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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Duff Gillespie to Barbara Turner re: International Working Group meeting on international AIDS (4 pages)	03/06/2000	P1/b(1)
002. table	re: NSC recommendations on AIDS (5 pages)	03/06/2000	P1/b(1)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office
Sandra Thurman
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FOLDER TITLE:
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2018-0764-F
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RESTRICTION CODES

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

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
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b(1) National security classified information [(b)(1) of the FOIA]
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b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Dear Ken,

Given that the tables we have been working with are a bit difficult to read, below follows a more recent update, with backup documents from UNAIDS and DFID that may also help.

US Additional USG appropriation of $100 m in FY 00 and another $100 m in FY 01 expected for a total USG commitment of $335 m in 01 (includes $10 m in food aid reprogramming by USAID). Of the $235 FY 00 total budget, about $168 m was for Africa. (FY 01 numbers not yet clear).

UK 22.7 million pounds ($36.3 m) in new funds was announced by PM Blair in South Africa for HIV/AIDS. Of this amount, 14 million pounds was for IAVI, 1.2 million pounds for training UK Voluntary Service Overseas volunteers, and 7.5 million pounds for a southern Africa regional project (over 5 years, or 2.5 million pounds per year). This translates into a potential of 17.7 million pounds for one year or $28.3 m in one year.

We have heard via UNAIDS that DFID is considering another 27-28 million pound initiative for Asia and HIV/AIDS. Not confirmed as yet.

Canada The attached communication indicates a net increase of $10 CDN per year (about $6.8 M USD) over a base of $15 M CDN/year. The $10 CDN is also for 5 years (e.g., $50 m CDN)

Italy Announced a new $20 m commitment to HIV/AIDS. I presume it will be obligated in one year.

Dutch Has already donated about $1.5 m in new funds to the International Partnership Against AIDS in Africa (IPAA - via UNAIDS).

Norway Contributed $3.6 m to UNAIDS for the IPAA in the 6 priority countries. Unofficially, $5 million additionally may be forthcoming.

Portugal Contributed a new $300,000 to UNAIDS.

Denmark Unofficially, they are considering a new $3-4 m in new HIV/AIDS funds

France A possible new announcement, but nothing yet

Japan Forthcoming??

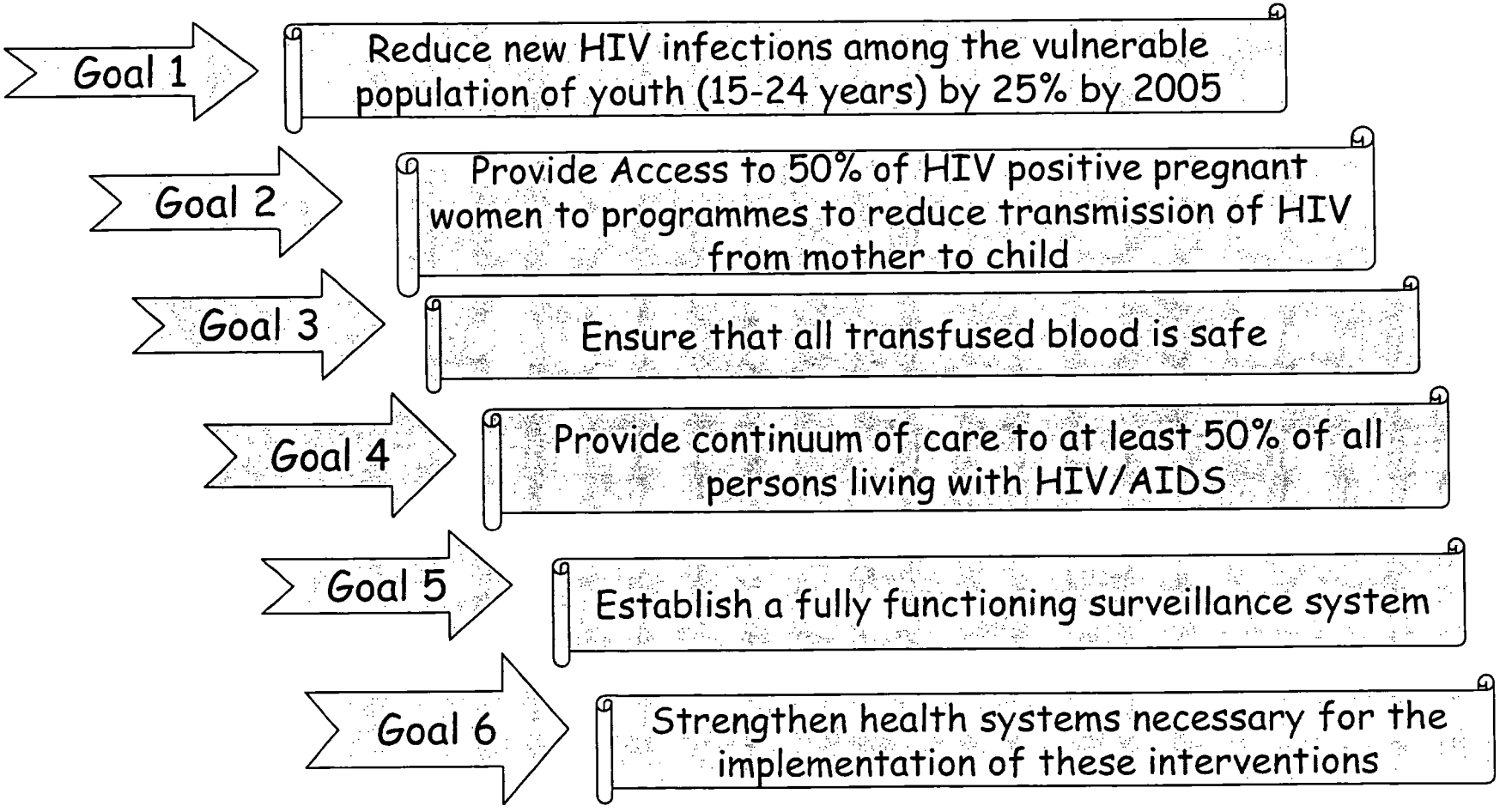
EU Unknown.

PRIVATE

Turner Foundation	$6.2 m for UN AIDS activities in Mozambique and Zimbaber. Another $15-16 m possible for an additional 4 African countries
Gates Foundation	New award to the UNFPA US organization for AIDS work in 4 countries.

Draft: Alex Ross, USAID based on information from UNAIDS 4/16/00

International Partnership Against HIV/AIDS in Africa (IPAA)



Keenan, Josefine (Chris) (HEALTH)

From:	WHSR
Sent:	Thursday, April 13, 2000 12:04 PM
To:	Babbitt, James F. (VP); Byrne, Catherine E. (AF); Cables; Dempsey, Nora B. (AF); Feldman, Daniel F. (MULTI); Mclean, Matthew K. (MULTI); Naplan, Steven J. (MULTI); Patten, Wendy L. (MULTI); Schwartz, Eric P. (MULTI); Smith, Gayle E. (AF); Vaccaro, Jonathan M. (Matt) (MULTI); Wilcox, Richard M. (MULTI)
Subject:	NEW REPORT ON THE MACROECONOMIC IMPACT OF HIV/AIDS
ActionAddees:	RUEHC/SECSTATE WASHDC IMMEDIATE 1288
Classification:	UNCLASSIFIED
DateTime:	131451Z APR 00
Distribution:	SIT: BABBITT BYRNE NSC DEMPSEY FELDMAN MCLEAN NAPLAN PATTEN SCHWARTZ SMITH VACCARO WILCOX
Identifier:	M4394491
InfoAddees:	RUCPDOC/DEPT OF COMMERCE WASHDC IMMEDIATE
Line1:	OAAUZYUW RUEHSAA2860 1041451-UUUU--RHEHAAX.
Line2:	ZNR UUUUU ZZH
Line3:	O 131451Z APR 00
Line4:	FM AMEMBASSY PRETORIA
Originator:	AMEMBASSY PRETORIA
Precedence:	IMMEDIATE
Profiles:	BABBITTJ BYRNEC CABLES DEMPSEYN FELDMAND MCLEANM NAPLANS PATTENW SCHWARTE SMITHG VACCAROJ WILCOXR
StationRoutingIndicator:	RUEHSA
StationSerialNumber:	2860
TimeOfReceipt:	04/13/2000 11:05:51 ET

UNCLAS SECTION 01 OF 03 PRETORIA 002860

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USDOC FOR 4510/ITA/IEP/ANESA/OA/SMILLER

E.O. 12958: N/A
TAGS: ECON, SOCI, TBIO, SF
SUBJECT: NEW REPORT ON THE MACROECONOMIC IMPACT OF HIV/AIDS

REF: 99 PRETORIA 12722

SUMMARY
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1. IN A RECENT REPORT, ING BARINGS ATTEMPTED TO FORECAST THE MACROECONOMIC EFFECTS OF HIV/AIDS IN SOUTH AFRICA. ITS REPORT CONCLUDES THAT THE EPIDEMIC WILL HAVE A PROFOUND IMPACT ON THE COUNTRY'S ECONOMY. THE INFECTION RATES FOR THE ECONOMICALLY ACTIVE POPULATION WILL REACH 26 PERCENT, CONCENTRATED MOSTLY IN THE UNSKILLED OR SEMI-SKILLED WORKFORCE, BUT ALSO SIGNIFICANTLY AFFECTING THE SKILLED WORKFORCE. AS A RESULT, THE STUDY CALCULATES THAT GDP WILL BE ON AVERAGE 0.3 TO 0.4 PERCENT LESS PER YEAR THAN IT WOULD BE WITHOUT AIDS. ACCORDING TO THE REPORT, THE COSTS OF AIDS ARE LIKELY TO INCREASE INFLATION AND DEPRESS DOMESTIC SAVINGS AS WELL AS EXACERBATING THE SKILLS SHORTAGE. END SUMMARY.

INTRODUCTION

2. ING BARINGS RECENTLY RELEASED ITS FORECAST OF THE MACROECONOMIC EFFECTS OF HIV/AIDS IN SOUTH AFRICA. THEY BEGAN BY MODELING THE DEMOGRAPHIC CHANGES LIKELY TO OCCUR AND THEN CONDUCTED LONG-TERM ECONOMIC FORECASTS TAKING THESE CHANGES INTO ACCOUNT. THE REPORT CAUTIONED THAT LITTLE PREVIOUS WORK HAS BEEN DONE ON ECONOMIC MODELING OF THE EPIDEMIC AND SERIOUS GAPS IN THE DATA EXIST.

THE DEMOGRAPHIC IMPACT

3. USING THE ACTUARIAL SOCIETY OF SOUTH AFRICA NATIONAL AIDS MODEL, ING BARINGS FORECAST THAT THE TOTAL POPULATION WILL BE 23 PERCENT LOWER BY 2015 THAN IT WOULD BE WITHOUT AIDS. IN MAKING THIS FORECAST, THE REPORT ASSUMES THAT SEXUAL BEHAVIOR DOES NOT SIGNIFICANTLY CHANGE AND THAT NO MEDICAL ADVANCES OCCUR.

4. OTHER FINDINGS INCLUDED:
--HIV INFECTION RATES WILL PEAK AT 16.7 PERCENT IN 2006 AND THEN START TO DECLINE.
--AIDS DEATHS WILL PEAK IN 2010 AT 1.8 AIDS DEATHS PER 100 PEOPLE AND 256 AIDS DEATHS PER 100 NORMAL DEATHS ANNUALLY.
--APART FROM THE 0-9 AGE GROUP, AIDS DEATHS ARE MAINLY CONCENTRATED IN THE 25-50 AGE GROUP.

5. WITH REGARD TO LABOR FORCE, THE STUDY FOUND:
--THE HIV INFECTION RATE AMONG ECONOMICALLY ACTIVE PERSONS WILL PEAK AT ABOUT 25.5 PERCENT BY 2006.
--THE HIV INFECTION RATE OF UNSKILLED OR SEMI-SKILLED LABOR WILL PEAK AT 32.8 PERCENT AFTER 2015.
--THE HIV INFECTION RATE OF SKILLED LABOR WILL PEAK AT 22.8 PERCENT IN 2006.
--THE HIV INFECTION RATE AMONG HIGHLY SKILLED LABOR WILL PEAK AT 13.1 PERCENT IN 2005.
--AIDS DEATHS OF HIGHLY SKILLED PEOPLE WILL PEAK AT 1.2 PER 100 WORKERS ANNUALLY.
--AIDS DEATHS OF SEMI AND UNSKILLED PEOPLE WILL PEAK 3.4 PER 100 WORKERS ANNUALLY.

MACROECONOMIC ASSUMPTIONS

6. THE REPORT IDENTIFIED KEY ECONOMIC COSTS OF THE HIV/AIDS CRISIS IN SOUTH AFRICA AND SETS FORTH BASIC ASSUMPTIONS ABOUT THEM. THE COSTS INCLUDE:

A) LOWER LABOR FORCE AND PRODUCTIVITY: THE REPORT DETERMINED THAT THE LABOR SUPPLY WILL BE ADVERSELY AFFECTED BY AIDS, WITH SKILLED LABOR COSTING THE ECONOMY MORE. THERE WILL ALSO BE LOWER LABOR PRODUCTIVITY BECAUSE OF ABSENTEEISM FROM ILLNESS OR COPING WITH FAMILY MEMBER'S ILLNESS.

B) COST PRESSURES: COMPANIES WILL BE AFFECTED BY BOTH DIRECT COSTS SUCH AS INCREASED CONTRIBUTIONS TO PENSION, LIFE AND MEDICAL BENEFITS, AND INDIRECT COSTS SUCH AS INCREASED SPENDING ON RECRUITMENT, LEAVE, AND THE NEGATIVE IMPACTS ON CLIENTS. THESE COSTS WILL FILTER THROUGH THE ECONOMY.

	IMPACT ON WAGE COSTS		
YEAR	INCREASE IN WAGE BILL	PASSED TO CONSUMER	IMPACT ON PPI
2015	45 PERCENT	15.0 PERCENT	4.5 PERCENT

(THE REPORT ASSUMES ONLY THE SKILLED AND HIGHLY SKILLED HAVE BENEFITS THAT WILL BE INCREASED)

C) DEMAND CHANGES: THE REPORT ASSUMES THAT THE HIGHER WAGE BILL WILL BE LARGELY ABSORBED BY THE EMPLOYER WHO WILL PASS IT ON THROUGH HIGHER PRICES OR ABSORB IT IN OPERATING COSTS.

THE REMAINING PORTION WILL BE ABSORBED BY THE LABOR FORCE (AGAIN, THE REPORT ONLY CONSIDERS THE SKILLED AND HIGHLY SKILLED SECTIONS OF THE FORCE FOR THIS PURPOSE). THIS IN TURN WILL TRANSLATE INTO A WAGE INCOME THAT IS ALMOST 6

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PERCENT LESS THAN WOULD HAVE BEEN EXPECTED WITHOUT AIDS BY 2010. INITIALLY, HOWEVER, THE REPORT NOTED THAT LOWER POPULATION FIGURES MIGHT ACTUALLY RAISE HOUSEHOLD INCOMES. COMBINING THE TWO, AND ADDING HIGHER DEMAND FOR HEALTH SERVICES, THE REPORT CONCLUDES THAT THE DECLINE IN HOUSEHOLD DEMAND WILL BE GREATEST FOR SEMI AND NON-DURABLE PRODUCTS.

NET CHANGE IN HOUSEHOLD DEMAND IN 2015
PERCENT CHANGE IN DEMAND FOR

RESIDENCES	DURABLES	SEMI DURABLES	NON-DURABLES	SERVICES	SAVINGS
-9.1	-7.8	-9.3	-9.3	5.5	-6.5

D) HIGHER GOVERNMENT EXPENDITURE ON HEALTH SERVICES: THE REPORT ASSUMES THAT THOSE PEOPLE WHO ARE NOT SKILLED OR HIGHLY SKILLED WILL HAVE THEIR MEDICAL CARE COVERED BY THE STATE. USING AN ESTIMATED CURRENT AVERAGE AMOUNT EXPENDED BY THE GOVERNMENT ON AIDS PATIENTS (R3,750), THE REPORT ESTIMATES THE GOVERNMENT WILL HAVE TO SPEND R3,656 MILLION ON AIDS PATIENTS IN 2015. THE REPORT ASSUMES NO CHANGE IN THE COST OR TYPE OF CARE THE GOVERNMENT CURRENTLY PROVIDES. THE REPORT THEN ASSUMES THE INCREASE EXPENDITURE WILL BE FINANCED BY THE BUDGET.

THE FORECAST
---
7. USING THE FIGURES AND ASSUMPTIONS ABOVE, THE REPORT CONCLUDES THAT:
--GDP AND GROWTH WILL BE LOWER DUE TO LOWER CONSUMPTION, BUT INVESTMENT WILL BE STABLE. GDP WILL DECLINE 0.3 TO 0.4 PERCENT A YEAR AS A RESULT OF AIDS, RESULTING IN A GDP THAT IS 4.7 PERCENT LESS AND GROWTH 0.8 PERCENT LESS THAN THEY WOULD BE WITHOUT AIDS IN 2011.
--THE UNEMPLOYMENT RATE WILL DECLINE MARGINALLY.
--THE FISCAL DEFICIT DETERIORATES DUE TO HIGHER EXPENDITURE AND LOWER REVENUE. THE REPORT ASSUMES THE BUDGET DEFICIT IS FLEXIBLE AND THUS THE SAG WILL AVOID FURTHER GOVERNMENT EXPENDITURE DECLINES CAUSING REVENUE TO DECLINE FURTHER AND DRAGGING GDP DOWN FURTHER. INSTEAD, THE REPORT ASSUMES THERE WILL BE MORE PUBLIC BORROWING AND LOWER GOVERNMENT SAVINGS.
--DOMESTIC SAVINGS WILL SUFFER AND WILL NEED TO BE MADE UP BY FOREIGN SAVINGS, WHICH WILL LEAD TO A HIGHER CURRENT ACCOUNT DEFICIT. THE STUDY CALCULATES TOTAL DOMESTIC SAVINGS WILL BE 15 PERCENT LESS IN 2011 THAN IT WOULD BE WITHOUT THE AIDS EPIDEMIC.
--THE CURRENT ACCOUNT DEFICIT WILL BE PUSHED CLOSE TO 3 PERCENT OF GDP.
--HIGHER CPI WILL PUT PRESSURE ON INTEREST RATES AND EXCHANGE RATES.

SECTOR RISK EXPOSURE
---
8. THE REPORT ALSO LOOKED BY SECTOR AT INFECTION RISK AS WELL AS POTENTIAL WAGE COSTS. MINING, GENERAL GOVERNMENT AND AGRICULTURE WERE FOUND TO HAVE THE HIGHEST INFECTION RISK, WITH THE INFECTION IN THESE POPULATIONS PEAKING AT 26 TO OVER

29 PERCENT. FINANCE AND INSURANCE AND BUSINESS SERVICES FACED THE GREATEST POTENTIAL WAGE COSTS. COMBINING THE TWO RISKS, THE STUDY FOUND THAT THE TRANSPORT AND STORAGE INDUSTRY AS WELL AS THE CATERING AND ACCOMMODATION SECTOR ARE THE MOST EXPOSED TO THE AIDS RISK.

CONCLUSION

9. THE STUDY CONCLUDES THAT THE NET EFFECT OF THE EPIDEMIC WILL BE NEGATIVE FOR GROWTH. IT CAUTIONS THAT THERE IS A POSSIBILITY OF A VICIOUS CYCLE IN WHICH COSTS OF DISEASE WILL DRAIN SAVINGS AND EXACERBATE THE ALREADY LOW SAVINGS RATE. THE ECONOMY WILL THEN REQUIRE MORE FOREIGN SAVINGS, BUT THE GROWING RISK PERCEPTION BECAUSE OF AIDS IS UNLIKELY TO LEAD TO FOREIGN CAPITAL INFLOWS. THUS, THE GOVERNMENT WILL HAVE TO TAKE OUT FOREIGN LOANS THAT WILL IN TURN LEAD TO HIGHER CURRENT ACCOUNT DEFICITS. THE DEFICITS WILL PUSH INTEREST RATES HIGHER THEREBY DEPRESSING ECONOMIC GROWTH FURTHER.

10. ALTHOUGH THE SOUTH AFRICAN UNEMPLOYMENT RATE IS OVER 25 PERCENT AND THUS PRACTICALLY MATCHES THE INFECTION RATES FOR THE ECONOMICALLY ACTIVE POPULATION, THE REPORT CAUTIONS THAT EVERY PERSON DYING OF AIDS CANNOT BE REPLACED BY THE UNEMPLOYED. MOST OF THE UNEMPLOYED ARE UNSKILLED OR SEMI-SKILLED LABORERS. EVEN THOUGH MOST OF THE AIDS DEATHS WILL OCCUR AMONG THIS SAME GROUP, SKILLED AND HIGHLY SKILLED PEOPLE WILL ALSO BE SIGNIFICANTLY AFFECTED. THE REPORT THEREFORE CONCLUDES THAT AIDS WILL "EXACERBATE THE EXISTING SKILLS SHORTAGE WITHIN THE ECONOMY."

11. THE REPORT CALLS ON THE GOVERNMENT TO:
--FORMULATE A CLEAR AIDS STRATEGY,
--MOVE FASTER TO DISMANTLE STRUCTURAL OBSTACLES TO FOREIGN INVESTMENT,
--CONSIDER CHOICES ON ANTI-AIDS DRUGS, ESPECIALLY REGARDING

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TRANSMISSION, AND
--FOCUS ON EDUCATION, ACCESS TO CONDOMS AND TREATMENT OF STDS.

COMMENT

12. IN THE FIRST MAJOR STUDY TO LOOK AT THE ECONOMIC EFFECTS OF HIV/AIDS, ING BARINGS PAINTS A DEPRESSING PICTURE. THE AREAS WHERE THE SOUTH AFRICAN ECONOMY IS ARGUABLY THE WEAKEST--SKILLS AND SAVINGS--ARE LIKELY TO BE THE WORST HIT BY THE AIDS EPIDEMIC. IT MAKES APPROPRIATE SAG ACTION ALL THE MORE URGENT.

13. THE REPORT ALSO HIGHLIGHTS THE NEED FOR MORE AND BETTER STUDIES OF THE IMPACT OF HIV/AIDS. USAID IS FUNDING ONE SUCH STUDY WHICH SHOULD FURTHER HELP SAG POLICYMAKERS UNDERSTAND THE IMPLICATIONS OF THE DISEASE.
LEWIS

FAX MESSAGE

U.S. Agency for International Development
HIV-AIDS Division, Office of Health and Nutrition
Global Bureau
Mailing address: G/PHN/HN/HIV-AIDS
3.07–075M, 3rd Flr, RRB
Washington, DC 20523-3700
U.S.A.

To: Ken Bernard
NSC

Phone:
FAX: 456 9390

cc:

From: Paul DeLay, M.D., D.T.M.& H.
Chief, HIV/AIDS Division

Phone: 202 712 0683
FAX: 202 216 3046

Pages: 12
Date: 6/1/00

Subject:

For internal USG use

Preliminary Estimates of the Cost of HIV/AIDS Prevention & Care
For Sub-Saharan Africa

The cost figures reflect the estimated costs of improving the coverage of programme activities at a national scale. The following prevention strategies are costed:

Prevention:
1. Youth-focused interventions
2. Sex Worker interventions
3. Strengthening of public sector condom distribution
4. Condom social marketing, male condom only
5. Strengthening STI services
6. Voluntary counselling and testing (VCT)
7. Workplace interventions
8. Strengthening blood transfusion services
9. Interventions to reduce mother-to-child transmission (MTCT), including VCT
10. Mass media campaigns
11. Start up capacity building (for weakest countries)

Care:
1. Palliative care
2. Clinical management of opportunistic infections
3. Home based care
4. Treatment for HIV infected infants
5. Support for orphans
6. Psychosocial support and counseling
7. ARV

The figures presented are given in US $ (2000 value). These costs give an idea of the magnitude of resources which need to be spent next year, if one hopes to reach the scale of the target coverage levels in 2005.

Table 1. Grouping of Countries by Existing Strength of HIV/AIDS Programme Activities

Estimated Programme Strength			
Very Low	**Low**	**Medium**	**Strong**
Angola	Benin	Botswana	Cote d'Ivoire
Congo	Burkina Faso	Burundi	Senegal
Djibouti	Burundi	Cameroon	Uganda
Eritrea	*Chad*	Central African Rep.	
Ethiopia	*Equatorial Guinea*	Kenya	
Liberia	*Gabon*	Lesotho	
Nigeria	Gambia	Malawi	
Sierra Leone	Ghana	Mozambique	
Somalia	Guinea	Tanzania	
Zaire	*Guinea Bissau*	*Namibia*	
	Madagascar	South Africa	
	Mali	*Swaziland*	
	Mauritius	Zambia	
	Niger	Zimbabwe	
	Rwanda		
	Togo		

Note: Figures for countries in italics extrapolated from other countries within same group

Table 2: Baseline and target coverage assumptions for 2005

Coverage assumptions										
			Very Low		Low		Medium		Strong	
Form of intervention	Potential target group	Measure of coverage	Baseline	Target	Baseline	Target	Baseline	Target	Baseline	Target
Youth focused interventions In school youth	Male and female youth enrolled in school. 6 – 11 12 – 16	Proportion 6 – 11 receiving HIV education Proportion 12 – 16 receiving HIV education	5% 20%	50 % 80%	5% 20%	50% 80%	10% 30%	50% 80%	20% 50%	50% 80%
Youth focused interventions Out of school youth	Males and females 12 – 16	Proportion 12 – 16 receiving HIV education	5%	50%	5%	50%	10%	50%	20%	50%
Sex worker interventions	4% urban women aged 15 – 49. Average 2 sex acts per week	Proportion total reached Proportion using condoms often	20% 10%	60% 70%	20% 10%	60% 70%	40% 20%	60% 70%	50% 30%	60% 70%
Strengthening public sector condom distribution	All sex acts with non-regular partners 20% sex acts in regular partners	Proportion using condoms often in non-regular partnerships Proportion using condoms in regular partnerships	10% 2%	70 % 2%	10% 1%	70% 2%	20% 2%	70% 2%	40% 2%	70% 2%
Condom social marketing	All sex acts with non-regular partners 20% sex acts in regular partners	Proportion using condoms often in non-regular partnerships Proportion using condoms in regular partnerships	10% 2%	70% 2%	10% 2%	70% 2%	20% 2%	70% 2%	40% 2%	70% 2%
Strengthening STI services	Men and women with curable STIs and access to health services	Among those with access to health services, proportion of curable STIs treated by health service	5%	30%	5%	30%	15%	30%	20%	40%
Voluntary counselling and testing	Current sexually active population	Proportion receiving VCT urban Proportion receiving VCT rural	1% 0 %	5% 5% (including MTCT testing)	1% 0%	5% 5% (including MTCT testing)	1% 0 %	5% 5% (including MTCT testing)	1% 1%	5% 5% (includir MTCT testing)
Strengthening blood transfusion services	Blood for transfusion	Proportion units of blood for transfusions tested Urban Rural	 70% 70%	 100% 100%	 70% 70%	 100% 100%	 90% 75%	 100% 100%	 90% 90%	 100% 100%
Mother to child transmission	Pregnant women aged 15 – 49	Proportion pregnant women tested HIV Urban Rural	 0.5% 0%	 10% 5%	 0.5% 0%	 10% 5%	 0.5% 0%	 10% 5%	 0.5% 0%	 10% 5%
IEC / mass media	National campaigns for entire country	Number campaigns per year	2	6	2	6	2	6	2	6

TABLE 3: Low and high cost estimates for sub-Saharan Africa

BILLIONS US$ 2000

	LOW	HIGH
PREVENTION		
Youth focused interventions	.226	.335
Interventions focused on sex worker interventions	.105	.199
Increased public sector condom provision	.013	.037
Condom social marketing	.076	.149
Strengthening STI services	.467	.554
Voluntary counselling and testing	.044	.160
Workplace interventions	.082	.100
Strengthening blood transfusion services	.003	.011
MTCT	.005	.014
Mass media	.099	.105
Start-up capacity development (very low only)	.003	.012
TOTAL PREVENTION (billions US$ 2000)	**1.120**	**1.664**
CARE		
Palliative care	.035	.042
Clinical management of opportunistic infections	.174	.245
Home based care	.024	.076
Treatment for HIV infected infants	.014	.020
Support for orphans	.107	.177
Psychosocial support and counseling	.003	.005
ARV	.110	.350
TOTAL CARE	**.467**	**.914**
TOTAL PREVENTION AND CARE	**1.587**	**2.578**

Summary:

Total cost for sub-Saharan Africa: between 1.6 and 2.6 billion per year (in order to achieve targets by the year 2005). Prevention targets for the weakest countries are similar to what was achieved in countries like Thailand and Uganda, where the response had a major impact on the epidemic. ARV scaling up to similar levels as TB care (working on that, to get better figures).

Targets (examples):

Condom social marketing: Condom use with non regular partners about 70% (up from current levels between 10% and 40%)

ARV: coverage from 0.5% of those who need it up to about 5%.

Level and flow of international resources for the response to HIV/AIDS:

1998 Update

Introduction

During its sixth meeting in May 1998, the UNAIDS Programme Coordinating Board recommended that the UNAIDS Secretariat continue to monitor national and international resource flows to HIV/AIDS on a long-term basis. The Secretariat was advised to build on its experience with the UNAIDS Secretariat/Harvard School of Public Health study on 1996-1997 HIV/AIDS financing to establish sustainable monitoring processes.

Following this recommendation, in mid-1999, the UNAIDS Secretariat joined an ongoing collaboration between UNFPA and the Netherlands Interdisciplinary Demographic Institute (NIDI) to collect information on the official development assistance disbursed to HIV/AIDS by donor countries. In the aftermath of the International Conference on Population and Development, UNFPA and NIDI have been collecting on a yearly basis data on the national and international resource flows to population activities including HIV/AIDS. UNAIDS collaborated in the 1998 data collection. During this process, the UNAIDS Secretariat has collaborated closely with UNFPA, NIDI and the donor country members of the Development Assistance Committee (DAC) to improve existing HIV/AIDS data collection methodologies.

In addition to these efforts to collect information on donor country allocations to HIV/AIDS, the UNAIDS Secretariat is also collecting information on UNAIDS Cosponsor HIV/AIDS allocations as well as country-level resource flows. Data on the Cosponsor HIV/AIDS expenditure were collected during the preparations for the Unified Budget and Workplan, 2000-2001 (see the Unified Budget and Workplan, 2000-2001, Addendum 1). Efforts to further improve the quality of these data will be part of the joint United Nations planning and programming process. Finally, the Secretariat has made substantial progress in the development of a country database on the national responses to the epidemic including data on country-level resource flows to HIV/AIDS.

This paper presents the 1998 HIV/AIDS official development assistance collected from fourteen of the twenty-two DAC member countries. Almost 80% of the official development assistance disbursed by DAC member countries in 1998 came from these fourteen countries - Australia, Belgium, Canada, Denmark, Finland, Germany, Japan, the Netherlands, Norway, Sweden, Switzerland, the United Kingdom and the United States. All available data suggest that they also provide at least 80% of the official development assistance disbursed for HIV/AIDS activities in 1998.[1]

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[1] *All information on level and flow of official development assistance was taken from "Development Assistance Committee International Development Statistics." OECD website: http://www.oecd.org/dac/htm/dcdrsd-e.htm, 22 May 2000*

Level of 1998 official development assistance to HIV/AIDS

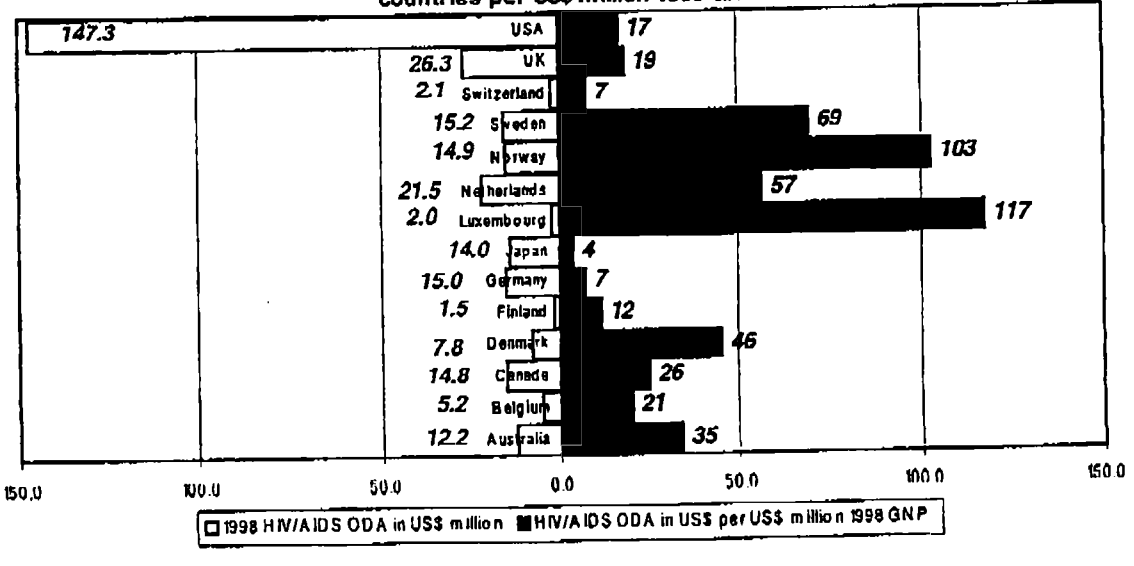
Australia, Belgium, Canada, Denmark, Finland, Germany, Japan, the Netherlands, Norway, Sweden, Switzerland, the United Kingdom and the United States reported having disbursed almost US$ 300 million for HIV/AIDS activities in developing countries and countries in transition in 1998 (Table 1).

Table 1. HIV/AIDS ODA Disbursements for Selected Donor Countries at Current Prices and Exchange Rates, 1998

Donor country	1998 HIV/AIDS ODA (US$ million)	Percent of total 1998 HIV/AIDS ODA
Australia	12.2	4%
Belgium	5.2	2%
Canada	14.8	5%
Denmark	7.8	3%
Finland	1.5	<1%
Germany	15.0	5%
Japan	14.0	5%
Luxembourg	2.0	1%
Netherlands	21.5	7%
Norway	14.9	5%
Sweden	15.2	5%
Switzerland	2.1	1%
UK	26.3	9%
USA	147.3	49%
Total	**300.0**	**100%**

The United States was by far the largest donor of HIV/AIDS ODA, disbursing US$ 147.3 million (49%). The United Kingdom and the Netherlands were the next largest donors disbursing US$ 26.3 million (9%) and US$ 21.5 million (7%) respectively. But when allocations are broken down as a proportion of gross national product (GNP) for each country, the picture is quite different.[2] Luxembourg and Norway disbursed the largest proportion of their country's GNP to HIV/AIDS activities in developing countries with US$ 117 and US$ 103 per US$ million GNP respectively (Figure 1). The United States and the United Kingdom disbursed US$ 17 and US$ 19 per US$ million GNP respectively.

Figure 1.HIV/AIDS ODA as reported by 14 donor countries: Total amount obligated, 1998, in US$ million and obligations reported by donor countries per US$ million 1998 GNP



[2] *Information on donor country GNP was taken from "Development Assistance Committee International Development Statistics." OECD website: http://www.oecd.org/dac/htm/dcdrsd-e.htm, 22 May 2000*

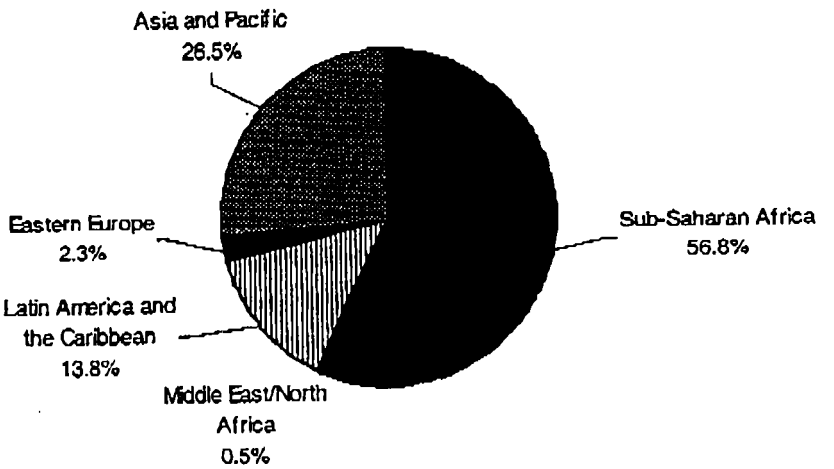
Another way to assess the level of HIV/AIDS ODA by individual donors is to consider HIV/AIDS ODA as a percentage of total ODA. In this case, Luxembourg, the United States and Australia disbursed the highest percentage of total ODA to HIV/AIDS activities with 1.8%, 1.7% and 1.3% respectively. On the other end of the scale, Japan, Switzerland and Germany disbursed 0.1%, 0.2% and 0.3% of total ODA to HIV/AIDS activities respectively. Overall, the US$ 300 million allocated to HIV/AIDS by the fourteen DAC member countries in 1998 represent 0.7% of the US$ 41 450 million that they disbursed in total ODA for that year.

Flow of 1998 official development assistance to HIV/AIDS

Of the US$ 300 million in ODA that were allocated to HIV/AIDS in 1998, 20% was channeled through multilateral agencies. Of the funds channeled through the Untied Nations and its specialized agencies, almost all (95%) were core budget contributions or supplemental funding for general agency HIV/AIDS activities. Only 5% of the funds channeled through multilateral agencies were multi-bilateral – or channeled through multilateral agencies for projects in specific countries. The large majority of the 1998 HIV/AIDS ODA reported (80%) was transferred directly to recipient governments or channeled through non-governmental organizations and other private institutions.

An additional way to assess the flow of HIV/AIDS ODA is to review the regional distribution of these funds. Over one third (35%) of the US$ 300 million reported was earmarked for "global or inter-regional activities." It is not possible to disaggregate these funds though a substantial proportion - including core contributions to the UNAIDS Secretariat – are eventually allocated to regions. Of the remaining 65% (US$ 195 million), 56.8% was earmarked for activities in sub-Saharan Africa (Figure 2), 26.5% was allocated to activities in Asia/Pacific; 13.8% to activities in Latin America/Caribbean; 2.3% to activities in Eastern Europe; and 0.5% to activities in the Middle East/North Africa region.

Figure 2. Distribution of regionally allocated HIV/AIDS ODA disbursements for selected donor countries, 1998

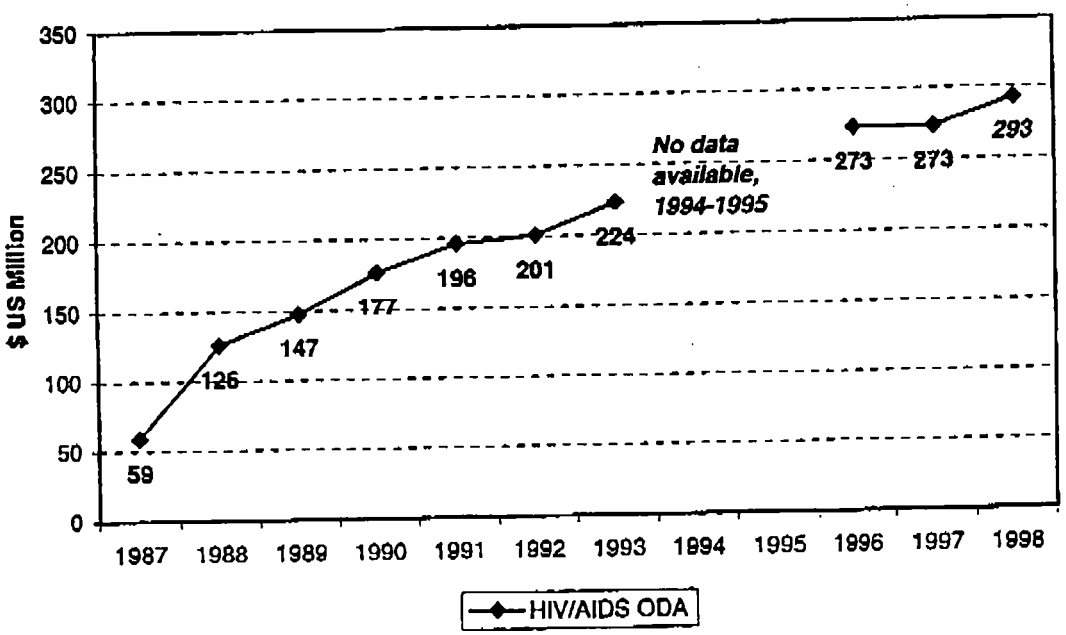


Trends in official development assistance to HIV/AIDS, 1987-1998

The 1998 data for the 10 donor countries for which data are available over time - Australia, Canada, Denmark, Germany, Japan, the Netherlands, Norway, Sweden, the United Kingdom and the United States - confirm most of the trends highlighted in the "Level and flow of national and international resources for the response to HIV/AIDS, 1996-1997."[3]

When inflation and changes in purchasing power parity are taken into account, the flow of HIV/AIDS ODA from these 10 countries increased each year from 1987 to 1996, remained stable between 1996 and 1997and continued to increase between 1997 and 1998 (Figure 3).

Figure 3. Total HIV/AIDS ODA Disbursements by Selected Donor Countries at 1997 Prices and Exchange Rates, 1987-1998



Similarly, when trends in the flow of HIV/AIDS ODA are compared to the trends in overall ODA for these countries, the proportion of HIV/AIDS ODA within the total pot of ODA does increase slightly between 1987 and 1998 from 0.2% to 0.7%.

Finally, the trend in the decreasing flow of HIV/AIDS ODA through United Nations agencies is also confirmed with the 1998 data. This trend has been longstanding (since 1987), but reviewing only the last 3 years; donor countries decreased the HIV/AIDS ODA that they channeled through multilateral and multi-bilateral channels from 26% of all HIV/AIDS ODA in 1996 to 22% in 1997 to 20% in 1998.

[3] *Trend information also based on Mann J & Tarantola D, ed., AIDS in the World II (New York, Oxford: Oxford University Press, 1996) and Mann J, Tarantola T, eds., AIDS in the World (Cambridge, London: Harvard University Press, 1992)*

Issues and next steps in the monitoring of official development assistance to HIV/AIDS

- The UNAIDS Secretariat has made significant progress in establishing sustainable processes for the monitoring of donor country resource flows to HIV/AIDS on a long term and sustainable basis, but some key issues remain.

- Some major DAC members including France and the European Commission continue to have major difficulties in the reporting of their official development assistance allocated to HIV/AIDS.

- There continue to be differences in the ways that different donors define HIV/AIDS activities. This is particularly problematic the monitoring of HIV/AIDS components within integrated development projects or HIV/AIDS allocations within sector wide approaches and common basket funding schemes.

- Because of administrative differences among the DAC member countries, including differences in fiscal years, there is a significant delay in reporting. It is only possible to report on donor country HIV/AIDS expenditures almost 2 years late (i.e. reporting on 1998 data in mid 2000).

- Working closely with the DAC, UNFPA and the Netherlands Interdisciplinary Demographic Institute (NIDI), the UNAIDS Secretariat plans to convene a meeting of donor country representatives to agree on a common methodology for reporting on HIV/AIDS components within integrated development projects and HIV/AIDS allocations within sector wide approaches and common basket funding schemes.

- To supplement its monitoring of donor country HIV/AIDS obligations, the UNAIDS Secretariat is in the process of establishing a process to systematically monitor pledges and allocations to HIV/AIDS.

strategies to promote the sustainable access to drugs, such as the encouragement of local manufacturing and import practices consistent with national laws and international agreements acceded to. It further encouraged UNAIDS to actively support countries in the development, implementation and financing of care strategies that enhance the overall effectiveness and sustainability of national responses to HIV/AIDS such as clinical guidelines, drug administrative and control management, diagnostic infrastructure and follow-up mechanisms.

11. The PCB took note of a proposal to organize a meeting under UN auspices on access to care for HIV/AIDS. In this respect, the feasibility of such a meeting should be further analyzed in the appropriate UN fora.

12. The UNAIDS Secretariat should, in collaboration with Cosponsors and other international organizations, work with countries at their request, in regularly updating databases in order to provide member states with information on prices of HIV-related drugs.

AIDS and Debt Relief

At their Summit last June, G-7 leaders endorsed a new initiative spearheaded by the President to enable Heavily Indebted Poor Countries (HIPCs) to receive deeper, broader and faster debt relief. Under the so-called Cologne Initiative, international financial institutions are developing a new framework for linking debt relief with poverty reduction. The goal is to boost resources for priority social expenditures, including health, child survival, AIDS prevention and education, as well as improve transparency in government budgeting and consultation with civil society in the development and implementation of economic programs. Together with earlier debt relief commitments, the Cologne Initiative provides for reduction of up to 70 percent of the total debts for these countries, decreasing the stock of debt from about $127 billion today to as low as $37 billion with the cancellation of official development assistance (ODA) debt by G-7 and other bilateral creditors. As part of the initiative, the President announced in September that the US would seek to write off all of the $5.7 billion it is owed by as many as 36 heavily indebted poor countries. Last fall, Congress passed part of the funding and authority necessary for the United State's full participation in the initiative, and the President is seeking approval of the remainder this year.

Since most of the potentially eligible countries are located in Sub-Saharan Africa, the Cologne Initiative has the potential to make a major contribution to HIV/AIDS treatment and prevention in the region. Nevertheless, some have suggested that in light of the scale and urgency of the HIV/AIDS problem in Africa, additional debt relief initiatives for countries suffering from the pandemic should be considered. Among the additional efforts that could be explored are:

a) Provision of debt relief for countries that face an HIV/AIDS emergency but are not eligible for the Cologne Initiative.

Pros: Could free up additional resources for HIV/AIDS in countries such as Nigeria, Botswana and other countries not eligible for Cologne framework.

Cons: Could undercut Administration efforts to persuade Congress to support funding of the Cologne Initiative given additional budget costs. As a unilateral initiative, could result in implicit US taxpayer subsidy for debt repayments to other international creditors. Debt relief is a blunt instrument for combating HIV/AIDS relative to increased bilateral and multilateral assistance.

b) Creation of debt relief mechanisms targeted to the HIV/AIDS problem, for example through establishment of a "Debt-for-HIV/AIDS" debt swap program in which a reduction in foreign debt service obligations would be accompanied by a commitment to increase local currency public health expenditures on the treatment and prevention of HIV/AIDS.

Pros: Could free up additional domestic resources for the fight against HIV/AIDS in a targeted fashion and without appearing to weaken eligibility requirements for HIPC/Cologne Debt Initiative relief. Could provide a targeted means for recognizing, rewarding, and offsetting the costs of cooperation with the US policy in other areas (e.g., peacekeeping).

Cons: Debt swaps, in particular, would require new legislative authority. Would require a potentially complex structure in which a third party (NGO, foundation, quasi-governmental entity) would have to purchase US debt and possibly administer local currency public health expenditure arrangements. Opposed by USDA and Eximbank, which hold the majority of non-concessional USG loans.

c) Expanded U.S. Export-Import Bank financing of medicine, medical equipment, and medical services delivery in hard-hit countries.

Pros: Could increase availability of latest medicines, supplies, and personnel from private sector sources in Africa countries.

Cons: Unclear whether there would be significant interest in such non-concessional financing.

Debt-for-AIDS Swaps. A debt-for-AIDS program would require legislative authorization – which we do not have – and appropriations action from Congress, whether it has a budget impact or not. A debt-for-AIDS swap would involve three parties: the creditor, the debtor, and a third party. A creditor country (the US) initiates the debt swap by selling its claim (loan note) on a debtor country to a third party at a discount. The third party then sells this claim to the debtor country for a premium above its purchase price, usually in local currency. Please note that if a country is not servicing its debts, then there is no benefit to swapping out its debt: there is no cash flow (from debt service) to re-route to an AIDS alleviation program.

Pros – Frees up budget resources for AIDS alleviation programs in recipient countries that are servicing their debt obligations to the USG.

Cons
- Requires a third party willing to finance the purchase of USG debt;
- May require separate appropriations (to cover budget costs) if there is no third party or if loans are purchased at prices less than their value;
- Requires sound macroeconomic framework conditionality, at the very least;
- Swapping of non-concessional debts is not supported by EXIM or USDA, which administer the majority of the non-concessional loan portfolio of the USG and have charters that conflict with the objectives of debt-for-development swaps;
- May have negative impact on country's monetary or fiscal policy if the swap is structured as a lump-sum repayment of debt balance (even though it is discounted).

Debt Reduction for Non-HIPCs. For FY 2000, we have appropriations to grant debt reduction under just two programs for countries that are not classified by the World Bank as "IDA-only": under section 572 of the 1989 foreign assistance appropriations act, for the cost of reducing loans to Sub-Saharan African countries or to relatively least developed countries that were made under the Foreign Assistance Act; and under section 411 of the PL-480 statute, for the cost of reducing loans to least developed countries made under PL-480. However, since these appropriations have been justified for debt reduction for HIPC countries, any other use of these funds should be notified to Congress. In general, debt reduction is not – as stipulated by Congress – considered foreign assistance.

Pros – Frees up budget resources for social or other targeted programs in recipient countries that are servicing their debt obligations to the USG.

Cons
- Could undercut support in Congress for the HIPC program;
- May benefit other official creditors if done unilaterally, since resources freed up by debt reduction could be used to service debt to other creditors;
- Assumes recipient country services its debt to the USG:
  1. if it does, then the cost to reduce its debt will be high given its creditworthiness
  2. if it does not, then there is no benefit given lack of cash flow to re-route;
- May have negative impact on investor confidence in recipient economy, particularly the country's current and future access to capital markets;
- May encourage other countries to cease paying obligations to the USG in anticipation of receiving similar treatment from the USG.

Helen.Walsh@do.treas.gov
04/28/2000 02:42:17 PM

Record Type: Record

To: Kenneth W. Bernard/NSC/EOP

cc:
Subject: debt reduction for non-hipcs and debt for aids swaps -Forwarded

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Date: 04/28/2000 02:08 pm (Friday)
From: Helen Walsh
To: kenb
Subject: debt reduction for non-hipcs and debt for aids swaps
-Forwarded

Date: 04/28/2000 01:10 pm (Friday)
From: Luyen Tran
Subject: debt reduction for non-hipcs and debt for aids swaps
To: walshh
Cc: loweryc, kaplanm, donovanst, barberf
MIME-version: 1.0
Content-type: multipart/mixed; boundary="Boundary_(ID_IKGE/8c7RUnmTqJGRVNyIw)"

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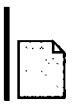
helen, as i mentioned on the phone, attached
has been cleared by francine barber and bill
scheurch. it can be distributed to the
working/deputies group.

 - DEBT_F~3.DOC

Alex Ross <aross@afr-sd.org>
05/17/2000 11:16:39 AM

Record Type: Record

To: See the distribution list at the bottom of this message

cc:
Subject: [Fwd: Re: Revised USG Battle Plan]

Ken and Laura,

Here is the revised version that incorporates some edits from Mike Iskowitz and for which we are comfortable with.

Regarding your question, Ken, on coverage. This is tough. When you look at the sheet that Paul had sent over with the breakout of the $3 billion, you will see what it would purchase (for Africa) and some sense of coverage. It does not appear that we have one number to reflect what % of the African population the entire $3 billion would cover.

Indeed, there is a great deal of difference between covering people with mass media messages vs. intense treatment. So here is a rough guide referring to the table you have:

Prevention ($1.03 b)
Mass media would cover 100% of the African population (on the order of 620 million people in sub-Saharan Africa)
More intense behavior change targeted at 30% of those in need (e.g., truck druvers, CSW, etc). I cannot give you a denominator figure here.

CARE AND TREATMENT ($1.3 billion)
If you divide $1.3 b by $194/yr/person, you end up with 6.7 million people (but that probably includes the various types of interventions).
[There are 22+ million people living with HIV/AIDS in Africa, presumably not all need care right away)
For an additional $14 million, coverage for 1.1 million with cotrimoxazole.

TESTING AND COUNSELING ($470 million)
15% of adults 15-49 in sub-Saharan Africa (or 261 million people) = 39.15 million people

CARE FOR VULNERABLE CHILDREN ($390 million)
Coverage of 7.8 million children

MTCT ($120 million)
We expect this would cover (VCT, drug, administration, breast feeding, and cost of case finding). Uses an overall prevalence rate for Africa

as a whole of 8%. There are 25.4 million pregnancies in Africa (assume 8% of women infected).

Rough coverage is 1.7-2 million people.

A sidenote, these budget numbers above total more than $3 billion, yet what we are saying is that AT LEAST $3 billion is needed.

Hope this helps

Alex

-------- Original Message --------
Subject: Re: Revised USG Battle Plan
Date: Wed, 17 May 2000 09:14:24 -0400
From: Cheryl_S._Bauerle@opd.eop.gov
To: Alex Ross <aross@afr-sd.org>

here it is - thanks!

(See attached file: USG BATTLE PLAN.doc)

 - USG BATTLE PLAN.doc

Message Sent To:

Kenneth W. Bernard/NSC/EOP
Laura L. Efros/OSTP/EOP
Paul Delay <pdelay@usaid.gov>
Sandra Thurman/OPD/EOP
David Stanton <dstanton@usaid.gov>

Preliminary Estimates of the Cost of HIV/AIDS Prevention For Sub-Saharan Africa

Lilani Kumaranayake and Charlotte Watts

September 5, 1999

Prepared for UNAIDS

1. Purpose

The purpose of this note is to provide preliminary costs estimates of HIV/AIDS prevention strategies for Sub-Saharan Africa (SSA) and a number of sub-regions within SSA.

These cost figures reflect the estimated costs of improving the coverage of programme activities at a national scale. The following prevention strategies are costed:

1. Youth-focused interventions
2. Sex Worker interventions
3. Strengthening of public sector condom distribution
4. Condom social marketing, male condom only
5. Strengthening STI services
6. Voluntary counselling and testing (VCT)
7. Strengthening blood transfusion services
8. Interventions to reduce mother-to-child transmission (MTCT), including VCT
9. Mass media campaigns

2. General Approach to Estimation of Cost Figures

a. Background: Currently, there is very little information available on the relative cost and likely impact of each intervention in different settings, either individually or in combination. When compiling these costs there are two challenges: first, to obtain any available costs for these prevention strategies from the empirical literature and second, to scale-up these costs for national programmes.

Due to the low national coverage of many interventions, even when cost information is available, it is generally obtained at the individual facility or project level, operating on a small-scale (e.g. community or district).[1] For this reason, we adopt a model-based

[1] However, unit costs themselves change with the scale of activity. Economists hypothesize a "u-shaped" cost curve whereby for a certain scale of activity, unit costs decline as the level of activity or output increases (e.g. economies of scale), and then after a minimum point (the minimum efficient scale), unit costs are thought to rise, displaying diseconomies of scale. Thus projection of costs by using constant unit costs may be biased. For example, if one were to scale up the project and there were economies of scale, then unit costs would decline as the scale of activity increased, and total costs would go up by less than $125. Conversely, if diseconomies of scale were present, a projection based on average costs would underestimate the costs of expanding the project.

There have been very few alternatives offered to the linear projection of unit costs. Rowley and Anderson (1994) use a pure modeling approach to project costs. They use a very generic specification of unit costs, based on factors such as the target population, and then make assumptions about the relative size of average costs between different types of programs. However, given the lack of reference to existing data and cost structures, this pure modeling approach may not be robust to different settings (Watts and Kumaranayake, 1999). Over (1986) uses a combination of data and knowledge about the project to consider costs of scaling-up a project. He establishes a minimum efficient scale of production for the program and then derives unit costs from this. However, this requires a working knowledge of

approach to estimate the required scale of the prevention strategies and then to estimate the likely costs for these strategies, based on existing cost data. The development and use of this model used has been documented in Kumaranayake and Watts (1999), referred to as KW99.

b. Modelling Strategy:

The modelling strategy was developed by discussion with UNAIDS technical staff. There were a number of useful revisions suggested for KW99, however given time-constraints, we were unable to incorporate them, as this required substantial re-programming of the model.

This paper estimates the costs of undertaking each of the prevention strategies at both a regional and sub-regional level. At the sub-regional level the countries were grouped into four categories according to estimated programme strength for HIV/AIDS prevention activities. ('very low', 'low', 'medium' and 'strong'). The classification of countries is given in Table 1.

Estimates were then made of the current level of coverage in each of the 4 sub-regions, by type of intervention. Target levels of coverage for 2005 were set for each of the prevention strategies. These target levels were based on what was felt to be realistically possible to achieve in a five year time-period by UNAIDS technical staff. The existing and target levels of coverage are presented in Table 2.

The model was then used to estimate the additional costs of reaching these higher levels of coverage, taking into account the assumed levels of existing coverage.

3. Interpretation of Cost Figures

The figures presented are given in US $2000. These costs give an idea of the magnitude of resources which need to be spent next year, if one hopes to reach the scale of the target coverage levels in 2005. **This cost is in addition to the current level of spending, which is used to support existing activities.** In general these costs are given for the level of direct service or project provision. There are a few issues to note:

a. Institutional and capacity constraints to scaling up: While in theory we should be able to scale the costs of projects for any level of activity or target group for each form of intervention, we have only attempted to cost what may be potentially feasible levels of implementation. Thus for example, we have only costed MTCT activities for those women having access to ante-natal and health services. The level of coverage then relates to this potentially feasible level of implementation. In general, we have not tried to cost levels of implementation that require wholesale changes in infrastructure. We do not provide cost estimates of the capacity development that is required to implement

each program in a country-specific context.

these scaled-up activities, with exception of the 'very low' group. It is assumed that among these countries additional investment is required to "jump-start" programme activities, and we have added a costing component for this.

b. Use of Annualised Costs: There is a differential timing in terms of when costs of certain inputs are incurred and when their benefits or use occur over the life-time of a programme intervention. For example, the purchase of capital items and start-up components (e.g. recruitment and training of staff, social mobilisation and IEC campaigns) will occur at the beginning of the intervention, but their use/benefit will be over the duration of the project. For other input categories, the purchase and use of the items will be reflected completely in the current year's costs. In order to obtain total costs, we need to add these two categories together in a consistent fashion. This is done by calculating the annual equivalent cost of those capital/start-up items, and then adding them to other costs. We thus use these 'annualised' costs as the basis of estimation.

In practice these annualised costs will then give you a good idea of the overall resource requirements for an intervention, over the life-time of the project. However, the actual budgetary requirements may be different depending on the extent of the capital and start-up activities which are required at the beginning of the intervention.

c. Impact not considered: This analysis does not look at effectiveness or the likely impact of different prevention strategies. The achievement of coverage targets is reliant on both resource availability as well as the implementation of effective programmes. Effectiveness will also depend on intangibles such as political commitment. Issues related to impact have not been considered in this note.

d. Requirements for priority-setting: While costs are important in examining resource requirements for different activities, prioritisation between different activities should also consider their likely and differentiated impact in various settings.. It is only when both costs and effectiveness are considered together, that we can compare alternatives in terms of their success in averting HIV infections. Given the absence of overall impact information, this analysis does not quantify the likely benefits achieved by the different interventions, and only serves as a guide for the determining resource requirements for each strategy.

e. Double-counting: As we have adopted an intervention-by-intervention approach to modelling costs, there is the danger of double-counting a particular activity found across different interventions. This is particularly important for the public sector condom distribution and condom social marketing interventions. Currently target levels are set at 70%, and so the combined cost estimates of these two strategies will substantially over-estimate the resources required to meet the potential demand for condoms. This double-counting can be eliminated if assumptions are made about the relative importance of achieving these programs.

4. The Resource Determination Model - KW99

This section briefly reviews the methodology used for the calculation of these figures. KW99 adopts a two-fold approach to generating cost estimates for scaling-up HIV/AIDS activities to a national level. First, available demographic, behavioural and epidemiological data are used to determine the size of the relevant target groups or population groups for which the prevention and care interventions are designed to reach. This is referred to as the potential target group (PTG). Second, facility or project-level cost data from the published and grey literature provide baseline unit costs, which are then used to scale-up and provide national estimates under various coverage scenarios, by strategy. Table 2 also provides a summary of the PTG for each intervention.

- The model estimates the costs for each strategy using context-specific estimates of the PTG by different strategies. The model only attempts to cost what may be potentially feasible levels of implementation, given current capacity development.

- The unit costs used in the calculations are drawn from a range of projects in Sub-Saharan Africa. These are used to consider the total costs for each strategy. The model estimates the costs of implementing the HIV prevention activities to a national level, considering different target levels of coverage in urban and rural areas.

- The model uses a unit-cost methodology to attribute costs to each strategy, and these unit cost-measures are specific to each PTG. This means that unit costs vary between intermediate and process measures[2]. Thus the unit costs themselves are not sufficiently comparable between strategies to allow for direct comparison of relative costs. The cost measure to be used for comparison should be the total costs of each strategy.

- Given the uncertainties associated with the data, the model uses a range of cost data, to present low-medium-high cost scenarios for scaling up of national programme activities.

- Ideally, a regional or sub-regional figure would be based on a national estimate of the cost of providing each strategy on an individual country basis and then summing up these national figures, to obtain a regional number. However, data were only available for 26 countries. Estimates were done on a country-basis and then aggregated to the regional and sub-regional level. For countries with missing

[2] There are a range of possible outcomes associated with an intervention. Immediate or process outcomes measure the level of activities or outputs associated with the intervention. For example, this could be the number of condoms distributed or the number of peer educators trained. An intermediate outcome, reflects intermediate changes due to the intervention of the project, necessary before there is a health impact. Examples of intermediate outcomes are the number of people educated in peer sessions or the number of people successfully treated for an STI. Impact or final outcome measures include the number of HIV infections averted, and are in practice difficult to obtain outside the clinical trial environment. HIV infections averted are generally estimated by the use of modelling methods.

information, cost estimates were extrapolated from other countries in the sub-region. Projected total population in the year 2000 was used to weight these figures when calculating the regional and sub-regional aggregates. The sum of the total population of the countries listed in Table 1 was used as the basis of calculation.

- A widely-used approach to scaling up unit costs is to use a linear function to scale up. This is done by taking the unit cost associated with a program and then multiplying this by a factor reflecting activity at a larger scale (e.g. if the unit cost per person is $5 for 100 people, the increase in expanding the program for another 25 people is $125). For simplicity, we have adopted this approach.

5. Unit Cost Figures

KW99 compiled available costs for HIV prevention activities in sub-Saharan Africa. Based on available data, an annual unit cost was then calculated, based on the relevant unit cost measures for each activity. Hence the original studies presented figures for a variety of different years, we have converted them to constant US dollars for the year 2000 using the average annual inflation rate, as measured by the GDP deflator (World Bank, 1997b) for the period between 1985-1995[3]. We also use this rate to present US dollars in constant dollars for the year 2000.

For this preliminary assessment, we have assumed one cost-structure for the entire region of Sub-Saharan Africa, and do not differentiate by low and middle-income countries. At this time, there is insufficient cost data to be able to distinguish between low and middle-income accurately. While this is misleading at the individual country-level, given the small number of countries in the middle-income level, we estimate that this bias the estimates by a magnitude of 3-5% on are a regional basis. The unit costs are presented in Table 3.

6. Data Limitations and Results

The model was estimated using a variety of data from published results. The sources are referred to in the appendix. There were some key limitations in generating the estimates:

- Paucity of general cost information on HIV prevention activities. It was not possible to distinguish between high and low income countries and some of the ranges for the cost estimates are extrapolations based on 1 or 2 existing studies.
- No real information about existing levels of coverage. While we know that existing coverage is low, there are no systematic estimates of the existing levels of coverage, and so it is difficult to know where to scale-up from.

The results are presented in Tables 4 and 5. Table 4 presents estimates by sub-region,

[3] The GDP deflator for this period was 3.2% for the US over this period.

and Table 5 presents estimates for SSA.

The KW99 model was developed in anticipation that as data collection improves, the determination of resource requirements for HIV prevention can also become increasingly refined. The KW99 model is currently under a process of review, before being finalised. Thus there will some changes to estimated costs in the future. The numbers presented here are preliminary.

Table 1. Grouping of Countries by Existing Strength of HIV/AIDS Programme Activities

Estimated Programme Strength			
Very Low	**Low**	**Medium**	**Strong**
Angola	Benin	Botswana	Cote d'Ivoire
Congo	Burkina Faso	Burundi	Senegal
Djibouti	Burundi	Cameroon	Uganda
Eritrea	*Chad*	Central African Rep.	
Ethiopia	*Equatorial Guinea*	Kenya	
Liberia	***Gabon***	Lesotho	
Nigeria	Gambia	Malawi	
Sierra Leone	Ghana	Mozambique	
Somalia	Guinea	Tanzania	
Zaire	*Guinea Bissau*	*Namibia*	
	Madagascar	South Africa	
	Mali	*Swaziland*	
	Mauritius	Zambia	
	Niger	Zimbabwe	
	Rwanda		
	Togo		

Note: Figures for countries in italics extrapolated from other countries within same group

Table 2: Coverage assumptions used

Coverage assumptions										
			Very Low		Low		Medium		Strong	
Form of intervention	**Potential target group**	**Measure of coverage**	**Baseline**	**Target**	**Baseline**	**Target**	**Baseline**	**Target**	**Baseline**	**Target**
Youth focused interventions In school youth	Male and female youth enrolled in school. 6 – 11 12 – 16	Proportion 6 – 11 receiving HIV education Proportion 12 – 16 receiving HIV education	5% 20%	50 % 80%	5% 20%	50% 80%	10% 30%	50% 80%	20% 50%	50% 80%
Youth focused interventions Out of school youth	Males and females 12 – 16	Proportion 12 – 16 receiving HIV education	5%	50%	5%	50%	10%	50%	20%	50%
Sex worker interventions	4% urban women aged 15 – 49. Average 2 sex acts per week	Proportion total reached Proportion using condoms often	20% 10%	60% 70%	20% 10%	60% 70%	40% 20%	60% 70%	50% 30%	60% 70%
Strengthening public sector condom distribution	All sex acts with non-regular partners 20% sex acts in regular partners	Proportion using condoms often in non-regular partnerships Proportion using condoms in regular partnerships	10% 2%	70 % 2%	10% 1%	70% 2%	20% 2%	70% 2%	40% 2%	70% 2%
Condom social marketing	All sex acts with non-regular partners 20% sex acts in regular partners	Proportion using condoms often in non-regular partnerships Proportion using condoms in regular partnerships	10% 2%	70% 2%	10% 2%	70% 2%	20% 2%	70% 2%	40% 2%	70% 2%
Strengthening STI services	Men and women with curable STIs and access to health services	Among those with access to health services, proportion of curable STIs treated by health service	5%	30%	5%	30%	15%	30%	20%	40%
Voluntary counselling and testing	Current sexually active population	Proportion receiving VCT urban Proportion receiving VCT rural	1% 0 %	5% 5% (including MTCT testing)	1% 0%	5% 5% (including MTCT testing)	1% 0 %	5% 5% (including MTCT testing)	1% 1%	5% 5% (including MTCT testing)
Strengthening blood transfusion services	Blood for transfusion	Proportion units of blood for transfusions tested Urban Rural	 70% 70%	 100% 100%	 70% 70%	 100% 100%	 90% 75%	 100% 100%	 90% 90%	 100% 100%
Mother to child transmission	Pregnant women aged 15 – 49	Proportion pregnant women tested HIV Urban Rural	 0.5% 0%	 10% 5%	 0.5% 0%	 10% 5%	 0.5% 0%	 10% 5%	 0.5% 0%	 10% 5%
IEC / mass media	National campaigns for entire country	Number campaigns per year	2	6	2	6	2	6	2	6

Table 3 UNIT COSTS US$2000

Strategy	Unit Cost US$ 2000		
In-school youth interventions	**Low**	**Medium**	**High**
Cost per teacher trained primary school education	75	200	400
Cost per teacher trained secondary school education	121	241	495
Cost per person reached / peer education out of school youth	8	10.81	16.2
Interventions focused on sex workers and clients	**Low**	**Medium**	**High**
Cost per SW targeted urban	15.83	21.12	31.66
Cost per condom distributed urban	0.1	0.14	0.17
Increased public sector condom provision	**Low**	**Medium**	**High**
Cost per condom distributed urban public sector	0.1	0.34	0.5
Cost per condom distributed rural public sector	0.1	0.34	0.5
Strengthening condom logistics (cost per condom)	0.045	0.07	0.1
Condom social marketing	**Low**	**Medium**	**High**
Cost per condom distributed urban areas	0.21	0.29	0.40
Cost per condom distributed rural areas	0.25	0.40	0.65
Strengthening STI services	**Low**	**Medium**	**High**
Cost per STI case treated/visited	12.65	15	20
Cost per woman screened for syphillis	.91	2.00	2.80
Voluntary counselling and testing	**Low**	**Medium**	**High**
Cost per person counselled and tested	3.8	4.4	6.92
Strengthening blood transfusion services	**Low**	**Medium**	**High**
Cost per safe unit blood collected	5.34	18.22	30
Prevention MTCTHIV	**Low**	**Medium**	**High**
Cost per woman screened	3.8	4.4	6.92
Cost per woman testing HIV positive and receiving regimen	5	50	180
Cost per woman HIV positive provided formula-feed	50	55	60

Mass Media	Low	Medium	High
Cost per campaign	450,000	517,000	650,000

Start-up capacity development (very low group only)	Low	Medium	High
Cost per capita	.021	.026	.033

TABLE 4: Low, medium and high cost estimates by sub-region

MILLIONS US$ 2000

Low cost estimates	Programme strength VERY LOW	LOW	MEDIUM	HIGH
Youth focused interventions	129.9	56.6	77.1	16.1
Interventions focused on sex worker interventions	20.9	8.5	14.3	2.3
Increased public sector condom provision	83.3	42.5	81.6	3.9
Condom social marketing	6.8	2.7	7.1	2.2
Strengthening STI services	64.2	23.7	33.1	8.2
Voluntary counselling and testing	21.7	8.9	15.2	3.5
Strengthening blood transfusion services	2.6	1.1	0.6	.15
MTCT	2.6	1.1	1.8	0.4
Mass media	5.5	23.1	24.4	5.8
Start-up capacity development	1.9	0	0	0
TOTAL (millions US$ 2000)	339.4	168.2	255.2	42.6

Medium cost estimates	VERY LOW	LOW	MEDIUM	HIGH
Youth focused interventions	189.7	81.5	109.0	23.5
Interventions focused on sex workers and clients	32.9	13.4	36.7	3.7
Increased public sector condom provision	199.0	77.9	136.1	11.3
Condom social marketing	19.2	7.6	22.0	6.2
Strengthening STI services	97.2	36.1	63.2	11.8
Voluntary counselling and testing	39.6	16.2	27.2	6.4
Strengthening blood transfusion services	8.9	3.7	2.1	.5
MTCT	5.4	2.2	3.9	0.9
Mass media	5.8	24.4	34.3	6.2
Start-up capacity development	7.1	0	0	0
TOTAL (millions US$ 2000)	604.6	262.9	434.5	70.7

High cost estimates	VERY LOW	LOW	MEDIUM	STRONG
Youth focused interventions	300.1	127.8	178.2	37.1
Interventions focused on sex workers and clients	44.9	18.2	49.5	5.0
Increased public sector condom provision	297.5	117.0	207.5	17.3
Condom social marketing	28.1	11.0	34.3	9.2
Strengthening STI services	129.5	48.2	84.2	15.8
Voluntary counselling and testing	165.8	68.0	114.0	26.9
Strengthening blood transfusion services	14.7	6.0	3.5	.8
MTCT	18.9	7.8	13.5	3.3
Mass media	7.2	30.6	43.2	7.8
Start-up capacity development	9.0	0	0	0
TOTAL (millions US$ 2000)	1015.8	434.7	727.9	123.16

TABLE 5: Low, medium and high cost estimates for sub-Saharan Africa

BILLIONS US$ 2000

	LOW	MEDIUM	HIGH
Youth focused interventions	.28	.40	.64
Interventions focused on sex worker interventions	.05	.09	.18
Increased public sector condom provision	.21	.42	.64
Condom social marketing	.02	.05	.08
Strengthening STI services	.13	.21	.28
Voluntary counselling and testing	.05	.09	.37
Strengthening blood transfusion services	.004	.015	.025
MTCT	.006	.012	.043
Mass media	.059	.07	.09
Start-up capacity development (very low only)	.002	.007	.009
TOTAL (billions US$ 2000)	**.80**	**1.37**	**2.30**

Note: Totals may differ slightly due to rounding.

References

Kumaranayake L and Watts C. (1999). Costs of Scaling HIV Program Activities to a National Level for Sub-Saharan Africa: Issues and Methods. Prepared for the World Bank. Draft 6, August 1999.

Over, M. (1986). "The Effect of Scale on Cost Projections for a Primary Health Care Program in a Developing Country." Social Science and Medicine 22(3), 351-360

Rowley J.T. and Anderson, R.M. "Modeling the Impact and Cost-Effectiveness of HIV Prevention Efforts." Aids 1994, Vol 8 No 4.

Sources of Data

UNAIDS/WHO (1998). Report on the Global HIV/AIDS Epidemic. Geneva: UNAIDS/WHO.

UNDP (1998). Human Development Report 1998. New York: Oxford University Press

UNDP (1997). Human Development Report 1996. New York: Oxford University Press

World Bank. 1997a. Confronting Aids: Public Priorities in a Global Epidemic . New York: Oxford University Press

World Bank. 1997b. World Development Report 1997. New York: Oxford University Press.

World Bank. 1998. World Development Report 1998. New York: Oxford University Press

DRAFT

May 17

US CAMPAIGN TO CLOSE THE GLOBAL AIDS RESOURCE GAP:

I. Strategic Purpose: To significantly reduce worldwide HIV transmission; improve basic care and treatment for those infected and affected; and, reduce the associated impacts. Taking aggressive and concerted action to realize these goals is in the strategic interest of the United States and the public interest of all Americans.

II. Resources Required:

Financial resources (FY2000):

Sub-Saharan Africa alone: $3 billion annually[1]

For Asia, Eastern Europe/NIS, and Latin America: $3 billion annually[2]

[1]Of this amount, 20% of annual public sector costs should be leveraged from HIPC governments, 40% from mid-income countries; Target region: all of sub-Saharan Africa. Figures exclude US-based research efforts.

[2]Target region includes clusters of countries as described in section V below.

Annual Amount Required for Africa for HIV/AIDS Prevention and Care and Current Spending in FY2000

	Amount needed	World Spending[1]	Shortfall	USAID[2]	Other USG (CDC)
Prevention	$1.5 billion	$425 million	$1.075 billion	$ 99 million	$ 34 million
Care	$1.5 billion	$ 75 million	$1.425 billion	$ 35 million	$ 0
Total	**$3.0 billion**	**$500 million[3]**	**$2.5 billion**	$134 million	$34 million

[1]Includes all donors, lending agencies and host country public sector. Does not include foundations or personal out-of-pocket expenditures.

[2]Included in World Spending total; USAID annual funding needs in section VIII. USAID worldwide HIV spending is $200 million in FY2000.

[3]Of this amount, approximately $415 million is funded through developed country grants and loans and $85 million derives from host country governments, primarily for inpatient care costs.

Annual Amount Required for other Developing Regions (LAC, Asia, EE/NIS) and Current Spending in FY2000[1]

	Amount needed	World Spending[2]	Shortfall	USAID	Other USG
Prevention	$2.0 billion	$1 billion	$1.0 billion	$ 60 million	$ 1 million
Care	$1.0 billion	$0.5 billion	$0.5 billion	$ 6 million	$ 0
Total	**$3.0 billion**	**$1.5 billion[3]**	**$1.5 billion**	$ 66 million	$1 million

[1]ExludesChina.

[2]Host country resources are more substantial in these regions. Thus the anticipated shortfalls are less and the need for developed country input is less.

[3]Of this amount, approximately $500 million is funded through developed country grants and loans and $1 billion derives from host country governments.

Human and institutional resources:

1. Additional US personnel devoted to HIV/AIDS internationally. Expansion of USG agencies involved. Increased utilization of US-based expertise (NGOs, universities)
2. Significant increase in African and other national human and institutional capacity devoted to HIV/AIDS.

III. Key Trends

- 4 million new infections in Africa; 6 million worldwide; 95% of infections in the developing world. 34 million total infected in Africa;
- In the past 20 years, 16.3 million deaths from HIV/AIDS (11.5m deaths in Africa). Death toll will double in 5 to 6 years, most of it occurring in sub-Saharan Africa;
- One-third of African countries (16) have adult (15-49) HIV prevalence rates above 10 percent. Of these, 7 countries have HIV prevalence rates above 20 percent;
- Negative population growth by 2010 in South Africa, Botswana, and Zimbabwe (–1.3, -1.3, and –0.9 respectively). Six more countries in sub-Saharan Africa will see their population growth rates approach zero because of HIV/AIDS. Mozambique's growth rate will slow to just 0.1% per year, a twenty-fold decline in population due to HIV/AIDS;
- By 2010, over 40 million children will have lost one or both parents to HIV/AIDS in Africa;
- Prevalence rates in African militaries can be as high as 40-60%, with highest rates in officer cadres; and,
- By 2000, cumulative worldwide direct and indirect costs of HIV/AIDS top $500 billion. HIV/AIDS will account for over 50% of health spending in many African countries.

IV. Result Targets:

- Reduce the expected new HIV infections over the next five years in Africa from 20 million to 10 million, and in other regions from 10 million to 7 million.
- At least 30% of HIV infected persons have access to basic care and support services.
- At least 30% of AIDS orphans will have access to basic community support services.

V. Strategic Approach:

Twenty years of experience with this pandemic has allowed for the development and small scale implementation of AIDS strategies with documented success. These approaches include: a combination of prevention, care and treatment, capacity building, as well as political will, multisectoral involvement, donor coordination, financing, and monitoring and evaluation.

The primary focus is on sub-Saharan Africa, which has generalized HIV infection throughout the adult population. This focus will recognize migration patterns and the mosaic of epidemics in different sub-regions. In Asia, Eastern Europe, the newly independent states of the former Soviet Union, and Latin America, the epidemics are concentrated in specific vulnerable populations. Our action is focused on these subpopulations and will target clusters of countries with significant cross border migration: India-Bangladesh-Nepal; Thailand-Vietnam-Cambodia-Laos; Russia-Ukraine-NIS countries-Poland-Romania; Caribbean-Guyana-Brazil. For these countries and non-focus countries, an expanded and rigorous sentinel surveillance system will monitor the epidemic and identify trends and outbreaks of transmission.

- **Primary prevention:** Essential to controlling and stopping this global scourge. Enhanced and new activities to focus on targeted vulnerable populations (e.g., youth, women, military), as well as highly used transport corridors, better access to voluntary

testing and counseling (VCT), massive investments in mother-to-child prevention; reductions in stigma and discrimination.

- **Care and support for those infected and their families**: Focus on three points of access to infected persons: VCT, antenatal clinic attenders, and inpatients, especially those with active TB. Each of these points of access will provide the optimum way to identify HIV infected persons and to initiate care and support interventions. Each of these also will dramatically enhance our primary prevention agenda. Provide training for health workers and health care system infrastructure improvements to deliver care and support community based care programs (including food distribution). Special focus on drug procurement and distribution systems will enhance the availability and accessibility of these medications.

- **Programs addressing orphans and vulnerable children**: Provide support to community based programs assisting children and families at risk. Includes medical care, education, food, and income generation activities.

- **Capacity building**: Support building national analytical, planning and management capabilities to combat HIV/AIDS in Africa and elsewhere. Strengthen HIV/AIDS surveillance efforts, as well as national monitoring and evaluation efforts. Health system infrastructure development to assure safe and effective delivery of HIV/AIDS drugs and prevention services, including: training, clinics, basic drugs for opportunistic infections, expanded NGOs, PWA empowerment, and bicycles for community health workers.

- **Enhanced multisectoral response.** Engage multiple sectors: education, agriculture, military, economic growth, microenterprise, democracy and governance, commerce, and others to launch HIV/AIDS advocacy, education, prevention and/or care programs. Specific funding is required.

VI. Managing the Global Battle:

- US-based: restructure ONAP to manage the Federal Agency response;
- Using the PEACS apparatus, engage OECD and affected countries at the highest political level;
- The US LIFE Initiative and International Partnership Against AIDS in Africa (IPAA) Initiative can work together to focus on the hardest hit countries in Africa; and,
- Periodic NSC/ONAP convened IWG, along with executive committee to monitor US and worldwide progress;

VII. Key USG Actors:

USAID is the designated lead USG agency for field based action. Other key implementation agencies include DHHS, DOD, DOL, State, Treasury, USTR, and the intelligence community. All other USG agencies have important roles to play, e.g., DOCommerce.

VIII. Major Challenges that now confront us:

- Closing the Resources Gap:
  - In FY2000, as part of the "LIFE Initiative" (Leadership and Investment in Fighting an Epidemic), the President proposed and the Congress appropriated a $100

million increase for the USG's global AIDS effort. For FY2001, the President has requested an additional $100 million increase. This initiative has not only enabled the USG to more than double its global HIV prevention and AIDS care programs but to expand participation in this effort to include HHS, DOL, DOD, and Ag in the funding, and a host of other strategic players in the overall implementation of the USG's program.

- The USG will redouble its global AIDS spending in the next two years and will develop a plan for the accelerated assistance needed to do its share to help close the global gap for the next five years;
- The USG will call on other countries to double their bilateral HIV/AIDS assistance over the next two years, and to develop a plan for the accelerated assistance needed to do its share to help close the global gap over the next five years.

- Limited Capacity:
  -In affected countries, governments, NGOs, communities, institutions, all need major capacity building efforts
  -USAID requires dedicated HIV/AIDS staff in each LIFE emphasis country to manage its programs and coordinate USG efforts.

- Lack of Critical Tools: (such as AIDS prevention vaccines and microbicides.) Requires an intensive focused effort (NIH, IAVI, GAVI) involving a coordinated, multi-pronged approach to simultaneously testing promising vaccine and drug candidates. Currently $1.9 billion is expended by the USG on AIDS research.

IX. Monitoring and Evaluation

The USG will use indicators firmly established under the LIFE Initiative and the International Partnership Against AIDS in Africa to monitor progress. A country profile database will be established providing country-based information on the epidemiology of the epidemic, scope of the country response, and indicators of progress. These profiles will be created through a collaborative effort led by the USG (USAID, CDC, Bureau of Census, NIA, DOD, etc) working with UNAIDS, WHO and selected other governments (e.g. U.K. and Sweden), and will use established indicators, and data aggregation and analysis systems. Profiles will be updated semi-annually and will facilitate regrouping/strategy revisions, etc. A semi-annual supplemental report will address data that relates to security issues.

X. Next Steps: (12 month plan)

- Discussion of HIV/AIDS at international fora: G-8, SADC, EU-US, UNAIDS PCB;
- Discussion of HIV/AIDS efforts and required assistance in upcoming President Mbeki visit and with other high level visits;
- UN special meeting of General Assembly; Millennium conference;
- Personal calls by POTUS/VP with specific leaders to galvanize worldwide attention and resource mobilization;
- Specific work with DOD, DOL, Treasury—US HIV/AIDS "strikeforce". Coordination with USAID to provide background HIV/AIDS technical assistance on the issues;
- Increased communication and collaboration with USG advocacy and expert groups (e.g. NGOs, universities, etc);

- Identification of necessary studies (e.g. economic, intelligence, military, HIV surveillance) to be undertaken; and,
- Increased USG participation in country level IPAA actions.

ANNEX 1: HIV/AIDS GLOBAL PANDEMIC FUTURE TRENDS

CONTINUED SPREAD OF HIV AROUND THE WORLD: Large increases in HIV infections are projected by the U.S. Bureau of the Census for sub-Saharan Africa. In South Africa, for example, adult prevalence is expected to increase from 22% to 38% within the decade. In the same time frame, Nigeria's adult prevalence will jump from 5.6% to 11% -- rise of nearly 50%.

One-third of African countries (16) have adult (15-49) HIV/AIDS prevalence rates above 10 percent. Of these, 7 countries have HIV prevalence rates above 20 percent. While HIV will continue to take a staggering toll on sub Saharan Africa, other regions particularly parts of Asia and the former Soviet Union will experience a rapid growth in HIV infections. The National Intelligence Council in its report on the global infectious disease threat, estimates that by 2010 Asia could surpass Africa in the number of persons living with HIV infection. Already, India with 3.7 million persons infected is second only to South Africa with 4.2 million.

MORTALITY: In the last twenty years, 16.3 million people died from HIV/AIDS. At current rates, this death toll will double in 5 to 6 years with most of the deaths occurring in sub Saharan Africa. For example, infant mortality in Zimbabwe is projected to triple from 22 to 66 deaths per 1,000 live births and child mortality will have risen five-fold from 29 to 153 deaths per 1,000 children under 5. By 2010, life expectancy in Zimbabwe will have fallen from 73 years to less than 33 years.

DECLINING POPULATION GROWTH: U.S. Bureau of Census projections show that by 2010, South Africa, Botswana, and Zimbabwe will experience negative population growth as a result of HIV/AIDS, with growth rates of –1.3, -1.3, and –0.9 respectively. Six more countries in sub-Saharan Africa will see their population growth rates approach zero because of HIV/AIDS. Mozambique's growth rate will slow to just 0.1% per year. Without the HIV/AIDS epidemic the 2010 growth rate would have been 2%. This represents a twenty-fold decline in population growth because of HIV/AIDS.

ORPHANS: In 34 of the most severely impacted developing countries over 40 million children will have lost their mother or both parents to HIV/AIDS within the next decade. Many of these children will be adolescents and young adults. Without adequate education and social integration, orphans will add significantly to crime rates, serve as child soldiers, and could threaten political stability.

IMPACTS ON ECONOMIES, POLITICAL AND SOCIAL STABILITY: Significant impacts of HIV/AIDS on multiple sectors are being seen. HIV prevalence rates in militaries of heavily affected countries can range from 10 to 60%, and is often double the civilian population rate. HIV/AIDS causes at least a 1% GDP rate decline in heavily affected countries, as well as large costs for firms. Millions of orphans translate into a significant pool of untrained adults further exacerbating social and political instability. In Zambia, 1300 teachers died (many from AIDS) last year, whereby only 700 were trained. Swaziland, using a national 30% HIV prevalence rate, estimates that it would require an 86% increase in the education budget (above current levels) just to maintain teacher levels of two years ago.

1.033
1.400
470
120
023

FAX TRANSMISSION

USAID DIVISION OF HIV/AIDS
3.06-81, 3RD Floor, RRB
Washington, DC 20523-3700
202 712 5681
Fax: 202 216 3046

To:	Kenneth Bernard	**Date:**	Thursday, April 06, 2000
Fax #:	202 456 9390	**Pages:**	5, including this cover sheet.
From:	David Stanton		
Subject:	Estimates of cost for HIV-AIDS programs in Sub-Saharan Africa.		

COMMENTS: Attached are two documents. One estimating the cost of MTCT prevention in SSA and the other estimating the costs of HIV-AIDS prevention, care of children affected, voluntary counseling and testing, and care.

Feel free to call me if you need anything else.

David
(202) 712-5681

RESPONDING TO THE GLOBAL AIDS PANDEMIC:
What is the level of resources needed?

ASSUMPTIONS:

1. This assessment only covers Sub Saharan Africa. Two thirds of the world's AIDS cases are currently in Sub-Saharan Africa. The costs of providing HIV/AIDS prevention and care services vary dramatically from country to country based on local labor productivity and costs and the local health infrastructure strength and coverage. Given this variability, it is best to separate the analysis by region.

2. This assessment uses the methods of Boerma and Bennett that assumes that a minimum package of prevention services consists of a combination of interventions with different target populations and different levels of coverage. For example, highly targeted interventions are assumed to reach 50% of their intended populations, while some generalized interventions are assumed to reach nearly 100% of their intended populations.

3. This assessment assumes that the care components (treatment and orphan services) will be made available to 30% of those in need. While this number may seem low, if implemented this would represent a substantial increase in the proportion of affected persons who receive assistance. For example, 10% or less of all HIV infected persons in Sub Saharan Africa have been tested. Current programs to assist families and communities caring for children reach an even smaller proportion of those in need.

4. This assessment does not include the cost of antiretroviral drugs. The costs of the treatment component of care services include the cost of treating opportunistic infections (including tuberculosis) and the costs of providing palliative care.

5. This assessment does not include estimates of institutional care for orphans. The costs of the orphans support component of care focuses on foster and community-based care.

6. Where high and low estimates of cost appear in the literature, the average cost is used.

7. The data are presented in year 2000 dollars, assuming an annual inflation rate of 5%.

TOTAL COST OF PREVENTION, CARE, ORPHANS:

Prevention	$1.03 billion
VCT	$0.470 billion
Treatment/care	$1.28 billion
OVC	$0.389 billion
TOTAL	**$3.17 billion**

COST OF PREVENTION: $1.03 BILLION

In an analysis commissioned by WHO/GPA, Broomberg et al conclude that the minimal cost of providing a basic package of prevention services, including behavior change communications, condom social marketing, STD services, and safe blood programs, in Africa would range between $462 million - $1.6 billion. Estimates of resource needs are based on the variability of the optimal allocation of funds. The low estimate assumes that countries allocate funds optimally, while the high estimate assumes that no attempt is made to allocate funds optimally. Given that many different circumstances govern resource allocation decisions, optimal allocation of resources does not always occur. Utilizing the data presented by Broomberg and more recent information on cost of interventions, Boerma and Bennett estimated the cost of providing a minimum package of prevention services to a hypothetical district in Africa. Using the Boerma approach in estimation for sub Saharan Africa, a minimum package of prevention services cost $846 million, or $1.03 billion in year 2000.

COST OF TESTING AND COUNSELING (VCT): $470 million

The cost of testing and counseling varies with local labor costs, training costs and infrastructure costs. The fully loaded cost of lab tests plus counseling is $18 in Zambia, a high prevalence country in Southern Africa (Source: Ndola District Health Department, Zambia). This estimate is also confirmed by Boerma and Bennett who estimate VCT costs to be between $6 and $16 using assumptions of inexpensive and expensive labor and infrastructure costs and DfID which uses an average cost of $12. Using this latter figure providing VCT to 15% of all adults (15 – 49) in SSA would total $470 million per year.

[261.4 million adults in SSA x $12 x 15% = $470 million]

COST OF TREATMENT/CARE:

$1.28 billion for treatment of HIV related illness including TB

The World Bank estimates the *lifetime* cost of treatment for a person with AIDS in the developing world at $300 to $1000. DfID estimates that in 1996 dollars the combined costs of caring for persons with HIV infection and AIDS at $194 per person with HIV/AIDS per year. This figure was adjusted for inflation and increased prevalence. The costs associated with VCT were also factored out (this cost is kept separate in this analysis). The adjusted cost of care per PLHA is $194. (The similarity between the 1996 figure and the adjusted figure is coincidence.) Therefore, the estimated cost of care for 30% of the 22 million persons in SSA infected with HIV is 1.28 billion.

[22 million PLHA x 30% x $194 = $1.28 billion]

Caring for orphans and vulnerable children: $ 389 MILLION

Estimating the annual costs of services to children affected by HIV/AIDS is difficult due to the rapid increase in children needing assistance and the variation of services offered to children orphaned by AIDS. First the total number of children needing assistance is growing rapidly. *Children on the Brink* estimates that the number of children orphaned by HIV/AIDS in SSA by 2000 will be nearly 25 million. In the next ten years (by 2010) the number of children orphaned is expected to reach 40 million. The second difficulty in

calculating costs is the lack of data and uniformity of types of assistance to children affected by HIV/AIDS.

The types of services offered to orphans and vulnerable children vary by where they receive services and the type of services they receive. Given the magnitude of the needs of children orphaned by AIDS, community based responses are the best option to provide services for these children. Institution-based care which may seem common in the developed world are not appropriate in the majority of circumstances in SSA. The types of services offered to orphans and vulnerable children have many different components and therefore the costs of these programs are highly variable. The World Bank estimates the annual cost of institutional care (orphanage) per child at over $1000 while it estimates the annual cost of foster care at one tenth of that or about $100 per child. In an analysis of community based care of children in Uganda, Williamson estimates the annual cost per child recipient at $50.

Given the magnitude of the problem of children affected by AIDS, orphanage based care is not a realistic option. The average of estimated costs of foster and community-based care is used: $50 per child per year. Providing assistance to 30% of all children affected at an average cost of $50 per child would cost $474 million.
[24.7 million x 30% x $50 = $370 million in 1999 dollars; 389 million in 2000 dollars]

COLLABORATION

USAID is working together with the UNAIDS, World Bank, and the London School of Hygiene to improve and refine these projections.

References:

1. Broomberg, J.,Soderlund N, Mills A: Economic analysis at the global level: a resource requirement model for HIV prevention in developing countries,"
2. Foster and Williamson, Children on the Brink, USAID 1996
3. USAID analysis of Uganda's successful HIV prevention programs
4. Drew, Makufa, Foster: Strategies for Providing Care and Support to Children Orphaned by AIDS
5. Boerma, T. Bennett, J.: Chapter 21 Costs of District AIDS Programs; in Financing and Sustainability
6. Over and Ainsworth "Confronting AIDS"
7. Williamson J, Personal communication
8. Foster et al, Community Mobilization Best Practices The Families, Orphans and Children Under Stress (FOCUS) Programme

Estimating Costs for Prevention of Mother to Child Transmission of HIV in Sub Saharan Africa

According to U.S. Bureau of Census estimates, 25 million women become pregnant each year in sub Saharan Africa. Approximately half of these women (12,500,000) have contact with the formal health care system and could in theory be screened for HIV infection and offered a package of interventions to prevent mother to child transmission of HIV. This package would likely consist of the antiretroviral drug Nevirapine and breast milk replacements.

Since not all of the facilities where antenatal care is delivered would be capable of offering this package it is assumed that about one half of pregnant women receiving antenatal care or 6,250,000, would be eligible for HIV testing and subsequent intervention. On average 6.5% of pregnant women in sub Saharan Africa are infected with HIV so that about 400,000 women could potentially benefit from the package. (HIV prevalence among pregnant women in sub-Saharan Africa ranges from less than one percent to fifty percent in high prevalence settings.)

To provide voluntary counseling and testing to 6,250,000 women annually would cost roughly $75 million. To provide Nevirapine and breast milk substitutes to the 400,000 HIV infected women identified would cost roughly $22 million. Therefore the total annual cost to provide MTCT services in sub Saharan Africa would reach nearly 100 million dollars. This does not include the additional costs of training, improvements to facilities, and additional personnel, which would likely add another $10 to $20 million.

This expenditure could be expected to prevent 97,500 infections at a cost of $1,000 per infection (death) averted. The cost per death averted goes down as the prevalence of HIV among pregnant women goes up. As a result the cost per death averted exceeds $5000 in low prevalence countries such as Madagascar, and is less than $350 in high prevalence settings such as Botswana. The World Bank has estimated the cost per death averted for measles vaccination programs and tuberculosis treatment at about $650 and $100 respectively. Thus MTCT interventions in high prevalence countries are competitive with other prevention and treatment interventions.

Estimating the cost of providing Cotrimoxazole in SSA

Estimation of an annual cost of providing Cotrimoxazole to persons with HIV/AIDS in SSA need to consider the following:

1. Cotrimoxazole is recommended for persons with moderately advanced disease. Therefore not all persons with HIV infection necessarily need to take it. This may be about one third of persons with HIV in SSA. However since illness may be a reason to seek testing the number of tested persons meeting the criteria are probably higher. *50% is assumed.*
2. Not all persons with HIV infection in SSA are aware of their status. Best estimates are that 5 to 10% of persons living with HIV/AIDS know their status. *10% is assumed*
3. UNAIDS estimates an annual per person cost of $8 to $17. An average cost of *$12.50 is assumed.*

Estimates of people living with HIV in SSA	22,000,000
Persons who know their HIV status (10%)	2,200,000
Persons likely to meet criteria for use of Cotrimoxazole prophylaxis (50%)	1,100,000
Annual cost of daily Cotrimoxazole at $12.5 per person per year	**$13,750,000**

Recommendation: The provision of Cotrimoxazole needs to be carried out in the context of a comprehensive testing, counseling and treatment program. Given the modest cost of this intervention relative to the costs of other program components this cost should be assumed to be part of the $1.28 billion cost of treatment of AIDS related illnesses.

FAX TRANSMISSION

USAID DIVISION OF HIV/AIDS
3.06-81, 3RD Floor, RRB
Washington, DC 20523-3700
202 712 5681
Fax: 202 216 3046

To: Kenneth Bernard **Date:** Friday, April 07, 2000

Fax #: 202 456 9390 **Pages:** 2, including this cover sheet.

From: David Stanton

Subject: Estimating the cost of Cotrimoxazole prophylaxis in SSA.

COMMENTS: When I made the estimate the amount appears very modest. It makes most sense to assume this cost will be absorbed in the overall cost of providing care.

NATIONAL SECURITY COUNCIL

FAX COVER SHEET

NATIONAL SECURITY COUNCIL

17th & Penn, N.W.
Washington, D.C.
20504

Did you get a complete, clear transmission? If not, please call:

Chris Keenan at
(202) 456-9394

From: **Kenneth W. Bernard**
International Health Affairs
Phone: 202 456-9391, Fax: 202 456-9390

To: **Sandy Thurman, ONAP 6-2439**
~~**Jack Chow, State 202 647-2746**~~

Date/Time: **June 2, 2000**

No. of pages to follow: ~~3~~ 1

Your comments/concurrence, ASAP, will be appreciated.

Appendix A

Cost Estimates for Prevention, Care and Treatment of HIV/AIDS for sub-Saharan Africa

UNAIDS and USAID have estimated the costs, as outlined below, of prevention, treatment, and orphan care in Sub-Saharan Africa. There are substantial needs in Asia and Eastern Europe as well. It must be noted that most of these activities are inter-related and funding one category requires concomitant funding of others. The rough estimates are the annual bare minimum costs in FY2000 dollars:

- **Treatment and care** **$1.3 billion**
  Assumes reaching 30 percent of those in need at $194/yr/person. Includes treatment of HIV-related illness such as TB, but excludes treatment with anti-retrovirals. Providing Cotrimoxazole (antibiotic sold as Bactrim/Septra) would add only $14 million, assuming treating 1.1 million per year - only those with moderately advanced disease.

- **Prevention activities** **$1.03 billion**
  Including behavior change communications, condom social marketing, STD services, and safe blood programs.

- **HIV Testing and counseling** **$470 million**
  Assumes reaching 15 percent of all adults (15-49) at $12/person.

- **Care for orphans and vulnerable children** **$390 million**
  Assumes reaching 30 percent of affected children at $50/yr/child. Excludes orphanage care.

- **Prevention of mother-child transmission** **$120 million**
  Based on $4 Nevirapine, not $80 (other) drugs. Includes administration of drugs and breast milk substitutes for 400,000 infected women/yr at $55/person (about $70/each if you include HIV testing). Could cost 20 times that amount.

Total needed for sub-Saharan Africa: <u>at least</u> **$3.0 billion/year**
Total currently available from all sources: **$0.5 billion/year**

FAX MESSAGE

U.S. Agency for International Development
HIV-AIDS Division, Office of Health and Nutrition
Global Bureau
Mailing address: G/PHN/HN/HIV-AIDS
3.07–075M, 3rd Flr, RRB
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U.S.A.

To: Sandy Thurman

Phone:
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cc:

From: Paul DeLay, M.D., D.T.M.& H.
Chief, HIV/AIDS Division

Phone: 202 712 0683
FAX: 202 216 3046

Pages: 13
Date: 3/06/00

Subject: WSC IWG

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Duff Gillespie to Barbara Turner re: International Working Group meeting on international AIDS (4 pages)	03/06/2000	P1/b(1)

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

FOLDER TITLE:
NSC [National Security Council]/State/USAID [U.S. Agency for International Development]

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jm2015

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SUMMARY OF THE RECOMMENDATIONS OF THE PREVENTION AND CARE SUB-COMMITTEE OF THE INTERAGENCY WORKING GROUP ON INTERNATIONAL AIDS.

3/06/00

The sub-committee met on February 23rd from 1:00 to 3:00 p.m. Participants are listed in Attachment #1. Because this sub-committee was responsible for multiple diverse activities, the group outlined major categories under prevention, care and capacity building. Each of these categories was reviewed in order to explore possible recommendations to the NSC or to other relevant partners. (Attachment #2) The resulting recommendations were made on the premise that they would accelerate, expand or intensify critical program actions. These recommendations are not prioritized.

Recommendations for Action to the NSC:

1. In order to improve overall coordination among Federal Agencies responding to the Global AIDS pandemic, the sub-committee endorsed the general concept presented by the OVP for strengthening the Office for National AIDS Policy.

2. The subcommittee recommended that the Administration restate their commitment for the development of a preventive HIV vaccine within the next 10 years. As part of this initiative there should be a strong assurance to increase African participation in this critical research and to establish centers of excellence in the developing world.

3. The sub-committee recommended that there be consistent messages delivered by the Administration on the need for further empowering women to reduce their vulnerability and that there be greater involvement by people living with HIV and AIDS in the planning and implementation of our programs.

4. The sub-committee requested that the Administration make a statement on the proposed initiative to more fully involve the faith communities, both here and in Africa, with prevention efforts and care for infected persons and their families.

5. Because TB is the leading cause of death in persons with AIDS in the developing world, the Administration should pledge to support the "Stop TB" initiative and make a strong statement in this regard at the upcoming meeting in the Netherlands on March 24.

6. The Administration should identify a lead agency and describe a strategic process, that involves relevant Federal agencies and private partners, to explore ways to increase access to critical drugs and other health commodities (e.g. diagnostic tests) in the developing world. The PC/DC should authorize the establishment of this process. This entity would focus on identifying incentives for preferential tiered pricing and ways to remove barriers to access, such as revisions in drug licensing regulations.

7. The PC/DC should endorse the focus on community-based approaches rather than the establishment of institutions (orphanages) to support children affected by AIDS. (either children with parents sick or dying, AIDS orphans, or infected infants)

8. Every possible venue should be used to advocate for increased resources and commitment for combating the global AIDS pandemic, including the upcoming G-8, meetings of SADC, and a possible Heads of State Summit.

Recommendations for Action by the Prevention/Care Sub-Committee and for other relevant partners:

1. A recommendation was made to the Economics, Trade and Finance sub-committee to explore ways to provide USG assistance in order to improve local production of critical health commodities, such as condoms. This may involve potential linkages with the proposed Africa Trade Bill and other pending legislation. The "Buy America" policy that is currently adhered to by USAID should be re-examined to determine if there are possible waivers for use in emergency situations.

2. USAID, as lead for country level activities, will work with CDC and Department of State to develop a protocol to facilitate new partners who are entering into collaboration in individual country programs.

3. The sub-committee recommended that a "thematic" interagency working group be established to focus on the challenges surrounding delivering services to reduce mother-to-infant HIV transmission. This will serve to accelerate this important component of the response to the AIDS pandemic and there are a number of outstanding technical and ethical issues that must be resolved quickly in order to "scale up" this activity.

4. The sub-committee recommended that NIH and other relevant partners establish a "global clinical trials network", that could be region specific, to monitor the efficacy and feasibility of treatment regimens for HIV infected persons.

5. The sub-committee recommended that NIH and other relevant partners review the status of development of a therapeutic HIV vaccine and to propose an appropriate strategic approach.

6. The sub-committee recommended that all partners seek ways to strengthen regional NGO networks and regional training and academic institutions.

PREVENTION/ CARE IWG MEETING
FEBRUARY 23, 2000
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002. table	re: NSC recommendations on AIDS (5 pages)	03/06/2000	P1/b(1)

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MEMORANDUM

TO: Sandy Thurman
Director, Office of National AIDS Policy

Ken Bernard
Special Advisor to the Assistant to the President
for National Security Affairs, NSC

FROM: Alan Bowser, Commerce
Co-Chair, Subcommittee on Economics, Trade and Finance

Helen Walsh, Treasury
Co-Chair, Subcommittee on Economics, Trade and Finance

SUBJECT: Subcommittee's Recommendations for NCS IWG

DATE: March 6, 2000

Alan Bowser, Commerce and Helen Walsh, Treasury co-chaired three meetings of the Subcommittee on Economics, Trade and Finance. Agencies participating in the subcommittee were Commerce, Treasury, USAID, State, OVP, DOL, USTR, HHS, OVP and OMB.

We surveyed the USG's bilateral resources directly and indirectly committed to international HIV/AIDS and the amount of multilateral development bank lending for health and HIV/AIDS. The attached chart presents our findings.

To enhance multilateral, bilateral, private sector and other efforts, we prepared recommendations for the NSC interagency working group. With these recommendations in mind, we ask that the interagency working group maintain a global perspective beyond Africa and consider the impact of other infectious diseases.

Bilateral Agency Resources Directly and Indirectly Committed to International HIV/AIDS (Millions of USD in FY2000 excluding FTE)

	USAID	CDC	NIH	DOD	Treasury	Labor	Commerce	State	USTR	TOTAL
Primary Prevention	154	13								167
Community and Home Based Care and Treatment	14	9								23
Capacity Building and Infrastructure Development	24	13								37
Research										
Vaccine			25							25
Non-Vaccine Prevention			35							35
Research Capacity Bldg			10							10
Other			20							20
Other Programs	8	11								19
TOTAL	200	46	90							336

Multilateral Development Bank Lending for Health and HIV/AIDS 1995-1999 (Billions USD)

	Total Health	Basic Health	HIV/AIDS	UNAID	TOTAL
World Bank/TDA	7.502	5.233	0.52		13.255
African Development Bank	0.251		0.063		0.314
Asian Development Bank	1.226	1.061	0.0001		2.2871
Inter-American Development Bank/FSO	1.106		0.045		1.151
TOTAL	10.085	6.294	0.6281	0	17.0071

US Contribution to UNAIDS FY2000 (Millions USD)

	USAID	TOTAL
UNAIDS	15	15

Subcommittee on Economics, Trade and Finance

Recommendations for the National Security Council Interagency Working Group on International HIV/AIDS

MULTILATERAL

Continue Support of UNAIDS
Financially and politically support the work of the Joint United Nations Program on HIV/AIDS (UNAIDS) under its International Partnership Against AIDS in Africa. (HHS)

Encourage Increased Funding from Multilateral Development Banks and Other Sources
Commend the World Bank as a UNAIDS cosponsor for its Intensified Action Against AIDS in Africa AND encourage the World Bank and the multilateral development banks (MDBs) -- in particular the African Development Bank and the Asian Development Bank -- to increase their commitments for loans addressing HIV/AIDS. The series of loans by the World Bank to Brazil and India are examples with positive and negative lessons (to be) learned. (HHS)

Encourage support for HIV/AIDS activities that may result from the use of savings of debt service by each country which is eligible for debt relief under the Highly Indebted Poor Countries (HIPC) debt initiative. (Treasury)

Encourage increased World Bank funding of basic health/vaccines and medicines. (Treasury)

Encourage other Organization for Economic Cooperation and Development (OECD) donors to increase their funding for activities addressing HIV/AIDS. The recent initiatives by the United Kingdom (UK) in southern Africa and with the International AIDS Vaccine Initiative (IAVI) are good examples. (HHS)

Include HIV/AIDS in Debt Relief Poverty Reduction Strategies
Collaborate with the World Bank and regional development banks to ensure that HIV/AIDS programs are included in debt-relief poverty reduction strategies and benefit from said relief. (USAID)

Maintain Existing Policy on Intellectual Property and Health Related Trade Issues
Continue to implement the USTR/HHS initiative on intellectual property and health-related trade issues. Encourage other countries to take a similar approach to TRIPS-plus issues where health issues are of concern. (USTR)

Expand Overseas Workplace Intervention
Explore possible collaboration with the International Labor Organization and others to establish a multi-sectorial framework for HIV/AIDS workplace education and prevention initiative. Solicit input from non-governmental organizations for the purpose of information gathering on technical assistance and best practices. (DOL)

Follow-up the DOL-AFL-CIO February Trade Unionist Summit by working with the ICFTU to advance HIV prevention issues at the April meeting in Durban, Africa; explore similar DOL involvement on HIV/AIDS within other African political/social forums such as the April/May Southern African Development Community meeting and the XIIIth International AIDS Conference in Durban in July. (DOL)

Add the Global AIDS issue to the agenda for every ministerial meeting and international summit to promote awareness at the highest levels of government (DOL)

Increase Access to Medical Supplies in Developing Countries
Host a follow-up round table discussion to the WIPO session on increased access to medical supplies for the developing countries. This session would concentrate on medical products needed in the battle against AIDS.

BILATERAL

Expand Overseas Workplace Intervention
Expand the involvement of in-country labor unions in AIDS prevention programs. [President's budget requests $10 million in the FY 2001 budget for DOL HIV/AIDS in Africa prevention efforts working with unions]. (USAID, DOL)

Develop a bilateral program to enlist technical assistance for project design and implementation in select country(ies) or region(s) for workplace based education and prevention programs. A DOL representative is now in Africa researching possible bilateral opportunities. (DOL)

Combine multilateral and bilateral programs involving outreach to trade unions in the US and Africa for networking, support, and assistance with best practices. Continue to work with the AFL-CIO. To increase access to information on AIDS in the workplace, place workplace intervention manual on the Internet. (DOL, DOC)

PRIVATE SECTOR

Convene Round Table Discussion / Expand Industry Outreach
Convene representatives from several different industry sectors to discuss the trade, financial, and economic consequences of the HIV/AIDS epidemic. Government HIV/AIDS programs will be reviewed, and industry will be asked to offer concrete suggestions regarding what they are willing to do to increase public/private cooperation in the battle against AIDS. The meeting could also work to expand industry's involvement in international AIDS programs such as UNAIDS, World Bank, and Global AIDS Vaccine Initiative. Once public/private initiatives are drafted, a second round table meeting could be convened between industry and NGOS. The purpose of this meeting would be to discuss ways government, industry, and NGOS could work together on an international AIDS initiative. (DOC)

Create an IWG on Access to Essential Drugs
Support the recommendation to create an IWG focused on Access to Essential Drugs, to be staffed by HHS, DOC, USTR, AID, Treasury, and other relevant agencies. That it address all aspects of the access issue (price, infrastructure, host government agreement) and perform the one outreach function to NGOs and industry on this topic. (USTR)

Expand Collaboration with U.S. Foundations and Private Sector
Provide technical assistance to U.S. foundations interested in health care to ensure effective programming of resources and identify opportunities to increase the resources programmed for HIV/AIDS. (USAID)

Encourage foundations to increase their funding for activities addressing HIV/AIDS. The initiatives of the Bill and Melinda Gates Foundation, e.g., $750 million in funding ($150 million per year for five years) for the Global Alliance for Vaccines and Immunization (GAVI); the United Nations/Turner Foundation; and the Kaiser Family Foundation are good examples. (HHS)

Support the coordination of drug donations to existing PVOs and NGOs that engage in existing HIV/AIDS care. (DOC)

Expand Overseas Workplace Intervention
Expand industry's active participation in AIDS education and prevention training programs in the workplace. Increase the number of companies that participate in such AIDS programs. Utilize the resources of the Foreign Commercial Service and other Department programs. (DOC)

Encourage domestic, foreign, and multinational business and labor to work in partnership to address HIV/AIDS in the workplace and in the home. The work of Business Responds to AIDS (BRTA) and Labor Responds to AIDS (LRTA) are good domestic examples. (HHS, DOL)

Coordinate with American Chambers of Commerce with the purpose of gaining ground level

information on what activities the private sector is engaging in to further HIV/AIDS awareness in the work place. Through a poll asking companies for their observations and experiences with AIDS in the work place, valuable private sector perspectives could be acquired, which may allow for the development of more effective AIDS programs in the workplace. (DOC)

Conduct International Health Care Trade Missions
Lead a group of industry representatives to several countries especially hard hit by the AIDS epidemic. Members on the Mission would address audiences on increasing access to prevention commodities and methods of treatment. Countries selected for the mission would play an active role in developing an agenda and what products should be promoted. (DOC)

Emphasize Health Related Investment Promotion
Promote private sector investment in health care. The Department would work with industry partners to facilitate direct investment in sustainable health care projects in developing countries. These projects could emphasize production of prevention and health care goods and services. (DOC)

Develop International Awareness Project
Work with industry to develop a multimedia commercial that would showcase an unified public, private, NGO, international organization AIDS effort. One area of interest is to feature the health and social needs of AIDS orphans. The purpose of the commercial will be to motivate industry participation and raise he public awareness of the AIDS epidemic (DOC)

Increase Donations of Communications Equipment
Outreach to industry and NGOs for the donation of multi-media equipment to communities and grass-roots organizations to facilitate promotion of HIV/AIDS awareness through prevention and education to the broadest segments of the population. (DOL)

OTHER

Maintain Focus on Cost-Effective Interventions
Ensure that activities encompass the continuum from research to prevention to care and treatment but focus on the most cost-effective interventions such as:

- Primary prevention, e.g., voluntary counseling and testing (VCT), social marketing, and the prevention of mother-to-child transmission (MTCT); and
- Home- and community-based care and treatment, e.g., treatment of sexually transmitted diseases (STDs) and opportunistic infections (OIs) and palliative care. (HHS)

Construct Global AIDS Initiative Internet Site
Construct an Internet site to serve as a clearinghouse for information on the Global AIDS Initiative. The site would provide an international fora for governments, NGOs, industry, trade

unions, and the private sector to post contact information, including relevant links, and facilitate the exchange of timely data on statistics, summits, regional meetings, and best practices addressing the pandemic. The concept of Millennium Networking Against the Global HIV/AIDS epidemic would be a substantive focal point for a Global Village Online. Note: to date there is no Website address in use for Globalaids.com. (DOL)

Form a Team Against Global AIDS (TAGS)
Select a group of high profile U.S. and foreign personalities for public service announcements and work as ambassadors for advocacy and social mobilization in the Global AIDS Campaign. (DOL)

Produce Prevention and Education Video
Sponsor multisectoral video production and distribution, initially utilizing the synergy between the USG and national film producers, providing expertise and support in partnership with African national governments, regional officials, and local media, to produce documentary videos depicting real people, real stories, and the real results of the ravages of the HIV/AIDS pandemic. Ultimately this would be a cost effective way to reach a maximum number of people. The benefits of video production would include the ability to tailor the message to the targeted group by country, customs, gender and age. This medium would also facilitate the incorporation of addressing the critical element of behavioral change and the empowerment of women. Videos would include referral information and could be utilized by grass-roots organizations with a two-person team to respond to questions and encourage referrals. This may also be considered a logical arena in which to provide male and female condoms. (DOL)

Adopt-a-School
Initiate an adopt-a-school program through outreach to NGOs, religious groups, and the private sector. In Uganda, it costs $1 per day to keep an orphan in high school as a boarding student 365 days per year. It costs 50 cents per day to educate a day student in high school. To qualify for adoption, the school must provide an aggressive HIV/AIDS awareness through prevention and education program. (DOL)

SUMMARY OF THE RECOMMENDATIONS OF THE PREVENTION AND CARE SUB-COMMITTEE OF THE INTERAGENCY WORKING GROUP ON INTERNATIONAL AIDS.
3/06/00

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Recommendations to the NSC:

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4. The sub-committee requested that the Administration make a statement on the proposed initiative to more fully involve the faith communities, both here and in Africa, with prevention efforts and care for infected persons and their families.

5. Because TB is the leading cause of death in persons with AIDS in the developing world, the Administration should pledge to support the "Stop TB" initiative and make a strong statement in this regard at the upcoming meeting in the Netherlands on March 24.

6. The Administration should identify a lead agency and describe a strategic process, that involves relevant Federal agencies and private partners, to explore ways to increase access to critical drugs and other health commodities (e.g. diagnostic tests) in the developing world. The PC/DC should authorize the establishment of this process. This entity would focus on identifying incentives for preferential tiered pricing and ways to removing barriers to access, such as drug licensing regulations.

7. The PC/DC should endorse the focus on community-based approaches rather than the establishment of institutions (orphanages) to support children affected by AIDS. (either children with parents sick or dying, AIDS orphans, or infected infants)

8. Every possible venue should be used to advocate for increased resources and commitment for combating the global AIDS pandemic, including the upcoming G-8, meetings of SADC, and a possible Heads of State Summit.

Recommendations to other relevant partners:

1. A recommendation was made to the Economics, Trade and Finance sub-committee to explore ways to provide USG assistance in order to improve local production of critical health commodities, such as condoms. This may involve potential linkages with the proposed Africa Trade Bill and other pending legislation. The "Buy America" policy that is currently adhered to by USAID should be re-examined to determine if there are possible waivers for use in emergency situations.

2. USAID, CDC and Department of State were encouraged to develop a protocol to facilitate new partners who are entering into collaboration in individual country programs.

3. The sub-committee recommended that a thematic interagency working group be established to focus on the challenges surrounding delivering services to reduce mother-to-infant HIV transmission.

4. The sub-committee recommended that NIH and other relevant partners establish a "global clinical trials network", that could be region specific, to monitor the efficacy and feasibility of treatment regimens for HIV infected persons.

5. The sub-committee recommended that NIH and other relevant partners review the status of development of a therapeutic HIV vaccine and to propose an appropriate strategic approach.

6. The sub-committee recommended that all partners seek ways to strengthen regional NGO networks and regional training and academic institutions.

prev&carerecommendations to NSC.doc
Submitted by Dr. Paul De Lay, USAID, Chair of the Prevention and Care sub-Committee

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NATIONAL SECURITY COUNCIL

FAX COVER SHEET

NATIONAL SECURITY COUNCIL

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Did you get a complete, clear transmission? If not, please call:

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From: **Kenneth W. Bernard**
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To: **Sandy Thurman, ONAP**
Fax Number: **6-2439**
Date/Time: **March 6, 2000**
No. of pages to follow: **3**

Sandy - FYI

Attached is the draft action plan developed by the AIDS IWG Subcommittee for Diplomacy and Awareness

PROPOSED DIPLOMACY AND AWARENESS ACTION PLAN

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

State Department Goal: In support of combating the epidemic as a both a national security and public health threat, the Department will pursue a leadership role to ensure through diplomacy that a strong, sustainable effort will be originated from the United States, the international community, and those countries strongly impacted by, or vulnerable to, the epidemic.

Objectives:

1. Strengthen U.S. diplomatic efforts and capabilities to more effectively confront the HIV/AIDS pandemic.
2. Persuade foreign leaderships and potential donor organizations that the global spread of HIV/AIDS has profound security implications for its impact on economic growth, political stability and civil society. Reinforce that message to those countries whose leaderships are already undertaking efforts.
3. Develop innovative policies in partnership with other US agencies and international bodies.
4. Enhance international scientific and health collaboration among the U.S., other nations, and international bodies.

Taking each objective in turn:

1. Strengthen U.S. diplomatic efforts and capabilities to more effectively confront the HIV/AIDS pandemic.

SUPPORTING ACTIONS:

In Washington:

- Advance the Presidential Envoy concept originated by USUN to catalyze action by key donor and recipient countries.
- Consider establishing a State Department task force or special advisory board on international AIDS.
- Target efforts at countries most at risk and target leadership in countries already heavily afflicted. In those countries, develop leadership briefs, demarches, and commit resources. While confronting AIDS in Africa is a top priority, broaden efforts to include other countries and regions with high incidence or high vulnerability to rapid propagation of HIV, such as India, South-east Asia, and the nations of the former Soviet Union. (G/OES/AF/EAP/SA/EUR)
- Highlight the success of countries such as Uganda, Senegal, and Thailand in reducing incidence and prevalence rates. Identify and analyze common traits from those countries that have been successful in addressing HIV/AIDS. (G/OES/USAID/PAPD)

- Develop a communications strategy through Public Affairs/Public Diplomacy and the regional bureaus that delivers a compelling USG message on global AIDS to domestic and international audiences and propagates lessons learned from successful interventions. Such a strategy may include a targeted media campaign, centralized information sources, enhanced Internet sites, a catalog of available financial and information resources that posts could share with host governments. (PAPD/G/AID/OES/Regional Bureaus)
- Intensify efforts to educate bureau and department personnel about basic facts of HIV/AIDS through briefings and other information dissemination efforts. (AF/G/OES/Regional Bureaus)

At Posts:

- Each Ambassador should direct the Embassy to develop a comprehensive HIV/AIDS action plan and integrate into the post MPPs, work requirement statements, and resource allocations. (AF/SA/EAP/POST)
- Devote substantial time at the annual Chiefs of Mission conference to HIV/AIDS. (AF/SA/EAP/EUR/POST)
- Establish briefings for Ambassadors, DCMs and EST officers posted in Africa on the status and implications of the epidemic in their assigned country. Such briefings could be held individually or collectively, such as at sub-regional HIV/AIDS gatherings, or in Washington during consultations. (AF/G/OES/USAID/ONAP)
- Encourage and organize sub-regional meetings for Ambassadors, USAID Mission Directors, and Public Diplomacy personnel to discuss HIV/AIDS within their respective countries and regions of Africa and Asia. (AF/G/Regional Bureaus/POST/USAID)
- Provide posts with sufficient epidemiological information, both globally and in each particular country and region. This could be done through a dedicated DOS AIDS Information Officer, through USAID missions, or through an information clearinghouse. (G/OES/USAID)
- Use all available diplomatic venues to advance HIV/AIDS as a topic of discussion and action and to promote the linkages to foreign policy and international security. (i.e. U.S.-SADC Forum, International AIDS Conference in Durban etc.). (G/OES/Bureaus)

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

SUPPORTING ACTIONS:

- Ambassadors and country teams should strongly urge top leaders – heads of state and ministers in charge of economics, finance, trade and foreign affairs - to make AIDS a high priority on their national agenda, emphasizing the wide impact that an unchecked epidemic would have upon their societies. (AF/SA/EAP/POST)
- Provide leadership briefs and analyses that clearly defines AIDS as a high-priority foreign policy issue and highlights the non-health implications of the disease –

distribute the National Intelligence Estimate, "The Global Infectious Disease Threat and Its Implications for the United States". (G/OES/Bureaus)

- Issue a new demarche (to follow up on the demarche delivered in March 1999) that directs posts to encourage host governments to address AIDS at the highest levels. (G/OES/Regional Bureaus)
- Special attention should be placed on devising responses to HIV/AIDS in situations of instability and conflict, notably in southern Sudan, Burundi, Angola and DROC. (AF/PRM/Regional Bureaus/DOD/USAID)
- Provide humanitarian HIV/AIDS assistance to African military organizations, where the loss due to AIDS of critical skills constitutes a threat to stability and security in affected countries. Assistance might be channeled directly to military entities through DOD or other USG programs, or indirectly through NGOs. (PRM/AF/Regional Bureaus/DOD/USAID)
- Ensure that the UNAIDS Partnership Against AIDS in Africa encourages action by African governments. (G/OES/USAID/POST/IO)

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

SUPPORTING ACTIONS:

- Increase involvement with the business community on HIV/AIDS issues, working with other concerned USG entities on issues such as IPR, cost reduction, service expansion or information dissemination. (AID/G/OES/EB/IO/NGOs)
- Provide HIV/AIDS counseling and education to U.S. and foreign national employees of posts abroad.
- Pursue creative financing mechanisms, such as debt reduction efforts, working with MDBs, Treasury, OMB. (EB/G/P/OES)
- Consider establishing departmental award for HIV/AIDS reporting and advocacy for an individual officer, or journalistic awards for media coverage.

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

SUPPORTING ACTIONS:

- Use FY '00 OES project funding, through a USG technical agency, to support an innovative project in HIV/AIDS.
- Assist technical agencies in expediting USG personnel placement in host countries, such as supporting CDC's efforts to place specialists in South Africa.

FAX MESSAGE

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Pages: 8
Date:

Subject: Commerce Paper

MEMORANDUM

TO: Sandy Thurman
Director, Office of National AIDS Policy

Ken Bernard
Special Advisor to the Assistant to the President
for National Security Affairs, NSC

FROM: Alan Bowser, Commerce
Co-Chair, Subcommittee on Economics, Trade and Finance

Helen Walsh, Treasury
Co-Chair, Subcommittee on Economics, Trade and Finance

SUBJECT: Subcommittee's Recommendations for NCS IWG

DATE: March 6, 2000

Alan Bowser, Commerce and Helen Walsh, Treasury co-chaired three meetings of the Subcommittee on Economics, Trade and Finance. Agencies participating in the subcommittee were Commerce, Treasury, USAID, State, OVP, DOL, USTR, HHS, OVP and OMB.

We surveyed the USG's bilateral resources directly and indirectly committed to international HIV/AIDS and the amount of multilateral development bank lending for health and HIV/AIDS. The attached chart presents our findings.

To enhance multilateral, bilateral, private sector and other efforts, we prepared recommendations for the NSC interagency working group. With these recommendations in mind, we ask that the interagency working group maintain a global perspective beyond Africa and consider the impact of other infectious diseases.

Bilateral Agency Resources Directly and Indirectly Committed to International HIV/AIDS (Millions of USD in FY2000 excluding FTE)

	USAID	CDC	NIH	DOD	Treasury	Labor	Commerce	State	USTR	TOTAL
Primary Prevention	154	13								167
Community and Home Based Care and Treatment	14	9								23
Capacity Building and Infrastructure Development	24	13								37
Research										
Vaccine			25							25
Non-Vaccine Prevention			35							35
Research Capacity Bldg			10							10
Other			20							20
Other Programs	8	11								19
TOTAL	200	46	90							336

Multilateral Development Bank Lending for Health and HIV/AIDS 1995-1999 (Billions USD)

	Total Health	Basic Health	HIV/AIDS	UNAID	TOTAL
World Bank/IDA	7.502	5.233	0.52		13.255
African Development Bank	0.251		0.063		0.314
Asian Development Bank	1.226	1.081	0.0001		2.2871
Inter-American Development Bank/FSO	1.106		0.045		1.151
TOTAL	10.085	6.294	0.6281	0	17.0071

US Contribution to UNAIDS FY2000 (Millions USD)

	USAID	TOTAL
UNAIDS	15	15

Subcommittee on Economics, Trade and Finance

Recommendations for the National Security Council Interagency Working Group on International HIV/AIDS

MULTILATERAL

Continue Support of UNAIDS
Financially and politically support the work of the Joint United Nations Program on HIV/AIDS (UNAIDS) under its International Partnership Against AIDS in Africa. (HHS)

Encourage Increased Funding from Multilateral Development Banks and Other Sources
Commend the World Bank as a UNAIDS cosponsor for its Intensified Action Against AIDS in Africa AND encourage the World Bank and the multilateral development banks (MDBs) -- in particular the African Development Bank and the Asian Development Bank -- to increase their commitments for loans addressing HIV/AIDS. The series of loans by the World Bank to Brazil and India are examples with positive and negative lessons (to be) learned. (HHS)

Encourage support for HIV/AIDS activities that may result from the use of savings of debt service by each country which is eligible for debt relief under the Highly Indebted Poor Countries (HIPC) debt initiative. (Treasury)

Encourage increased World Bank funding of basic health/vaccines and medicines. (Treasury)

Encourage other Organization for Economic Cooperation and Development (OECD) donors to increase their funding for activities addressing HIV/AIDS. The recent initiatives by the United Kingdom (UK) in southern Africa and with the International AIDS Vaccine Initiative (IAVI) are good examples. (HHS)

Include HIV/AIDS in Debt Relief Poverty Reduction Strategies
Collaborate with the World Bank and regional development banks to ensure that HIV/AIDS programs are included in debt-relief poverty reduction strategies and benefit from said relief. (USAID)

Maintain Existing Policy on Intellectual Property and Health Related Trade Issues
Continue to implement the USTR/HHS initiative on intellectual property and health-related trade issues. Encourage other countries to take a similar approach to TRIPS-plus issues where health issues are of concern. (USTR)

Expand Overseas Workplace Intervention
Explore possible collaboration with the International Labor Organization and others to establish a multi-sectorial framework for HIV/AIDS workplace education and prevention initiative. Solicit input from non-governmental organizations for the purpose of information gathering on technical assistance and best practices. (DOL)

Follow-up the DOL-AFL-CIO February Trade Unionist Summit by working with the ICFTU to advance HIV prevention issues at the April meeting in Durban, Africa; explore similar DOL involvement on HIV/AIDS within other African political/social forums such as the April/May Southern African Development Community meeting and the XIIIth International AIDS Conference in Durban in July. (DOL)

Add the Global AIDS issue to the agenda for every ministerial meeting and international summit to promote awareness at the highest levels of government (DOL)

Increase Access to Medical Supplies in Developing Countries
Host a follow-up round table discussion to the WIPO session on increased access to medical supplies for the developing countries. This session would concentrate on medical products needed in the battle against AIDS.

BILATERAL

Expand Overseas Workplace Intervention
Expand the involvement of in-country labor unions in AIDS prevention programs. [President's budget requests $10 million in the FY 2001 budget for DOL HIV/AIDS in Africa prevention efforts working with unions]. (USAID, DOL)

Develop a bilateral program to enlist technical assistance for project design and implementation in select country(ies) or region(s) for workplace based education and prevention programs. A DOL representative is now in Africa researching possible bilateral opportunities. (DOL)

Combine multilateral and bilateral programs involving outreach to trade unions in the US and Africa for networking, support, and assistance with best practices. Continue to work with the AFL-CIO. To increase access to information on AIDS in the workplace, place workplace intervention manual on the Internet. (DOL, DOC)

PRIVATE SECTOR

Convene Round Table Discussion / Expand Industry Outreach
Convene representatives from several different industry sectors to discuss the trade, financial, and economic consequences of the HIV/AIDS epidemic. Government HIV/AIDS programs will be reviewed, and industry will be asked to offer concrete suggestions regarding what they are willing to do to increase public/private cooperation in the battle against AIDS. The meeting could also work to expand industry's involvement in international AIDS programs such as UNAIDS, World Bank, and Global AIDS Vaccine Initiative. Once public/private initiatives are drafted, a second round table meeting could be convened between industry and NGOS. The purpose of this meeting would be to discuss ways government, industry, and NGOS could work together on an international AIDS initiative. (DOC)

Create an IWG on Access to Essential Drugs
Support the recommendation to create an IWG focused on Access to Essential Drugs, to be staffed by HHS, DOC, USTR, AID, Treasury, and other relevant agencies. That it address all aspects of the access issue (price, infrastructure, host government agreement) and perform the one outreach function to NGOs and industry on this topic. (USTR)

Expand Collaboration with U.S. Foundations and Private Sector
Provide technical assistance to U.S. foundations interested in health care to ensure effective programming of resources and identify opportunities to increase the resources programmed for HIV/AIDS. (USAID)

Encourage foundations to increase their funding for activities addressing HIV/AIDS. The initiatives of the Bill and Melinda Gates Foundation, e.g., $750 million in funding ($150 million per year for five years) for the Global Alliance for Vaccines and Immunization (GAVI); the United Nations/Turner Foundation; and the Kaiser Family Foundation are good examples. (HHS)

Support the coordination of drug donations to existing PVOs and NGOs that engage in existing HIV/AIDS care. (DOC)

Expand Overseas Workplace Intervention
Expand industry's active participation in AIDS education and prevention training programs in the workplace. Increase the number of companies that participate in such AIDS programs. Utilize the resources of the Foreign Commercial Service and other Department programs. (DOC)

Encourage domestic, foreign, and multinational business and labor to work in partnership to address HIV/AIDS in the workplace and in the home. The work of Business Responds to AIDS (BRTA) and Labor Responds to AIDS (LRTA) are good domestic examples. (HHS, DOL)

Coordinate with American Chambers of Commerce with the purpose of gaining ground level

information on what activities the private sector is engaging in to further HIV/AIDS awareness in the work place. Through a poll asking companies for their observations and experiences with AIDS in the work place, valuable private sector perspectives could be acquired, which may allow for the development of more effective AIDS programs in the workplace. (DOC)

Conduct International Health Care Trade Missions
Lead a group of industry representatives to several countries especially hard hit by the AIDS epidemic. Members on the Mission would address audiences on increasing access to prevention commodities and methods of treatment. Countries selected for the mission would play an active role in developing an agenda and what products should be promoted. (DOC)

Emphasize Health Related Investment Promotion
Promote private sector investment in health care. The Department would work with industry partners to facilitate direct investment in sustainable health care projects in developing countries. These projects could emphasize production of prevention and health care goods and services. (DOC)

Develop International Awareness Project
Work with industry to develop a multimedia commercial that would showcase an unified public, private, NGO, international organization AIDS effort. One area of interest is to feature the health and social needs of AIDS orphans. The purpose of the commercial will be to motivate industry participation and raise he public awareness of the AIDS epidemic (DOC)

Increase Donations of Communications Equipment
Outreach to industry and NGOs for the donation of multi-media equipment to communities and grass-roots organizations to facilitate promotion of HIV/AIDS awareness through prevention and education to the broadest segments of the population. (DOL)

OTHER

Maintain Focus on Cost-Effective Interventions
Ensure that activities encompass the continuum from research to prevention to care and treatment but focus on the most cost-effective interventions such as:

- Primary prevention, e.g., voluntary counseling and testing (VCT), social marketing, and the prevention of mother-to-child transmission (MTCT); and
- Home- and community-based care and treatment, e.g., treatment of sexually transmitted diseases (STDs) and opportunistic infections (OIs) and palliative care. (HHS)

Construct Global AIDS Initiative Internet Site
Construct an Internet site to serve as a clearinghouse for information on the Global AIDS Initiative. The site would provide an international fora for governments, NGOs, industry, trade

unions, and the private sector to post contact information, including relevant links, and facilitate the exchange of timely data on statistics, summits, regional meetings, and best practices addressing the pandemic. The concept of Millennium Networking Against the Global HIV/AIDS epidemic would be a substantive focal point for a Global Village Online. Note: to date there is no Website address in use for Globalaids.com. (DOL)

Form a Team Against Global AIDS (TAGS)
Select a group of high profile U.S. and foreign personalities for public service announcements and work as ambassadors for advocacy and social mobilization in the Global AIDS Campaign. (DOL)

Produce Prevention and Education Video
Sponsor multisectoral video production and distribution, initially utilizing the synergy between the USG and national film producers, providing expertise and support in partnership with African national governments, regional officials, and local media, to produce documentary videos depicting real people, real stories, and the real results of the ravages of the HIV/AIDS pandemic. Ultimately this would be a cost effective way to reach a maximum number of people. The benefits of video production would include the ability to tailor the message to the targeted group by country, customs, gender and age. This medium would also facilitate the incorporation of addressing the critical element of behavioral change and the empowerment of women. Videos would include referral information and could be utilized by grass-roots organizations with a two-person team to respond to questions and encourage referrals. This may also be considered a logical arena in which to provide male and female condoms. (DOL)

Adopt-a-School
Initiate an adopt-a-school program through outreach to NGOs, religious groups, and the private sector. In Uganda, it costs $1 per day to keep an orphan in high school as a boarding student 365 days per year. It costs 50 cents per day to educate a day student in high school. To qualify for adoption, the school must provide an aggressive HIV/AIDS awareness through prevention and education program. (DOL)