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002b. agenda	re: Global AIDS crisis (1 page)	05/04/2001	P1/b(1)
002c. discussion paper	re: Global AIDS crisis (6 pages)	05/04/2001	P1/b(1)

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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 year 2000 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 (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

Multilateral Development Bank (MDB) Activities on AIDS

Lending Activities

The World Bank has been the major MDB supporter of activities to combat HIV/AIDS. Regional MDB engagement has generally been more modest through technical assistance and support for epidemiology and disease control in general.

Following are summaries of health sector interventions on AIDS in each of the MDBs, which encompass direct lending for HIV/AIDS prevention/treatment. This does not include multi-sector and other activities which substantially support AIDS prevention, e.g., girls education, womens microenterprise endeavors, and womens rural extension training.

The World Bank/IDA

Cumulative HIV/AIDS lending by the World Bank and IDA has been around $986 million between FY85 to FY99, or 7 percent of total health/nutrition/population lending during this period. Recently, the World Bank has intensified its efforts to combat HIV/AIDS in Sub-Saharan Africa by making its containment a central development objective of its lending and on-lending programs in the countries of the region. It will use its policy dialogue with finance and planning ministers to encourage greater openness concerning HIV/AIDS and develop preventive interventions to assist in containing the disease. The Bank has done analysis on the economic/development impact of the disease and has supported the International AIDS Vaccine Initiative (IAVI). It has developed expertise within the Bank to assess the impact and growth of the disease and suggest "push" and "pull" mechanisms to provide incentives for the pharmaceutical industry to undertake the necessary R & D to discover and develop an AIDS vaccine.

As part of an international vaccine/health initiative, the World Bank is contemplating a $1 billion increase of its funding in basic health/vaccines and medicines to be considered by the IDA Deputies. Although not as yet finalized, part of this amount would support efforts to prevent and control AIDS, and would probably be in addition to the $400 million for HIV/AIDS activities for FY2000-FY02, a rough estimate by operations staff of the prospective pipeline of projects.

The African Development Bank/Fund

Cumulative lending by the African Development Bank/Fund for components and stand alone projects to combat HIV/AIDS has totaled $183 million to date in 15 borrowing member countries, or 14 percent of cumulative lending to the health sector. Since 1990, these projects have been to Cote d'Ivoire, Togo, Mali, Malawi, Burundi, Gabon, Morocco, Mauritania, Tanzania, Uganda, and Burkina Faso. In addition, a permanent task force on HIV/AIDS has been established to develop a multi- sectoral policy to guide future assistance. Current operations in the southern region of borrowing countries are mainstreaming HIV/AIDS control activities in all

sector work and projects.

Asian Development Bank

The Asian Development Bank has not financed any stand alone HIV/AIDS projects to date. However, the ADB has financed several regional technical assistance for HIV/AIDS programs: (I) to support the Fourth International Congress on AIDS in Asia and the Pacific in 1997 ($100,000); (ii) to develop cooperation in the prevention and control of HIV/AIDS in the Greater Mekong Subregion; and (iii) to help prevent HIV/AIDS among mobile populations in the Greater Mekong Subregion. A seminar on the current situation of HIV/AIDS in the region is being developed as an adjunct to the ADB Annual General Meeting in 2000 in Chiang Mai, Thailand. In the project pipeline 2000-2002, in 2000 the Bank is preparing a technical assistance to assist capacity building for the HIV/AIDS program in Cambodia ($600,000).

Inter-American Development Bank

The Inter-American Development Bank has, also, not as yet, funded any stand-alone activities to constrain HIV/AIDS in the region, although, a regional technical cooperation for HIV/AIDS and sexually transmitted diseases is pending for approval in 2000 ($126,000). In 1999, the Bank funded a epidemiological/health project in Bolivia ($45 million) which will control the supply of blood and blood products which will help block the transmission of AIDS. Three other regional technical cooperations, one in 1999, and two pending for 2000 will support epidemiology and disease control, as well.

HIPC Initiative

Support for HIV/AIDS activities 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. Priorities for allocation of savings to reduce poverty will be made by each country in the drafting of its "Poverty Reduction Strategy", which will then be reviewed by the World Bank and IMF. Bilateral donors, including USAID, will be consulted by the HIPC countries as they develop this strategy. This would be an opportunity to urge these countries to include expanded programs for immunization, prevention and treatment of infectious diseases, and support for effective basic health service delivery, including AIDS, in each country's "Poverty Reduction Strategy". (Bolivia, Uganda and Mauritania have been found eligible for HIPC debt relief; Mozambique, Benin, Burkina Faso, Tanzania and Mali are expected to be considered before the World Bank/IMF Development Committee Meeting, April 17, 2000.)

OASIA/IDB 2/8/00

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

	USAID	CDC	NIH	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	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	1.061	0.0001	2.2871
Inter-American Development Bank/FSO	1.106		0.045	1.151
TOTAL	10.085	6.294	0.6281	17.0071

US Contribution to UNAIDS FY2000 (Millions USD)

	USAID	TOTAL
UNAIDS	15	15

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]

[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

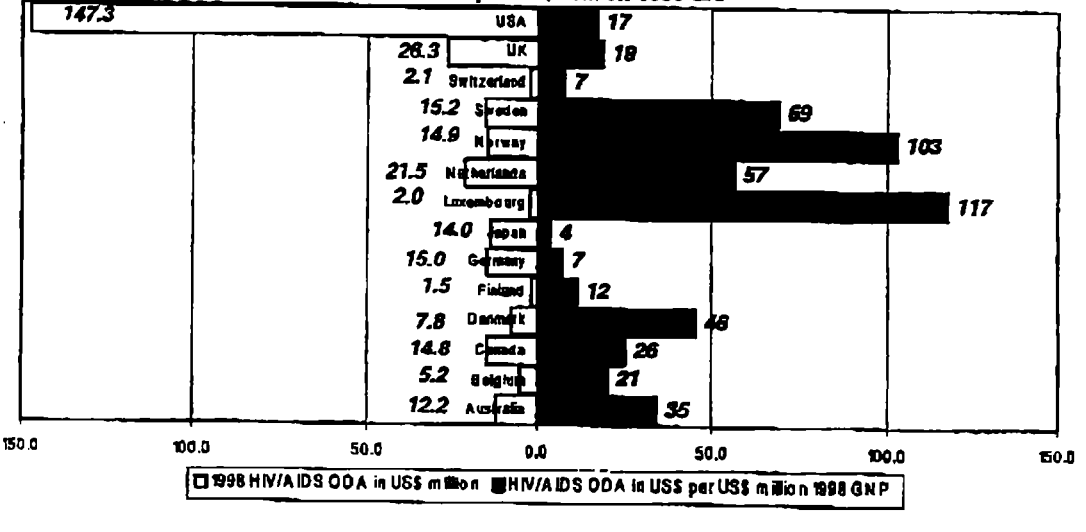
Australia, Belgium, Canada, Denmark, Finland, Germany, Japan, the Netherlands, Norway, Sweden, Switzerland, the United Kingdom and the United States reported having disbursed almost US$ 300 million for HIV/AIDS activities in developing countries and countries in transition in 1998 (Table 1).

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*

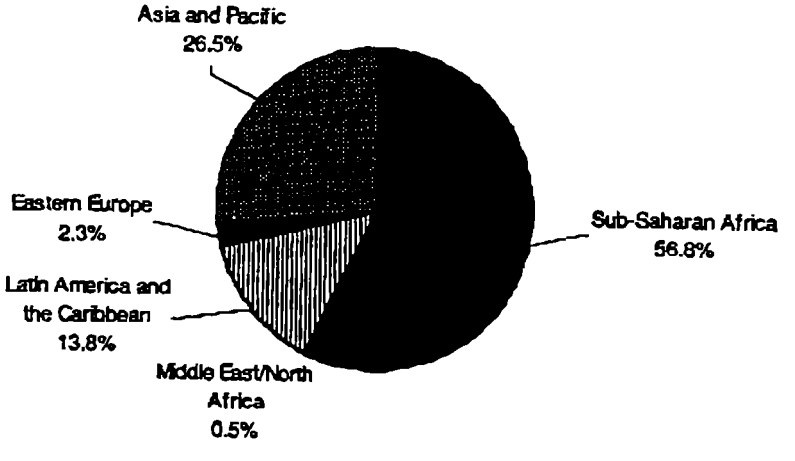
Another way to assess the level of HIV/AIDS ODA by individual donors is to consider HIV/AIDS ODA as a percentage of total ODA. In this case, Luxembourg, the United States and Australia disbursed the highest percentage of total ODA to HIV/AIDS activities with 1.8%, 1.7% and 1.3% respectively. On the other 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

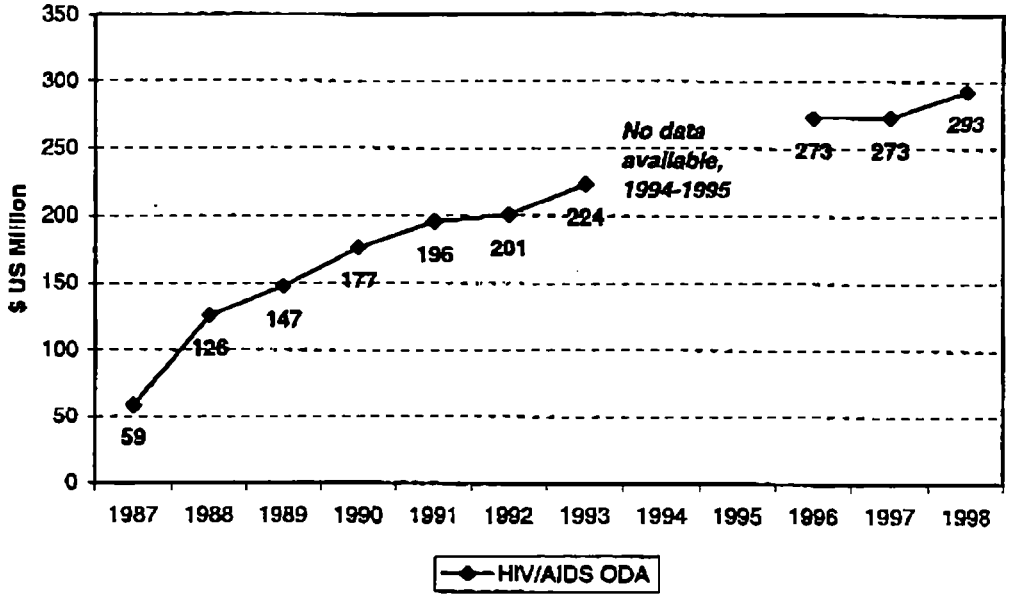


Trends in official development assistance to HIV/AIDS, 1987-1998

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.

Preliminary Estimates of the Cost of HIV/AIDS Prevention
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

the initiative countries

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% (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: 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	.198
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**	**1.684**
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%.

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Sandy Thurman	ONAP	456-2959	456-2439
Nora Dempsey	NSC	456-9261	456-9260
Ken Bernard	NSC	456-9298	456-9390
Laura Efros	NSC	456-6065	456-6028
Joyce Holfeld	USAID	712-4727	216-0077
Hal Shapiro	NEC	456-5905	456-2223
Hoyt Yee	NSC	456-9156	456-9150

6 pages

Here is the May 23 version of the statement. The gaps have narrowed considerably. I have highlighted differences in the attached text (with the exception of minor editorial changes). We need to turn this around by close of business today. The EU is meeting with member states tomorrow and hopes to finalize the statement. I am checking with Treasury about the HIPC statement. The two things the EU wanted drop were the reference to bioethics training and the specific mention of the various drug and vaccine initiatives (the French apparently wanted a reference to the International Therapeutic Solidarity Fund.) I have attached a note from my EU Counterpart.

Please let me hear from you by COB, Tuesday, May 23. Thanks.

Ray Walser
647-1605 - Fax- 647-9959

Italics - EU

Underscoring- my edits, suggestions.

EU-draft with U.S. response - 5/23/00 10:36 AM

U.S.-EU Statement on the Expanding Threat of HIV/AIDS, Malaria and Tuberculosis in Africa

Few challenges are more profoundly disturbing or more far-reaching than the collective threat posed to the citizens of Africa by three major communicable diseases: HIV/AIDS, tuberculosis and malaria. While the scope of the threat is global, Africa bears a disproportionate share of the suffering caused by these diseases. This year alone, HIV/AIDS will claim more than two million victims in Africa while another million lives will be lost to malaria and tuberculosis. The devastating effects of these diseases reverse decades of development and robs an entire generation, especially those caught in the trap of poverty, of hope for a better future. This health crisis in much of Africa deepens the vicious cycle of disease and poverty, erodes security and undermines social and economic development and poverty reduction.

We, the U.S. and EU, reiterate our commitment to combat HIV/AIDS and control diseases such as tuberculosis and malaria. Together with other countries and international organizations, we are already making a major effort. But the scale of the problem requires new mechanisms to mobilize international opinion, resources and to take appropriate actions to assist African countries. We welcome the work done in the UN Security Council during the January 2000 U.S. Presidency. In the Cairo Declaration and Action Plan of April 2000, the EU and African leaders pledged their commitment to pursue further action in this field. The renewal of the ACP-EU Partnership Agreement in June 2000 also highlights the need to work with the African, Caribbean and Pacific Partners on a comprehensive approach in the context of poverty reduction. We are looking forward to G8 initiatives on communicable diseases and poverty at the upcoming Summit in Okinawa.

Today, at the EU-US Summit, we agreed to join forces and look at new mechanisms and partnerships for finding responses and solutions to the threats posed by HIV/AIDS, malaria and tuberculosis. This will become part of our global agenda. We will work together to advance the following objectives:

International partnerships

- The EU and the US call for commitment and leadership to control malaria and tuberculosis and to combat HIV/AIDS in Africa.

- We welcome initiatives aimed at developing international partnerships with the WHO and other UN agencies, the donor community, governments in developed as well as developing countries, the pharmaceutical industry and civil society in order to find ways to encourage new international responses and sustain successful national health strategies.

- We recognize the central role and responsibilities of governments in Africa in setting priorities and coordinating country efforts and call upon our partners to support such national ownership.

Public awareness

- We will cooperate to increase public awareness of the scope of the crisis and to propagate effective health and prevention measures against these scourges. *The roles of primary health care services and basic education are crucial* as are information and other disease-targeted campaigns.

- We call upon political leaders in Africa and elsewhere to encourage information and education campaigns, including on how to prevent mother to child transmission of HIV/AIDS. *We welcome the success in some countries where strong leadership, openness to issues and flexible responses come together.*

- We will mobilize our diplomats and other representatives at the individual country level to work with national leaders and others to intensify cooperative actions, to share relevant information needed to strengthen local capacity and to deliver necessary health services and cost-effective treatments for HIV/AIDS and other infectious diseases.

Drugs and vaccines

- Together with developing country partners and with industry, we will strengthen our research and development cooperation in the fight against these poverty-related diseases. In this respect, we call for enlarged partnerships aimed at speeding up research and development. We will explore new methods of evaluating needed drugs and vaccines, including strengthening capacity and training in those countries most impacted by these diseases.

- In order to make new drugs, vaccines and other public health intervention methods available, we will stimulate increased links between our respective research activities and coordinate research tasks. We will support the introduction of new financial, legal and investment incentives designed to make drugs and vaccines more accessible and affordable to countries in need.

- **(EU: We welcome international initiatives on increased investments in the development of drugs and vaccines.)*

- (U.S. - We will support international coordination initiatives, such as the Global Alliance for Vaccines and Immunization (GAVI), the Multilateral Initiative on Malaria and the EU-ACP West African Vaccine Independence Initiative.

Resources

- The EU and US will seek increased governmental and private resources dedicated to the fight against HIV/AIDS and other diseases, including through multilateral organizations and institutions. We *acknowledge and encourage* the important role of NGOs and civil society.

- In the World Bank and other relevant organizations, we will support the setting up of mechanisms such as concessionary loans and debt relief.

- (U.S. - We will look for incentives and support for governments such as a linkage of the health budget to the HIPC debt relief initiative.)

- *(EU: We will support governments which improve their health systems*

within the HIPC debt relief initiative and the Poverty Strategy Paper as defined by the Bretton Wood Institutions.)

- We will seek to augment multilateral bank lending for healthcare systems.

Walser, John R

From: Nora.STEHOUWER@cec.eu.int
Sent: Monday, May 22, 2000 12:09 PM
To: WalserJR@state.gov; helmercs@state.gov; swansonsq@state.gov; gag@reper-portugal.be; noel.purcell-o'byrne@consilium.eu.int
Cc: Oliver.NETTE@delusw.cec.eu.int; Vlassia.VASSIKERI@delusw.cec.eu.int; Lotte.KNUDSEN@cec.eu.int; Eric.HAYES@cec.eu.int; Percy.WESTERLUND@cec.eu.int; Lieve.FRANSEN@cec.eu.int; Philippe.DARMUZEY@cec.eu.int; Fraser.CAMERON@delusw.cec.eu.int; Nina.HVID@cec.eu.int; Paul.VANDOREN@cec.eu.int; Luca.MARTINELLI@cec.eu.int; Francois.GOVAERTS@cec.eu.int; Jaak.SINNAEVE@cec.eu.int; Michel.PLETSCHETTE@cec.eu.int
Subject: draft EU-US Statement on HIV/AIDS, malaria and tuberculosis in Africa

Africa AIDS declaration.doc

Ray, Colin and Suzanne,

Please find attached a consolidated version of the draft-Statement for the Summit on HIV/AIDS, malaria and tuberculosis. It takes into account your comments as well as those by EU Member States.

We have taken on board most of your proposed changes.
However,in the part dealing with research and development, we propose to delete reference to specific international co-ordination initiatives and keep the sentence general. The reason behind this is that several Member States have proposed to also include other initiatives than already mentioned by us, such as the International Aids Vaccine Inititiative and the International Therapeutic Solidarity Fund. We considered this to complicate the issue and therefore propose the general line.

The reference to bioethics was take out, because it is included in the general sentence on strenghtening capacity and training and also because - according to our services- you would open a pandora box by mentioning it...

Under the heading of 'international partnerships' we specifically refer to UNAIDS, because of insistance by the Member States.

We will discuss this draft with the Member States on wednesday 24 May in the COTRA.

Hope to hear from you soon. Best regards, Nora Stehouwer