, but I believe America is moving inexorably to be a much better partner over the long run for Africa. It is one of the things that I was determined to do when I became President. I am more determined today than I was. And I am more convinced today that it is not an act of charity -- it is an act of enlightened self-interest for the world that we should be building together.

Thank you very much. (Applause.)

END 1:00 P.M. EDT

 Laura L. Efros
09/08/2000 10:37:10 AM

Record Type: Record

To: Irene Bueno/WHO/EOP@EOP

cc:

Subject: POTUS security council speech 

THE WHITE HOUSE

Office of the Press Secretary
(New York, New York)

For Immediate Release

September 7, 2000

REMARKS BY THE PRESIDENT
TO THE SECURITY COUNCIL

Security Council Chamber
The United Nations
New York, New York

2:08 P.M. EDT

THE PRESIDENT: Thank you very much. Mr. President, Mr. Secretary General, members of the Security Council. We come together in this historic session to discuss the role of the United Nations in maintaining peace and security. I thank President Konare for the moment of silence for the U.N. workers who died in West Timor yesterday, and ask the Indonesian authorities to bring those responsible to justice, to disarm and disband the militias, and to take all necessary steps to ensure the safety of those continuing to work on humanitarian goals there.

Today I would like to focus my peacekeeping remarks on Africa, where prosperity and freedom have advanced, but where conflict still holds back progress. I can't help noting that this historic meeting in this historic chamber is led by a President and a Secretary General who are both outstanding Africans. Africans' achievements and the United Nations' strengths are evident. Mozambique and Namibia are just two success stories.

But we asked the United Nations to act under increasingly complex conditions. We see it in Sierra Leone, where U.N. actions saved lives, but

could not preserve the peace. Now we're working to strengthen the mission. In the Horn of Africa, U.N. peacekeepers will monitor the separation of forces so recently engaged in brutal combat. In Congo civil strife still threatens the lives of thousands of people and warring parties prevent the U.N. from implementing its mandate.

We must do more to equip the United Nations to do what we ask it to do. They need to be able to be peacekeepers who can be rapidly deployed, properly trained and equipped, able to project credible force. That, of course, is the thrust of the Secretary General's report on peacekeeping reform. The United States strongly supports that report. It should be the goal of our assistance for West African forces that are now going into Sierra Leone.

Let me also say a word, however, beyond peacekeeping. It seems to me that both for Africa and the world, we will be forced increasingly to define security more broadly. The United Nations was created to save succeeding generations from the scourge of war. War kills massively, crosses borders, destabilizes whole regions. Today, we face other problems that kill massively, cross borders and destabilize whole regions.

A quarter of all the deaths on the planet now are caused by infectious diseases like Malaria, TB and AIDS. Because of AIDS alone, life expectancy in some African nations is plummeting by as much as 30 years. Without aggressive prevention, the epicenter of the epidemic likely will move to Asia by 2010 with very rapid growth rates also in the New Independent States.

The affected nations must do more on prevention, but the rest of us must do more, too -- not just with AIDS, but also with malaria and TB. We must invest in the basics -- clean water, safe food, good sanitation, health education. We must make sure that the advances in science work for all people.

The United States is investing \$2 billion a year in AIDS research, including \$210 million for an AIDS vaccine. And I have asked our Congress to give a tax credit of \$1 billion to speed the development in the private sector of vaccines against AIDS, malaria and TB. We have to give the tax credit because the people who need the medicine can't afford to pay for it as it is. We've worked to make drugs more affordable, and we will do more. And we have doubled our global assistance for AIDS prevention and care over the last two years.

Unfortunately, the U.N. has estimated that to meet our goals, we will collectively need to provide an additional \$4 billion a year. We must join together to help close that gap. And we must advance a larger agenda to fight the poverty that breeds conflict and war.

I strongly support the goal of universal access to primary education by 2015. We are helping to move toward that goal, in part, with our effort to provide school lunches to 9 million boys and girls in developing nations. For about \$3 billion a year, collectively, we could provide a nutritious meal to every child in every developing country in a school in the world. That would dramatically change the future for a lot of poor

nations today.

We have agreed to triple the scale of debt relief for the poorest countries, but we should do more. This idea of relieving debt if the savings will be invested in the human needs of the people is an idea whose time has long since come, and I hope we will do much more.

Finally, Mr. Secretary General, you have called on us to support the millennium ecosystem assessment. We have to meet the challenge of climate change. I predict that within a decade -- or maybe even a little less -- that will become as big an obstacle to the development of poor nations as disease is today.

The United States will contribute the first complete set of detailed satellite images of the world's threatened forests to this project. We will continue to support aggressive efforts to implement the Kyoto protocol and other objectives which will reduce the environmental threats we face.

Now, let me just say in closing, Mr. President, some people will listen to this discussion and say, well, peacekeeping has something to do with security, but these other issues don't have anything to do with security and don't belong in the Security Council. This is my last meeting; I just have to say I respectfully disagree -- these issues will be more and more and more in the Security Council. Until we confront the iron link between deprivation, disease, and war, we will never be able to create the peace that the founders of the United Nations dreamed of.

I hope the United States will always be willing to do its part, and I hope the Security Council increasingly will have a 21st century vision of security that we can all embrace and pursue.

Thank you very much.

MEMORANDUM

TO: MARIA ECHAVESTE
FROM: IRENE BUENO
RE: INTERNATIONAL AIDS MEETING ON LEGISLATIVE
STRATEGY – Monday, September 8, 2000 at 11:00 AM in the Ward
Room

PURPOSE: You are holding an internal meeting to discuss further the global AIDS package that we are seeking for FY 2001 and to develop a strategy to get this additional funding while at the same time not undermine our other foreign operations priorities. Attached are the President's recent statements on this matter.

BACKGROUND: Two weeks ago, the group consensus was to push a package would that include the following:

- Funding for USAID (this will include funds HHS/CDC and the Peace Corp)
- Funding for preventative and care programs including Orphan Care
- Funding for World Bank Trust Fund
- Funding would be provided to other countries outside of Africa

OMB is preparing talking points on this package.

ATTENDEES: You
Sylvia Matthews
Mara Rudman
Sandy Thurman
Michael Iskowitz
Michael Casella
Robert Kyle
Laura Efros
Rebecca Walldorff
Martha Foley
Miles Lackey
Mara Rudman
Chris Jennings

**The Peace Corps****Fax****To:** Rochelle Thompson**From:** Liz Notman**Fax:** 456-1907**Pages:** 3 TOTAL**Phone:****Date:** 8/30/2000**Re:** HIV/AIDS request**CC:**☐ **Urgent**☒ **For Review**☐ **Please Comment**☒ **Please Reply**

Rochelle:

Attached is a memo from the Peace Corps Director requesting additional funding for HIV/AIDS programming in our FY2001 budget. This memo is in response to a conversation Maria had with our Peace Corps Counselor, Suzanne Palmieri, late last week. You all had asked that we detail our request in writing.

Please call me if something is unclear or you need additional information. As always, we at the Peace Corps, appreciate your office's help.

Liz Notman

Deputy Director of Congressional Relations/Intergovernmental Affairs
and White House Liaison
692-2245

THE DIRECTOR OF THE PEACE CORPS
WASHINGTON, D.C.

August 29, 2000

MEMORANDUM

FOR: Maria Echaveste
White House Deputy Chief of Staff

FROM: Mark L. Schneider *Mark L. Schneider*
Peace Corps Director

SUBJECT: Request for Increase in FY 2001 Funding to Address HIV/AIDS

As the Administration prepares to negotiate the FY 2001 Foreign Operations bill, I would like to request an adjustment of \$7.8 million to our original \$275 million request to fund a portion of the Peace Corps HIV/AIDS Initiative.

This initiative was developed over the past several months in close consultation with Sandra Thurman, Director of the White House Office of National Aids Policy, with a view toward complementing the President's Millennium Initiative and other Administration efforts to combat the disease. Over the next three years, 5,000 Peace Corps Volunteers—every Volunteer in Africa today and every Volunteer going to Africa in the future—will become a part of the effort to contain this pandemic.

We have heard positive responses to the HIV/AIDS Initiative from Members of Congress, United States Ambassadors serving in Africa, the NGO community, and members of the press. After my trip to southern Africa a few weeks ago, I can testify that our Volunteers are on the front lines, in the most remote villages, and intimately a part of the lives of the people suffering the most from this tragic disease. They are uniquely placed to make a difference in the lives of the men, women, and children who need our help.

This adjustment to our original FY 2001 request will allow the Peace Corps to play a more significant role in the President's commitment to a strong U.S. HIV/AIDS response. It will also allow the Peace Corps to stay on course in meeting the President's 1998 goal of reaching 10,000 Volunteers early in this decade.

On behalf of our 7,000 Volunteers, thank you for your continued support of the Peace Corps and for your consideration of this request.

cc: Rodney Bent
Deputy Associate Director for International Affairs
Office of Management and Budget

The Peace Corps HIV/AIDS Initiative Funding Needs (Dollars in thousands)



❖ **HIV/AIDS Volunteers** **\$3,065**

Supports an additional 50 Peace Corps Volunteers in both FY 2001 and FY 2002 specifically trained in prevention, awareness, and support strategies for ongoing projects to combat the spread of this disease.

❖ **Crisis Corps Volunteers** **\$2,230**

Provides for an additional 100 Crisis Corps Volunteers in both FY 2001 and FY 2002 comprised of former Volunteers providing short-term assistance to this humanitarian crisis.

❖ **Additional Training for Other Peace Corps Volunteers throughout Africa** **\$1,525**

Funds training for all Peace Corps Volunteers in Africa -- regardless of their assignment -- in ways to integrate HIV/AIDS prevention and awareness activities in their host communities.

❖ **Additional Training for Peace Corps Volunteers in other Countries** **\$1,015**

Funds training for Peace Corps Volunteers in other countries where HIV/AIDS has been identified as a serious concern.

Total Funds Requested \$7,835

Withdrawal/Redaction Marker

Clinton Library

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001. calendar	Re: personal (1 page)	09/04/2000	b(6)

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Domestic Policy Council
Irene Bueno
OA/Box Number: 19893

FOLDER TITLE:

Global AIDS

2017-1120-S
ry2204

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MEMORANDUM

TO: MARIA ECHAVESTE
FROM: LAURA ~~EFFORD~~ *CFROS*
RE: INTERNATIONAL AIDS MEETING –
Thursday, August 31st at 10:30 am in the Roosevelt Room

PURPOSE: You are meeting to discuss (1) the FY 2001 budget for international AIDS programs; and (2) what markers we should lay out for the future at next week's UN Millennium Summit. On the budget issue, the key questions for discussion are:

- ✓ What is the absorptive capacity of USAID, HHS, NGOs, and the affected countries themselves?
- ✓ If additional resources become available, how much should we put into the World Bank Trust Fund, the Peace Corps, the International AIDS Vaccine Initiative, other?
- ✓ How much, if any, of USAID's budget should be allocated for research into AIDS-related technologies, such as microbicides?
- ✓ What is the appropriate balance between prevention and care?
- ✓ What should the regional distribution of funds be? How much should be spent beyond sub-Saharan Africa and India?
- ✓ How would an increase for USAID impact other AIDS-related priorities, like HIPC and IDA?

For the Millennium Summit, the key questions are:

- Should we explicitly call for closing the \$4 billion annual global resource gap (\$2.5 billion for Africa alone) for AIDS prevention and basic care?
- Should we lay down a marker for future U.S. contributions to this goal? What should the U.S. share be?
- Should AIDS will be included the President's speech to the UN General Assembly, where it would get the most visibility, or the address to the UN Security Council session, which has an Africa focus? (You might prefer to discuss this outside the meeting.)

BACKGROUND: This is a follow-up to last week's international AIDS meeting. At your request, USAID prepared a budget document detailing how increased funding would be used at several levels:

- (1) \$255 million, the current House/Senate level;
- (2) \$320 million, with a \$65 million increase proposed by appropriations committee Democrats;

- (3) \$400 million, in intermediate option;
- (4) \$530 million, with the additional \$275 million proposed by the Global Health Council.

USAID's plan would both increase the number of countries covered and rapidly scale up programs in certain key countries. USAID would also expand its programs to place more emphasis on care and support, as well as research into new tools to fight AIDS.

USAID maintains that it could effectively use additional resources at each of the proposed funding levels. OMB and ONAP are in the process of making their own determinations about USAID's absorptive capacity. USAID and OMB are also discussing what additional measures -- like adding FTEs and streamlining procurement procedures -- are needed to enable USAID to obligate the proposed additional resources. OMB is also assessing whether HHS could effectively use the proposed \$52 million increase above the \$62 million request for CDC's component of the LIFE initiative.

ATTENDEES:

You

~~Sylvia Matthews~~

~~Mara Rudman~~

Sandy Thurman / *Michael Iskowitz*

Michael Casella

Laura Efros

Ken Bernard

Jim Babbitt

Richard M. Samans

Rebecca Walldorff

Paul DeLay (USAID)

Barbara Turner (USAID)

Chris Jennings

USAID's Expanded Response to the Global HIV/AIDS Pandemic

- I. Introduction**
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 - III. What We Will Achieve**
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-
- Appendix I. HIV Prevalence by Country**
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Section I. Introduction

The global community continues to underestimate the scope, severity and impact of the AIDS pandemic. At the end of 1999, HIV/AIDS prevalence (See Appendix 1) among adults nationally exceeded 20% in 7 countries in the developing world—all in Africa—and was above 10% in 16 countries—14 in Africa. In another 54 countries, prevalence equals or exceeds 1%. Thirty-eight of these are in Africa. However it is important to note that 11 are in Latin America, 4 in Asia and 1 in Eurasia. In contrast, HIV/AIDS prevalence in the United States was 0.6% at the end of 1999. 1994 was the first year when country level HIV prevalence statistics were validated by host country governments. Just 6 short years ago, there were no countries with rates exceeding 20% and only 5 countries where national rates exceeded 10%.

Since 1986, the U.S. Agency for International Development (USAID) has been engaged in combating the HIV/AIDS pandemic in the developing world. USAID has become the global and US Government (USG) leader in this international fight, due to USAID's strong field presence, technical leadership, the level of its financial support, and the extensive, long-term relationships with host country institutions. These relationships in the field provide the foundation for USAID's track record for building sustainable systems, using highly participatory approaches, and applying lessons learned to enhance the effectiveness and efficiency of programs. USAID sustained investments in Uganda have resulted in a reversal of the explosive upward trends and in Senegal have kept prevalence low. Recent reports from Zambia also suggest a reversal of the epidemic in the 15-19 year olds. Building on this experience, USAID will guide the development of an overall expanded plan for USG foreign assistance to combat the AIDS pandemic, and will facilitate and coordinate the USG response in host countries. In order to utilize USG and other global resources in a synergistic manner, USAID will use its vast network of partners, both at local and international levels, to ensure optimum coordination and collaboration.

Section II. Our Commitment

USAID is committed to enhancing the capacity of developing and transitional countries to protect their populations not yet infected by HIV and to provide services to those infected and others affected by the epidemic. Towards this end, USAID will strengthen its financial and technical support to countries to:

- Prevent the transmission of HIV, with a dual emphasis on high and those low prevalence countries that are deemed at risk for an impending epidemic (High prevalence is defined as >1% HIV infection in adults aged 15-49 years old. Low prevalence is defined as < 1% with the presence of risk factors that include HIV trend data and levels of risk behavior);
- Build the capacity to provide care and support for as many affected individuals, families and communities as possible, particularly in those countries most severely affected;
- Reduce significantly the social and economic impact of the epidemic on vulnerable groups and particularly within key sectors of health, education and democracy/governance; and
- Develop and introduce new HIV/AIDS prevention and care approaches and technologies. These would include a female controlled microbicide, more effective behavior change models for men, rapid STD and HIV diagnostic tests which are applicable for low resource settings, and preventive and therapeutic vaccines.

Section III. What We Will Achieve

Expected achievements for "high prevalence" and "low prevalence-at risk" countries would be different. By 2007, USAID will assist selected countries to:

- Reduce HIV prevalence rates among those 15-24 years of ages by 50% in high prevalence countries, and maintain prevalence below 1% among 15 to 49 year olds in those low prevalence countries that are deemed at risk of impending epidemics,
- Ensure that at least 25-50% of HIV/AIDS infected mothers in high prevalence countries will have access to interventions to reduce HIV transmission to their infants,
- Enable host country institutions to provide basic care and psychosocial support services to at least 25-50% of HIV infected persons in high prevalence countries,
- In high prevalence countries, enable host country institutions to provide community support services to at least 25-50% of children affected by AIDS¹, and
- Mitigate the impact of HIV/AIDS on key sectors (education, health, democracy/government) in severely affected countries.

The total cost from all sources for achieving these ranges of targets in all of Sub-Saharan Africa alone are estimated to be from \$3-4.9 billion per year. The expected funding levels for USAID in FY 2001 could vary between \$255-\$530 million annually. These amounts represent 9-17% of the funding requirements for achieving the targets mentioned above and would focus on a subset of these countries. The impact of USAID's investments will then be proportional to these funding levels. Lower funding levels would achieve the lower range for the targets noted above and would occur in a smaller number of countries. (See Section X.-What are the resource needs) However, USAID achievements could exceed the proportion of expected contributions, as it can gain efficiency for the investments due to its long experience and field presence. It is expected that our funds will also leverage other partner funding. Finalizing the actual target percentages which are attributable to USAID and the final selection of countries will depend on the resources available. See Section V. (Where We Will Work) and Section IX (What Are Our Resource Needs).

The above targets will be regularly reviewed and revised in the light of evolving data and ongoing analyses of the cost effectiveness of programs. In collaboration with CDC, WHO and UNAIDS, HIV sentinel surveillance systems will be improved in selected countries to report annually on HIV prevalence among 15-24 year olds. Beginning in 2001, USAID, with its partners, will begin periodic national surveys to collect information on changes in reported sexual behavior and to measure the quality and coverage of care and support services specified under this initiative. For more details, see Section VII (How Will We Measure Our Achievements)

Section IV. What We Will Do

¹ "Children Affected by AIDS" include those in households with sick or dying parents and those children orphaned by AIDS.

Unlike other crises due to war, famine or natural disaster, the investments made to secure the changes in risk behavior and to strengthen social and health services to address the pandemic must be immediate and intensive, but also **sustained over longer timeframes**. The importance of protecting future generations requires that our response prioritize protecting vulnerable populations, particularly children and adolescents. Given the pace and span of the pandemic, it is clear that our response cannot be "business as usual." The global USAID response should be broad in scope (multisectoral) and coverage (high and low prevalence countries) in order to make a sustained and cost-effective difference. USAID will focus particularly on sub-Saharan Africa, because most countries have prevalence over 1% and critical countries on the other regions of the world.

Five factors will define the programmatic expansion of USAID programs as new resources are made available. USAID will help countries:

- Prioritize implementation of proven interventions that can be rapidly taken to nationwide scale.
- Focus prevention and care interventions to reach the most vulnerable populations in high transmission areas.
- Expand country capacity to track the epidemic, implement programs, measure their impact, coordinate donor and other partner activities and utilize resources effectively.
- Adapt and utilize development interventions and increase the capacity of various development sectors (e.g., education, microfinance, etc) to reach and respond to communities impacted by HIV.
- Strengthen country commitment to build aggressive and sustained local involvement needed to curb the epidemic and significantly reduce the impact on individual communities.

Using the array of mechanisms available to USAID, we will meet the dual challenge of rapidly scaling up HIV prevention interventions known to be effective, while building the capacity for sustaining them. Known prevention interventions that we will expand include combined use of mass media and targeted interpersonal communication strategies, diagnosis and treatment of sexually transmitted infections, increasing access to male and female condoms, and voluntary HIV counseling and testing.

In addition to expanding the traditional approaches to prevention, USAID will broaden its array of interventions to include new and emerging areas. These will include:

- Prevention of mother to child transmission;
 - Increasing access to care and treatment services for opportunistic infections;
 - Providing assistance to children affected by the pandemic; and
 - Creating a multi-sectoral response to the epidemic.
- **PREVENTION OF MOTHER TO CHILD TRANSMISSION**
The number of infants infected each year through mother-to-child transmission (MTCT) is growing with the increasing number of women infected with HIV. About 55 percent of all new infections in Africa occur among women most of whom are in their childbearing years. MTCT is estimated to be the cause of about 10 percent of all

new HIV infections each year representing about approximately half-a-million infants.

Recognizing that comprehensive interventions can reduce transmission rates by 20 to 50 percent, USAID will primarily assist countries with high HIV prevalence to establish MTCT prevention programs. These programs will set standards; promote voluntary counselling and training; provide training to health care workers; establish linkages to community based care services, and scale up primary prevention for all women. USAID will assist in the management, logistical support, and if necessary procurement of antiretroviral drugs for the purpose of reducing mother to child transmission.

- **CARE AND TREATMENT**

In developing countries basic HIV care services are minimal. Few infected persons know their HIV status; most health care workers lack the training to treat HIV and its associated infections; and the capacity to use state-of-the-art antiretroviral treatment exists only in a few select settings, unavailable to the vast majority of those infected. But even in the absence of antiretroviral drugs there is much that can be done to improve the well-being of HIV infected persons and their families.

USAID places highest priority on assuring access to a basic package of care that includes treatment of tuberculosis, treatment and prevention of other opportunistic and AIDS related illnesses, and the provision of palliative care to reduce suffering and enhance the quality of life. To achieve this USAID will work with countries to establish linked networks of hospital, clinic, faith-based, and community-based services.

The special case of tuberculosis: Tuberculosis is a growing epidemic itself with 2 million deaths per year worldwide. Because it is the leading cause of death for persons with AIDS, efforts to treat and prevent tuberculosis will receive special attention. A package of care services will be developed for HIV infected persons that includes an evaluation for TB disease, provision of preventive therapy, as well as improvement and expansion of TB treatment programs.

- **PROVIDING ASSISTANCE TO ORPHANS AND OTHER CHILDREN MADE VULNERABLE BY HIV/AIDS**

Globally, AIDS has killed the mother or both parents of an estimated 13.2 million children. Many additional children have lost a father to AIDS; others are living with and often caring for a parent who is ill. Ninety-five percent of the children orphaned by AIDS live in Africa. The overwhelming majority of children orphaned and otherwise made vulnerable by HIV/AIDS are living within their extended families and communities. Unfortunately AIDS is undermining family and community capacity to protect and care for the growing number of vulnerable children.

Additional funding would enable USAID to help build and support community responses through which public, private, and voluntary sector donors in the

industrialized world can channel resources to national and grassroots programs in the countries hardest hit by HIV/AIDS. The most promising interventions to strengthen family and community capacities to protect and care for orphans and other vulnerable children are (1) systematic community mobilization and capacity building and (2) microfinance services. Paired, these two approaches can be mutually supportive and produce significant, sustainable results.

USAID will also use additional funds to support interventions that improve access to education for the most vulnerable children in areas seriously affected by HIV/AIDS. This will include a wide variety of interventions, ranging from policy reforms to direct interventions to enable orphans and other vulnerable children to return to or stay in school.

Grassroots groups urgently need funds and food to support home care for people living with AIDS and to integrate the identification and support for vulnerable children into such programs. These programs need ongoing access to food and medicines to treat the most common opportunistic infections. This can enable parents living with HIV/AIDS to live longer and more comfortably, and greatly benefit their children. These programs can also be strengthened to become an initial point of identification and support for children whose safety and well-being is being undermined by HIV/AIDS.

- **CREATING A MULTI-SECTORAL RESPONSE TO THE EPIDEMIC:**
Multisectoral approaches to prevention and care: USAID will continue to use multisectoral approaches for HIV/AIDS prevention, care and treatment, support for orphans, and to assess the effects of the epidemic on different sectors of society. USAID expects to intensify assistance to families and communities to cope with the financial impacts of the epidemic. Financial stresses will be addressed through microenterprise development and microfinance institutions offering loan products, trusts, as well as medical and death insurance to individuals and families. We will insure appropriate use of HIV/AIDS funding for non-health sector activities through indicators that have a measurable and direct impact on HIV/AIDS prevention or mitigation.

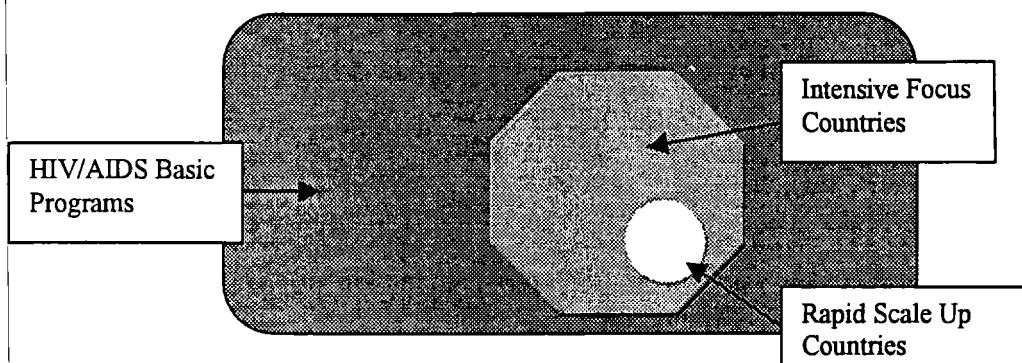
Reducing the impact on sectors of society: The HIV/AIDS epidemic is a development crisis that impacts all sectors of the economy in terms of loss of manpower and demand for various services e.g. health, education, democracy and governance. Realistic assessments of manpower shortages due to HIV/AIDS in these key sectors must be done and updated as the epidemic progresses. Adverse impacts on each sector need to be mitigated in order for the economy to achieve modest growth. In addition, different sectors have to work together to provide care and support to affected families and individuals as well as promote preventive measures among high risk groups and high transmission areas. USAID will continue to work with the education sector to assess the impact of HIV/AIDS on the sector and assist in the design of appropriate responses to reduce the impact. It will also help the health sector undertake similar assessments and design activities. USAID has developed

toolkits for such assessments for all sectors. In addition, USAID will provide support to countries to strengthen the management of key aspects of the program and generate necessary public and political commitment for dealing with the epidemic.

Section V. Where We Will Do It

USAID envisions three groups of countries for HIV/AIDS assistance programs:

- **Basic HIV/AIDS Programs:** Currently, USAID implements HIV prevention programs in 47 developing countries. These programs would continue to provide assistance and would focus on targeted interventions for those identified populations who engage in high-risk behavior. In these countries, there would also be an increased emphasis on maintaining credible surveillance systems in order to monitor HIV trends and allow timely warning of impending concentrated epidemics of HIV.
- **Intensive Focus Countries:** Within the LIFE Initiative, 15 countries were identified for significant scaling up of prevention activities and expanding services to provide care and support for those persons infected with HIV and their families. Under this expanded response, and depending on the level of available resources, this initial list of intensive focus countries would be enlarged. Intensive Focus countries would be determined by the criteria in Section VI. and countries from all regions of the world would be evaluated. Within this augmented response, it would be expected that in high prevalence countries no less than 80% of the country population would be provided a comprehensive package of prevention and care services. This nationwide coverage would occur within three to five years and would be achieved through careful coordination with donors, lending agencies and other resources. In "low prevalence-at risk countries," no less than 80% of targeted high-risk populations would be provided services. The goals presented in Section III would apply to all of these intensive focus countries. Selected "Intensive Focus" countries will also be targeted for increased resources for expanded tuberculosis programs. Expansion of HIV/AIDS and TB efforts will be closely coordinated and for the basis for model "care and treatment" efforts. (See Appendix II for more details)
- **Rapid Scale-Up Countries:** A small subset (two to four) of the "intensive focus" countries would be immediately identified to serve as settings for extremely rapid scaling up of prevention programs and enhancement of care and support activities. Intensive monitoring and evaluation systems would allow detailed tracking of financial obligations, expenditures and measurement of the impact of interventions. We would expect massive increases in program coverage and intensity to occur within one to two years



The allocation of additional resources for intensified programs will be based on several criteria. A matrix has been developed to rank the countries according to these criteria. Data is being obtained from USAID health officers, UNAIDS and from cooperating agency reports. For the purposes of this exercise, large countries, such as India and Nigeria, will be disaggregated and assessed at the state or province level in order to truly capture the complexity and scope of the pandemic within these countries. The criteria for consideration as an “intense focus country” include the following. A more detailed description of the criteria is presented in Appendix III

- The relative **severity** of the epidemic
- The **magnitude** of epidemic
- The **impact on economic and social sectors**
- The **risk of a rapid increase in prevalence**
- **Availability of other sources of funding**
- **Return on investment**
- **Enabling Environment**
- **Security** and safety issues

Section VI. What Are the Resource Needs

Four potential funding scenarios are envisioned. In order to achieve the targets that are presented, it is expected that this funding be sustained over a minimum of five years. With augmented funding, not only would the number of Intensive Focus and Rapid Scale-Up countries increase, but the spectrum of interventions would expand to allow more emphasis on care and support efforts and critical research and development of new tools.

Funding Amount	Geographic Focus	Interventions: Prevention, care, orphans, capacity building, monitoring systems, commodities, research, expanded partners
\$ 255 million	47 basic programs, which include 18 <u>Intensive Focus</u> countries, including	

	2 <u>Rapid Scale-Up</u> countries	
\$ 320 million	47 basic programs which include 25 <u>Intensive Focus</u> countries, including 3 <u>Rapid Scale-Up</u> countries	
\$ 400 million	47 basic programs which include 30 <u>Intensive Focus</u> countries, including 4 <u>Rapid Scale-Up</u> countries	
\$ 530 million	47 basic programs which include 35 <u>Intensive Focus</u> countries, including 5 <u>Rapid Scale-Up</u> countries.	

Section VII. How We Will Do It

Expanding Partnerships

To carry out this major increase in AIDS programming quickly, USAID will mobilize the collective capacity of a wide range of partners worldwide—from national governments, NGOs, faith-based organizations, business groups and the military in developing countries, to multilateral organizations and US-based public, non-profit and commercial institutions. USAID will work with national governments to develop policies, laws and programs and to make resource allocations needed to minimize HIV transmission, provide services, and care for the affected. USAID will also encourage the expansion of global efforts for coordination and sharing of lessons learned

USAID will work with indigenous and international non-governmental organizations that are uniquely positioned to provide information and services to hard-to-reach groups at high risk, like men who have sex with men, commercial sex workers, IV drug users, and adolescents. USAID will work with faith-based organizations that can tap their extensive and committed networks of members to educate people in HIV prevention, set community standards for protecting adolescents, and care for the affected. USAID will work with the private business sector and the military in their capacity as major employers to educate their workforces on prevention, and to incorporate attention to HIV into their health and benefits programs. In keeping with its commitment to make a difference in the lives of people, the Agency will emphasize the creation of an enabling environment for program implementation, including improving relevant policies, building capacity and strengthening the commitment of policymakers and the private sector.

USAID will work in countries with USAID Missions and options will be explored to reach selected "non-presence countries." To enhance country level programs, improvements are urgently needed in regional and global efforts for coordination and sharing of lessons learned. Multilateral organizations, including the UNAIDS, the World Health Organization and the World Bank can play special coordination roles because they have the systems in place to convene the international community, set standards for addressing HIV, mobilize donor resources, and share lessons learned rapidly. US based institutions, including universities, community groups, and local and state governments, will be valuable partners because they can share their experience addressing similar issues in the United States with developing country partners and provide them with assistance in training and capacity building. By tapping this wide range of partners, USAID also will be able to monitor and evaluate the cumulative effect of a wide array of activities and identify and share innovations widely with all those involved.

Building the Capacity of Our Partners

The Agency's extended experience in family planning and child survival has demonstrated a critical need to invest in the building up of both human and institutional capacity in the regions and countries where we work. It will be necessary to scale up existing mechanisms and to create new procurements which involve the partnering of U.S. institutions with host country counterparts, be they academic institutions, non-governmental organizations, or national and local level governments.

To maximize impact and build sustainable capacity, a training package would be developed and include both long- and short-term training for host-country personnel. Through new and existing arrangements with host country and regional training institutions, U.S. academic institutions (including HBCUs) and U.S. NGOs, training programs would be designed to provide the required HIV/AIDS technical, program and policy skills. Specially designed programs would produce "leaders" who would acquire skills needed to respond to HIV/AIDS challenges over the next ten years.

Building Capacity at USAID

Over the past 13 years USAID's HIV/AIDS activities have been constrained by a number of obstacles, including limited numbers of staff, lengthy and ponderous procurement procedures, and lack of access to critical health-related commodities. These obstacles must be overcome if USAID is to succeed in its efforts. The Agency must approach the expanded HIV/AIDS activities as an urgent and compelling global crisis, and that USAID does everything possible to implement effective programs with minimal delay.

- **Staffing:** To successfully implement an expanded program, it is imperative to recruit and retain human capacity with the appropriate skills. Rapid and flexible mechanisms are needed if USAID is to attract skilled individuals to serve in technical and support (such as Office of Procurement and Financial Management) functions.

USAID will request three legislative actions:

- 1) authority to hire Personnel Service Contractors for USAID/W in the areas of HIV/AIDS and Infectious Diseases (ID), and
 - 2) increase the ceiling on the Technical Advisors to AIDS and Child Survival program to \$16,000,000.
 - 3) USAID will also need to ensure that a percentage (e.g., 7%) of program funds are available for administrative (OE-like) costs.
- "Swat" Teams: To help missions develop and finalize plans for a rapidly implementing an expanded response to HIV/AIDS and tuberculosis, project development "swat" teams, including both technical and procurement personnel would be made available for two to eight week periods to assist in the design of country-level strategies. A "virtual" team that would be responsible for providing overall consistency and feedback would support these teams from AID/W.
 - Training: USAID staff, including direct hires, New Entry Program personnel (NEPS), FSNs and U.S. nationals, would participate in specially designed programs to gain technical, programmatic and political skills to respond to the AIDS pandemic. Through assistance relationships between U.S. institutions (including HBCUs), U.S. government agencies and U.S. NGOs, training would include interventions to reduce mother-to-child HIV transmission, innovative interpersonal behavior change strategies, how to support children affected by AIDS, and the multiple elements of a prevention to care continuum. Optimum use must be made of "in-service" training, the use of "state of the art" courses, and individual learning methodologies.
 - Procurement of Service Related Agreements: Streamlined, simplified, accelerated service procurement mechanisms must be put into place in order to program resources in an expedited manner. This may require statutory language to enable us to expedite the procurement process, including the modification of existing contracts. In addition, USAID needs to be able to allocate funding for HIV/AIDS outside of the normal OYB setting process.
 - Commodities: The majority of people living in high HIV/AIDS prevalence countries do not have access to a) drugs for basic palliative care; b) condoms for the prevention of sexually transmitted infection (STI), c) basic treatment for STIs, d) testing services that enable them to determine their HIV-status e) or to drugs to combat HIV associated infections. Hospitals that provide care and support lack basic commodities necessary to safeguard both patients and health care personnel, such as gloves and sterilization equipment.

USAID proposes to devote a significant share of its HIV/AIDS budget to improving client access to the commodities essential to prevent the transmission of HIV and to mitigate the effects of HIV infection on individuals, families, and communities. The Agency has over three decades of experience in providing a range of contraceptive commodities in support of its worldwide family planning programs. This long-term investment and experience has resulted in the development at USAID of the premier contraceptive/condom management capability among donors. The Agency would explore similar mechanisms for procuring and delivering these critical commodities.

- **Multisectoral Programming:** USAID will coordinate its own development activities so that they are focussed and geared towards HIV/AIDS prevention and mitigation efforts. In addition, each sector will work with counterpart agencies in the countries to help them assess the impact of HIV/AIDS and develop and implement appropriate responses to reduce the impact. Since no single agency can provide all the resources for mitigating the impact on HIV/AIDS, USAID will focus its work on assessing the level of impact on these sectors and will help countries mobilize alternative resources for such mitigation. USAID will use procurement mechanisms in other sectors, if these activities adhere to current guidance on use of CSD funds. These activities must have a direct and measurable impact on HIV/AIDS indicators.

Section VIII. Developing and Introducing New HIV/AIDS Prevention and Care Approaches and Technologies

USAID has provided technical leadership in developing new technologies and approaches to health and health-related issues for many years. USAID will use that experience to expand knowledge and develop tools for both individuals and programs to improve global effectiveness and efficiency in combating HIV/AIDS. As the pandemic expands in countries with very limited resources, research to identify sustainable and cost-effective responses is urgently needed.

- **Identifying Approaches:** USAID will continue to support activities designed to identify the most effective components of HIV/AIDS prevention strategies-- from interventions designed to change individual behavior, to larger arenas, such as the impact of policy changes. In addition, interventions to improve care, support, and service delivery will be tested and refined. Finally, USAID will disseminate and utilize these findings in order to replicate and scale-up these newly identified and successful interventions.
- **Technology Development:** USAID is unique among bilateral donors in that the Agency supports a portfolio of reproductive health technology research and development. The HIV/AIDS pandemic has challenged the world to develop new technologies to allow women and men to protect themselves from infection. As part of a comprehensive STI/HIV prevention strategy, USAID will invest in research on the development, use and appropriate introduction of existing and new prevention and care technologies, including vaginal microbicides; improved male and female condoms; rapid, simple diagnostic tests for HIV and other sexually transmitted infections; effective therapeutic regimens for HIV infected persons; and for the development of preventive and therapeutic vaccines.

To enhance country level programs, there is an urgent need to improve regional and global efforts for coordination and sharing of lessons learned. USAID will continue to monitor and evaluate the effect of its activities and the potential for innovation.

Section IX. How We Will Measure Our Achievements

Programmatic Reporting

Over the last several years, USAID has provided leadership in monitoring and evaluating HIV/AIDS programs. USAID will continue to expand and develop these systems in order to routinely monitor, evaluate and report on the progress of the Agency's HIV/AIDS programs worldwide.

Progress and Impact Measurements: An expanded monitoring and evaluation system will collect information on the national and USAID program levels:

- **Reduction of HIV Transmission - National Level:** USAID's most important objective is to reduce the rate of HIV transmission. USAID, in collaboration with CDC, UNAIDS, WHO and others, will improve and expand National Sentinel Surveillance Systems. Sentinel Surveillance Systems in all selected countries will report annually on HIV incidence rates to measure the overall effect on the pandemic of national (including USAID) HIV/AIDS prevention and mitigation programs.
Standard Indicator: HIV seroprevalence rates for 15-24 year olds
- **Changes in Sexual Behavior – National and USAID Program Level:** Monitoring changes in sexual behavior is important to both measure the success of and to improve the efficiency and coverage of National (and USAID) HIV/AIDS programs. The implementation of routine (every 3-5 years), standardized national sexual behavior surveys will begin in 2001. **Standard Indicators:** Number of sexual partners; Condom use with last non-regular partner
- **Coverage of Target Populations – USAID Program Level:** USAID will report annually on the Agency's progress toward implementing its HIV/AIDS programs and increases in the proportion of the target population(s) covered by these programs. Information systems collecting routine data will be strengthened. In each selected country, USAID will establish a system to aggregate this information and report on USAID activities at the country level. USAID will establish this reporting system and begin reporting in 2001.
- **Standard Indicators:**
 - Total condoms sold (Condom Social Marketing Programs)
 - % of target population requesting an HIV test and receiving counseling (VCT Programs)
 - % of target orphans/vulnerable children (OVC) with access to community services (OVC Programs)
 - % of target population with access to drug treatment to reduce mother-to-child HIV transmission (MCTC Programs)
 - % of STI cases treated according to national standards (STI Treatment Services)
 - % of HIV infected person with access to basic care and psychosocial support (Care and Support Programs)

- **Intervention Effectiveness – USAID Program Level:** USAID will conduct a series of impact evaluations of the Agency’s HIV/AIDS prevention and mitigation interventions to measure the relationship between program outputs and behavior change in the target populations. The results of these studies will document the effectiveness of USAID-supported interventions and the “best practices” will be identified and implemented widely. A summary of these research results will be published annually.

Reporting on Results

As outlined, USAID will report on national and program level progress annually. Additionally, USAID will allocate resources to report on USAID’s global impact on the HIV/AIDS epidemic every two years.

II. Financial Reporting

On the global level, USAID will report the following financial data annually:

1. The amounts of HIV/AIDS funds allocated to each country, each Regional Bureau, and each Global Bureau project each year;
2. For the Global Bureau projects, the amounts allocated to core activities;
3. Yearly obligations by country (this includes both direct Mission obligations and field support designations);
4. Yearly obligations by type of activity (e.g., policy analysis and reform, prevention, care and support, children affected by AIDS, MTCT, etc.) on a worldwide basis, by region, or by country.

Section X. Timeline for Disbursements for FY2000 and 2001

In FY2001:

Obligations could occur to current agreements/contracts that have HIV/AIDS in their Scopes of Work/Strategic Objectives and have allowable ceiling levels and project completion dates.

Step 1. List of instruments that can accept HIV/AIDS funding generated by December, 2001

Step 2. For those instruments eligible, decisions made as to which will receive funds by April, 2001

Step 3. Percentage of obligations completed for identified instruments/activities by May, 2001

Human capacity recruitment begins.

Step 1. Recruitment notices posted by March, 2001

Step 2. Percentage positions filled by June, 2001

“SWAT” teams provide technical assistance to country strategy expansion/development in context of other partners' activities and contributions

Step 1. Number of Swat teams requested by January, 2001

Step 2. Percentage of requests completed by April, 2001

Begin technical design and internal administrative requirements to award new procurements

Step: Process indicators would need to be defined

Begin strategy design for procuring necessary commodities and providing logistics management

Step 1: Negotiations with pharmaceutical and hospital supply companies begun by February, 2001

Donor Coordination strategy begun: One donor meeting held, possibly as an annex to a UNAIDS meeting

Step 1. Two coordinating meetings with relevant USG Agencies held to discuss components of a Coordination Strategy by March, 2001

Step 2. One meeting held with UNAIDS and other interested parties to discuss coordination of commodities procurement and logistics management by June, 2001

FY2002

For ongoing agreements/contracts where the ceiling or completion date was a barrier in 2001, complete actions to amend agreements/contracts to allow obligation of funds in FY2002

Step 1. Percentage of agreements/contracts eligible amended

Step 2. Percentage of agreements amended that received obligations

Human capacity in place and oriented to USAID programs, policies and processes

Step 1. Percentage of new personnel that have completed defined training programs

Competition and Award of new agreements/contracts

Step 1. Percentage of planned agreements/contracts awarded

Global Strategy. With input from USAID/W, USAID Field Missions, the results of swat team visits, and other USG Agencies, external donors and partners, USAID defines a two-year and five-year global strategy

Step 1. Draft two-year strategy ready for circulation

Step 2. Draft five-year strategy ready for circulation

Donor Coordination strategy drafted in collaboration with others, especially UNAIDS.

Second donor coordination meeting held, possibly as an annex to a UNAIDS meeting

Step 1. Draft Donor Coordination Strategy circulated to partners

Step 2. One coordinating meeting held to discuss Coordination Strategy

Step 3. One meeting held with UNAIDS and other interested parties to discuss coordination of commodities procurement and logistics management

Appendix I: Adult HIV Prevalence greater than 1% by Country at the end of 1999

GLOBAL

Rank	Country	% prevalence	Rank	Country	% prevalence
1	Botswana	36	28	Cambodia	4
2	Swaziland	25	29	Ghana	4
3	Zimbabwe	25	30	Guyana	3
4	Lesotho	24	31	Sierra Leone	3
5	Zambia	20	32	Eritrea	3
6	South Africa	20	33	Liberia	3
7	Namibia	20	34	Dominican Republic	3
8	Malawi	16	35	Angola	3
9	Kenya	14	36	Chad	3
10	Central African Republic	14	37	Guinea-Bissau	3
11	Mozambique	13	38	Benin	2
12	Djibouti	12	39	Thailand	2
13	Burundi	11	40	Mali	2
14	Rwanda	11	41	Belize	2
15	Cote d'Ivoire	11	42	Myanmar	2
16	Ethiopia	11	43	Gambia	2
17	Uganda	8	44	Honduras	2
18	United Rep. of Tanzania	8	45	Senegal	2
19	Cameroon	8	46	Panama	2
20	Burkina Faso	6	47	Guinea	2
21	Congo	6	48	Guatemala	1
22	Togo	6	49	Niger	1
23	Haiti	5	50	Suriname	1
24	Dem. Republic of Congo	5	51	Barbados	1
25	Nigeria	5	52	Trinidad and Tobago	1
26	Gabon	4	53	Sudan	1
27	Bahamas	4	54	Ukraine	1

Rank	Country	% prevalence	Rank	Country	% prevalence
AFRICA			32	Guinea-Bissau	3
1	Botswana	36	33	Benin	2
2	Swaziland	25	34	Mali	2
3	Zimbabwe	25	35	Gambia	2
4	Lesotho	24	36	Senegal	2
5	Zambia	20	37	Guinea 2	
6	South Africa	20	38	Niger	1
7	Namibia	20	LATIN AMERICA / CARIBBEAN		
8	Malawi	16	1	Haiti	5
9	Kenya	14	2	Bahamas	4
10	Central African Republic	14	3	Guyana	3
11	Mozambique	13	4	Dominican Republic	3
12	Djibouti	12	5	Belize	2
13	Burundi	11	6	Honduras	2
14	Rwanda	11	7	Panama	2
15	Cote d'Ivoire	11	8	Guatemala	1
16	Ethiopia	11	9	Suriname	1
17	Uganda	8	10	Barbados	1
18	United Rep. of Tanzania	8	11	Trinidad and Tobago	1
19	Cameroon	8	ASIA AND THE NEAR EAST		
20	Burkina Faso	6	1	Cambodia	4
21	Congo	6	2	Thailand	2
22	Togo	6	3	Myanmar	2
23	Dem. Republic of Congo	5	4	Sudan	1
24	Nigeria	5	EUROPE AND EURASIA		
25	Gabon	4			
26	Ghana	4			
27	Sierra Leone	3			
28	Eritrea	3			
29	Liberia	3			
30	Angola	3			
31	Chad	3			
				Ukraine	1

Appendix II. Expanded Response to TB and Malaria

I. Summary

USAID is also developing plans to strategically allocate potential increased resources for tuberculosis and malaria. Strategies have been carefully developed to have the greatest impact on the growing epidemic of TB and increasing problem of malaria, while complementing on-going investments in cross-cutting infectious disease issues of antimicrobial resistance and surveillance.

TB. Ninety-five percent of all TB cases and 98% of the 2 million annual TB deaths occur in developing countries. TB threatens the poorest and most marginalized, and undermines economic development. Most TB deaths are among those in economically active populations. The HIV/AIDS pandemic is fueling the spread of tuberculosis – TB is the leading cause of death among HIV-positive people and accounts for one third of AIDS deaths worldwide. USAID is committed to making a significant contribution to the global effort to prevent and control tuberculosis, leading to a reduction in the morbidity and mortality associated with the disease. USAID will work to build capacity in countries most affected, to expand implementation of proven, cost-effective interventions for preventing the transmission of TB, help strengthen policy commitment and surveillance, and help ensure an adequate supply of drugs – through better drug management and support for the purchase of TB drugs. At the same time, USAID will increase its investments in the development of new tools to prevent, diagnose and treat TB; continue to contribute to global and regional TB partnerships; and invest in the development of an expanded cadre of TB experts – from the developing as well as the developed world.

USAID will expand TB programs in a limited number of focus countries, selected on the basis of (1) greatest need: high incidence of TB (estimated case detection rates of over 100/100,000 population) and those that significantly contribute to the global burden of TB; countries with high HIV/AIDS prevalence, and countries at risk of escalating epidemics of multi-drug resistance; (2) political commitment; and (3) technical and managerial feasibility.

Malaria. Additional malaria funding would be used to mount a strategically focused, high impact effort in support of expanded malaria control activities. Expanded efforts would complement ongoing malaria activities and be largely focused in Africa, but also include sub-regional efforts in South America and Southeast Asia. Four targeted activities are proposed: (1) Scaling up malaria prevention and control activities; (2) Addressing malaria in complex emergencies; (3) Slowing the emergence and spread of drug-resistant malaria; and (4) Accelerating the development of new tools and approaches for malaria control

A limited number of countries and subregions will be selected for expanded resources, based on: an analysis of the national malaria burden, political commitment by national governments, the infrastructure capacity, and the overall potential for success.

II. Expanded Program in Tuberculosis

Of the 2 billion people infected with tuberculosis, 8 million develop the disease, and two million die each year. Ninety-five percent of all TB cases and 98% of all TB deaths occur in developing countries. It threatens the poorest and most marginalized groups, disrupts the social fabric of society, and undermines gains in economic development. The HIV/AIDS pandemic is helping to fuel the spread of tuberculosis – TB is the leading cause of death among HIV-positive people and accounts for one third of AIDS deaths worldwide.

The U.S. Agency for International Development is committed to addressing the global burden of TB in close collaboration with our local and global partners. In 1998, as part of a new strategy expanding USAID's efforts in infectious and reemerging diseases, USAID began to develop a significant and focused program in tuberculosis. Since then, the resources available for TB have increased each year, to an estimated \$20 million in FY 2000. Currently, USAID is supporting TB activities in about 10 countries. In addition, USAID has invested in TB surveillance, provided support to the global Stop TB Initiative, as well as critical research areas, including operations research for addressing multi-drug resistant TB, improved drug regimens, and the development of a new TB diagnostic.

Objective:

USAID's goal is to make a significant contribution to the global effort to prevent and control tuberculosis, leading to a reduction in the morbidity and mortality associated with the disease. There are proven, cost-effective interventions for preventing the transmission of TB; USAID will work to build capacity in countries most affected to expand the appropriate and effective implementation of these interventions. At the same time, USAID will increase its investments in the development of new tools to prevent, diagnose and treat TB, and continue to contribute to global and regional TB partnerships.

Strategy:

USAID's strategy for TB will focus on four areas:

1. Focused, expanded programs in key countries

Resources will be targeted at countries of greatest need, defined by:

- Greatest burden of TB – high incidence of TB (case detection estimated rates of over 100/100,000) and/or those that significantly contribute to the global burden of TB²;

² According to WHO, 22 countries contribute over 80% of the global burden of TB. These include: India, China, Indonesia, Bangladesh, Pakistan, Nigeria, Philippines, South Africa, Ethiopia, Viet Nam, Russia, Congo (DR), Brazil, Tanzania, Kenya, Thailand, Myanmar, Afghanistan, Uganda, Peru, Zimbabwe and Cambodia.

- Countries with high HIV/AIDS prevalence, and
- Countries at risk of escalating epidemics of multi-drug resistance.

A limited number of countries will be targeted for additional resources based on the technical criteria cited above as well as political commitment and technical and managerial capacity.

The Directly Observed Treatment, Short-Course (DOTS) strategy has proven to be a highly effective strategy for controlling TB. If implemented appropriately, DOTS has been shown to have a success rate (cure and completion of treatment) of 80% of cases, on average. DOTS is an effective and affordable strategy for controlling TB, and is especially valuable in resource-poor settings.

The DOTS strategy has 5 components: political commitment; passive case detection and diagnosis using sputum smear microscopy; standardized short course treatment with direct observation of therapy at least in the initial phase; assurance of an uninterrupted supply of quality drugs; and standardized recording/reporting with systematic evaluation of treatment outcome. Implementing DOTS appropriately requires investments in strengthened health systems, trained personnel, a dependable supply of high quality TB drugs, and an effective monitoring and surveillance system. If implemented appropriately, DOTS can help prevent the spread of MDR TB, and in areas where MDR TB already has a foothold, operations research is currently underway to determine the most effective programs to combat the disease.

2. Continued investments in global and regional partnerships

USAID was one of the original supporters of the global Stop TB Initiative, an expanded global partnership across all sectors of society to ensure that every TB patient has access to TB treatment and cure, protect vulnerable populations from TB and multi-drug resistant TB, and reduce the social and economic toll that TB exerts on families and communities. USAID has continued to support this initiative and ongoing efforts to secure these goals. In addition, USAID works with other US government agencies (HHS, including OIRH, CDC, and NIH) to maximize the resources available for TB by emphasizing the comparative advantages of each agency. The Agency is also involved in the Global Partnership to develop new anti-TB drugs, the development of a Global Drug Facility to ensure availability of quality anti-TB drugs, and support for a new international coalition (including the Royal Netherlands TB Association, The International Union Against TB and Lung Disease, the American Lung Association, the American Thoracic Society, and the WHO) to provide extensive technical assistance to TB programs in developing countries. Support for coordinated research into optimal diagnostics and treatment regimens will also play a major role in the USAID portfolio.

3. Investment in expanding cadre of TB experts – in developing and developed world

Support for TB programs, including training of individuals capable of running programs, has languished for years. As a result, there are few TB experts capable of

performing these responsibilities. At the same time, the increasing caseload related to the HIV epidemic, and the new threat of emerging TB strains resistant to medications used to treat it, increase the urgency of a global response. It is imperative that a cadre of experts able to deal with all aspects of the disease is developed, and that these individuals are deployed as soon as possible. USAID is therefore investing in the training and development of individuals in both developed and developing countries to ensure adequate coverage, particularly in those countries most affected. This will be accomplished through our agreements with the TB Coalition for Technical Assistance, as well as agreements with CDC, NIH, WHO, and other non-governmental organizations.

4. Expanded research investments:

Increased interest in the global TB problem, formation of new global alliances, and recent technical advances in a wide range of scientific fields have catalyzed a revolution in the development of diagnostics, vaccine and new drugs for infectious diseases.

Rapid and sensitive TB diagnostic tests are urgently needed. Deficiencies in current TB diagnostic tests in disease endemic countries leave large numbers of patients with TB undetected, impedes expansion of DOTS, and most importantly, facilitates continued transmission of disease. USAID will increase its support for the development of TB diagnostics appropriate for low-income countries by working with its partners to mobilize the efforts and expertise of public health workers, industry, academic researchers, donors and other partners.

In the face of evidence of increasing resistance to our current arsenal of TB drugs, USAID will target support for collaborative efforts to develop cost-effective new TB drugs and combination therapies. This will add value to treatment regimens with high cure rates, low treatment and administrative costs, few side effects, and good patient compliance, thus minimizing the development of drug resistance.

Future research investments by USAID may expand to include targeted areas of TB vaccine development. Current models predict that an effective TB vaccine would save tens of millions of lives over the next three decades. There is widespread agreement that effective drug therapy regimens and effective immunization could have synergistic effects on the ultimate control of the TB epidemic.

Finally, USAID will increase its support for operational research associated with its expanded research investments in the development of new tools to prevent, diagnose and treat TB.

What we will achieve:

By 2005, depending on the availability of funding, USAID will contribute to:

- Increased number of countries that report cure rates of 85% or greater and case detection rates of 70% or more (in targeted countries).
- Increased number of targeted countries that have implemented drug resistance surveillance
- Expanded cadre of international experts (developed and developing country nationals) capable of providing technical assistance in TB programming.
- Availability of a new diagnostic, appropriate for field use.

Approaches and mechanisms:

USAID will work in close collaboration with host country partners – in the public and private sectors – either directly or in collaboration with other international partners. Our objective at the country level is to build the political commitment and local capacity to implement DOTS programs effectively – including monitoring and reporting.

Because TB is a new area for USAID, there are limited existing relationships (contracts, grantees) for implementing TB programs. To overcome this, USAID/Washington will:

- Continue to work with international partners, such as WHO and CDC
- Sign an umbrella agreement with the TB Coalition -- including KNCV, the International Union Against TB and Lung Disease, American Lung Association/American Thoracic Society, WHO, and CDC. The members of the TB Coalition already have relationships in a number of countries; USAID resources will be used to significantly expand DOTS programs in a number of targeted countries, and to provide technical assistance to TB programs worldwide.
- Provide assistance to USAID missions to include TB in bilateral agreements or develop other local assistance mechanisms
- Develop other worldwide mechanisms available for field implementation and mission use.
- In partnership with the Stop TB Initiative, invest in a global TB drug facility, that would help make TB drugs available to countries in greatest need, and to strengthen local capacity to implement TB programs.

III. EXPANDED MALARIA EFFORTS

If, as part of the Agency's FY 2001 appropriations, there are additional resources for the prevention and control of malaria (above the Agency's FY 2000 levels) additional funding would be used to mount a strategically focused, high impact effort in support of expanded malaria control activities. These "expanded" efforts would complement ongoing malaria activities and be largely focused in Africa, but also include sub-regional efforts in South America and Southeast Asia. Four special activities are proposed:

1. Scaling up malaria prevention and control activities
2. Addressing malaria in complex emergencies
3. Slowing the emergence and spread of drug-resistant malaria
4. Accelerating the development of new tools and approaches for malaria control

1. "Scaling-up" Malaria Prevention and Control Activities In Africa – where 90% of the world's malaria related deaths occur - the major challenge facing malaria control operations is ensuring effective malaria control services are widely available to those populations at greatest risk from malaria illness. Currently, less than 25% of Africa's children have access to effective pediatric services; only 10% of women at risk of complications from placental infection during pregnancy have access to intermittent treatment, despite the availability of an effective, cheap and simple treatment; and, fewer than 10% of Africa's children sleep under a bednet, and even fewer sleep under an insecticide treated one. In April of this year 31 African heads of state met in Abuja, Nigeria to discuss the threat posed to the region by malaria and explore options for its prevention and control. The major outcome of this meeting was the "Abuja Declaration" which specifically commits each country to initiate appropriate and sustainable action so that by the year 2005:

- At least 60 per cent of those suffering from malaria have prompt access to and are able to use correct, affordable and appropriate antimalarials within 24 hours of the onset of symptoms;
- At least 60 per cent of those at risk benefit from protective measures, such as insecticide treated mosquito nets; and,
- At least 60 per cent of all pregnant women who are at risk of malaria have access to presumptive, intermittent treatment.

These goals are achievable, and would save an estimated 800,000 lives, annually. But to reach them will require a significant scaling up of existing malaria control efforts, which are largely limited to the district or provincial level. As part of Africa Bureau's and Global Bureau's commitment to these goals we are proposing that as first priority, any "extra" funding available in the Agency's FY 2001 malaria budget be targeted to support "national level" malaria prevention and control efforts in up to four African countries. By focusing these "extra" resources on a limited number of countries we expect to achieve significant reduction in the burden of malaria.

Target countries for expanded resources will be chosen based on an analysis of the national malaria burden, political commitment by national governments, the

infrastructure capacity, and the overall potential for success. An initial short list of candidate countries³ for expanded malaria control efforts will be pared to four in consultation with missions and depending on feasibility for expanding in-country efforts, either through mission funded programs, or through supplements to mission budgets.

2. Addressing Malaria in Complex Emergencies In addition, there is a growing recognition that African countries experiencing “complex emergencies” account for a rapidly growing percentage of the total deaths due to malaria in the region. This is especially true for Democratic Republic of the Congo where recent studies have shown malaria accounting for over 40% of the total deaths of internally displaced populations. A portion of the additional resources would be used to provide expanded support for, malaria control activities in the DROC .

3. Slowing the Emergence and Spread of Drug Resistant Malaria In recent years the Mekong Region of Southeast Asia, the Amazon Region of South America and a number of countries in Africa have experienced an ominous deterioration of their malaria situation with the emergence and spread of new and even more lethal strains of malaria that are resistant to all major antimalarial treatments, including chloroquine, mefloquine, fansidar and quinine. In all three areas, the larger concern is the further spread of drug-resistant infections and thus more extensive outbreaks. Inadequate drug policies, insufficient monitoring of drug resistance, lack of training opportunities for health providers in diagnosis and treatment, and poor public awareness of appropriate antimalarial drug use practices have exacerbated the effects of drug resistance.

USAID will give special attention to addressing the challenges posed by the emergence and spread of multi-drug resistant malaria. Given the highly cross-border nature of the threat and the need for a well coordinated effort among affected countries it is proposed that the additional resources be used to provide expanded support for regional initiatives: in the Amazonian region, the Mekong region, and Africa - to prevent and slow the emergence and spread of multi-drug resistance malaria.

4. Accelerating the Development of New Tools for Malaria Control In addition to providing expanded support for prevention and control programs, additional resources will also be made available for support three critical research efforts: (a) the Agency’s Malaria Vaccine Development Program (MVDP) and (b) the development of new drug therapies for malaria, and (c) operations research on behavioral, community, drug use and treatment regimen compliance issues as well as potential community approaches to environmental management of malaria.

Additional support for the MVDP would accelerate progress towards the availability of a malaria vaccine, which can be used as part of malaria control efforts. Similarly, extra funding for ongoing USAID supported clinical trials for new treatment therapies for malaria would ensure the timely availability of alternative treatments for malaria – an increasingly critical issue in light of the emergence and spread of resistance to existing

³ Initial list of countries for consideration include Nigeria, Senegal, Uganda, Mozambique, Zambia, and Malawi

antimalarial drugs. Lastly targeted and expanded operations research efforts will help guide treatment policy and practice, as well as behavior change communication.

Expanded Malaria Programs - Summary

Special Activity	Target	Expected Outcome
1. "Scaling-up" Malaria Prevention and Control Activities	Four Target Countries*: Nigeria, Senegal, Uganda, Zambia, Malawi, Mozambique	Accelerated expansion to the national level of a high impact malaria package.
2. Addressing Malaria in Complex Emergencies	Democratic Republic of the Congo	Expanded access of life-saving services to highly vulnerable internally displaced populations
3. Slowing the Emergence and Spread of Drug Resistant Malaria	Sub-regional initiatives in the Mekong, Amazon regions, and subregions in Africa	A highly coordinated approach to the threat of multi-drug resistant malaria
4. Accelerating the Development of New Tools for Malaria Control	(a) malaria vaccine (b) new treatment therapies (c) operations research	Accelerated availability of vaccine and treatments, and improved treatment protocols and regimens.

* The final selection - from six to four countries - will be done in dialogue with prospective Missions.

Appendix III: Criteria for selection of Intensive Focus Countries

- 1) The relative **severity** of the epidemic: measured by HIV/AIDS prevalence among the adult population aged 15 - 49.
- 2) The **magnitude** of epidemic: measured by the absolute number of infected persons.
- 3) The **impact on economic and social sectors**, including number of children orphaned by AIDS, and the decrease of critical education and health sector personnel due to AIDS mortality.
- 4) The **risk of a rapid increase in prevalence**: measured by a number of sub-indicators including: recent trends in the prevalence of HIV and other sexually transmitted diseases; the presence and size of populations engaging in risk behavior; the extent of international and internal migration due to economic forces, conflict, or natural disaster; levels of male circumcision; age of first marriage; assessment of women's empowerment; use of condom in last act of casual sex; and the presence of cofactors, such as wide spread alcohol use.
- 5) **Availability of other sources of funding** measured by GDP per capita and contributions from other donors, foundations and lending agencies.
- 6) **Return on investment** measured by whether the epidemic is localized and thus can be addressed with a relatively small investment or whether the epidemic has spread to the general population.
- 7) **Enabling Environment** measured by internal and external assessments, including the AIDS Program Effort Index (API) which is a joint effort of UNAIDS, USAID and the POLICY Project to measure the amount of effort put into national AIDS programs by both domestic and international organizations, and measured by the USAID Mission assessment of capacity.
- 8) **Security**: a yes or no indicator. Is the country sufficiently stable and secure for an HIV/AIDS program to be implemented?

**UNIFIED DRAFT TECHNICAL CHANGE REVISION DOCUMENT TO THE
WORLD BANK AIDS MARSHALL PLAN TRUST FUND ACT**
**Using the original bill, strikethroughs and underline (to show new additions) are
used to suggest changes—FOR DISCUSSION PURPOSES**

World Bank AIDS Marshall Plan Trust Fund Act

106th CONGRESS

2d Session

H. R. 3519

AN ACT

To provide for negotiations for the creation of a trust fund to be administered by the International Bank for Reconstruction and Development or the International Development Association to combat the AIDS epidemic.

HR 3519 EH

106th CONGRESS

2d Session

H. R. 3519

AN ACT

To provide for negotiations for the creation of a trust fund to be administered by the International Bank for Reconstruction and Development or the International Development Association to combat the AIDS epidemic.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the 'World Bank AIDS Marshall Plan Trust Fund Act'.

SEC. 2. FINDINGS AND PURPOSES.

(a) FINDINGS- The Congress finds the following:

(1) According to the Surgeon General of the United States, the epidemic of human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) will soon become the worst epidemic of infectious disease in recorded history, eclipsing both the bubonic plague of the 1300's and the influenza epidemic of 1918-1919 which killed more than 20,000,000 people worldwide.

(2) According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), 33,600,000 people in the world today are living with HIV/AIDS, of which approximately 95 percent live in the developing world.

(3) UNAIDS data shows that among children age 14 and under worldwide, 3,600,000 have died from AIDS, 1,200,000 are living with the disease; and in one year alone--1999--an estimated 570,000 became infected, of which over 90 percent were babies born to HIV-positive women.

(4) Although sub-Saharan Africa has only 10 percent of the world's population, it is home to 23,300,000--roughly 70 percent--of the world's HIV/AIDS cases.

(5) Worldwide, there have already been an estimated 16,300,000 deaths because of HIV/AIDS, of which 13,700,000--over 80 percent--occurred in sub-Saharan Africa.

(6) According to testimony by the Office of National AIDS Policy, an entire generation of children in Africa is in jeopardy, with one-fifth to one-third of all children in some countries already orphaned and the figure estimated to rise to 40,000,000 by 2010.

(7) The 1999 annual report by the United Nations Children's Fund (UNICEF) states '[t]he number of orphans, particularly in Africa, constitutes nothing less than an emergency, requiring an emergency response' and that 'finding the resources needed to help stabilize the crisis and protect children is a priority that requires urgent action from the international community.'

(8) A 1999 Bureau of the Census report states that the average life expectancy in the Republic of Botswana, the Republic of Zimbabwe, the Kingdom of Swaziland, the Republic of Malawi, and the Republic of Zambia has decreased from approximately age 65 to approximately age 40--the lowest life expectancy in the world--due to high mortality rates from HIV/AIDS.

(9) A January 2000 unclassified United States National Intelligence Estimate (NIE) report on the global infectious disease threat concluded that the economic costs of infectious diseases--especially HIV/AIDS--are already significant and could reduce GDP by as much as 20 percent or more by 2010 in some sub-Saharan African nations.

(10) According to the same NIE report, HIV prevalence among militias in Angola

and the Democratic Republic of the Congo are estimated at 40 to 60 percent, and at 15 to 30 percent in Tanzania.

(11) The HIV/AIDS epidemic is of increasing concern in other regions of the world with UNAIDS reporting, for example, that there are 6 million cases in South and South-east Asia, that the rate of HIV infection in the Caribbean is second only to sub-Saharan Africa, and that HIV infections have doubled in just two years in the former Soviet Union.

(12) Despite the grim statistics on the spread of HIV/AIDS, some developing nations--such as Uganda, Senegal, and Thailand--have implemented prevention programs that have substantially curbed the rate of HIV infection.

(13) AIDS, like all diseases, knows no boundaries, and there is no certitude that the scale of the problem in one continent can be contained within that region.

(14) According to a 1999 study prepared by UNAIDS and the Francois-Xavier Bagnoud Center for Health and Human Rights at the Harvard School of Public Health, HIV/AIDS is spreading three times faster than funding available to control the disease.

(15) The United Nations Secretary General has stated '[n]o company and no government can take on the challenge of AIDS alone,' and that 'what is needed is a new approach to public health--combining all available resources, public and private, local and global.'

(16) The World Bank, declaring AIDS not just a public health problem but 'the foremost and fastest-growing threat to development' in Africa, has launched a new strategy for HIV/AIDS in Africa, declaring it a top priority for the Bank on that continent.

(17) The World Bank estimates that for Africa alone \$1,000,000,000 to \$2,300,000,000 annually is needed for prevention in contrast to the approximately \$300,000,000 a year in official assistance currently available for HIV/AIDS in Africa.

(18) Accordingly, United States financial support for medical research, education, and disease containment as a global strategy has beneficial ramifications for millions of Americans and their families who are affected by this disease, and the entire population which is potentially susceptible.

(b) PURPOSES- The purposes of this Act are to prevent the spread of HIV/AIDS and promote its eradication, prevent human suffering, and to mitigate the devastating impact of the disease on economic and human development, social stability, and security in the developing world, through the creation of a trust fund which is designed to--

(1) work with governments, civil society, non-governmental organizations, the

Joint United Nations Program on HIV/AIDS (UNAIDS), the International Partnership Against AIDS in Africa, other international organizations, donor agencies, and the private sector to intensify action against the HIV/AIDS epidemic and to support essential field work in the most affected countries to assist in the development of AIDS vaccines; and

(2) seek to leverage financial commitments by the United States in order to mobilize additional resources from other donors, the private sector, nongovernmental organizations, and recipient countries to combat the spread of HIV/AIDS.

TITLE I--NEGOTIATIONS FOR THE CREATION OF A WORLD BANK AIDS TRUST FUND

SEC. 101. TRUST FUND TO ASSIST IN HIV/AIDS PREVENTION, CARE AND TREATMENT, AND ERADICATION.

The Secretary of the Treasury is authorized to enter into negotiations with the International Bank for Reconstruction and Development or the International Development Association, in consultation with other U.S. government agencies, and with the member nations of the IBRD or IDA and with other interested parties, for the creation of a trust fund which would be authorized to solicit and accept contributions from governments, the private sector, and nongovernmental entities of all kinds and use the contributions to address the HIV/AIDS epidemic in countries eligible to borrow from such institutions, as follows:

- (1) **PROGRAM OBJECTIVES-** The trust fund would provide only grants, including grants for technical assistance, to support measures to build local capacity in national and local government, civil society, and the private sector to lead and implement effective and affordable HIV/AIDS prevention, education, treatment and care services, and research and development activities, including access to affordable drugs. Among the activities the trust fund would provide grants for would be programs to promote best practices in prevention, including health education messages that emphasize risk avoidance; measures to ensure a safe blood supply; voluntary HIV/AIDS testing and counseling; measures to stop mother-to-child transmission of HIV/AIDS, including through diagnosis of pregnant women, access to cost-effective treatment and counseling and access to infant formula or other alternatives for infant feeding; and deterrence of gender-based violence and provision of post-exposure prophylaxis to victims of rape and sexual assault.
- (2) **PROGRAM COORDINATION-**In carrying out these objectives, the trust fund is expected to closely collaborate and coordinate its activities with governments, civil society, nongovernmental organizations, the Joint United Nations Program on HIV/AIDS (UNAIDS), the International Partnership Against AIDS in Africa, other international organizations, the private sector, and donor

agencies working to combat the HIV/AIDS crisis.

- (3) **PRIORITY-** In providing such grants, the trust fund would give priority to countries that have the highest HIV/AIDS prevalence rate or are at risk of having a high HIV/AIDS prevalence rate, and that have or agree to carry out a national HIV/AIDS program which--

(A) has a government commitment at the highest level and multiple partnerships with civil society and the private sector;

(B) invests early in effective prevention efforts;

(C) requires cooperation and collaboration among many different groups and sectors, including those who are most affected by the epidemic, religious and community leaders, nongovernmental organizations, researchers and health professionals, and the private sector;

(D) is decentralized and uses participatory approaches to bring prevention care programs to national scale; and

(E) is characterized by community participation in government policymaking as well as design and implementation of the program, including implementation of such programs by people living with HIV/AIDS, nongovernmental organizations, civil society, and the private sector.

(4) GOVERNANCE-

(A) **IN GENERAL-** The trust fund would be administered as a trust fund of the International Bank for Reconstruction and Development. The Trust Fund is expected to use technical expertise from UN agencies, such as UNAIDS, or other appropriate organizations in the execution of the grants program.

(B) **MANAGEMENT STRUCTURES** - Subject to general policy guidance from the President of the United States and representatives of the other donors to the trust fund, the Trustee would establish appropriate management structures to ensure proper day to day operations of the Fund, accountability of grants, host country commitment, oversight and monitoring and evaluation, and relevance to countries.

(C) **SELECTION OF PROJECTS AND RECIPIENTS-** In consultation with the President and other donors to the trust fund, the Trustee would establish criteria, that have been agreed on by the donors, for the selection of projects to receive support from the trust fund, standards and criteria regarding qualifications of recipients of such support, as well as such rules and procedures as would be necessary for cost-effective management of the

trust fund. The trust fund would not make grants for the purpose of project development associated with bilateral or multilateral development bank loans.

(D) **TRANSPARENCY OF OPERATIONS-** The Trustee shall ensure full and prompt public disclosure of the proposed objectives, financial organization, and operations of the trust fund.

(E) **ADVISORY BOARD-**

(i) **APPOINTMENT-** The President of the United States should seek, together with representatives of other participating donors to the trust fund, to establish an Advisory Board, and appoint to the Advisory Board renowned and distinguished international leaders who have demonstrated integrity and knowledge of issues relating to development, health care (especially HIV/AIDS), and Africa.

(ii) **DUTIES-** The Advisory Board would, in consultation with other international experts in related fields (including scientists, researchers, and doctors), advise and provide guidance for the trust fund on the development and implementation of the projects receiving support from the trust fund. In negotiating the terms of the trust fund pursuant to Section 101, the Secretary of the Treasury shall require the Trustee to provide the Advisory Board access to information and documents of the trust fund as necessary for the effective functioning of the Advisory Board.

TITLE II--UNITED STATES FINANCIAL PARTICIPATION

SEC. 201. LIMITATIONS ON AUTHORIZATION OF APPROPRIATIONS.

In addition to any other funds authorized to be appropriated for multilateral or bilateral programs related to AIDS or economic development, there are authorized to be appropriated \$500,000,000 for fiscal years 2001 to 2005 for payment to the trust fund established as a result of negotiations entered into pursuant to section 101.

TITLE III--REPORTS

SEC. 301. REPORTS TO THE CONGRESS.

(a) **ANNUAL REPORTS-** Not later than 1 year after the date of establishment of trust fund pursuant to this Act, and annually thereafter for the duration of the trust fund established pursuant to section 101, the Secretary of the Treasury shall submit to the appropriate committees of the Congress a written report on the trust fund, the goals of the trust fund, the programs, projects, and activities, including any vaccination approaches, supported by the trust fund, and the effectiveness of such programs, projects, and activities in reducing the worldwide spread of AIDS.

(b) APPROPRIATE COMMITTEES DEFINED- In subsection (a), the term 'appropriate committees' means the Committees on Appropriations, on International Relations, and on Banking and Financial Services of the House of Representatives and the Committees on Appropriations, on Foreign Relations, and on Banking, Housing, and Urban Affairs of the Senate.

TITLE IV--HIV/AIDS PREVENTION AND CARE

SEC. 401. STRENGTHENING LOCAL CAPACITY IN SUB-SAHARAN AFRICA TO IMPLEMENT HIV/AIDS PREVENTION AND CARE PROGRAMS.

Title XVI of the International Financial Institutions Act (22 U.S.C. 262p--262p-7) is amended by adding at the end the following:

'SEC. 1625. STRENGTHENING LOCAL CAPACITY IN SUB-SAHARAN AFRICA TO IMPLEMENT HIV/AIDS PREVENTION AND CARE PROGRAMS.

'The Secretary of the Treasury shall instruct the United States Executive Director at the International Bank for Reconstruction and Development to use the voice and vote of the United States to encourage the Bank to work with sub-Saharan African countries to modify projects financed by the Bank and develop new projects to build local capacity to manage and implement programs for the prevention of human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) and the care of persons with HIV/AIDS, including through health care delivery mechanisms which facilitate the distribution of affordable drugs for persons infected with HIV.'.