Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. list	re: Personally Identifiable Information (2 pages)	00/00/0000	b(6)
002. list	re: Personally Identifiable Information (1 page)	00/00/0000	b(6)

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

FOLDER TITLE:
AIDS [Acquired Immune Deficiency Syndrome] Meeting [1]

2013-0534-S
rc1882

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

file
AIDS

AIDS meeting

file AIDS

THE WHITE HOUSE
WASHINGTON

Piot - crisis in development

Ivory Coast - every single day someone dying ?
AIDS - teacher.

optimism: Uganda
- Some Countries done a great job - not stopped

- Senegal
- Zambia

Increase visibility, reduce stigma

Sustain pol. momentum - strengthen Afr. leaders.
strengthen
Social safety nets -
actively engaged sectors = mass not.

THE WHITE HOUSE
WASHINGTON

Strengthen
tech. capacities – U.S. convene
majr donor gmt's.

Standard q care.

– Shalala.
not ~~claiming~~ complaining
any more about Pres. + now
its about financial ministers.

Improved methods to prevention
for health care delivery
infrastructure.

Satcher – global strategy –
Can't be successful in public
health unless we look at
broad dev. + econ. issues.

THE WHITE HOUSE
WASHINGTON

epidemic of people of color, women, young

Summers:

(1) AIDs devast'ng to econ'c policies
girls educ'n need to be
done on its own, AIDs makes
it more acute.
World Bank - AIDs Devlop'ng
undermined.

Gd Devlop - undermine AIDs

(2) be aware of how countries
are spending. Mexico.
asst'a needs to be used
to make a diff'ce.

THE WHITE HOUSE
WASHINGTON

[redacted] Cologne can reduce debt service burdens - only make a diff'ce if $ well used

③ pay close attn. to incentives at all levels. -
make choices - not everything that can be positive -
can be funded.
focus on what's cost effective.

$ Also a probs. in India re So. Asia.

If a silent epidemic
more so if left silent.

THE WHITE HOUSE
WASHINGTON

Wolfensohn

Issue not so much $, but
will of Countries -
Really needs to go beyond
top elites.
- train health workers
- civil society to work w/ govt.
- infrastructure

providing horizontal level of
Credit for AIDS

* Demand not Medic from
Clients

THE WHITE HOUSE
WASHINGTON

Rockefeller
- capacity bldrs - e.g. teachers
- need prevention techniques
  espec'ly among the
  poor

- vaccine

McCarthur -
Soltva Men Fenton - chair of
  Human Rts fund -
issue of stigma.

---

how foundat'ns look at → { - research
- individ'ls
- NGOs

THE WHITE HOUSE
WASHINGTON

seeking complementary approaches.

disease
overlapping prevention prog-

Frank Loy: raise profile of issue.

Add AIDS to bilateral + multilateral agenda

Harpers - New Aids Epidemic
Spread of So. African version
to India — more virulent
kills faster + mutate faster
heterosex'l trans'n.
→ infect'n rate in So. Africa
soaring.

Bristol Myers - "Secure Future"

THE WHITE HOUSE
WASHINGTON

Mother Child Transmission
Public Heath Training
- focus on Vertical transmission in resource constraint settings

So Afr., Namibia, Swaziland
Botswana

① Research
② focus on women + children - Educ'n
AIDS orphans
③ ~~Capacity~~ bldg.
41 new fellows in public health.
rural nurses

Did an outcome get changed by
these models.

<work with others in field + cross sectors>

THE WHITE HOUSE
WASHINGTON

Prio t:

Resources for capacity bldg. w accountability - for prevention + care.

incentives - why be tested if no stigma + no care.

hope for commitments for demo projects - debt relief.

US support technical resources internat'ly

THE WHITE HOUSE
WASHINGTON

BET -
govt controls much of media -
need Telcom ministries
to get involved.

* Convene Telcom ministers + major advertisers (also can help)
Coke
It's a smart thing to get involved.
Edu'n + media

Amer programming needs to have a message on this.

Kaiser - initiative on kids
for prevention in So. Africa.
40-45% young in popul'n.

THE WHITE HOUSE
WASHINGTON

Youth centers connected to public health centers.
"Love life campaign"
want to take to scale
Mrs. Mbeki

Foreign policy apparatus needs to address this unprecedented global pandemic.

Jump-
elevate gender dimensions of this. AIDS would look where it is if people who work on maternal child health - had a higher standing

→ integrating issues into foreign policy

THE WHITE HOUSE
WASHINGTON

Rel. leaders.

Rel. leaders - Imams
Caritas

(Real concrete ideas - follow up.)

Countries affected must want to address this as much as we.

Summers - address global problems is key in 1990's foreign assistance this post cold war era.

AIDS

Eric,
Can you get names of CEOs, addresses + phone #'s for checked companies (if I might have them

TO: ***Melanne Verveer***

FROM: ***Gayle Smith***

RE: ***FLOTUS AIDS Event***

Melanne:

Sorry we have been unable to connect. Sometimes I think voicemail is a terrible curse.

I've talked to Sandy Thurman and to my team about corporate invitees for the FLOTUS event, and have come to the conclusion that what we need to aim for is inspiring and leveraging a greater commitment from the corporate community, as opposed to simply coordinating with those companies which are already engaged. My reasoning is pragmatic: few large American corporations investing in Africa have taken on the HIV/AIDS issue in a serious way, as yet.

As such, I recommend the following:

Bristol Meyers
Squibb

Johnson, BET. As we discussed

✓ **CEO, Coca-Cola**. Coke has not taken the AIDS crisis seriously enough, but has engaged on social issues through its foundations. I suspect that there may be some apprehension about the impact on corporate profit of being seen to be raising a sensitive issue. It is possible, however, for Coke to initiate support for HIV/AIDS prevention in countries – like Uganda – that have taken the issue into the public arena at the highest levels, and where association is not a risk, simply because the AIDS issue is not sensitive.

✓ **CEO, American Airlines**. I understand that among U.S. corporations active in this country, American Airlines is among the best. AA is establishing a partnership with South African Airlines, and thus offers a link between a corporation with a track record of involvement (and experience) here, and a new link with Africa.

✓ **Chevron**. We need one of the oil companies (NSC, State and others can follow up with all of the oil companies, including through our extensive work

with the Corporate Council on Africa), simply because they are our biggest investors.

Please let me know if you'd like additional information, and what assistance we can offer as you put this event together.

And now, on an important note --- **Erica Barks-Ruggles is about to depart the NSC**. As you may know, she will be moving back to State to work with Tom Pickering. As you may suspect, I am devastated. I will be hosting a reception on August 11 at 5:00 in the Indian Treaty Room for her and another member of my staff who is departing. We will send you an invitation, and I sincerely hope you'll be able to join us. I know that Erica has loved working with you, the First Lady, and your office.

I'm in over the weekend if you have questions.

5 24-99

THE WHITE HOUSE

WASHINGTON

[redacted]

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

cc: Back to me

May 21, 1999

MEMORANDUM TO THE PRESIDENT

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

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

---

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

AIDS is a plague of biblical proportion

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

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

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

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

The combination of leadership and resources can turn the tide.

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

Copied POTUS NSC WL 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.

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.

The Washington Post
WEDNESDAY, AUGUST 11, 1999

LETTERS TO THE EDITOR

Who Is Worrying About the Children?

The Post's front-page story "Welfare Reform Is on a Roll" [Aug. 3] was grossly misleading. Not until the very end, on the inside page (headline: "Welfare Reform's Triumph Is Affirmed") is it revealed that the central finding of the Urban Institute's study—which is the subject of the article—was that 60 percent of the people surveyed had jobs at the time they were interviewed. Hardly a triumph. It means that of the 2.1 million adults who went off the welfare rolls during the period studied, 840,000 did not have jobs. With their children, that is a total of 2.5 million people. Who is worrying about those children?

The real news is deeply troubling. The poor are barely better off in this phenomenal prosperity, and the extremely poor—those with incomes below half the poverty line (less than $6,750 for a family of three)—are worse off. During the same two years studied by the Urban Institute (1996 and 1997), the number of extremely poor rose by 700,000 people—from 13.9 million to 14.6 million people. The lowest 10 percent of single mothers lost nearly one-sixth of their income, and the lowest 40 percent all lost income. Why? Very simple. Benefits lost exceeded earnings gained.

A large minority of those leaving welfare do not find work, many of those who find work don't find steady work, and most of those with steady work don't earn enough to get out of poverty. In a four-state study, only a third of recent welfare recipients with jobs had steady jobs. Another analysis showed that the average income of families still in poverty after leaving welfare was less than $9,000.

Why do so many leave welfare without getting work? Because they are pushed off for failure to show up for an appointment or some other dereliction. In Mississippi the welfare rolls have declined by something like 69 percent, but only 35 percent of those leaving found jobs. Mississippi has an aggressive sanctioning policy. Work is generally better than welfare, but getting out of poverty is the policy aim—not reducing the welfare rolls by any means possible.

The Urban Institute study is in fact very unsettling. It implies a need for policy change, not satisfaction, especially because so many children are involved. The Post's story helped no one except the politicians who are trumpeting the success of a policy that has hurt so many poor children.

PETER EDELMAN
Washington

The writer, a professor at Georgetown University Law Center, was an assistant secretary of Health and Human Services during the first Clinton administration.

Leninists All Along

In their Aug. 2 op-ed piece, "Nicaragua Still Needs Our Help," Lawrence Pezzullo—former U.S. ambassador to Nicaragua at the beginning of the Sandinista regime—and his son, David Pezzullo, have it wrong.

They suggest that President Carter's policy of "constructive engagement," by which the United States offered the Sandinistas "the carrot of economic assistance coupled with advice" to behave as good guys, would have been good enough to prevent the Sandinistas from being the bad guys they actually were. The Sandinistas knew better when they said that their intention was to build "a communist society with dollars from the capitalist world."

The authors go further to blame the Reagan administration for the collapse of economic production in Nicaragua. The economy collapsed in Nicaragua for the same reasons it collapsed in the entire former socialist bloc: very bad economic policies.

JORGE SALAVERRY
Managua, Nicaragua

Belated Water Conservation

Cheers to The Post for its recent stories on the region's water woes and scorching heat. But in stating that the "Drought Is Worst Since Depression" [front page, Aug. 2], a major point is missed: Times have changed since the last great drought of 1930-31. Expanding populations and sprawl throughout the Mid-Atlantic region, including the Washington metropolitan area, have spawned innumerable vehicles, roads, homes and businesses. This transformation has placed enormous demand on natural resources, including water for agricultural and domestic uses.

Although these patterns are not to blame for current weather conditions, they do play a role in exacerbating the problem. The drought did not happen suddenly but has been creeping up in a series of dry and hot spells that have worried farmers (the hardest hit) and environmentalists for months. Yet many area residents and policymakers are just beginning to acknowledge that reducing water consumption is a good idea. Still others—most notably in the District—remain complacent and shortsighted.

Must we reach a point of severe crisis to act? Even when drought doesn't strike and even in places where water restrictions are not in effect, small sacrifices can go a long way toward saving one of our most precious resources. Watering lawns and gardens less, not hosing sidewalks, fixing leaky plumbing, taking shorter showers and recycling water are easy habits.

Practicing them reduces wasteful consumption and mitigates the impact of dry periods (including this one, which has no end in sight). We would be well served not only to look back but ahead to the future and ask ourselves what legacy we want to leave behind.

NADIA STEINZOR
Washington

■

On my early-morning runs in downtown Washington, I am daily shocked and dismayed by what can only be called a flagrant and selfish abuse of our natural resources—the watering of sidewalks in front of many businesses as well as federal government offices. Watering sidewalks? Yes! During this, one of the worst droughts in the 20th century on the Eastern seaboard, we suffer from a collective blindness that is truly amazing.

For nearly three weeks, we have heard of the need to conserve our drastically reduced water resources. Curbs have even been put on watering our lawns and washing our cars. Why, then, has no legislator curtailed our ability to water the sidewalks, for goodness' sake?

EMILY S. GOLDMAN
Washington

The Dud Rate Of Cluster Bombs

Virgil Wiebe's Aug. 3 letter, "Duds Keep on Killing," is somewhat misleading in its assertion that the dud rates of cluster bombs were as high as 30 percent during the Vietnam War and 20 percent during the Persian Gulf War. The very nature of cluster bomb units makes a precise figure impossible. Estimates depend on the experience and judgment of witnesses—usually the pilots involved.

When I was a forward air controller in Southeast Asia, I observed about 1,500 sorties of fighters—of which about 85 percent delivered cluster bomb units in some form. I would estimate that about 10 percent of the bomblets did not detonate. Contrary to Mr. Wiebe's pejorative language, only a tiny percentage of the cluster bomb units used in Southeast Asia fell into the category of "mines," and these were supposed to self-destruct after 28 days (although some undoubtedly did not). Commentary on weapons use and dud rates should be influenced by some firsthand experience.

Bomblets then were olive drab in color. They are now, apparently, yellow—a cautionary color in most cultures. This makes detection and removal of duds far easier. Cluster bombs, used appropriately, are a superb force-multiplier weapon in situations involving massed troops, armor, support facilities and anti-aircraft installations. Perhaps Mr. Wiebe would prefer a return to the good old days of mass dumps of 500-pound bombs—which dud at a similar rate.

KARL POLIFKA
Williamsburg

The writer is a retired Air Force colonel.

The Washington Post

EUGENE MEYER, 1875-1959
PHILIP L. GRAHAM, 1915-1963

DONALD E. GRAHAM
Publisher

LEONARD DOWNIE JR. Executive Editor
STEPHEN S. ROSENFELD Editorial Page Editor

STEVE COLL
Managing Editor

MILTON COLEMAN
Deputy Managing Editor

BOISFEUILLET JONES JR.
President and General Manager

VICE PRESIDENTS

BENJAMIN C. BRADLEE — At Large
MICHAEL CLURMAN — Production
PATRICIA A. DUNN — Labor
STEPHEN P. HILLS — Advertising
ELIZABETH ST. J. LOKER — Systems and Engineering
THEODORE C. LUTZ — Business Manager
CAROL D. MELAMED — Government Affairs
GERALD M. ROSBERG — Affiliates
MARGARET SCOTT SCHIFF — Controller/Pers./Admin.
WILLIAM G. TOMPKINS JR. — Marketing
MARY ANN WERNER — Counsel

Published by The Washington Post Company

KATHARINE GRAHAM
Chairman of the Executive Committee

DONALD E. GRAHAM
Chairman of the Board and Chief Executive Officer

ALAN G. SPOON
President and Chief Operating Officer

1150 15th St. NW • Washington, D.C. 20071 • (202) 334-6000

INTERNATIONAL
INTELLECTUAL
PROPERTY
INSTITUTE

-> MELANNE VERVEER -
-> COPY TO TOM ROSSER - VP

July 29, 1999

Richard Socarides
Special Assistant to the President
The White House
Washington, D.C. 20500

Dear Richard,

-> // Thank you for taking my telephone call this morning about my interest in being included in the September 7 meeting on AIDS in sub-Saharan Africa which is being convened by Hillary Rodham Clinton on September 7. As I explained to you on the phone, since leaving my post as Assistant Secretary of Commerce and Commissioner of Patents and Trademarks at the end of last year, I have formed a nonprofit organization with the principal purpose of assisting developing countries to utilize the global intellectual property system for their benefit. FLOTUS

TOM -> One of the first issues I was asked to look at by UNAIDS was the controversy surrounding delivery of patented HIV therapies to developing countries. This led to the enclosed paper which has been widely circulated in the world AIDS community. This week my colleague Lee Feldman and I had a very productive discussion with HHS Secretary Donna Shalala about our ideas and she expressed great interest in serious follow-up. The paper also has been shared with Pharma, GlaxoWellcome Corp. and the Merck Corp., who have expressed significant interest in the plan. The essence of the plan is to bring together the global public and private sectors to more efficiently bring to developing countries the benefits of state-of-the-art patented therapies for HIV disease. I believe that this is directly relevant to the September 7 meeting.

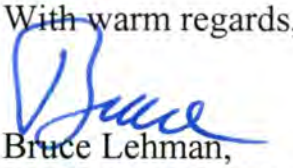
I would deeply appreciate your assistance in having the International Intellectual Property Institute invited to participate in the September 7 meeting. I believe that we have a significant contribution to make. With regard to any concern about conflicts of interest or ethical concerns, please be advised that I in no way participated in decision making regarding this issue while I was in the Administration, and have no ethical bar to dealing

201 Massachusetts Ave., NE, Suite C-3 • Washington, DC 20002 • Tel: (202) 544-6610 • Fax: (202) 478-1955 • E: iipi@iipi.org

with the White House or any other Executive Branch department or agency other than the Department of Commerce.

Thank you very much for your interest.

With warm regards,



Bruce Lehman,
President and CEO,
IIPI

Enclosure

DRAFT

A PROPOSAL FOR A PILOT PROJECT TO DELIVER PATENTED HIV/AIDS THERAPIES AND OTHER TREATMENTS TO PATIENTS IN DEVELOPING AND LEAST DEVELOPED COUNTRIES

DRAFT VERSION 1.3

PRINTED: 07/29/99 2:35 PM

LEE FELDMAN

CO-MANAGING DIRECTOR

HEALTHMINDER, L.L.C.

301-593-7864

LFeldman@HealthMinder.com

BRUCE LEHMAN

INTERNATIONAL INTELLECTUAL PROPERTY INSTITUTE

202-544-6610

BLehman@iipi.org

Precis

The need to better control the spread and treatment of HIV and other diseases such as tuberculosis in the developing countries is a widely known and serious issue that calls for diligent and aggressive attention. This proposal addresses three critical problems:

- the high cost of pharmaceutical treatments,
- the lack of infrastructure needed to effectively deliver treatment and support services to patients, and
- inadequate incentives and assurances needed to stimulate additional subsidies and investments in the impacted countries

This paper proposes a framework of national exhaustion, tiered pricing and subsidization coupled with innovative technology that can achieve sustained and effective service delivery to patients thereby yielding improved outcomes. These measures would remove barriers and create incentives for pharmaceutical companies to actively participate in the delivery of essential therapeutics. Accordingly it should be possible to attain the level of multi-party cooperation and clinical effectiveness needed to build a program that brings meaningful treatments to the developing world.

Pharmacological interventions are a critical component in the management of HIV/AIDS, opportunistic infections and other high-impact diseases in the developing world. Affordability is a critical issue. Yet, efforts to simply restructure the price of pharmaceutical treatments to make them more affordable do nothing to bring the treatment to the patient in need. Affordability does not, by itself, translate into availability. Few developing nations have the service infrastructure needed to properly deliver the full spectrum of HIV and other treatments and critical patient support services that are required over a sustained period of time. Available pharmacological interventions and accessible clinical interventions are the necessary predicates for a successful disease containment program.

This paper discusses the implementation of policies and technologies that would help assure the affordable and effective delivery of pharmaceuticals, treatments and support services resulting in improved outcomes. In particular, the framework:

- Lays a foundation that encourages developing countries to accept national exhaustion of patent rights and support for patent holder rights.
- Discusses how a full spectrum of care can be effectively delivered to patients
- Creates incentives for patent holders to participate in both special pricing models and programs that bring the benefits of the latest innovations to the developing world.
- Helps address the concerns of patent holders that special pricing would lead to the formation of gray markets that erode the fundamentals of their business.
- Helps create an environment where subsidization of pharmaceutical purchases required by the impacted countries can be made with greater assurance that treatments are being delivered in a manner that is clinically effective.

The policies and technologies discussed are not revolutionary, but there is an obvious need for a demonstration project. While a pilot project would necessarily include private industry, three international entities, by virtue of their mandates, should coalesce to shepherd the effort: (a) the World Bank, (b) the World Intellectual Property Organization and (c) UNAIDS.

A successful pilot program will demonstrate the effective case management of patients, a regulated and rational pharmaceutical distribution model and a measurable impact on HIV, opportunistic and other high-impact disease.

INTRODUCTION

In recent years HIV/AIDS and tuberculosis have become the principal public health crisis for a number of countries in the developing world, particularly in sub Saharan Africa. While new advances in drug therapy such as AZT, protease inhibitors, non-nucleoside reverse transcriptase inhibitors and antiretrovirals have drastically lowered morbidity in the United States and developed countries, these therapies are virtually unknown in impacted areas of the developing world. First line therapies for TB are becoming less effective as multiple drug resistant strains evolve. Second line therapeutics and other more complex interventions are often considerably more expensive.

The problem of making effective therapies available in developing and least developed countries stems from several causes. First, of course, is the high cost of treatment. In the United States the annual bill for prescriptions of protease inhibitors usually exceeds $10,000 per patient. This is a price beyond the reach of individuals in countries where annual per capita incomes may be a fraction of this annual cost. Second, these pharmaceuticals require a sophisticated medical infrastructure and level of patient cooperation beyond the capacity of many developing and least developed nations. Finally, the relative poverty of populations in these countries and their resulting inability to stimulate market demand deprives developers of the necessary incentive for investing in solutions. Absent potential consumer demand, the patent system is ill equipped to impel producers of these therapies to risk scarce venture capital.

This paper proposes an integrated policy and technological approach to resolving these difficult problems. The first section outlines a policy based on principles of national exhaustion, tiered pricing and subsidized pharmaceutical purchases. The second section describes technological measures based on sophisticated information systems, established models of patient care and controlled pharmaceutical delivery.

PART I
NATIONAL EXHAUSTION, TIERED PRICING AND SUBSIDIZED PURCHASING

At the present time developers of state-of-the-art therapies look to the exclusivity, which they enjoy in developed country markets, as the means to command a product price enabling them to amortize the cost of their investment and produce a profit. To the extent that individual patients lack the financial means to pay for these prescription therapies, governments pay the costs.

Until recently, few countries in the developing world offered patent protection to pharmaceutical products. Therefore, the basic market foundation underlying manufacture and distribution of newly developed drugs has not been a factor in making pharmaceuticals available in the developing world. As a result of the Agreement on Trade-Related Aspects of Intellectual Property rights ("TRIPS Agreement") adopted as part of the Uruguay Round of Negotiations, all WTO member countries must begin the process of integrating into the patent-based system of developing and distributing pharmaceuticals. Fear of this change has caused a backlash among public health professionals in the developing world, leading recently to a heated debate in the World Health Organization over a code of conduct, which would conflict directly with the TRIPS agreement.

The TRIPS Agreement allows developing countries until January 1, 2005 to provide product patent protection for pharmaceuticals and least developed countries until January 1, 2006, with a possible extension. Due to fears that patent protection will adversely impact costs, a number of non-

governmental organizations and policy makers in the developing world have begun to look for mechanisms within TRIPS that would allow for compulsory licensing and parallel importing of protected pharmaceutical agents. While this would not address the cost of the fine chemicals used in the production of many of drugs at issue, it could potentially impact the worldwide pricing structure for these products. It is not clear that widespread use of compulsory licensing will significantly impact affordability and certainly it does nothing to address availability. Today, the absence of patent protection in many countries is not providing inexpensive or effective access to patients in need of many of these treatments. Nevertheless, even if it does not impact availability, a large-scale effort to use compulsory licensing to address issues of affordability could have serious impact on the integrity of the international system of patent protection and could undermine the incentives at the heart of a very successful system of innovation. Furthermore, the sophistication of manufacture and delivery of state-of-the-art HIV treatments is beyond the means of most developing countries. Therefore, compulsory licensing could only create reliable sources of supply if countries imported product from generic-producing countries. Again, large-scale importing of products produced under compulsory licenses could have the effect of undermining the cost structure of these same products in countries where parallel import is legal. In other countries, gray markets will likely develop if reliable sources of alternative "low-price" product become available. Accordingly, the challenge is to develop a plan that both harnesses the powers of innovation and investment of product developers and addresses the cost issues of populations in developing and least developed countries.

Such a plan has three components:

1. segregation of territorial markets so that ability to pay can be figured into the pricing of a pharmaceutical product in a developing country;

2. a system of determining price levels appropriate to the ability to pay in such a market;

3. a system of sustainable subsidization to assist the purchase of a pharmaceutical when the ability to pay is out of reach even at a below market price point.

A discussion of each of these three components follows.

Segregation of Territorial Markets – The Issue of Exhaustion of Rights

A longstanding controversy in international intellectual property law has been whether a patent holder exhausts his or her rights to control the resale or use of a product in a territorial market different than the one into which the product was first sold. In general patent holders have argued that the principle of national exhaustion applies, meaning that their loss of control after the first sale of a given patented product applies only in the territory of the country in which it was first sold. Opponents support the principle of international exhaustion; meaning that rights to control resale and use of a legally manufactured product exhaust anywhere in the world after the first sale takes place. Consumer groups have generally supported the principal of international exhaustion.

With regard to pharmaceutical products, public health policy makers in the developing world have generally favored the principle of international exhaustion. This is consistent with the point of view that the less control pharmaceutical manufacturers have the fewer difficulties poorer countries will have obtaining and administering needed pharmaceuticals.

However, a practical side effect of international exhaustion is that it is much more difficult for drug manufacturers to consider ability to pay in establishing different price points for different markets. Were pharmaceutical companies to establish significantly lower prices for developing country markets, they would risk having products sold in those markets re-imported into their profit-

generating home markets. These re-imports are generally known by the name "gray market" products. Consumer groups in developed countries such as the United States naturally favor the "gray market" and oppose marketing strategies that result in consumers in their societies subsidizing lower prices in other markets.

Even under a regime of international exhaustion, countries can adopt systems of price controls (discussed in the next section) which reduce the cost of drugs within national markets. The difficulty with this strategy, standing alone, is that drug companies may refuse to manufacture in or export to those markets. And, with full implementation of the WTO/TRIPS agreement, developing countries that wish to be a part of the international trading system will be unable to copy without a license from the patent owner. While the WTO/TRIPS agreement does allow countries to grant compulsory licenses, they can only be granted once some comparatively strict preconditions are met. In any event, therapies such as AZT and protease inhibitors are difficult, if not impossible, to replicate and administer without the cooperation of their developers. This calls for a cooperative relationship between patent holders and licensees rather than a relationship imposed upon them by the state. Therefore, in the post WTO/TRIPS world developing countries may have to reconsider where their self-interest lies in the debate over territorial versus international exhaustion. Effective implementation of the principle of national exhaustion requires its broad acceptance at the international level – in particular among higher-priced countries so that the differential pricing scheme described above may work. If not, it is inevitable that the products placed on the market at a lower, concessional price in one country will find their way into a higher-priced country.

Setting Price Levels Appropriate to Developing and Least Developed Country Markets

The market price of sophisticated HIV/AIDS treatments is clearly beyond the reach of consumers in developing or least developed countries. Therefore, a key element in supplying drugs such as AZT and protease inhibitors to these markets must be a method of establishing appropriate price levels likely below the world market price. The use of price controls is not unknown in the pharmaceutical world. Government regulation of prices has been utilized in the past in highly developed countries such as Canada. As an alternative to direct price regulation, the single payer health systems of some European countries operate in such a way as to set prices at a level lower than would be the case where there are multiple consumers. These developed country models should be examined as a basis for establishing below world market price levels appropriate to specific developing and least developed countries. Although producers generally oppose any kind of price controls or non-market price setting, the advantage of such a system for them is that it would open up markets and revenue streams which are currently unavailable to them. Two factors would be of critical importance in gaining their cooperation in such a system. First, they would have to be assured that drugs sold at non-market price points would not find their way into non- regulated markets. This implies both a relationship between a system of national exhaustion and price controls and a need for cooperation between health authorities and patent holders. As discussed above, a broadly accepted system of national exhaustion allows patent owners to consider ability to pay in a given country in setting prices for pharmaceutical products. Price controls are imposed by health authorities also on the basis of ability to pay. Thus, with a system of national exhaustion and cooperation between patent owners and health authorities there should be a convergence between price points set by patent owners and health authorities.

The second factor in obtaining the cooperation of the pharmaceutical producers in a system of price controls would be that developed countries not use such a system as a precedent to establish additional price controls themselves.

International Subsidization of Pharmaceutical Purchases

Even assuming a significantly lower price level could be established for HIV/AIDS drugs sold in a given developing country market, few developing or least developed countries enjoy income levels enabling them to pay. This is particularly true in sub Saharan Africa. Therefore, any comprehensive effort to supply state-of-the-art pharmaceuticals to these countries will require a significant program of international subsidization by wealthy states and manufacturers. Given the moral imperative involved, the costs of political destabilization resulting from unchecked epidemics, and the significant risk of new disease strains which could defy treatment and find their way back into the developing world, a program of international subsidization is reasonable. The World Bank has a history of organizing such programs. Along with UNAIDS it could put together a coordinated plan, involving international aid programs of developed countries and private sector humanitarian organizations to supply the necessary funding. Over time it will be necessary to create a subsidization regime that is sustainable. Given an appropriately controlled product delivery infrastructure, such an effort can include long-term price support by manufacturers for imported product and local production facilities.

Of course, in addition to assisting in the coordination of fund raising, UNAIDS has an extremely important role to play in organizing the means to deliver the therapies involved to patients, including the training programs, patient education programs, and the infrastructure for delivering sophisticated pharmaceutical products in general. The last section of this proposal suggests the implementation of a patient care delivery and pharmaceutical distribution system.

Conclusion: The Need for a Pilot Project Coordinated by Three Specialized Organizations

The costs and administrative complexity of a global effort to supply new drug therapies to developing and least developed countries are sufficiently high that it would be imprudent to attempt such an effort without testing its feasibility first. Therefore, this proposal is focused on identifying one developing country in a position to host a pilot project.

Together with private industry, three international specialized agencies have the mandate, expertise, and ability to organize the pilot project outlined above. They are the World Bank, the World Intellectual Property Organization and UNAIDS.

Expertise and norm setting authority over international patent law lies with the World Intellectual Property Organization in Geneva. Establishing an international consensus on how rules of territorial exhaustion should apply to developing country pharmaceutical markets clearly are within the jurisdiction of WIPO. UNAIDS, also located in Geneva, has the expertise to develop a program directed at the training and medical infrastructure issues critical to the effective administration of state-of-the-art anti-AIDS pharmaceuticals. Finally, the World Bank is in a position to put together the international effort to raise the funds necessary to subsidize the purchase of patented pharmaceuticals.

PART II
IMPLEMENTING A REGIME TO MANAGE DISTRIBUTION AND TREATMENTS

The success of this program relies on the ability to successfully deliver drugs to patients in combination with an effective treatment regime. HIV risk management and HIV/AIDS treatments are complex and require sustained therapeutic management. Accordingly, pharmacological therapies alone are insufficient absent other clinical management and support services.

Three major challenges must be met in order to deliver meaningful treatments to patients:

1. An effective clinical case management program must exist to coordinate the delivery of a full spectrum of care (including pharmaceutical therapeutics, HIV and other disease risk management, clinical services, social services, etc.) so as to achieve the maximum clinical benefit
2. A regulated pharmaceutical distribution network to help: (a) control delivery of these specific pharmaceutical products to patients, (b) achieve appropriate utilization, and (c) reduce product diversion and the development of a gray market
3. A multi-tiered, resource optimized, case management infrastructure to coordinate patient care, risk management and the delivery of pharmaceutical product.

Resource Optimized Case Management Services

Supplying pharmaceutical interventions alone will not provide the level of measurable clinical benefit and improved outcomes required to make this proposed program a success. The complexity of the disease necessitates execution of a case management capability to help provide patient support services and appropriate clinical management of each case.

In the developing nations, case management services can be provided by an array of providers arranged in tiers according to level of sophistication and training. Examples are First Nation's programs in Canada that employ local residents as "front line" care workers working under the remote supervision of specially trained nurses and clinicians. Other examples are midwife programs that successfully operate in rural regions throughout Pakistan.

In these programs, local care workers provide the wide array of fairly comprehensive, hands-on support services required by patients during intervals between visits by more highly trained case managers. While not a requirement for this program, rudimentary telemedicine systems can also be implemented. Front line care workers can be remotely supervised and assisted to provide an even higher level of support service.

Case Management Tiers

Patients require continuous, but varying levels of support over the duration of their treatments. It is reasonable to provide services with the least expensive resource capable of accomplishing the task. Different "tiers" of case management resources and primary care services would be assembled. Each tier would be trained and outfitted to provide services based on the complexity of the support activity and the skill level of the caseworkers in that tier. Patients requiring services beyond the skill/capabilities of the tier are identified and moved to the next tier.

The critical ingredient to managing a tiered care delivery system is an underlying set of protocols and technologies that:

1. help senior case managers properly evaluate the level of support required by a patient at any particular point in time, and

2. help determine how and when services are provided to those patients.

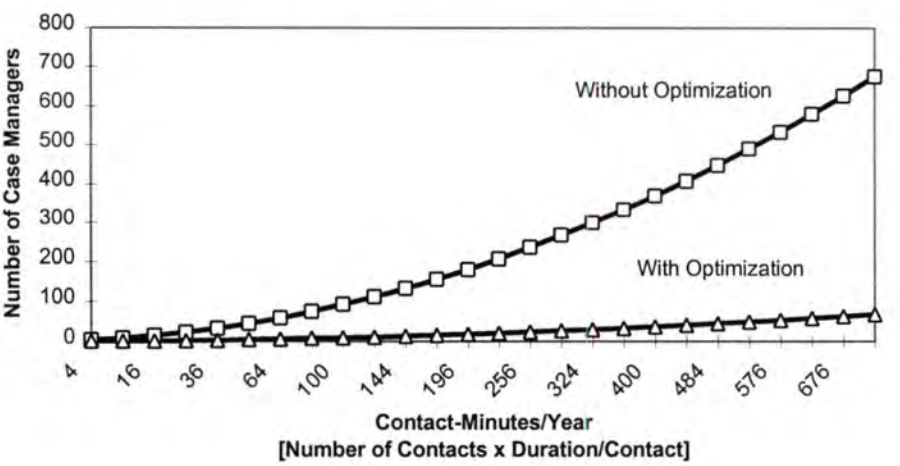
It is envisioned that the most senior nurse case managers and a network of participating clinicians will have access to a sophisticated, but easy to use, modeling and optimization technology. This technology enables the nurse case managers to understand how to schedule interventions with patients and, utilizing geographic overlays, can help them coordinate their rotations (visits with patients). Optimization technology also helps case managers task care coordination by local care workers who perform basic support services. Local care workers can also utilize the system to access case managers when an episode occurs that requires a more complex type of intervention. The infrastructure to implement and operate such a technology in the developing world is currently available and the advanced algorithms and computational platforms employed can be operated remotely where required.

This technology can substantially leverage the population that can be served by one senior nurse case manager. Therefore, it is possible to cost-effectively create a system that uses lower-skilled and lower wage local workers to provide many of the hands-on interventions that would otherwise have to be provided by an expensive nurse case manager. With supervision and occasional visits from more highly trained nurse case managers, patients will be assured of receiving an appropriate level of care sufficient to achieve an improved outcome.

Without the technology, meaningful case management would likely be impossible as it would require hundreds of personnel to support the large number of patients and the level of coordination would overwhelm management's ability to rapidly respond to patient needs. Without a sustained program, the treatment regime collapses and the outcomes are poor.

The following table shows one analysis of the labor required to provide equivalent levels of case management interventions with and without the support of optimization technology.

Case Managers Needed for 100,000 Cases as a Function of Increasing Contacts and Durations [With and Without Resource Optimization]



Regulated Pharmaceutical Distribution Network

In the industrialized nations, pharmaceuticals are delivered through a homogeneous, well-developed product distribution system. A logistically sophisticated delivery pipeline includes wholesalers, distributors and retailers. In this distribution model, many different parties retain quantities of product as inventory before it is delivered to the consumer. This inventory is often maintained in regional and local warehousing facilities with automated picking systems designed to minimize labor costs. Just-in-time delivery capabilities, eliminate the need to maintain inventory at retail locations where space is very expensive.

This robust model of distribution can not work in countries where the distribution infrastructure does not exist and where there are tremendous opportunities to engage in arbitrage by diverting product from one market to another. It is especially difficult to manage dissemination of pharmaceuticals if:

- the product is sold domestically at a price substantially below the world price
- there are limited inventory management and control systems to track inventory
- there are large quantities of product available in the distribution system that are subject to "inventory leakage" and diversion
- there is no way to ascertain patient utilization to ensure that the product is reaching those patients in need
- the product is manufactured locally under license and excess production is not controlled.

In the developing world, it will be necessary to implement a "pull" distribution model. The underlying premise of a pull distribution system is that product does not enter the local-market distribution pipeline in large quantities, and it only enters the pipeline when there is a known consumer (patient) demand in a controllably small geography. Furthermore, product is paid for in a manner that inhibits the formation of local black markets. A "pull" distribution model operates much like a drop shipment system wherein product is not shipped from the manufacturer or controlled warehouse until the end consumer generates an "order" (much like how a catalog order is processed). Rather than distributing and warehousing the inventory in any quantity, the product is distributed to a geography only in anticipation of a particular order being generated (i.e., a refill is going to come due). Because there is no infrastructure to create the "order", a modeling approach coupled to the case management system is used to determine when demand necessitates re-supply and this generates the insertion order. Orders can be aggregated, but no large stockpiles are allowed. Shipments can be tracked and monitored to the point where it is delivered or administered to the patient or to a local distributor (this does not have to employ a great deal of physical or labor infrastructure). Because of the wide disparity between the value of the product and the income of people who work in the distribution system, there is always the issue of local black market diversion. A number of techniques can be used to reduce the incidence of diversion including paying distributors a percentage of product value for successful delivery to the patient. Another technique is to make the product freely available at the local level, thus reducing its "street value". Product is paid for at the national or regional level where it is easier to implement controls that prevent diversion. By eliminating the street price and paying a commission only for successful delivery to patients, there is less incentive to divert product from patients to be sold on a local black market

Coordinating Case Management with Pharmaceutical Supply

Because the management of HIV and the treatment of AIDS and other high-impact disease requires a clinical and social case management adjunct to patient care, there is an opportunity to implement a drug delivery system that runs concurrently with the case management system. The case management system is approximately aware of the quantities of pharmaceutical and other supplies being used by patients under management and, at the right time, it triggers the insertion of refill orders into the pipeline for ultimate delivery by a visiting case worker or fulfillment by a local pharmacy.

Factors such as the inherent latency of the pipeline and the projected demand for product in a given geography are computed by the optimizer as is the projected interval until each patient is expected to need supplies. The optimizer also computes when case management interventions will be required based on a number of factors including case plans and episodic incidents. The scheduling algorithm then uses the output from these models to calculate when the patient will next see a skilled care worker or case manager. These case managers can be entrusted to arrange the delivery of pharmaceuticals directly to patients in that geography.

Such a system makes it possible to "feed" the distribution pipeline in a much more controlled way and reduce the incidence of untraceable diversion. Other control measures can be implemented to reduce the likelihood of significant quantities of product being outside of control while in the distribution pipe. This approach makes it significantly more difficult for the gray market to assemble and divert meaningful quantities of product and dramatically increases the costs of doing so.

It must be pointed out that even in the developed nations there have been instances of gray market product diversion for "street" resale of products by patients (and others) that need money (e.g., for food or housing). Yet, when drug delivery strategies have been coupled to clinical case management services, appropriate utilization increases and the instances of "street resale" have been significantly reduced. This has been shown to result in better compliance and improved patient outcomes – especially as measured by the incidence of hospital admissions related to opportunistic disease.

Even in those areas where a reliable retail distribution system exists, the technology will help caseworkers oversee and coordinate appropriate drug utilization – a critical factor in managing this disease.

CONCLUSION

A powerful arsenal of new treatments now exists to help manage the course of HIV and other high-impact disease such as TB. Information management technologies have been developed that make it possible to cost-effectively deliver treatments and the adjunctive patient support needed to improve outcomes. HIV infection is being treated with some real success in the developed world and there is a reasonable expectation that it is now possible to manage the treatment of HIV and other intractable diseases in the developing world. A mandate to create the policy and legal foundation to make these treatments available is forming. There are compelling reasons of global dimension to find a way to bring these capabilities together.

A coordinated pilot program consisting of:

- innovative policies,
- international cooperation and funding

can be combined with

- sophisticated information technology,

- established models of case-managed patient care, and
- controlled pharmaceutical delivery systems

to achieve an affordable and effective effort to stem the course of a pandemic.

White House to unveil AIDS strategy

By Susan Page and Steve Sternberg, USA TODAY

WASHINGTON - Calling the **AIDS** epidemic in sub-Saharan A "a plague of biblical proportions," the White House on Monday w propose spending an additional $100 million next year for preven and treatment and will urge the rest of the world to do more to jo the battle.

Vice President Gore will unveil a new White House report on **AIDS** in Africa, and Hillary Rodham Clinton will convene a meeting next month of officials from the World Bank, the United Nations, foundations and corporations to fortify and coordinate efforts to stem the epidemic.

By the end of the year, the White House also promises to host a religious leaders' meeting, and the National Security Council will help sponsor a summit of African leaders.

"**AIDS** is not only causing unfathomable human suffering; it is jeopardizing economic growth, political stability and civil society in many sub-Saharan African nations," the White House report concludes. In the past decade, 12 million people in sub-Saharan Africa have died of the disease, which is expected to deprive 40 million children of one or both parents in the next decade.

Within a few years, the 30-page report warns, the epidemic will spread in force to India, Southeast Asia and the former Soviet republics.

Poll on AIDS

▶ Most Americans don't believe global **AIDS** crisis is coming unde control.

Sure, that is false **30%**
Probably false **37%**
Probably true **20%**
Sure it's true **2%**
Don't know **11%**

▶ A majority support increasing U assistance to fight **AIDS** in Africa

Very fav. to increased **aid 23%**
Somewhat favorable **31%**
Neutral **15%**
Somewhat unfavorable **14**
Very unfavorable **15%**
Not sure **2%**

▶ African-Americans are more th twice as likely as all voters to be v favorable to increased U.S. assista

African-American voters **5**
All voters **23%**

Poll by Peter D. Hart Associates, commissioned by Children's Resea and Education Institute. Phone su of 1,411 respondents in March. Margin of error: +/-3 percentage points.

- look at activities
how AIDS fits

So. africa -

Zambia - hgr 'n debt
2 projects
1-3 orphaned by AIDS
Chituba Prov.

The White House report was prepared by Sandra Thurman, direc of the Office of National **AIDS** Policy, who conducted two fact-finding tours to the region this year.

AIDS activists welcomed the announcement. "The most importa thing is that the U.S. has to show leadership in combating this di everywhere in the world," said Cornelius Baker, president of the National Association of People with **AIDS**. But, he added, " Thi very small down payment."

South African Archbishop Desmond Tutu is to join Gore at Mon announcement, as will Olivia Nantongo, a 20-year-old Ugandan woman who lost her mother and other family members to the dis

This year, the U.S. government is spending $125 million on HIV prevention and **AIDS** care worldwide, with $74 million of it dev to Africa. Of the additional $100 million, $48 million would go t prevention, $23 million to care of **AIDS** patients, $10 million to of **AIDS** orphans and $19 million to help governments deal with epidemic.

Congress must approve the new funding, 70% of which is earma for Africa and 30% for Asia and the former Soviet republics.

The report emphasizes the need to mobilize other countries and international organizations. "I hope that the developed world join together to help our African neighbors," said Sen. Orrin Hatch, R-Utah, who has been active on the issue.

key product'n - do ops -
- produce generic - lawsuits
emergency how to abrogate medicine law.
- trade agreements

Jim Bassett VP.

$ 600 mill - africa procurem't

vaccine → Int'l trade agreements emergency

tips + Amer

Conflict in Adm

1 in every 5 injected

In So. africa - still to experience

challenges debt relief
resources
part'p dev. strategy
political issue

patient care
1 prev.
2 care + treatment
3 infrastructure
4 orphans

more collaborative efforts - training + infrastructure dev. not free drugs

Comprehensive industry response

HIV/AIDS - more broadly part of econ. + dev. piece.

Uganda -
Adm - init'ive.

Plot - UNAIDS - agencies in one country doing shopping
best practices + nat'l plans

* needs to be seen as development issue

Malaria in africa - issue can't ignore

Next steps - Such a crisis

* Summers + Wolfensohn - demo for tied to debt relief

show how it can be done

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. list	re: Personally Identifiable Information (2 pages)	00/00/0000	b(6)

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

FOLDER TITLE:
AIDS [Acquired Immune Deficiency Syndrome] Meeting [1]

2013-0534-S
rc1882

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

July 30, 1999

Dear:

I would like to invite you to the White House on September 7 to join me and a small group of senior representatives from the U.S. 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 even know HIV existed. And 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. But this is just a part of the international effort necessary to control the spread of HIV and deal with the associated problems of patient care.

Today, 34 million people are living with HIV or AIDS worldwide. 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 ground to a halt, and the hard won social and health advances of the last 20 years are being reversed by the new realities of the epidemic. And 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. Heads-of-State worldwide 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 are losing the battle with the epidemic – overwhelmed by human and financial costs.

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

The meeting is planned for September 7 at 10:30 AM at the White House. Please arrive at the East Appointments Gate of the White House no later than 10:15 AM.

I hope you can join me at this meeting, and I look forward to seeing you in September. Please call Katy Button in my office at (202) 456-6266 to confirm your participation.

Sincerely yours,

Hillary Rodham Clinton

Embassy of the United States of America

Pretoria, August 16, 1999

MEMORANDUM

TO: Ms. Melanne Verveer, Office of the First Lady
Fax: (202) 456-6244

Ms. Sandy Thurman, Director, Officer of National AIDS
Fax: (202) 456-2438

FROM: James A. Joseph, U.S. Ambassador to South Africa

SUBJECT: **First Lady's Conference on HIV/AIDS**

The Kaiser Family Foundation is willing to match a contribution from the U.S. Government of up to $10 million in new funding for AIDS prevention in South Africa. This funding would be directed through the National Adolescent Sexual Health Initiative (NASHI) chaired by First Lady Zanele Mbeki.

The Foundation would be happy for this to be announced as a deliverable at the First Lady's conference on September 7.

Dr. Michael Sinclair, Senior Vice President of the Kaiser Family Foundation, is based in Washington and prepared to meet with you or anyone you recommend to move this idea along. Please let me know how we should proceed.

cc: Mr. Leon Fuerth, OVP
A/S Susan Rice, DOS
Dr. Michael Sinclair

SACHS ON DEVELOPMENT

Bernard

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.

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.

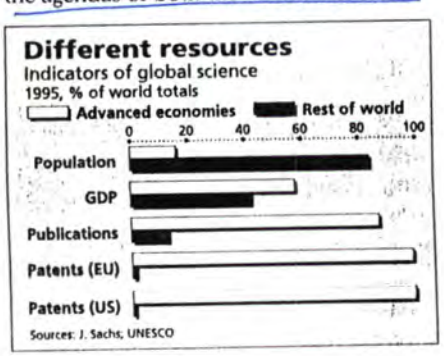
Consider malaria. The disease kills more than 1m people a year, and perhaps as many as 2.5m. The disease is so heavily concentrated in the poorest tropical countries, and overwhelmingly in sub-Saharan Africa, that nobody even bothers to keep an accurate count of clinical cases or deaths. Those who remember 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-

Different ecologies

1995	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
mixed	17.6	3.7
dry	12.5	92.6
temperate and snow	14.0	2.5
highland		

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



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.

Bernard

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.

HELPING THE THIRD WORLD

How to make aid work

WASHINGTON, DC, LUSAKA AND GABORONE

Aid to poor countries has largely failed to spur growth or relieve poverty. It can work—but only if aid is limited to countries that are pursuing sound economic policies. More donors should try it

"THE poor always ye have with you," said Jesus, and 2,000 years of history have not proven him wrong. People who live permanently hungry, racked by parasites and forced to walk miles each day to fetch water, are more numerous now than ever before. Roughly 1.2 billion people—a fifth of the world's population—subsist on less than $1 a day. On June 18th, at a summit in Cologne, the rich world's leaders came up with a plan to ease their plight.

Under the "Cologne Initiative" the G8 group of industrialised countries agreed to provide more debt relief, more quickly, to more poor countries. This, it is hoped, will release resources for health and education and generally make life in the third world less miserable. Tony Blair, Britain's prime minister, spoke of "the biggest step forward in debt relief and help to the poorest countries that we have seen for many years." Perhaps. But that depends on how it is put into practice.

The initiative is directed at the clumsily-named Heavily Indebted Poor Countries (HIPCs). The first comprehensive HIPC debt-relief plan dates from 1996. It aimed to reduce the debts of countries that maintained good economic policies to a "sustainable" level. This is calculated for most countries as a stock of debt (discounted to reflect its present value) equal to no more than 200-250% of annual exports. Alternatively, for extremely open economies, sustainability could be defined as a ratio of debt to government revenue of 280%.

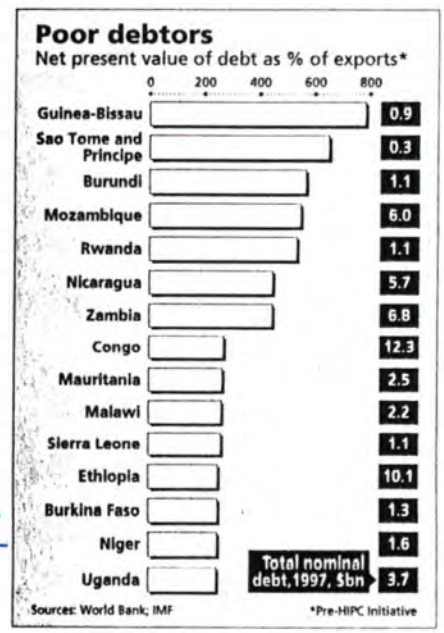
Unfortunately, the original HIPC plan proved slow (only Uganda, Bolivia and Guyana have benefited so far) and stingy (in many cases the amount of debt service actually paid was likely barely to budge). Led by bishops, rock stars and charities, a loud campaign emerged to push for more and faster debt relief. The Scriptures call for forgiveness of debts every 50 years, some noted, reckoning that the next mass write-off was due in the year 2000.

The Cologne Initiative may fall short of millennial salvation but it is an improvement on its predecessor. The criteria for defining HIPCs have been broadened: a sustainable debt burden now implies a debt/export ratio of 150% or a debt/revenue ratio of 250%, and it will be easier to qualify for the second.

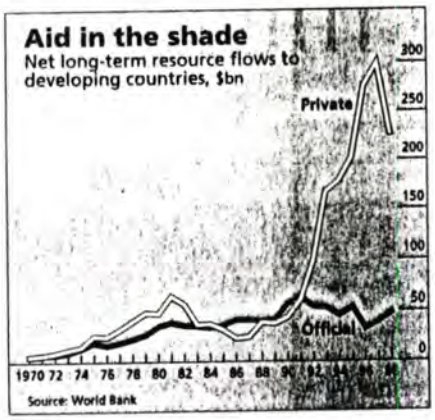
Under the new plan 33 countries (with a total of 430m inhabitants) are likely to be eligible for debt relief, compared with 26 under the original plan. And relief should arrive more quickly: the G8 have agreed to shorten the time a country must follow good policies before its debts are cut and to offer "cash-flow" relief in the meantime. Creditors also promised to include for the first time some $20 billion-worth of concessional loans in the debt calculation. When added to earlier pledges, the G8 claim, their efforts could reduce the stock of nominal HIPC debt by up to $70 billion: from some $130 billion today to as little as $60 billion. Viewed in present-value terms, the initiative itself offers debt reduction of $27.5 billion, which is more than double the $12.5 billion available before.

That is a big change—if it attracts genuinely new aid money. The G8 say that the IMF's share of financing debt relief should come from selling up to 10m ounces of gold and reinvesting the proceeds. But America's Congress must approve that arrangement, and a number of lawmakers have said that they want no part of a gold sale. There is also talk of using World Bank profits, though these are unlikely to cover the Bank's proposed whack of $5 billion. Conspicuously absent are financial commitments from the rich countries: the G8 merely promised to consider new contributions "in good faith". The debt-relief plan will be put to the annual IMF-World Bank meetings in September for agreement on its structure and financing.

The danger is that the promised relief for HIPC debtors will either prove elusive or come at the expense of other aid and other recipients. Official aid flows have been broadly stagnant anyway throughout the



1990s (see top chart)—in part because aid has produced so few successes and so many mistakes. But there is hope in the fact that this initiative comes at a time when many donors—not least the World Bank—are rethinking their whole approach to aid. History offers one outstanding clue: if relief is not carefully aimed at countries with a genuine commitment to sound economic management, it will be wasted.



Unhelpful help

Over the past 50 years rich nations have given $1 trillion in aid to poor ones. This stupendous sum has failed spectacularly to improve the lot of its intended beneficiaries. Aid should have boosted recipient countries' growth rates and thereby helped millions to escape from poverty. Yet countless studies have failed to find a link between aid and faster economic growth. Poor countries that receive lots of aid do no better, on average, than those that receive very little.

Why should this be? In part, because economic growth has not always been donors' first priority. A sizeable chunk of Saudi Arabian aid, for example, aims to tackle spiritual rather than material needs by sending free Korans to infidels. During the cold war, the Soviet Union propped up odious communist despots while America bankrolled an equally unsavoury bunch of anti-communists. Keeping thugs like North Korea's Kim Il Sung and Liberia's Samuel Doe in power hardly improved the lives of their hapless subjects. Even today, strategic considerations often outweigh charitable or developmental ones. Israel gets the lion's share of American aid largely for historical reasons, and millions of American voters support it. Egypt gets the next biggest slice for recognising Israel. Russia and Ukraine receive billions to ensure that they do not sell their surplus nuclear warheads.

Even where development has been the goal of aid, foul-ups have been frequent. Big donors like to finance big, conspicuous projects such as dams, and sometimes fail to notice the multitudes whose homes are flooded. Gifts from small donors are often strangely inappropriate: starving Somalis have received heartburn pills; Mozambican peasants have been sent high-heeled shoes. Poor research can render aid worthless: a fish farm was built for Mali in canals that were dry for half the year. The Turkana nomads of north-western Kenya, long pestered with ill-planned charitable projects, refer to foreign aid workers and their own government alike as *ngimoi*: "the enemy".

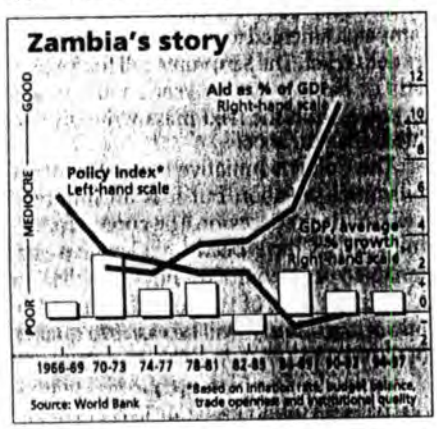
Aid faces further hurdles in recipient countries. War scuppers the best-laid plans. A shipment of vaccines was destroyed in Congo when rebels cut the power supply to the capital, shutting down the refrigerators where the medicines were stored. In Afghanistan, Taliban zealots have closed aid-financed hospitals for employing female doctors. Less spectacularly but more pervasively, corruption, incompetence and foolish economic policies can often be relied on to squander any amount of donor cash. One example, Zambia, speaks for many.

At independence in 1964, Zambia seemed poised for success. The second-richest country in Africa, it had a popularly elected government committed to helping the poor, big copper mines and a generous stream of aid. Most donors believed that the main obstacle to third-world development was lack of capital, and that giving poor governments cash to invest would spur rapid growth. It was not so simple.

Zambia's first president, Kenneth Kaunda, set up a one-party socialist state and nationalised everything from dry-cleaners to car-part retailers. His officials told farmers what to grow, bought their crops and sold them at heavily subsidised prices. Mr Kaunda assumed that the copper mines would provide an inexhaustible source of revenue, however badly managed. Zambians came to see government loans as a perk of freedom from colonial rule.

In the mid-1970s, the price of copper tumbled, and it became harder to pay for all this. Foreign donors picked up the slack. As Mr Kaunda's economic policies grew worse, aid climbed steadily, reaching 11% of real GDP by the early 1990s. IMF loans were tied to free-market reforms, but these were enacted reluctantly and frequently reversed.

Donors agitated for free elections and in 1991 Frederick Chiluba, a former union leader and avowed economic reformer, became president. Aid began to flow again, but Mr Chiluba's zeal to privatise was soon dampened by the discovery that state-owned firms provided ministers with lucrative opportunities for patronage. Corruption is becoming as great a brake on growth as socialism was under Mr Kaunda. William Easterly of the World Bank says that, if aid had had the predicted accelerating effect on growth between 1961 and 1994, Zambia's income per head would now be more than $20,000. In fact, it has dawdled at around $400.



Growth and poverty

GDP is not a foolproof measure of well-being. Wealth may be unevenly spread, so that a high average disguises widespread wretchedness. Nor does GDP take account of the hidden costs of pollution, for example. But when GDP grows, social indicators tend to improve with it.

In Thailand, where income per capita tripled between 1966 and 1990, the proportion of the population living in poverty fell from more than half to just 2%. Infant mortality fell by two-thirds. Slower-growing countries did less well: in India, income per head doubled, infant mortality fell by half and half the population stayed stuck in poverty. In no-growth countries such as Ethiopia, all the advances in modern medicine and the efforts of foreign donors could not effect more than a 27% drop in infant mortality over the same period.

Until recently, the fastest-growing emerging economies were clustered in East Asia whereas the disaster zones were disproportionately African. This led many to conclude that culture was the best predictor of economic success. Actually, sound policies and institutions, backed by liberal helpings of aid, are usually a better guide.

Take Botswana. Zambia's neighbour was, at independence in 1966, one of the world's poorest countries. One British official called it "a useless piece of territory". To begin with, aid financed virtually all government investment and much of its recurrent expenditure too. Then prospectors found diamonds under the Botswanan desert. Unlike many African governments, Botswana's did not squander the windfall. Diamond dollars were ploughed into infrastructure, education and health. Private business was allowed to grow; foreign investment was welcomed. Aid projects were approved only if they were sustainable and did not duplicate the work of others.

From 1966 to 1991, Botswana's economy grew faster than almost any other in the world. It helped that its government was unusually honest and competent. Cabinet ministers did not award themselves huge pensions, mansions and public contracts. In Zambia, government bigwigs drive Mercedes limousines. Those in Botswana choose locally-assembled Hyundai sedans. Even

the president, Festus Mogae, has been seen doing his own shopping.

Botswana abolished exchange controls this year. Its budget is usually in surplus and GDP per head tops $3,000. The country remains vulnerable to swings in the price of diamonds, but it has made a better job of diversifying than most third-world mineral producers. Their task completed, donors are packing their bags.

Cash advances or advice?

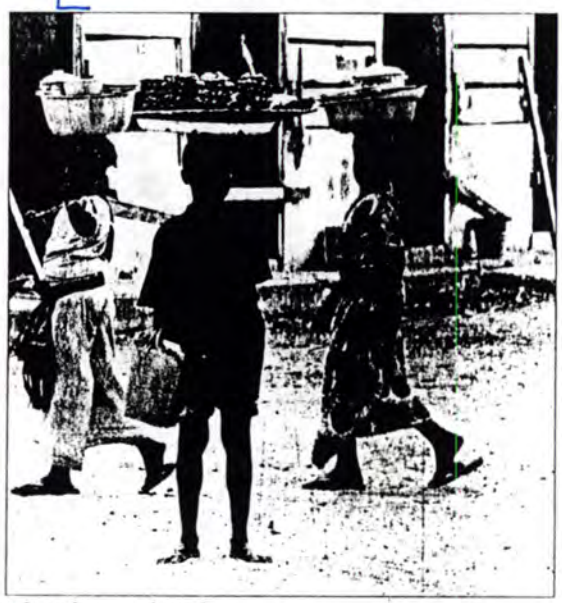
The reason that aid has worked in Botswana but not in Zambia is simple. Botswana had good economic policies, soundly administered. Zambia did not. A recent study by the World Bank* sorted 56 aid-receiving countries by the quality of their economic management. Those with good policies (low inflation, a budget surplus and openness to trade) and good institutions (little corruption, strong rule of law, effective bureaucracy) benefited from the aid they got. Those with poor policies and institutions did not. Badly run countries showed negligible or negative growth, and no amount of aid altered this. Well run countries that received little aid grew steadily, with GDP per head increasing by 2.2% a year. Well run countries with a lot of aid grew faster, at 3.7% per head a year.

Several things explain these differences. In countries with poor management, aid is sometimes stolen. Its effectiveness is often limited anyway by the fact that it tends to displace, rather than complement, private investment. In countries with good management, aid "crowds in" private investment: if an economy is growing fast, the returns on road-building or setting up a new airline are likely to be high. A poorly managed, stagnant economy offers private investors fewer opportunities.

It seems clear that aid should be directed towards countries with good management and lots of poor citizens. Yet many donors continue to behave as if it were not. Bilateral aid has tended to favour allies and ex-colonies. A 1998 study by Alberto Alesina and David Dollar found that a former colony with a closed economy received about twice as much assistance as a non-colony with an open one. Undemocratic ex-colonies also received twice as much as democratic non-colonies. On some figures, countries with poor management got just as much bilateral aid as those with good management. (Nordic aid was an exception to this dismal trend.)

Can aid persuade countries with bad policies and institutions to adopt good ones? It is not easy. For years the IMF and World Bank have made their loans conditional on policy reform, but the record is mixed, to put it kindly. Governments often agree to cut subsidies or tackle corruption, but later backtrack. Zimbabwe's president, Robert Mugabe, frequently promises one thing to donors and the opposite to domestic interest-groups. Kenya's Daniel arap Moi is skilled at selling the same reforms several times. Even when recipients blatantly flout aid conditions, donors often hand over the money anyway, for fear of sparking an economic collapse or even bloodshed.

Good policies cannot be imposed on unwilling pupils. Attaching conditions to aid can strengthen the arm of governments that are trying to push through wise but unpopular measures. Broadly, however, reforms rarely succeed unless a government considers the reform programme essential, and its own. A recent study by David Dollar and Jakob Svensson found that elected governments were much more likely to implement reforms than unelected ones, and new regimes more likely than old ones.



Give them a break

For countries with foolish leaders, a better approach than offering money is offering ideas. The architects of successful reforms in Indonesia in the 1970s, and in several Latin American countries in the 1980s and 1990s, were largely educated abroad, often at aid-givers' expense. The crash course in market economics given to top African National Congress members before they won South Africa's first all-race elections in 1994 helped turn them from Marxists into fiscal conservatives. Ethiopia's new leaders took degrees in business administration in the mid-1990s.

Rethinking aid

A condition of the G8's new debt-relief plan is that the cash it frees be spent on worthy things like education and health. The World Bank is well aware of the difficulties in ensuring that this actually happens but many donors are not. Aid-givers often finance specific projects, such as irrigation and the building of schools. Since the schools are usually built and the ditches dug, donors are satisfied that their money has served its intended purpose. But has it? Probably not.

Most evidence suggests that aid money is fungible—that is, that it goes into the pot of public funds and is spent on whatever the recipient wants to spend it on. If donors earmark money for education, it may cause the recipient government to spend more on education, or it may make available for something else the money that it would otherwise have spent on education.

If the government is benign, the alternative may be agriculture or tax cuts. If the government is crooked, donors' funds may be spent on shopping trips to London for the president's wife or fighter planes to strafe unpopular minorities. The important factor is not the donor's instructions but the recipient's priorities. A 14-country study published by the World Bank in 1998 showed that each extra aid dollar aimed at agriculture, for example, actually decreased total agricultural spending by five cents.

This does not mean that donors should never support specific projects. Sometimes the real value of a donor-financed dam or telephone network lies in the technology that is transferred, and the advice given on how to operate and maintain the infrastructure. But the fact of fungibility suggests that aid-giving could be greatly simplified if most took the form of unconditional "balance-of-payments support". That is, cash.

Rich countries should be much more ruthless about how they allocate their largesse, whether earmarked or not. Emergency relief is one thing. But mainstream aid should be directed only to countries with sound economic management. The HIPC debt-relief plans, to their credit, do this. More donors should follow suit. Aid should also favour countries with large numbers of very poor citizens. India, Vietnam, Mozambique and Uganda, among others, meet both conditions. Many countries that receive substantial aid, such as Zimbabwe, Kenya and Russia, do not.

According to the World Bank, an extra $10 billion in aid could lift 25m people a year out of poverty—so long as it went to poor countries that manage their economies well. The same sum spread across the current cast of aid recipients would lift only 7m out of destitution. In other words, aid could work if it were properly directed. And if taxpayers in rich countries saw their money actually doing some good, they might be happy to give more of it. ■

*Assessing Aid: What Works, What Doesn't, and Why, OUP, November 1998. Website: http://www.worldbank.org/research/aid

The Economist
AUGUST 14TH 1999

Bernard

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.

AIDS Convening
September 7, 1999

Participants List

Administration

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
Office of Global Affairs
Department of State

Multinational Organizations

Hon. James Wolfensohn
World Bank

Mr. Eduardo Doryan
World Bank

Ms. Debrework Zewdie
The World Bank

Ms. Jan Piercy
U.S. Executive Director
The World Bank

Mr. Peter Piot
United Nations Joint Program on HIV/AIDS

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

Foundations

Dr. Timothy Evans
The Rockefeller Foundation

Mr. Seth Berkeley
The Rockefeller Foundation

Mr. Robert Johnson
Black Entertainment Television

Ms. Debrah Lee
Black Entertainment Television

Mr. Aryeh Neier
Open Society Institute

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

Mr. Gordon Perkin
William H. Gates Foundation

Mr. Drew Altman
President and CEO
Kaiser Family Foundation

Corporations/Others

Mr. Charles Heimbold
Chief Executive Officer
Britsol Myers Squibb

Mr. Ken Weg, Vice Chairman
Bristol Myers Squibb

Mr. Anthony J.F. O'Reilly (T)
Chairman
H.J. Heinz Company

Observers

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

Mr. Paul Boneberg
Director
Global AIDS Action Network

The New York Times

THE DOCTOR'S WORLD

In Africa, a Deadly Silence About AIDS Is Lifting

By LAWRENCE K. ALTMAN, M.D.

Earlier this year, AIDS became the leading killer in Africa, just 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.

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 time recently in their own countries and to beef up prevention efforts.

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, the World Health Organization says.

•

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

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 new attitude toward the disease among African leaders.

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, Mr. Kaunda lost a son to AIDS.

Three years after that, Mr. Kaunda became one of the first to speak out. In describing his family's loss at an international AIDS meeting in Montreal, Mr. 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 Mr. Kaunda's silence, hundreds of thou-

"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

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.

•

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

A Boost To Research On Women's Sexuality

By ANNE EISENBERG

A host of pharmaceutical companies are working to do for women what Viagra does for men. To do this effectively, they need far more scientific data on female sexual response than is presently available.

"Inadvertently, Viagra has done a world of good in the field of research into female sexual function," said Dr. Cindy M. Meston, professor of clinical psychology at the University of Texas at Austin, who has one of the few labs in the United States that measures physical changes in sexual arousal in women. "After years of very few opportunities for funding, I am now deluged by offers from pharmaceutical companies."

Little is known about what facilitates or inhibits feminine sexual arousal, Dr. Meston said. "The nerves that innervate the female genitalia have not been intensely studied," she said. "All we know is that we don't know much."

One of Dr. Meston's preliminary findings is that exercise aids arousal. She also investigates ways to counter the dampening effects of antidepressants on women's orgasms.

"Clinicians don't know what to do about delayed and abolished orgasms associated with antidepressants, be-

Demanding more data to create a Viagra-type drug for women.

cause we don't know what's really causing these side effects in the first place," Dr. Meston said.

Dr. Gregory A. Broderick, professor of urology at the Mayo Clinic in Jacksonville, Fla., is concerned with a different research area in female sexuality —

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.

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 time recently in their own countries and to beef up prevention efforts.

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, the World Health Organization says.

•

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, as leaders denied the severity of their AIDS problem.

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, Mr. Kaunda lost a son to AIDS.

Three years after that, Mr. Kaunda became one of the first to speak out. In describing his family's loss at an international AIDS meeting in Montreal, Mr. 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 Mr. 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 me why I use the word epidemic," he said.

•

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," Mr. Mandela said on World AIDS Day in December. "It is time to break the silence."

Dr. Piot applauded Mr. Mandela and Mr. 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 with H.I.V.-infected Ethiopians in meeting with them publicly for the first time, Dr. Piot said.

"That may have been a small thing, but it was highly symbolic in Africa," he added.

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

Senegal 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 to Senegal, 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.

•

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

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 new attitude toward the disease among African leaders.

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.

•

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.

•

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."

ON THE WEB

The Epidemic

The New York Times on the Web explores AIDS in a special package that includes a detailed chronology and a multimedia essay, at:
www.nytimes.com/science

world of good in the field of research into female sexual function," said Dr. Cindy M. Meston, professor of clinical psychology at the University of Texas at Austin, who has one of the few labs in the United States that measures physical changes in sexual arousal in women. "After years of very few opportunities for funding, I am now deluged by offers from pharmaceutical companies."

Little is known about what facilitates or inhibits feminine sexual arousal, Dr. Meston said. "The nerves that innervate the female genitalia have not been intensely studied," she said. "All we know is that we don't know much."

One of Dr. Meston's preliminary findings is that exercise aids arousal. She also investigates ways to counter the dampening effects of antidepressants on women's orgasms.

"Clinicians don't know what to do about delayed and abolished orgasms associated with antidepressants, because we don't know what's really causing these side effects in the first place," Dr. Meston said.

Demanding more data to create a Viagra-type drug for women.

Dr. Gregory A. Broderick, professor of urology at the Mayo Clinic in Jacksonville, Fla., is concerned with a different research area in female sexuality — damage to nerves during hysterectomy.

"For men," Dr. Broderick said, "we spare the nerves important for erection when we do radical prostatectomy, but there hasn't been an equal amount of attention given to the concept of nerve-sparing hysterectomy.

"When you look at standard medical textbooks, there's no discussion of how to preserve sexual sensation when operating either through the abdomen or through the vagina," he said.

Why the dearth of research-based information on these neural pathways? Dr. Sandra Leiblum, professor of psychiatry at the Robert Wood Johnson Medical School in Piscataway, N.J., said she suspected "most male researchers are more interested in male genitalia."

Dr. Julia R. Heiman, the director of reproductive and sexual medicine at the University of Washington in Seattle, said she hoped the Federal Government would also support additional research.

Dr. Vivian W. Pinn, the director of the Office of Research on Women's Health at the National Institutes of Health, said that her agency was aware of the lack of research on women's sexuality.

"Because there is so little scientific data, interventions to treat women's sexual problems have lagged behind those developed for men," Dr. Pinn said. "We've brought breast cancer and menopause out of the closet. It's time to address the issues of sound research initiatives to better define women's sexual functions and dysfunctions."

Global AIDS

MEMORANDUM TO JACK LEW

From: Sandy Thurman

cc: John Podesta

Date: November 23, 1999

Re: Global AIDS 2001

Thank you very much for your support in securing a $100 million increase for our global AIDS effort in the final FY2000 budget. While the budget was working its way up and down Pennsylvania Avenue, we have been working closely with the agencies in the development of an extensive implementation plan to ensure that we maximize the effectiveness of these new resources. In addition, we had a very productive meeting with the British this past week. It seems clear that the impetus for their recently announced $35 million initiative for AIDS in Africa was our effort, beginning with the conversation on HIV/AIDS that the President had with Prime Minister Tony Blair at the G7 meeting in Cologne.

FY2001: Given the magnitude of this crisis, and the level of visibility that it is now receiving, I believe that it is very important that we build on our initiative in the FY2001 budget. Now that that this is being called "a plague of biblical proportion" and the WHO has called it the "worst health disaster since the bubonic plague", our effort cannot be a one shot deal. While it is certainly true that the US cannot fight this battle alone, it is also clear that if we seek to remain the credible leader, much more remains to be done. I would like to propose that last year's funding become part of the base and that we again request a $100 million increase for our multi-sectoral global AIDS effort. This would enable us to do two important things including: (1) doubling the USAID global AIDS program over two years (which would require an investment of an additional $70 million); and (2) engaging additional agencies in this fight (DOD and HHS).

Interest in, and concern for, Africa is building. The global AIDS issue continues to be a very high priority for the Congressional Black Caucus, and popular with the Congress as a whole. This weekend, a bipartisan codel of 12 members leaves for Africa, and will be looking at HIV/AIDS in Nigeria, Zimbabwe, and South Africa. [Democratic members: Gephardt, Jefferson, Kilpatrick, Meeks, and Payne; Republican members: Castle, Dickey, Dunn, Houghton, and Kelly]. I did a luncheon briefing for the members and it is clear that this trip will only serve to strengthen their already active interest. I have attached a letter to the President from Gephardt and Pelosi asking that we "redouble our efforts" with a "significant increase above the final FY2000 appropriation".

As you know, Ron Dellums has been pushing for what he calls a "Marshall Plan for AIDS in Africa". He has seen the VP several times on this matter, and is scheduled to see him again soon. His "plan" is to create a new African AIDS Agency with an annual $200 million appropriation. I join the NSC, AID, and State in believing that the creation of a new US agency designed to deal with HIV/AIDS in a vacuum is a bad idea. But Rep. Barbara Lee has introduced this legislation with the support of more than 50 co-sponsors, including almost the entire CBC.

I believe that if we ask for an additional $100 million in FY2001, combined with the $100 million we secured in FY2000, we can tell them that we are pushing for a $200 million appropriation, without getting bogged down with the Congress over the creation of a new agency. I hear that the AIDS, African American, and international communities will all be writing to the President asking for a $200 million increase for the global fight against AIDS in FY2001.

Threats to India and the New Soviet States are the next wave. While we seek to be responsive to the reality of the devastation already unfolding in Africa, we also need to pay attention to the danger that lurks in other parts of the world. While the epidemic in India is approximately a decade behind that of sub-Saharan Africa, there may still be time to turn the tide on current projections, and prevent a tragedy of African proportions. Senator Daschle is leading a codel to India in January, and we were asked to put together AIDS briefing materials for that delegation as well. India is slated to get some money under the FY2000 effort, but they are a long way from where they need to be.

Again, thank you very much for all of your help and support on this issue. I look forward to working with you.

Remarks by First Lady Hillary Clinton
World AIDS Day, December 1, 1999

(Excerpt)

"I want you to know that the United States is committed to being a partner in all of these efforts. And I am proud that the congress passed the President's Initiative to add $100 million this year to our global fight against AIDS. This will enable us to double our financial efforts in Africa.

The LIFE initiative will help countries protect children orphaned by AIDS, care for people living with AIDS, fund strategies to prevent further HIV infections, and support clinics, organizations, and outreach programs.

This cannot and will not be a one-time commitment. The United States' efforts must be sustained and strengthened to meet the challenges posed by this pandemic.

And I want you to know that the President and I will continue to fight for the funds from the Congress in the remaining time that the President has, so that the United States will do its part in the struggle against AIDS."

RICHARD A. GEPHARDT
MISSOURI
DEMOCRATIC LEADER

H-204 U.S. CAPITOL
202-225-0100

Congress of the United States
House of Representatives
Office of the Democratic Leader
Washington, DC 20515-6537

November 24, 1999

The Honorable William J. Clinton
President of the United States
The White House
Washington, DC 20500

Dear Mr. President:

Thank you for your leadership on the global AIDS problem. We are very pleased that, working together with the Administration, we were able to secure the additional funds you requested to help fight this epidemic in Africa and around the world. We believe this was one of the most important victories in our negotiations on the final fiscal year 2000 budget.

As important as this victory was, however, we cannot afford to rest. The dimensions of the problem remain daunting. In light of the disturbing trends not only in Africa and the Caribbean but in Asia and Eastern Europe, as well, we believe we must redouble our efforts if we are to make serious inroads in curbing the spread of HIV and treating those who have already contracted the virus or who are sick with AIDS.

Therefore, as you develop your final fiscal year 2001 budget, we strongly urge you to include a significant increase above the final fiscal year 2000 appropriation for global AIDS. We also strongly believe that this increase should be in addition to an increase in your budget request for our efforts to combat other infectious diseases. Building upon the success of this year's budget outcome will demonstrate to people in Africa and elsewhere around the world that our country is committed to doing its part to help bring an end to the terrible human suffering and death as a result of the global AIDS epidemic.

Again, thank you for your consideration of our concerns.

Sincerely,

Richard A. Gephardt
Richard Gephardt, M.C.

Nancy Pelosi
Nancy Pelosi, M.C.

cc: John Podesta
Jack Lew

until it's over
AIDS ACTION

The Honorable Jack Lew
Director, Office of Management and Budget
Old Executive Office Building
Washington, DC 20500

Dear Mr. Lew:

On behalf of AIDS Action, the national voice on AIDS, representing all Americans affected by HIV/AIDS and the 3,200 community-based organizations that serve them, I am writing to express our strong support for funding increases for Fiscal Year 2001 in global HIV/AIDS programs. Given your commitment to increasing the federal investment in fighting the epidemic worldwide, we urge your diligence in securing maximum funding levels for these programs.

In the face of this worldwide epidemic, we urge you to push for a $200 million increase in our global AIDS effort for FY 2001. The Administration took an important first step towards ending the global epidemic with the announcement of a $100 million dollar initiative that is critical in ensuring that entire nations are not devastated as a result of the epidemic. The initiative must be ongoing if it is to have any measurable outcome.

The global epidemic continues to demand strong federal leadership. According to UNAIDS, 5.6 million people were newly infected with HIV in 1999, including 2.3 million women and 570,000 children under the age of 15. There are now 33.6 million people living with HIV/AIDS worldwide, and there were 2.6 million deaths, half of which were women. An increase in our investment will put our nation on track toward a global AIDS program that begins to address the magnitude of this pandemic, and would help to further stem the rising tide of HIV and bring some modest level of care and support to those who are suffering.

This increase in funding for global AIDS programs must be new money, rather than funds shifted from the strapped budgets of other essential development accounts. Health, education, child-survival and micro-finance are all interconnected parts of a comprehensive human investment and AIDS strategy that must not be traded against each other.

We commend your commitment to assisting millions of people affected by HIV/AIDS worldwide. Your leadership is needed again in your last budget request to dramatically affect the direction of this global epidemic and create a legacy of hope for the future.

Thank you in advance for your consideration of our views.

Sincerely,

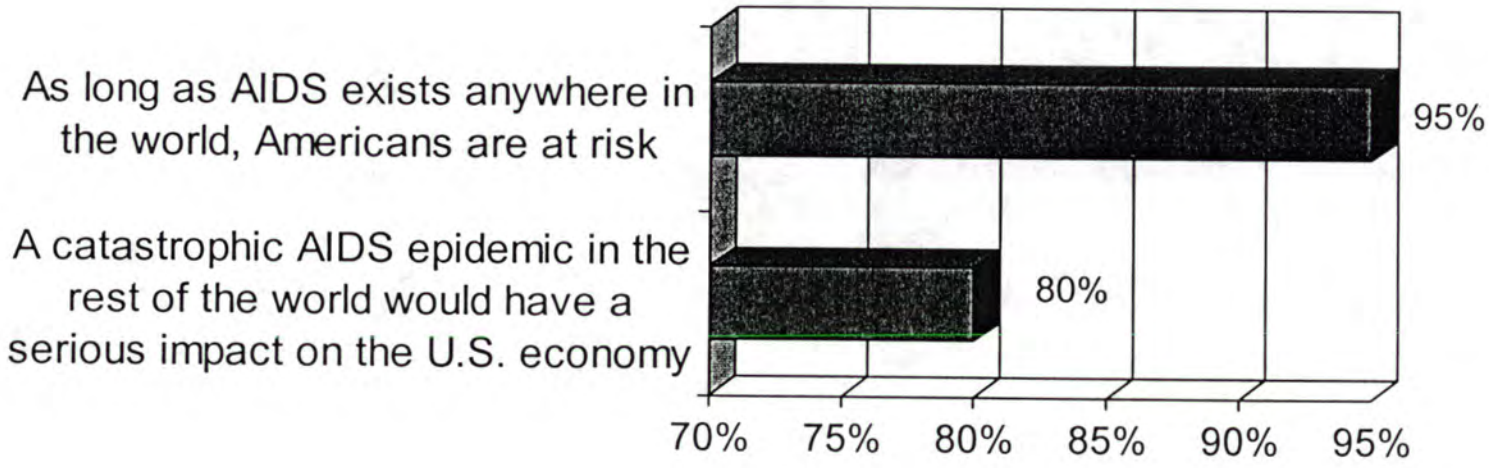
Daniel

Daniel Zingale
Executive Director

cc: John Podesta
cc: Leon Fuerth

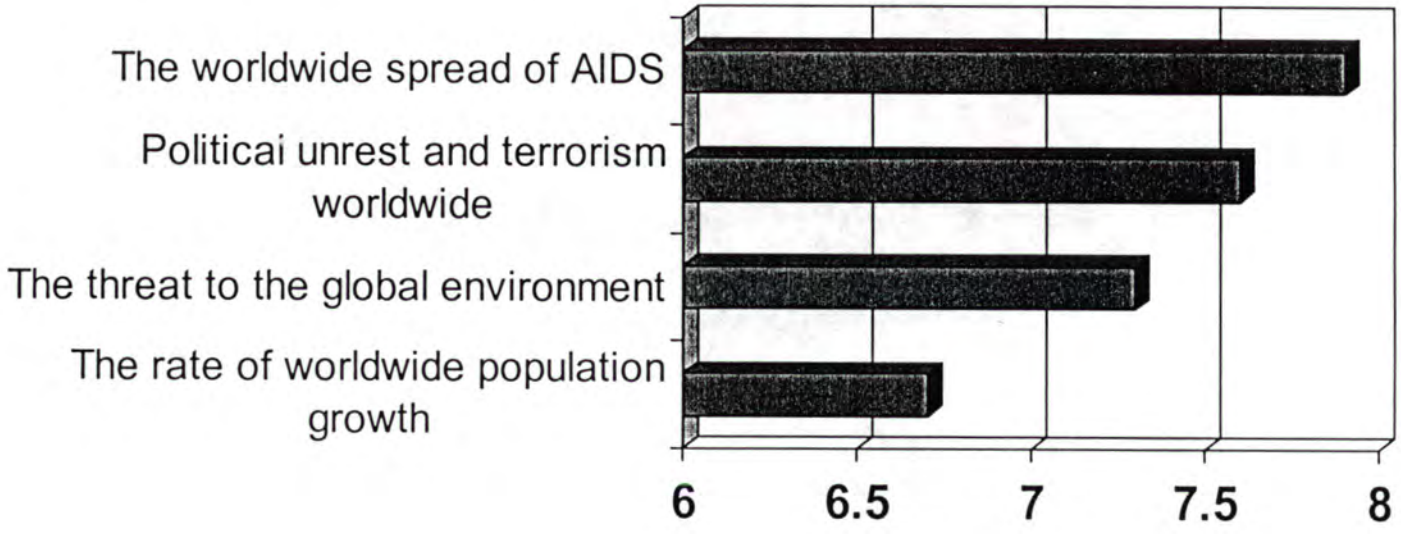
1906 Sunderland Place, NW Washington, DC 20036 P 202 530 8030 F 202 530 8031 www.aidsaction.org

Public Considers Global AIDS Epidemic A Serious Threat to the U.S.



Base: All Adults

Public Considers AIDS Among the Most Serious Problems Facing the World



Highest Possible (Most Serious) Score: 10

Base: All Adults

Herald INTERNATIONAL Tribune
PUBLISHED WITH THE NEW YORK TIMES AND THE WASHINGTON POST

Drugs for AIDS Victims

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 U.S. 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.

Part of the challenge is to increase the availability of already affordable drugs. Last month the Clinton 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-to-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. U.S. trade pressure on Thailand throughout the 1990s, 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 that 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.

Defending intellectual property is important, but 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 U.S. policy on the issue of drugs in poor nations. Surely the needs of 35 million people infected with HIV worldwide should count for more.

— THE NEW YORK TIMES

The Shape of Russia

...nd profitably, primarily oil- and diamond-
...ucing areas, and recycled it to

W...

LONDO...
siles, C...
India-Pakis...
it can app...
under imm...
flict. What...
of Asian c...
tensions c...
of real wa...
These c...
in part be...
vironment...
threshold ...
the stakes ...
In the cr...
rea's suspe...
clear weap...
of mobiliz...
erations a...
Japanese...
balked at th...
to the creat...
Energy D...
KEDO, and...
anese secur...
a distant thu...
In the cu...
if Pyongya...
range ballist...
presence of ...
forces in the...
will be no u...

Aust...

LOS ANGEL...
U.S.-Aust...
ought to be read...
if violence s...
Timorese indep...
The governm...
tralia and the...
have strenuously...
port this month...
bourne newspap...
that both countrie...
ed on contingen...
rush as many as ...
to the troubled...
province of East...
situation there...
Official denial i...
way for governm...
when they are no...
show all their card...
Rather than be...
by the news story,...
and Canberra o...
lauded for not t...
backs on a histori...
to support Indone...
courageous effort...
democracy af...
dictatorsh...
In...
ar...

August 9, 1999

The Honorable Samuel R. Berger
National Security Advisor
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20502

Dear Sandy:

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

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002. list	re: Personally Identifiable Information (1 page)	00/00/0000	b(6)

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

FOLDER TITLE:
AIDS [Acquired Immune Deficiency Syndrome] Meeting [1]

2013-0534-S
rc1882

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

file
AIDS

THE WHITE HOUSE
WASHINGTON

To: Melanne Verveer

From: Cheryl Bauerle for Sandy Thurman

Date: December 6, 1999

Sandy thought you also might like to see the enclosed excerpt from the First Lady's speech in New York and the following cable sent by the US Ambassadors and the USAID Mission Directors in Southern Africa to the State Department. It was formulated as a result of a meeting they convened and attended regarding the AIDS pandemic and it's effects on the region. In fact, it was the first meeting of its kind.

In summary, the message is, "None of us living in this region can remain silent in the face of the overwhelming impact this epidemic is having on our own staffs, programs, U.S. foreign policy objectives and the social fabric of the countries we are living in. This meeting highlighted the impressive concern and commitment of USG personnel in the region. This issue will be with us for some time to come. Sustained engagement is critical to success in controlling and eventually stopping the epidemic. U.S. leadership can make a difference."

Remarks by First Lady Hillary Clinton
World AIDS Day at The United Nations, December 1, 1999

(Excerpt)

"I want you to know that the United States is committed to being a partner in all of these efforts. And I am proud that the congress passed the President's Initiative to add $100 million this year to our global fight against AIDS. This will enable us to double our financial efforts in Africa.

The LIFE initiative will help countries protect children orphaned by AIDS, care for people living with AIDS, fund strategies to prevent further HIV infections, and support clinics, organizations, and outreach programs.

This cannot and will not be a one-time commitment. The United States' efforts must be sustained and strengthened to meet the challenges posed by this pandemic.

And I want you to know that the President and I will continue to fight for the funds from the Congress in the remaining time that the President has, so that the United States will do its part in the struggle against AIDS."

******* HARARE 7005 - XXSECTION 09 OF 13 *********

UNCLASSIFIED

SE 01 HARARE 07005 09 OF 13 170951Z
TION AP-00

FO LOG-00 NP-00 AID-00 AMAD-01 CIAE-00 CIME-00
DODE-00
ITCE-00 SRPP-00 EAP-00 EB-00 EXME-00 OTED-00
HHS-01
TEDE-00 INR-00 ITC-01 LAB-01 L-00 ADS-00
MMP-00
NEA-01 NSAE-00 OES-01 OMB-01 OPIC-01 PER-01
STR-00
TRSE-00 SA-01 DRL-02 SAS-00 /012W
----------10696C 170955Z /38

170952Z NOV 99
FM AMEMBASSY HARARE
TO SECSTATE WASHDC 4627
SOUTHERN AFRICAN DEVELOPMENT COMMUNITY
AMEMBASSY KAMPALA
AMEMBASSY KINSHASA
AMEMBASSY NAIROBI
INFO AMEMBASSY NEW DELHI
AMEMBASSY JAKARTA
AMEMBASSY KUALA LUMPUR
AMEMBASSY BANGKOK
AMEMBASSY BEIJING
USC WASHDC
DEPT OF LABOR WASHDC

USDOC WASHDC
CDC ATLANTA GA
DEPT OF HHS WASHDC

UNCLASSIFIED

UNCLASSIFIED

PAGE 02 HARARE 07005 09 OF 13 170951Z
UNCLAS SECTION 09 OF 13 HARARE 007005

DEPT FOR AF/S, AP/EPS, OES, AND DRL
USC FOR SENIOR AFRICA DIRECTOR GAYLE SMITH
WHITE HOUSE FOR ONAP DIRECTOR SANDY THURMAN
DOL FOR ILAB/ROBERT SHEPARD
USDOC FOR DHENKE-ROGERS.
NAIROBI FOR REDSO
AFRICAN POSTS FOR AMBASSADORS AND USAID MISSION
DIRECTORS
CDC FOR DR. HELENE GAYLE
HRS FOR SECRETARY DONNA SHALALA

PASS USAID WASHDC FOR AA/AFR, DAA/AFR NEWTON AND AFR/SA
D/HR, LINDA LION
STATE DIRECTOR GENERAL AMBASSADOR GNEHM
PASS DHHS/NIH/FIC FOR SHARON HRYNKOW

E.O. 12958: N/A
TAGS: TBIO, EAID, SOCI, ZI
SUBJECT: AIDS IN SOUTHERN AFRICA: AMBASSADORS AND USAID
MISSION DIRECTORS REAFFIRM OUR REGIONAL COMMITMENT

8 CONT

--CREATING A PRIVATE SECTOR FORUM TO SHARE HIV/AIDS
PREVENTION BEST PRACTICES;

--PUBLICLY RECOGNIZING BUSINESSES THAT HAVE BEST
PRACTICES, AND ENCOURAGING COMPANIES TO ADOPT SUCH
PRACTICES WHEN MERGERS AND ACQUISITIONS OCCUR;

--ENCOURAGING LOCAL ROTARY CLUBS TO PROMOTE HIV/AIDS

UNCLASSIFIED

UNCLASSIFIED

PAGE 03 HARARE 07005 09 OF 13 170951Z
AWARENESS AND WORKPLACE POLICIES;

--HELPING THE FOREIGN COMMERCIAL SERVICE AND DEPARTMENT
OF COMMERCE PREPARE AND DELIVER APPROPRIATELY BALANCED
[illegible] HIV/AIDS, INCLUDING ACCURATE RISK ASSESSMENTS; AND
--ENCOURAGING PRIVATE SECTOR SOCIAL RESPONSIBILITY IN
THREE WAYS: (1) ADOPTING PROGRESSIVE INTERNAL WORKPLACE
POLICIES; (2) EXTRAMURAL FUNDING OF LOCAL HIV/AIDS
PREVENTION AND CARE ACTIVITIES; (3) PROMOTING A PUBLIC
IMAGE OF A BUSINESS THAT CARES ABOUT ITS EMPLOYEES AND
THE PUBLIC.

8

US WORK FORCE POLICY: WALKING THE TALK

---

29. THE FOURTH CATEGORY OF SUGGESTED ACTIVITIES RELATES TO HIV/AIDS POLICY IN THE U.S. MISSION. PARTICIPANTS NOTED THAT CURRENTLY THERE IS A DOUBLE STANDARD FOR AMERICAN EMPLOYEES AND FSNS. AMERICANS, FOR EXAMPLE, HAVE ACCESS TO ANTIRETROVIRAL DRUGS, BUT FSNS DO NOT. USDH CAN DONATE LEAVE TO OTHER USDH BUT NOT TO FSNS. THE GROUP CHALLENGED ITSELF AND WASHINGTON TO DETERMINE HOW A STANDARD FOR "BEST PRACTICES" COULD BE SET SO THAT THE USG, PROBABLY THE LARGEST US EMPLOYER IN AFRICA, COULD BE A MODEL FOR OTHER EMPLOYERS. THE GROUP DISCUSSED WHETHER CERTAIN FSN POLICIES SHOULD BE DECENTRALIZED AND DELEGATED TO THE FIELD, OR IF WORLDWIDE STANDARDS WOULD BE MORE APPROPRIATE. ALTHOUGH COGNIZANT OF THE POSSIBLE COST AND ETHICAL IMPLICATIONS.

UNCLASSIFIED

UNCLASSIFIED

PAGE 04 HARARE 07005 09 OF 13 170951Z
THE GROUP CONCLUDED THAT THE MAGNITUDE OF THE HIV/AIDS EPIDEMIC WARRANTED ATTENTION ON A WORLDWIDE THAT BOTH AMBASSADORS AND SENIOR
OFFICIALS IN WASHINGTON SHOULD REVIEW HIV/AIDS WORKPLACE POLICIES, CONSIDERING IN PARTICULAR:

--LEAVE POLICIES FOR SICK EMPLOYEES WHO HAVE AN UNDERLYING HIV INFECTION;
--EMPLOYMENT POLICY FOR HIV POSITIVE APPLICANTS;
--HEALTH INSURANCE POLICIES;
--DEATH BENEFITS AND WILL PLANNING FOR HIV POSITIVE EMPLOYEES;
--MEDICAL ATTENTION AND FOLLOW-UP CARE FOR RAPE VICTIMS;
--OFFICIAL TRANSPORTATION POLICIES IN AREAS WHERE RAPE IS PREVALENT; AND
--POLICIES FOR INDIRECT STAFF SUCH AS LOCAL SECURITY GUARDS PROVIDED IN CONTRACTS;
--POLICIES IN DOUBLE ENCUMBERING POSITION CEILINGS AND DISABILITY.

30. ACTION REQUESTED: WASHINGTON IS REQUESTED TO INITIATE A REVIEW OF ITS PERSONNEL POLICIES IN THIS AREA

UNCLASSIFIED

NNNN

******** HARARE 7005 - XXSECTION 10 OF 13 *********

N VZCZCAID0297

UNCLASSIFIED

PAGE 01 HARARE 07005 10 OF 13 170952Z
ACTION AP-00

INFO LOG-00 NP-00 AID-00 AMAD-01 CIAE-00 CIME-00
DODE-00
ITCE-00 SRPP-00 EAP-00 EB-00 EXME-00 OTED-00
HHS-01
TEDE-00 INR-00 ITC-01 LAB-01 L-00 ADS-00
MMP-00
NEA-01 NSAE-00 OES-01 OMB-01 OPIC-01 PER-01
STR-00
TRSE-00 SA-01 DRL-02 SAS-00 /012W
----------10698C 170956Z /38

R 170952Z NOV 99
FM AMEMBASSY HARARE

--CONSIDERING WHETHER IT IS APPROPRIATE FOR PEACE CORPS VOLUNTEER TEACHERS TO PROMOTE HIV/AIDS AWARENESS IN RURAL SCHOOLS AND THROUGH ANTI-AIDS CLUBS, RECOGNIZING THE LIKELY SENSITIVITY OF LOCAL SCHOOL ADMINISTRATORS;

--INSTRUCTING THE POLITICAL SECTION TO CONSIDER USING DEMOCRACY AND HUMAN RIGHTS FUNDS TO SUPPORT HUMAN RIGHTS GROUPS THAT PERFORM HIV/AIDS ADVOCACY;

--INSTRUCTING THE ECONOMIC SECTION TO: (1) EMPHASIZE COMMUNITY-BASED HIV/AIDS ACTIVITIES IN THE AMBASSADOR'S SELF HELP PROGRAM; AND (2) INCLUDE HIV/AIDS ISSUES IN DISCUSSIONS WITH U.S. COMPANIES;

UNCLASSIFIED

NNNN

********** HARARE 7005 - XXSECTION 08 OF 13 **********

N VZCZCAID0295

UNCLASSIFIED

PAGE 01 HARARE 07005 08 OF 13 170951Z
ACTION AF-00

INFO LOG-00 NP-00 AID-00 AMAD-01 CIAE-00 CIME-00
DODE-00
ITCE-00 SRPP-00 EAP-00 EB-00 EXME-00 OTED-00
HHS-01
TEDE-00 INR-00 ITC-01 LAB-01 L-00 ADS-00
NMP-00
NEA-01 NSAE-00 OES-01 OMB-01 OPIC-01 PER-01
STR-00
TRSE-00 SA-01 DRL-02 SAS-00 /012W
----------106954 170954Z /38

R 170952Z NOV 99
FM AMEMBASSY HARARE
TO SECSTATE WASHDC 4626
SOUTHERN AFRICAN DEVELOPMENT COMMUNITY
AMEMBASSY KAMPALA
AMEMBASSY KINSHASA
AMEMBASSY NAIROBI
INFO AMEMBASSY NEW DELHI
AMEMBASSY JAKARTA
AMEMBASSY KUALA LUMPUR
AMEMBASSY BANGKOK
AMEMBASSY BEIJING
NSC WASHDC
DEPT OF LABOR WASHDC

USDOC WASHDC
CDC ATLANTA GA
DEPT OF HHS WASHDC

UNCLASSIFIED

UNCLASSIFIED

PAGE 02 HARARE 07005 08 OF 13 170951Z
UNCLAS SECTION 08 OF 13 HARARE 007005

DEPT FOR AF/S, AF/EPS, OES, AND DRL
NSC FOR SENIOR AFRICA DIRECTOR GAYLE SMITH
WHITE HOUSE FOR ONAP DIRECTOR SANDY THURMAN
DOL FOR ILAB/ROBERT SHEPARD
USDOC FOR DHENKE-ROGERS
NAIROBI FOR REDSO
AFRICAN POSTS FOR AMBASSADORS AND USAID MISSION DIRECTORS
CDC FOR DR. HELENE GAYLE
HHS FOR SECRETARY DONNA SHALALA

PASS USAID WASHDC FOR AA/AFR, DAA/AFR NEWTON AND AFR/SA M/HR, LINDA LION
STATE DIRECTOR GENERAL AMBASSADOR GNEHM
PASS DHHS/MIN/PIC FOR SHARON HRYNKOW

E.O. 12958: N/A
TAGS: TBIO, EAID, SOCI, ZI
SUBJECT: AIDS IN SOUTHERN AFRICA: AMBASSADORS AND USAID MISSION DIRECTORS REAFFIRM OUR REGIONAL COMMITMENT

--INSTRUCTING THE RSO TO ASSIST LOCAL POLICE AND SECURITY GUARD COMPANIES TO DEVELOP HIV/AIDS AWARENESS PROGRAMS; AND

--INCLUDING HIV/AIDS ON THE AGENDAS OF VISITING CODELS AND STAFFDELS.

27. AMBASSADORS CAN USE THEIR PUBLIC POSITION TO PROMOTE

UNCLASSIFIED

UNCLASSIFIED

PAGE 03 HARARE 07005 08 OF 13 170951Z
HIV/AIDS ACTIVISM BY:

--BEING "OUT IN FRONT" AND NOT DELEGATING TO STAFF THE OPPORTUNITY TO PROMOTE HIV/AIDS ACTIVISM;
--SEIZING THEIR POSITION AS THE "PRESIDENT'S REPRESENTATIVE" TO ENSURE THAT THEY PERSONALLY REPRESENT PRESIDENTIAL INITIATIVES, COORDINATE ACCESS TO OSG RESOURCES AND STRESS THAT THEY ARE ALSO REPRESENTATIVES OF THE AMERICAN PEOPLE;

--RAISING THE PROFILE OF THE ISSUE BY MENTIONING HIV/AIDS IN ALL MEETINGS WITH THE HOST COUNTRY PRESIDENT, CABINET MEMBERS, AND OTHER SENIOR GOVERNMENT OFFICIALS;

--BEING PROACTIVE IN CAPTURING MEDIA COVERAGE FOCUSING ATTENTION ON HIV/AIDS IN EVERY PUBLIC SPEECH, EVEN IF IT SEEMS UNRELATED;

--MOTIVATING AND MOBILIZING OTHER AMBASSADORS AND THE INTERNATIONAL COMMUNITY, FOR EXAMPLE, BY HOSTING FORUM TO DISCUSS HIV/AIDS CHALLENGES;

--USING THE MEDIA TO ADVERTISE THE AMBASSADORS' SUPPORT FOR PERSONS LIVING WITH AIDS IN HIV/AIDS AWARENESS BY ATTENDING EVENTS AND FUNCTIONS HOSTED BY OTHER ORGANIZATIONS, AND BY PERSONALLY VISITING AND HOLDING HANDS OF THOSE LIVING WITH AIDS;

--URGING HOST GOVERNMENTS TO PROVIDE TAX INCENTIVES TO COMPANIES AND INDIVIDUALS WHO SUPPORT LOCAL NGO HIV/AIDS

UNCLASSIFIED

UNCLASSIFIED

PAGE 04 HARARE 07005 08 OF 13 170951Z
INITIATIVES; AND

--STRESSING TO LOCAL GOVERNMENT OFFICIALS THE IMPORTANCE OF FREE PUBLIC SERVICE ANNOUNCEMENTS, RATHER THAN USING SCARCE DONOR FUNDS TO PURCHASE MEDIA SPOTS.

28. AMBASSADORS CAN ENGAGE U.S. AND LOCAL PRIVATE SECTORS COMPANIES ON HIV/AIDS ISSUES BY:

--PROVIDING LEADERSHIP IN THE AMERICAN BUSINESS COMMUNITY THROUGH AMCHAM OR THE LOCAL AMERICAN BUSINESS ASSOCIATIONS;

--DEMONSTRATING TO COMPANIES THAT HIV/AIDS HAS A DIRECT IMPACT ON BOTTOM LINE PROFITS, IN PART BY USING ANALYSES THAT SHOW THE COST OF PREVENTION PROGRAMS VERSUS THE COST OF COPING WITH HIV/AIDS IN THE WORKPLACE;

--HELPING TO ESTABLISH LINKS BETWEEN COMPANIES INTERESTED IN DEVELOPING HIV/AIDS WORKPLACE PROGRAMS AND HIV/AIDS NGOS THAT CAN ASSIST;

UNCLASSIFIED

(6)

...ATED ILLNESSES AND THE NEED FOR THE USG TO ADDRESS
...S INCREASINGLY SERIOUS PROBLEM IN INNOVATIVE WAYS.
...ELISTS FROM A USAID GRANTEE (PACT) AS WELL AS DR.
...GG POWELL OF THE ZIMBABWE CHILD PROTECTION SOCIETY, A
...AL NGO, DESCRIBED THE INABILITY OF MOST AFRICAN
...ERNMENTS TO DEAL WITH THE PROBLEM AND OFFERED
...GESTIONS FOR POSSIBLE USG INTERVENTION.

UNCLASSIFIED

UNCLASSIFIED

...E 04 HARARE 07005 06 OF 13 170951Z

23. MOST AFRICAN AND INTERNATIONAL EXPERTS AGREE THAT ...EPING ORPHANS IN THEIR EXTENDED FAMILIES IS BY FAR THE ...FERABLE OPTION. INSTITUTIONAL CARE IS A LAST RESORT. ...THOUGH MOST SOUTHERN AFRICAN GOVERNMENTS HAVE ORPHANS' ...D CHILDREN'S PROGRAMS IN PLACE, MOST ARE NOT BEING - ...PLEMENTED EFFECTIVELY DUE TO A LACK OF STAFF AND ...SOURCES. CARE AND SUPPORT PROGRAMS FOR ORPHANS ARE ...IMARILY BEING IMPLEMENTED BY NGOS WITH VERY LIMITED ...NANCIAL RESOURCES.

24. PANELISTS STRESSED THAT POVERTY ALLEVIATION AND ...COME GENERATION PROJECTS--WHICH ARE WELL MANAGED AT ...E COMMUNITY LEVEL ARE THE MOST EFFECTIVE MEANS OF ...DRESSING THE ORPHAN ISSUE. STRENGTHENING THE CAPACITY ... HOUSEHOLDS TO SUPPORT ORPHANS BOTH FINANCIALLY, AND ...TH PSYCHOSOCIAL SUPPORT IS CRITICAL. PANELISTS NOTED ...AT EDUCATION IS ONE OF THE BEST ENTRY POINTS AND ...GGESTED THAT DONORS PROVIDE INFRASTRUCTURAL SUPPORT IN ...CHANGE FOR TUITION WAIVERS FOR "CHILDREN IN DIFFICULT ...RCUMSTANCES" RATHER THAN "AIDS ORPHANS."

UNCLASSIFIED

NNN

******** HARARE 7005 - XXSECTION 07 OF 13 *********

UNCLASSIFIED

...AGE 01 HARARE 07005 07 OF 13 170951Z
...CTION AF-00

...NFO	LOG-00	NP-00	AID-00	AMAD-01	CIAE-00	CIAE-00
	DODE-00					
	ITCE-00	SRPP-00	EAP-00	EB-00	EXME-00	UTED-00
	NHS-01					
	TEDE-00	INR-00	ITC-01	LAB-01	L-00	ADS-00
	...MP-00					
	NEA-01	NSAE-00	OES-01	OMB-01	OPIC-01	PER-01
	STR-00					
	TRSE-00	SA-01	DRL-02	SAS-00	/012W	
				106949	170953Z	/38

...170952Z NOV 99
...M AMEMBASSY HARARE
...O SECSTATE WASHDC 4625
...OUTHERN AFRICAN DEVELOPMENT COMMUNITY
...MEMBASSY KAMPALA
...MEMBASSY KINSHASA
...MEMBASSY NAIROBI
...NFO AMEMBASSY NEW DELHI
...MEMBASSY JAKARTA
...MEMBASSY KUALA LUMPUR
...MEMBASSY BANGKOK
...MEMBASSY BEIJING
...SC WASHDC
...EPT OF LABOR WASHDC

...SDOC WASHDC
...DC ATLANTA GA
...EPT OF HHS WASHDC

UNCLASSIFIED

PAGE 02 HARARE 07005 07 OF 13 170951Z
UNCLAS SECTION 07 OF 13 HARARE 007005

DEPT FOR AF/S, AF/EPS, OES, AND DRL
NSC FOR SENIOR AFRICA DIRECTOR GAYLE SMITH
WHITE HOUSE FOR ONAP DIRECTOR SANDY THURMAN
DOL FOR ILAB/ROBERT SHEPARD
USDOC FOR DHENKE-ROGERS
NAIROBI FOR REDSO
AFRICAN POSTS FOR AMBASSADORS AND USAID MISSION DIRECTORS
CDC FOR DR. HELENE GAYLE
HHS FOR SECRETARY DONNA SHALALA

PASS USAID WASHDC FOR AA/AFR, DAA/AFR NEWTON AND AFR/SA M/HR, LINDA LION
STATE DIRECTOR GENERAL AMBASSADOR GREEN
PASS DHHS/NIH/FIC FOR SHARON HRYNKOW

E.O. 12958: N/A
TAGS: TBIO, EAID, SOCI, ZI
SUBJECT: AIDS IN SOUTHERN AFRICA: AMBASSADORS AND USAID MISSION DIRECTORS REAFFIRM OUR REGIONAL COMMITMENT

USG RESPONSE TO THE EPIDEMIC IN EACH COUNTRY: WHAT CAN AMBASSADORS DO?

---

25. THE GROUP BRAINSTORMED THROUGHOUT THE TWO-DAY CONFERENCE TO IDENTIFY ACTIVITIES THAT COMS CAN DO TO ENHANCE THE USG RESPONSE TO THE HIV/AIDS EPIDEMIC. MOST

UNCLASSIFIED

UNCLASSIFIED

PAGE 03 HARARE 07005 07 OF 13 170951Z
OF THE SUGGESTED ACTIVITIES CAN BE UNDERTAKEN WITHOUT ADDITIONAL RESOURCES. THE LIST IS NOT INTENDED TO BE A GUIDE OF REQUIRED ACTIONS BUT RATHER AN ILLUSTRATIVE MENU OF ACTIONS THAT CAN BE UNDERTAKEN AS APPROPRIATE TO THE COUNTRY SETTING. THE FOUR BROAD CATEGORIES FOLLOW IN PARAGRAPHS 24-27 WITH SUGGESTED ACTIVITIES LISTED IN EACH.

26. AMBASSADORS CAN MAKE HIV/AIDS A COUNTRY TEAM PRIORITY, INVOLVING ALL MEMBERS IN STRATEGY DEVELOPMENT, BY:

--PERSONALLY LEADING AND COORDINATING COUNTRY TEAM EFFORTS REGARDING HIV/AIDS;

--TALKING ABOUT THE EPIDEMIC IN THE MANAGEMENT TEAM;

--BEING THE POST'S SENIOR ADVOCATE FOR OBTAINING RESOURCES FROM WASHINGTON;

--USING THE MISSION PROGRAM PLAN (MPP) TO FLAG THE IMPORTANCE OF HIV/AIDS AS A GLOBAL AND REGIONAL ISSUE AND ENSURE USG SUPPORT FOR HIV/AIDS PROGRAMS;

--INCORPORATING HIV/AIDS INTO PUBLIC AFFAIRS PROGRAMS BY: (1) BRINGING IN HIGH-LEVEL HIV/AIDS SPEAKERS; (2) ESTABLISHING A MEDIA AWARD PROGRAM FOR HIV/AIDS REPORTING TO ENCOURAGE RESPONSIBLE AND SUSTAINED LOCAL MEDIA COVERAGE; (3) INCORPORATING UNIVERSITY-BASED HIV/AIDS AWARENESS CAMPAIGNS INTO THE PROGRAMS OF FULBRIGHT PROFESSORS AND VISITING RESEARCHERS;

UNCLASSIFIED

UNCLASSIFIED

PAGE 04 HARARE 07005 07 OF 13 170951Z

--DISCUSSING THE EPIDEMIC WITH THE DEFENSE ATTACHE OFFICE TO SEEK WAYS FOR THE MILITARY ASSISTANCE PROGRAMS TO ADDRESS HIV/AIDS WITHIN THE HOST COUNTRY SECURITY ESTABLISHMENT BY: (1) WORKING WITH DEFENSE COUNTERPARTS TO INCORPORATE HIV/AIDS MESSAGES INTO ACTS; AND (2) ENCOURAGING HIV/AIDS EDUCATION AT MILITARY INSTALLATIONS;

17. THE GOAL OF VCT PROGRAMS IS TO REDUCE HIGH RISK BEHAVIOR AMONG CLIENTS, AND TO REDUCE THE STIGMA ASSOCIATED WITH HIV/AIDS BY ENCOURAGING OPEN DISCUSSION. DRS. MARUM AND OSEWE NOTED THAT UGANDA'S VCT PROGRAM IS ENJOYING TREMENDOUS INTEREST AND SUSTAINED ATTENDANCE, TESTING AN AVERAGE OF 650,000 CLIENTS EACH YEAR, WHILE THE FIVE VCT CENTERS OPENED IN ZIMBABWE SINCE AUGUST 1998 ARE RECEIVING INCREASING NUMBERS OF CLIENTS EACH MONTH. DESPITE THESE SUCCESS STORIES, DR. MARUM NOTED SOME CHALLENGES FOR THE VCT PROGRAM IN THE FUTURE, INCLUDING THE RELATIVELY HIGH COSTS OF THE INTERVENTION, THE NEED TO INCREASE ITS AVAILABILITY IN RURAL AREAS, AND THE NEED TO ENSURE ITS SUSTAINABILITY.

PRIVATE SECTOR INVOLVEMENT

---

18. MR. TOM WALTER, MANAGING DIRECTOR OF MOBIL OIL IN ZIMBABWE, DESCRIBED THE DIFFICULTIES HIS COMPANY FACED IN EARLY 1998 WHEN, IMMEDIATELY AFTER HIS ARRIVAL IN

COUNTRY, MOBIL LOST THREE OF ITS SENIOR MANAGERS TO AIDS. WALTER SAID THAT, AS HE WATCHED PROFITS DROP, HE BECAME ACUTELY AWARE OF THE IMPACT THAT THE VACUUM OF EXPERTISE AND EXPERIENCE HAD ON PRODUCTIVITY. IN THE WAKE OF THE PERSONNEL LOSSES, WALTER WORKED WITH A LOCAL NGO TO IMPLEMENT AN HIV/AIDS WORKPLACE PROGRAM. HE EMPHASIZED THAT TO ACHIEVE RESULTS COMPANIES AND NGOS MUST CLEARLY OUTLINE PROJECT GOALS, STRATEGIES, AND TIMETABLES BEFORE EMBARKING ON AN HIV/AIDS WORKPLACE PROGRAM. (SEE PARA 26 FOR OTHER PRIVATE SECTOR ACTIVITIES.)

THE MEDIA

---

19. MR. ANDREW MUTANDWA, A FREELANCE ZIMBABWEAN JOURNALIST AND FORMER DEPUTY DIRECTOR OF INFORMATION AT THE ZIMBABWEAN MINISTRY OF INFORMATION, POSTS, AND TELECOMMUNICATIONS, ADDRESSED THE GROUP AT LUNCH ON OCTOBER 22. HIS PERSUASIVE COMMENTS HELPED THE GROUP UNDERSTAND WHY ACCURATE AND SUSTAINED HIV/AIDS REPORTING

NNNN

********** HARARE 7005 - XXSECTION 06 OF 13 **********

R 1709522 NOV 99
FM AMEMBASSY HARARE
TO SECSTATE WASHDC 4624
SOUTHERN AFRICAN DEVELOPMENT COMMUNITY
AMEMBASSY KAMPALA
AMEMBASSY KINSHASA
AMEMBASSY NAIROBI
INFO AMEMBASSY NEW DELHI
AMEMBASSY JAKARTA
AMEMBASSY KUALA LUMPUR
AMEMBASSY BANGKOK
AMEMBASSY BEIJING
NSC WASHDC
DEPT OF LABOR WASHDC

USDOC WASHDC
CDC ATLANTA GA
DEPT OF HHS WASHDC

DEPT FOR AF/S, AF/EPS, OES, AND DRL
NSC FOR SENIOR AFRICA DIRECTOR GAYLE SMITH
WHITE HOUSE FOR ONAP DIRECTOR SANDY THURMAN
DOL FOR ILAB/ROBERT SHEPARD
USDOC FOR DHENKE-ROGERS
NAIROBI FOR REDSO
AFRICAN POSTS FOR AMBASSADORS AND USAID MISSION DIRECTORS
CDC FOR DR. HELENE GAYLE
HHS FOR SECRETARY DONNA SHALALA

PASS USAID WASHDC FOR AA/AFR, DAA/AFR NEWTON AND AFR/SA M/HR, LINDA LION
STATE DIRECTOR GENERAL AMBASSADOR GNEHM
PASS DHHS/NIH/FIC FOR SHARON HRYNKOW

E.O. 12958: N/A
TAGS: TBIO, EAID, SOCI, ZI
SUBJECT: AIDS IN SOUTHERN AFRICA: AMBASSADORS AND USAID MISSION DIRECTORS REAFFIRM OUR REGIONAL COMMITMENT

IS SO SCARCE IN SOUTHERN AFRICA. MUTANDWA REFERRED TO THE COMPETITION AMONG NEWSPAPERS FOR READERSHIP AND ADVERTISING DOLLARS THAT OFTEN DRIVES EDITORS TO BUMP A GOOD HIV/AIDS STORY FROM THE FRONT PAGE -- OR EVEN FROM THE PAPER ALTOGETHER -- TO MAKE ROOM FOR MORE SENSATIONAL NEWS ABOUT POLITICIANS AND CELEBRITIES.

20. HE ALSO NOTED THAT THE MEDIA IN MANY AFRICAN COUNTRIES IS EMERGING FROM A TRADITION OF GOVERNMENT

CONTROL. MUTANDWA ASSERTED THAT ZIMBABWEAN JOURNALISTS, PARTICULARLY THOSE EMPLOYED BY THE GOVERNMENT-INFLUENCED ZIMBABWE NEWSPAPERS AND THE ZIMBABWE BROADCASTING CORPORATION, FEEL PRESSURE FROM THE GOVERNMENT TO AVOID CERTAIN CONTROVERSIAL TOPICS, INCLUDING THE HIGHLY STIGMATIZED SUBJECT OF HIV/AIDS.

21. MUTANDWA SUGGESTED THAT CDMS CAN MOTIVATE LOCAL JOURNALISTS AND ADVOCATE BETTER REPORTING BY INSTITUTING AWARDS PROGRAMS FOR REPORTERS, EDITORS AND NEWS ORGANIZATIONS. ACCORDING TO MUTANDWA, "THIS WOULD CREATE THAT COMPETITIVE ENVIRONMENT IN WHICH JOURNALISTS OFTEN THRIVE." HE ADDED THAT CDMS SHOULD FACILITATE MORE EXCHANGE PROGRAMS FOR JOURNALISTS, AS THESE ARE EXTREMELY EFFECTIVE IN EDUCATING REPORTERS ON HIV/AIDS. AS A FORMER IV, MUTANDWA ACKNOWLEDGED THE POSITIVE IMPACT THAT THE EXCHANGE HAD ON HIS REPORTING.

ORPHANS

---

(4)

ASS USAID WASHDC FOR AA/AFR, DAA/AFR NEWTON AND AFR/SA
/HR, LINDA LION
TATE DIRECTOR GENERAL AMBASSADOR GNEHM
ASS DHHS/NIH/FIC FOR SHARON HRYNKOW

.O. 12958: N/A
AGS: TBIO, EAID, SOCI, ZI
UBJECT: AIDS IN SOUTHERN AFRICA: AMBASSADORS AND USAID
ISSION DIRECTORS REAFFIRM OUR REGIONAL COMMITMENT

ROM 11 COUNTRIES FOCUSING ON KEY POLICY ISSUES IN
OLUNTARY COUNSELING AND TESTING (VCT), MOTHER-TO-CHILD
RANSMITTION (MTCT), AND IMPLEMENTING A MULTISECTORAL
PPROACH. FOLLOW-UP IDEAS ARE CURRENTLY BEING DISCUSSED
Y THE TECHNICAL TEAM: (3) HIV/AIDS SURVEILLANCE: A
RANT HAS BEEN MADE TO WHO/AFR TO HELP COORDINATE
URVEILLANCE ACTIVITIES IN THE REGION; AND (4)
NFORMATION SHARING ON HIV/AIDS: A REGIONAL ADVISOR IS
EING RECRUITED AND TECHNICAL SHARING BETWEEN COUNTRIES

AS INCREASED THROUGH THE REGIONAL WORK.

12. A REGIONAL USG ADVISOR ON HIV/AIDS, TO BE BASED IN
RETORIA, SHOULD BE SELECTED BY THE END OF NOVEMBER.
HE ADVISOR'S DUTIES WILL BE TO RUN THE DAILY OPERATIONS
F THE PROGRAM; PROVIDE TECHNICAL BACKSTOPPING TO THE
ON-PRESENCE COUNTRIES IN SOUTHERN AFRICA (BOTSWANA,
ESOTHO, AND SWAZILAND); ACT AS A CONDUIT OF INFORMATION
MONG REGIONAL POSTS; AND HELP POSTS DEVELOP COORDINATED
IV/AIDS PROGRAMS.

13. AMBASSADOR DAVID DUNN FROM ZAMBIA BRIEFED
ARTICIPANTS ON THE INTERNATIONAL CONFERENCE ON AIDS AND
TDS IN AFRICA (ICASA) WHICH OCCURRED IN LUSAKA (REF A &
). AMBASSADOR DUNN NOTED THAT, ALTHOUGH THE CONFERENCE
AS WIDELY CONSIDERED TO BE A SUCCESS, THE ABSENCE OF
EADS OF STATE FROM ZAMBIA AND PARTICIPATING COUNTRIES
ENT A POOR MESSAGE ABOUT THE REGIONAL GOVERNMENTS'
OMMITMENT TO ADDRESSING THE HIV/AIDS EPIDEMIC. MUCH
TTENTION WAS FOCUSED ON COMMUNITY RESPONSES, AND THE
OLES OF PEOPLE LIVING WITH AIDS, YOUTH, WOMEN, AND
RPHANS WERE HIGHLIGHTED. THE NEXT HIV/AIDS CONFERENCE
ILL BE THE BI-ANNUAL INTERNATIONAL HIV/AIDS CONFERENCE
O BE HELD IN DURBAN, JULY 9-14, 2000, WHILE THE NEXT
CASA WILL TAKE PLACE IN BURKINA FASO IN 2001. TENS OF
HOUSANDS OF PEOPLE ARE EXPECTED TO ATTEND THE DURBAN
ONFERENCE, INCLUDING A U.S. DELEGATION OF APPROXIMATELY
0 PEOPLE LED BY THE SECRETARY OF HEALTH AND HUMAN
ERVICES, DONNA SHALALA. FULL DETAILS OF THE ICASA ARE
ESCRIBED IN REFTEL A AND B.

CONFERENCE HIGHLIGHTS

14. THE FOLLOWING SECTION HIGHLIGHTS SEVERAL OF THE
CONFERENCE TOPICS, INCLUDING VOLUNTARY COUNSELING AND
TESTING, PRIVATE SECTOR INVOLVEMENT, THE MEDIA AND
ORPHANS.

VOLUNTARY COUNSELING AND TESTING

15. DRS. ELIZABETH MARUM AND PATRICK OSEWE, BOTH USAID
TECHNICAL EXPERTS ON HIV/AIDS, BRIEFED PARTICIPANTS ON
USAID-FUNDED VOLUNTARY COUNSELING AND TESTING (VCT)
PROGRAMS NOW OPERATING IN UGANDA AND ZIMBABWE.
PARTICIPANTS WERE ENCOURAGED TO TAKE HOME LESSONS
LEARNED REGARDING THE IMPORTANCE OF VCT IN AN INTEGRATED
HIV/AIDS PREVENTION PROGRAMS.

16. DR. MARUM, WHO CURRENTLY IS POSTED TO MALAWI BUT

NNNN

N VZCZCAID0292

ACTION AF-00

INFO LOG-00 NP-00 AID-00 AMAD-01 CIAE-00 CIME-00
DODE-00
ITCE-00 SRPP-00 EAP-00 EB-00 EXME-00 OTED-00
HHS-01
TEDE-00 INR-00 ITC-01 LAB-01 L-00 ADS-00
MMP-00
NEA-01 NSAE-00 OES-01 OMB-01 OPIC-01 PER-01
STR-00
TRSE-00 SA-01 DRL-02 SAS-00 /012W
----------106925 170952Z /38

R 170952Z NOV 99
FM AMEMBASSY HARARE
TO SECSTATE WASHDC 4623
SOUTHERN AFRICAN DEVELOPMENT COMMUNITY
AMEMBASSY KAMPALA
AMEMBASSY KINSHASA
AMEMBASSY NAIROBI
INFO AMEMBASSY NEW DELHI
AMEMBASSY JAKARTA
AMEMBASSY KUALA LUMPUR
AMEMBASSY BANGKOK
AMEMBASSY BEIJING
NSC WASHDC
DEPT OF LABOR WASHDC

USDOC WASHDC
CDC ATLANTA GA
DEPT OF HHS WASHDC

UNCLAS SECTION 05 OF 13 HARARE 007005

DEPT FOR AF/S, AF/EPS, OES, AND DRL
NSC FOR SENIOR AFRICA DIRECTOR GAYLE SMITH
WHITE HOUSE FOR ONAP DIRECTOR SANDY THURMAN
DOL FOR ILAB/ROBERT SHEPARD
USDOC FOR DHENKE-ROGERS
NAIROBI FOR REDSO
AFRICAN POSTS FOR AMBASSADORS AND USAID MISSION
DIRECTORS
CDC FOR DR. HELENE GAYLE
HHS FOR SECRETARY DONNA SHALALA

PASS USAID WASHDC FOR AA/AFR, DAA/AFR NEWTON AND AFR/SA
M/HR, LINDA LION
STATE DIRECTOR GENERAL AMBASSADOR GNEHM
PASS DHHS/NIH/FIC FOR SHARON HRYNKOW

E.O. 12958: N/A
TAGS: TBIO, EAID, SOCI, ZI
SUBJECT: AIDS IN SOUTHERN AFRICA: AMBASSADORS AND USAID
MISSION DIRECTORS REAFFIRM OUR REGIONAL COMMITMENT

SERVED FOR MANY YEARS IN UGANDA, OFFERED THE HEARTENING
FACT THAT, IN THE MIDST OF A CONTINENT-WIDE EPIDEMIC,
THE HIV INFECTION RATE IN UGANDA HAS DECLINED STEADILY
SINCE 1992 (SEE REF C). A KEY ELEMENT TO USAID'S
SUCCESSFUL PROGRAM IN UGANDA HAS BEEN THE NATIONAL
NETWORK OF VCT CENTERS. USAID/ZIMBABWE RECENTLY
ESTABLISHED ITS VCT PROGRAM, WHICH ALREADY IS MEETING
WITH STRONG LOCAL DEMAND. DR. OSEWE EXPLAINED THAT FIVE
VCT CENTERS CURRENTLY ARE OPERATING IN ZIMBABWE, WITH

(6)

USDOC WASHDC
CDC ATLANTA GA
DEPT OF HHS WASHDC

UNCLASSIFIED

UNCLASSIFIED

PAGE 02 HARARE 07005 03 OF 13 170950Z
UNCLAS SECTION 03 OF 13 HARARE 007005

DEPT FOR AF/S, AF/EPS, OES, AND DRL
NSC FOR SENIOR AFRICA DIRECTOR GAYLE SMITH
WHITE HOUSE FOR ONAP DIRECTOR SANDY THURMAN
DOL FOR ILAB/ROBERT SHEPARD
USDOC FOR DKENKE-ROGERS
NAIROBI FOR REDSO
AFRICAN POSTS FOR AMBASSADORS AND USAID MISSION DIRECTORS
CDC FOR DR. HELENE GAYLE
HHS FOR SECRETARY DONNA SHALALA

PASS USAID WASHDC FOR AA/AFR, DAA/AFR NEWTON AND AFR/SA M/HR, LINDA LION
STATE DIRECTOR GENERAL AMBASSADOR GNEHM
PASS DHRS/NIH/FIC FOR SHARON BRYNKOW

E.O. 12958: N/A
TAGS: THIO, EAID, SOCI, ZI
SUBJECT: AIDS IN SOUTHERN AFRICA: AMBASSADORS AND USAID MISSION DIRECTORS REAFFIRM OUR REGIONAL COMMITMENT

INDICATIONS WERE THAT NO INCREMENTAL USAID FUNDS WOULD BE AVAILABLE AND ITS BUDGET FOR HIV/AIDS WOULD BE INCREASED THROUGH OFF-SETTING REDUCTIONS IN UNEARMARKED ACCOUNTS. OTHER AGENCIES' COMPONENTS, E.G., DEPARTMENT OF DEFENSE (DOD) AND HEALTH AND HUMAN SERVICES (HHS), MAY BENEFIT FROM INCREMENTAL FUNDING.

--REPRESENTATIVE BARBARA LEE (D-CA) WILL SUBMIT A BILL TO CONGRESS IN EARLY 2000 THAT WOULD CALL FOR MATCHING

UNCLASSIFIED

UNCLASSIFIED

PAGE 03 HARARE 07005 03 OF 13 170950Z
PRIVATE SECTOR CONTRIBUTIONS AND USG FUNDS OF U.S.$200 MILLION ANNUALLY FOR INTERNATIONAL HIV/AIDS PROGRAMS. UNDER THE PROPOSED "AIDS MARSHALL PLAN," A NEW GOVERNMENT AGENCY WOULD BE CREATED TO ADMINISTER THE FUND.

--ORGANIZERS OF FUTURE U.S.-SADC FORUMS WILL INCLUDE AN HIV/AIDS COMPONENT IN CONFERENCE PROGRAMMING.

--AN INITIATIVE BY U.S. CONGLOMERATE BRISTOL MYERS-SQUIBB WILL OFFER TRAINING AND SERVICE DELIVERY TO COMPANIES IN SUB-SAHARAN AFRICA THAT ALREADY HAVE, OR WISH TO DEVELOP, HIV/AIDS PROGRAMS IN THE WORKPLACE.

9. CONFERENCE PARTICIPANTS RESPONDED WITH CONCERN TO THE NEWS THAT THE "LIFE" INITIATIVE IS NOT LIKELY TO RESULT IN INCREASED USAID FUNDING AND THAT IN PARTICULAR ECONOMIC GROWTH AND DEMOCRACY/GOVERNANCE FUNDS WERE LIKELY FY 2000 SOURCES FOR "LIFE." PARTICIPANTS AGREED THAT USAID NEEDS MORE FLEXIBILITY TO USE EXISTING FUNDING TO EXPAND HIV/AIDS PROGRAMS. ONE EXAMPLE CITED WAS THE CHILD SURVIVAL EARMARK WITHIN THE CHILD SURVIVAL AND DISEASE ACCOUNT, WHICH CURRENTLY ENTAILS A DEFINITION THAT LIMITS HIV/AIDS ACTIVITIES. PARTICIPANTS UNDERTOOK TO SEND A JOINT MEMO PRESENTING THEIR CONCERN TO THE DEPARTMENT OF STATE AND USAID/WASHINGTON. (SEE "CONFERENCE WRAP-UP" FOR AN ACTION ITEM REGARDING JOINT MEMO.)

USG RESPONSE TO THE EPIDEMIC IN THE REGION

UNCLASSIFIED

UNCLASSIFIED

PAGE 04 HARARE 07005 03 OF 13 170950Z

---

10. WALTER NORTH, DIRECTOR OF USAID/ZAMBIA, DESCRIBED THE BACKGROUND OF THE HIV/AIDS SOUTHERN AFRICA PROGRAM, AN INITIATIVE INTRODUCED IN 1998 BY USAID REGIONAL TECHNICAL OFFICERS TO DEVELOP A COORDINATED USAID APPROACH TO COMBATING HIV/AIDS IN THE REGION. HE EXPLAINED THAT THE PROGRAM WAS, IN REALITY, VERY NEW, WITH ONLY US$950,000 OF FY99 FUNDING (CONTRIBUTED BY AFR/SD) OBLIGATED ON 9/30/99. PARTICIPANTS HAVE CONVENED ON FIVE OCCASIONS.

11. ROBERT CLAY, PHN DIRECTOR, USAID/ZAMBIA REVIEWED THE PROGRESS OF THE FOUR COMPONENTS OF THE REGIONAL PROGRAM. 1) "CORRIDORS OF RISK, CORRIDORS OF HOPE," AN HIV/AIDS AWARENESS PROGRAM FOR TRUCKERS AND COMMERCIAL SEX WORKERS: ASSESSMENTS HAVE BEEN COMPLETED AT FOUR BORDER SITES AND DETAILED FINDINGS WERE SHARED WITH THE GROUP. IMPLEMENTATION ACTIVITIES BASED ON THE ASSESSMENTS WILL BEGIN IN JANUARY, 2000; (2) POLICY AND POLITICAL ADVOCACY: A POLICY-LEVEL WORKSHOP WAS HELD BEFORE THE ICASA CONFERENCE WITH OVER 25 PARTICIPANTS

UNCLASSIFIED

NNNN

********** HARARE 7005 - XXSECTION 04 OF 13 **********

N VZCZCAID0289

UNCLASSIFIED

PAGE 01 HARARE 07005 04 OF 13 170950Z
ACTION AF-00

INFO LOG-00 NP-00 AID-00 AMAD-01 CIAE-00 CIMS-
DODE-00
ITCE-00 SRPP-00 EAP-00 ED-00 EXME-00 OTED-
HHS-01
TEDE-00 INR-00 ITC-01 LAB-01 L-00 ADS-0
MMP-00
NEA-01 NSAE-00 OES-01 OMB-01 OPIC-01 PER-0
STR-00
TRSE-00 SA-01 DRL-02 SAS-00 /012W
---------- 106913 170952Z /38

R 170952Z NOV 99
FM AMEMBASSY HARARE
TO SECSTATE WASHDC 4622
SOUTHERN AFRICAN DEVELOPMENT COMMUNITY
AMEMBASSY KAMPALA
AMEMBASSY KINSHASA
AMEMBASSY NAIROBI
INFO AMEMBASSY NEW DELHI
AMEMBASSY JAKARTA
AMEMBASSY KUALA LUMPUR
AMEMBASSY BANGKOK
AMEMBASSY BEIJING
NSC WASHDC
DEPT OF LABOR WASHDC

USDOC WASHDC
CDC ATLANTA GA
DEPT OF HHS WASHDC

UNCLASSIFIED

UNCLASSIFIED

PAGE 02 HARARE 07005 04 OF 13 170950Z
UNCLAS SECTION 04 OF 13 HARARE 007005

DEPT FOR AF/S, AF/EPS, OES, AND DRL
NSC FOR SENIOR AFRICA DIRECTOR GAYLE SMITH
WHITE HOUSE FOR ONAP DIRECTOR SANDY THURMAN
DOL FOR ILAB/ROBERT SHEPARD
USDOC FOR DKENKE-ROGERS
NAIROBI FOR REDSO
AFRICAN POSTS FOR AMBASSADORS AND USAID MISSION DIRECTORS
CDC FOR DR. HELENE GAYLE
HHS FOR SECRETARY DONNA SHALALA

(2)

TEDE-00 INR-00 ITC-01 LAB-01 L-00 ADS-00
HP-00
NEA-01 NSAE-00 OES-01 OMB-01 OPIC-01 PER-01
TR-00
TRSE-00 SA-01 DRL-02 SAS-00 /012W
----------1068E7 170950Z /38

709522 NOV 99
AMEMBASSY HARARE
SECSTATE WASHDC 4620
THERN AFRICAN DEVELOPMENT COMMUNITY
MBASSY KAMPALA
MBASSY KINSHASA
MBASSY NAIROBI
O AMEMBASSY NEW DELHI
MBASSY JAKARTA
MBASSY KUALA LUMPUR
MBASSY BANGKOK
MBASSY BEIJING
C WASHDC
PT OF LABOR WASHDC

OOC WASHDC
C ATLANTA GA
PT OF HHS WASHDC

UNCLASSIFIED

UNCLASSIFIED

GE 02 HARARE 07005 02 OF 13 170949Z
CLAS SECTION 02 OF 13 HARARE 007005

PT FOR AF/S, AF/EPS, OES, AND DRL
C FOR SENIOR AFRICA DIRECTOR GAYLE SMITH
ITE HOUSE FOR ONAP DIRECTOR SANDY THURMAN
L FOR ILAB/ROBERT SHEPARD
DOC FOR DHENKE-ROGERS
AIROBI FOR REDSO
FRICAN POSTS FOR AMBASSADORS AND USAID MISSION
IRECTORS
C FOR DR. HELENE GAYLE
S FOR SECRETARY DONNA SHALALA

ASS USAID WASHDC FOR AA/AFR, DAA/AFR NEWTON AND AFR/SA
/HR, LINDA LION
TATE DIRECTOR GENERAL AMBASSADOR GWERM
ASS DHHS/NIH/FIC FOR SHARON HRYNKOW

.O. 12958: N/A
AGS: TBIO, EAID, SOCI, ZI
UBJECT: AIDS IN SOUTHERN AFRICA: AMBASSADORS AND USAID
ISSION DIRECTORS REAFFIRM OUR REGIONAL COMMITMENT

FRICA, AND NINE OUT OF TEN AIDS ORPHANS WORLDWIDE LIVE
N SUB-SAHARAN AFRICA. RESEARCHERS HAVE FOUND NO
VIDENCE TO SUGGEST THAT THE EPIDEMIC WILL REACH A
NATURAL" PLATEAU AND LEVEL OFF IN THE NEAR FUTURE.
NDEED, MANY EXPERTS PREDICT THAT THE EPIDEMIC WILL
ONTINUE TO WORSEN OVER THE NEXT 15-20 YEARS.

. YAMASHITA DESCRIBED THE COMPLEX AND SERIOUS
ONSEQUENCES THAT THE EPIDEMIC HAS ON ECONOMIES IN THE
UNCLASSIFIED

UNCLASSIFIED

AGE 03 HARARE 07005 02 OF 13 170949Z
EGION. THE EFFECTS ARE SHOWING ACROSS INDUSTRIAL
ECTORS AND AMONG INDIVIDUAL BUSINESSES IN THE FORM OF
OST SKILLED AND UNSKILLED LABOR, AND SKYROCKETING
NSURANCE COSTS. THE EPIDEMIC'S IMPACT WAS THE MOST
RAMATIC ON HOUSEHOLDS WHERE THE MAIN WAGE EARNER IS NO
ONGER ABLE TO GENERATE INCOME FOR THE FAMILY. THE
POUSE MUST THEN TAKE TIME OFF FROM WORK, AND/OR
HILDREN AND FREQUENTLY THE GIRL CHILD MUST STAY HOME
ROM SCHOOL, TO CARE FOR SICK FAMILY MEMBERS. GIVEN THE
REMENDOUS ECONOMIC AND SOCIAL IMPACT OF THE DISEASE AND
TS PREDICTED LONGEVITY IN THE REGION, THE GROUP AGREED
HAT USG HIV/AIDS POLICIES IN THE REGION MUST BE WELL
OORDINATED WITH ALL STAKEHOLDERS AND INCLUDE LONG-TERM,
UBSTANTIAL PROGRAMMING.

. YAMASHITA PRESENTED SOME FUNDING NEEDS PROJECTIONS
SSUED BY UNAIDS, USAID, AND OTHER AGENCIES. IT HAS
BEEN ESTIMATED THAT OVER US$1.0 BILLION PER YEAR WOULD BE NEEDED TO SIGNIFICANTLY SLOW THE CURRENT EPIDEMIC. SUCH FUNDING LEVELS WILL REQUIRE STRONG COMMITMENT BY GOVERNMENTS AND DONORS. YET EVEN AT THE LEVEL OF REQUIRED FUNDING OF US$1.0 BILLION, THE LEVEL OF INVESTMENT PALES IN COMPARISON WITH THE USG COMITTMENT TO DOMESTIC HIV/AIDS PROGRAMS, WHICH IN 1998 TOTALED NEARLY US$7 BILLION. THE GROUP NOTED THIS STAGGERING DIFFERENCE, AND COMMENTED ON THE CHALLENGE AHEAD FOR GOVERNMENTS, PRIVATE SECTOR, AND DONORS TO PROVIDE THE FUNDING NEEDED.

USG RESPONSE TO THE EPIDEMIC IN WASHINGTON
UNCLASSIFIED

UNCLASSIFIED

PAGE 04 HARARE 07005 02 OF 13 170949Z

8. MR. WILLIAM JEFFERS, DIRECTOR OF AFR/SA, USAID/WASHINGTON, BRIEFED PARTICIPANTS ON CURRENT FEDERAL INITIATIVES TO COMBAT HIV/AIDS IN AFRICA. JEFFERS DESCRIBED SEVERAL NEW WASHINGTON INITIATIVES:

--IN JULY 1999, THE WHITE HOUSE ANNOUNCED THE PRESIDENT'S "LEADERSHIP AND INVESTMENT IN FIGHTING AN EPIDEMIC" (LIFE) INITIATIVE, WHICH FEATURED A REQUESTED BUDGET INCREASE OF U.S.$100 MILLION TO SUPPORT HIV/AIDS PROGRAMS IN SUB-SAHARAN AFRICA AND INDIA. THE INITIATIVE RELIES ON CLOSE COLLABORATION AMONG USAID, THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, AND THE DEPARTMENT OF DEFENSE, WITH USAID TAKING THE LEAD AS THE COORDINATING AGENCY. THE INITIATIVE CONTAINS FOUR MAIN PROGRAM ELEMENTS: (1) PRIMARY PREVENTION OF HIV/AIDS; (2) COMMUNITY AND HOME-BASED CARE AND TREATMENT; (3) CARING FOR CHILDREN AFFECTED BY HIV/AIDS; AND (4) CAPACITY BUILDING AND INFRASTRUCTURE DEVELOPMENT. WHILE THE OUTCOME OF THE FY 2000 FOREIGN OPERATIONS FUNDING BILL WAS NOT CERTAIN AT THE TIME OF THE CONFERENCE.

UNCLASSIFIED

NNNN -

******** HARARE 7005 - XXSECTION 03 OF 13 ********

N VZCZCAID0286
UNCLASSIFIED

PAGE 01 HARARE 07005 03 OF 13 170950Z
ACTION AF-00

INFO LOG-00 NP-00 AID-00 AMAD-01 CIAE-00 CIME-00
DODE-00
ITCE-00 SRPP-00 EAP-00 EB-00 EXME-00 OTED-00
HRS-01
TEDE-00 INR-00 ITC-01 LAB-01 L-00 ADS-00
MMP-00
NEA-01 NSAE-00 OES-01 OMB-01 OPIC-01 PER-01
STR-00
TRSE-00 SA-01 DRL-02 SAS-00 /012W
----------1068F2 170951Z /38

R 170952Z NOV 99
FM AMEMBASSY HARARE
TO SECSTATE WASHDC 4621
SOUTHERN AFRICAN DEVELOPMENT COMMUNITY
AMEMBASSY KAMPALA
AMEMBASSY KINSHASA
AMEMBASSY NAIROBI
INFO AMEMBASSY NEW DELHI
AMEMBASSY JAKARTA
AMEMBASSY KUALA LUMPUR
AMEMBASSY BANGKOK
AMEMBASSY BEIJING
NSC WASHDC
DEPT OF LABOR WASHDC

AFSAG3: /tell/./99/11/17/748762m

U S AGENCY FOR INT'L DEV.
TELECOMMUNICATIONS CENTER

!AAAF AAAF01 AFDP01 AFEA AFMS AFSA AFSA03
AFSD AFSD02 AFSD07 AFSO AFWA AFWA05 AL
BHR COTASK CRTF FFP04 FFP13 FFP18 FFP29
FFP32 GEM HPP02 HR ICIS IG IGPS LAV MLC
OFDA PDSP PVC TDA TRASH WID

********* HARARE 7005 - XXSECTION 01 OF 13 *********

N VZCZCAID0284

UNCLASSIFIED

PAGE 01 HARARE 07005 01 OF 13 1709492
ACTION AF-00

INFO LOG-00 NP-00 AID-00 AMAD-01 CIAE-00 CIME-00
DODE-00
ITCE-00 SRPP-00 EAP-00 EB-00 EXME-00 OTED-00
HHS-01
TEDE-00 INR-00 ITC-01 LAB-01 L-00 ADS-00
MMP-00
NEA-01 NSAE-00 OES-01 OMB-01 OPIC-01 PER-01
STR-00
TRSE-00 SA-01 DRL-02 SAS-00 /012W
----------1068CF 1709502 /38

R 1709522 NOV 99
FM AMEMBASSY HARARE
TO SECSTATE WASHDC 4619
SOUTHERN AFRICAN DEVELOPMENT COMMUNITY
AMEMBASSY KAMPALA
AMEMBASSY KINSHASA
AMEMBASSY NAIROBI
INFO AMEMBASSY NEW DELHI
AMEMBASSY JAKARTA
AMEMBASSY KUALA LUMPUR
AMEMBASSY BANGKOK
AMEMBASSY BEIJING
NSC WASHDC
DEPT OF LABOR WASHDC

USDOC WASHDC
CDC ATLANTA GA
DEPT OF HHS WASHDC

UNCLASSIFIED

UNCLASSIFIED

PAGE 02 HARARE 07005 01 OF 13 170949Z
UNCLAS SECTION 01 OF 13 HARARE 007005

DEPT FOR AF/S, AF/EPS, OES, AND DRL
NSC FOR SENIOR AFRICA DIRECTOR GAYLE SMITH
WHITE HOUSE FOR ONAP DIRECTOR SANDY THURMAN
DOL FOR ILAB/ROBERT SHEPARD
USDOC FOR DHENKE-ROGERS
NAIROBI FOR REDSO
AFRICAN POSTS FOR AMBASSADORS AND USAID MISSION DIRECTORS
CDC FOR DR. HELENE GAYLE
HHS FOR SECRETARY DONNA SHALALA

PASS USAID WASHDC FOR AA/AFR, DAA/AFR NEWTON AND AFR/SA M/MR, LINDA LION
STATE DIRECTOR GENERAL AMBASSADOR GNEHM
PASS DHHS/NIH/FIC FOR SHARON HRYNKOW

E.O. 12958: N/A
TAGS: THIO, EAID, SOCI, ZI
SUBJECT: AIDS IN SOUTHERN AFRICA: AMBASSADORS AND USAID MISSION DIRECTORS REAFFIRM OUR REGIONAL COMMITMENT

REF: (A) LUSAKA 05681 (B) LUSAKA 05223, (C) KAMPALA 01767

1. THIS IS BOTH A REPORTING AND AN ACTION CABLE. ACTION FOR WASHINGTON IS NOTED IN PARA 30.

2. THIS CABLE HAS BEEN CLEARED BY EMBASSIES HARARE, PRETORIA, AND LUSAKA.

3. U.S. AMBASSADOR TO ZIMBABWE TOM MCDONALD HOSTED A "CHIEFS OF MISSION/USAID MISSION DIRECTORS' SOUTHERN AFRICA REGIONAL HIV/AIDS WORKSHOP," OCTOBER 22-23, 1999, IN HARARE. A TOTAL OF 33 USG OFFICIALS PARTICIPATED IN THE EVENT, INCLUDING SEVEN AMBASSADORS (TOM MCDONALD, DEAN CURRAN OF MOZAMBIQUE, DAVID DUNN OF ZAMBIA, ELLEN SHIPPY OF MALAWI, CHARLES STITH OF TANZANIA, ROBERT KRUEGER OF BOTSWANA, AND KATHERINE PETERSON OF LESOTHO), NINE USAID MISSION DIRECTORS, AND USAID TECHNICAL EXPERTS. THE PURPOSE OF THE MEETING WAS TO REVIEW THE HIV/AIDS CRISIS IN SOUTHERN AFRICA AND DEVELOP STRATEGIES TO DEEPEN THE RESPONSE TO THE EPIDEMIC IN THE REGION. THE WORKSHOP FOCUSED SPECIFICALLY ON GENERATING IDEAS TO HELP CHIEFS OF MISSION (COM) BETTER PROMOTE HIV/AIDS ACTIVELY AT THEIR POSTS AND ACROSS THE REGION. WORKSHOP PARTICIPANTS UNANIMOUSLY AGREED THAT REGIONAL DIALOGUE AND A COORDINATED USG APPROACH ARE INVALUABLE TO WAGING A SUCCESSFUL CAMPAIGN AGAINST HIV/AIDS IN SOUTHERN AFRICA. THEY DECIDED TO HOLD ANOTHER MEETING ON THE PERIPHERY OF THE U.S.-SADC FORUM, TO BE HELD AS EARLY AS THE FIRST QUARTER OF 2000.

4. THE GROUP PRODUCED A DETAILED LIST OF IDEAS AND ACTIVITIES BY WHICH COMS CAN ENGAGE HOST COUNTRIES, THE COUNTRY TEAM, THE PRIVATE SECTOR, AND THE MEDIA TO BETTER PROMOTE HIV/AIDS ACTIVISM IN SOUTHERN AFRICA (SEE PARAS 23-27). IN LIGHT OF THE IMPACT OF THE EPIDEMIC ON

UNCLASSIFIED

UNCLASSIFIED

PAGE 04 HARARE 07005 01 OF 13 1709492
POST OPERATION, THEY NOTED THE NEED FOR A WASHINGTON REVIEW OF USG WORKPLACE POLICY, (SEE PARA 30) PARTICIPANTS ALSO PRODUCED A "CONFERENCE WRAP-UP" DOCUMENT THAT IDENTIFIES SUGGESTED ACTION ITEMS AND NEXT STEPS FOR SOUTHERN AFRICAN POSTS AND WASHINGTON AGENCIES (SEE PARAGRAPH 37). END SUMMARY.

SCOPE OF THE EPIDEMIC

---

5. DR. KEN YAMASHITA, USAID/SOUTH AFRICA'S HEALTH OFFICER, SUMMARIZED THE STAGGERING HIV/AIDS EPIDEMIC IN SOUTHERN AFRICA AS 'BAD AND GETTING WORSE'. IN SOUTHERN AFRICA, IT IS ESTIMATED THAT OVER 2,000 NEW INFECTIONS OCCUR EVERY DAY, NEARLY 800,000 EVERY YEAR. THIS COMPARES TO APPROXIMATELY 40,000 NEW INFECTIONS WHICH OCCUR IN THE U.S. EVERY YEAR. SUB-SAHARAN AFRICA IS THE REGION WHICH HAS BEEN MOST SERIOUSLY AFFECTED BY THE EPIDEMIC. OF THE TOTAL WORLDWIDE NUMBER OF HIV/AIDS CASES, TWO THIRDS OCCUR IN SUB-SAHARAN AFRICA. EIGHT OUT OF TEN AIDS DEATHS WORLDWIDE OCCUR IN SUB-SAHARAN

UNCLASSIFIED

NNNN

********* HARARE 7005 - XXSECTION 02 OF 13 *********

N VZC2CAID0285

UNCLASSIFIED

PAGE 01 HARARE 07005 02 OF 13 1709492
ACTION AF-00

INFO LOG-00 NP-00 AID-00 AMAD-01 CIAE-00 CIME-
DODE-00
ITCE-00 SRPP-00 EAP-00 EB-00 EXME-00 OTED-

TO SECSTATE WASHDC 4628
SOUTHERN AFRICAN DEVELOPMENT COMMUNITY
AMEMBASSY KAMPALA
AMEMBASSY KINSHASA
AMEMBASSY NAIROBI
INFO AMEMBASSY NEW DELHI
AMEMBASSY JAKARTA
AMEMBASSY KUALA LUMPUR
AMEMBASSY BANGKOK
AMEMBASSY BEIJING
NSC WASHDC
DEPT OF LABOR WASHDC

OSDOC WASHDC
CDC ATLANTA GA
DEPT OF HHS WASHDC

UNCLASSIFIED

UNCLASSIFIED

PAGE 02 HARARE 07005 10 OF 13 170952Z
ONCLAS SECTION 10 OF 13 HARARE 007005

DEPT FOR AF/S, AF/EPS, OES, AND DRL
NSC FOR SENIOR AFRICA DIRECTOR GAYLE SMITH
WHITE HOUSE FOR ONAP DIRECTOR SANDY THURMAN
DOL FOR ILAB/ROBERT SHEPARD
USDOC FOR DHENKE-ROGERS
NAIROBI FOR REDSO
AFRICAN POSTS FOR AMBASSADORS AND USAID MISSION DIRECTORS
CDC FOR DR. HELENE GAYLE
HHS FOR SECRETARY DONNA SHALALA

PASS USAID WASHDC FOR AA/AFR, DAA/AFR NEWTON AND AFR/SA M/HR, LINDA LION
STATE DIRECTOR GENERAL AMBASSADOR GNEHM
PASS DHHS/NIH/FIC FOR SHARON HRYNKOW

E.O. 12958: N/A
TAGS: TDIO, EAID, SOCI, ZI
SUBJECT: AIDS IN SOUTHERN AFRICA: AMBASSADORS AND USAID MISSION DIRECTORS REAFFIRM OUR REGIONAL COMMITMENT

AND IDENTIFY A TASK MANAGER FOR THE REVIEW. THE SOUTHERN AFRICAN MISSIONS WOULD BE GLAD TO ASSIST.

11. PARTICIPANTS ALSO DISCUSSED WORKPLACE PROGRAMS BEING PROMOTED IN USG MISSION IN THE REGION. ACTIVITIES INCLUDED:

- HIV/AIDS EDUCATION AND PREVENTION PROGRAMS FOR ALL MISSION STAFF AND THEIR DEPENDENTS, INCLUDING CHILDREN;

UNCLASSIFIED

UNCLASSIFIED

PAGE 03 HARARE 07005 10 OF 13 170952Z

--USE OF NGOS, PARTICULARLY THOSE REPRESENTING PEOPLE LIVING WITH AIDS, TO PROVIDE WORKPLACE EDUCATION;

--CREATION OF FSN HIV/AIDS AWARENESS GROUPS;

--PROVISION OF PRTS CONDOMS IN RESTROOMS AND CONSIDERATION FOR REIMBURSING PERSONNEL FOR VCT SERVICES;

--REVIEW OF LITERATURE SUCH AS THE UNAIDS AND OAU DOCUMENTS ON BEST PRACTICES IN THE WORKPLACE TO DETERMINE WHAT OTHER PROGRAMS ARE NEEDED; AND

--CROSS-TRAINING OF SENIOR FSNS TO FILL GAPS AS ILLNESS AND DEATH INCREASINGLY BECOME AN ISSUE.

OTHER ISSUES OF INTEREST AT THE CONFERENCE

---

12. PARTICIPANTS DISCUSSED THE OVERARCHING NEED FOR BEHAVIOR CHANGE. THEY AGREED THAT KNOWLEDGE OF HIV/AIDS IS HIGH IN MOST COUNTRIES AND NEARLY UNIVERSAL IN SOME. THE CHALLENGE OF ENGENDERING BEHAVIOR CHANGE, HOWEVER, HAS NOT YET BEEN MET. TECHNICAL OFFICERS ARGUED THAT EVIDENCE FROM COUNTRIES LIKE UGANDA SHOWS THAT VCT IS A COMPLEMENTARY SERVICE TO EXISTING PROGRAMS THAT OFFERS THE BEST OPTION IN HIGH PREVALENCE SETTINGS FOR LOWERING STIGMA AND PROMOTING BEHAVIOR CHANGE.

UNCLASSIFIED

UNCLASSIFIED

PAGE 04 HARARE 07005 10 OF 13 170952Z
33. THE GROUP ALSO DISCUSSED WAYS TO COMBAT THE HIV/AIDS EPIDEMIC AT A STRATEGIC LEVEL. COM/DIRECTORS ASKED HOW THEY COULD USE A REGIONAL PLATFORM AND THEIR COLLECTIVE VOICE TO MAKE THE CASE THAT IMMEDIATE ACTION IS NEEDED. PARTICIPANTS DISCUSSED THE CONCEPT OF FORMING "STRATEGIC ALLIANCES" AMONG USG ENTITIES, HOST COUNTRY INSTITUTIONS, NGOS AND THE PRIVATE SECTOR TO HELP BRING ATTENTION TO AND FIND WAYS OF COMBATING THE EPIDEMIC.

34. USAID TECHNICAL STAFF AGREED THAT MANDATORY HIV TESTING NOT ONLY RAISES HUMAN RIGHTS ISSUES, BUT ALSO HAS NEGATIVE CONSEQUENCES BECAUSE OF THE STIGMA ASSOCIATED WITH THE DISEASE. IF ENFORCED, MANDATORY TESTING COULD NEGATE CURRENT SUCCESSES MAKING BEHAVIOR CHANGE AN EVEN MORE PROBLEMATIC GOAL. VOLUNTARY AND ANONYMOUS COUNSELING AND TESTING IS PREFERABLE, ESPECIALLY IF VIEWED AS A MEANS OF MAINTAINING A HEALTHY POPULATION.

35. WITH RESPECT TO PRE-EMPLOYMENT SCREENING, MANDATORY TESTING DOES NOT GUARANTEE AN HIV/AIDS-FREE WORKPLACE.

UNCLASSIFIED

NNNN

******** HARARE 7005 - XXSECTION 11 OF 13 ********

N

UNCLASSIFIED

PAGE 01 HARARE 07005 11 OF 13 170952Z
ACTION AF-00

INFO LOG-00 NP-00 AID-00 AMAD-01 CIAE-00 CIME-00
DODE-00
ITCE-00 SRPP-00 EAP-00 EB-00 EXME-00 UTED-00
HHS-01
TEDE-00 INR-00 ITC-01 LAB-01 L-00 ADS-00
NMP-00
NEA-01 NSAE-00 OES-01 OMB-01 OPIC-01 PER-01
STR-00
TRSE-00 SA-01 DRL-02 SAS-00 /012W
----------10699B 170956Z /38

R 170952Z NOV 99
FM AMEMBASSY HARARE
TO SECSTATE WASHDC 4629
SOUTHERN AFRICAN DEVELOPMENT COMMUNITY
AMEMBASSY KAMPALA
AMEMBASSY KINSHASA
AMEMBASSY NAIROBI
INFO AMEMBASSY NEW DELHI
AMEMBASSY JAKARTA
AMEMBASSY KUALA LUMPUR
AMEMBASSY BANGKOK
AMEMBASSY BEIJING
NSC WASHDC
DEPT OF LABOR WASHDC

OSDOC WASHDC
CDC ATLANTA GA
DEPT OF HHS WASHDC

UNCLASSIFIED

UNCLASSIFIED

PAGE 02 HARARE 07005 11 OF 13 170952Z

EPT FOR AF/S, AF/EPS, OES, AND DRL
SC FOR SENIOR AFRICA DIRECTOR GAYLE SMITH
HITE HOUSE FOR ONAP DIRECTOR SANDY THURMAN
OL FOR ILAB/ROBERT SHEPARD
SDOC FOR DHENKE-ROGERS
AIROBI FOR REDSO
FRICAN POSTS FOR AMBASSADORS AND USAID MISSION
IRECTORS
DC FOR DR. HELENE GAYLE
HS FOR SECRETARY DONNA SHALALA

ASS USAID WASHDC FOR AA/AFR, DAA/APR NEWTON AND AFR/SA
/HR, LINDA LION
TATE DIRECTOR GENERAL AMBASSADOR GNEHM
ASS DHHS/NIH/FIC FOR SHARON HRYNKOW

..O. 12958: N/A
'AGS: TBIO, EAID, SOCI, ZI
UBJECT: AIDS IN SOUTHERN AFRICA: AMBASSADORS AND USAID
ISSION DIRECTORS REAFFIRM OUR REGIONAL COMMITMENT

IOT ONLY SCREENS OUT THOSE ALREADY INFECTED. THE MORE
.PPROPRIATE FOCUS IS ON MAINTAINING A HEALTHY WORKFORCE.

3. A PANEL OF USAID TECHNICAL STAFF DISCUSSED SOME
SSUES RELATED TO HIV/AIDS. THESE INCLUDED:

--AN UPDATE ON THE LATEST INFORMATION REGARDING DRUG
HERAPIES AND SOME ONGOING RESEARCH. PRESENTORS
STRESSED THAT CURRENT DRUG THERAPIES IN THE U.S. COST

UNCLASSIFIED

UNCLASSIFIED

PAGE 03 HARARE 07005 11 OF 13 170952Z
OSS1,000/MONTH AND OFFER NO MAGIC CURE FOR AIDS.

--MOTHER TO CHILD TRANSMISSION OF HIV/AIDS IS AN IMPORTANT AREA, BUT USG SHOULD MOVE FORWARD CAUTIOUSLY, AS THERE ARE STILL MANY ISSUES THAT NEED TO BE FURTHER RESEARCHED, ESPECIALLY WITH RESPECT TO SERVICE DELIVERY CAPACITY AND FINANCIAL SUSTAINABILITY.

--THE NEED TO BE COGNIZANT OF THE MANY ETRICAL CONSIDERATIONS SURROUNDING USG-SPONSORED RESEARCH. THERE WAS RECOGNITION THAT SOME RESEARCH ACTIVITIES HAVE THE POTENTIAL TO COMPROMISE RELATED ASSISTANCE PROGRAMS, PARTICULARLY IN THE AREA OF DRUG VACCINE RESEARCH. AS A RESULT, COMS SHOULD REQUIRE THAT APPROVAL FROM LOCAL ETHICAL AND RESEARCH COUNCILS SHOULD BE OBTAINED BEFORE ANY USG-FUNDED RESEARCH COMMENCES. USAID MISSION DIRECTOR JOHN GRAYZEL, REPRESENTING AMBASSADOR SWING, STRESSED THAT WHILE DROC IS SEEN AS THE "RESEARCH VENUE" FOR EVERY NEW DISEASE, NO HIV/AIDS PROGRAM ASSISTANCE IS BEING PROVIDED. THIS ISSUE OF NEGLECT WAS PRESENTED AS AN UNCONSCIONABLE POSITION.

CONFERENCE WRAP-UP

---

37. THE GROUP PRODUCED A CONFERENCE SUMMARY DOCUMENT THAT LISTS THE CONFERENCE'S ACCOMPLISHMENTS AND IDENTIFIES SUGGESTED ACTION ITEMS FOR AFRICAN POSTS AND WASHINGTON AGENCIES.

UNCLASSIFIED

UNCLASSIFIED

PAGE 04 HARARE 07005 11 OF 13 170952Z
BEGIN TEXT OF CONFERENCE SUMMARY DOCUMENT:

THE MEETING EXPRESSED THE STRONG SHARED CONCERN OF U.S. AMBASSADORS AND USAID MISSION DIRECTORS ABOUT THE DEVASTATING ECONOMIC AND POTENTIAL POLITICAL IMPACT OF THE HIV/AIDS PANDEMIC IN SOUTHERN AFRICA, AND ITS ADVERSE IMPACT ON THE REGION'S PEOPLE AND U.S. INTERESTS IN THE AREA.

THE MEETING ACHIEVED ITS OBJECTIVES OF DRAWING A COMPREHENSIVE PICTURE OF THE PROBLEM AND OF USG HIV/AIDS ASSISTANCE IN THE REGION; AND IDENTIFYING NEW IDEAS ABOUT HOW U.S. AMBASSADORS AND USAID MISSION DIRECTORS CAN ENHANCE THEIR JOINT EFFORTS TO ADDRESS HIV/AIDS IN

AREA DAILY WORK AND ESTABLISH COUNTRY TEAM-BASED ACTION PROGRAMS FOR THE FUTURE. THIS MEETING CAN SERVE AS A MODEL FOR HOW TO CONDUCT POSITIVE INTERAGENCY COOPERATION. PARTICIPANTS AGREED THAT THE GROUP WILL MEET AGAIN IN THE FIRST QUARTER OF 2000, PERHAPS AS PART OF THE U.S.-SADC FORUM MEETING.

IT IS THE SENSE OF THIS MEETING THAT:

UNCLASSIFIED

NNNN

******** HARARE 7005 - XXSECTION 12 OF 13 ********

R VZC2CAID0300

UNCLASSIFIED

PAGE 01 HARARE 07005 12 OF 13 170952Z
ACTION AF-00

INFO LOG-00 NP-00 AID-00 AMAD-01 CIAE-00 CIME-00
DODE-00
ITCE-00 SRPP-00 EAP-00 EB-00 EXME-00 UTED-00
HHS-01
TEDE-00 INR-00 ITC-01 LAB-01 L-00 ADS-00
MMP-00
NEA-01 NSAE-00 OES-01 OMB-01 OPIC-01 PER-01
STR-00
TRSE-00 SA-01 DRL-02 SAS-00 /012W
---------- -------1069B3 170957Z /38

R 170952Z NOV 99
FM AMEMBASSY HARARE
TO SECSTATE WASHDC 4630
SOUTHERN AFRICAN DEVELOPMENT COMMUNITY
AMEMBASSY KAMPALA
AMEMBASSY KINSHASA
AMEMBASSY NAIROBI
INFO AMEMBASSY NEW DELHI
AMEMBASSY JAKARTA
AMEMBASSY KUALA LUMPUR
AMEMBASSY BANGKOK
AMEMBASSY BEIJING
NSC WASHDC
DEPT OF LABOR WASHDC

USDOC WASHDC
CDC ATLANTA GA
DEPT OF HHS WASHDC

UNCLASSIFIED

UNCLASSIFIED

PAGE 02 HARARE 07005 12 OF 13 170952Z
UNCLAS SECTION 12 OF 13 HARARE 007005

DEPT FOR AF/S, AF/EPS, OES, AND DRL
NSC FOR SENIOR AFRICA DIRECTOR GAYLE SMITH
WHITE HOUSE FOR ONAP DIRECTOR SANDY THURMAN
DOL FOR ILAB/ROBERT SHEPARD
USDOC FOR DHENKE-ROGERS
NAIROBI FOR REDSO
AFRICAN POSTS FOR AMBASSADORS AND USAID MISSION
DIRECTORS
CDC FOR DR. HELENE GAYLE
HHS FOR SECRETARY DONNA SHALALA

PASS USAID WASHDC FOR AA/AFR, DAA/AFR NEWTON AND AFR/SA
M/HR, LINDA LION
STATE DIRECTOR GENERAL AMBASSADOR GNEHM
PASS DHHS/NIH/FIC FOR SHARON HRYNKOW

E.O. 12958: N/A
TAGS: TBIO, EAID, SOCI, ZI
SUBJECT: AIDS IN SOUTHERN AFRICA: AMBASSADORS AND USAID
MISSION DIRECTORS REAFFIRM OUR REGIONAL COMMITMENT

(11)

5)ADDRESS WITH WASHINGTON THE NEED TO DEVELOP A COMPREHENSIVE WORLDWIDE POLICY ON HIV/AIDS PERSONNEL ISSUES AT OVERSEAS MISSIONS.

END TEXT OF "WRAP-UP" DOCUMENT.

CONCLUSION

---

38. THE GROUP AGREED ON THE EFFECTIVENESS OF COORDINATED DIALOGUE TO ADDRESS THE ISSUE OF HIV/AIDS. AS THIS GLOBAL EPIDEMIC DOES NOT RESPECT COUNTRY BORDERS. A LARGE NUMBER OF INNOVATIVE INITIATIVES WERE RECOMMENDED TO BE UNDERTAKEN BY COMS, MANY OF WHICH DONOT REQUIRE ADDITIONAL RESOURCES. ALL STATISTICS POINT TO THE FACT THAT THE HIV/AIDS EPIDEMIC WILL GET WORSE AND THAT NO FORMULA EXISTS TO SOLVE THE CRISIS. PARTICIPANTS UNANIMOUSLY AGREED THAT THE USG MUST BE CREATIVE ABOUT HOW BEST TO USE ITS SCARCE FOREIGN ASSISTANCE RESOURCES TO EFFECTIVELY COMBAT THE EPIDEMIC. THE MEETING WAS A UNIQUE OPPORTUNITY THAT BROUGHT

UNCLASSIFIED

UNCLASSIFIED

PAGE 04 HARARE 07005 13 OF 13 1709537
TOGETHER CHIEFS OF MISSION, USAID DIRECTORS AND USAID TECHNICAL OFFICERS TO DISCUSS A COMMON REGIONAL PROBLEM. PARTICIPANTS SUGGEST THAT THIS MODEL HAS APPLICABILITY FOR OTHER HIGH PRIORITY FOREIGN POLICY ISSUES THAT CUT ACROSS FOREIGN AFFAIRS AGENCIES.

39. COMMENT BY AMBASSADOR MCDONALD: "NONE OF US LIVING IN THIS REGION CAN REMAIN SILENT IN THE FACE OF THE OVERWHELMING IMPACT THIS EPIDEMIC IS HAVING ON OUR OWN STAFFS, PROGRAMS, US FOREIGN POLICY OBJECTIVES AND THE SOCIAL FABRIC OF THE COUNTRIES WE ARE LIVING IN. THIS MEETING HIGHLIGHTED THE IMPRESSIVE CONCERN AND COMMITMENT OF USG PERSONNEL IN THE REGION. THIS ISSUE WILL BE WITH US FOR SOME TIME TO COME. SUSTAINED ENGAGEMENT IS CRITICAL TO SUCCESS IN CONTROLLING AND EVENTUALLY STOPPING THE EPIDEMIC. U.S. LEADERSHIP CAN MAKE A DIFFERENCE."

MCDONALD

UNCLASSIFIED

NNNN

(1) THE USG SHOULD MAKE AVAILABLE ADDITIONAL RESOURCES AND PROVIDE GREATER FLEXIBILITY IN THE USE OF EXISTING FUNDS E.G. CHILD SURVIVAL EARMARKED/DISEASE) TO ADDRESS THE HIV/AIDS PANDEMIC IN SOUTHERN AFRICA. (LEAD: AMBASSADOR MCDONALD, AMBASSADOR CURRAN. AMBASSADOR DUNN AND CYNTHIA ROZELL)

--WASHINGTON TO PROVIDE MORE SPECIFIC AND TRANSPARENT

UNCLASSIFIED

UNCLASSIFIED

PAGE 03 HARARE 07005 12 OF 13 170952Z
INFORMATION ON THE PRESIDENT'S "LIFE" INITIATIVE. I.E., WHAT COUNTRIES WILL BE INCLUDED AND AT WHAT LEVEL. WE STRONGLY RECOMMEND THAT "LIFE" FUNDS BE ADDITIONAL TO THE CURRENT USAID OPERATIONAL YEARLY BUDGET (OYB). IT SHOULD NOT MEAN LESS ECONOMIC GROWTH OR DEMOCRACY FUNDS, WHICH ALREADY ARE TOO SCARCE.

--U.S. AMBASSADORS TO SEND A JOINT MEMO TO THE SECRETARY OF STATE AND THE USAID ADMINISTRATOR URGING EFFORTS WITH THE CONGRESS TO ALLOW USAID TO USE EXISTING RESOURCES MORE FLEXIBLY TO ADDRESS HIV/AIDS ISSUES.

(2) THERE ARE MANY IMPORTANT DIPLOMATIC INITIATIVES PRIMARILY ADDRESSED BY U.S. AMBASSADORS WHICH MAY NOT REQUIRE SIGNIFICANT FINANCIAL RESOURCES. AN ANNOTATED CHECKLIST OF POSSIBILITIES FOR U.S. AMBASSADORIAL INTERVENTIONS (BOTH INTERNAL AND EXTERNAL) SHOULD BE (SEE PARAS 25-28) DEVELOPED. (LEAD: AMBASSADOR CURRAN, AMBASSADOR STITH. AMBASSADOR SHIPPY AND WALTER NORTH)

--MEETING TO ADOPT POSSIBLE OPTIONS ESTABLISHED FOR U.S. AMBASSADORS AS DISCUSSED AT THE CONFERENCE AND TO CIRCULATE IT MORE BROADLY FOR COMMENT AND IMPROVEMENT.

--DEVELOP AND SHARE BEST PRACTICES ON DIPLOMATIC INITIATIVES ON EACH OF THESE OPTIONS IDENTIFIED.

(3) REGIONAL COOPERATION AND SYNERGIES AMONG THE U.S. POSTS IN SOUTHERN AFRICA ON HIV/AIDS ISSUES SHOULD BE EXPANDED, AS IT IS ESSENTIAL TO THE SUCCESSFUL IMPACT OF USG ASSISTANCE ACROSS THE REGION. (LEAD: AMBASSADOR

UNCLASSIFIED

UNCLASSIFIED

PAGE 04 HARARE 07005 12 OF 13 170952Z
KRUEGER, AMBASSADOR PETERSON, STACY RHODES AND EDWARD SPRIGGS)

--ESTABLISH SHARED VISION AMONG POSTS FOR CROSS-BORDER BILATERAL ACTIVITIES FROM CONGO TO CAPE TOWN.

--CONTINUE TO SHARE INFORMATION ON USG HIV/AIDS EFFORTS AMONG ALL SOUTHERN AFRICAN POSTS.

--HIRE REGIONAL ADVISOR BASED IN PRETORIA TO GET REGIONAL PROGRAM OPERATIONAL IN NON-PRESENCE COUNTRIES AND KEEP AMBASSADORS IN THE LOOP.

--USAID TECHNICAL STAFF AT SOUTHERN AFRICAN POSTS TO HOLD REGULAR MEETINGS.

(4) EXPAND AVAILABILITY OF U.S. INFORMATION TO FIELD PERSONNEL FOR USE IN HIV/AIDS PROGRAMS IN SOUTHERN AFRICA. PRIMARILY BY TAPPING THE KNOWLEDGE OF U.S. RESEARCH ORGANIZATIONS, RATHER THAN EMBARKING ON NEW USG RESEARCH PROGRAMS. (LEAD: USAID WASHINGTON TECHNICAL TEAM IS REQUESTED TO PROVIDE INFORMATION)

UNCLASSIFIED

NNNN

********** HARARE 7005 - XXSECTION 13 OF 13 **********

N VZCZCAID0301

UNCLASSIFIED

PAGE 01 HARARE 07005 13 OF 13 170953Z
ACTION AF-00

INFO LOG-00 NP-00 AID-00 AMAD-01 CIAE-00 CTME-00
DODE-00
ITCE-00 SRPP-00 EAP-00 EB-00 EXME-00 OTED-00
HHS-01
TEDE-00 INR-00 ITC-01 LAB-01 L-00 ADS-00
NMP-00
NEA-01 NSAE-00 OBS-01 OMB-01 OPIC-01 PER-01
STR-00
IRSE-00 SA-01 DRL-02 SAS-00 /012W
----------106988F 170957Z /38

R 170952Z NOV 99
FM AMEMBASSY HARARE
TO SECSTATE WASHDC 4631
SOUTHERN AFRICAN DEVELOPMENT COMMUNITY
AMEMBASSY KAMPALA
AMEMBASSY KINSHASA
AMEMBASSY NAIROBI
INFO AMEMBASSY NEW DELHI
AMEMBASSY JAKARTA
AMEMBASSY KUALA LUMPUR
AMEMBASSY BANGKOK
AMEMBASSY BEIJING
NSC WASHDC
DEPT OF LABOR WASHDC

USDOC WASHDC
CDC ATLANTA GA
DEPT OF HHS WASHDC

UNCLASSIFIED

UNCLASSIFIED

PAGE 02 HARARE 07005 13 OF 13 170953Z
UNCLAS SECTION 13 OF 13 HARARE 007005

DEPT FOR AF/S, AF/EPS, OES, AND DRL
NSC FOR SENIOR AFRICA DIRECTOR GAYLE SMITH
WHITE HOUSE FOR ONAP DIRECTOR SANDY THURMAN
DOL FOR ILAB/ROBERT SHEPARD
USDOC FOR DMENKE-ROGERS
NAIROBI FOR REDSO
AFRICAN POSTS FOR AMBASSADORS AND USAID MISSION DIRECTORS
CDC FOR DR. HELENE GAYLE
HHS FOR SECRETARY DONNA SHALALA

PASS USAID WASHDC FOR AA/AFR, DAA/AFR NEWTON AND AFR/SA M/HR, LINDA LION
STATE DIRECTOR GENERAL AMBASSADOR GRAHM
PASS DHHS/NIH/FIC FOR SHARON HRYNKOW

E.O. 12958: N/A
TAGS: THIO, EAID, SOCI, ZI
SUBJECT: AIDS IN SOUTHERN AFRICA: AMBASSADORS AND USAID MISSION DIRECTORS REAFFIRM OUR REGIONAL COMMITMENT

--ESTABLISH MORE RELIABLE STATISTICS ON THE PARAMETERS OF THE PANDEMIC AND THE CONTRIBUTIONS OF HOST COUNTRIES TO HIV/AIDS PROGRAM.

--EXPLORE AND ADVISE ON THE NATURE OF SUB-TYPE 'C' OF THE HIV/AIDS VIRUS (THE PREDOMINANT STRAIN IN SOUTHERN AFRICA), HOW IT RELATES TO VACCINE DEVELOPMENT, AND THE EFFICACY AND SAFETY OF NAVIRPINE FOR REDUCTION OF MOTHER-

UNCLASSIFIED

UNCLASSIFIED

PAGE 03 HARARE 07005 13 OF 13 170953Z
TO-CHILD TRANSMISSION.

--ASSESS BEST STRATEGIES FOR ALLOCATION OF USG RESOURCES VIS-A-VIS ALTERNATIVE INTERVENTIONS IN PREVENTION (INFORMATION AND EDUCATION); VOLUNTARY COUNSELING AND TESTING (VCT); LONG-TERM CARE AND SUPPORT; AND INNOVATIVE APPROACHES FOR CARE OF CHILDREN WHOSE PARENTS WHO HAVE DIED FROM AIDS.

file AIDS

Richard Socarides 09/12/99 01:47:11 PM

Record Type: Record

To: Sandra Thurman/OPD/EOP@EOP, Todd A. Summers/OPD/EOP@EOP, Katharine Button/WHO/EOP@EOP

cc:
Subject: RE:White White House Meeting on Global AIDS with Mrs. Clinton and Others

---------- Forwarded by Richard Socarides/WHO/EOP on 09/12/99 01:51 PM ----------

GlobalAIDS@aol.com
09/11/99 10:30:06 PM

Record Type: Record

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

cc:
Subject: RE:White White House Meeting on Global AIDS with Mrs. Clinton and Others

---

To: AIDS Activists Concerned with US Global AIDS Policy

From: Paul Boneberg
Global AIDS Action Network (GAAN) 202-667-6300

RE: White House Meeting on Global AIDS with Mrs. Clinton and Others

Date: September 11, 1999

Friends and Colleagues-

This is a brief report on this week's meeting at The White House concerning US global AIDS policies and programs. It is not our intent to give a comprehensive report here, only the informal perspective of one community group that was in attendance in the hope that this is useful to other organizations. I attach below the USAID report on the same meeting and will try not to repeat the points made there.

This meeting, held in the west wing of the White House and chaired by the First Lady, represented the first time some key policy makers discussed the pandemic and provided a glimpse into thinking at the highest levels of the Clinton administration. In GAAN's opinion the most important aspect of the meeting was that it occurred at all, not the content. Further within the discussion what was most important was not the fairly formal statements but what was not said.

In attendance were perhaps 35 individuals including: World Bank President James Wolfensohn, Secretary of the Treasury Lawrence Summers, Secretary of HHS Donna Shalala, USAID Administrator Anderson, ONAP Director Sandy Thurman and UNAIDS head Peter Piot as well as other key administration officials. Also present were several key foundations, one pharmaceutical company (Bristol Meyers Squib), one television company (Black Entertainment Television) and a few others including three NGOs: Global AIDS Action Network, National Association of People with AIDS, and International AIDS Vaccine Initiative. (See the USAID list below.) About half of those in attendance were seated at a large table with the other half in chairs against the walls. All seating was assigned and the NGOs were not placed at the table, but rather seated directly behind Mrs. Clinton, Secretary Summers, and Mr. Wolfensohn.

The purpose of the meeting was to further the administration's effort to expand US global AIDS activities including $100,000,000 in increased funding called for by the Vice President in July 1999. In this sense the meeting was a success before it began since it represented a follow-through by the highest levels of the administration to increase the American response to AIDS. Clearly the attendees were chosen with a focus on funders--Treasury, the World Bank, and the foundations-- to secure commitments of increased support.

Mrs. Clinton made a strong opening statement about the US commitment and the need to secure the administration's proposal for increased funding. Mrs. Clinton then called on key individuals for their perspectives and proposals beginning with Dr. Piot, and continuing with Secretary Shalala, Dr. Satcher, Secretary Summers, and Mr. Wolfensohn.

The presentations by Piot, Shalala, and Satcher were excellent (they are outlined in the USAID memo below). Secretary Summers, in the first public remarks on global AIDS by any Treasury Secretary, spoke in some depth about the seriousness of the problem, the need for increased commitment, and his strong concern that funds provided be well spent. Mr. Wolfensohn made a strong statement regarding the World Bank's commitment and referred to a possible new mechanism to expedite provision of AIDS funds to nations seeking them. He also indicated that the Bank could have done better in responding to the pandemic and intends to strengthen its efforts. This was the only indication by any agency at the meeting that they recognized that their past AIDS activities were inadequate.

We were now well into the meeting and three key things have emerged:

1. Although the meeting is addressing a vital foreign policy and development issue, neither the Department of State nor USAID have spoken much less laid out their vision of the US response. Leadership is being provided instead by the health and finance experts.
2. Although there is clear recognition of the severity of the pandemic, there is no recognition that the US response has been grossly inadequate.
3. There is ongoing reiteration that much of the problem rests with the unwillingness of affected nations to address the seriousness of the problem, thus limiting the ability of the US to increase its response.

Moving formally--via recognition by Mrs. Clinton--others now made statements about how they see the pandemic and their institution's response. This discussion is reiterated in the USAID summary below, but GAAN would make three observations:

--It was extremely discouraging that the Department of State made no mention of human rights in discussing their role in response to the pandemic. This confirms our perception that they have paid no attention to the human rights ramifications of dramatically expanded AIDS programs, particularly HIV testing.

--The plan outlined by Black Entertainment Television to mobilize TV stations and advertisers in Africa was visionary and credible, by far the most clear proposal made during the entire discussion.

--The foundations present made few specific commitments that were not previously known, but clearly are energized and committed to an increased response to the pandemic. They should be flooded with concepts and proposals by community groups as to how to effectively fund increased global AIDS activities.

At this point we were well over an hour into the meeting and the discussion had become a bit less formal with people at the table raising their hands and being recognized by Mrs. Clinton. I realized that not only were community groups not at the table holding the discussion, but also we were seated in such a way that it would be impossible to raise our hands and be seen by the First Lady. I felt that the discussion needed a community voice and therefore interrupted the discussion by saying "Mrs. Clinton! May I say something from a community perspective?" She replied affirmatively and turned to face us, as did that entire side of the table. I spoke for perhaps three minutes and tried to make three points:

1. The US response to the global AIDS pandemic has been a failure. It is not been simply a weak response that needs to be improved, but one that has failed to fundamentally grasp the magnitude of the problem.
2. This failure has occurred because the US foreign policy apparatus has not fully engaged itself in responding to the AIDS pandemic. Although the proposed increase of $100,000,000 is essential and other efforts to increase action worthy of support, unless the US fundamentally changes its foreign policy to prioritize AIDS and health our efforts will remain inadequate. GAAN and other community groups do not believe that these priorities have been adopted.
3. American AIDS activists care deeply about global AIDS issues and are seeking to increase the US response. Although this sometimes upsets the administration, these are Americans who want only to improve US foreign policy. The administration should not exclude these voices, but find a way to bring them into the discussion.

It had been my desire not to disrupt the meeting, but to alter the tone that "we have done well, but now we'll do better". I wanted to clearly state that while some leaders of affected nations may be in denial about the pandemic, the same is true of American foreign policy leaders. GAAN believes the US response is not just weak, it is failing, and I wanted to interject some sense of urgency and passion into the debate.

Mrs. Clinton replied that she and her husband had tried to prioritize AIDS, but that it was made extremely difficult when leaders of affected nations refused to even engage in the discussion. Secretary Shalala replied that I

was wrong that health was not being prioritized within foreign policy because she felt that increasingly it was. Secretary Summers responded most articulately making two points:
1. AIDS activists are right to criticize the administration for not doing more on global AIDS, but we needed to also criticize others (i.e. -the congress) and help build a national commitment for an overall increase in foreign assistance.
2. Despite our passion and commitment to the issue, American AIDS activists needed to recognize that we can not care more about the problems of other nations then do the people in those nations themselves.

It was difficult not to respond to these comments, but I felt it was inappropriate to engage in dialog with those speaking and waited to see if there would be time to reply. As it turned out there were a few more comments, most notably from Seth Berkley of IAVI on the need for increased efforts to develop vaccines that would clearly be effective in southern nations. Sandy Thurman summarized the meeting and we adjourned.

As is often the case the most interesting discussion occurred now that the meeting was over. Mrs. Clinton was, of course, seated three feet in front of Terry Anderson from NAPWA and myself so as she began to leave we engaged her in five minutes of further discussion. Besides thanking her for including us in the meeting we indicated that NORA agreed with Secretary Summers remarks regarding the need to increase overall foreign assistance, but that it was difficult to organize support when the administration has never sought to increase funding for global AIDS programs. (NORA is National Organizations Responding to AIDS an AIDS policy coalition of some 150 groups.) She seemed a bit perplexed at this so we asked directly: "You do know that USAID has not sought an increase in global AIDS funding since 1993? The funding has remained level for the last seven years."

She replied that she did not know this and called over Sandy Thurman to ask if it was correct that USAID had not sought to increase global AIDS programs since 1993. Sandy replied that yes funding had been basically level since 1993. Mrs. Clinton seemed startled by this and called over Donna Shalala to ask the same question and received the same answer. Both Terry and I were persuaded that the First Lady, who is perhaps USAID's foremost champion in the administration, was unaware that the agency had not sought to increase its global AIDS funding.

The group slowly broke up. I was able to briefly raise concerns about human rights with Mrs. Clinton as well as ask Secretary Summers if he would meet with AIDS groups about the role Treasury. (He agreed Treasury would meet, but wouldn't commit to a personal meeting.) Many others also used the few minutes after the meeting to arrange meetings and make contacts as well.

As I stated in the beginning of this memo, although the meeting itself was interesting, the most important point was that it happened at all. Clearly the First Lady herself has weighed in to support the $100,000,000 global AIDS initiative and in response the highest levels of the US government and others are seeking to increase their commitment.

GAAN is now engaged in an all-out effort to support the administration's new global AIDS initiative. We will also continue to speak out over the lack of

vision and commitment from the principle vehicles of US foreign policy: the Department of State and USAID, which heretofore have been woefully inadequate in their response to the pandemic. (By this we do not mean the excellent small teams that run current global AIDS programs, but the past leadership of these large agencies which not only not sought no expansion, but actually neglected AIDS programs shamefully.)

We urge American AIDS groups who care about global AIDS issues to stay informed and seek to improve the US response to the pandemic. For more information or to comment please reply to globalaids@aol.com or contact Paul Boneberg at GAAN 202-667-6300.

(USAID meeting Report)

Subj: [233] White House global AIDS meeting
Date: 9/9/99 7:28:45 PM Eastern Daylight Time
From: intaids@hivnet.ch (INTAIDS - Paul Zeitz)
Sender: intaids@hivnet.ch (Intaids Moderator)
Reply-to: intaids@hivnet.ch
To: intaids@hivnet.ch (Intaids)

The following participated in a 90 minute meeting on 7 September 1999 at the White House to discuss how to accelerate and increase the response to the global AIDS pandemic

1. Hillary Clinton, First Lady of the United States
2. Ms. Sandra Thurman, Director of the White House Office for National AIDS Policy
3. Mr. Leon Feurth, Office of the Vice President
4. Mr. Frank Loy, Department of State
5. Ms. Donna Shalala, Secretary of Health, DHHS
6. Dr. Ken Bernard, National Security Council
7. Dr. Larry Summers, Secretary of the Treasury
8. Dr. Peter Piot, Executive Director, UNAIDS
9. Dr. David Satcher, Surgeon General
10. Mr. James Wolfensohn, President, with Jan Piercy, U.S. Executive Director, The World Bank
11. Mr. Stuart Burden, MacArthur Foundation
12. Mr. Gordon Perkin, Gates Foundation
13. Dr. Drew Altman, Kaiser Family Foundation
14. Mr. Arya Neier, Open Society Foundation
15. Mr. Tim Evans and Dr. Seth Berkley, Rockefeller Foundation
16. Mr. Charles Heimbold, Chariman and CEO of Bristol Meyers Squibb
17. Mr. Robert Johnson, Black Entertainment Television
18. Mr. Terry Andersen and Mr. Paul Boneberg, North American Organizations Responding to AIDS (NORA)

The First Lady began the meeting by briefly describing the components of the

recently announced LIFE Initiative. Dr. Piot described the current status of the pandemic, but that there were reasons for optimism, including the successes of Senegal and Uganda and the recent improvement in African political commitment. He mentioned five challenges: (1) sustaining the political momentum, (2) adjusting social policy to provide social safety nets, particularly for vulnerable women and youth; (3) we must do things differently and involve a broader array of partners (religious leaders, business, etc); (4) we must strengthen technical capacity; and (5) we must intensify research and development.

There followed a general open discussion. Secretary Donna Shalala stated that while African Presidents were finally understanding the significance of AIDS, Ministers of Finance still had a long way to go. Secretary Larry Summers discussed the need for us to ensure that increased resources are properly spent and don't wind up in Swiss Bank accounts. Mr. Anderson reiterated that USAID has been the lead donor, particularly in Africa and now possess a wealth of technical expertise and partnerships in each country that should be utilized, particularly in the debt relief restructuring, as well as by the Foundations who were new to this issue.
Mr. Wolfensohn reaffirmed the World Bank's emphasis on AIDS in all of its development loans.

Rockefeller Foundation discussed the need to provide health prevention services for the poorest populations, with a focus on research and training. Mr. Frank Loy brought up the multiple "common agendas" that the USG has with other governments and the need to include AIDS prevention in these efforts. Mr Heimbold described the new Bristol Meyers Squibb initiative in southern Africa, "Secure the Future" which involves $100 million over five years for five southern African countries. This initiative will work with Morehouse College, Baylor and Medunsa and will focus primarily on reducing mother to child transmission of HIV. Mr. Robert Johnson of Black Entertainment Television spoke of his experiences in Africa with mass media and communications. He stressed the ongoing cultural reasons for pandemic and the continued denial that exists in Africa. He reported that mass media still has poor penetration in much of sub-Saharan Africa and because Governments control most of the media can have adverse impact.

Drew Altman of the Kaiser Family Foundation presented the Love Life Campaign in South Africa, directed at adolescents. Kaiser will give $2.5 million which will be matched by the South African government. Paul Boneberg from NORA stated that we need a radical change in our foreign policy. Mrs. Clinton replied that in her experience, she had raised the issue of AIDS numerous times with African leaders and that they had rebuffed her. Mr. Summers also defended the foreign policy stand thus far, stating that it is difficult to achieve results if "we care more about a problem than a host country." He went on to lament the woeful underfunding of foreign assistance, at .09% of the US GNP.

Next Steps:

1. The U.S. (USAID and DHHS) and UNAIDS will co-convene a meeting on improving technical resource platforms for Africa.
2. BET will convene a meeting of African and American television managers and advertisers to discuss how to improve public health message communications.

3. All of the partners present will work on the next series of meetings with business leaders, labor unions, religious leaders, etc.
4. MacArthur Foundation will convene a meeting of Foundation directors in Seattle in January. USAID and UNAIDS will participate.
5. USAID and UNAIDS will assist Treasury to more fully explore the use of debt restructuring to increase resources fo AIDS.

Dr. Paul Zeitz
Senior Policy and Technical Advisor for PHN
USAID/Zambia and GRZ/Central Board of Health
tel: 260-1-254-303 fax: 260-1-254-532
home: 260-1-264-700 email: pzeitz@usaid.gov

 - WHITEH~1.DOC

Message Sent To:

vcb3@cdc.gov
Pbhatt@usaid.gov
ncarterf@state.gov
kcavanaugh@usaid.gov
ccortez@usaid.gov
pdelay@usaid.gov
dr.bopper.deyton@mail.va.gov
Keri A. Eisenbeis/OMB/EOP
MElskowitz@aol.com
AFAUCI@niaid.nih.gov
hdg1@cdc.gov
jgayle@worldbank.org
dgillespie@usaid.gov (Gillespie Duff)
EGoosby@osophs.dhhs.gov
mmartin@os.dhhs.gov
mazinraf@paho.org
cmcdermott@usaid.gov
"Neal/OAR"@aol.com
vnewton@usaid.gov
eyates@mailserver.peacecorps.gov
dpiet@usaid.gov
aross@afr-sd.org
rjs4@cdc.gov
Richard Socarides/WHO/EOP
Todd A. Summers/OPD/EOP
Todd A. Summers/OPD/EOP
thurman_s@a1.eop.gov
helen.walsh@treas.sprint.com
rwhitaker@ustr.gov
bzalduondo@usaid.gov
mosullivan@usaid.gov
vbasile@mailserver.peacecorps.gov
pzeitz@usaid.gov

fax A155

White House Sounds Alarm on AIDS Crisis in Africa
Harvard World Health News
September 9, 1999

Boston - First Lady Hillary Rodham Clinton convened a meeting on September 7th, at the White House to mobilize top international health officials amid deepening concern over the unchecked spread of AIDS in sub-Saharan Africa and the epidemic's growing threat to South-East Asia and Eastern Europe.

Reports from Africa describe a catastrophe in the making that threatens an entire generation of children and two decades of economic development. Average life expectancy is plummeting by 20 years in some areas, as aggressive new strains of HIV decimate the continent.

The September 7th meeting with Mrs. Clinton followed the release in July of a little-noticed White House report which warned, "As goes Africa, so will go India, South-East Asia, and the Newly Independent States of the former Soviet Union, and by 2005, more than 100 million people worldwide will have been infected with HIV. Leadership and resources are desperately needed if we are to turn the tide." The report proposes an action plan for mobilizing international leadership and resources.

The report presents findings of a March 27-April 5, 1999, Presidential Mission on Children Orphaned by AIDS in sub-Saharan Africa, and paints a grim picture of the situation facing children. In nine countries, between one-fifth and one-third of all children will be orphaned by AIDS by the end of this year, rendering them at "extraordinary risk of physical and sexual abuse as well as child labor exploitation" and subsequent HIV infection. Over the next decade, the report projects, more than 40 million children will be orphaned by AIDS. The report describes fragile health care systems buckling under the weight of the crisis, with AIDS patients already occupying 50-80% of all hospital beds in some areas.

More than 22 million adults and 1 million children in sub-Saharan Africa currently are infected with HIV. Most new infections are occurring among women, and are spreading to newborns during childbirth and breastfeeding. Nearly 600,000 new HIV infections are occurring among infants in the region each year.

The implications of the epidemic are profound and far-reaching, threatening the region's political stability, security, and development. The epidemic is hitting especiall hard at the region's infrastructure--civil servants, teachers, health personnel, engineers, and industrial workers. According to the White House report, companies like British Petroleum and Barclays Bank are hiring two skilled workers for each open position, expecting that one will die of AIDS.

It is the worst infectious disease catastrophe since the Bubonic plague in 1348. Its rapid spread is fueled by cultural norms and sexual practices. A major piece in The Economist (Jan. 1999) described the widespread acceptance of commercial sex workers; resistance to using condoms; adolescent girls who believe they will only become beautiful through a regular infusion of sperm; and men who believe they can rid themselves of HIV by infecting a virgin.

The Economist observed, "HIV tends not to strike just one member of a family. Husbands give it to wives, mothers to babies." The Economist correspondent's driver in Kampala lost his mother, his father-in-law, two brothers and their wives to AIDS.

But it is not a situation without hope. Dr. Barry R. Bloom, dean of the Harvard School of Public Health and chairman of the UNAIDS Vaccine Advisory Committee, argues that millions of lives can be saved in the short term through massive social mobilization and education, while research continues to develop effective, affordable vaccines. "In the short term, the critical ingredient is political will and commitment within each country, supplemented by external resources."

Attending the September 7th, White House strategy session were leaders from the World Bank and UNAIDS, heads of foundations, corporate CEOs, and U.S. health officials

Next week, the spotlight shifts directly to sub-Saharan Africa, where 3,500 delegates will assemble in Lusaka, Zambia from September 12 to 16 for the Eleventh International Conference on AIDS and STDs in Africa.

The conference is expected to focus major attention on Uganda, which has mounted an effective response, achieving reversals in HIV infection rates.

The Mail and Guardian (Johannesburg) reports, "Uganda's President Yoweri Museveni has personally spearheaded an ambitious country-wide initiative to spread the word about HIV. Shortly after coming to power in 1986 after Uganda's brutal civil war, Museveni rapidly masterminded a multi-pronged strategy to combat the disease."

Citing Uganda's experience, Dean Bloom observed, "While it is difficult to affect longstanding patterns of behavior in any society, amazingly enough, education has had an impact. In Africa, Uganda has done the most in terms of massive publicity and community mobilization to educate the public and reduce the stigma associated with HIV infection. Most importantly, the government has openly recognized the AIDS problem, and has aggressively supported disease prevention efforts including condom distribution, HIV testing, counseling and support services, and widespread mobilization of women's groups and community groups.

In 10 years of massive public health mobilization, HIV infection rates in some districts have been reduced from 25% to 13%."

South Africa's new President, Thabo Mbeki, has made AIDS a top priority. In October 1998, while still Deputy President, Mr. Mbeki, in a speech launching the South African Partnership Against AIDS, said, "For too long we have closed our eyes as a nation, hoping the truth was not so real. For many years, we have allowed the human immunodeficiency virus to spread at times we did not know that we were burying people who had died from AIDS. At other times we knew, but chose to remain silent.

"Now we face the danger that half of our youth will not reach adulthood. Their education will be wasted. The economy will shrink. There will be a large number of sick people whom the healthy will not be able to maintain. Our dreams as a people will be shattered."

Last month, South Africa's new Health Minister, Dr. Manto Tshabalala-Msimang, led a 23-person delegation to Uganda and signed a joint agreement to cooperate on prevention of mother-to-child HIV transmission, drug research, procurement and distribution, HIV surveillance, and the development of HIV vaccines.

Over the long term, everything depends on the invention of effective and affordable vaccines to prevent either HIV infection or the development of clinical AIDS.

Dean Bloom, a leading immunologist, commented on the challenge confronting researchers: "HIV is not a single type of virus, like polio or measles. It is constantly changing as it is being attacked by the immune system necessitating the development of complex, so-called 'cocktail' vaccines. In the long run, I am optimistic that affordable vaccines will be developed. They are unlikely to be as effective as the polio and measles vaccines, but even if the vaccines are only 50% effective, they will save millions of lives.

"Developing and testing vaccines will require genuine scientific collaboration with colleagues in Africa and Asia and with the industry that produces them," he said. "The industrialized world has not previously made a commitment on a scale that this crisis demands. What is required is a different kind of globalization--a spirit of international cooperation in which every life is given equal value."

---

file AIDS
So Africa

THE HENRY J. KAISER FAMILY FOUNDATION

VIA FACSIMILE

August 19, 1999

DREW E. ALTMAN, PH.D.
PRESIDENT AND CHIEF EXECUTIVE OFFICER

Ms. Melanne Verveer
Office of the First Lady
Room 100 OEOB
Washington, DC 20500

Dear Ms. Verveer, MELANNE,

On Monday, before the White House event on *Children and Violence,* the First Lady and I discussed her upcoming meeting on HIV in southern Africa. I promised to send some further information to you for the First Lady on a new national HIV Prevention initiative we have organized in South Africa. Since that time I know you have spoken with Ambassador Joseph about the initiative and his proposal for an announcement at the September 7th event. We think Ambassador Joseph's proposal would be a plus for everyone and I address it below.

First some background. The Kaiser Family Foundation first got involved in South Africa in 1987 when the late Congresswoman Barbara Jordan, then a Foundation trustee, suggested the Foundation develop a South Africa program. South Africa remains the Foundation's only commitment outside of the United States and over the years we have become major players there.

Our newest major effort is the National Adolescent Sexual Health Initiative (NASHI). NASHI is South Africa's first comprehensive HIV prevention effort for youth. Organized by the Foundation over the past eighteen months, NASHI brings together South Africa's national and provincial departments of health and non-governmental and corporate sectors in one coordinated national effort. The initiative is overseen by a distinguished national advisory board chaired by South Africa's First Lady, Zanele Mbeki, and directed on a day-to-day basis by a national coordinator and staff. Funding for NASHI is administered by the Health Systems Trust. The Trust is a highly respected non-governmental organization established to lead the process of planning for the restructuring of South Africa's public health system with funding from the Foundation, the South African government and the European Commission.

NASHI's ambitious goal is to achieve a fifty percent reduction in the incidence of HIV among young South Africans over the next five to ten years. To accomplish that, South Africa's entertainment and news media has been mobilized on an unprecedented scale to spread the HIV prevention message, and a broad array of new services for youth are being established across the country, including adolescent centers, hotlines, and peer groups.

NASHI will be launched with an initial $2.5 million commitment from the Foundation. A matching commitment is expected soon from the South African government and substantial additional funds are also expected from other sources. Many of South Africa's leading celebrities have added their voices to the campaign. The South African Broadcasting Corporation (SABC) has also made a major commitment of air time and many leading South African corporations are making substantial in-kind contributions.

NASHI represents a unique model of public/private sector and U.S./South African collaboration to stop the spread of HIV. With that in mind, I believe Ambassador Jim Joseph has written to you and Sandy Thurman suggesting a $10 million commitment in new U.S. AIDS prevention funding for NASHI, with matching funds provided by our Foundation. We think this is a critically important effort and with $5 million already committed by the Foundation and the South African Government, we would be pleased to commit to provide and/or raise the remaining matching funds. Indeed, we are confident that matching funds in excess of $10 million can be provided.

Ambassador Joseph further suggested that the effort and funding partnership could be announced at your upcoming September 7th conference. We would also be comfortable with that. I will also be in Johannesburg on September 15th with my Board of Trustees to announce NASHI. That occasion would provide a further opportunity, in South Africa, to call attention to the effort and the U.S. commitment to HIV prevention in South Africa.

If this is of interest to you or you would like to explore this further please don't hesitate to give me a call. I am in Washington on an almost weekly basis and would also be happy to participate in any meeting that would be helpful. The director of our South Africa program, Dr. Michael Sinclair, is based in our D.C. office and is also available on short notice.

Thank you for your attention to this matter. Please thank the First Lady again for me for her support for the *Talking With Kids About Tough Issues* campaign and her participation in Monday's White House event.

Best wishes,

Drew E. Altman, Ph.D.

DEA/mo

Cc: James A. Joseph, U.S. Ambassador to South Africa
Sandra Thurman, Director, Office of National AIDS Policy