Withdrawal/Redaction Sheet
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Sandra Thurman to the President re: Report on Presidential Mission Looking at Children Orphaned by AIDS in sub-Sahara Africa (6 pages)	04/21/1999	P1/b(1)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Melanne Verveer
OA/Box Number: 20018

FOLDER TITLE:
AIDS [Acquired Immune Deficiency Syndrome] [Folder 2] [2]

2013-0534-S
ry1535

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]
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P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
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AIDS Convening
September 7, 1999

Briefing Book

I - Briefing Memo

II - Participants

1 - List
2 - Bio of Dr. Peter Piot and fact sheet on UNAIDS
3 - "Bristol Myers Heeds Calls to Bolster War Against HIV in Africa" – *Wall Street Journal*
4 - "Gates to Give Away Fortune" – UPI
5 - "The Global HIV/AIDS Epidemic" – The Surgeon General

III - Agenda

IV - Invite Letter

V - Background Information

1 - AIDS in Africa is a Serious Crisis
2 - Press Release on Administration Initiative
3 - Backgrounder on Administration Initiative and Q&A
4 - Wolfensohn Letter to the President
5 - USTR Paper in Intellectual Property Rights
6 - "Helping the Poorest" – *The Economist Editorial*
7 - Statement and Fact Sheet on Cologne Debt Relief Agreement
8 - "Helping the Poorest" – *The Economist*, Jeffrey Sachs article
9 - "Balms for the Poor" – *The Economist*
10 - "Orphans of the Virus" – *The Economist*
11 - "Drugs for AIDS in Africa" – *New York Times Editorial*
12 - "Facing a Global AIDS Crisis" – *The Washington Post*
13 - "A Global Disaster" – *The Economist*
14 - "In Africa, a Deadly Silence About AIDS is Lifting" – *New York Times*
15 - HIV/AIDS Prevalence Rates for Sub Saharan Africa

VI - Talking Points

THE WHITE HOUSE

WASHINGTON

September 3, 1999

MEMORANDUM TO THE FIRST LADY

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

SUBJECT: Need for an Enhanced Response to the AIDS Crisis in Africa and Around the World

---

Summary

- In the next decade, 40 million children will be orphaned as a result of losing one or both parents to AIDS.
- AIDS is not just taking lives, it is threatening economics, stability, and civil society.
- AIDS is wiping out decades of progress on a variety of development fronts, including per capita GNP, infant mortality, and life expectancy.
- Leadership and investment can help, and has helped, to turn the tide.
- Political support for a more aggressive United States response is building.
- As goes Africa, so will go India, Asia, and the new Soviet states, and by 2005, more than 100 million people worldwide will have been infected with HIV.

Background

On World AIDS Day last year, the President highlighted the growing global tragedy of children orphaned by AIDS in sub-Saharan Africa. At that time, he directed me to lead a fact-finding mission to the region and to report back to you with recommendations for productive action. From March 27 through April 5, I led a Presidential Delegation to Zambia, Uganda, and South Africa. I was accompanied by Representatives Jackson-Lee, Kilpatrick, and Lee, and assorted senior staff. We were also joined by a select group of individuals from outside of government including Mayor Dinkins, Bishop Felton May, and William Harris. [Attachment A: Manifest]

The goals of the trip were: to heighten awareness, promote leadership, and identify promising interventions. In Zambia and Uganda, we met with the Presidents and a variety of government ministers (health, welfare, community development, finance, etc.). In each country we visited a host of community-based programs serving children and families affected by AIDS, and talked with donors, experts, providers, and consumers about actions taken, lessons learned, and barriers to further progress.

On July 19, 1999 the White House released the subsequent report to the President on the mission and our proposed plan of action (press release attached). The new initiative includes a request to the Congress for an additional $100 million to combat AIDS primarily in Africa. This is the largest-ever budget increase in the global battle against AIDS and more than doubles the United States efforts.

In addition to the $100 million, the initiative includes a variety of strategic opportunities for challenging other partners to join in an enhanced effort starting with your meeting with key stakeholders on Tuesday. Others include:

- Business Leaders Meeting - The Department of Commerce will facilitate a meeting of business leaders active in Africa to encourage them to increase their efforts in the battle against AIDS. This is tentatively scheduled for early November and the Vice President has expressed interest in participating.

- Labor Leaders Meeting – The Department of Labor, led by Secretary Herman, and the AFL-CIO will co-host a meeting of US and African labor leaders to determine ways to expand existing programs which use trade unions to provide outreach and HIV/AIDS education (Note: In many parts of South Africa one in four mine workers in HIV-positive).

- Religious Leaders Summit – The Office of National AIDS Policy will facilitate a meeting of African, American and other religious leaders to discuss ways to more effectively engage communities of faith in the fight against AIDS. Several prominent religious leaders have tentatively committed to participate including Reverends Jesse Jackson, Leon Sullivan, Andrew Young and Archbishop Desmond Tutu.

- UN Conference on Children Orphaned by AIDS – On December 1,1999 (World AIDS Day), the United Nations in conjunction with the National Black Leadership Commission on AIDS (chaired by David Dinkins), The White House Office of National AIDS Policy, The Magic Johnson Foundation and a variety of NGO's will hold a conference to focus attention on the growing number of children orphaned by AIDS. You have been asked to deliver a keynote address.

Attached please find the Memoranda to the President on this issue for your review.

I welcome the opportunity to discuss this with you further, and greatly appreciate your continued support and leadership on behalf of people living with HIV/AIDS both at home and abroad.

Withdrawal/Redaction Marker
Clinton Library

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ATTACHMENT A

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

MEMBERS OF CONGRESS

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

CONGRESSIONAL STAFF

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

NON-GOVERNMENTAL PARTICIPANTS

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

ADMINISTRATION OFFICIALS

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

MILITARY PERSONNEL

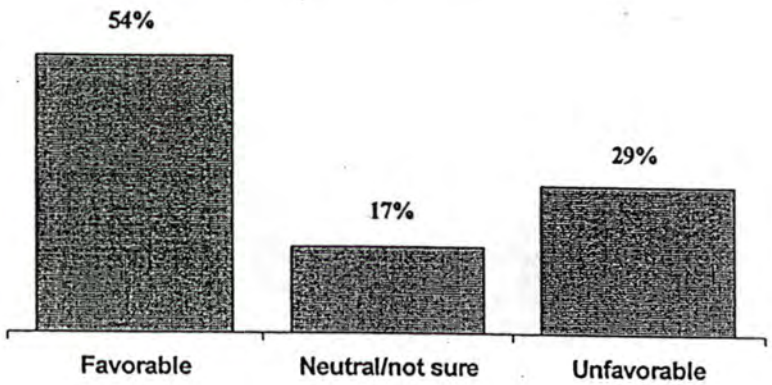
Lt. Commander James Erskine
Dr. Anthony Barile
Brenda Geist, Director Congressional Travel

ATTACHMENT B

Peter D. Hart Research Associates, Inc.

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

Increase U.S. Assistance to Fight AIDS in Africa



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

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

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

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

AIDS in Africa

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

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

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

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

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

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

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

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

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

Study #9408
CREI/Social Issues
Interviews: 1411 voters, including 310 African Americans
Dates: February 20-26, 1999

AIDS in Africa

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

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

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

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

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

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

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

AIDS in Africa

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

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

5 24-99

THE WHITE HOUSE
WASHINGTON

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

May 21, 1999

cc: Back to me

MEMORANDUM TO THE PRESIDENT

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

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

---

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

AIDS is a plague of biblical proportion

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

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

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

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

The combination of leadership and resources can turn the tide.

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

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Berger
Sperling
Podesta
Thurman

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

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

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

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

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

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

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

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

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

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

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

II. Participants

1- List

2- Bio of Dr. Peter Piot and fact sheet on UNAIDS

3- "Bristol Meyers Heeds Calls to Bolster War Against HIV in Africa" – *Wall Street Journal*

4- "Gates to Give Away Fortune" – UPI

5- "The Global HIV/AIDS Epidemic" – The Surgeon General

AIDS Convening
September 7, 1999

Participants List

Administration

First Lady Hillary Rodham Clinton

Secretary Donna Shalala
Department of Health and Human Services

The Honorable David Satcher
Surgeon General

Secretary Lawrence Summers
Department of the Treasury

Administrator Brady Anderson
US Agency for International Development

The Honorable Leon Fuerth
Assistant to the Vice President for National Security Affairs
The White House

The Honorable Sandy Thurman
Director
National AIDS Policy Office
The White House

Ms. Gayle Smith
Senior Director for African Affairs
National Security Council
The White House

Under Secretary Frank Loy
Under Secretary for Global Affairs
Department of State

Melanne Verveer
Assistant to the President and Chief of Staff to the First Lady
The White House

Dr. Ken Bernard
International Health Affairs
National Security Council
The White House

Multinational Organizations

Mr. James Wolfensohn
President
World Bank

Ms. Jan Piercy
The Executive Director of the United States
The World Bank

Dr. Peter Piot
Executive Director
Joint United Nations Program on HIV/AIDS

Foundations

Dr. Timothy Evans
Team Director for Health Services
The Rockefeller Foundation

Mr. Aryeh Neier
President Soros Foundations Network
Open Society Institute

Mr. Stewart Burden
Senior Program Officer
The John D. and Catherine T. MacArthur Foundation

Dr. Gordon Perkin
President of PATH
William H. Gates Foundation

Dr. Drew Altman
President and CEO
Kaiser Family Foundation

Corporations/Others

Mr. Charles Heimbold
Chairman and Chief Executive Officer
Bristol Myers Squibb

Mr. Robert Johnson
Chairman and CEO
Black Entertainment Television

Observers

B.A. Rudolph
Chief of Staff to the Administrator
Agency for International Development

Paul Delay
Agency for International Development

Duff Gillespie
Agency for International Development

Dr. Jim Sherry
United Nations Joint Program on HIV/AIDS

Mr. Eduardo Doryan
Vice President and Head of Network
The World Bank

Ms. Debrework Zewdie
Lead Specialist, Population
The World Bank

Timothy Geithner
Under Secretary for International Affairs
Department of the Treasury

William Schuerch
Deputy Assistant Secretary for International Development, Debt and Environmental Policy
Department of the Treasury

Ms. Debrah Lee
President and COO
Black Entertainment Television

Mr. Ken Weg
Vice Chairman
Bristol Myers Squibb

Dr. Seth Berkley
President
International AIDS Vaccine Initiative
The Rockefeller Foundation

Mr. Terry Anderson
Executive Director of Public Policy
National Association of People with AIDS

Mr. Paul Boneberg
Director
Global AIDS Action Network

Ms. Diane Graham
Special Assistant for Global Affairs
State Department

Richard Socaridies
Special Assistant to the President and Senior Adviser for Public Liaison
Office of the Public Liaison
The White House

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

Joint United Nations Programme on HIV/AIDS

PETER PIOT
Executive Director, UNAIDS

Biographical information

Peter Piot was appointed Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS) and Assistant-Secretary-General of the United Nations on 12 December 1994.

Dr Piot joined UNAIDS from a position as Director of the Division of Research and Intervention Development at the Global Programme on AIDS of the World Health Organization. Dr Piot had previously served from 1980 to 1992 as Professor of Microbiology and Head of the Department of Infection and Immunity at the Institute of Tropical Medicine in Antwerp, Belgium. During this period, he also launched and expanded a series of collaborative projects in Burundi, Côte d'Ivoire, Kenya, Tanzania and Zaire, including "Projet SIDA" in Kinshasa, Zaire, which was the first international HIV/AIDS project to be established in the developing world.

Dr Piot was Associate Professor of Public Health at the Free University of Brussels from 1989 to 1992, and Associate Professor of Microbiology at the University of Nairobi from 1986 to 1987. From 1978 to 1979, he was Senior Fellow at the University of Washington, where he carried out research on infectious diseases. During an investigation into an outbreak of haemorrhagic fever in northern Zaire in 1976, he became co-discoverer of the Ebola virus. He served as the President of the International AIDS Society from 1991 to 1994. Prior to joining UNAIDS, he was editor of *AIDS*, the leading scientific journal in its field.

Dr Piot qualified as a Doctor of Medicine at the University of Ghent in 1974 and received a Doctorate in Microbiology from the University of Antwerp in 1980. He has received many awards for scientific achievement and public service, and has published over 500 articles and 14 books, mostly on issues related to AIDS, sexually transmitted diseases and women's reproductive health. He was awarded a baronetcy by H.M. King Albert II of Belgium in 1995. Dr Piot was born in Leuven, Belgium in 1949.

14.01.99 - Doc #9496
20, avenue Appia • CH-1211 Geneva 27 • Switzerland • Tel: (+4122) 791.3666 • Fax: (+4122) 791.4187 • e-mail: UNAIDS@WHO.CH

14/01 '99 JEU 15:35 FAX +4122 791 48 98 unaids/ext Relation 005

UNAIDS

Peter Piot, Executive Director, Joint United Nations Programme on HIV/AIDS (UNAIDS).
For information, please contact UNAIDS, Geneva, Switzerland. Phone: (+4122) 791 3666,
Fax: (+4122) 791 4187, e-mail: UNAIDS@WHO.ch, Internet: http://158.232.20.3/unaids.htm

Please give credit to UNAIDS/Yoshi Shimizu.

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FACT SHEET

Joint United Nations Programme on HIV/AIDS

November 1998

UNAIDS

The HIV/AIDS epidemic continues to progress. Each day, some 16 000 people are newly infected with HIV, the virus that causes AIDS. UNAIDS estimates that more than 33 million people are currently living with HIV/AIDS, over 90% of whom live in the developing world.

Meeting the complex long-term challenge of HIV/AIDS calls for an expanded response. Direct health interventions and action to influence the immediate aspects of AIDS prevention and care must be pursued and intensified, while innovative action must be undertaken to address the broader context of the epidemic, including its socio-economic causes and consequences.

A major reform

In recognition of this concern, the Joint United Nations Programme on HIV/AIDS (UNAIDS) was established in January 1996. UNAIDS is a co-sponsored programme that brings together the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO) and the World Bank in a common effort against the epidemic. It is the first programme of its kind in the UN system, a small programme with a large outreach and the potential to lever significant resources and action through the creation of strategic partnerships.

The UNAIDS cosponsors bring to this joint endeavour complementary mandates and multisectoral expertise, ranging from education and socio-economic development to women's reproductive health. They are committed to joint planning and action, giving UNAIDS a "cooperative advantage" that translates into greater synergy and efficiency. Benefits include more effective advocacy, more effective use of UN system resources through the sharing of costs, and greater coherence in United Nations support to national AIDS programmes.

Mission of UNAIDS

As the main advocate for global action on HIV/AIDS, UNAIDS leads, strengthens and supports an expanded response aimed at preventing the transmission of HIV, providing care and support, reducing the vulnerability of individuals and communities to HIV/AIDS, and alleviating the impact of the epidemic.

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Guiding principles of UNAIDS

- *Long-term response:* HIV/AIDS requires a long-term sustainable response, including coping capacity on the part of individuals and communities. UNAIDS helps to strengthen national capacity for action ranging from prevention and care to impact alleviation.
- *Technical soundness:* Action in response to the HIV/AIDS epidemic must be not only expanded but also improved in quality through the identification and use of technically sound policies, strategies, tools and approaches.
- *Focus on vulnerability:* An effective response requires societal and structural change to reduce the vulnerability of women, young people, migrants, drug users, sexual and ethnic minorities and other population groups.
- *Support, not coercion:* A supportive social; political and legal environment helps individuals exercise their responsibilities to protect themselves and others from HIV infection.
- *Human rights:* People are entitled to enjoy all human rights without discrimination, including discrimination based on HIV infection status. These include the right to health, travel and privacy, the right to freedom from sexual violence and coercion, and the right to the information and means to prevent infection.
- *Participation and partnership:* A multisectoral response to HIV/AIDS can best be achieved through partnership.
- *National autonomy:* It is a national responsibility to design, implement and coordinate the response to HIV/AIDS at the country level. The role of external partners, including UNAIDS, is to support and build on national action.
- *Complementarity:* Rather than undertaking itself what can be or is already being done by others, UNAIDS attempts to facilitate these efforts and to fill gaps in action and research.

Global and local impact

At the global level, UNAIDS is the AIDS programme of the six cosponsors, carrying out the roles of policy development and research, technical support, advocacy, and coordination. At the same time, the six cosponsoring organizations integrate HIV/AIDS-related issues and UNAIDS policies and strategies into their ongoing work.

At the country level, UNAIDS can best be seen as the sum of AIDS-related activities carried out by its six cosponsors with the backing of UNAIDS technical guidance and resources. In countries where some or all of the cosponsors are present, their representatives meet regularly in a special "Theme Group" to jointly plan, programme and evaluate their AIDS-related activities.

In addition, UNAIDS has staff known as Country Programme Advisors posted in selected countries to support the Theme Groups on HIV/AIDS, to strengthen cooperation with national partners, and to provide technical support.

Important partners in national AIDS activities include governments (through both political leadership and the relevant ministries); community-based organizations; nongovernmental organizations (NGOs); the private sector; academic and research institutes; religious and other social and cultural institutions; and people living with HIV/AIDS.

Governance

UNAIDS is the first programme of the United Nations system to have NGO representation on its governing body. The Programme Coordinating Board (PCB) is comprised of representatives of 22 Member States of the UN system, (including both donor and recipient countries), of the six cosponsors, of NGOs and people living with HIV/AIDS.

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Strategic areas

Country support: The overriding goal of UNAIDS at country level is to enhance national capabilities to mount an expanded, multisectoral response to HIV/AIDS. Priority is given to nationally determined needs, in particular those of developing countries and economies in transition.

International best practice: Garnering practical experience from around the world, UNAIDS identifies sound policies and strategies that have proven to be effective - what is known as "international best practice". These approaches are analysed and promoted with a view to their adaptation at country level.

The programme also supports research to develop new tools and innovative approaches for slowing the spread of HIV and advocates for improving the quality of life of people living with HIV/AIDS. Examples are vaccine development, vaginal microbicides for women, practical approaches to reducing mother-to-child transmission of HIV, and better ways of preventing and treating the common opportunistic infections in HIV-infected individuals.

Structure & staffing

UNAIDS has adopted a flat organizational structure, with as few layers of management as possible. The programme consists of four departments: Policy, Strategy and Research; Country Planning and Programme Development; External Relations; and Programme Support. A total of 175 posts have been budgeted. The New York and Geneva offices currently comprise 49 professionals and 33 support staff. At country level there are 42 Country Programme Advisers, 10 Technical Advisers, 7 intercountry team members and 8 support staff. The working culture values partnership, team work and facilitation.

Funding

With its modest resource base of US $ 120 million for the 1998-99 biennium, UNAIDS is not a funding agency. It is a small programme that aims to increase its impact and outreach through strategic alliances with its cosponsors and other partners. UNAIDS cosponsors fund their own HIV/AIDS country-level programmes and activities. A further US $ 20 million was sought for 1998-1999 cosponsor activities at the global and regional levels through the *UNAIDS Coordinated Appeal for Supplemental Funded Activity*. Funds are received from traditional donor countries, but also from developing countries (e.g. China and Thailand) and the private sector. UNAIDS aims to increase the resources available to national AIDS programmes by supporting fund-raising activities at the national level and providing training in resource mobilization to its national partners.

For more information, please contact Anne Winter, UNAIDS, Geneva, (+41 22) 791.4577 or Lisa Jacobs, UNAIDS, Geneva, (+41 22) 791.3387. You may also visit the UNAIDS Home Page on the Internet for more information about the programme (http://www.unaids.org)

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Wall St. Journal 6.5.99

Foreign Aid

Bristol-Myers Heeds Calls to Bolster War Against HIV in Africa

Plan Focuses on Training, Prevention Where Virus Is Raging Most Fiercely

It Isn't Only About Altruism

By MICHAEL WALDHOLZ
Staff Reporter of THE WALL STREET JOURNAL

Drug companies are facing a dilemma when it comes to dispensing powerful new AIDS medicines where they are needed most: sub-Saharan Africa, home to 70% of the world's HIV-infected population. The therapies are too expensive for most patients, and much of the region lacks basic medical services.

So far, most companies have tried to deal with the problem through limited drug giveaways or discounting programs. But many international health officials and AIDS activists view those efforts as grossly inadequate. Already, several governments, including South Africa's, are threatening to hand over drug patents to local manufacturers, potentially flooding markets with cheap copycat versions of the industry's hugely profitable anti-AIDS medicines.

Now, Bristol-Myers Squibb Co., maker of three AIDS drugs, is trying another approach. Today it is expected to announce that it will spend $100 million in five southern African nations over the next five years to fund extensive research trials, train more than 200 physicians and help nongovernmental organizations bolster community AIDS-prevention and treatment programs. The program won't include drug discounts or handouts.

A Drop in the Bucket?

The effort is designed to help provide the sort of in-depth, long-term care and research that is common in the West, where the death toll from AIDS has plunged by two-thirds in recent years, largely as a result of the widespread use of the new "cocktails" of AIDS medicines.

No one, not even Bristol-Myers, with $18.3 billion in annual sales, believes $100 million will come close to solving the problem, even though the company calls the effort the largest AIDS grant ever by a corporation. The infection rate in sub-Saharan Africa is growing by 20% a year, and in South Africa alone the number of HIV-infected people has almost doubled to close to four million in the past two years. World-wide, 34 million people are believed to be infected with HIV, the virus that causes AIDS.

Bristol-Myers Chairman Charles Heimbold, in an interview yesterday, said his company's action, while perhaps slow in coming two decades into the epidemic, is a sincere effort to get other companies to join with it or to begin similar undertakings of their own. The 65-year-old executive says the company acted quietly and on its own "because that's the way to get things done quickly . . . and given the numbers we were seeing, speed seemed to be critical."

While Bristol-Myers says altruism is driving its efforts, there are other factors at work. The program will allow it to develop longer-term business interests in developing nations for its AIDS drugs and other therapies.

Charles Heimbold

And in a move certain to rouse ethical questions in the U.S., Bristol-Myers hopes to support South African studies involving 20,000 AIDS patients, mostly women and children, taking drug cocktails that in some cases consist solely of Bristol-Myers's three AIDS products: its antiviral drugs Videx, Zerit and hydroxyurea. Some of the trials will involve only two drugs, perhaps even in intermittent therapy, an approach considered suboptimal in the U.S. If proved effective, however, this lower-cost therapy could be a boon in the developing world.

Bristol-Myers was prodded into action when Mr. Heimbold happened to sit next to United Nations Secretary General Kofi Annan late last year at a dinner party, and the U.N. official urged him to do something for AIDS in Africa.

Officials with the U.N.'s AIDS program, UNAIDS, have been pounding the doors of U.S. and European drug companies for several years. Led by a Lebanese-born, Paris-trained physician named Joseph Saba, UNAIDS staffers in early 1997 began urging AIDS drug makers to join a pilot effort to get lower-priced medicines into four countries, including two in Africa: Uganda and the Ivory Coast.

But while sympathetic to the problem, the companies were uncomfortable with setting a precedent for a two-tier pricing system — one for the West and one for poor nations. Their main concerns: that activists in Western nations would demand similar discounts, and that the low-priced medicines would find their way onto the black market and end up in the U.S. and Europe.

Moreover, Merck & Co. argued that even if it halved the price of its big-selling protease inhibitor Crixivan, which costs about $600 a month in the U.S., few Africans could afford it or use it properly because of a lack of the necessary medical infrastructure. Protease inhibitors are an

Please Turn to Page A8, Column 1

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Bristol-Myers Heeds Call to Bolster AIDS War in Africa

Continued From First Page

essential ingredient in the multidrug cocktail that must be taken several times a day, without interruption, to be effective in reducing virus levels in the blood. Even in the U.S., many patients have difficulty adhering to the complex daily regimen. Merck's concern was that if patients in the pilot countries went on and off the cocktails, they would develop drug-resistant strains of the virus that could spread throughout Africa, and even imperil countries elsewhere, including the U.S.

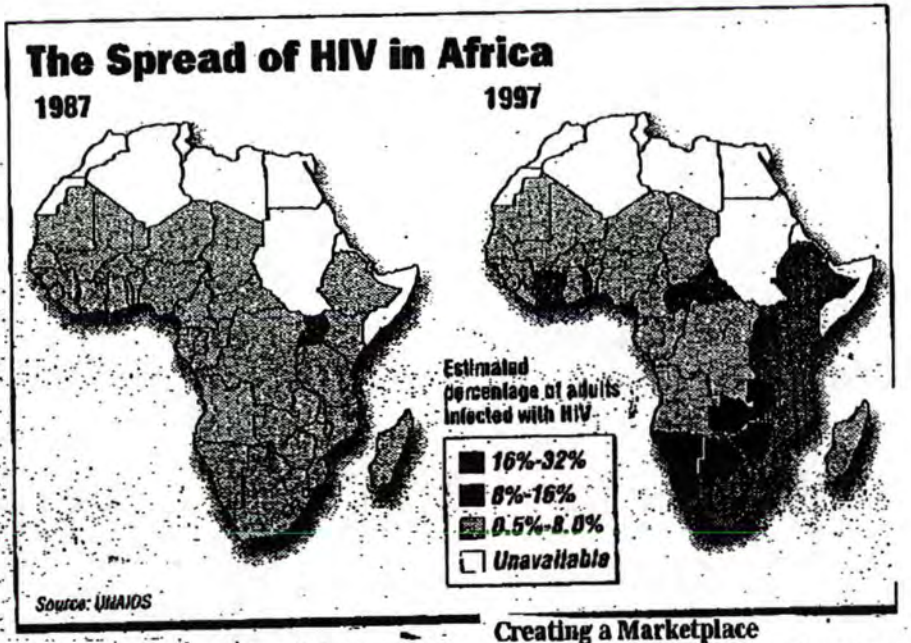
But from the perspective of UNAIDS's Dr. Saba, a courtly man who gave up a lucrative practice to work on HIV-vaccine development in Rwanda, it appeared that the world drug industry was principally concerned about protecting huge AIDS drug profits in the U.S. and Europe.

For months, he and Brian Elliot, a gregarious Irish consultant to UNAIDS, pitched their plan to company after company. Their proposal called on the companies to put up just $25,000 in each pilot country to help fund an independent body that would buy AIDS drugs at steep discounts and closely monitor their administration to avoid misuse and theft.

Deep Cut

The unlikely duo was largely met with skepticism, with one exception: Peter Young, a top executive based at Glaxo Wellcome PLC's North Carolina operations, whose AZT is a mainstay in treating AIDS. Mr. Young was the first drug-industry official to agree to slash prices, last June cutting AZT's monthly cost to patients in Uganda and the Ivory Coast by more than two-thirds to about $60 a month. The company also is providing short-term AZT dosages free to pregnant women to block the transmission of the virus to their newborns.

Mr. Young understood that this wasn't a solution, but he says Glaxo Wellcome felt it had to do something. "When we look back in 20 years or so, I wanted us to be seen as on the side of those who tried, who tried to do something, even in the face of insurmountable odds," Mr. Young says.



Critics in Africa were quick to point out that Glaxo Wellcome's patent on AZT was about to expire, and said that the company was merely motivated by a desire to sustain sales. In Uganda, Peter Mugenyi, an eminent AIDS physician and researcher, says, "I'm glad Glaxo cut its price, but if they didn't, we would have gone elsewhere" for AZT—namely to generic-drug makers.

Pharmaceuticals executives say Glaxo's willingness to slash AZT prices in Africa forced several other reluctant AIDS-drug makers, including Bristol-Myers and Roche Holding Ltd.'s Hoffmann-La Roche unit to join the UNAIDS pilot project.

However, since the project's start last summer, only 650 of the two million infected Ugandans have been able to afford the discounted drug cocktail. Even at $200 to $400 a month for the cocktail, it wasn't affordable for most AIDS patients in Uganda, where there is virtually no health insurance and the cash-starved government doesn't pay for drugs.

Creating a Marketplace

Beyond price, it was becoming clear to UNAIDS that much more than cheap drugs was needed. Mr. Elliot, who formerly ran a Johnson & Johnson unit's drug-marketing operations in Africa in the early 1990s, had come to realize that a pharmaceuticals marketplace needed to be created. In this forum, drug makers would compete with each other for patients, help train doctors and support clinics and hospitals—much as occurs in the U.S. and in Europe.

Even Dr. Saba had to be convinced of this necessity, however. One January night at an Italian restaurant in Chicago, where they were attending an AIDS conference and lobbying drug makers, tempers flared. The normally even-keeled Dr. Saba raised his voice in frustration and said he was certain the drug companies would reduce their prices even more, "because it's right." Mr. Elliot countered sharply, "Joseph, the drug makers are run by businessmen, and they respond to the market and to profits. Our job is to show them it's in their interest to lower prices and help build a medical infrastructure in Africa."

Mr. Elliot had been hammering away at this theme in dozens of meetings with drug-company executives, including several at Bristol-Myers, which had discounted its AIDS drugs by 33% to 46% under the pilot program. So when Mr. Annan, the U.N. secretary general, turned to Bristol-Myers's Mr. Heimbold and asked him to take drastic action against African AIDS, top management had a fairly clear understanding of what was needed.

That was underscored when Kenneth Weg, the company's vice chairman, and several other managers visited Botswana, Swaziland and South Africa over the winter, accompanied by former Congressman Ron Dellums, a consultant and frequent go-between for American companies and African governments.

"You can't help but become involved when you go out and see people," says the normally strait-laced Mr. Weg, 60, who, during an interview in his plush Manhattan office, becomes emotional when describing his encounters with HIV-infected women and children in Africa. At one hospital, he says quietly, he was introduced to a mother and her four-year-old child, both infected, and on the spot decided to pay for their future medical care.

Provided with data by UNAIDS, including a map illustrating the disease's rapid incursion, Mr. Weg and others at Bristol-Myers say they were stunned by the magnitude of the problem. "Of the 2.9 million children who have died due to AIDS, 2.5 million of them live in sub-Saharan Africa," he says. In addition, up to 40% of women in Swaziland and one-third of their children are also infected. In South Africa, there are 200,000 children orphaned by the disease.

The Bristol executives weren't always warmly embraced in southern Africa—especially in South Africa. In one instance, the South Africans bristled at the company's suggestion to train African physicians in the U.S., under a fellowship program run by Baylor College of Medicine in Houston, rather than in Africa; it also didn't seem to make sense to teach doctors how to use drug regimens, methods and equipment that wouldn't be available in South Africa. William Malegapuru Magkoba, director of the Medical Research Council in South Africa, says he and other black South Africans, given the recent his-

tory of apartheid, are sensitive about being dictated to by white Westerners. In the end, the two sides reached a compromise: 50 South African doctors will be trained in Texas, 50 in Africa.

Naive Approach

Bristol-Myers staffers also concede they were "embarrassingly" naive about what could be accomplished. "We thought there'd be easy answers once we got involved," says Mark Ahn, the company's project leader, who hadn't been to Africa until a weeks-long fact-finding trip in early February.

"Our assumption was that what people needed most were drugs; maybe we could make a large drug donation," Mr. Ahn says. That was before he dropped in on a support group in Soweto for 11 HIV-infected mothers. The women, who survived by making peanut butter, told him they would probably best be helped with funds to pay for more equipment rather than drugs. "These women were primarily worried about how they were going to support themselves today and tomorrow, not about whether they would be alive in five or 10 years," he says.

A large chunk of Bristol-Myers's money will go to train community workers in public health, and to provide existing programs like the African Red Cross "with the ability to greatly expand what they are already trying to do, such as caring for the orphans," Mr. Ahn says.

He adds that in recent weeks, there was a "raucous" debate inside the company over exactly how much to spend, especially since the funds will come off Bristol-Myers's bottom line. (The company says the tax-deductible grant could reduce earnings by a bit less than one cent a share in each of the five years.) Only last week, Messrs. Heimbold and Weg decided on the $100 million figure, topping lesser amounts proposed by Mr. Ahn and others.

Patent Threat

Although Bristol-Myers says there isn't any connection between its effort and recent drug-licensing moves in Africa, some observers tie the two together. Last year, South Africa passed a law saying it will license local manufacturers to make the anti-AIDS medicines unless big drug companies voluntarily reduce prices. This so upset the U.S. pharmaceuticals industry that it lobbied Congress to place a rider in a foreign appropriations bill to temporarily cut off foreign aid to South Africa. That threat postponed the South African action.

Nonetheless, later this month in Geneva, the World Health Assembly of health ministers will vote at its annual meeting on a proposal to open access to the medicines through so-called compulsory licensing that would encourage poorer nations to pass laws similar to the one in South Africa.

"What Bristol is doing is sure to be seen as a mix of good citizenship and commercial interest," says UNAIDS's Mr. Elliot. "It can't help but be seen that way."

Allen Herman, dean of the National School of Public Health at the Pretoria-based Medical University of Southern Africa, readily acknowledges that Bristol-Myers's effort is only a tiny piece of what's needed. But, paraphrasing an African proverb, he says, "How do you eat an elephant? One bite at a time." Then he adds, "What Bristol is doing is only a bite, but it's a big bite."

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LONDON, Aug. 1 (UPI) -- Bill Gates, the richest man in the world, plans to give away his $100 billion fortune, his father told the Sunday Times of London.

In an interview published today, William Gates Sr. said that after leaving more than $20 million to his son, the founder of Microsoft will give the rest of his money to the William H. Gates Foundation to wipe out deadly diseases such as AIDS and malaria.

The 73-year-old father of Gates said that in the next three months, the foundation will announce a number of newly funded programs that will go a long way toward its ultimate aim of becoming the world's largest private charity.

Bill Gates Jr. lives with his wife and child in a mansion on the shores of Lake Washington near Seattle. Gates and his wife Melinda have previously funded a family charity that currently has $10 billion in its coffers and ranks fifth in the league of the world's philanthropic foundations.

William Gates Sr., who runs the family foundation, said one of his son's favorite books is Andrew Carnegie's ``The Gospel of Wealth,'' in which the philanthropist wrote, ``The man who dies rich dies in

disgrace."

Gates Sr. said his 43-year-old son and daughter-in-law have been worried about world health since their visits to South Africa and India in the mid-1990s.

Gates Sr., 73, said the couple found themselves increasingly concerned about the effects of disease and poverty in developing countries. ``Bill and Melinda believe that one's success is not some sort of God-given thing," he said.

In May, the Gates Foundation donated more than $20 million to the International AIDS Vaccine Initiative, a group based in New York that invests money in a number of research teams looking to cure Acquired Immune Deficiency Syndrome.

Some have criticized Gates Jr. for making relatively small donations to charity and has been especially scorned for making donations of Microsoft-based computers to libraries.

Gates Sr. said: ``My son is going to have critics all his life because of his wealth. But I'm optimistic now that we have put to rest any criticism on the basis of his not being sufficiently generous. We've pretty much drowned that out."

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JAMA
The Journal of the American Medical Association

Medical News & Perspectives - April 28, 1999
From the Surgeon General

The Global HIV/AIDS Epidemic

An enormous human tragedy is unfolding in many less-developed countries because of the spread of HIV/AIDS. Of the 33.4 million HIV-infected people around the world, there are an estimated 22.5 million in sub-Saharan Africa, 6.7 million in South and Southeast Asia, 1.4 million in Latin America, and 665,000 in the United States. Globally, more than 14 million people have died of the disease, including 2.5 million last year.

In many southern African countries, HIV/AIDS has become an unprecedented emergency, with 20% to 26% of people between the ages of 15 and 49 infected. In Botswana, Kenya, Malawi, Mozambique, Namibia, Rwanda, South Africa, Zambia, and Zimbabwe, HIV/AIDS will reduce life expectancy from 64 to 47 years by 2015. The progress of decades of work immunizing children, controlling diseases, and improving nutrition is being negated by HIV/AIDS.

Conditions in many parts of the world promote rapid spread of the HIV/AIDS epidemic. For example, India, with a population approaching 1 billion, has estimated that 3 million to 5 million of its people are infected, and the number of new infections will double every 14 months.

Social and political issues surrounding sex, injecting drug use, and blood transfusion in many countries have created special circumstances in which the disease has been able to spread unchecked. Some less-developed countries also bear a burden of political and economic instability that makes prevention even more difficult. It was only a few years ago that epidemiologists offered projections of disease prevalence for sub-Saharan Africa that were met with disbelief. If the present warnings go unheeded, South Asia, Southeast Asia, and, perhaps, China will follow the disastrous course of sub-Saharan Africa.

More than a decade of experience has taught us how to control HIV/AIDS—we know what works. Many developed countries have successfully checked the spread of the epidemic. While development of therapy and a vaccine continue, prevention must be emphasized. The basic elements of prevention include education, behavior change, voluntary testing and counseling, prevention of perinatal transmission, and political commitment. Each country must find the mix of methods appropriate to its

particular conditions.

Education about HIV/AIDS is necessary but alone does not change the behavior of populations. Promotion of voluntary testing and counseling must complement education. Testing and counseling break the deadly silence around HIV/AIDS and empower individuals to make informed decisions and change behaviors. Breaking the silence also will begin to diffuse the stigma surrounding the disease. We have seen success with behavioral change in Uganda and Thailand, the only two less-developed countries with extensive capacity for voluntary testing and counseling.

It is known that perinatal transmission of HIV can be reduced by more than 50% by using antiretroviral therapy; however, problems with access to these drugs limit their use in some countries. Transmission of HIV through breast-feeding and poor survival of orphans make the avoidance of disease via treatment for perinatal transmission more complex. We continue to work with international organizations, other governments, and pharmaceutical companies to lower costs and expand access to antiretroviral drugs. Current treatment for perinatal transmission (as well as use of antiretrovirals in general) in less-developed countries is also limited by the fact that very few people have been tested for HIV infection.

Treatment of other sexually transmitted diseases (STDs) is important to control the spread of HIV. One of the reasons HIV has spread so rapidly in Africa is that so many STDs go untreated. Untreated STDs break down natural barriers that prevent transmission. Access to even basic treatment for STDs remains a problem for many less-developed countries.

Perhaps most important in the global battle against HIV/AIDS is political commitment. Leaders at the national, provincial, and local levels of government must speak out about HIV/AIDS and encourage businesses and nongovernmental organizations to commit to work against the disease. I was encouraged by US Vice President Al Gore and Deputy President Thabo Mbeki of South Africa, who put the HIV/AIDS threat at the top of the international agenda at the recent meeting of the United States-South Africa Joint Commission. They set an important example for leaders in developed and less-developed countries.

American medicine and public health have an important role to play in the global battle against HIV/AIDS by supporting international organizations such as the Joint United Nations Program on HIV/AIDS, the World Health Organization, and the World Bank.

HIV/AIDS can be likened to the plague that decimated the population of Europe in the 14th century. While the

modern epidemic affects people of all age groups, those of working age are at highest risk, posing potentially dire economic, social, and political consequences for the global community. Unfortunately, the world continues to devote greater attention and resources to traditional national security issues such as wars, postponing notice of an epidemic that, if left to spread unchecked, will kill more people than any of the terrible conflagrations that have so marked this century.

—David Satcher, MD
Surgeon General of the United States and Assistant Secretary,
Department of Health and Human Services

(*JAMA*. 1999;281:1479)

Table of Contents

Journals · **JAMA** · **AMNews** · **JAMA Condition-Specific Sites**
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HIV/AIDS Leadership Meeting

The White House
September 7, 1999 - 10:30 a.m.

Overview and scope of the problem

Brief outline of the Administration's new Global AIDS Initiative

- ***Increasing U.S. Government investment***
  - Prevention
  - Care and treatment
  - Infrastructure/capacity development
  - Care of orphans
- ***Building partnerships***

Open discussion by key stakeholders

- ***Sectors***
- ***Topics***
  - Enhancing and coordinating AIDS efforts
  - Incorporating AIDS into existing portfolios (AIDS as a development issue; AIDS as a business issue; AIDS as an international finance issue)
  - Innovative approaches and partnerships

Next steps

August 4, 1999

Mr. John M. Doe
Address Line 1
Address Line 2
City, State 20001-Zip

Dear John:

I am pleased to invite you to the White House on September 7, 1999, to join me and a small group of senior representatives from the United States government, multinational institutions, foundations and the corporate sector for a meeting to explore strategies to better address the international AIDS crisis.

This devastating epidemic is an assault on health and development that has few, if any, modern equals. Only 20 years ago we did not know that HIV existed. At the beginning of this decade, who among us would have thought that by 1999 AIDS would be the leading cause of death in sub-Saharan Africa and the fourth leading cause of death worldwide?

In the face of this reality, the President has recently asked for a $100 million increase in funding for international HIV/AIDS programs as the cornerstone of a broad and comprehensive new international initiative to combat the epidemic. This is just a part of the international effort necessary to control the spread of HIV and to deal with the associated problems of patient care.

Today 34 million people worldwide are living with HIV or AIDS. AIDS related diseases have killed 14 million men, women and children--mostly in Africa where more than 5,000 deaths are reported each day. By 2010, 40 million children will have been orphaned by HIV/AIDS. Economic development in many African countries has come to a stop and the hard won social and health advances of the last 20 years are being reversed by the new realities of the epidemic. These statistics do not begin to describe the personal tragedy for many of those living with HIV/AIDS and their families.

Still there is cause for hope. Throughout the world, heads-of-state are increasingly acknowledging AIDS prevention as a public health and political priority. National HIV/AIDS control strategies have been written, and Uganda and Thailand have shown that successful national AIDS prevention programs can work. Unfortunately, a serious crisis remains and much

more needs to be done. Many developing countries, overwhelmed by human and financial costs, are losing the battle with the epidemic.

I am asking you to join me to help build the momentum necessary to engage all stakeholders in winning the war against HIV/AIDS. Although financial support for AIDS prevention efforts remains the most critical unmet need, this meeting is not intended to be a donors conference. Rather, we will discuss strategies and identify priorities and new partnerships for assisting countries in their HIV/AIDS control efforts.

We will meet at the White House on Tuesday, September 7th. Please plan to arrive at the East Appointments Gate no later than 10:00am. To confirm your participation, please call Katy Button in my office at (202) 456-6266. I look forward to seeing you on September 7th.

Sincerely yours,

Hillary Rodham Clinton

V. Background Information

1- AIDS in Africa is a Serious Crisis

2- Press Release on Administration Initiative

3- Backgrounder on Administration Initiative

4- Wolfensohn Letter to the President

5- USTR Paper in Intellectual Property Rights

6- "Helping the Poorest" – *The Economist Editorial*

7- Statement and Fact Sheet on Cologne Debt Relief Agreement

8- "Helping the Poorest" – *The Economist*, Jeffrey Sachs article

9- "Balms for the Poor" – *The Economist*

10- "Orphans of the Virus" – *The Economist*

11- "Drugs for AIDS in Africa" – *New York Times Editorial*

12- "Facing a Global AIDS Crisis" – *The Washington Post*

13- "A Global Disaster" – *The Economist*

14- "In Africa, a Deadly Silence About AIDS is Lifting" – *New York Times*

15- HIV/AIDS Prevalence Rates for Sub Saharan Africa

AIDS in Africa is a Serious Crisis

But Opportunities Exist for Helping to Save Millions of Lives

AIDS in sub-Saharan Africa is shattering families and communities.

- In many countries in southern Africa, between 16% (South Africa) and 26% (Zimbabwe) of the adult population (15 to 49) is already HIV+.

- UNAIDS has declared HIV/AIDS in Africa "the worst infectious disease catastrophe since the bubonic plague." In sub-Saharan Africa, each and every day more than 11,000 additional people become HIV+. In South Africa alone, at least 1,500 people a day become HIV+, 1,000 of whom are under the age of 20.

- 83% of all AIDS deaths to date, nearly 12 million people, have been in sub-Saharan Africa.

- There are over 5,500 AIDS related funerals a day in Africa. That number will rise to 13,000 a day by 2005.

- By 2010, more than 40 million children worldwide will be orphaned by AIDS; 95% in sub-Saharan Africa.

AIDS is wiping out decades of progress on a host of development objectives in sub-Saharan Africa.

- According to US Census Bureau, AIDS has already reduced life expectancy Zimbabwe from 65 to 39 years, in Uganda from 54 to 43 years, and in Zambia from 56 to 37years. In the next few years, AIDS will reduce life expectancy in South Africa by a third, from 60 to 40 years.

- In the coming decade, AIDS will double infant mortality (infants under the age of 1) in many sub-Saharan Africa countries and triple child mortality (children ages 1 to 5).

AIDS is not only causing unfathomable human suffering it is jeopardizing the economies, the stability, and civil society of many sub-Saharan African nations.

- AIDS is a trade and investment issue. At the recent meeting with African trade and finance ministers, Professor Jeffrey Sachs, director of the Harvard Institute for International Development, stated that, "a frontal attack on AIDS in Africa may now be the single most important strategy for economic development."

- According to *The Economist*, a recent study in Namibia estimated that AIDS cost the country almost 8% of GNP in 1996. Another analysis predicts that Kenya's GNP will be 14.5% smaller in 2005 than it would have been without AIDS, and the per capita income will be 10% lower.

- A report released by the World Bank last week states: "The question is, will this pandemic destroy the developing nations' hard earned economic gains or will governments get their act together in time? Clearly time is running out."

- AIDS has hit professionals hard in sub-Saharan Africa, particularly civil servants, engineers, teachers, miners, and military personnel. According to one study in Kigali, Rwanda, 34% of people with post-secondary education were HIV positive, compared to 18% of those with primary education, and civil servants were more than three times more likely to be HIV

positive than farmers. Increased benefits and training costs, and disruption due to sick and bereavement leave are seriously affecting both the private and public sectors. Companies like British Petroleum and Barclay Bank told us that they are now hiring two employees for every one skilled job, assuming that one will die of AIDS.

- ❖ AIDS is a security issue. According to the Economist, "the estimated HIV prevalence in the seven armies embroiled in the Congo range from 50% for the Angolans to 80% in Zimbabweans". Recent reports confirm that 40% of the South African military is already HIV positive. US military officials have raised this as a serious stability concern.

- ❖ A South African anti-crime institute has linked the growing number of children orphaned by AIDS to future increases in crime and civil unrest. Without appropriate intervention, many of the 2 million children projected to be orphaned by AIDS in South Africa will raise themselves on the streets, often turning to crime, drugs, commercial sex, and gangs for survival. This not only effects social stability but also dramatically increases their risk of HIV.

Determined leadership and partnerships have made, and are continuing to make, an extraordinary difference, saving millions of lives.

- ❖ Uganda has been the world leader in demonstrating that even a country with limited resources and low levels of literacy could turn the tide on a burgeoning epidemic. President Museveni demonstrated bold leadership early on, making every government ministry take the problem seriously, and develop and implement its own plan for reducing stigma and transmission, and caring for those who become sick.

- ❖ Uganda has created an enabling environment for donors, such as the US, to be active partners in the battle against AIDS. The US has invested $46 million in HIV prevention and care in Uganda (26% of all donor AIDS funding), and as a result, HIV rates have been slashed by more than half. Through stigma reduction, education, HIV counseling and testing, treatment of STDs, and community based HIV care and support, Uganda has begun to turn the tide.

- ❖ Countries such as Zambia, Malawi, Uganda, and Kenya have begun to develop initiatives to respond to the growing number of children orphaned by AIDS. In the longstanding African tradition, communities are finding creative ways to support the village in its efforts to raise its children, but the growing number of orphaned children already overwhelms many of these villages.

- ❖ Through micro-finance programs like FINCA (Foundation for International Community Assistance), women are receiving loans, starting small businesses, and with increased household incomes, taking in children orphaned by AIDS. With support of non-governmental organizations, communities are coming together to deal with school fees, nutritional assistance, immunization and oral hydration, counseling, and the range of other needs that arise for orphaned children. These efforts are low cost strategies designed to empower women, protect children, and support extended families and communities in carrying for their own. For a small fraction of the cost of one orphanage bed an entire community of vulnerable children can receive care. The problem is that only a very small number of children receive even this modest level of support.

THE WHITE HOUSE

Office of the Vice President

For Immediate Release
Monday, July 19, 1999

Contact:
(202) 456-7035

VICE PRESIDENT GORE ANNOUNCES ADMINISTRATION WILL SEEK $100 MILLION INITIATIVE – A RECORD INCREASE -- IN FUNDS TO FIGHT AIDS AROUND THE WORLD

Washington, DC -- Vice President Al Gore today joined Archbishop Tutu, Director of the Office of National AIDS Policy Sandra Thurman, Members of Congress, and leaders of the African-American, religious, children's, and AIDS communities to announce that the Administration will seek the largest-ever budget increase in the global battle against AIDS – a new investment of $100 million. The Vice President also unveiled a new report from the Office of National AIDS Policy that assesses the AIDS crisis in Africa and recommends this investment. In addition, the Vice President announced new efforts to encourage other public and private entities across the world to address AIDS across the world.

"AIDS in Africa is the worst infectious disease catastrophe in the history of modern medicine," Vice President Gore said. "More than twenty million people are now infected and nearly 500 more become infected each hour. We hope this initiative will not only provide much-needed relief but will inspire decisive action by other countries and institutions – and bring hope to the millions of children and families trapped in this horror." Today, the Vice President:

RELEASED A NEW REPORT ON THE PRESIDENTIAL MISSION ON CHILDREN ORPHANED BY AIDS IN SUB-SAHARAN AFRICA. Last December, President Clinton directed the Director of the Office of National AIDS Policy to go on a fact-finding mission to assess the problem of HIV/AIDS in Africa. Today, the Vice President is releasing the report that includes new findings and a plan of action resulting from this mission. The report finds that:

- **AIDS in sub-Saharan Africa is one of the largest health crises in the history of the world.** In the past decade, twelve million people in sub-Saharan Africa have died of AIDS -- one quarter of them children -- and each day AIDS buries another 5,500 women and children. Over the next decade, AIDS will kill more people in sub-Saharan Africa than the total number of casualties in all of the wars of the 20th century combined. By 2005, the daily death toll will reach 13,000 people per day.

- **Millions of children will be orphaned by this epidemic.** In some areas up to one-quarter of all children already live with an HIV-positive parent. In the next decade, more than forty million children in sub-Saharan Africa will lose a parent to HIV/AIDS.

- **This epidemic has a devastating impact on many aspects of life in sub-Saharan Africa.** AIDS is

undermining much of the progress in development that has been made in Africa. AIDS is reducing life expectancy by more than 20 years in some countries. Many children are dropping out of school to care for dying parents undermining improvements in education, and AIDS will continue to have a major negative impact on the economy, hitting a range of professionals, from teachers to military to business leaders and therefore undermine its current trade with other nations throughout the world.

UNVEILED NEW $100 MILLION INITIATIVE TO COMBAT HIV/AIDS ACROSS THE GLOBE. The Vice President also unveiled a new initiative to double the existing efforts to prevent and treat AIDS. This initiative will be targeted to Africa in addition to other parts of the world where this epidemic is growing. It will help move forward on four critically important and interconnected fronts including:

- **Containing the AIDS Pandemic.** A new $48 million initiative will be used to implement a variety of prevention and stigma reduction strategies including: HIV education; engagement of political, religious and other leaders; voluntary counseling and testing; blood supply screening, and, interventions to reduce mother-to-child transmission (MTCT). In addition, the Department of Defense (DoD) will begin new efforts to work with African militaries to provide educational material and training on AIDS prevention.

- **Providing Home and Community-Based Care.** This $23 million investment will be used to deliver counseling, support palliative and basic medical care including treatment for sexually transmitted diseases, opportunistic infections, and tuberculosis (TB) through community-based clinics and home-based care workers and enhance training and technical assistance efforts.

- **Caring for Children Orphaned by AIDS.** This new $10 million initiative will be used to assist families, extended families, and communities in caring for their children through nutrition, education, health and counseling support, in coordination with micro-finance programs.

- **Strengthening Prevention and Treatment by Augmenting Planning, Infrastructure, and Capacity Development.** This $19 million initiative will help strengthen host country ability to plan and implement effective interventions. It will also strengthen the capacity for effective partnerships between local government and community-based organizations. Strengthen local surveillance systems to track the spread of HIV infection, AIDS, and the effects of interventions to enable the best targeting of HIV/AIDS prevention programs.

  This United States Government investment would be provided through AID ($55 million), HHS ($35 million) and DOD ($10 million) and will be fully offset.

ENGAGING OTHER PARTNERS TO ADDRESS THIS CRISIS. Addressing the crisis of AIDS worldwide will require a broad-based commitment from public and private partners across the globe. The Vice President also unveiled a series of new initiatives to enhance efforts to address this problem including:

- **Multi-lateral Partners Meeting to Enhance Coordination Around the World.** On September 7,

1999, First Lady Hillary Rodham Clinton will convene a meeting of donors, The World Bank, UNAIDS, international foundations, CEOs and others to discuss how we can best enhance and coordinate our AIDS efforts in Africa and around the world.

- **A United Nations Conference on Children Orphaned by AIDS.** The United Nations, in conjunction with the National Black Leadership Commission on AIDS, The White House Office of National AIDS Policy, The Magic Johnson Foundation and a variety of NGOs, will organize a conference on World AIDS Day to focus attention on the growing number of children orphaned by AIDS worldwide, with a special emphasis on sub-Saharan Africa.

- **New Partnerships with Private Sector Leaders to Address This Crisis, Such As the Religious, Business and Labor Communities.**

  -- Given the impact of AIDS on businesses active in Africa as well as the overall economic-impact on African countries, the White House will facilitate a meeting of business leaders to encourage commitment and involvement in AIDS programs, such as workplace education, outreach to communities, and increased funding support for AIDS efforts.

  -- The White House will host a meeting of US and African labor leaders, co-chaired by the AFL-CIO, to build on successes in working with the Council of South African Trade Unions to address AIDS.

  -- The White House will also facilitate a religious summit of African, American, and other religious leaders to discuss the important role of communities of faith in the fight against AIDS. In Uganda and Senegal it is very clear that the involvement of religious communities and leaders had a dramatic impact on the ability of these two countries to reduce HIV prevalence or to maintain it at low levels over time.

Joining Forces for LIFE:

Leadership and **I**nvestment in **F**ighting an **E**pidemic

A Global AIDS Initiative

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

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

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

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

- **Containing the AIDS Pandemic ($48 million)** Implement a variety of prevention and stigma reduction strategies, especially for women and youth, including: HIV education, engagement of political, religious, and other leaders; voluntary counseling and testing; interventions to reduce mother-to-child transmission (MTCT); and enhance training and technical assistance efforts, including Department of Defense efforts with African militaries.

- **Providing Home and Community-Based Care ($23 million)** Deliver counseling, support, palliative and basic medical care including treatment for sexually transmitted diseases, opportunistic infections (OIs), and tuberculosis (TB) through community-based clinics and home-based care workers. Enhance training and technical assistance efforts.

- **Caring for Children Orphaned by AIDS ($10 million)** Assist families, extended families, and communities in caring for their children through nutritional assistance, education, training, health, and counseling support, in coordination with micro-finance programs.

- **Strengthening Prevention and Treatment by Augmenting Planning, Infrastructure, and Capacity Development ($19 million)** Strengthen host country ability to plan and implement effective interventions. Strengthen the capacity for effective partnerships and the ability of community based organizations to deliver essential services. Strengthen surveillance systems to track the epidemic and target HIV/AIDS programs.

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

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

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

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

- **Leadership Meeting** On September 7, 1999, First Lady Hillary Rodham Clinton will convene a meeting of key US officials, The World Bank, UNAIDS, as well as heads of foundations, corporate CEOs, and others to discuss how best to enhance AIDS prevention and treatment efforts in Africa and around

the world. The meeting will focus not only on leveraging additional resources, but also on establishing priorities, identifying effective public/private partnerships, and identifying targets for action to combat the crisis of HIV/AIDS.

- **African Leaders Summit** We propose hosting a high-level meeting with Africa government and community leaders within the next ten months. This meeting will highlight the critical role of leadership in arresting the epidemic and will work to encourage increased leadership efforts. Topics will include the economic impact of HIV/AIDS, examination of models of success in reducing the transmission of HIV, and addressing the need for increased investment in health programs. Additional topics will include AIDS care and treatment and support for children orphaned by AIDS.

- **UN Conference on Children Orphaned by AIDS** On December 1, 1999 (World AIDS Day), the United Nations in conjunction with the National Black Leadership Commission on AIDS, The White House Office of National AIDS Policy, The Magic Johnson Foundation and a variety of NGOs, will organize a conference to focus attention on the growing number of children orphaned by AIDS worldwide. Special emphasis will be placed on assessing the needs of orphaned children in sub-Saharan Africa and the Americas. Participants will include noted experts on the priority issues identified by UNAIDS, UNICEF, and other UN agencies.

- **Business** The Department of Commerce will facilitate a meeting of business leaders active in Africa to encourage them to increase their efforts to rise to the AIDS challenge. Given the impact that AIDS is having on businesses as well as the overall economic-impact on African countries, such a meeting will seek enhanced business commitment and involvement in AIDS programs.

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

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

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

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

"Joining Forces for LIFE: Leadership and Investment in Fighting an Epidemic" is an excerpt from *Report on the Presidential Mission on Children Orphaned by AIDS in sub-Saharan Africa: Findings and Plan of Action*, The White House, June 19, 1999.

AIDS Initiative: Qs & As

For Internal Use Only

Q: Is this initiative a response to the recent problems facing the Vice President on international patents in South Africa?

A: No. The President, the Vice President and others throughout this Administration recognize the critical nature of this pandemic and is committed to helping the African people combat AIDS. This effort began on December 1, 1998 (World AIDS Day) when the President and Vice President focused attention on this issue and directed AIDS czar Sandy Thurman to lead a fact finding mission to sub-Saharan Africa and report back with recommendations. Today we are releasing a report from Director Thurman and moving forward on the Plan of Action.

The Vice President has worked with President Mbeki and other African leaders to address the crisis of AIDS and worked with Director Thurman and others to assure that the Administration responded to the recommendations of Director Thurman's report. The Vice President looks forward to continuing to work to find ways to address this problem.

Q: How is the budget amendment being paid for?

A: This new proposed investment of $100 million is fully paid for. The Office of Management and Budget worked with many agencies to come up with a series of reasonable offsets, such as areas where appropriated funds are in excess of what is needed. These include:

$40 million comes from unspent activities at the Department of Justice for enforcement activities against unlawful diversion of prescription drug medications.

$30 million in unobligated balances from the National Institutes of Health Buildings and Facilities still available because they were not spent last year.

$10 million in balances from the Agency for International Development Sustainable Development Assistance Account in appropriated funds. (IF PRESSED: Typically, in the course of a given year, due to changing conditions, a small portion of AID funding is available to be shifted from one program to another. This year, there will be a shift toward prevention and treatment in Africa.)

$10 million comes from a small percentage of unobligated commodity funding in the International Assistance Programs.

$10 million from the Department of Defense from sales of excess raw minerals.

Q: Are any of these funds being taken from existing AIDS programs, Africa programs, or programs to support orphans?

A: None of the funds are being shifted away from AIDS, Africa or programs which provide support to orphans. These funds are additional to what is currently being spent on both AIDS and Africa.

Q: Does this initiative really double funding for prevention and treatment in Africa?

A. The United States Government currently spends $81 million in prevention and treatment in Africa. This new $100 million proposed for FY2000 represents a more than doubling of our investments in this area. We also are hopeful that this level of commitment will encourage other nations to step up their efforts. We need many nations and private sector commitments to address a problem of this magnitude.

Q: How much of the $100 million goes towards prevention? towards treatment?

A: $48 million will primarily go towards prevention and $23 million for treatment of sexually transmitted diseases and opportunistic infections. Of the remaining dollars, $10 million will provide care for children orphaned by AIDS and $19 million will strengthen prevention and treatment by augmenting planning, infrastructure, disease surveillance and capacity development.

Q: How will you determine which countries receive funding?

A: Countries will be chosen based on a combination of factors. The most important factor is the receptivity of host countries to partnering. Other factors to be considered include the adult HIV prevalence rates, the potential for impact, the rate of increase in HIV, the status of ongoing programs, the political commitment of governments and the opportunity for innovation. Some of the countries which are currently under consideration are: South Africa, Nigeria, Kenya, Uganda, Mozambique, Zimbabwe, Senegal, Malawi, Zambia, Rwanda, Cambodia, and India. In addition, two regional programs (West/Southern Africa Programs) may be necessary to target migrant workers, and other trans-border issues.

Q: How will the US Government accomplish the goals described with only $100 million

in FY2000?

A: The goals are part of a larger strategy to battle AIDS outside the U.S., primarily in Sub-Saharan Africa. Our initiative seeks to link the US comparative advantage in assisting developing countries battle AIDS with that of other bilateral and multilateral donors, as well as on the host countries themselves. The battle against AIDS can not be won by the US alone or in one year. Although US leadership is a critical component of the effort, there must be a substantial effort on the part of other donors and the African nations themselves. The goals of the initiative, developed in coordination with UNAIDS, are part of a five year strategy. The global effort of all parties must be sustained over time to address this urgent problem.

Q: Has funding been allocated for FY2001?

A: It is clear that the difficult battle against AIDS will require sustained attention from the US government, other bilateral and multilateral donors and especially from the African nations themselves for many years. Our goals, which are coordinated with the UNAIDS program goals, are five year goals. We are committed to working towards reaching these important goals.

(IF PRESSED:) Today we are making a commitment for $100 million in the global battle against AIDS. We have not made any funding commitments beyond this. However, recognizing the extreme need, we anticipate future funding commitments will be part of our sustained effort.

1999-SE-005934 (COPY)

The World Bank
Washington, D.C. 20433
U.S.A.

JAMES D. WOLFENSOHN
President

May 27, 1999

The Honorable
William J. Clinton
The President
United States of America
The White House
1600 Pennsylvania Avenue
Washington, D.C. 20500

Dear Mr. President:

The AIDS epidemic is reversing decades of progress in improving the quality of life in developing countries. More than 33 million men, women, and children are infected with HIV worldwide, and more than 90 percent of those infected live in developing countries—two-thirds in Sub-Saharan Africa. In the hardest-hit African countries, life expectancy is now 10-20 years shorter than it would have been without AIDS. Meanwhile 16,000 more people worldwide become infected each day.

AIDS has therefore become a core development issue, and confronting the AIDS epidemic in developing countries has become critical to all our efforts for poverty reduction, growth, and improved quality of life. I welcome the strong concern G8 leaders have shown at past meetings, but I believe we now have to move together to a new level of action, on three fronts:

First, we must reinforce political commitment and active leadership in preventing HIV/AIDS. There is no cure for AIDS and no vaccine, but there *are* educational and behavioral interventions that work *now* to curb its spread. Half of the population of developing countries—3.5 billion people—live in countries or areas where there is still time to prevent an epidemic. Top-level, visible political leadership can make a critical difference in bringing AIDS to the top of the social and political agenda.

Second, we must urgently find low-cost, effective therapies that are within the reach of developing countries—for example to prevent mother-child transmission and to fight AIDS-related infections like TB—and strengthen health systems to deal with the increased demand for health care. This is particularly acute in Sub-Saharan Africa, where the largest number of AIDS patients live, health systems are weak, and the ability to pay is very low.

Third, we need to recognize that there is an emerging set of global health issues for which we need new approaches and instruments: accelerating the development of an HIV/AIDS vaccine that is affordable and effective in developing countries is a crucial instance. An AIDS vaccine for low-income countries is an *international public good* which is not likely to happen without innovative international public action. Private industry must play the critical role in developing and marketing a vaccine, but the private sector currently does not have the incentives to develop an AIDS vaccine for the strains of the virus and the health system capabilities of developing countries. There is growing consensus on the need for global partnership to ensure that AIDS vaccine development will move swiftly—but it will take a number of years, and much longer unless we act now.

The Bank is already hard at work on this through a special task force charged with developing new partnerships and financing instruments which bring the private and public sectors worldwide together to speed the advent of an AIDS vaccine. In this, we are working closely with UNAIDS, WHO, the International AIDS Vaccine Initiative, and other international partners. And we are starting a major program to push much greater deployment of existing vaccines, which will be good for poor people's health now, and will also encourage industry to bring new vaccines onstream.

The World Bank has lent more than US$765 million since 1986 to help developing countries deal with the AIDS epidemic, and in recent years has been lending about $1.6 billion annually for programs to strengthen health systems. But this is not enough. We are developing a new initiative of intensified action against AIDS in Africa, and I am determined that we will dramatically increase our response to this global epidemic. On all these fronts, we will work closely with our partner institutions of the UNAIDS coalition.

It is time to take collective action on the G8 communiqués from Denver and Birmingham to spur the development of an AIDS vaccine, and perhaps to link this effort to other global health challenges, such as the need for new therapies and a vaccine for malaria. The international community, including the developing countries, urgently needs to elaborate a global strategy for advancing this effort, an understanding of what different actors are already doing, and where there are gaps that need to be filled. The World Bank is ready to play its part in bringing it to fruition.

We will warmly welcome your support and ideas, and your commitment to urgent international action.

Sincerely yours,

James D. Wolfensohn

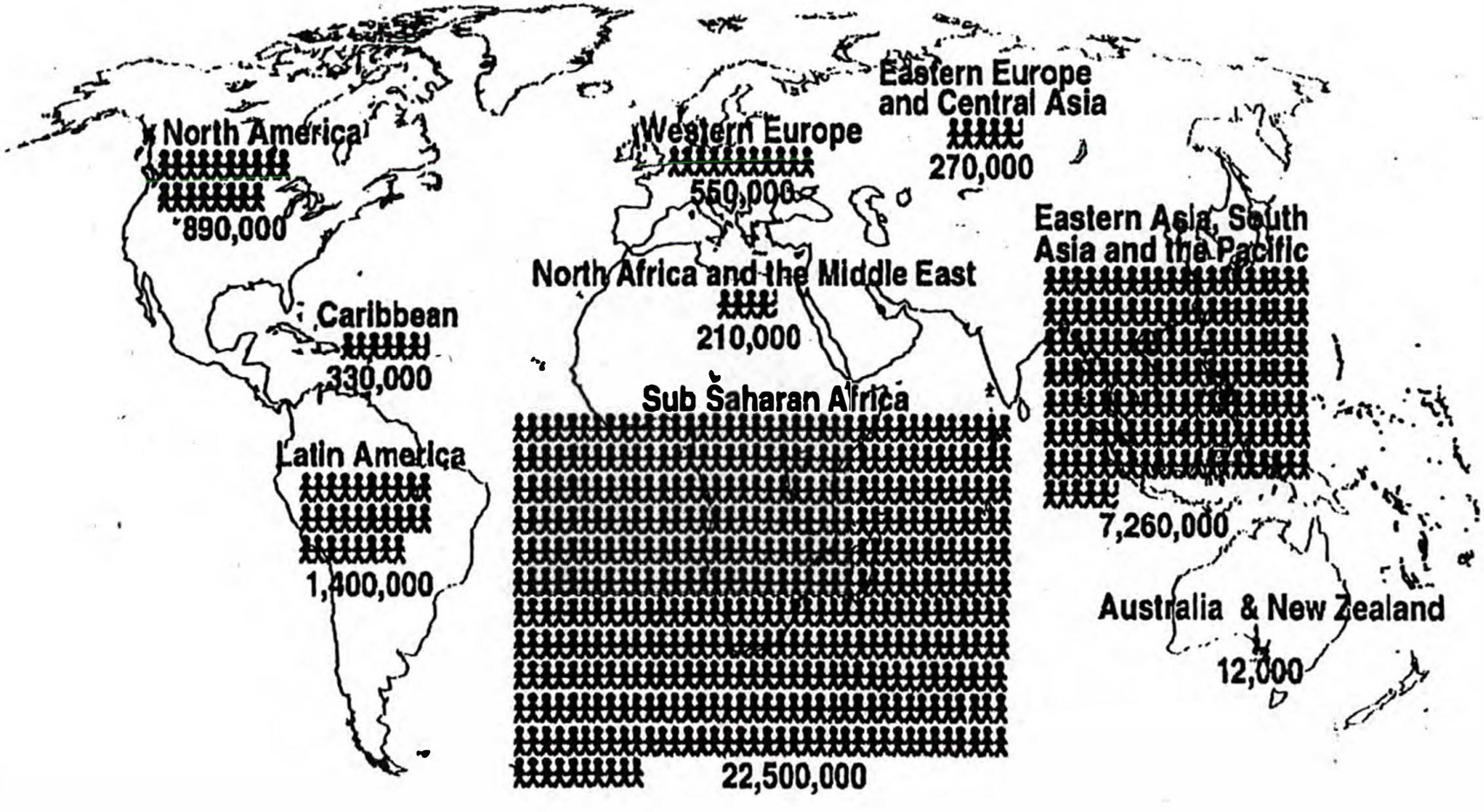
cc: Hon. Robert Rubin, Secretary of the Treasury

Attachment

Global Overview of the HIV/AIDS Epidemic

- HIV/AIDS is now the number one overall cause of death in Africa, and has moved up to fourth place among all causes of death worldwide, according to the latest annual World Health Report.
- An estimated 33.4 million people are living with HIV/AIDS worldwide and almost 14 million people already have died of AIDS (1998).
- 16,000 individuals are newly infected with HIV each day.
- Greater than 8.2 million children have been orphaned by HIV/AIDS. This figure may increase to 40 million HIV/AIDS orphans by 2010.
- Of all global regions, **Sub-Saharan Africa** has been hardest hit by the epidemic. The 21 countries possessing the highest HIV/AIDS prevalence rates in the world are all in this region. Two-thirds (22.5 million) of all those living with HIV/AIDS globally are from Sub-Saharan Africa.
- The **Asian** HIV/AIDS epidemic is building momentum, with South and Southeast Asia experiencing the most dramatic increases in HIV infection. About 6.7 million people are presently living with HIV/AIDS in South and Southeast Asia.
- There is also a rapid rise in the epidemic in **Eastern Europe and Central Asia.** HIV/AIDS infection rates have increased six-fold between 1990-1997.
- Qver 1.7 million people are living with HIV/AIDS in **Latin America and the Caribbean.**
- **North Africa and the Middle East** still possess relatively low epidemic levels, although much is still unknown about the status of the HIV/AIDS epidemic in this region.

Number of Adults and Children Living with HIV/AIDS, 1998



FROM WORLD BANK FRMRP 202 522 2515 (TUE) 6. 1'99 12:15/ST. 12:13/NO. 4260895443 P 4

August 31, 1999

SENSITIVE **For U.S. Government Use Only**

South Africa
Intellectual Property Rights

ISSUE:

The SAG has undertaken to extend adequate and affordable healthcare to all South Africans. The USG supports this goal. In 1997, the South African National Assembly amended prior legislation in an attempt to ensure the supply of affordable medicines. The effect was to grant the Health Minister broad, ill-defined powers to abrogate the patent rights of pharmaceuticals companies. The pharmaceutical industry and their Congressional advocates have urged the USG to pressure the South African Government (SAG) through use of U.S. trade laws and diplomatic channels into repealing or amending the Medicines Act. At the same time, a coalition of South African and foreign pharmaceutical companies is challenging the legislation as unconstitutional in South African courts while also trying to negotiate a compromise directly with the SAG. Recently, a coalition of consumer and AIDS activists has been pressuring the USG -- especially the Vice President -- to stop pursuing the issue with South Africa in view of its HIV/AIDS epidemic.

In our efforts to resolve this issue, we have recognized that the HIV/AIDS crisis in South Africa is a special situation that may require special measures. Thus, we informed the SAG and stated publicly that while we do not believe that compromising intellectual property rights is the solution to the greater problem, contrary to our general policy, we will raise no objection to compulsory licensing or parallel importing of pharmaceuticals (described below) on the part of South Africa, as long as it is done in a way that complies with the SAG's international trade obligations under the World Trade Organization Agreement on the Trade-Related Aspects of Intellectual Property Rights (TRIPS).

BACKGROUND:

Actions by the Administration

Under the Special 301 provisions of the Trade Act of 1974, the Office of the U.S. Trade Representative is required annually to identify foreign countries that deny adequate and effective protection of intellectual property rights and to issue a public report to this effect at the end of each April. South Africa was named to the Special 301 "Watch List" (the report's lowest category) in 1998 over concern about the authority granted the Minister of Health to abrogate patent rights as well as other intellectual property issues. During this year's Special 301 review, U.S. industry recommended we designate South Africa as a "Priority Foreign Country" (the report's highest category), which could have resulted in trade sanctions. We chose not to do so, however, because we had already developed a framework to resolve our differences. As a result, South Africa was maintained on the Watch List.

The framework the Administration proposed for the resolution of our differences with South Africa was through the Binational Commission, chaired by Vice President Gore and then deputy President Mbeki. The intent of the proposal was to bring together an experts group including all

relevant decision makers – trade, health, and intellectual property – to reach a mutual goal of bringing better healthcare to the people of South Africa while assuring effective and adequate protection of intellectual property. Discussions have continued since the framework's acceptance.

A number of South African officials have recently stated that the Medicines Act will only be used to compulsory license and parallel import pharmaceutical in a manner consistent with South Africa's international trade obligations. We are now working to obtain satisfactory assurances that the Medicines Act will be implemented in this manner so that this issue can be removed from our bilateral agenda.

U.S. industry has expressed concern that any government-to-government settlement at this time could undermine their efforts to negotiate a settlement with the new government.

Congress

In the closing days of last year's budget process, Congressman Frelinghuysen of New Jersey inserted into the foreign aid bill a provision that blocked U.S. aid to the central Government of South Africa until the State Department provided a report explaining the Administration's efforts to obtain the repeal of the Medicines Act. Dissatisfied with State's first report, Congress asked for a revised report. The final report contains language that portrays U.S. efforts as being more aggressive. Congressional critics of the Administration's approach and consumer and AIDS activists have now seized on this report, as well as USTR's Special 301 report, as evidence of the Administration's heavy-handedness on the issue.

On June 25, in a response to a letter from the Chairman of the Congressional Black Caucus, the Vice President responded stating that he supports "South Africa's efforts to enhance health care for its people -- including efforts to engage in compulsory licensing and parallel importing of pharmaceuticals -- so long as they are done in a way consistent with international agreements."

On July 21, the Office of the United States Trade Representative testified before the House Committee on Government Reform's Subcommittee on Criminal Justice, Drug Policy and Human Resources chaired by Congressman Mica. In that testimony, USTR stated that, contrary to our general approach, we will raise no objection to compulsory licensing or parallel importing of pharmaceuticals on the part of South Africa, as long as it is done in a way that complies with TRIPS.

U.S. Policy

The Administration's approach to patent protection for pharmaceuticals is to ensure that the necessary incentives are provided to promote rapid innovation of new drug therapies and to safeguard the protection of the medicines that now exist. We generally do not support policies that allow for the parallel importation or compulsory licensing of pharmaceuticals because such practices compromise intellectual property rights and raise concerns about the safety and efficacy of imported drugs. Under U.S. law, compulsory licensing and parallel importing of pharmaceuticals is generally prohibited. However, the TRIPS Agreement does allow for these

practices under certain conditions. We will not object to South Africa's efforts to compulsory license and parallel import pharmaceuticals, but want South Africa to abide by the TRIPS Agreement.

Our policy approach has been responsive to both sides in this debate. On the one hand we seek to ensure that South Africa honors its international obligations with respect to intellectual property but on the other hand are demonstrating flexibility in the application of U.S. trade policy to address concerns about South Africa's HIV/AIDS crisis.

Compulsory Licensing

In this situation we are concerned that the South African Government would grant a compulsory license to one or more domestic manufacturer(s) for the purpose of allowing it (or them) to produce a patented drug for sale in the domestic market without the consent of the patent holder. TRIPS imposes a number of disciplines on compulsory licensing including, for example:

- the requirement that authorization of such use shall be considered on a case-by-case basis;
- such use shall be authorized predominantly for the supply of the domestic market;
- the right holder shall be paid adequate remuneration; and
- such use may only be permitted if, prior to such use, the proposed user has made efforts to obtain authorization from the right holder on reasonable commercial terms and such efforts have not been successful within a reasonable period of time.

The last requirement (but not the others) may be waived in a national emergency. However, none of these conditions are included in the Medicines Act.

Parallel Imports

Parallel imports of pharmaceuticals are pharmaceuticals that are produced by, or with the authorization of, the patent holder and intended for sale in one market, for example Kenya, but that are diverted from the designated market, away from authorized distribution channels, and imported into another market, such as South Africa, without the authorization of the patent holder. The diversion occurs in many instances because the drugs are offered for sale in the intended market at a lower price than the market to which they are diverted. It is difficult to ensure the safety and efficacy of drugs that are parallel imported because they were not handled by authorized distributors. Thus, parallel importing of pharmaceuticals is generally prohibited in the United States and the European Union as well as Kenya.

The Economist
AUGUST 14TH 1999

Bernard

Editorial

Helping the poorest

ONE world, two fates. Of children who die before their fifth birthday, 98% are in the developing world. Of people who are HIV positive, some 95% are in poor countries. Of the millions who die prematurely of tuberculosis, malaria, measles, tetanus and whooping cough, all but a few thousand live in the poor world. Indeed, tuberculosis alone kills more people each year than lung cancer, the most prevalent cancer and the terror of the West. The gap is widening between rich and poor countries, especially between the very richest and the very poorest. Although that has happened for a century or more, the continued early deaths of the poor and their children are a reproach to us all. What is to be done to save those millions of young lives?

The good news is that there is some new thinking about ways to respond to this challenge. Aid agencies and drug companies are talking to each other in more constructive ways than they once did. For donor countries, this is not mere altruism: as international travel grows, rich-world governments acquire a direct interest in halting diseases such as tuberculosis, which may otherwise infect their own citizens. But affordable drugs are only part of the cure. Developing-country governments can do more to improve the health of their people than simply getting hold of western money and ingenuity.

Part of the new thinking lies in the application of economics to what has too often been a purely emotional pitch for aid. Since it published an influential report on health in 1993, the World Bank has consistently advanced the argument that unhealthy countries are condemned to slow growth. The idea that ill health reinforces poverty is less familiar than the view that poverty causes ill health, but equally true. However, one of the main virtues of the World Bank's argument is that it allows multinational aid donors to talk straight to developing-country finance ministers, who typically have more clout in the allocation of resources than do their colleagues in the health ministry.

Now, economists are tackling—or struggling with—another aspect of the health of the poor: their lack of access to drugs. Jeffrey Sachs, a Harvard economist, has drawn attention to the scale of the problem: poor countries cannot afford expensive medicines, and drug companies naturally tend to focus their research on finding cures for the ills of the rich (see pages 17-20 and 63) rather than the afflictions of the poor. Americans and Europeans rarely suffer from schistosomiasis, which afflicts 200m people worldwide, or lymphatic filariasis, which makes life miserable for another 120m. So the market is said to be too small to attract research. Gone are the days when Jonas Salk refused to patent polio vaccine, saying that to do so would be "like patenting the sun". When a drug company spends millions to develop a vaccine, it wants an economic return.

The machinery that might guarantee such a return is now taking shape. The World Bank, the World Health Organisation and other do-gooding bodies have formed alliances with the pharmaceutical industry to promote research on affordable drugs for neglected tropical ailments. Legislation under consideration in the American Congress and to be proposed by the European Commission would also give a helping hand. All this talk still needs to be backed by money, though. Others need to emulate Bill Gates's medical philanthropy.

Important though such initiatives are, they are not enough to heal the poor. The remarkable fall in mortality rates in Europe and North America a century ago owed little to drugs and almost everything to improved nutrition and better public health arrangements: reliable water supplies, safe drains, regular rubbish collection. Yet one in six of the world's people lack safe drinking water; most of the giant cities of Africa and Asia have no sewerage system; and rubbish collection is so disorganised that between a third and half of their garbage lies uncollected. The main answers lie in making local government more efficient and more accountable. Another is money—although appropriate technology can cut costs. It is quicker to help the poor by ensuring that the water sellers on whom they rely have access to safe water than by struggling to install expensive piped supplies to the home; and wiser to arrange for septic tanks to be emptied promptly than to build water-borne sewerage systems.

Education for health

With some of the diseases that kill the poor, the surest answer is to change habits. No single change would save more lives than if people routinely washed their hands before touching food. They need, too, to filter what they drink, to feed babies hygienically, to use mosquito nets, to avoid drunken driving—and to practise safe sex. One success story is sex education in Senegal: along with condom distribution and prompt treatment of other sexually transmitted diseases, this has helped to keep HIV infection rates in Dakar below 2%, compared with 20% in Kenya's Nairobi.

Spreading such messages needs government enthusiasm. But education ministers may not think it their job to teach personal hygiene, while politicians may prefer building hospitals to preaching the virtues of hand-washing. In fact, good health care also entails reorganising national systems so that they concentrate on primary care for the poor, rather than five-star clinics for those, like the president and his cronies, who ought to pay for their own care.

Even drug-buying could be done more effectively. Poor-

country governments need to make existing cheap medicines, such as oral rehydration salts and childhood vaccines, more available. They also need to care better for those drugs they get: all too often part of the consignment ends up on the black market or spoiled by bad storage. Foreign aid for malarial drugs in Kenya was recently withdrawn by donors exasperated by corruption, inertia and political chicanery. And there's the rub. As Professor Sachs says in his article, getting good government is not the whole answer. But of all the ills that kill the poor, none is as lethal as bad government.

THE WHITE HOUSE

Office of the Press Secretary

(Cologne, Germany)

For Immediate Release June 18, 1999

STATEMENT BY THE PRESIDENT

The G-7 agreement we reached today is an historic step to help the world's poorest nations achieve sustained growth and independence while targeting new resources for poverty reduction, education and combatting AIDS. It represents a sound, humane effort to promote widely shared prosperity in the new milennium.

30-30-30

Bernard

THE WHITE HOUSE

Office of the Press Secretary
(Cologne, Germany)

For Immediate Release June 18, 1999

FACT SHEET

The Cologne Debt Initiative

The G-7 leaders have endorsed a new Initiative to enable Heavily Indebted Poor Countries (HIPCs) to receive deeper, broader and faster debt relief in return for firm commitments to channel the benefits into improving the lives of all their people. The HIPC Initiative was created in 1996 to provide deeper multilateral debt reduction for poor countries with unsustainable debt burdens.

New focus on poverty: The Cologne Initiative calls on the International Financial Institutions to develop a new framework for linking debt relief with poverty reduction that centers around better targeting of budgetary resources for priority social expenditures, for health, child survival, AIDS prevention, education, greater transparency in government budgeting, and much wider consultation with civil society in the development and implementation of economic programs.

Substantially deeper relief: Together with earlier debt relief commitments, the Cologne Initiative provides for reduction of up to 70 percent of the total debts for these countries, (reducing the stock) 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. In today's dollars (net present value -- NPV terms), this would more than triple the amount of relief to be provided from $13 billion under the current HIPC framework to as much as $50 billion. This would be accomplished by reducing the HIPC program target ratios for the NPV of outstanding debt to 150 percent of exports, and 250 percent of government revenues, with fiscal thresholds of 30 percent exports to GDP and 15 percent revenues to GDP, and by providing full cancellation of ODA debts.

Faster relief: Relief will be available significantly faster than under the current framework by providing early cash flow relief ("Interim Relief") and allowing earlier stock reduction.

Broader participation: The number of countries expected to qualify for HIPC relief would rise from 26 to 33, meaning that more than 430 million people could ultimately be affected.

Releasing resources for priority needs: For the average HIPC country, the share of scarce government revenue devoted to debt service could fall by 10 percentage points to a ratio for debt service to revenues of well below 20 percent and close to 10 percent in some cases. This is equivalent to a reduction in actual payments of about 25 percent. Mozambique's debt will be reduced by some $3.5 billion ($1.7 billion in NPV terms), for example, which could cut in half the share of government revenues allocated to external debt service from over 30 percent to about 15 percent in 1999 and free about $30 million in budgetary resources each year. These savings are equivalent to over half the health budget in 1999 in a country where children are 3 times more likely to die before the age of five than they are to go to secondary school.

In proposing this Initiative on March 16, President Clinton stated that "Our goal is to ensure that no country committed to fundamental reform is left with a debt burden that keeps it from meeting its people's basic human needs and spurring growth. We should provide extraordinary relief for countries making extraordinary efforts to build working economies." On June 16, the President pledged "to work to find the resources so we can do our part and contribute our share toward an expanded trust fund for debt relief."

SACHS ON DEVELOPMENT

Sachs article

Helping the world's poorest

Jeffrey Sachs, a top academic economist, argues that rich countries must mobilise global science and technology to address the specific problems which help to keep poor countries poor

IN OUR Gilded Age, the poorest of the poor are nearly invisible. Seven hundred million people live in the 42 so-called Highly Indebted Poor Countries (HIPCS), where a combination of extreme poverty and financial insolvency marks them for a special kind of despair and economic isolation. They escape our notice almost entirely, unless war or an exotic disease breaks out, or yet another programme with the International Monetary Fund (IMF) is signed. The Cologne Summit of the G8 in June was a welcome exception to this neglect. The summiteers acknowledged the plight of these countries, offered further debt relief and stressed the need for a greater emphasis by the international community on social programmes to help alleviate human suffering.

The G8 proposals should be seen as a beginning: inadequate to the problem, but at least a good-faith prod to something more useful. We urgently need new creativity and a new partnership between rich and poor if these 700m people (projected to rise to 1.5 billion by 2030), as well as the extremely poor in other parts of the world (especially South Asia), are to enjoy a chance for human betterment. Even outright debt forgiveness, far beyond the G8's stingy offer, is only a step in the right direction. Even the call to the IMF and World Bank to be more sensitive to social conditions is merely an indicative nod.

A much more important challenge, as yet mainly unrecognised, is that of mobilising global science and technology to address the crises of public health, agricultural productivity, environmental degradation and demographic stress confronting these countries. In part this will require that the wealthy governments enable the grossly underfinanced and underempowered United Nations institutions to become vibrant and active partners of human development. The failure of the United States to pay its UN dues is surely the world's most significant default on international obligations, far more egregious than any defaults by impoverished HIPCS. The broader American neglect of the UN agencies that assist impoverished countries in public health, science, agriculture and the environment must surely rank as another amazingly misguided aspect of current American development policies.

The conditions in many HIPCS are worsening dramatically, even as global science and technology create new surges of wealth and well-being in the richer countries. The problem is that, for myriad reasons, the technological gains in wealthy countries do not readily diffuse to the poorest ones. Some barriers are political and economic. New technologies will not take hold in poor societies if investors fear for their property rights, or even for their lives, in corrupt or conflict-ridden societies. *The Economist*'s response to the Cologne Summit ("Helping the Third World", June 26th) is right to stress that aid without policy reform is easily wasted. But the barriers to development are often more subtle than the current emphasis on "good governance" in debtor countries suggests.

Research and development of new technologies are overwhelmingly directed at rich-country problems. To the extent that the poor face distinctive challenges, science and technology must be directed purposefully towards them. In today's global set-up, that rarely happens. Advances in science and technology not only lie at the core of long-term economic growth, but flourish on an intricate mix of social institutions—public and private, national and international.

Currently, the international system fails to meet the scientific and technological needs of the world's poorest. Even when the right institutions exist—say, the World Health Organisation to deal with pressing public health disasters facing the poorest countries—they are generally starved for funds, authority and even access to the key negotiations between poor-country governments and the Fund at which important development strategies get hammered out.

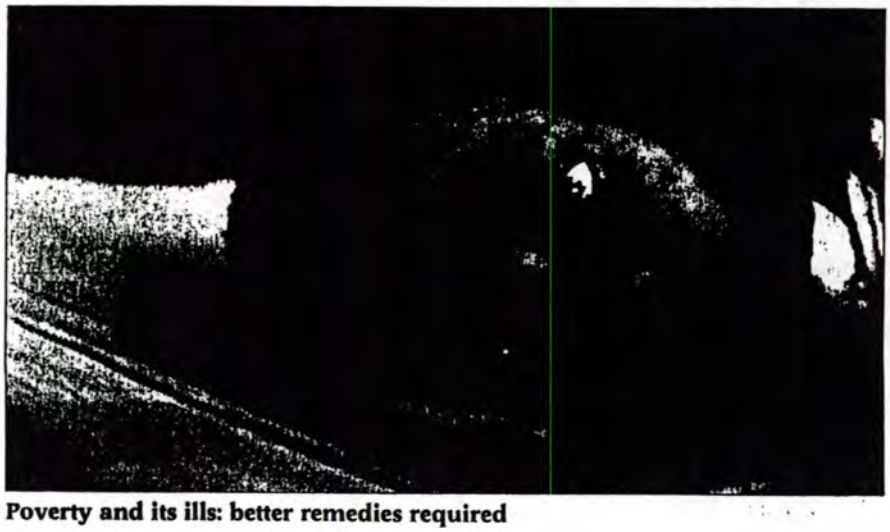
The ecology of underdevelopment

If it were true that the poor were just like the rich but with less money, the global situation would be vastly easier than it is. As it happens, the poor live in different ecological zones, face different health conditions and must overcome agronomic limitations that are very different from those of rich countries. Those differences, indeed, are often a fundamental cause of persisting poverty.

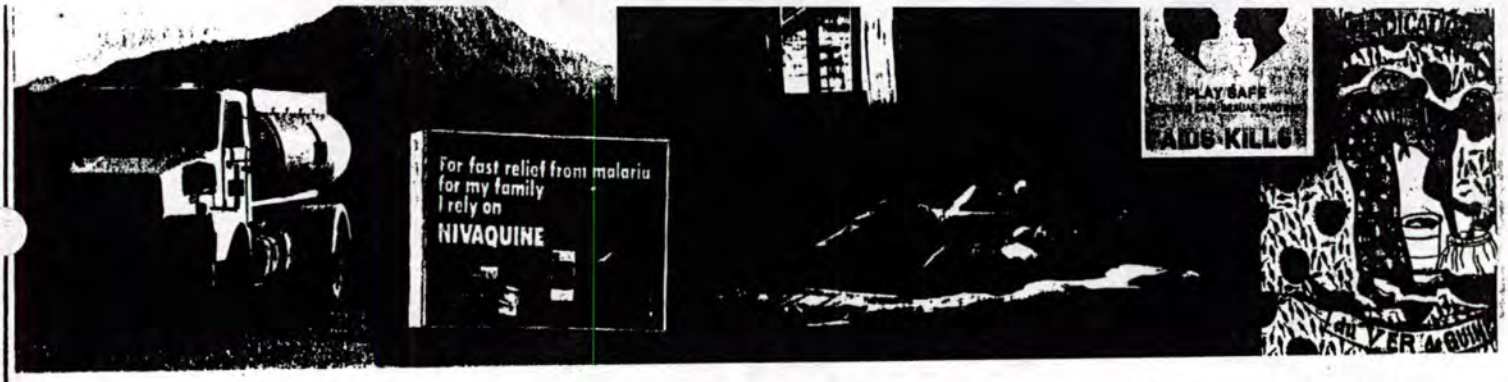
Let us compare the 30 highest-income countries in the world with the 42 HIPCS (see table on next page). The rich countries overwhelmingly lie in the world's temperate

BY INVITATION

Jeffrey Sachs is director of the Centre for International Development and professor of international trade at Harvard University. A prolific writer, he has also advised the governments of many developing and East European countries.



Poverty and its ills: better remedies required



zones. Not every country in those bands is rich, but a good rule of thumb is that temperate-zone economies are either rich, formerly socialist (and hence currently poor), or geographically isolated (such as Afghanistan and Mongolia). Around 93% of the combined population of the 30 highest-income countries lives in temperate and snow zones. The HIPCs, by contrast, include 39 tropical or desert societies. There are only three in a substantially temperate climate, and those three are landlocked and therefore geographically isolated (Laos, Malawi and Zambia).

Not only life but also death differs between temperate and tropical zones. Individuals in temperate zones almost everywhere enjoy a life expectancy of 70 years or more. In the tropics, however, life expectancy is generally much shorter. One big reason is that populations are burdened by diseases such as malaria, hookworm, sleeping sickness and schistosomiasis, whose transmission generally depends on a warm climate. (Winter may be the greatest public-health intervention in the world.) Life expectancy in the HIPCs averages just 51 years, reflecting the interacting effects of tropical disease and poverty. The economic evidence strongly suggests that short life expectancy is not just a result of poverty, but is also a powerful cause of impoverishment.

All the rich-country research on rich-country ailments, such as cardiovascular diseases and cancer, will not solve the problems of malaria. Nor will the biotechnology advances for temperate-zone crops easily transfer to the conditions of tropical agriculture. To address the special conditions of the HIPCs, we must first understand their unique problems, and then use our ingenuity and co-operative spirit to create new methods of overcoming them.

Modern society and prosperity rest on the foundation of modern science. Global capitalism is, of course, a set of social institutions—of property rights, legal and political systems, international agreements, transnational corporations, educational establishments, and public and private research institutions—but the prosperity that results from these institutions has its roots in the development and applications of new science-based technologies. In the past 50 years, these have included technologies built on solid-state physics, which gave rise to the information-technology revolution, and on genetics, which have fostered breakthroughs in health and agricultural productivity.

Different ecologies

	HIPCs* (42)	Rich countries (30)
GDP per person, PPP$†	1,187	18,818
Life expectancy at birth, years†	51.5	76.9
Population by ecozones, % in:		
tropical	55.6	0.7
dry	17.6	3.7
temperate and snow	12.5	92.6
highland	14.0	2.5

Source: J. Sachs *Highly indebted poor countries †Unweighted averages

Science at the ecological divide

In this context, it is worth noting that the inequalities of income across the globe are actually exceeded by the inequalities of scientific output and technological innovation. The chart below shows the remarkable dominance of rich countries in scientific publications and, even more notably, in patents filed in Europe and the United States.

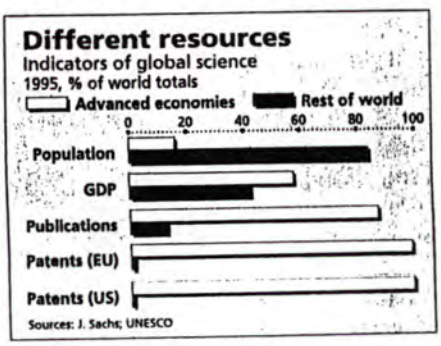
The role of the developing world in one sense is much greater than the chart indicates. Many of the scientific and technological breakthroughs are made by poor-country scientists working in rich-country laboratories. Indian and Chinese engineers account for a significant proportion of Silicon Valley's workforce, for example. The basic point, then, holds even more strongly: global science is directed by the rich countries and for the rich-country markets, even to the extent of mobilising much of the scientific potential of the poorer countries.

The imbalance of global science reflects several forces. First, of course, science follows the market. This is especially true in an age when technological leaps require expensive scientific equipment and well-provisioned research laboratories. Second, scientific advance tends to have increasing returns to scale: adding more scientists to a community does not diminish individual marginal productivity but tends to increase it. Therein lies the origin of university science departments, regional agglomerations such as Silicon Valley and Route 128, and mega-laboratories at leading high-technology firms including Merck, Microsoft and Monsanto. And third, science requires a partnership between the public and private sectors. Free-market ideologues notwithstanding, there is scarcely one technology of significance that was not nurtured through public as well as private care.

If technologies easily crossed the ecological divide, the implications would be less dramatic than they are. Some technologies, certainly those involving the computer and other ways of managing information, do indeed cross over, and give great hopes of spurring technological capacity in the poorest countries. Others—especially in the life sciences but also in the use of energy, building techniques, new materials and the like—are prone to "ecological specificity". The result is a profound imbalance in the global production of knowledge: probably the most powerful engine of divergence in global well-being between the rich and the poor.

Consider malaria. The disease kills more than 1m people a year, and perhaps as many as 2.5m. The disease is so heavily concentrated in the poorest tropical countries, and overwhelmingly in sub-Saharan Africa, that nobody even bothers to keep an accurate count of clinical cases or deaths. Those who remember that richer places such as Spain, Italy, Greece and the southern United States once harboured the disease may be misled into thinking that the problem is one of social institutions to control its transmission. In fact, the sporadic transmission of malaria in the sub-tropical regions of the rich countries was vastly easier to control than is its chronic transmission in the heart of the tropics. Tropical countries are plagued by ecological conditions that produce hundreds of infective bites per year per person. Mosquito control does not work well, if at all, in such circumstances. It is in any event expensive.

Recent advances in biotechnology, including mapping the genome of the malaria parasite, point to a possible malaria vaccine. One would think that this would be high on the agendas of both the international com-



munity and private pharmaceutical firms. It is not. A Wellcome Trust study a few years ago found that only around $80m a year was spent on malaria research, and only a small fraction of that on vaccines.

The big vaccine producers, such as Merck, Rhône-Poulenc's Pasteur-Mérieux-Connaught and SmithKline Beecham, have much of the in-house science but not the bottom-line motivation. They strongly believe that there is no market in malaria. Even if they spend the hundreds of millions, or perhaps billions, of dollars to do the R&D and come up with an effective vaccine, they believe, with reason, that their product would just be grabbed by international agencies or private-sector copycats. The hijackers will argue, plausibly, that the poor deserve to have the vaccine at low prices—enough to cover production costs but not the preceding R&D expenditures.

The malaria problem reflects, in microcosm, a vast range of problems facing the HIPCs in health, agriculture and environmental management. They are profound, accessible to science and utterly neglected. A hundred IMF missions or World Bank health-sector loans cannot produce a malaria vaccine. No individual country borrowing from the Fund or the World Bank will ever have the means or incentive to produce the global public good of a malaria vaccine. The root of the problem is a much more complex market failure: private investors and scientists doubt that malaria research will be rewarded financially. Creativity is needed to bridge the huge gulfs between human needs, scientific effort and market returns.

Promise a market

The following approach might work. Rich countries would make a firm pledge to purchase an effective malaria vaccine for Africa's 25m newborn children each year if such a vaccine is developed. They would even state, based on appropriate and clear scientific standards, that they would guarantee a minimum purchase price—say, $10 per dose—for a vaccine that meets minimum conditions of efficacy, and perhaps raise the price for a better one. The recipient countries might also be asked to pledge a part of the cost, depending on their incomes. But nothing need be spent by any government until the vaccine actually exists.

Even without a vast public-sector effort, such a pledge could galvanise the world of private-sector pharmaceutical and biotechnology firms. Malaria vaccine research would suddenly become hot. Within a few years, a breakthrough of profound benefit to the poorest countries would be likely. The costs in foreign aid would be small: a few hundred million dollars a year to tame a killer of millions of children. Such a vaccine would rank among the most effective public-health interventions conceivable. And, if science did not deliver, rich countries would end up paying nothing at all.

Malaria imposes a fearsome burden on poor countries, the AIDS epidemic an even weightier load. Two-thirds of the world's 33m individuals infected with the HIV virus are sub-Saharan Africans, according to a UN estimate in 1998, and the figure is rising. About 95% of worldwide HIV cases are in the developing world. Once again, science is stopping at the ecological divide.

Rich countries are controlling the epidemic through novel drug treatments that are too expensive, by orders of magnitude, for the poorest countries. Vaccine research, which could provide a cost-effective method of prevention, is dramatically underfunded. The vaccine research that is being done focuses on the specific viral strains prevalent in the United States and Europe, not on those which bedevil Africa and Asia. As in the case of malaria, the potential developers of vaccines consider the poor-country market to be no market at all. The same, one should note, is true for a third worldwide killer. Tuberculosis is still taking the lives of more than 2m poor people a year and, like malaria and AIDS, would probably be susceptible to a vaccine, if anyone cared to invest in the effort.

The poorer countries are not necessarily sitting still as their citizenry dies of AIDS. South Africa is on the verge of authorising the manufacture of AIDS medicines by South African pharmaceutical companies, despite patents held by American and European firms. The South African government says that, if rich-country firms will not supply the drugs to the South African market at affordable prices (ones that are high enough to meet marginal production costs but do not include the patent-generated monopoly profits that the drug companies claim as their return for R&D), then it will simply allow its own firms to manufacture the drugs, patent or no. In a world in which science is a rich-country prerogative while the poor continue to die, the niceties of intellectual property rights are likely to prove less compelling than social realities.

There is no shortage of complexities ahead. The world needs to reconsider the question of property rights before patent rights allow rich-country multinationals in effect to own the genetic codes of the very foodstuffs on which the world depends, and even the human genome itself. The world also needs to reconsider the role of institutions such as the World Health Organisation and the Food and Agriculture Organisation. These UN bodies should play a vital role in identifying global priorities in health and agriculture, and also in mobilising private-sector R&D towards globally desired goals. There is no escape from such public-private collaboration. It is notable, for example, that Monsanto, a life-sciences multinational based in St Louis, Missouri, has a research and development budget that is more than twice the R&D budget of the entire worldwide network of public-sector tropical research institutes. Monsanto's research, of course, is overwhelmingly directed towards temperate-zone agriculture.

People, food and the environment

Public health is one of the two distinctive crises of the tropics. The other is the production of food. Poor tropical countries are already incapable of securing an adequate level of nutrition, or paying for necessary food imports out of their own export earnings. The HIPC population is expected to more than double by 2030. Around one-third of all children under the age of five in these countries are malnourished and physically stunted, with profound consequences throughout their lives.

As with malaria, poor food productivity in the tropics is not merely a problem of poor social organisation (for example, exploiting farmers through controls on food prices). Using current technologies and seed types, the tropics are inherently less productive in annual food crops such as wheat (essentially a temperate-zone crop), rice and maize. Most agriculture in the equatorial tropics is of very low productivity, reflecting the fragility of most tropical soils at high temperatures combined with heavy rainfall. High productivity in the rainforest ecozone is possible only in small parts of the tropics, generally

on volcanic soils (on the island of Java, in Indonesia, for example). In the wet-dry tropics, such as the vast savannahs of Africa, agriculture is hindered by the terrible burdens of unpredictable and highly variable water supplies. Drought and resulting famine have killed millions of peasant families in the past generation alone.

Scientific advances again offer great hope. Biotechnology could mobilise genetic engineering to breed hardier plants that are more resistant to drought and less sensitive to pests. Such genetic engineering is stymied at every point, however. It is met with doubts in the rich countries (where people do not have to worry about their next meal); it requires a new scientific and policy framework in the poor countries; and it must somehow generate market incentives for the big life-sciences firms to turn their research towards tropical foodstuffs, in co-operation with tropical research centres. Calestous Juma, one of the world's authorities on biotechnology in Africa, stresses that there are dozens, or perhaps hundreds, of underused foodstuffs that are well adapted to the tropics and could be improved through directed biotechnology research. Such R&D is now all but lacking in the poorest countries.

The situation of much of the tropical world is, in fact, deteriorating, not only because of increased population but also because of long-term trends in climate. As the rich countries fill the atmosphere with increasing concentrations of carbon, it looks ever more likely that the poor tropical countries will bear much of the resulting burden.

Anthropogenic global warming, caused by the growth in atmospheric carbon, may actually benefit agriculture in high-latitude zones, such as Canada, Russia and the northern United States, by extending the growing season and improving photosynthesis through a process known as carbon fertilisation. It is likely to lower tropical food productivity, however, both because of increased heat stress on plants and because the carbon fertilisation effect appears to be smaller in tropical ecozones. Global warming is also contributing to the increased severity of tropical climatic disturbances, such as the "one-in-a-century" El Niño that hit the tropical world in 1997-98, and the "one-in-a-century" Hurricane Mitch that devastated Honduras and Nicaragua a year ago. Once-in-a-century weather events seem to be arriving with disturbing frequency.

The United States feels aggrieved that poor countries are not signing the convention on climatic change. The truth is that these poor tropical countries should be calling for outright compensation from America and other rich countries for the climatic damages that are being imposed on them. The global climate-change debate will be stalled until it is acknowledged in the United States and Europe that the temperate-zone economies are likely to impose heavy burdens on the already impoverished tropics.

New hope in a new millennium

The situation of the HIPCs has become intolerable, especially at a time when the rich countries are bursting with new wealth and scientific prowess. The time has arrived for a fundamental re-thinking of the strategy for co-operation between rich and poor, with the avowed aim of helping the poorest of the poor back on to their own feet to join the race for human betterment. Four steps could change the shape of our global community.

First, rich and poor need to learn to talk together. As a start, the world's democracies, rich and poor, should join in a quest for common action. Once again the rich G8 met in 1999 without the presence of the developing world. This rich-country summit should be the last of its kind. A G16 for the new millennium should include old and new democracies such as Brazil, India, South Korea, Nigeria, Poland and South Africa.

Second, rich and poor countries should direct their urgent attention to the mobilisation of science and technology for poor-country problems. The rich countries should understand that the IMF and World Bank are by themselves not equipped for that challenge. The specialised UN agencies have a great role to play, especially if they also act as a bridge between the activities of advanced-country and developing-country scientific centres. They will be able to play that role, however, only after the United States pays its debts to the UN and ends its unthinking hostility to the UN system.

We will also need new and creative institutional alliances. A Millennium Vaccine Fund, which guaranteed future markets for malaria, tuberculosis and AIDS vaccines, would be the right place to start. The vaccine-fund approach is administratively straightforward, desperately needed and within our technological reach. Similar efforts to merge public and private science activities will be needed in agricultural biotechnology.

Third, just as knowledge is becoming the undisputed centrepiece of global prosperity (and lack of it, the core of human impoverishment), the global regime on intellectual property rights requires a new look. The United States prevailed upon the world to toughen patent codes and cut down on intellectual piracy. But now transnational corporations and rich-country institutions are patenting everything from the human genome to rainforest biodiversity. The poor will be ripped off unless some sense and equity are introduced into this runaway process.

Moreover, the system of intellectual property rights must balance the need to provide incentives for innovation against the need of poor countries to get the results of innovation. The current struggle over AIDS medicines in South Africa is but an early warning shot in a much larger struggle over access to the fruits of human knowledge. The issue of setting global rules for the uses and development of new technologies—especially the controversial biotechnologies—will again require global co-operation, not the strong-arming of the few rich countries.

Fourth, and perhaps toughest of all, we need a serious discussion about long-term finance for the international public goods necessary for HIPC countries to break through to prosperity. The rich countries are willing to talk about every aspect except money: money to develop new malaria, tuberculosis and AIDS vaccines; money to spur biotechnology research in food-scarce regions; money to help tropical countries adjust to climate changes imposed on them by the richer countries. The World Bank makes mostly loans, and loans to individual countries at that. It does not finance global public goods. America has systematically squeezed the budgets of UN agencies, including such vital ones as the World Health Organisation.

We will need, in the end, to put real resources in support of our hopes. A global tax on carbon-emitting fossil fuels might be the way to begin. Even a very small tax, less than that which is needed to correct humanity's climate-deforming overuse of fossile fuels, would finance a greatly enhanced supply of global public goods. No better time to start than as the new millennium begins.

AIDS pharmaceuticals

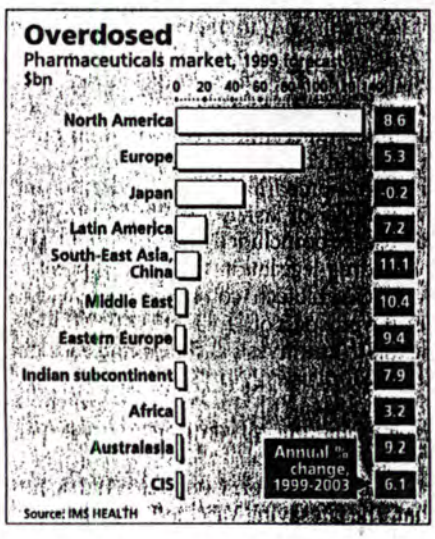
Balms for the poor

Infectious diseases hinder developing countries from developing. Making existing drugs cheaper there would help. Making entirely new drugs would help even more

PEER over the counter at a pharmacy in America, Europe or Japan and you see a wealth of drugs. Americans and Europeans spend more than $220 billion a year on prescription medicines for everything from high blood pressure to low mood—a powerful incentive for pharmaceutical companies to keep them supplied with current remedies and to concoct new ones (see chart). Of course, drugs for such diseases as river blindness and sleeping sickness are not routinely found on western shelves since there is little demand for them. But walk into a dispensary in, say, Cameroon, and you discover that such drugs are equally scarce there—not because they are not needed, but because nobody can afford them.

Lack of money not only restricts access to existing drugs and vaccines and means of dispensing them; it also offers little incentive for drug companies to develop new medicines for people in poor countries. Globally, the World Health Organisation (WHO) estimates that more than $56 billion a year is spent on health research—but less than 10% of that sum is directed toward diseases that afflict 90% of the world's population.

As Piers Whitehead of Mercer Consulting notes, large drug companies are more like supermodels than charities: they won't get out of bed and into work for less than $350m in annual sales for any given product. This is because turning a gleam in a researcher's eye into a handful of useful pills is an expensive and time-consuming business: on average, it costs $300m and takes more than a decade. Between 1975 and 1997, an impressive 1,223 new compounds were launched on the market. But as Patrice Trouiller, a consultant with Médecins sans Frontières (MSF), an aid group, points out, only 11 of them were designed for tropical diseases.



The problem is not merely one of human welfare, important though that is. Many economists, among them Jeffrey Sachs of Harvard University (see pages 17-20), believe it is also an issue of economic development. Better access to better medicines is not the only way to improve the health of poor countries, but it is a significant one. And creating new drugs and vaccines is such a technology-intensive business that the developing world is likely to remain dependent on western pharmaceutical firms for years to come.

New pills, old ills

Encouraging the development of new medicines is difficult because it requires both the push of financial incentives (to offset the risk of research in largely uncharted fields) and the pull of secure funding (to ensure that there is a paying market once the drugs are ready). Recently, however, some new ideas about how to solve these problems have emerged, based on new alliances between industry and the public sector.

One approach is that being taken by the new Medicines for Malaria Venture (MMV), which brings together public-sector organisations and drug companies under the umbrella of the WHO. Robert Ridley, director of MMV, sees the venture as a "not-for-profit virtual drug company", combining public- and private-sector research through funding collaborative discovery and development projects. Drug companies have millions of molecules in their chemical libraries created for more lucrative diseases such as cancer, along with thousands of old drugs currently used for other ailments, which could be developed for malaria at roughly a tenth of the cost of starting from scratch.

But finding the money to finance the research is not easy. MMV aims to register one new antimalarial product every five years, and is likely to need $30m a year to do so. The drug companies' gifts-in-kind are worth millions, but the bulk of the required money is still expected to come from public funds and philanthropic institutions. Initial promises of $5m have enabled MMV to begin the process of project selection, and the venture will be formally launched later this year.

Seth Berkley, head of the International AIDS Vaccine Initiative (IAVI), is hoping to do something similar for AIDS vaccines. Roughly $2 billion a year is spent on research into AIDS treatments, most of which are either too costly or too complicated for use in poor countries. But IAVI estimates that only

Flying high

COCAINE, as addicts well know, has curious effects on the body. One of them is "reverse tolerance": rather than becoming accustomed to cocaine with increasing exposure (as happens with, say, alcohol), the brain becomes more sensitive. With each hit, responses, such as fidgeting, are more exaggerated. This sensitisation is thought to be a first step in creating an overwhelming craving for the drug that eventually leads to addiction.

In humans, studying cocaine sensitisation is tricky since most governments have strong views on giving drugs to the uninitiated, and tend to enforce them with lengthy prison sentences. So instead researchers have turned to creatures such as the fruit fly, *Drosophila melanogaster*, to probe the cellular basis for cocaine craving. In this week's issue of *Science*, biologists Jay Hirsh, Sarah Chaney and Rozi Andretic of the University of Virginia report that an appetite for cocaine seems to be connected to the mechanisms which control circadian rhythm—the so-called "body clock".

Fruit flies, like humans, have an internal biological clock that governs their activity over a 24-hour cycle. Ms Andretic recently found that the brain makes use of a biochemical called dopamine to regulate its circadian rhythm. Other experiments on mice and flies have shown that dopamine is also involved in cocaine sensitisation. So the researchers put the two together and decided to see whether disrupting the body's internal clock might also affect cocaine craving.

When exposed to purified "freebase" cocaine, fruit flies behave surprisingly like junkies. They twitch, gnaw and groom themselves compulsively while wandering about in circles. As the drug dose rises, such erratic movements become more severe until the fly is paralysed and drops dead. Ordinarily, one cocaine hit is enough to sensitise a fly. But Dr Hirsh's team found that mutant *Drosophila* lacking genes called "Clock", "Period", "Cycle" and "Doubletime"—all of which are known to control circadian rhythm—also lack heightened responses to cocaine even after multiple doses. In fact, "Doubletime" mutants proved particularly resistant to the drug, requiring substantially higher quantities before behaving strangely.

In fruit flies, a biochemical called tyramine seems to be responsible for such drug responses, and Dr Hirsh thinks that tyramine regulation is the chemical link between these two very different processes. After a single cocaine dose, the enzyme that makes tyramine becomes more active in normal flies. In the circadian-gene mutants, however, the enzyme's activity stays steady after a dose of the drug, so tyramine levels remain low. The absence of the circadian genes, which seem to regulate the release of tyramine, prevents flies from becoming more responsive to cocaine.

Whether sky-high flies can teach scientists much about human addiction remains to be seen. Only about a fifth of the people who use cocaine actually become addicted to it: the puzzle lies in understanding what distinguishes the casual user from the hard-core addict. But if the propensity to addiction is also genetically controlled in humans, it could provide a mechanism to address the problem at the cellular level, by regulating tyramine or its vertebrate equivalent. It might then be possible to treat cocaine addiction as a disease, rather than a criminal activity.

Fruit flies on the rocks

$250m is spent creating vaccines, few of which are potentially useful for poor countries where about 95% of HIV infections occur. Dr Berkley wants to make life as easy as possible for potential vaccine developers by mustering expertise and money to help companies negotiate regulatory hurdles and organise clinical trials in developing countries.

IAVI is also trying to use the tricky issue of intellectual property to expand access to new vaccines. Patents have long been a sore point between the companies which own them and developing countries (such as South Africa) which want to get their hands on nifty new medicines and resent having to pay the premiums which patent-holders expect as a reward for their innovation. IAVI will invest in drug companies if they promise to provide their vaccines to poor countries (though not rich ones) at just above manufacturing cost, rather than including the usual hefty margin. If they do not, IAVI has the right to transfer the patent to another producer. IAVI has already struck a deal with one biotech company, Alphavax of North Carolina, along these lines and is hoping to do business with large pharmaceutical firms as well. Another proposal is to allow companies that agree to develop an HIV vaccine a limited extension to their patents on blockbuster drugs in their most lucrative markets.

A different approach, being championed by MSF, is to make a virtue of the rarity of tropical diseases in the West. Since 1983 America has offered incentives in the form of tax credits and marketing monopolies to companies willing to develop drugs for "orphan" diseases, which afflict fewer than 200,000 people and so offer markets too small to attract much attention from pharmaceutical companies. The European Commission is preparing similar legislation, and Dr Trouiller of MSF is lobbying for tropical diseases to be included in it. But although orphan drug legislation has been a boon to America's biotech companies, which can use the prospect of a market of a few million dollars to lure investors, that is scarcely loose change for large pharmaceutical firms. And since only big firms can manufacture drugs in large quantities, it is crucial to engage their interest too.

A bill now before Congress could do just that. The Lifesaving Vaccine Technology Act of 1999, introduced by Nancy Pelosi, aims to encourage drug makers to develop vaccines for malaria, tuberculosis and HIV, which together kill almost 8m people each year. The legislation proposes substantial tax credits on research and development expenses, and would cost about $25m a year.

But while the bill has received backing from both politicians and industry executives for its tax credits, it may face opposition to its explicit endorsement of "tiered pricing"—the simple idea that poor countries be charged less than rich ones for drugs. In the past, American congressmen have complained that it is "unfair" that their voters should pay 100 times more for a measles vaccine than, say, a mother in Bangladesh.

Such opposition to tiered pricing alarms drug companies, according to Amie Batson, a vaccine consultant with the World Bank. Even more worrying, says Walter Vandersmissen, head of government affairs at SmithKline Beecham Biologicals, is the prospect that rich countries might allow the import of discounted drugs from poor countries, and undercut the drug industry's sales in their profitable markets. (At the moment, America

and the European Union strictly control imports of drugs made outside their borders.)

Though many in the pharmaceutical industry are impressed by these proposals, some feel that there are now too many competing "initiatives" and that they all fall short of inspiring novel drug development. Mr Vandersmissen considers them "interesting think-tank exercises". The best way to stimulate new research, he believes, is to prove that sustainable markets can be created for relatively expensive medicines already on the shelf. This is the aim of a new international consortium, the Global Alliance for Vaccines and Immunisation, to be launched next year. It brings together the World Bank, the WHO, wealthy donor countries, poor recipient ones, philanthropic organisations and the drug industry, with the aim of improving access to existing vaccines and developing new ones.

According to Geoffrey Lamb, head of "resource mobilisation" at the World Bank, one way to finance such a programme is through a global trust fund for vaccines for needy countries. But wealthy donor governments are not keen to tie up large sums of money for long periods of time on uncertain odds. A more likely prospect, in Mr Lamb's view, is "contingent lending", in which donors promise to give money and needy countries promise to buy a vaccine if and when a useful one appears.

Ultimately, says Tim Evans, director of health sciences at the Rockefeller Foundation, rich donor countries prefer to give their money to projects (such as drug donation and immunisation programmes) which show results in a couple of years, rather than put up with the long and uncertain slog of developing new medicines. But some donors are prepared to take a more long-term view. The biggest splash has been made by the Bill and Melinda Gates Foundation. Since last December, the foundation has given $50m for malaria vaccine development, $25m for AIDS vaccine research and $100m to the Gates Children's Vaccine Programme which aims to improve access to expensive new shots against hepatitis-B, *Haemophilus influenzae* and rotavirus.

Though such contributions are welcomed by international health workers, they are, in Mr Evans's view, largely "catalytic"—enough to kickstart a reaction among drug developers and public health authorities, but not enough to sustain it. He would like to see a new group of donors: multinational corporations whose business in poor countries depends on a healthy workforce, who would benefit from novel drugs for their old ailments. In the end, developing new medicines for the world's poorest will depend on appeals to both altruism and self-interest. Balancing the two may prove the toughest trick of all for the new alliances between the public and private sector.

AIDS orphans

Orphans of the virus

NDOLA, ZAMBIA

The AIDS epidemic is leaving a horrifying number of African children without their parents

TWO-THIRDS of the patients at the main hospital in Ndola, in the copper-mining region of northern Zambia, are dying of AIDS. Some have lost so much weight that their arms look like broken broom handles and their tattoos are shrivelled and illegible. Their immediate wish is not for costly anti-retroviral drugs, but for food. In theory, the state-run hospital provides meals for all patients, but several complain that they have not eaten all day, and beg for 100 kwacha (four American cents) for breakfast.

Poverty hastens death among AIDS sufferers. And in Zambia, as in much of Africa, the sheer number of AIDS deaths aggravates the poverty of those who survive. The disease in Zambia is so common that it has lost its social stigma. The Zambian health ministry estimates that half the country's population will eventually die of it. Only tycoons and cabinet ministers can afford proper treatment. The death toll is worse than anything Peter McDermott, who runs the Zambian office of Unicef, the UN's agency for children, has seen in the numerous war zones where he has worked. Most of those who die are mothers or bread-winners. Estimates of the proportion of Zambian children under 15 who have lost one or both parents (usually but not always from AIDS) range from 13% to as high as 50%. Even at the lowest estimate, this is a dozen times higher than the level in industrialised countries.

It is not only children who are hit. Faides Zulu, a grandmother from a shanty town outside Ndola, was supported by her daughter until she and her husband both died. Suddenly, Mrs Zulu had lost her only source of income and gained five new dependants. Despite her age (she is old enough to have no idea when she was born) and frailty, she has resumed the heavy task of growing vegetables in her small plot and carrying them to market. Hand-outs from a local charity cover clothes and the $7-a-year school fees for each child. She says that without the 25kg of maize meal she is given each month, the family would starve.

Many are less fortunate. About half of all Zambian children are malnourished to the point of being stunted, a fifth severely so. Lack of food hinders these children's mental development. Lack of education retards young brains still further: half of rural children and 68% of rural orphans in Zambia do not attend any classes at all. In Ndola, unemployment has become the norm as the copper mines, mismanaged for decades, are now sacking workers by the thousand. Hundreds of families face eviction from mine-owned houses. In the recently expanded cemeteries around Ndola, several graves have been dug up: local thieves are so desperate that they strip fresh corpses of the smart suits in which they are buried.

State welfare payments reach less than 2% of Zambians; charitable organisations help only a tenth. Almost the entire burden of coping with the orphan problem falls on the extended family. Zambian families have adapted impressively to the crisis. According to one study, 72% of Zambian households care for one or more orphans. Zambia's old socialist regime preferred to put orphans into state institutions, but the current government, arguing that orphanages are an expensive way of making children miserable, has closed almost all of them.

Most orphans are now fostered by relations, who offer more love and pumpkin-leaf stew than the government ever could. But extra mouths mean less food to go round, so many fostered children are made to work for their keep. And since fostering is informal, orphans usually enjoy fewer legal rights than other children. Formal adoptions require paperwork and the co-operation of sluggish bureaucrats, so they are rare: in 1996 there were only 18 in the whole of Zambia.

The unlucky ones receive no care at all. Babies born HIV-positive in Zambia usually die within a year. Uninfected babies should be able to survive, but, if the mother dies, her relations sometimes wrongly think the baby too is doomed, and so do not waste scarce food delaying the inevitable. The disease has led to a dramatic increase in the number of homeless children: perhaps 90,000 live on Zambia's streets or in the bush, scratching a living by recycling broken bottles or through petty theft. Too poor to afford glue to dull the evening chill, they sniff fermented sewage.

Other African countries' statistics on AIDS orphans are even less reliable than Zambia's. But a study of 19 sub-Saharan countries by USAID reckoned they would have 40m orphans by 2010, largely because of AIDS. According to the UN, there were 35 countries (all poor) where the proportion of orphans doubled, tripled or quadrupled between 1994 and 1997. However good the care of these children, it is hard to imagine robust economic growth where so many adults are dying in their productive prime, leaving the very young and the very old to cope alone.

Drugs for AIDS in Africa

The average African nation spends less than $10 per person each year on health care. The mix of drugs, including the new protease inhibitors, necessary to turn AIDS from a death sentence into a chronic disease costs at least $12,000 per person each year. That disparity virtually guarantees that most of the 22 million Africans infected with the AIDS virus will not get the best available treatment. Few will even be able to afford less expensive life-prolonging drugs such as AZT or ddI or — far cheaper and just as crucial — medicines to fight the infections that accompany AIDS.

Washington is now arguing with South Africa about a new law in that country that could allow South Africa to make cheap versions of still-patented drugs or import them at less than the manufacturers want to charge. The debate is important, and it has revealed the need to broaden the Administration's policy, which has been dominated by trade issues and the desire to protect American pharmaceutical patents. Washington should stop pressuring South Africa to change the law, but even then far more will need to be done to get lifesaving medicines to poor Africans with AIDS.

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Part of the challenge is to increase the availability of already affordable drugs. Last month, the Administration announced a $100 million effort to fight AIDS in Africa. It will buy and help countries use some cheap treatments, like medicines for tuberculosis and other AIDS-related infections and drugs to prevent mother-child transmission.

While some pharmaceutical manufacturers, most recently Bristol-Myers Squibb, are making substantial donations to fight AIDS in poor countries, they want to see governments or health organizations bear the cost of AIDS drugs. But most of the newer ones are far too expensive. Many third-world countries have long responded to the high cost of patented drugs by copying them, sometimes for a tenth of the patented price. The pharmaceutical industry argues that this pirating discourages the search for new medicines, as patented drugs are priced high in part to allow manufacturers to recover the research and development costs of all their projects, even the unsuccessful ones.

The drug companies, and the Clinton Administration's trade negotiators, have fought the efforts of third-world countries to manufacture or import cheap versions of still-patented drugs. American trade pressure on Thailand throughout the 1990's, for example, caused the country to put restrictions on its manufacture of cheap patented drugs and ban their import, which AIDS doctors say reduced the country's ability to fight the disease.

What really worry the drug industry today, however, are the new intellectual property rules of the World Trade Organization. Over Washington's objections, poor nations won the right to make patented drugs in certain situations, especially when there is a "national emergency." While Washington says it objects to technicalities in the new South African law, the larger reason trade officials have pressed so hard is that the industry fears South Africa could set precedents, within the world's trade rules, for the manufacture of cheap drugs. Drug makers have sued in South African courts to block the law.

While defending intellectual property is important, the narrowness of the Administration's views is dismaying. Pharmaceutical companies would lose little if they found legal and controllable ways to let poor countries — which offer scant market anyway — reproduce drugs or buy them cheaply.

In addition, some of the most important AIDS drugs were discovered in the National Institutes of Health, or with Government grants. Two examples are ddI and the protease inhibitor Norvir. That financing may well give Washington the right to allow the World Health Organization to license the drugs' manufacture, for sale only in poor nations in case of emergency. The Administration should explore this option for all such vital medicines developed at taxpayer expense. The desires of America's pharmaceutical companies have been the overwhelming force driving American policy on the issue of drugs in poor nations. Surely the needs of 35 million people infected with H.I.V. worldwide should count for more.

Washington Post
11 August 99

Princeton N. Lyman

Facing a Global AIDS Crisis

The toll from the HIV/AIDS epidemic is becoming more evident each day. Last year close to 2 million people worldwide died from the disease. The number of AIDS orphans is horrifying: 8.3 million children, according to UNICEF.

Less well reported is the growing economic impact. In Zimbabwe, companies report training seven workers for each job, as the death roll is so great. In Zambia, colleges graduated 300 new teachers last year; but AIDS took the lives of 600. In South Africa, analysts predict that the epidemic could kill up to 10 percent of the mining work force each year. AIDS will drive up the payroll costs of this critical industry in South Africa by 45 percent, an industry already racked by falling world prices.

While the impact today is greatest in Africa, the rate of spreading infection in South Asia is one of the most rapid in the world, threatening havoc in that already volatile region within a decade.

Faced with this devastating epidemic, African countries have become increasingly frustrated with the gap between the industrialized countries' ability to treat AIDS patients, and thus lower death rates, and their own lack of the resources to do so. This has led to attacks on the patent rights of pharmaceutical companies, by South Africa in particular, and challenges to these rights by others in the World Health Organization.

Led by Zimbabwe, countries are arguing that health should take priority over trade or intellectual property protection. The South African challenge is technically not aimed at AIDS medicines per se. But the confrontational attitude behind these challenges has its origins in the AIDS crisis.

Most African countries would be unable to administer the complex use of AIDS "cocktails" even if the price were within reach. But a new development has offered the prospect of a partnership between the international community, pharmaceutical companies and African and other nations under siege. This is the discovery of a relatively simple means of interrupting the transmission of HIV from an infected mother to the unborn child. At least this much could be addressed now.

Such a partnership would involve major donors, such as the United States, to cover the administrative costs, UNICEF to ensure proper ministration of the medicine, the pharmaceutical companies to make this relatively low-cost medicine available free or at least at cost, and the governments of Asia and Africa to launch and oversee the program.

ASSOCIATED PRESS

This is still a small step toward controlling this disease. Some day, a much greater partnership will be needed to administer a vaccine, once it is developed. For now, however, pharmaceutical companies, which have been notoriously insensitive to the underlying crisis when vigorously defending their patent rights (Bristol-Myers being a welcome exception), can demonstrate concern in a tangible way.

For Vice President Al Gore, dogged by protesters over his alleged defense of the pharmaceutical industries' claims against South Africa, this would be a most appropriate initiative to lead. It would have far more impact than the extra $100 million request for HIV/AIDS he recently announced with Archbishop Desmond Tutu, as welcome as that is.

The HIV/AIDS epidemic is perhaps the most serious source of future social and economic upheaval in large parts of the world today. It demands initiatives far greater than anything done so far. A public-private partnership as described here could be the forerunner of the kind that eventually will be needed.

The writer, a former U.S. ambassador to South Africa, is a visiting fellow at the Overseas Development Council.

AIDS IN THE THIRD WORLD

A global disaster

PIETERMARITZBURG, HARARE, KAMPALA

The AIDS virus has infected 47m people, and shows no signs of slowing. It cannot be cured. Can it be curbed?

IN RICH countries AIDS is no longer a death sentence. Expensive drugs keep HIV-positive patients alive and healthy, perhaps indefinitely. Loud public-awareness campaigns keep the number of infected Americans, Japanese and West Europeans to relatively low levels. The sense of crisis is past.

In developing countries, by contrast, the disease is spreading like nerve gas in a gentle breeze. The poor cannot afford to spend $10,000 a year on wonder-pills. Millions of Africans are dying. In the longer term, even greater numbers of Asians are at risk. For many poor countries, there is no greater or more immediate threat to public health and economic growth. Yet few political leaders treat it as a priority.

Since HIV was first identified in the 1970s, over 47m people have been infected, of whom 14m have died. Last year saw the biggest annual death toll yet: 2.5m. The disease now ranks fourth among the world's big killers, after respiratory infections, diarrhoeal disorders and tuberculosis. It now claims many more lives each year than malaria, a growing menace, and is still nowhere near its peak. If India, China and other Asian countries do not take it seriously, the number of infections could reach "a new order of magnitude", says Peter Piot, head of the UN's AIDS programme.

The human immuno-deficiency virus (HIV), which causes acquired immune deficiency syndrome (AIDS), is thought to have crossed from chimpanzees to humans in the late 1940s or early 1950s in Congo. It took several years for the virus to break out of Congo's dense and sparsely populated jungles but, once it did, it marched with rebel armies through the continent's numerous war zones, rode with truckers from one rest-stop brothel to the next, and eventually flew, perhaps with an air steward, to America, where it was discovered in the early 1980s. As American homosexuals and drug injectors started to wake up to the dangers of bath-houses and needle-sharing, AIDS was already devastating Africa.

So far, the worst-hit areas are east and southern Africa. In Botswana, Namibia, Swaziland and Zimbabwe, between a fifth and a quarter of people aged 15-49 are afflicted with HIV or AIDS. In Botswana, children born early in the next decade will have a life expectancy of 40; without AIDS, it would have been nearer 70. Of the 25 monitoring sites in Zimbabwe where pregnant women are tested for HIV, only two in 1997 showed prevalence below 10%. At the remaining 23 sites, 20-50% of women were infected. About a third of these women will pass the virus on to their babies.

The region's giant, South Africa, was largely protected by its isolation from the rest of the world during the apartheid years. Now it is host to one in ten of the world's new infections—more than any other country. In the country's most populous province, KwaZulu-Natal, perhaps a third of sexually active adults are HIV-positive.

Asia is the next disaster-in-waiting. Already, 7m Asians are infected. India's 930m people look increasingly vulnerable. The Indian countryside, which most people imagined relatively AIDS-free, turns out not to be. A recent study in Tamil Nadu found over 2% of rural people to be HIV-positive: 500,000 people in one of India's smallest states. Since 10% had other sexually transmitted diseases (STDs), the avenue for further infections is clearly open. A survey of female STD patients in Poona, in Maharashtra, found that over 90% had never had sex with anyone but their husband; and yet 13.6% had HIV. China is not far behind.

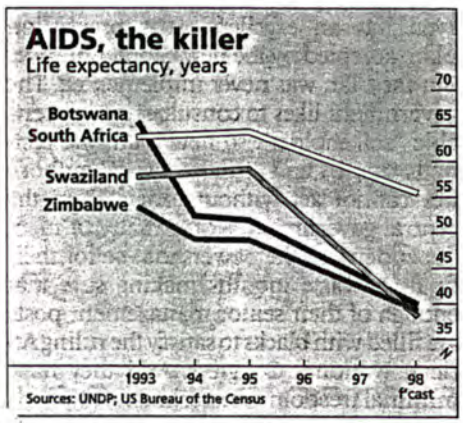
No one knows what AIDS will do to poor countries' economies, for nowhere has the epidemic run its course. An optimistic assessment, by Alan Whiteside of the University of Natal, suggests that the effect of AIDS on measurable GDP will be slight. Even at high prevalence, Mr Whiteside thinks it will slow growth by no more than 0.6% a year. This is because so many people in poor countries do not contribute much to the formal economy. To put it even more crudely, where there is a huge oversupply of unskilled labour, the dead can easily be replaced. Some people argue that those who survive the epidemic will benefit from a tighter job market. After the Black Death killed a third of the population of medieval Europe, labour scarcity forced landowners to pay their workers better.

Other researchers are more pessimistic. AIDS takes longer to kill than did the plague, so the cost of caring for the sick will be more crippling. Modern governments, unlike medieval ones, tax the healthy to

help look after the ailing, so the burden will fall on everyone. And AIDS, because it is sexually transmitted, tends to hit the most energetic and productive members of society. A recent study in Namibia estimated that AIDS cost the country almost 8% of GNP in 1996. Another analysis predicts that Kenya's GDP will be 14.5% smaller in 2005 than it would have been without AIDS, and that income per person will be 10% lower.

The cost of the disease

In general, the more advanced the economy, the worse it will be affected by a large number of AIDS deaths. South Africa, with its advanced industries, already suffers a shortage of skilled manpower, and cannot afford to lose more. In better-off developing countries, people have more savings to fall



back on when they need to pay medical bills. Where people have health and life insurance, those industries will be hit by bigger claims. Insurers protect themselves by charging more or refusing policies to HIV-positive customers. In Zimbabwe, life-insurance premiums quadrupled in two years because of AIDS. Higher premiums force more people to seek treatment in public hospitals: in South Africa, HIV and AIDS could account for between 35% and 84% of public-health expenditure by 2005, according to one projection.

Little research has been done into the effects of AIDS on private business, but the anecdotal evidence is scary. In some countries, firms have had to limit the number of days employees may take off to attend funerals. Zambia is suffering power shortages because so many engineers have died. Farmers in Zimbabwe are finding it hard to irrigate their fields because the brass fittings on their water pipes are stolen for coffin handles. In South Africa, where employers above a certain size are obliged to offer generous benefits and paid sick leave, companies will find many of their staff, as they sicken, becoming more expensive and less productive. Yet few firms are trying to raise awareness of AIDS among their workers, or considering how they will cope.

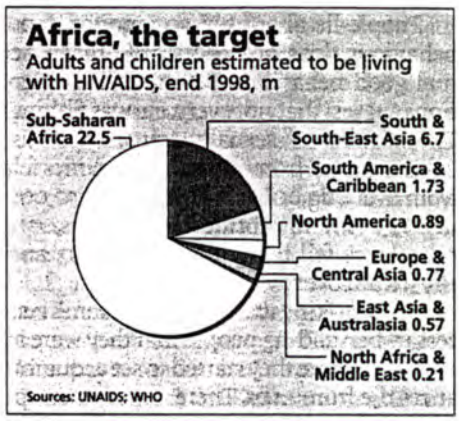
In the public sector, where pensions and health benefits are often more generous, AIDS could break budgets and hobble the provision of services. In South Africa, an estimated 15% of civil servants are HIV-positive, but government departments have made little effort to plan for the coming surge in sickness. Education, too, will suffer. In Botswana, 2-5% of teachers die each year from AIDS. Many more take extended sick leave.

At a macro level, the impact of AIDS is felt gradually. But at a household level, the blow is sudden and catastrophic. When a breadwinner develops AIDS, his (or her) family is impoverished twice over: his income vanishes, and his relations must devote time and money to nursing him. Daughters are often forced to drop out of school to help. Worse, HIV tends not to strike just one member of a family. Husbands give it to wives, mothers to babies. This correspondent's driver in Kampala lost his mother, his father, two brothers and their wives to AIDS. His story is not rare.

Obstacles to prevention

The best hope for halting the epidemic is a cheap vaccine. Efforts are under way, but a vaccine for a virus that mutates as rapidly as HIV will be hugely difficult and expensive to invent. For poor countries, the only practical course is to concentrate on prevention. But this, too, will be hard, for a plethora of reasons.

- Sex is fun ... Many feel that condoms make it less so. Zimbabweans ask: "Would you eat a sweet with its wrapper on?"
- ... and discussion of it often taboo. In Kenya, Christian and Islamic groups have publicly burned anti-AIDS leaflets and condoms, as a protest against what they see as the encouragement of promiscuity. A study in Thailand found that infected women were only a fifth as likely to have discussed sex openly with their partners as were uninfected women.
- Myths abound. Some young African women believe that without regular infusions of sperm, they will not grow up to be beautiful. Ugandan men use this myth to seduce schoolgirls. In much of southern Africa, HIV-infected men believe that they can rid themselves of the virus by passing it on to a virgin.
- Poverty. Those who cannot afford television find other ways of passing the evening. People cannot afford antibiotics, so the untreated sores from STDs provide easy openings for HIV.
- Migrant labour. Since wages are much higher in South Africa than in the surrounding region, outsiders flock in to find work. Migrant miners (including South Africans forced to live far from their homes) spend most of the year in single-sex dormitories surrounded by prostitutes. Living with a one-in-40 chance of being killed by a rockfall, they are inured to risk. When they go home, they often infect their wives.
- War. Refugees, whether from genocide in Rwanda or state persecution in Myanmar, spread HIV as they flee. Soldiers, with their regular pay and disdain for risk, are more likely than civilians to contract HIV from prostitutes. When they go to war, they infect others. In Africa the problem is dire. In Congo, where no fewer than seven armies are embroiled, the government has accused Ugandan troops (which are helping the Congolese rebels) of deliberately spreading AIDS. Unlikely, but with estimated HIV prevalence in the seven armies ranging from 50% for the Angolans to an incredible 80% for the Zimbabweans, the effect is much the same.
- Sexism. In most poor countries, it is hard for a woman to ask her partner to use a condom. Wives who insist risk being beaten



up. Rape is common, especially where wars rage. Forced sex is a particularly effective means of HIV transmission, because of the extra blood.

- Drinking. Asia and Africa make many excellent beers. They are also home to a lot of people for whom alcohol is the quickest escape from the stresses of acute poverty. Drunken lovers are less likely to remember to use condoms.

How to fight the virus

Pessimists look at that list and despair. But three success stories show that the hurdles to prevention are not impossibly high.

First, **Thailand**. One secret of Thailand's success has been timely, accurate information-gathering. HIV was first detected in Thailand in the mid-1980s, among male homosexuals. The health ministry immediately began to monitor other high-risk groups, particularly the country's many heroin addicts and prostitutes. In the first half of 1988, HIV prevalence among drug injectors tested at one Bangkok hospital leapt from 1% to 30%. Shortly afterwards, infections soared among prostitutes.

The response was swift. A survey of Thai sexual behaviour was conducted. The results, which showed men indulging in a phenomenal amount of unprotected commercial sex, were publicised. Thais were warned that a major epidemic would strike

if their habits did not change. A "100% condom use" campaign persuaded prostitutes to insist on protection 90% of the time with non-regular customers.

By the mid-1990s, the government was ending $80m a year on AIDS education and palliative care. In 1990-93, the proportion of adult men reporting non-marital sex was halved, from 28% to 15%; for women, it fell from 1.7% to 0.4%. Brothel visits slumped. Only 10% of men reported seeing a prostitute in 1993, down from 22% in 1990. Among army conscripts in northern Thailand, a group both highly sexed and well-monitored, the proportion admitting to paying for sex fell from 57% in 1991 to 24% in 1995. The proportion claiming to have used condoms at their last commercial entanglement rose from 61% in 1991 to 93% in 1995.

People lie about sex, so reported good behaviour does not necessarily mean actual good behaviour. But tumbling infections suggest that not everyone was fibbing. The number of sexually transmitted diseases reported from government clinics fell from over 400,000 in 1986 to under 50,000 in 1995. Among northern conscripts, HIV prevalence fell by half between 1993 and 1995, from over 7% to under 3.5%.

Most striking was the government's success in persuading people that they were at risk long before they started to see acquaintances die from AIDS. There was no attempt to play down the spread of HIV to avoid scaring off tourists, as happened in Kenya. Thais were repeatedly warned of the dangers, told how to avoid them, and left to make their own choices. Most decided that a long life was preferable to a fast one.

Second, **Uganda.** Thailand shows what is possible in a well-educated, fairly prosperous country. Uganda shows that there is hope even for countries that are poor and barely literate. President Yoweri Museveni recognised the threat shortly after becoming president in 1986, and deluged the country with anti-AIDS warnings.

The key to Uganda's success is twofold. First, Mr Museveni made every government department take the problem seriously, and implement its own plan to fight the virus. Accurate surveys of sexual behaviour were done for only $20,000-30,000 each. Second, he recognised that his government could do only a limited amount, so he gave free rein to scores of non-governmental organisations (NGOs), usually foreign-financed, to do whatever it took to educate people about risky sex.

The Straight Talk Foundation, for example, goes beyond simple warnings about AIDS and deals with the confusing complexities of sex. Its staff run role-playing exercises in Uganda's schools to teach adolescents how to deal with romantic situations. Its newsletter, distributed free, covers everything from nocturnal emissions to what to do if raped. Visiting AIDS workers from South Africa and Zimbabwe asked the foundation's director, Catharine Watson, how she won government permission to hand out such explicit material, and were astonished to hear that she had not felt the need to ask.

The climate of free debate has led Ugandans to delay their sexual activity, to have fewer partners, and to use more condoms. Between 1991 and 1996, HIV prevalence among women in urban ante-natal clinics fell by half, from roughly 30% to 15%.

Third, **Senegal.** If Uganda shows how a poor country can reverse the track of an epidemic, Senegal shows how to stop it from taking off in the first place. This West African country was fortunate to be several thousand miles from HIV's origin. In the mid-1980s, when other parts of Africa were already blighted, Senegal was still relatively AIDS-free. In concert with non-governmental organisations and the press and broadcasters, the government set up a national AIDS-control programme to keep it that way.

In Senegal's brothels, which had been regulated since the early 1970s, condom use was firmly encouraged. The country's blood supply was screened early and effectively. Vigorous education resulted in 95% of Senegalese adults knowing how to avoid the virus. Condom sales soared from 800,000 in 1988 to 7m in 1997. Senegalese levels of infection have remained stable and low for a decade—at around 1.2% among pregnant women.

Contrast these three with South Africa. On December 1st, World AIDS Day, President Nelson Mandela told the people of KwaZulu-Natal that HIV would devastate their communities if not checked. The speech was remarkable not for its quality—Mr Mandela is always able to move audiences—but for its rarity. Unlike Mr Museveni, South Africa's leader seldom uses his authority to encourage safer sex. It is a tragic omission. Whereas the potholed streets of Kampala are lined with signs promoting fidelity and condoms, this correspondent has, in eight months in South Africa, seen only two anti-AIDS posters, both in the UN's AIDS office in Pretoria.

How to dither and die

South Africa has resources and skills on a scale that Uganda can only marvel at. It even has an excellent AIDS prevention plan, accepted by the new cabinet in 1994. But the plan was never implemented. The government likes to consult every conceivable "stakeholder", so new plans are eternally drafted and redrafted. Local authorities cannot act without orders from the central government. NGOs, many of them dependent on the powers-that-be for their finance, waste months making sure that enough of their senior management posts are filled with blacks to satisfy the ruling African National Congress. And they have minimal freedom to experiment.

"There's an idea that if you disagree with the government, you are betraying the liberation struggle," says Mary Crewe, head of the Greater Johannesburg AIDS project. As a result, soldiers in the South African army are so ignorant that they snip the tips off their free condoms, and HIV has spread through South Africa as fast, according to Dr Neil McKerrow of Grey's Hospital in Pietermaritzburg, as if no preventive measures at all had been taken.

Such bungling is not unique to South Africa. Most governments have been slow to recognise the threat from AIDS. From Bulawayo to Beijing, apathy and embarrassment have hamstrung preventive efforts.

In anarchic countries, such as Congo and Angola, there have been almost no preventive efforts. Many people believe that the cause—a bid to restrain one of the most basic human instincts—is hopeless. As a Zimbabwean novelist, Chenjerai Hove, puts it with disturbing fatalism: "Since our women dress to kill, we are all going to die." But if the sexual drive is basic, so is the desire to live. If governments in poor countries wake up to the need to persuade their citizens that unprotected sex is Russian roulette, Mr Hove could be proved wrong.

This article is indebted to a number of UNAIDS reports, including AIDS epidemic update (December 1998), AIDS in Africa (November 1998), and "A measure of success in Uganda" (May 1998).

July 13, 1999

THE DOCTOR'S WORLD

In Africa, a Deadly Silence About AIDS Is Lifting

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By LAWRENCE K. ALTMAN, M.D.

Earlier this year, AIDS became the leading killer in Africa, a mere 18 years after the infection was first recognized. But if political and religious leaders had responded with effective public health programs much earlier, they might have prevented hundreds of thousands, if not millions, of deaths.

Some leaders simply denied the scientific evidence that H.I.V. was being transmitted in their countries. Others mistakenly believed they had more pressing health problems to address.

Now, as the epidemic in Africa becomes an even greater catastrophe, Dr. Peter Piot, Assistant Secretary General of the United Nations and head of its AIDS programs, says he sees signs of momentum among African leaders to fight the disease. The momentum promises to slow the relentless transmission of H.I.V., conveyed on the continent primarily through heterosexual sex, Dr. Piot said in an interview.

Ruby Washington/The New York Times

Dr. Peter Piot, the Assistant Secretary General in charge of the United Nations AIDS program, said he is finding a

Nelson Mandela, the former President of South Africa; his successor, Thabo Mbeki, and Dr. Negasso Gidada, the President of Ethiopia, are among the leaders of countries with high infection rates to speak out on AIDS for the first

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time recently in their own countries and to put more money into prevention efforts.

program, said he is finding a new attitude toward the disease among African leaders.

And, in May, at their annual meeting in Addis Ababa, Ethiopia, African finance ministers for the first time called AIDS a major threat to economic and social development.

The United Nations General Assembly recently called for a 25 percent reduction in new H.I.V. infections among young people over the next five years in the countries most affected by AIDS.

And the Clinton Administration, appalled by the staggering dimensions of the African AIDS epidemic, is planning an initiative to help, Dr. Piot said.

Large-scale efforts clearly are needed. In sub-Saharan Africa, H.I.V. has infected 34 million people and killed 11.5 million since 1981, dwarfing malaria and tuberculosis. Last year, AIDS accounted for 1.8 million deaths in sub-Saharan Africa, nearly double the 1 million deaths from malaria and about nine times the 209,000 deaths from tuberculosis, according to Dr. Piot's agency, which has headquarters in Geneva.

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Based on meetings with leaders of 10 African countries this year, Dr. Piot says he has noted a striking change in attitudes toward AIDS: at earlier meetings, he initiated discussions about AIDS; at the recent sessions, African leaders admitted their problems and asked for help.

"It is such a big change," Dr. Piot, a 50-year-old Belgian and a pioneer in AIDS research in Africa, said in a brief visit to New York. In years past, Dr. Piot said, even meeting with an African head of state was difficult.

He recalled an incident about 15 years ago when he and another AIDS expert waited nearly a day in the office of the Kenyan Minister of Health while officials debated whether to expel the two because they had talked to reporters about AIDS in Kenya.

In 1985, Zaire refused to give me a visa to report on AIDS, and the Government of Kenya confiscated issues of The International Herald Tribune, which carried my articles, because of its displeasure with my coverage of AIDS there.

African political leaders remained silent even when AIDS was killing members of their own families.

In 1985, the press secretary to Kenneth D. Kaunda, then the President of Zambia, denied my request for an interview about AIDS. The press secretary threatened to expel me for reporting on what he called an American disease. A year later, Kaunda lost a son to AIDS.

In 1989, Kaunda was one of the first to speak out. In describing his family's loss at an international AIDS meeting in Montreal, Kaunda said that if scientists failed to cure AIDS, the epidemic would become "a soft nuclear bomb on human life." But in the years of Kaunda's silence, hundreds of thousands of Africans became infected.

Yet even now realism has not fully set in. Dr. Piot still encounters government officials who "ask why I use the word epidemic," he said.

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It takes an average of nine years for H.I.V. to progress to AIDS, and the virus spread widely and silently for a decade before being discovered. Yet even with the undetected early spread, there was time to initiate programs to prevent subsequent infections, as was done effectively among gay men in the United States and other developed countries.

In South Africa, H.I.V. rates soared during Nelson Mandela's Administration, a fact that he later acknowledged.

"It's the silence that is letting this disease sweep through the country," Mandela said on World AIDS Day in December. "It is time to break the silence."

Dr. Piot applauded Mandela and Mbeki, his successor, for calling national attention to AIDS, but said, "It took a long time, and a lot of deaths could have been prevented if they had spoken out earlier."

Today, AIDS continues to thin the ranks of Africa's small middle class, killing at least one teacher a day in Malawi and the Ivory Coast. It is devastating already weak economies across Africa and forcing children to drop out of school to till the farms and care for sick parents.

Dr. Piot challenged African finance ministers at their annual meeting in Addis Ababa in May to learn more about how AIDS was devastating their economies.

"After my speech, there was dead silence," Dr. Piot said. "I thought, another of those moments of supreme denial."

But then, he added, "One after the other, the finance ministers spoke, often making personal references to AIDS in the family or a colleague."

That evening, many joined him for a drink.

"The problem was how to stop the discussions," Dr. Piot said.

"That was a great moment for me."

The next day, Dr. Gidada, the President of Ethiopia, and His Holiness Abune Paulos, the Patriarch of the Ethiopian Orthodox

Church, shook hands as they met publicly for the first time with H.I.V.-infected Ethiopians, Dr. Piot said.

"That may have been a small thing, but it was highly symbolic in Africa," he added. Yet it was a gesture that political leaders elsewhere had made in the 1980's.

Uganda, which acted early, showed that educational programs could change sexual behavior after AIDS had struck in vast numbers.

Senegal and Brazil also thwarted the assault of AIDS, Dr. Piot said, taking "vigorous action" on sex education, AIDS prevention and condom promotion to keep the infection rate below 2 percent. "It is a major political challenge to invest in AIDS prevention when there is not a huge problem," Dr. Piot said, "yet that is exactly what Senegal has done."

Through programs that political and religious leaders encouraged, the Senegalese postponed having first sexual intercourse, used condoms more often and had sex with fewer partners and less sex with prostitutes, surveys there showed.

Nigeria, Africa's most populous country, stands in stark contrast, with an infection rate of about 9 percent and rising. A new regime appears to be willing to tackle the AIDS problem in Nigeria, which the previous regime denied, Dr. Piot said.

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Dr. Piot's team has a budget of $60 million a year, only enough to act as a catalyst for others to undertake prevention efforts. His AIDS team, for example, calls on African leaders to urge drastic efforts to fight the epidemic.

The latest figures show that international aid paid for $150 million of the $165 million spent on AIDS prevention in Africa in 1997. Uganda accounted for much of the $15 million that the African countries spent.

"It's a scandal that African countries have not spent more," Dr. Piot said.

Although the World Bank and other international agencies make money available for projects in Africa, much of it goes unspent because of bureaucratic complexities and other problems.

Dr. Piot said his agency was trying to identify untapped funds to direct toward prevention efforts, while recognizing that those nations "cannot afford everything for AIDS, certainly not lifetime anti-retroviral drugs."

Taken in combination, those drugs can cost $15,000 a year for a single patient, require adherence to rigid schedules, and often demand sophisticated monitoring tests unavailable in developing countries. That means few Africans can benefit from the drug

cocktails, which are prolonging lives and often restoring health among H.I.V.-positive people in developed nations.

To reach a largely captive audience, and one in its sexual prime, Dr. Piot is encouraging governments to spend more of their military budgets, which usually receive high priority, on AIDS prevention.

In Uganda, the infection rate is about 10 percent in the general population and up to 30 percent in the military. "There are African countries where it is said that more than 50 percent of all the military are H.I.V. infected," Dr. Piot said, "and that is a problem of national security."

It also means that many spouses and children are infected. So Dr. Piot's team aims to encourage teachers' unions, school systems and youth groups to join prevention programs in Africa.

In some West African countries, for example, Scouting groups have created an AIDS badge for those who do good deeds for people with H.I.V., Dr. Piot said.

His agency has also teamed on AIDS efforts with Caritas, a Catholic health agency based in the Vatican that is responsible for health care in many African countries, Dr. Piot said.

Although the Vatican does not approve of the use of condoms, Dr. Piot said that he had seen many Catholic priests, nuns and organizations promote condom use in Africa.

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In June 1998, Dr. Piot's agency issued the first country-by-country analysis of H.I.V. It showed that one in four adults was infected with H.I.V. in certain parts of Africa and that AIDS was hitting so fiercely that it compared to the greatest epidemics of history. The report was a crucial factor in changing political attitudes, Dr. Piot said.

Dr. Piot said he was criticized for the report by many Western epidemiologists and health workers, who called the figures exaggerated.

"A lot of the criticism had to do with turf battles, from scientists who believe their disease is more important than someone else's," Dr. Piot said, "and it's the type of nonsensical competition that exists in all countries."

But now, the criticism has come full circle. In 1992, a team headed by the late Dr. Jonathan M. Mann at the Harvard School of Public Health, published estimates of H.I.V. infections in sub-Saharan Africa ranging from 20.8 million to 33.6 million by 2000.

The World Health Organization criticized Dr. Mann's estimates as excessive. Now, academic scientists are criticizing the figures of Dr. Piot's team. "When we look at the figures today, they are

worse than the scenarios Jonathan had published," Dr. Piot said.

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Larger budgets are needed. But pumping money into a country where AIDS is a low priority will not end the epidemic. "If a country does not recognize that it has an AIDS problem, then it is not willing to take on the tough questions," Dr. Piot said. "Outside support for something that can only be solved from the inside will not work.

"We can only win," he added, "if there is a mass movement."

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ANNEX 2. HIV/AIDS PREVALENCE RATES FOR SSA

Adult (15-49 Years) HIV/AIDS Prevalence Rates, Sub-Saharan Africa, December 1997

Rank	Country	Adult HIV/AIDS rate (percent)	Rank	Country	Adult HIV/AIDS rate (percent)
1	Zimbabwe	25.84	23	Democratic Republic of Congo	4.35
2	Botswana	25.10	24	Gabon	4.25
3	Namibia	19.94	25	Nigeria	4.12
4	Zambia	19.07	26	Liberia	3.65
5	Swaziland	18.50	27	Eritrea	3.17
6	Malawi	14.92	28	Sierra Leone	3.17
7	Mozambique	14.17	29	Chad	2.72
8	South Africa	12.91	30	Ghana	2.38
9	Rwanda	12.75	31	Guinea-Bissau	2.25
10	Kenya	11.64	32	Gambia, The	2.24
11	Central African Republic	10.77	33	Angola	2.12
12	Djibouti	10.30	34	Guinea	2.09
13	Côte d'Ivoire	10.06	35	Benin	2.06
14	Uganda	9.51	36	Senegal	1.77
15	Tanzania	9.42	37	Mali	1.67
16	Ethiopia	9.31	38	Niger	1.45
17	Togo	8.52	39	Equatorial Guinea	1.21
18	Lesotho	8.35	40	Mauritania	0.52
19	Burundi	8.30	41	Somalia	0.25
20	Republic of Congo	7.78	42	Comoros	0.14
21	Burkina Faso	7.17	43	Madagascar	0.12
22	Cameroon	4.89	44	Mauritius	0.08

Note: Adult rates (percent) are derived from the number of adults (15-49 years) living with HIV/AIDS at the end of 1997 divided by the 1997 adult population.

Source: UNAIDS, 1998a.