FOIA Number: 2018-0764-F

FOIA MARKER

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Subgroup/Office of Origin: National AIDS Policy Office

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Subseries:

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Folder Title:
Memos to POTUS [3]

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Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Sandra Thurman to President Clinton re: Report on Presidential Mission looking at children orphaned by AIDS in sub-Saharan Africa (6 pages)	04/16/1999	P1/b(1)
002. memo	Sandra Thurman to President Clinton re: Report on Presidential Mission looking at children orphaned by AIDS in sub-Saharan Africa [Duplicate of 001] (6 pages)	04/16/1999	P1/b(1)
003. memo	Sandra Thurman to President Clinton re: Report on Presidential Mission looking at children orphaned by AIDS in sub-Saharan Africa [Duplicate of 001] (6 pages)	04/16/1999	P1/b(1)
004. memo	Sandra Thurman to President Clinton re: AIDS in South Africa (4 pages)	04/27/2000	P1/b(1)
005. memo	Sandra Thurman to President Clinton re: AIDS in South Africa (3 pages)	04/27/2000	P1/b(1)
006. memo	Sandra Thurman to President Clinton re: AIDS in South Africa (3 pages)	05/01/2000	P1/b(1)
007. memo	Sandra Thurman to President Clinton re: AIDS in South Africa (3 pages)	05/01/2000	P1/b(1)
008. memo	Samuel Berger and Sandra Thurman to President Clinton re: US leadership in the global battle against AIDS (3 pages)	00/00/0000	P1/b(1)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office
Sandra Thurman
OA/Box Number: 40015

FOLDER TITLE:
Memos to POTUS [3]

2018-0764-F
jm2014

RESTRICTION CODES

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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.

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5 24-99

THE WHITE HOUSE
WASHINGTON

May 21, 1999

[redacted]
cc: NSC/Sandy
cc: Gene S.
I'd like to help re this
cc: Back to me

MEMORANDUM TO THE PRESIDENT

FROM: Sandra L. Thurman, Director, Office of National AIDS Policy

SUBJECT: AIDS in Africa - Response to Your Request for Additional Information

---

Thank you for calling me in Ghana and for reiterating your concern about the AIDS emergency in Africa and the need for an invigorated US effort. As a follow-up to our conversation, this memorandum provides additional information that seeks to put the issue of AZT for pregnant women in the broader context of the AIDS pandemic in Africa.

AIDS is a plague of biblical proportion

Thanks to the commitment of Rev. Leon Sullivan, for the first time, the African African-American Summit focused much needed attention on the issue of AIDS in Africa and acknowledged the following bleak realities:

AIDS buries more than 5,500 people a day in Africa and that number will more than double in the next few years. The WHO just declared AIDS the leading cause of death among all people of all ages in Africa, and each day, an additional 11,000 people become HIV infected. Most of these new infections are among young people, under the age of 25. By 2005, more than 100 million people worldwide will be HIV-positive.

AIDS is leaving a generation of children in jeopardy. In ~~many countries, between~~ one-fifth and ~~one-third~~ of all children have already been orphaned by AIDS, and the worst is yet come. ~~Within~~ the next decade more than 36 million children will be orphaned by AIDS in sub-Saharan Africa, ~~and this tragedy will continue~~ to grow for at least another 30 years.

AIDS is wiping out decades of steady progress in development, doubling infant mortality, tripling child mortality, and slashing life expectancy by 20 years or more. AIDS is devastating economic growth, threatening political and regional stability, and stands a serious obstacle to the realization of your new partnership with Africa, again celebrated in Ghana.

The combination of leadership and resources can turn the tide.

In our battle against AIDS, Uganda is the model for success in the developing world. President Museveni has been a strong and effective AIDS leader, and has created an environment ripe for change. In response, the US has invested more than $50 million on AIDS in Uganda over a ten-

Copied POTUS NSC w/e Berger Sperling Podesta Thurman

year period. Through this combination of leadership and sustained resources, Uganda has cut the rate of HIV by more than half, and organized model AIDS care programs.

As an essential component of your new partnership with Africa, we need to help cultivate AIDS leadership among more African leaders, and we need to help enhance the overall investment in the war on AIDS to a level that meets the magnitude of this crisis. On the leadership front, we are beginning to see positive movement. As the realities of the AIDS become increasingly unavoidable, a growing number of African leaders are stepping up to the plate. However, the resources currently dedicated to winning this war, from both host governments and donors, are grossly inadequate. As I said in my previous memorandum, in the face of a 300% rise in annual HIV incidence and an AIDS explosion in sub-Saharan Africa, the USAID global AIDS budget has remained essentially stagnant since 1993. Other donors have followed suit. Without a dramatically enhanced response, we will lose this war.

Our Global AIDS Emergency Working Group is exploring three strategies for increasing the availability of resources to begin to meet the ever growing global AIDS crisis. First, we are looking at an increase in the USAID global AIDS budget. In this context, it is important that this increase be new money and not taken from other essential development accounts. Health, education, child-survival, and micro-finance are all interconnected components of a comprehensive human investment and AIDS strategy. Shifting money from one account to another will not improve our collective effort. Second, we are looking at an approach to debt relief that not only considers a debtor nation's economic policy but its strong commitment to investing in human capacity, particularly HIV and AIDS. Countries such as Côte d'Ivoire, Kenya, Nigeria, South Africa, and Zambia all hold considerable US debt and have a serious and growing AIDS emergency. Third, we are looking at public-private partnerships.

Finding ways to increase access to AZT for HIV-positive pregnant women is an integral part of an invigorated response to AIDS in Africa.

With additional resources, the US can partner with host governments and other donors to promote an aggressive strategy on four fronts including: containing the AIDS pandemic, providing home and community-based AIDS treatment and support, caring for children orphaned by AIDS, and gearing up for the long haul through health infrastructure and capacity development.

In the context of containing the AIDS pandemic, developing ways to prevent mother-to-child transmission that are workable in Africa is a high priority. In Africa today, for every ten children born to HIV-positive mothers, two become infected during delivery, one becomes infected through breast-feeding, and seven remain HIV-negative. A "short course" of AZT at the time of birth and for a week following has been found to reduce the number of babies who become HIV-positive during delivery by nearly 40%. This is extremely encouraging news. However, a host of additional issues need to be explored and addressed before this knowledge can be effectively implemented.

USAID is now devoting $6 million to answering key questions surrounding the use of AZT to reduce mother-to-child transmission of HIV in the developing world. For example, to keep babies HIV-negative, mothers who receive AZT during delivery should not breastfeed. However, in many areas of sub-Saharan Africa, babies are as likely to die from diarrhea resulting

from misuse of formula as they are from AIDS. The lack of health care infrastructure is also a serious issue. More than 95% of pregnant women do not know they are HIV-positive and currently lack access to vital testing and counseling services needed to find out. Further, in many areas, most women deliver their children with the assistance of midwives in their homes, or in makeshift clinics unequipped for AZT interventions.

Finally, the AIDS stigma is so great in places like South Africa, that fear and denial keep pregnant women from discovering their status, even if they have the option. Recently a woman in South Africa with HIV went public with her status and was stoned to death by her neighbors, and countless others have been left destitute on the street with their children after their husbands found out they were HIV-positive. As we begin to address these issues, we will increase our ability to move forward with the implementation of an AZT intervention.

The cost of AZT remains a serious concern. Even with a price reduction from Glaxo Wellcome, AZT is expensive, particularly by African standards, and health planners face difficult choices over the best use of scarce resources. In South Africa, Health Minister Zuma has opposed providing AZT to pregnant women because it cannot be made available to all who need it and because she believes that other approaches are more cost effective. For example, she believes that it is better to focus on keeping women of childbearing age HIV-negative, thereby not only saving children from becoming infected but from becoming orphaned as well. In addition, this AZT discussion has been caught up in the debate over US policy on compulsory licensing, and South Africa's desire to produce AZT at a more affordable price. It is for these reasons that the delivery of AZT to pregnant women is one prong of a multifaceted approach to respond to AIDS in Africa.

I welcome the opportunity to discuss this with you further, and hope to have a report to you on AIDS in Africa, including recommendations from the Global AIDS Emergency Working Group, in early June.

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ATTACHMENT A

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

MEMBERS OF CONGRESS

Rep. Carolyn Kilpatrick, Foreign Operations Subcommittee, Appropriations,
Congressional Black Caucus
Rep. Barbara Lee, Africa Subcommittee, International Relations,
Congressional Black Caucus
Rep. Sheila Jackson Lee, Founder and Chair, Congressional Children's Caucus,
Congressional Black Caucus

CONGRESSIONAL STAFF

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

NON-GOVERNMENTAL PARTICIPANTS

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

ADMINISTRATION OFFICIALS

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

MILITARY PERSONNEL

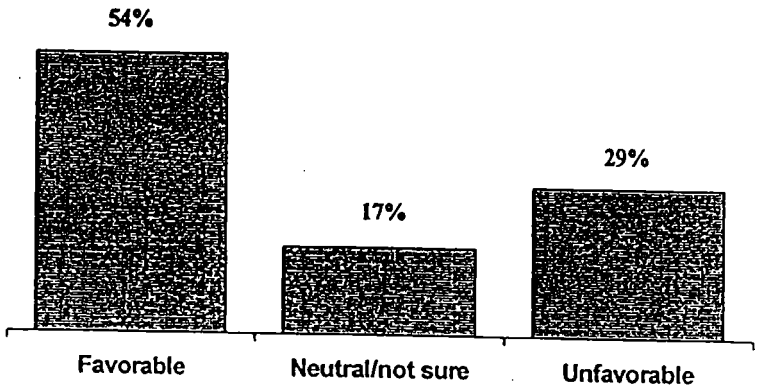
Lt. Commander James Erskine
Dr. Anthony Barile
Brenda Geist, Director Congressional Travel

ATTACHMENT B

Peter D. Hart Research Associates, Inc.

1724 Connecticut Avenue, N.W.
Washington, D.C. 20009
202-234-5570
202-232-8134 FAX

Increase U.S. Assistance to Fight AIDS in Africa



Peter D. Hart Research Associates surveyed 1,411 registered voters, including 310 African Americans, by telephone between February 20 and 26, 1999, for the Children's Research and Education Institute.

American voters view the spread of AIDS in Africa as a serious problem. Although many voters have not heard much about the issue, they nonetheless believe that it is likely to have an impact here at home. A majority of Americans have a favorable view of a proposal to increase U.S. government assistance for international AIDS programs in Africa.

- The spread of AIDS in Africa is viewed as a serious problem by two-thirds (67%) of American voters, with 45% saying that it is an extremely serious problem and an additional 22% describing it as a quite serious problem.
- The same proportion (67%) believe that it is false to say that the global AIDS crisis is coming under control.
- In addition, three-quarters (75%) of voters believe that the AIDS epidemic in Africa will affect people in the United States.
- Although the issue is important, only 19% of voters say that they have read or heard a lot about it. Nearly half (48%) say that they have heard little or nothing about it.
- A 54% majority are favorable to a proposal to increase government assistance for international efforts to fight the spread of AIDS in Africa. Only 29% are unfavorable.
  - An overwhelming 83% majority of African Americans are favorable (55% strongly favorable), and only 10% are unfavorable.
- Support for greater assistance increases when it is placed in the context of an international effort. Three-quarters (76%) of voters say that they would be more likely to support assistance to help Africa deal with the AIDS epidemic if they knew that it would be a part of a larger international effort with Europe, Japan, and other countries doing their share.

Study #5408
CREI/Social Issues
Interviews: 1411 voters, including 310 African Americans
Dates: February 20-26, 1999

AIDS in Africa

I'm going to mention some different issues, and I'd like to find out how serious a problem you consider each one to be in our country today. For each one, please tell me whether you consider it to be an extremely serious problem, a quite serious problem, a somewhat serious problem, or not that serious a problem.

	Extremely Serious Problem	Quite Serious Problem	Somewhat Serious Problem	Not That Serious A Problem	Not Sure
The spread of AIDS in Africa	45	22	13	8	12

Now I'm going to read you another list of statements. For each statement, please tell me whether you're sure it's true, think it's probably true, think it's probably false, or are sure it's false.

	Sure It's True	Think It's Probably True	Think It's Probably False	Sure It's False	Not Sure
The global AIDS crisis is coming under control	2	20	37	30	11

Now, I'm going to mention several proposals and I'd like to get your reaction. For each proposal I read, please tell me whether your reaction is very favorable, somewhat favorable, neutral, somewhat unfavorable, or very unfavorable.

	Very Favorable	Somewhat Favorable	Neutral	Somewhat Unfavorable	Very Unfavorable	Not Sure
Increasing U.S. government assistance for international efforts to fight the spread of AIDS in Africa						
ALL VOTERS	23	31	15	14	15	2
African Americans	55	28	6	5	5	1

How much have you heard or read about the issue of AIDS in Africa -- a lot, some, just a little, or not very much? **

Heard/Read	ALL VOTERS	African Americans
A lot	19	31
Some	32	28
Just a little	22	22
Have not heard/read very much	23	16
Heard/read nothing (VOL)	3	1
Not sure	1	2

** Asked of one-half the respondents (FORM B).

Study #5408
CREI/Social Issues
Interviews: 1411 voters, including 310 African Americans
Dates: February 20-26, 1999

AIDS in Africa

Do you think that the AIDS epidemic in Africa will affect people in the United States, or not? **

	ALL VOTERS	African Americans
Yes, will affect people in the U.S.....	75	83
No, will not affect people in the U.S ...	16	10
Not sure.....	9	7

** Asked of one-half the respondents (FORM B).

If you knew that the U.S. assistance to help Africa deal with the AIDS epidemic would be part of a larger international effort with Europe, Japan, and other countries doing their share, would you be much more likely to support it, somewhat more likely to support it, or no more likely to support it? **

	ALL VOTERS	African Americans
Much more likely to support	37	49
Somewhat more likely to support	39	35
No more likely to support.....	20	12
Less likely to support (VOL)	1	-
Not sure.....	3	4

** Asked of one-half the respondents (FORM B).

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CREI/Social Issues
Interviews: 1411 voters, including 310 African Americans
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AIDS in Africa

Now I am going to read you some reasons that people might give for supporting increased U.S. government assistance to fight the spread of AIDS in Africa . For each one, please tell me how convincing a reason it is to support increased assistance – very convincing, fairly convincing, only somewhat convincing, or not that convincing. **

	Very Convincing	Fairly Convincing	Only Somewhat Convincing	Not That Convincing	Not Sure
We all live on one planet, and the whole world benefits from fighting the spread of AIDS--if the epidemic has spread that much in Africa, we are fooling ourselves if we think that it won't affect the U.S.--it will, unless we do something now					
ALL VOTERS	44	14	21	16	5
African Americans	67	12	11	7	3
The AIDS epidemic is creating millions of orphans that are overwhelming the capacities of orphanages and churches, and filling the streets of many African cities. An estimated forty million children will lose a parent to AIDS by 2010					
ALL VOTERS	40	15	23	15	7
African Americans	56	18	17	6	3

S 24-99

THE WHITE HOUSE

WASHINGTON

[redacted]

cc: NSC/Sandy (I'd like to help re this)

cc: Gene S.

cc: Back to me

May 21, 1999

MEMORANDUM TO THE PRESIDENT

FROM: Sandra L. Thurman, Director, Office of National AIDS Policy

SUBJECT: AIDS in Africa - Response to Your Request for Additional Information

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Copied POTUS NSC WL Berger Sperling Podesta Thurman

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Attachment B

March 27 - April 5
Zambia,Uganda,South Africa
Thurman Presidential Delegation

Saturday, March 27

15:00	Assemble Distinguished Members Lounge. Baggage Call. Andrews Air Force Base
16:00	Depart Andrews

Sunday, March 28

Lusaka
ZAMBIA

03:55	Arrive Sal Amilcar Cabral Airport, Cape Verde. Refueling.
05:15	Depart Airport
15:50	Arrive Lusaka International Airport Met by Ambassador Render - VIP Lounge
16:15	Press Conference
16:45	Depart Airport
17:15	Arrive Pomodzi Hotel. Collect per diem from Control Room Staff.
Evening	Optional evening cultural event. TBD

Monday, March 29

Kitwe
ZAMBIA

07:45	Pick up Pomodzi
08:15	Arrive at Lusaka International Airport
08:30	Depart Lusaka
09:30	Arrive Ndola - Met by Government Officials, Mission Staff and Project Concern International Staff

10:00	Depart Airport
10:15	Arrive St. Anthony's Compound. Briefing, talk with community representatives, visit income generating activities, school, and services.
12:15	Depart St. Anthony's Compound
12:45	Arrive Sherbourne Guest House. Lunch with government officials, NGO staff, and others.
13:45	Depart Sherbourne Guest House
14:30	Arrive Twapia Widows Group. Meet with widows, tour clinic, and review community activities including home and community based care.
15:15	Depart Twapia
15:30	Arrive Ndola Airport.
15:45	Depart Ndola
16:45	Arrive Lusaka International Airport
17:00	Depart Lusaka International Airport
17:20	Arrive Pomodzi Hotel
17:30	Reception hosted by Minister of Health Luo
19:00	Reception ends
19:15	Pick up Pomodzi
19:30	Arrive at Ambassador Render's Residence. Dinner with Government Officials, NGO representatives and others. (list of attendees follows)
21:30	Depart Ambassador Render's Residence
21:45	Arrive Pomodzi Hotel
22:00	Depart for Cairo Road to visit with the hundreds of street children who stay there at night accompanied by PCI and Fountain of Hope outreach workers.
23:00	Arrive Pomodzi Hotel

Tuesday, March 30

Lusaka
ZAMBIA

07:00 Baggage Pick Up

07:50 Depart Pomodzi Hotel

08:00 Arrive Ndeke House -- Meet with representatives of the government's public-private orphan task force
- Facilitated by Peter McDermott, UNICEF Country Representative
UN Building
Alick NKata Road, Longacres
POBox 33610
260-1-251470

09:00 Depart Ndeke House

09:15 Arrive Fountain of Hope, Kabwata. Drop in center, school, and support organization for street children and other children in special circumstances.
- Roger Muchu, Director
Kamwala Community Centre
Chilumbulu Road

10:30 Depart Fountain of Hope

10:45 Arrive State House

11:00 Meet with President Chiluba, Minister for Health Dr. Nkandu Luo, GRZ HIV/AIDS Coordinator Dr. Moses Sichone and other Government Staff.

12:00 Depart State House

12:15 Arrive USIS - Working Lunch with HIV/AIDS Activists and Select Donors.

14:00 Depart USAID

14:15 Arrive at Society of Women Against AIDS in Zambia (SWAAZ). Community empowerment and mobilization including income generating activities, skills training, and HIV prevention, care and support programs.
- Patricia Ndele, SWAAZ Director
- Mark Chilongu, SWAAZ Arts Theatre (best I've ever seen)
POBox 50270

15:15 Depart SWAAZ

15:35 Arrive Lusaka International Airport

16:00 Depart Lusaka

20:30 Arrive Entebbe Airport

19:30 Depart Airport

20:00 Arrive Sheraton Kampala

Wednesday, March 31

Masaka
UGANDA

08:00 Briefing with Ambassador Powell, USAID Director, HIV advisor - Sheraton

08:35 Pick up Sheraton

10:10 Arrive Mukungwe, Masaka. Join Mrs. Museveni .

10:20 Welcome ceremony and briefing from United Women to Save Orphans Effort (UWESO) and Foundation for International Community Assistance (FINCA)

- Pellucy Ntanbirweki, Director, UWESO
  2 Tagore Cresent, Kamwokya
  POBox 8419
  Kampala
  256-041-532394/5

- Michael McCord, Africa Manager
- Clare Wavamunno, Africa Finance Specialist
  POBox 24450
  Bugolobi-Kampala
  256-075-721000

11:20 Thank you by a representative of the delegation.

11:25 Exit to vehicles

11:30 Depart Mukungwe for Kalagala home visits to UWESO Clients

11:40 Arrive UWESO Client 1

12:10 Depart UWESO Client 1

12:20 Arrive UWESO Client 2

12:50 Depart UWESO Client 2

13:05 Arrive Statehouse Masaka for lunch with First Lady

14:05 Depart Statehouse of tour of FINCA businesses

14:05 Arrive FINCA businesses - walking tour to grocery storekeeper, tailor, pancake maker, and beer maker/vendor

14:45 Depart FINCA

16:05 Arrive Equator - Rest stop and craft shops

16:35 Depart Equator

17:20 Arrive Sheraton

18:30 Pick up Sheraton

18:45 Arrive Ambassador's Residence, Reception w/ NGOs and officials

20:00 Depart Ambassador's Residence (list of attendees follows)

20:15 Arrive Sheraton

Thursday, April 1

Kampala
UGANDA

07:45 Depart Sheraton

08:00 Arrive The AIDS Support Organization (TASO) Mulago.
Care and support program for individuals and families living with AIDS.
Briefing, tour, and discussion with clients and families.

- Sophia Mukasa Monico, Director
  Mulago Hospital
  POBox 11485
  Kampala
  256-41--530034/567637

- Beatrice Were, Coordinator
  National Community of Women Living with AIDS (NACWOLA)
  POBox 4485
  Kampala
  256-41-269694

09:40 Depart TASO

10:00 Arrive Statehouse. Meeting with President Museveni,
Minister of Gender, Labor and Social Development, Hajat Janat Mukwaya,
Minister of Health, Dr. Crispus Kiyonga

12:00 Depart Statehouse

12:05 Arrive Sheraton. Lunch and Check out.

13:15 Department Sheraton

13:30 Arrive at AIDS Information Center. HIV counseling and testing center.
Briefing, tour, and discussion with clients.
- Jane Harriet Namwebya, Executive Director
Musajja Alumbwa Road
POBox 10446
Kampala
256-41-271433/347603

15:00 Depart for Entebbe Airport

15:45 Arrive Entebbe Airport - VIP Lounge, Wrap-Up Press Conference.

17:00 Depart Entebbe Airport for Johannesburg

20:00 Arrive Johannesburg Airport

20:30 Depart Johannesburg Airport

21:00 Arrive Park-Hyatt Hotel

Friday, April 2

Johannesburg
SOUTH AFRICA

08:00 Breakfast Briefing, Park-Hyatt

09:30 Baggage Call. Pick up Park-Hyatt.

10:00 Arrive Ethembeni (Place of Hope)Centre, Johannesburg.
A Salvation Army children's home for children affected or infected with HIV. Seeks to place children in families if possible.
- Mrs. Trollip, Head Nurse
63 Sherwell Street
Doornfontein, Johannesburg
27-11-402-8101

11:00 Depart Ethembeni Centre

11:30 Arrive Hope Worldwide - Jabavu Clinic, White City, Soweto
Provides care, support, prevention, and income generating activities.
Briefing, tour, and discussion with clients.
• Dr. Mark Ottenweller, Africa Director
Hope Worldwide, ltd.
220 Cornelis Street, Johannesburg -- 27-11-678-0991
-- Soweto Clinic 27-11-984-4422

12:30 Depart Jabavu Clinic

13:00 Arrive Wandie Shebeen, Lunch with Soweto NGOs.
• Dr. James McIntyre, Chief of Ob/Gyn; HIV Clinic
Chris Hani Baragwanath Hospital
PO Bertsham 2013
27-11-933-3110 x8156

14:30 Depart Wandie Shebeen

15:00 Arrive Bethesda House, Soweto
• Major Lenah Jwili, Director
Old Potchefstroom Road
Klipspruit Ext. 2
011-986-7417

16:00 Depart Bethesda House

16:30 Arrive Johannesburg Airport

17:00 Depart Johannesburg Airport

18:00 Arrive Durban Airport, KwaZuluNatal

18:30 Depart Airport

19:00 Arrive Edward Hotel

Evening Event TBD

Saturday, April 3

Durban
SOUTH AFRICA

08:45 Baggage Call

09:00 Depart Edward Hotel for Pietermaritzburg

10:00 Arrive at Grey's Hospital.
Site visits to Grey's (formerly all white) and Endendale (formerly all black) Hospitals. The hospitals delivers 13,000 between them with one ob/gyn; more than 30% are HIV+

• Dr. Neil McKerrow, hero and pediatrician
Townbush Road
Athlone, PMB
0331-458-181

• Dr. Zweli Mkhize, KZN Minister of Health
Private Bag X9051
PMB 3200
0331-952-016/953-028

12:30 Lunch at City Hall with Children in Distress (CINDI), a network of NGOs working with children affected by AIDS. (information follows)

• Themba Blose, Development Coordinator, CINDI
POBox 1659
PMB 3200
0331-452-970

-- CINDI held a conference earlier in the year on children orphaned by AIDS. More than 500 people attended from six countries, including First Lady Graca Machel. CINDI founder, Mark Loundon is currently writing a book from those proceedings and lessons learned to date.

• Mark Loundon
27-82-895-2742

• Siphiwe Gwala, Mayor
(former psychiatric nurse, solid understanding of psychosocial issues for orphans)
Private Bag 321
PMB 3200
0331-951-037

14:00 Depart City Hall

14:30 Arrive Lily of the Valley. Provides residential care and support for children abandoned or orphaned by AIDS.

• Kees and Anita Keyzer, Directors
POBox 158
Sarina 3615
031-7085127

15:30 Depart Lily of the Valley for Durban

16:30 Arrive Durban Airport

17:00 Depart Durban Airport for Cape Town

18:30 Arrive Cape Town

19:00 Depart Cape Town Airport

19:30 Arrive Table Bay Hotel - Check in

20:00 Reception with Ambassador James Joseph

Sunday, April 4

Cape Town
SOUTH AFRICA

08:30 Meet at Table Bay Lobby

08:45 Pick up Table Bay

09:15 Mass, St. George's Cathedral, Anglican Church
• Kevin Osborne, policy consultant, PWA coalition
POBox 1383
Sea Point 8060
27-21-790-3755

10:45 Depart St. George's Cathedral

11:30 Arrive Table Bay

12:45 Baggage Call

13:00 Depart Table Bay for Airport

17:30 Arrive Cape Town International Airport

18:30 Depart Airport

Sunday, April 5

Washington, DC
USA

02:30 Arrive Andrews Air Force Base

HIV/AIDS FACTS and FIGURES:
04/21/99

Basic HIV/AIDS Statistics:
Since the beginning of the HIV/AIDS pandemic 47 million persons have become infected with HIV, the virus that causes AIDS (33.5 million in sub-Saharan Africa)

Of this total number:

- 33. 4 million are currently living with HIV (22.5 million in sub-Saharan Africa)
- 14 million have died (12 million in sub-Saharan Africa)
- 5.8 million new HIV infections occurred in 1999 (4 million in sub-Saharan Africa)

We estimate that by the year 2005, the cumulative total of persons infected by HIV will reach 100 million, with approximately 60% of these persons living (or have died) in sub-Saharan Africa.

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

Since1986, USAID has expended in sub-Saharan Africa approximately $650 million dollars (50% of the total global expenditure) In 1999, total expenditure will be $74 million and an additional $ 7 million for Africa from the *Supplemental Fund for Children Affected by HIV.*

Since 1990, USAID South Africa has obligated approximately $28.5 million for HIV/AIDS programs. In 1999, planned obligations will be $1.5 million, plus an additional $1.4 million from the *Supplemental Fund for Children Affected by HIV/AIDS*.

Sandy:

The following are comments to the draft report (the version I had from a week ago Friday).

Summary Section.

Add an item 6:

6. We know what works—interventions have succeeded in many locations. Scaling up these efforts, along with commensurate resources, are required.

(Rationale: It is important to convey that we just don't recognize the problem but we know how to deal with it, and thus can use the resources well).

Page 4 – Findings Section

You may wish to add a subheading "The Problem" before launching into the text at the beginning (see later under page 10).

Page 5 – Findings Section

Para beginning "Fragile health care…": At the end of the first sentence, add a new sentence: "TB now accounts for half of all AIDS deaths in Africa, according to a recent study."

Para beginning with "Further, throughout…": Possibly before the sentence beginning "According to UNICEF.." add a new sentence: "Moreover, the enormous numbers of AIDS orphans will have negative effects on African society, particularly on the transmission of traditions, history, values, and norms."

(Rationale: African society, particularly at the village level, relies on oral traditions and history telling. With so many adults dying, the link with the past will be a casualty of the epidemic and its chaotic impacts.)

Page 5 – Graphic. I think it's OK. One minor revision to consider is to amend the graph title to read: "% of All Children Orphaned by AIDS"
(Rationale: this makes it clear that the denominator is all children in the given country).

Page 6 – graphic. Add the source of the data to the graph (in fine print). I believe it is the US Bureau of the Census.

Page 6, bottom, Para beginning with "AIDS is a trade and investment issue": You note that Jeffrey Sachs spoke at the recent meeting with African trade and finance ministers… If that refers to the Ministerial meeting we had in March, Sachs in the end did not speak there. He did prepare some papers for the meeting. As an aside, Treasury and others did not want him there. The quote however is great. The way the statement is currently formulated, it does not refer to *which* meeting he spoke at, so we may be OK. And his thoughts are documented in the papers.

Page 8—Bottom of page, Para that begins "As goes Africa, so will go India, Asia, and the new Soviet…": This is a technicality, but the Soviet Union referred to the old order. I am not sure that it is appropriate to refer to "new Soviet states" as they are now not Soviet and are independent states. One term often used is Newly Independent States, but you may want to check with a State Dept person for the current term.

Page 10 – Add a subheading at the top of the page "The Response". This sets this sub-section apart from the rest of the findings section which discusses the problem.

Perhaps add a new paragraph immediately following such a subheading such as "We know what works. Prevention programs, linked with basic care and support, in several countries have demonstrated success in preventing HIV transmission. But, the scale of these activities is too small. In order to make a lasting

difference, large scale increases in resources are required. Consider that total worldwide spending for AIDS in developing countries (all sources: national, bilateral and multilateral) was $550 million in 199_ for 34 million cases of AIDS (22 in Africa). Last year, U.S. spending for AIDS was $6-7 billion for 600,000 cases of AIDS."

p. 13 The special box on MTCT. Numerous typos and missing letters. Para beginning "The lack of health care..." Second sentence, the letter "d" missing from an—should be "and." Para beginning "Further, the AIDS..." Second sentence, the word is "breast". Same sentence, the HIV+ - is confusing, better to spell it out here. Next sentence, women should be singular, woman.

p. 14 – A thought on resources. First, the US is the leader worldwide when it comes to AIDS donor funding (by a large margin, Holland is next at $30+ million). If the US increases its resources for AIDS, it will send a clear signal to the rest of the donor community to increase their resources as well, thereby leveraging those resources. Increased US funding could also be used as an incentive to leverage important national reforms and resource increases favoring AIDS efforts.

p. 16. Para on "We recommend that the US establish a program... The terms debt forgiveness and debt swaps are used interchangeably in this paragraph—this should be avoided. Rather than saying a "debt swap agreement" I suggest using a "debt relief agreement."

Item 3 – the Headline of the section is unclear: "Other partnerships with African nations (no apostrophe)" is there a word(s) missing here?

Some thoughts on this section. First, there are numerous opportunities where US and African interests intersect. These often occur in established forums such as BNCs, Ministerial meetings, SADC Forums, and so on. Hence, the need for the USG to speak with one voice (a recommendation). A second recommendation involves using the upcoming ICASA and Durban AIDS conferences in Africa to highlight the issue and to send high level US delegations as speakers (particularly multisectoral, not just health).

US Ambassadors to Africa have voiced their tremendous concerns about AIDS in Africa. They have repeatedly asked for more information and action on the part of other USG agencies as well as from their hoist country counterparts. Moreover, a State Dept cable requiring a demarche on AIDS has been sent out earlier this year. A recommendation could be that the State Department work jointly with other country ambassadors to Africa in a unified diplomatic initiative to apply pressure on host country governments to respond to the AIDS epidemic.

To lead off with this section should be a strong recommendation on either a First Ladies summit or a Presidential summit. To the extent this could be tied down as a possibility (either one) at publication time, the better. It seems that a Presidential Summit would be less likely, but post Kosovo and as we get closer to the end of this Administration, the greater the possibility that it could actually happen. It may depend on the African American community's push as well as any inspiration that could be derived from the example of former President Carter and his efforts surrounding guinea worm and other humanitarian causes. It also begs the question as to what deliverables the US would be able to offer for such an event. But, what an event it could be (and what a workload ☺)

I am not so sure on the AIDS impact statement—moreso on the language used. Apparently, the World Bank is already doing something akin to an AIDS impact statement by requiring that their environmental impact assessments include AIDS. For USAID and other USG agencies working in Africa, we could recommend that AIDS impact assessments be considered to see how a given project would affect or be affected by AIDS.

p. 17 Item 4 – Partnerships with other donors. G8 language on debt forgiveness and use of benefits for social sectors and AIDS especially is moving forward. On a broader level, the US can work with other donors in providing leadership in donor coordination, as well as participating in the international Africa Partnership Against AIDS. To be honest, I cannot think of a headline grabbing initiative here. Working closer with the World Bank is a very interesting proposition—particularly as the Bank is launching their

new AIDS strategy and the US (via USAID) can leverage these WB projects by providing technical assistance to countries. The WB provides the money, the US provides the TA and the marriage is done. A meeting between you and Jan Peerce/Wolfensohn could be useful in developing a specialized initiative that increases/formalizes the WB-USAID relationship.

Item 5 – The Private sector. Business investment is directly linked with the President's "Partnership with Africa" (see p. 14) and his trade initiatives. Thus, the real appropriateness of this type of initiative. Dept of Commerce needs to play a role in this. One idea is to have the President issue awards of excellence to those companies that took the leadership to develop AIDS in the workplace programs. Although symbolic, it is something that companies would value i.e., recognition and PR.

As you have indicated, several US companies have taken the lead in developing AIDS programs: Levi Strauss, Ford, Chevron, and others. Another related initiative is to mobilize American Chambers of Commerce to assist with AIDS advocacy. Another idea is to develop Business Councils on AIDS in many countries that provides the forum for business leaders to talk with one another and support each other.

A Cabinet official/White House (i.e. you?) sponsored meeting for foundations on the topic of AIDS in Africa could be useful to mobilize their interest the subject.

Unions. The Solidarity Center experience with COSATU (Council of South African Trade Unions) is very valuable and should be mentioned. By successfully engaging COSATU and obtaining their agreement to place AIDS as a major labor policy issue, the union council reaches millions of South Africans and others from the region. Next steps are to implement the policies and to set up support programs for the membership.

PVOs and NGOs. The not for profit sectors, represented by international PVOs and indigenous NGOs, play a critical and vital role in the fight against AIDS in Africa, particularly at the community level—where it counts. A recommendation to hold some from of meeting, and possibly awards, would be useful. Global Council and others may have others specific ideas in this area.

Item 6 – Partnerships with the religious community. A White House summit of US and African religious leaders would go a very long way in mobilizing African religious leader commitment to the issue of AIDS prevention and care/support. Religion plays a very important role in the lives of Africans. It is where they derive their hope and seek comfort. It is an extremely powerful mobilizing and social support force. But, on AIDS, many religious leaders and institutions have not been supportive. They have not spoken out, and in many cases have shunned the very people that need their help the most—AIDS infected and affected persons. Key issues are stigma and reducing the discrimination that people with AIDS experience in Africa, as well as creating the spiritual home that all those affected require. All faiths would be welcome. Key US leaders such as Rev. Sullivan and Jackson; Bishop Haines, and other denomination leaders would be invited. US models such as NEAC and African models/inspirations such as the Ugandan and Senegalese experiences, as well as many others would be shared. A product of the meeting could be some form of joint statement of principles. A footnote: the World Parliament of Religions is slated to meet in Durban on Dec 1 1999 and this may provide some competition as far as the date is concerned. The Parliament also wishes to have an AIDS program.

Citations

p. 2 item 1 – USAID report Children at the Brink
item 2 – UNAIDS and USAID
item 3 – Based on economic and security facts (World Bank, DOD)
item 4 – UNAIDS
item 5 – USAID Uganda and other experiences

p.4 First para. Numbers on bubonic plague and influenza probably gotten from public health book AIDS vs all wars data from Global Health Council. Remainder of para data from UNAIDS December 1998 report.

Second para. UNAIDS and ONAP derivation of South African numbers since World AIDS Day 98. Graph from UNAIDS.

p. 5 First para. World Bank Confronting AIDS book. Next section (shattering families) probably derived from John Williamson (USAID) and UNICEF report.

Graph source: UNCIEF?

p. 6 Life expectancy data and graph derived from US Bureau of Census World Population Reports 1998 report.

AIDS as economic issue. Sachs quote from HIID articles on AIDS (will verify). Economist article from January 1999 I believe.

p. 7. World Bank data from Confronting AIDS book. Last para of economic section—South African study.. Not sure which one this is, do you all have it?

DOD for military issues.

South African crime institute report—you probably all have it.

p. 8 bottom and page 9. UNAIDS data

p. 10 Leadership matters. Uganda story from Elizabeth Marum, USAID technical advisor, Uganda.

Effective solutions based on your interviews and Jon Williamson's input.

p. 11 bottom. USAID and others as a source.

p. 12 Four pronged approach. USAID.

Bottom on MTCT – USAID as source.

p. 14 bottom. Funding stats from USAID.

p. 15 top. Again, funding from USAID.

Bottom, US Treasury Dept?

Congresswoman Barbara Lee

9th District of California
U.S. House of Representatives

Fax Cover Sheet

2:30 pm.

Date: 6/16 Pages to follow: 1

To: Michael or Cherly

From: Jennifer

Fax number: 456-2439

Message: Michael / Cherly - My boss discussed w/ Sandy a contribution to the Presidential mission report, so I wanted to send this draft language to you asap - Could one of you give me a call? (whoever is working on the report) Thanks!

414 Cannon HOB ♦ Washington, DC 20515 ♦ (202) 225-2661

Rep. Barbara Lee
June 15, 1999

DRAFT

5. Partnerships with the Private Sector

Corporate Involvement

The United States should significantly support the involvement of the private sector in establishing a comprehensive fund dedicated to education, research and treatment of men, women, and children living with and/or exposed to HIV/AIDS in Africa. An effective public-private initiative could be seeded and leveraged with federal money, challenging private industry to contribute significant resources for this effort. As has been demonstrated in the recent $100 million "Secure the Future" initiative put forth by Bristol-Myers Squibb, private industry is interested in becoming involved in the fight against the HIV/AIDS epidemic in Africa. Given the national focus on trade partnerships with African nations, it is in their own best interest to do so. The Federal government should provide a means not only to encourage the involvement of the private sector, but also coordinate and support future private sector initiatives.

May 21, 1999

MEMORANDUM TO THE PRESIDENT

FROM: Sandra L. Thurman, Director, Office of National AIDS Policy

SUBJECT: AIDS in Africa - Response to Your Request for Additional Information

---

Thank you for calling me in Ghana and for reiterating your concern about the AIDS emergency in Africa and the need for an invigorated US effort. As a follow-up to our conversation, this memorandum provides additional information that seeks to put the issue of AZT for pregnant women in the broader context of the AIDS pandemic in Africa.

AIDS is a plague of biblical proportion

Thanks to the commitment of Rev. Leon Sullivan, for the first time, the African African-American Summit focused much needed attention on the issue of AIDS in Africa and acknowledged the following bleak realities:

AIDS buries more than 5,500 people a day in Africa and that number will more than double in the next few years. The WHO just declared AIDS the leading cause of death among all people of all ages in Africa, and each day, an additional 11,000 people become HIV infected. Most of these new infections are among young people, under the age of 25. By 2005, more than 100 million people worldwide will be HIV-positive.

AIDS is leaving a generation of children in jeopardy. In many countries, between one-fifth and one-third of all children have already been orphaned by AIDS, and the worst is yet come. Within the next decade more than 36 million children will be orphaned by AIDS in sub-Saharan Africa, and this tragedy will continue to grow for at least another 30 years.

AIDS is wiping out decades of steady progress in development, doubling infant mortality, tripling child mortality, and slashing life expectancy by 20 years or more. AIDS is devastating economic growth, threatening political and regional stability, and stands a serious obstacle to the realization of your new partnership with Africa, again celebrated in Ghana.

The combination of leadership and resources can turn the tide.

In our battle against AIDS, Uganda is the model for success in the developing world. President Museveni has been a strong and effective AIDS leader, and has created an environment ripe for change. In response, the US has invested more than $50 million on AIDS in Uganda over a ten-

year period. Through this combination of leadership and sustained resources, Uganda has cut the rate of HIV by more than half, and organized model AIDS care programs.

As an essential component of your new partnership with Africa, we need to help cultivate AIDS leadership among more African leaders, and we need to help enhance the overall investment in the war on AIDS to a level that meets the magnitude of this crisis. On the leadership front, we are beginning to see positive movement. As the realities of the AIDS become increasingly unavoidable, a growing number of African leaders are stepping up to the plate. However, the resources currently dedicated to winning this war, from both host governments and donors, are grossly inadequate. As I said in my previous memorandum, in the face of a 300% rise in annual HIV incidence and an AIDS explosion in sub-Saharan Africa, the USAID global AIDS budget has remained essentially stagnant since 1993. Other donors have followed suit. Without a dramatically enhanced response, we will lose this war.

Our Global AIDS Emergency Working Group is exploring three strategies for increasing the availability of resources to begin to meet the ever growing global AIDS crisis. First, we are looking at an increase in the USAID global AIDS budget. In this context, it is important that this increase be new money and not taken from other essential development accounts. Health, education, child-survival, and micro-finance are all interconnected components of a comprehensive human investment and AIDS strategy. Shifting money from one account to another will not improve our collective effort. Second, we are looking at an approach to debt relief that not only considers a debtor nation's economic policy but its strong commitment to investing in human capacity, particularly HIV and AIDS. Countries such as Côte d'Ivoire, Kenya, Nigeria, South Africa, and Zambia all hold considerable US debt and have a serious and growing AIDS emergency. Third, we are looking at public-private partnerships.

Finding ways to increase access to AZT for HIV-positive pregnant women is an integral part of an invigorated response to AIDS in Africa.

With additional resources, the US can partner with host governments and other donors to promote an aggressive strategy on four fronts including: containing the AIDS pandemic, providing home and community-based AIDS treatment and support, caring for children orphaned by AIDS, and gearing up for the long haul through health infrastructure and capacity development.

In the context of containing the AIDS pandemic, developing ways to prevent mother-to-child transmission that are workable in Africa is a high priority. In Africa today, for every ten children born to HIV-positive mothers, two become infected during delivery, one becomes infected through breast-feeding, and seven remain HIV-negative. A "short course" of AZT at the time of birth and for a week following has been found to reduce the number of babies who become HIV-positive during delivery by nearly 40%. This is extremely encouraging news. However, a host of additional issues need to be explored and addressed before this knowledge can be effectively implemented.

USAID is now devoting $6 million to answering key questions surrounding the use of AZT to reduce mother-to-child transmission of HIV in the developing world. For example, to keep babies HIV-negative, mothers who receive AZT during delivery should not breastfeed. However, in many areas of sub-Saharan Africa, babies are as likely to die from diarrhea resulting

from misuse of formula as they are from AIDS. The lack of health care infrastructure is also a serious issue. More than 95% of pregnant women do not know they are HIV-positive and currently lack access to vital testing and counseling services needed to find out. Further, in many areas, most women deliver their children with the assistance of midwives in their homes, or in makeshift clinics unequipped for AZT interventions.

Finally, the AIDS stigma is so great in places like South Africa, that fear and denial keep pregnant women from discovering their status, even if they have the option. Recently a woman in South Africa with HIV went public with her status and was stoned to death by her neighbors, and countless others have been left destitute on the street with their children after their husbands found out they were HIV-positive. As we begin to address these issues, we will increase our ability to move forward with the implementation of an AZT intervention.

The cost of AZT remains a serious concern. Even with a price reduction from Glaxo Wellcome, AZT is expensive, particularly by African standards, and health planners face difficult choices over the best use of scarce resources. In South Africa, Health Minister Zuma has opposed providing AZT to pregnant women because it cannot be made available to all who need it and because she believes that other approaches are more cost effective. For example, she believes that it is better to focus on keeping women of childbearing age HIV-negative, thereby not only saving children from becoming infected but from becoming orphaned as well. In addition, this AZT discussion has been caught up in the debate over US policy on compulsory licensing, and South Africa's desire to produce AZT at a more affordable price. It is for these reasons that the delivery of AZT to pregnant women is one prong of a multifaceted approach to respond to AIDS in Africa.

I welcome the opportunity to discuss this with you further, and hope to have a report to you on AIDS in Africa, including recommendations from the Global AIDS Emergency Working Group, in early June.

May 21, 1999

MEMORANDUM TO THE PRESIDENT

FROM: Sandra L. Thurman, Director, Office of National AIDS Policy

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Finding ways to increase access to AZT for HIV-positive pregnant women is an integral part of an invigorated response to AIDS in Africa.

With additional resources, the US can partner with host governments and other donors to promote an aggressive strategy on four fronts including: containing the AIDS pandemic, providing home and community-based AIDS treatment and support, caring for children orphaned by AIDS, and gearing up for the long haul through health infrastructure and capacity development.

In the context of containing the AIDS pandemic, developing ways to prevent mother-to-child transmission that are workable in Africa is a high priority. In Africa today, for every ten children born to HIV-positive mothers, two become infected during delivery, one becomes infected through breast-feeding, and seven remain HIV-negative. A "short course" of AZT at the time of birth and for a week following has been found to reduce the number of babies who become HIV-positive during delivery by nearly 40%. This is extremely encouraging news. However, a host of additional issues need to be explored and addressed before this knowledge can be effectively implemented.

USAID is now devoting $6 million to answering key questions surrounding the use of AZT to reduce mother-to-child transmission of HIV in the developing world. For example, to keep babies HIV-negative, mothers who receive AZT during delivery should not breastfeed. However, in many areas of sub-Saharan Africa, babies are as likely to die from diarrhea resulting

from misuse of formula as they are from AIDS. The lack of health care infrastructure is also a serious issue. More than 95% of pregnant women do not know they are HIV-positive and currently lack access to vital testing and counseling services needed to find out. Further, in many areas, most women deliver their children with the assistance of midwives in their homes, or in makeshift clinics unequipped for AZT interventions.

Finally, the AIDS stigma is so great in places like South Africa, that fear and denial keep pregnant women from discovering their status, even if they have the option. Recently a woman in South Africa with HIV went public with her status and was stoned to death by her neighbors, and countless others have been left destitute on the street with their children after their husbands found out they were HIV-positive. As we begin to address these issues, we will increase our ability to move forward with the implementation of an AZT intervention.

The cost of AZT remains a serious concern. Even with a price reduction from Glaxo Wellcome, AZT is expensive, particularly by African standards, and health planners face difficult choices over the best use of scarce resources. In South Africa, Health Minister Zuma has opposed providing AZT to pregnant women because it cannot be made available to all who need it and because she believes that other approaches are more cost effective. For example, she believes that it is better to focus on keeping women of childbearing age HIV-negative, thereby not only saving children from becoming infected but from becoming orphaned as well. In addition, this AZT discussion has been caught up in the debate over US policy on compulsory licensing, and South Africa's desire to produce AZT at a more affordable price. It is for these reasons that the delivery of AZT to pregnant women is one prong of a multifaceted approach to respond to AIDS in Africa.

I welcome the opportunity to discuss this with you further, and hope to have a report to you on AIDS in Africa, including recommendations from the Global AIDS Emergency Working Group, in early June.

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002. memo	Sandra Thurman to President Clinton re: Report on Presidential Mission looking at children orphaned by AIDS in sub-Saharan Africa [Duplicate of 001] (6 pages)	04/16/1999	P1/b(1)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office
Sandra Thurman
OA/Box Number: 40015

FOLDER TITLE:
Memos to POTUS [3]

2018-0764-F
jm2014

RESTRICTION CODES

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

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ATTACHMENT A

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

MEMBERS OF CONGRESS

Rep. Carolyn Kilpatrick, Foreign Operations Subcommittee, Appropriations,
Congressional Black Caucus
Rep. Barbara Lee, Africa Subcommittee, International Relations,
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Rep. Sheila Jackson Lee, Founder and Chair, Congressional Children's Caucus,
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Michael Iskowitz, Consultant, USAID
Dr. Paul DeLay, Director, HIV/AIDS Programs, USAID
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Phil Drouin, Africa Bureau, State Department

MILITARY PERSONNEL

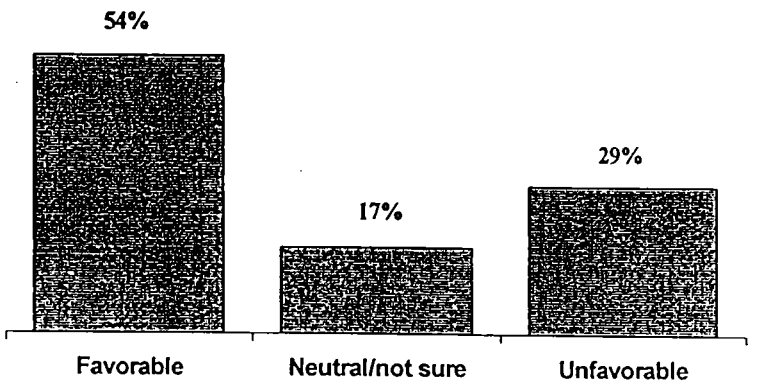
Lt. Commander James Erskine
Dr. Anthony Barile
Brenda Geist, Director Congressional Travel

ATTACHMENT B

Peter D. Hart Research Associates, Inc.

1724 Connecticut Avenue, N.W.
Washington, D.C. 20009
202-234-5570
202-232-8134 FAX

Increase U.S. Assistance to Fight AIDS in Africa



Peter D. Hart Research Associates surveyed 1,411 registered voters, including 310 African Americans, by telephone between February 20 and 26, 1999, for the Children's Research and Education Institute.

American voters view the spread of AIDS in Africa as a serious problem. Although many voters have not heard much about the issue, they nonetheless believe that it is likely to have an impact here at home. A majority of Americans have a favorable view of a proposal to increase U.S. government assistance for international AIDS programs in Africa.

- The spread of AIDS in Africa is viewed as a serious problem by two-thirds (67%) of American voters, with 45% saying that it is an extremely serious problem and an additional 22% describing it as a quite serious problem.
- The same proportion (67%) believe that it is false to say that the global AIDS crisis is coming under control.
- In addition, three-quarters (75%) of voters believe that the AIDS epidemic in Africa will affect people in the United States.
- Although the issue is important, only 19% of voters say that they have read or heard a lot about it. Nearly half (48%) say that they have heard little or nothing about it.
- A 54% majority are favorable to a proposal to increase government assistance for international efforts to fight the spread of AIDS in Africa. Only 29% are unfavorable.
  - An overwhelming 83% majority of African Americans are favorable (55% strongly favorable), and only 10% are unfavorable.
- Support for greater assistance increases when it is placed in the context of an international effort. Three-quarters (76%) of voters say that they would be more likely to support assistance to help Africa deal with the AIDS epidemic if they knew that it would be a part of a larger international effort with Europe, Japan, and other countries doing their share.

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CREI/Social Issues
Interviews: 1411 voters, including 310 African Americans
Dates: February 20-26, 1999

AIDS in Africa

I'm going to mention some different issues, and I'd like to find out how serious a problem you consider each one to be in our country today. For each one, please tell me whether you consider it to be an extremely serious problem, a quite serious problem, a somewhat serious problem, or not that serious a problem.

	Extremely Serious Problem	Quite Serious Problem	Somewhat Serious Problem	Not That Serious A Problem	Not Sure
The spread of AIDS in Africa	45	22	13	8	12

Now I'm going to read you another list of statements. For each statement, please tell me whether you're sure it's true, think it's probably true, think it's probably false, or are sure it's false.

	Sure It's True	Think It's Probably True	Think It's Probably False	Sure It's False	Not Sure
The global AIDS crisis is coming under control	2	20	37	30	11

Now, I'm going to mention several proposals and I'd like to get your reaction. For each proposal I read, please tell me whether your reaction is very favorable, somewhat favorable, neutral, somewhat unfavorable, or very unfavorable.

	Very Favorable	Somewhat Favorable	Neutral	Somewhat Unfavorable	Very Unfavorable	Not Sure
Increasing U.S. government assistance for international efforts to fight the spread of AIDS in Africa						
ALL VOTERS	23	31	15	14	15	2
African Americans	55	28	6	5	5	1

How much have you heard or read about the issue of AIDS in Africa -- a lot, some, just a little, or not very much? **

Heard/Read	ALL VOTERS	African Americans
A lot	19	31
Some	32	28
Just a little	22	22
Have not heard/read very much	23	16
Heard/read nothing (VOL)	3	1
Not sure	1	2

** Asked of one-half the respondents (FORM B).

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Do you think that the AIDS epidemic in Africa will affect people in the United States, or not? **

	ALL VOTERS	African Americans
Yes, will affect people in the U.S.	75	83
No, will not affect people in the U.S	16	10
Not sure	9	7

** Asked of one-half the respondents (FORM B).

If you knew that the U.S. assistance to help Africa deal with the AIDS epidemic would be part of a larger international effort with Europe, Japan, and other countries doing their share, would you be much more likely to support it, somewhat more likely to support it, or no more likely to support it? **

	ALL VOTERS	African Americans
Much more likely to support	37	49
Somewhat more likely to support	39	35
No more likely to support	20	12
Less likely to support (VOL)	1	-
Not sure	3	4

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Now I am going to read you some reasons that people might give for supporting increased U.S. government assistance to fight the spread of AIDS in Africa . For each one, please tell me how convincing a reason it is to support increased assistance -- very convincing, fairly convincing, only somewhat convincing, or not that convincing. **

	Very Convincing	Fairly Convincing	Only Somewhat Convincing	Not That Convincing	Not Sure
We all live on one planet, and the whole world benefits from fighting the spread of AIDS--if the epidemic has spread that much in Africa, we are fooling ourselves if we think that it won't affect the U.S.--it will, unless we do something now					
ALL VOTERS	44	14	21	16	5
African Americans	67	12	11	7	3
The AIDS epidemic is creating millions of orphans that are overwhelming the capacities of orphanages and churches, and filling the streets of many African cities. An estimated forty million children will lose a parent to AIDS by 2010					
ALL VOTERS	40	15	23	15	7
African Americans	56	18	17	6	3

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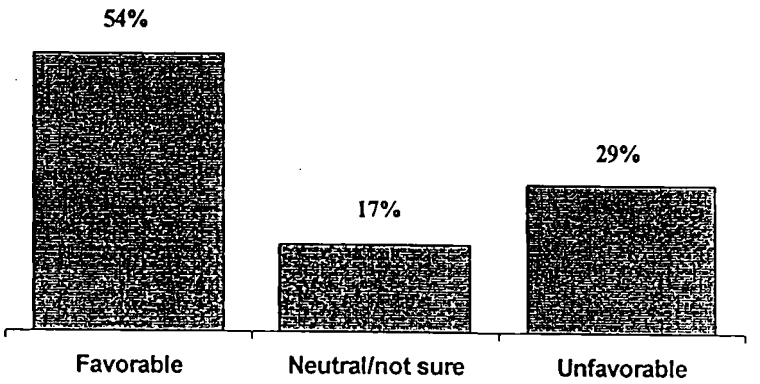

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THE WHITE HOUSE

WASHINGTON

November 3, 2000

MEMORANDUM TO THE PRESIDENT

FROM: Sandra L. Thurman, Director, Office of National AIDS Policy, and Presidential Envoy for AIDS Cooperation

SUBJECT: Response to Your Inquiry Concerning AIDS in Africa

In response to your question regarding what more we can do for people living with AIDS in Africa, here is a brief overview of our recent advances, as well as a few additional opportunities for moving this agenda forward in the remaining months of this Administration.

Resources: As you said in your speech to the U.N. Security Council in September: "Unfortunately, the U.N. has estimated that to meet our goals [to establish basic prevention and care programs for HIV/AIDS], we will collectively need to provide an additional $4 billion a year. We must join together to help close that gap."

To that end, the Foreign Operations FY2001 Appropriations bill contains two key improvements. First, the bill includes $315 million for the global AIDS program at USAID. It is likely that when the remaining appropriations bills are completed, we will have secured an additional $115 million for the CDC, and $10 million each for the Departments of Labor, Defense, and Agriculture – all now part of our multi-sectoral response to the AIDS pandemic. In total, over the past two years, we will have more than tripled our global AIDS prevention and care efforts to $461 million – more than the entire world was spending in FY98. Second, the full funding for debt relief in the bill will free up much needed resources that HIPC countries in sub-Saharan Africa and elsewhere can redirect into HIV/AIDS programs.

Securing these significant funding increases not only demonstrates leadership on the part of this Administration, but gives us the credibility needed to leverage additional action from other stakeholders including:

- challenging our G-8 partners to build on the progress made in Okinawa by pledging significant new resources toward closing the global AIDS resource gap (joining us in doubling or tripling their investments);

- utilizing the upcoming EU and the APIC summits to raise the AIDS issue and to accelerate and enhance the global AIDS mobilization;

- working with multi-lateral lending institutions as well as HIPC governments to encourage the redirection of debt service to AIDS prevention and care activities; and,

- working with Congress, prior to adjournment, to find additional resources for the U.S. contribution to the newly authorized multi-lateral AIDS trust fund to be established at the World Bank (a major Congressional Black Caucus priority).

Leadership and Visibility: We have consistently stated that the global battle against AIDS will take all sectors of all societies working together. It is for this reason we have sought to not only mobilize governments, but corporations, unions, foundations, NGOs, IFIs, etc. We believe that the religious community has a pivotal role to play and a great deal to offer – most of which has yet to be tapped. To that end, as the final deliverable of our LIFE Initiative, we are planning to bring together an extraordinary group of religious leaders from around the world for a summit on AIDS at the White House on World AIDS Day – December 1st. This would provide a timely and critically important opportunity to reframe the dialogue on AIDS as a moral and ethical imperative, and enlist powerful and vital allies. U.S. invitees include Reverend Jesse Jackson, Reverend Leon Sullivan, Ambassador Andrew Young and Dr. Elie Wiesel. Your participation in this event would make all the difference.

11-1-00

S. Thurman
can we do any
more about this

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S. Thurman
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Few Drugs for the Needy

In Poor Malawi, One Man Tries to Beat the Odds

By David Finkel
Washington Post Staff Writer

A1

BLANTYRE, Malawi

The surprise in this diseased and dying place isn't the man with AIDS, it's the sheets on his hospital bed. They're clean. They're ironed. They're a pleasant design of pastels. And most important, they're soft, giving immeasurable comfort to the 50-year-old man who is tucked in between them, listening in silence as his doctor explains what it will take for him to become one of the luckiest people in Malawi.

"So there are two issues you would have to be clear on," the doctor, Jack Wirima, is saying. "The first one is the duration of the treatment. It would have to be taken for a long time."

"For life?" asks the man, whose first name is Yasaya, whose voice is faint, whose arms are well on their way to bones.

"Yes. For the rest of your life. That's the first. And the second is the cost," Wirima goes on, explaining that the price for the treatment works out to about $10,000 a year. The treatment involves three drugs that, taken in combination, can prolong the life of an AIDS patient significantly. In the United States, where the treatment has become standard, the AIDS-related mortality rate fell 75 percent in three years. But in Malawi, which is one of the poorest countries in the world, and one of the sickest, the treatment isn't standard at all.

The number of people who are HIV-positive in Malawi: more than 1 million.

The number on triple-drug therapy, according to interviews and records of drug inventories: 30.

"So," says Wirima. "Let me know."

"Thank you," Yasaya says quietly and settles into his pillow, which matches the bedspread, which matches the sheets, wondering how he will be able to become number 31.

It will take several days for him to sort this through. He will have to decide what to say to his wife, who prays for his health, and sleeps in a chair next to the hospital bed, and tidies him up after he vomits, and has yet to be told he tested positive for HIV, the virus that causes AIDS. He will have to decide what to tell his employer, who he fears won't want to pay for his care, and maybe will no longer want him as an employee if his diagnosis is disclosed (which is why he asked to be identified only by his first name). He will have to decide what to say to his children, and he will have to decide how much of his income he is willing to spend before staying alive becomes, in his own mind, an act of selfishness.

All of which is to say that what happens to Yasaya between the time he learns it is possible to postpone his death and the time he is discharged from the hospital isn't only about AIDS, but about the consequences of privilege in a place that is an unfolding catastrophe.

The place isn't only Malawi but sub-Saharan Africa, and the catastrophe, by now, has been well documented. Of the 34 million HIV/AIDS cases in the world, 24 million, or 70 percent, are in Africa. Life expectancies are down dramatically. The number of orphans has surpassed 10 million. The number of AIDS-related deaths are estimated at 5,500 a day, according to the United Nations.

And so it is in Malawi, a small, densely populated country of 10 million people in south-central Africa. The United Nations reports that AIDS caused 70,000 deaths here last year alone, has created 400,000 orphans since the first case was noted in 1984, has reduced life expectancy from 47 years for a baby born in the mid-1980s to 36 for a baby born now, and has, to this point, infected 16 percent of the adult population.

"These unfortunate 1 million people," is what Wesley Sangala, a top Malawian health official, calls those here who are infected, knowing there is nothing to be done for them. "What can we do?" he says. "Really. What can we do?"

But even in the poorest, most devastated places possibilities exist, and in Malawi they can be found in a 64-bed hospital in Blantyre that is surrounded by a tall iron fence and has a sign above the front door that says, "Right of Admission Reserved."

This is Mwaiwathu Private Hospital, and as the name makes clear, and the sign makes clear, and the fence makes clear, and the guards at the entry gate make clear, it is not for everyone.

Rather, as Wirima puts it, "If you can pay, you can come here," and those who do include government officials, and the Indian business owners who drive around Malawi in Range Rovers, and the man from South Africa who owns two airplanes and comes barreling into the emergency room one night in a bathrobe and loafers with a touch of malaria, and the Malawian business executives whose medical insurance allows them access to a kind of care that most Malawians simply can't imagine.

Yasaya is one of those businessmen. Unlike most Malawians, who live in villages, in hand-built huts that have neither plumbing nor electricity, Yasaya lives in a house with several bedrooms and bathrooms and, dominating the living room, a large TV connected to a satellite dish. At night, he and his wife like to watch movies as they sit beneath family photographs and a wall hanging that says, "Have Faith in God." During the day, when he's not at work, he likes to rest outside in a wicker chair under a large shade tree while his wife sits nearby doing embroidery. It is a pleasant, upper-middle-class existence—or was until Yasaya started to get sick.

Because the town they live in is near Lake Malawi, there are plenty of mosquitoes around, and at first Yasaya suspected malaria. But it turned out to be tuberculosis. Followed by malaria. Followed by illness after illness, and weight loss, and weakness, and lethargy, and a constant cough, and a continuous fever, which is why he wasn't surprised when an AIDS test came back positive.

But even a year of sickness didn't prepare him for how ill he was to become. Late one night when he couldn't stop shaking, he went to the emergency room at the government-run hospital. Like all public hospitals in Malawi, it is severely overcrowded. Patients not only fill every bed, they sleep on the floor. Nurses are scarce. Only the most basic drugs are in stock. And on this night no doctor was available, so Yasaya, still shaking, went home.

And the following morning came to Mwaiwathu Private Hospital.

Where there are flowers in the foyer.

Where the hallways, upon instructions from the hospital administrator, always smell of pine spray.

Where, in a country in which the annual per-capita income is less than $200, the charge for a bed, just the bed, not the doctors, not the lab tests, not the drugs, is $50 a day.

Where in one of those beds, Yasaya is explaining how he might have become infected, saying maybe it was the time he had to carry his dying brother, who was bleeding and too weak to walk.

"Or it could be the condom that broke.

"Or it could be the hospital. Maybe they re-use syringes."

He looks at himself. He is on an IV. He is catheterized. He is, for the moment, alone. His wife is out in the hallway. She is his only wife, even though men are allowed several in Malawi, just as they're allowed girlfriends, which is one of the reasons the infection rate among women between the ages of 25 and 29 is 32 percent.

"It was sex, basically," he says after awhile.

"But I don't know who."

Dying in Silence

What he also doesn't know: Very much about antiretroviral drugs, which, though not a cure for AIDS, have had a dramatic effect on mortality and morbidity rates in developed countries, especially the United States, where the drugs have become a $1 billion-a-year business. He doesn't know about the ongoing debate over worldwide access to these drugs in which certain aid organizations are saying that anything less than *full* access in even the poorest countries is unconscionable, and drug companies are saying there has to be a balance between charity and business, and any number of studies are saying that even if the drugs were available, there are plenty of other problems that would prohibit their administration, from a shortage of trained health care workers to a lack of passable roads. He doesn't know anything about AZT, the first of these drugs, which has now been in use for 13 years. He doesn't know about 3TC, another commonly prescribed antiretroviral often used in tandem with AZT because it was discovered that two drugs can work better than one, or about the subsequent discovery that a third type of drug used in combination with the other two can restore an infected person's immune system to near-normal levels.

It is this third drug, known broadly as a protease inhibitor, that has offered the most hope for HIV/AIDS patients. But Yasaya knows nothing of this, either, or that Mwaiwathu Private Hospital keeps a small supply of a protease inhibitor called Crixivan in a special locked cabinet in the pharmacy.

Or that it is the only place in all of Malawi that stocks Crixivan.

Or that a one-month supply costs about $500.

What he does know:

Five hundred dollars is what he earns a month, after taxes; that there is a house to pay for, and food to buy, and his children's school tuition is coming due, and that "sex, basically" may have been the cause of his condition, but the issue most on his mind is money. He wants the drugs—of course he wants the drugs—but if his company doesn't pay for the treatment, "I would have to abandon it. It would be too costly."

Meaning?

"I

would die. Sooner than later. But sometimes dying is not the end," he says. "I would just relieve myself of certain obligations. If I live, the expectations of my family are very high."

Such are the unsentimental calculations of one man in a hospital bed—and, on a much wider scale, of Malawi itself. Unlike in other countries, the Malawian government at least has acknowledged the scope of AIDS, even producing an official "strategic framework" for dealing with the disease over the next several years. Should there be more AIDS testing? Yes. Should there be more education? Yes. Should there be more "hope, faith, compassion and a spirit of acceptance of the reality of HIV/AIDS among Malawians"? Yes.

But while the plan focuses on prevention, it pays hardly any attention to those already infected. What about them?

"Well, they'll be dying at various rates," says Wesley Sangala, the health official who oversaw the development of the government's plan.

How much of a priority is their treatment?

"In reality, we cannot entertain it," he says, sounding resigned. "It is just too expensive to contemplate. So all we are saying, unfortunately, is that they have to die."

That's the view from the top, and it filters down from there.

Charles Chidoti, a health worker who travels to villages throughout central Malawi to give seminars on AIDS, says he always begins by saying there's no treatment for the infected, even though he knows better. "We suppress information," he says. "I find myself saying nothing about triple-therapy antiretrovirals because I look at the village and think it will be of no benefit to these people."

"They make no war. They are quiet. They are so peaceful that they are dying in silence," is the way that Mayline Mulemba, head of the Doctors Without Borders mission in Blantyre, describes it. Meanwhile, in villages, which is where most Malawians live, people are doing whatever they can for help.

In one village, for instance, a scattering of mud-walled, grass-roofed huts along a dirt trail north of the town of Liwonde, medical help comes in the form of a 42-year-old witch doctor named Mussa Abelu, who diagnoses people by holding a mirror against their stomach, pressing a shell against their chest, listening to the shell, spitting on the mirror, wiping it clean with a brush made from animal hair and staring into it for several minutes. He says he can diagnose and treat tuberculosis, pneumonia, epilepsy, meningitis and malaria, but if he looks in the mirror and sees worms, it means the diagnosis is AIDS, and for AIDS, he says, which is a disease not of the spirits but of God himself, there's nothing he can do.

South of Liwonde, meanwhile, in an even more remote village, the medical help is another witch doctor, 74 years old, his own health in decline, who spends his days in his hut, ants crawling on his legs, flies crawling on his face, cataracts covering his eyes. This is Billy Chisupe, who let it be known several years ago that a cure for AIDS had come to him in a dream—and what happened next shows how desperate for help people are. The most conservative estimates are that tens of thousands of people made their way to Chisupe's village over the course of a year; others say the number was in the millions. So many came that the daily traffic jam stretched for miles, and the original cup of bitter brown liquid turned into 17 huge barrels that were constantly being replenished by government workers who kept things under control. Those who made their way to drink out of cups or bowls or hands included everyone from government officials who denounced Chisupe by day and dipped into the barrels at night, to prostitutes who said they would no longer insist that their customers wear condoms, to health care workers who knew better, to students from the universities, to, one day, an ordinary man, the picture of health at that point, who showed up with his wife and four children.

Yasaya.

"You just take it and believe," he says. "You didn't have to be intelligent about it. It was simple. What do you lose? You take it and forget it."

So he took it.

"The taste was rather flat."

And now he is in Mwaiwathu Private Hospital, waiting for the doctor.

The Chosen Few

Who walks into the room saying, "Hello, hello, hello"?

It isn't Jack Wirima, who had first seen Yasaya. It's a doctor named Cooper Nyirenda, who is covering Wirima's rounds for the weekend, and if there's such a thing as a lucky break for a terribly sick man in Malawi, this is Yasaya's.

"How are you feeling?" Nyirenda asks, flipping open the chart.

"All right," Yasaya says. "I vomited once in the morning. I wanted to brush my teeth, and the smell of Pepsodent was disagreeable." And then he tells Nyirenda of his condition, and of the drugs he hopes to start taking, and of his calculations suggesting he won't be able to.

And Nyirenda, who 16 years ago charted the very first case of AIDS in Malawi, and who tens of thousands of cases later knew exactly what he was looking at as soon as he saw the weary man folded into the pastels, says he might be able to help.

He tells Yasaya that the government of Malawi has in its possession a discreet supply of AZT and 3TC, that he knows this for a fact because he is the doctor in charge of distributing it at Queen Elizabeth Central Hospital, which is the public hospital in Blantyre, and that the drugs are available at a reduced price.

Not to just anyone, though, he says. Not to the majority. Not to what Wesley Sangala of the health ministry calls "these unfortunate 1 million people."

Rather, "The idea is to assist those who can afford," Nyirenda says—and as contorted, and even upside down, as that may sound, the full story underscores how deeply the word "unfortunate" applies to Malawi itself.

Two-and-a-half years ago, at the beginning of 1998, a few government officials were approached by a man named Henderson Namalima, who is the salesman in Malawi for the British pharmaceutical company Glaxo Wellcome, about the possibility of bringing antiretrovirals into the country. As Namalima remembers it, the officials were interested but pointed out that in a country that has a health budget of less than $1 a year per person, and where AIDS competes for attention with malaria, tuberculosis and other out-of-control diseases, there was no way to buy anything so expensive. In turn, Namalima told his company this and suggested that perhaps there could be some kind of a price reduction. Maybe so, he was told, and there things sat until the following year.

How long is a year in Malawi? According to health statistics, long enough for 70,000 Malawians to die of AIDS-related illnesses, according to economic reports, long enough for Malawi's tobacco crop, which is its main export, to have such a miserable season that it caused a 68 percent devaluation of the Malawian currency—which meant that foreign currency already budgeted for Malawi from international donors was now worth substantially more. "A windfall," Sangala says of the surplus suddenly available to Malawi's health ministry from the European Union. And after using the bulk of it to rewire hospitals that had become fire hazards, and pay overdue electric bills that were threatening to shut the hospitals down, and to rebuild Malawi's one deteriorating mental hospital, enough was left over to buy some drugs.

Fourteen months after their first meeting, Namalima and the officials got together again. This time Glaxo offered a 25 percent discount, and this time Malawi, using the last of the surplus, said it had the money in hand.

Deal.

Malawi would get a year's worth of AZT and 3TC.

Except it would only get enough for 50 people, and the drugs would be AZT and 3TC, instead of a newer drug called Combivir, a combined form of AZT and 3TC that was one pill rather than several, which made it much easier to take. Was Malawi buying the medical equivalent of a clearance model? "We wondered about that," says Sangala. "I don't know."

On top of that, it took the government most of 1999 to figure out what to do with the drugs it was getting, including the decision to sell the drugs rather than give them away so that at the end of the year there would be money available to buy more.

Then, when the first shipment from Glaxo arrived, according to Namalima, "instead of sending the antiretrovirals, they sent a different drug, DF 118. It's an analgesic. It was done by mistake. So we had to sort *that* out." Which took another month.

"Then," he continues, "it took the government two to three months to work out the ways the drugs would be distributed."

But at last, in May of this year, two years and four months after the first meeting, the right drugs were in Malawi and the program was ready to begin—which, as it happened, was when Glaxo and four other pharmaceutical companies announced that they were willing to reduce the price of AIDS drugs for poor nations not by 25 percent, as was the deal with Malawi, but by as much as 85 percent.

Too late for Malawi, though. It's deal was done. And as Sangala says, explaining why it would have been pointless to ask Glaxo to redo things, "How could we do that? It would be like asking Mercedes Benz to give us a Mercedes-Benz. It's impossible. It's business. They are in it to make money."

To which Peter Moore, who is Glaxo's medical director for sub-Saharan Africa, says, "I'm not really sure it's our responsibility to be involved in the ethical issues. . . . If our proposals aren't adequate, we need governments to tell us what we could be doing. You know, you can't negotiate in a vacuum."

At any rate, Malawi's antiretroviral program began quietly at the end of May, and as it nears its fifth month, it has 11 participants in the public hospital in Lilongwe and 21 at Queen Elizabeth in Blantyre and that's it—all of which is why Nyirenda says he might be able to help Yasaya.

The price: about one-fourth of what triple therapy would cost at Mwaiwathu Private Hospital.

The tradeoff: The program involves a regimen of two drugs, not three. It is not what Mwaiwathu Private Hospital offers. It is not what Jack Wirima talked about. There is no protease inhibitor. It is dual therapy, not triple therapy, and as Moore says, "Everyone accepts triple therapy as the gold standard."

But as Moore also says, "You have to adapt your standards to the environment," and as Sangala says, "We can't treat everybody, so those who can afford, let's at least help them"—and as Yasaya says now to Nyirenda, "How do I arrange an appointment?"

"You just come to Queens," Nyirenda says, "and ask for Nyirenda."

Another World

And what will Yasaya see when he does this? To someone in Mwaiwathu Private Hospital, how to describe Queens?

Maybe simply by numbers. Queens has nearly 1,000 beds—900 of which are for non-paying patients. Mwaiwathu, by comparison, has 64 beds. Thirty percent of Mwaiwathu's patients have HIV/AIDS-related illnesses. At Queens, it's more than 70 percent.

Or maybe by describing where Nyirenda can be found: down a dark hallway lined with benches of sick people, behind a door with a faded sign on it that reads, "What are you doing about AIDS?", standing by a sink connected to no plumbing, washing his hands with water stored in a plastic bucket that's leaking all over the floor.

Or maybe by watching Nyirenda during the first 15 minutes of one of his typical clinics. In comes a woman being treated for tuberculosis, but she goes with a note saying she should no longer be a schoolteacher. In comes a skinny man with an aching chest, but he goes with a prescription for medicine that the pharmacy may not have. In comes a man even skinnier, then comes a woman with malaria, then comes a pile of bones so weak with tuberculosis that two friends have to carry her in, and that's what 15 minutes is: Five patients, at least three of whom Nyirenda suspects are HIV positive, the last of whom he wants to test so at least she'll know why she is so weak, but who declines. And who can blame her, he says: "She can't afford treatment. So for her it is being sentenced to death."

In comes patient number six, and as Nyirenda tends to him, another doctor, Cecilia Chibwana, makes her way to the far reaches of the hospital. Past the line to see Nyirenda. Past the line for the pharmacy. Past the line for the emergency room. Past the longest line of all, easily a hundred people, on benches, on the floor, leaning against walls, holding children, sleeping, all waiting to enter a room where a woman at a desk will write them a ticket directing them to what line they should go to next.

"It's so frustrating to work here," Chibwana says. "Because you want to do something, but there is nothing. There is a shortage of staff, a shortage of materials, of medicines, of equipment, and the working environment—most people are HIV, and we give them drugs and so on, but it's depressing. There's nothing to do. So it's depressing."

She passes a courtyard filled with women, all women, sitting on mats, lying on grass, lying on dirt, building fires, washing clothing, and she explains they are relatives of patients. "There is a shortage of nurses," she says, "so if there aren't guardians there would be no one to feed the patients, to take them to the bathroom, to make sure they get medication."

In one of the wards, another doctor, James Chipwete, lists the illnesses in the room. "Tuberculosis. Pneumonia. Meningitis," he says of the primary ones, all of which are opportunistic infections of AIDS patients. There are 50 beds in the ward, all filled, all close together, and more patients on the floor. There is tuberculosis next to meningitis next to pneumonia next to meningitis next to tuberculosis, row after row, and as bad as this is, Chipwete makes his way to a small room off the main ward that's even worse.

It has six beds and 11 patients, which means five are on the floor. The same illnesses are in this room as well, but so is diarrhea, which is why these patients are isolated, or at least what passes for isolation at Queens.

This is where a man named Ronald Kolumbi, who is on the floor being held up in a sitting position by his guardian, tugs on the pants of Chipwete and says with whatever strength he can muster, "I'm not okay." And then says, "I want to be okay."

This is where Francis Nyamilandu is lying on a bare mattress, no sheet, no blanket, no pillow, thin beyond description, toes rotting, covered in sores, a fly walking across his dirty teeth. "I want a cover," Nyamilandu whispers, and the nurse says she's sorry but there are none to give him at the moment.

And what could be worse than this?

Except there is something, in the next ward, where Nyirenda, done with his clinic, is making his rounds. He is hurrying from one patient to the next when he hears the sound of someone vomiting and sees it is coming from a man curled up on the floor.

It is a man named Patrick Salama, whose illnesses include tuberculosis, Kaposi's sarcoma and AIDS.

Who until a few weeks before was a patient at Mwaiwathu Private Hospital, and, like Yasaya, was trying to figure out a way to afford antiretrovirals.

Whose unpaid bill was approaching $10,000, and so he had to leave.

"This gentleman, 31 years old, is terminally ill," says the letter in his file, written by one of the doctors at Mwaiwathu, explaining his transfer to Queens. "Kindly take over his management as the cost here has overtaken their income."

Who is now lying on his side in his vomit, mouth open, eyes fixed, motionless.

"He's gone," Nyirenda says.

Every day brings death in Queens. Already this day, just on this ward, there have been two. Nyirenda pulls a sheet as a shroud over Salama's face and goes to the next bed. Behind him come two attendants to take the body away.

They pull back the sheet.

And Salama gasps.

And then dies.

And what can Nyirenda do except move on, move on, move on, looking for the next patient, all of whom seem so much the same. He goes to a young man with jaundice and tuberculosis and asks him to sit up. But the man can't. He just can't, so Nyirenda and another doctor pull him up, and he winces, and he tries not to cry, and all Nyirenda can do is say to him, "Sorry, sorry, sorry, sorry, sorry."

A Plan for Survival

Past the woman in the lobby wearing the neon-green vinyl clogs.

Down the hall with the open windows and the screens to keep out the mosquitoes and the fluttering lace curtains.

Past the nurses' station with a dozen thank-you cards on display from former patients.

Nyirenda is back at Mwaiwathu Private Hospital, hurrying to tell Yasaya that he's come up with a plan—and how simple, how astonishingly simple, it turns out to be in the end.

"This is a suggestion," he says, going into the room.

"Yes?" Yasaya says.

He begins to explain, then opens Yasaya's chart.

"Combivir," he writes, officially ordering a supply of the antiretroviral that is a combination of AZT and 3TC.

"Crixivan," he writes next.

"To be discharged on 3 month supply," he writes next—and Yasaya immediately understands.

Because he was sick enough to be hospitalized, his company will pay whatever the hospital charges are, no questions asked. If a doctor in charge of treatment writes Combivir in the chart, the medical plan will pay for Combivir. If the doctor writes down Crixivan, Yasaya will get Crixivan. And if he writes down "3 month supply," which is the key to Nyirenda's plan, which he has never thought to do but is doing now, it means Yasaya will at least get that far on treatment before his company has a chance to say no.

"Three months," Nyirenda says to Yasaya, closing the chart. "And then you can do the double."

It is not a permanent solution, then, this bit of charting. But it is at least something, and it causes Yasaya to look at Nyirenda and say with gratitude, "I appreciate your consideration."

"So," Jack Wiruna says when he returns the next day and sees what Nyirenda has written in the chart, "it's all sorted out now."

"So," Yasaya says a few minutes later, alone, head bowed, blinking against sudden tears. "Triple therapy."

He is ready to go home. But first there are some things to take care of.

One is transportation. He needs a ride home, but when he phones for the company car he is told it's already in use. A funeral. A fellow employee. The previous afternoon. Just before 5. So he needs to find a way home.

Second, he needs to tell his wife what's ahead for him. He imagines she knows. Surely she knows. There has been his insistence on using condoms, his constant illnesses, his mentions of how short life is, the funerals of friends. "She is aware," he says, not knowing that while he's been on the phone, she's been in another room with Wiruna, asking him what the new medicines are for, watching him shake his head, listening to him say, "You don't know?" "Malaria?" she said. Perhaps on the ride home, Yasaya says, he'll have the energy to tell her. But he is afraid. "Fear," he says, "of how she would respond."

Third, he needs to pray. "Because I don't quite feel good about this," he says. "In the back of my mind, I know I'm a lucky man." But in the front of his mind: "Why should I alone live? To be alone, getting privileged treatment, is very unfair, very un-Christian."

"I am wondering, why me?"

In comes the Combivir.

"One tablet, twice a day," says the nurse.

"One tablet, twice a day," he repeats, and swallows the pill.

He is now a man on dual-therapy antiretrovirals.

But not on triple therapy—because in the end, of course, things *aren't* simple. The pharmacy, it turns out, is out of Crixivan, and the nurses aren't sure what to do, and Wiruna is unavailable, and Nyirenda is over at Queens, and Queens wouldn't have Crixivan anyway, and Yasaya is feeling suddenly wobbly, and finally it is the pharmacist who figures out a solution.

She calls the warehouse of Malawi Pharmacies, where the manager makes his way past the palettes of Good Morning Cough Tablets, past the palettes of Mr. Strong Pain-Killing Capsules, past the anti-malarials, past the analgesics, all the way to a locked room in the very back where, on the second shelf up from the bottom, he finds what he is looking for. It isn't Crixivan, but another protease inhibitor, called Viracept, and an hour later it is delivered to Yasaya.

"Made by Mova Pharmaceutical Corporation, Caguas, Puerto Rico, for F. Hoffman-LaRoche Ltd., Basel Switzerland," it says on the side of the box.

"Licensee: Agouron Pharmaceuticals, Inc., LaJolla, CA USA and Japan Tobacco, Inc., Tokyo, Japan."

All of that, for all of this:

One man in Malawi, who now holds in his hand three pastel-blue pills, which match his pillow, which matches the bedspread, which matches the sheets.

"Okay," he says, swallowing them, and away he goes, out of Mwaiwathu Private Hospital, the 31st person in Malawi on triple therapy, back among the million who aren't.

MEMORANDUM FOR THE PRESIDENT

From: Sandy Thurman

Date: July 21, 1997

Subject: Update on HIV/AIDS Issues for Your Meeting Tomorrow with Gay/Lesbian Leaders

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This memorandum is to provide you with a quick update on current HIV/AIDS issues for your meeting tomorrow with gay and lesbian activists.

Background - While the AIDS groups are grateful for the support the Administration has given them in the past, there is considerable anxiety and doubt regarding our ongoing commitment to this issue. This concern began when AIDS programs (including the Ryan White CARE Act) were not included on a small list of discretionary programs that were listed as protected programs in the balanced budget agreement (neither were many other important programs). The community interprets this action to mean that the issue has been "de-prioritized." In addition, following the release of guidelines for AIDS treatment which advocated more aggressive use of triple drug combinations, the Administration did not request any additional dollars in the 1998 budget for AIDS Drug Assistance Programs (ADAP). (However, it should be noted that we have continually supported increases in ADAP, including 2 budget amendments last year and have always indicated our willingness to consider additional requests for this program.) All this, combined with delays in receiving the report the Vice President requested on Medicaid expansion to people with HIV (due to indications from HCFA that there is no way to make this budget neutral), and that little visible progress has been made on removing the restrictions on federal funding for needle exchange programs, has made the AIDS community a little irritated with us.

We have been working nonstop with the AIDS groups on these issues. The bottom line is, while we have pending issues, it has been a pretty extraordinary year so far for the AIDS community.

Decrease in the AIDS Death Rate -On July 14, the CDC released new figures showing a 19% decrease in the number of AIDS deaths in the first nine months of 1996, compared with the same period of 1995. In contrast with earlier data, the number of deaths due to AIDS among women decreased 7%, and mortality numbers dropped for all racial groups and categories of HIV transmission. The CDC attributed these findings to greater access to medical care and the development of effective therapies for HIV and associated opportunistic infections. AIDS advocates noted that as AIDS death rates drop, there are increasing numbers of individuals living with HIV who require access to these lifesaving interventions. Clearly, our investment in

the AIDS epidemic is beginning to pay off as a significant achievement, given increasing AIDS deaths and infections worldwide. ***It is important to note, however, that there is no evidence that the number of new HIV infections is slowing indicating that prevention and education efforts must be reinforced.***

Funding Issues - In the House Appropriations subcommittee mark-up, the full $40 million increase in the Administration's FY 1998 budget request for the Ryan White CARE Act programs was provided, with some reallocation of the increases among Ryan White programs. In addition, the mark up included a $132 million increase for ADAP in the Chairman's mark. No formal budget amendment was sent forward by the Administration for this, given the size of the offset. You may want to take this opportunity to formally support this increase. OMB asserts that this increase is going to happen anyway, so we might as well take credit for it. The community will obviously appreciate your support.

The House subcommittee increased funds for AIDS prevention by $5 million ($12 million below budget request) and AIDS research by $73 million ($33 million above budget request). The Senate Labor/HHS subcommittee's 602B allocation is $200 million below the House's, making it less likely that the Senate will fund AIDS programs at the House levels. In VA/HUD, the Housing Opportunities for People With AIDS (HOPWA) program has been funded at the budget request of $204 million (an $8 million increase).

Model Clinical Practice Guidelines for Treatment of HIV Infection - On June 19, an independent panel of experts convened by HHS and the Kaiser Family Foundation published treatment guidelines for antiretroviral therapy in adults and adolescents. The draft guidelines address a critical need among providers as to how to best to use new AIDS drugs most effectively. The guidelines recommend a more aggressive approach to treatment using triple drug combinations at earlier stages of HIV infection to avert immune system damage.

While the draft of these guidelines is not technically a government document, issues of payment for this new standard of care clearly confront us. HHS has stressed that the responsibility for HIV treatment is shared one by the federal government, states, private and non-profit sectors and individuals each playing an important role. The additional $132 million in ADAP funding included in the House Appropriation's subcommittee is a good start towards trying to address expanding demand for these new therapies.

Medicaid Expansion for HIV Infection - On April 9, the Vice President requested that HHS report to him on the feasibility of a Medicaid demonstration project expanding Medicaid eligibility to people with HIV infection prior to the onset of full-blown AIDS. Currently, over 50% of people with AIDS depend on Medicaid for their health care. New AIDS therapies like the protease inhibitor drugs have been effective in delaying disability and reducing hospital costs for many people. This has raised speculation about whether the question if earlier access to drug therapies and primary care would prove cost-effective for Medicaid as well as other public spending for services to people with HIV/AIDS.

HHS briefed the Vice President's office in late May/early June and is now working to address

budget concerns. HHS will likely submit a report to the Vice President in the next few weeks. The report will likely say that it would be feasible to do a demonstration program limited to several sites but with capped enrollment. This demonstration, however, would not be budget neutral, and thus would represent a break in our longstanding budget neutrality criteria in Medicaid waivers. There are some at HHS and OMB who believe that it would be preferable for the Administration to support full legislation to change the Medicaid program to cover this population earlier rather than break our budget neutrality standard. However, this proposal would be quite expensive.

Needle Exchange Programs - The House Appropriations subcommittee for Labor, Health and Human Services marked up their bill on July 15, preserving the authority of the Secretary of HHS to lift the restrictions on use of federal funds for needle exchange programs. HHS does not expect a challenge to this at full committee next week, it is pursuing a strategy of watchful waiting, maintaining a low profile for as long as possible. Most of the AIDS groups accept this strategy as long as the Secretary's authority is not endangered. We held a meeting at the White House last week with the AIDS groups and HHS to facilitate communication on this issue.

MEMORANDUM

To: Maria Echaveste
From: Sandy Thurman
Date: March 28, 2000
Re: **Briefing Memo for Meeting on AIDS Trust Fund**
March 31, 2000 at 12:15pm

Background: AIDS is now considered the worst health catastrophe since the bubonic plague. By 2005, more than 100 million people worldwide will have become HIV+, 16,000 more each day. In several African nations, more than 1 in 5 adults is already infected and in the next decade, 40 million children on the continent will be orphaned by AIDS. It is increasingly clear that HIV is far more than a health crisis, raising serious economic and security threats. And what is now happening in Africa, will soon be happening in India and the Newly Independent States. This realization led Ambassador Holbrooke and the Vice President to engage the UN Security Council in a historic day long session on the global threat of AIDS. Given the growing awareness of the magnitude of this pandemic, the public, the press, and even the Congress are jumping on the bandwagon.

Administration Action: As you know, the global battle against AIDS has been a high priority for the President, the Vice President, and the Administration at large. With your help, we led a fact-finding mission to Africa last year which resulted in the President proposing, and the Congress enacting, a $100 million increase in our global AIDS effort. This FY2000 "LIFE (**L**eadership and **I**nvestment in **F**ighting an **E**pidemic) Initiative has enabled us to double our HIV prevention and AIDS care program in Africa. For FY2001, the President has proposed another $100 million increase to further enhance this effort.

Outstanding Need: According to UNAIDS, an effective HIV prevention program in Africa will cost $1 billion. Currently, all donors and host governments combined are spending less than one quarter that amount. In addition, a very basic AIDS care program in Africa would cost an additional $1 billion, and all donors and host governments combined are spending less than one-tenth that amount. Although we have made great strides in the last 18 months, much more remains to be done if we are to stem the tide of this growing tragedy.

Congressional Action: Over the last year, and mostly within the last few months, a variety of bills have been introduced – from both parties and in both chambers [see attached chart]. While it may have once seemed unthinkable, it now appears likely that the Congress will pass global AIDS legislation this session.

- **House**: Last week, Chairman Leach favorably reported a freestanding World Bank AIDS Marshall Plan Trust Fund Act from the Banking and Financial Services Committee. This bill merges Rep. Leach's AIDS Trust Fund with Rep. Lee's AIDS Marshall Plan. At the mark-up, the bill was doubled in size by an amendment put forward by Rep. Maxine Waters and now authorizes $1 billion over the next 5 years.

- **Senate**: This week, Chairman Helms and Senator Biden offered an amendment to the Foreign Assistance bill in the Senate Foreign Relations Committee that authorizes $510 million for global AIDS in FY2001. This amendment, which passed unanimously, includes $300 million for USAID's global AIDS program ($46 million more than proposed in the President FY2001 budget request) as well as a World Bank AIDS Trust Fund proposal similar to that passed by the House Banking Committee. In addition, Senator Hatch has floated a version of the World Bank AIDS Trust Fund proposal with conferees on the Africa Trade bill.

Political Landscape: The World Bank Trust Fund bill, having been passed by the committees of jurisdiction in both the Senate and House, now has considerable support and momentum. This support includes the strong backing of moderate Republicans as well as the Congressional Black Caucus, and for all practical purposes, is the brainchild of Ron Dellums, the new chair of the Presidential Advisory Council on HIV/AIDS. If the Administration seeks to maintain a leadership position on the global AIDS issue, it is critically important for us to engage the Congress. While my phone has been ringing off the hook from Members of Congress seeking "informal technical assistance", it is getting increasingly uncomfortable to have to deny more formalized Administration support.

I believe that securing the additional $100 million for our LIFE initiative should be our top priority. However, I am very concerned that, if we do not work with our friends on the Hill in crafting a comprehensive package, we will end up at the end of the session fighting over whether the $100 million for global AIDS should be invested in our initiative or theirs. The simple answer is – a problem of this magnitude requires both bilateral (our effort) and multilateral (theirs) approaches. As the Rev. Jesse Jackson said at a forum he and I did together a few weeks ago, "while I appreciate the Administration's effort to secure another $100 million, that is like trying to put out a raging fire with teaspoons of water".

Recommendation: I believe that we should strongly consider working closely with our allies in the Congress to secure the enactment of our additional $100 million for the LIFE initiative **and** the World Bank AIDS Marshall Plan Trust Fund. These approaches should be framed as complimentary rather than competitive. This would enable us to maintain our leadership role, to protect our initiative, and to help shape a congressional proposal that is likely to become law to our satisfaction. This could be accomplished in one of the two following ways.

(1). Despite the fact that the World Bank AIDS Trust Fund was not included in the President's budget, we could support it with the stipulation that funds should not be diverted from other essential programs in an already overburdened 150 account. We could say that we are willing to work with the Congress to identify the offsets needed. To date, both OMB and Treasury have been concerned that this could detract from other Administration priorities.

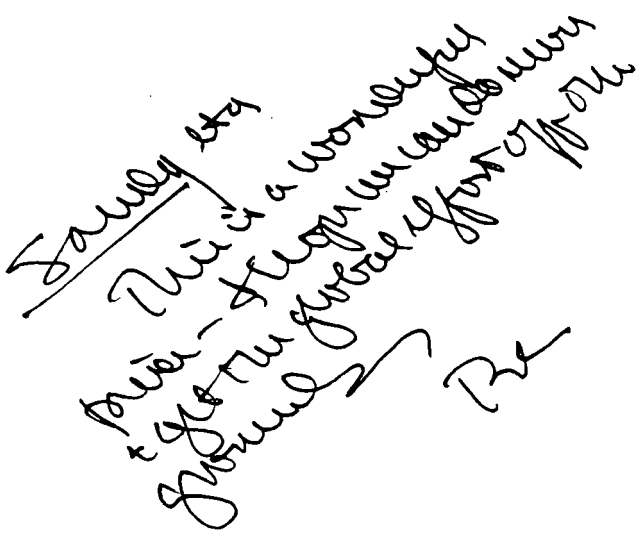
(2). We could stay within the President's budget and support the World Bank AIDS Trust Fund with the stipulation that these funds would have to be set-aside within the existing World Bank allocation. In our FY2001 budget, we proposed that between $400 and $900 million within the Bank be set-aside for improving health in Africa. Consistent with this proposal, $100 to $200 million could be targeted to HIV/AIDS.

To date, Treasury has not been comfortable with this approach. Their concerns are two-fold. First, they are anxious about an "AIDS-specific" approach. And secondly, they are not sure that trusts funds are efficient. While I agree that other infectious diseases and health issues are important, AIDS in Africa is far from a single issue. Like poverty, AIDS cuts across all sectors of society. If we fail to deal with AIDS, all other development gains (health, education, trade, and civil society) will be lost. On the flip side, if we develop the infrastructure needed to deal with AIDS, all other areas will benefit. As for the efficiency of trust funds, I believe that our allies in the Congress would welcome suggestions from Treasury for how they might increase the effectiveness of their proposal.

As a result of the President's leadership and your support, this issue is finally receiving the attention it deserves. As we move into our last legislative and budget cycle, I hope that we can secure this legacy in a way that makes everyone comfortable.

As always, thank you for your patience and support.

4-12-00



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Berger
Podesta
NSC W/H Desk
Sandy Thurman

4-12-00

Africa's Plague, and Everyone's

By Nadine Gordimer

JOHANNESBURG

Sixty-nine percent of the world's victims of H.I.V and AIDS are in sub-Saharan Africa. This figure is not easy to take in. AIDS seems to have come upon everyone while we were looking the other way: it happened to some sex or color other than our own; it was endemic to some other country.

In South Africa it was quite some time before the realization that the disease was not the unfortunate problem of our poorer neighboring countries, but was our own. Now, out of South Africa's 43 million people, about 4 million have been infected by H.I.V. and a further 1,700 are infected daily. Recently, in a Johannesburg home caring for orphaned or abandoned babies born with AIDS, there was a service in memory of 40 who had died there not long before. While South Africa is the most highly developed country on the African continent, we are faced with this kind of future for the generations to come.

But every community, every affected country, has to decide how to approach what is no longer a problem but a catastrophe. There is prevention, and there is cure. The ideal is to seek both at once, but this is beyond the capacity of most countries where the disease is rampant.

Cure, and prevention by inoculation, are not within the capacity of lay people; these are in the hands of medical science, which implies money to be provided to advance research. Immediate prevention is in the hands and initiative of each population itself.

I believe we cannot emphasize bluntly enough that the cure and vaccine development depend on money. And until recently, the country that has the money, the United States, perhaps inevitably has concentrated on a vaccine for a subtype of AIDS prevalent in the Northern Hemisphere. It was only at the World Economic Forum's meeting this year that President Clinton announced that large-scale aid for vaccine development would be forthcoming from the United States. Only now has the International AIDS Vaccine Initiative announced a third international development project, based on those subtypes of the virus most prevalent in the direly affected regions of Southern and East Africa, the subtypes C and A.

It is encouraging that the project is being pursued in wide collaboration among researchers of the United States, South Africa, Kenya and Oxford University, and that the philosophy of the initiative is that of "social venture capital," meaning that in return for financing, it has secured rights to ensure that a successful vaccine, when it is achieved, will be distributed in developing countries "at a reasonable price." The formation of an International Partnership Against HIV/AIDS in Africa is to be welcomed as extremely important in the same context.

The question of money — price — is vital in terms of the palliatives available to arrest the disease and alleviate symptoms. It is another piercing example of the gulf between the world's rich and the world's poor that the suffering from AIDS may be alleviated, and even the lives prolonged, of those victims who can afford expensive treatment. The same principle applies to prevention. Everywhere in Africa moral and humanitarian decisions are a common dilemma, with money the deciding factor.

At the level of international — global — responsibility, the total sum needed annually for AIDS prevention in Africa is on the order of $2.3 billion. Africa currently receives only $165 million a year in official assistance from the world community.

Other questions that rest with the world community become relevant:

> H.I.V thrives on a paucity of hope among the poor and of love among the rich.

debt relief for developing countries, for example. The director-general of the World Health Organization said last year that debt relief should be reviewed in light of the resources that governments with large debts need to confront H.I.V.

The role of governments in financing is another example. Where does the defense budget not far exceed the public health budget to combat AIDS? Nevertheless, what H.I.V. and AIDS mean to the capability to govern, ultimately, was revealed in South Africa by the minister of public service and administration in February. The public service is the largest employer in the country and the fundamental government structure. In 1999, one in eight South Africans was H.I.V.-positive. It is estimated that 270,000 out of 1.1 million public servants could be infected by 2004. This looming crisis in governance exists almost everywhere on the African continent. If, in developing countries, defense budgets continue to leave H.I.V. budgets relegated to a footnote, all we shall have left to defend in the end is a graveyard.

AIDS is not only a health catastrophe, a challenge to medical science. It is socially enmeshed in the conditions of life that obtain while it spreads, just as the medieval plague was in its time. Although AIDS is no respecter of class or caste, slum conditions, ignorance and superstition (it is a white man's disease; it is a black man's disease) make the poor its greatest source of victims.

In working to prevent the spread of the virus, we must accept the idea that promiscuity is difficult to condemn when sex is the cheapest or only available satisfaction for people society leaves to live on the street. On another socioeconomic level, casual sex thrives among young people who are materially privileged yet whom society has failed to endow with the real values of human sexuality, the knowledge that fulfillment involves contact with the other's personality, that the sexual act is not some mere bodily function like evacuation — which is what some campaigners seem to reduce it to.

There are subtleties, important ones, connected with any campaign against H.I.V. and AIDS, if it is to succeed in changing attitudes toward sexual mores. For there will be a cure discovered, there will be a vaccine — and after that? How shall we restore the quality of human relations that have been debased, shamed, reduced to the source of a fatal disease? The free condom dispenser is not the panacea. Neither, alone, is sex education restricted to anatomical diagrams and dire warnings in schools. The entire meaningfulness of personal sexual relations will need to be restored. That is what social health means, along with inoculation and survival.

Self-interest cannot be discounted. So, to the developed world, a pragmatic word from the stricken African continent: Call not to ask for whom the stock exchange bell tolls and the figures on the computer sound the alarm — the toll is for Europe, for the United States, even for those countries where H.I.V. and AIDS victims are few. For if the markets and vast potential markets for the developed world's goods fail — if decimated populations mean there is no one left economically active with money to spend — that bell tolls for thee, globally.

H.I.V./AIDS is everyone's disaster. It has, finally, something to do with our whole manner of existence. It confronts us with questions that must be answered historically: What have we done with the world, politically? What are we doing with the world? What do we mean by development? Some Ugandans who had been in the audience of an AIDS information play were asked what message it had brought them. One said, "Don't go out with bar girls." Another said, "Stick to one partner." Then an older woman said: "AIDS has come to haunt a world that thought it was incomplete. Some wanted children, some wanted money, some wanted property, and all we ended up with is AIDS."

Maybe she spoke for Africa. □

Nadine Gordimer, who was awarded the Nobel Prize for Literature in 1991, is a goodwill ambassador for the Race Against Poverty project of the United Nations Development Program.

The New York Times

TUESDAY, APRIL 11, 2000

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
004. memo	Sandra Thurman to President Clinton re: AIDS in South Africa (4 pages)	04/27/2000	P1/b(1)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office
Sandra Thurman
OA/Box Number: 40015

FOLDER TITLE:
Memos to POTUS [3]

2018-0764-F
jm2014

RESTRICTION CODES

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

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RR. Document will be reviewed upon request.

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

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5-15-00

AIDS Drug Discounts Offered to 3rd World

By David Brown A1
Washington Post Staff Writer

Five pharmaceutical companies have agreed to drastically lower the prices they will charge for AIDS drugs used in developing countries.

Although the agreement announced yesterday by the United Nations AIDS agency (UNAIDS) so far amounts to little more than a statement of principles, the goal appears to be to price AIDS drugs such that manufacturers get little or no profit from their sales in poor countries.

To take advantage of the rock-bottom prices, however, a country's medical system would have to be able to test for the AIDS virus, counsel people found to be carrying it, deliver the drugs in a timely fashion, and monitor the health of patients taking them. In many places, the cost of that medical "infrastructure" may be prohibitive, even if the drugs aren't.

Nevertheless, the announcement may turn out to be an epochal moment in the 20-year-old AIDS pandemic.

"It is a breakthrough in the sense that for the first time, a group of pharmaceutical companies are open to significantly decreasing the price of their products in poor markets," said Peter Piot, the head of UNAIDS, which is sponsored by U.N. agencies, the World Health Organization and the World Bank.

"Industry has taken a very big step in making pricing and profits no longer a major point of contention in the AIDS control discussion," said Nils Daulaire, president of the Global Health Council, a lobbying organization for international public health issues. "Now we can turn to issues of developing care programs, and better prevention programs."

The price of AIDS drugs has been a source of rancor ever since AZT, the first one, was introduced in 1987. With the rise of life-extending, health-restoring "combination therapy" in recent years, the cost of treatment has become a cruel symbol of the epidemic's inequities.

Of the 34 million people around the world infected with human immunodeficiency virus (HIV), 95 percent live in developing nations. Close to 70 percent live in sub-Saharan Africa, where few people are able to afford the $10,000-a-year, three-drug combinations used in the United States and other industrialized nations.

Triple-combination therapy reduced AIDS mortality in the United States 42 percent in 1997, the first full year the drugs were introduced. In some clinics with highly experienced practitioners and patients able and willing to take the pill-heavy combinations, deaths dropped by two-thirds.

The drug companies agreeing in principle to lowering prices are Glaxo Wellcome (headquartered in England), F. Hoffmann-La Roche (Switzerland), Boehringer Ingelheim (Germany), and Bristol-Myers Squibb and Merck (both United States).

Representatives of the last two were present at the United Nations in early December when Secretary General Kofi Annan convened a meeting to establish an "international partnership" to address AIDS in Africa. Subsequently, the other three companies expressed interest in greatly improving access of their products to developing countries. Piot and Daniel Tarantola, the senior policy adviser to Gro-Harlem Brundtland, head of the World Health Organization (WHO), intensively negotiated with the companies over the last three weeks.

Both men warned against any feeling that yesterday's announcement, first reported in the Wall Street Journal, was the beginning of the end of AIDS in Africa.

"This is more than we've had before," Tarantola said. "But we have to be aware that there are risks attached to this opportunity, such as the risk of raising expectations unduly and the risk of draining resources from other high-priority health problems."

Piot said the commitment to very low drug prices "is only one step in a complex process. Frankly, it would be outright irresponsible to dump these drugs where they wouldn't be used properly. It would promote [drug] resistance, and wouldn't help the patients anyway."

One of the few hints at how low the prices might go was offered by Glaxo Wellcome, which said it would sell Combivir, which contains the antiviral drugs AZT and 3TC in one pill, for about $2 a daily dose. The current "average global price" for Combivir is $16.50, said Ben Plumley, who manages the company's drug access programs for developing countries.

He wouldn't reveal how much it costs to manufacture the pills, or how much above cost the $2 price is. However, he said the company's objective in setting that price "is really to try to help make a contribution to this public health crisis, rather than open up new markets."

Piot said no rules on pricing had been set. Setting strict guidelines that all five companies—and possibly more in the future—would follow probably would violate antitrust laws, he added. Nevertheless, the prices are expected to be very low.

"Our position is that he benchmark is manufacturing cost and what it takes to get the drugs there [to developing countries]. The actual negotiations are starting now. My expectation is that it will be really production costs, plus a few pennies for everything that is needed so that they won't lose money on it."

UNAIDS in 1998 began a program testing the feasibility of delivering state-of-the-art AIDS treatment in four developing countries—Uganda, Ivory Coast, Chile and Vietnam. The numbers of people affected, however, are trivial. In Uganda, for example, 800 HIV-positive patients are in the program, out of more than 930,000 people infected. In Ivory Coast, 600 people are in the program.

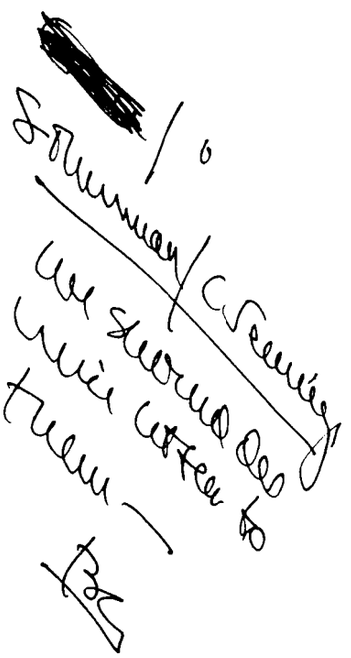
Dismissed by some as ridiculous tokenism, this initiative now will offer crucial lessons in what it takes to deliver triple therapy in resource-poor countries, said its head, Badara Samb.

"We come with the possibility of extending the lessons we have learned," he said.

One of the lessons is that the cost of the professional training, patient testing and equipment has been about $2,500 per patient per year in Uganda and Ivory Coast. (This is about half the cost of the drugs, which with the discounts has been about $5,000 per year for triple therapy.) Especially expensive has been the cost of the "reagents"—chemicals and other items—necessary to run the equipment that measures bloodstream viral load.

Samb said he hopes that with drug companies committed to drastically reducing prices, the firms that sell laboratory stocks will soon follow.

"If we come to a situation where the drugs are much cheaper than the expense of following the patients, then it will be difficult for the companies to maintain those prices," he said.



The Washington Post
Friday, May 12, 2000

5-15-00

S Thurman

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Thurman
Jennings
Podesta
Burkhardt
(for reply)

5-15-00

After you have seen,
we will send to
Burkhardt for reply.

Carl

THE WHITE HOUSE
WASHINGTON

THE PRESIDENT HAS SEEN
5-8-00

May 5, 2000

MEMORANDUM FOR THE PRESIDENT

FROM: LISEL LOY
JUSTIN COLEMAN

SUBJECT: Recent Information Items

We are forwarding the following recent information items:

(A) **Thurman memo re: AIDS in South Africa.** In response to your question regarding a *Washington Post* story about President Mbeki's comments on HIV/AIDS, Sandy provides a background memo on AIDS in South Africa. NSC has reviewed and concurs with the memo, with one exception: in the memo's final section on USG/SAG cooperation, Sandy describes your Office of National AIDS Policy's activities, including "ensuring participation" by U.S. scientists in Mbeki's scientific review panel, scheduled to meet next week; NSC would stress the importance of "encouraging" American scientists' participation rather than "ensuring" it, so as not to appear to be forcing our views on Mbeki regarding the science of this issue.

(B) **Witt Memo re: NATO Consultations on Civil Emergency Planning.** Director Witt reports on his meetings at NATO headquarters with the Allies and our Euro-Atlantic partners on civil emergency planning. Following NATO's poor performance in the initial stages of the Kosovo refugee crisis, he launched an initiative to strengthen our emergency preparedness; the U.S. continues to assert itself in the civil preparedness community, sharing lessons from our domestic disaster response experience, and developing viable operations and contingency planning capacity. Witt reports that NATO activity in support of State is important and will prove cost-effective, and FEMA is taking steps to strengthen its working arrangements as part of the State/Defense/FEMA operations at the U.S. Mission to NATO and here in Washington.

Item

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Tab B - copied cover and memo to NSC, Podesta

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jm2014

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7-19-99

THE WHITE HOUSE

WASHINGTON

'99 JUL 15 PM 4:35

July 16, 1999

copied
Thurman
Podesta

MEMORANDUM FOR THE PRESIDENT

FROM: Sandra Thurman, Director, Office of National AIDS Policy

SUBJECT: Update on AIDS in Africa Initiative

The Initiative: I am pleased to let you know that we have worked out the specifics of an enhanced US response to the global AIDS pandemic. We are now preparing to launch your global AIDS initiative – Joining Forces for "LIFE" – Leadership and Investment in Fighting an Epidemic. The initiative includes a two pronged strategy: (1) increasing our investment; and (2) leveraging an increased investment from our partners in this fight.

On the money side, the Administration will propose a FY2000 budget amendment to provide an additional $100 million for the global battle against AIDS. This effort will involve USAID, HHS, and DOD, and new funding will be used for HIV prevention, AIDS care and treatment, support for children orphaned by AIDS, and infrastructure and capacity development. We are currently spending $125 million on global AIDS, $74 million of which goes to HIV prevention and AIDS treatment in Africa. This new investment is the largest increase in global AIDS funding at any time and from any donor. This will allow us to double our HIV prevention and AIDS treatment efforts in Africa, as well as to provide new resources to India and other areas. It is my understanding that you have already talked about this with Prime Minister Tony Blair – and we should call on other G8 members to increase their commitment as well.

The Administration will also seek other opportunities to leverage an enhanced commitment from our partners. The First Lady will host a leaders conference on global AIDS with the World Bank, UNAIDS, foundations, and others. The NSC and State Department will promote an African Leaders AIDS Summit and a Religious Leaders AIDS Summit (both of which would seriously benefit from your participation). The Department of Labor and AFL-CIO will host a meeting of union leaders and the Department of Commerce will host a meeting of business leaders. Finally, we will work with the UN who has agreed to host a children orphaned by AIDS conference on World AIDS Day 1999.

The Roll-Out: The Vice President wants to make this announcement. It is currently scheduled to be rolled-out on Monday, July 19th at 1:30pm. The roll-out will include participation by the AIDS, African American, children's, religious, and international leaders and organizations that stood with you in launching this effort on World AIDS Day (December 1, 1998). A young girl we met in Uganda who was orphaned by AIDS is coming to tell her story – and we have asked Archbishop Desmond Tutu to join us as well.

Reducing Mother-to-Child Transmission: As I am sure you saw yesterday, we just got great news back from Uganda where the NIH is running mother-to-child transmission trials. A new drug, nevirapine (NVP), appears to reduce HIV transmission from mother to child by 50%. This appears more effective than an abbreviated "short course" of AZT and only requires one oral dose for the mother at delivery and one dose for the baby within 72 hours. The cost of the two doses of NVP is $4 retail. This is incredibly good news. Nevertheless, a host of additional issues remain including: will additional doses of NVP protect against HIV transmission through breastfeeding; if not, is formula available and workable; how do we reach the 80% of African women who deliver outside of a health facility or the 95% who do not know they are HIV-positive? These new funds will help to explore these issues and will enable us to begin to move forward on expanding access to this intervention.

Thank you again for your ongoing commitment to Africa and to our global battle against AIDS. This effort will surely help to save countless lives.

THE WHITE HOUSE

WASHINGTON

July 16,1999

MEMORANDUM FOR THE PRESIDENT

FROM: Sandra Thurman, Director, Office of National AIDS Policy

SUBJECT: Update on AIDS in Africa Initiative

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Sandra Thurman
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P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
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