Case Number: 2007-1550-F

FOIA MARKER

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Folder Title:
Dempsey-AIDS [1]

Staff Office-Individual:
African Affairs-Byrne, Cathy/Dempsey, Nora/Battenfield, Patricia

Original OA/ID Number:
3078

Row:	Section:	Shelf:	Position:	Stack:
29	4	3	2	V

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001a. fax	Fax coversheet from Kenneth Bernard to Frank Loy, et al. [partial] [10 U.S.C. 424] (1 page)	05/02/2000	P3/b(3)
001b. memo	Kenneth Bernard and Sandra Thurman to Leon Fuerth, et al., re: Interagency Working Group on the Global AIDS Crisis [partial] [10 U.S.C. 424] (0 page)		P3/b(3)
~~001c. paper~~	~~Interagency Working Group Consensus Paper (13 pages)~~	~~04/28/2000~~	~~P1/b(1)~~ KBH 10/21/2024
~~002. memo~~	~~Kenneth Bernard to Secretary Shalala and Sandra Thurman, re: French Proposal for a Conference on Access to HIV/AIDS Drugs (3 pages)~~	~~06/02/2000~~	~~P1/b(1)~~ KBH 10/21/2024
003. letter	Terje Anderson to Henry DuToit [partial] (1 page)	ca. 05/2000	P6/b(6)

COLLECTION:

Clinton Presidential Records
National Security Council
African Affairs (Byrne, Cathy/Dempsey, Nora/Battenfield, Patricia)
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FOLDER TITLE:

Dempsey - AIDS [1]

2007-1550-F
ke2005

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]
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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]

Byrne, Catherine E. (AF)

From: WHSR
Sent: Tuesday, November 28, 2000 6:04 AM
To: Babbitt, James F. (VP); Bernard, Kenneth W. (HEALTH); Byrne, Catherine E. (AF); Efros, Laura L. (NEC); Harris, Grant T. (AF); Smith, Gayle E. (AF)
Subject: FACTS AND FIGURES ABOUT AIDS IN AFRICA

Classification: UNCLASSIFIED
Distribution: SIT: BABBITT BERNARD BYRNE EFROS HARRISG SMITH
Identifier: R239eab0
Originator: Reuters
Precedence: RUSH
TimeOfReceipt: 11/28/2000 07:03:38 ET

a1122
^BC-HEALTH-AIDS-AFRICA-FACTBOX (EMBARGOED)
^Facts and figures about AIDS in Africa
(Release at 1300 GMT Nov 28)

NAIROBI, Nov 28 (Reuters) - The following are some facts and figures about the AIDS epidemic in Africa as issued by the United Nations ahead of World AIDS day on December 1.

- The total number of Africans living with HIV or AIDS is now 25.3 million out of 36.1 million cases worldwide. Africa is home to 70 percent of adults and 80 percent of children living with HIV.
- More than 15 million Africans have died of AIDS-related diseases out of 20 million global deaths.
- There are 12 women living with HIV for every 10 infected men in Africa. African women in their early twenties are three times more likely to be infected than men.
- Public health spending on AIDS exceeds two percent of gross domestic product in Africa. In South Africa, GDP is expected to be 17 percent lower in 2010 than it would have been without AIDS and wipe $22 billion from the economy.
- In Botswana, some 35.8 percent of adults are infected with HIV and the rate has more than tripled since 1992.
- In Zimbabwe, life expectancy has shrunk from 66 years to 43 as a result of AIDS.
- More than one in four Zambians living in urban areas is HIV positive.
- Over 70 percent of hospital beds in Burundi are taken by AIDS patients.

RB-- 11/28/00 07:01:47

Cooper, Colby J. (AF)

From: Efros, Laura L. (NEC)
Sent: Tuesday, November 21, 2000 7:16 PM
To: Bradtke, Robert A. (EXSEC); Smith, Gayle E. (AF); Samans, Richard (INTECON)
Cc: @AFRICA - African Affairs
Subject: Religious leaders list for World AIDS Day event [UNCLASSIFIED]

I'm forwarding you Sandy Thurman's list of religious leaders for the World AIDS Day event on the unclass system. They are mostly Africans, but let me know if you would like me to send it around to other regional directorates, multilat, etc. My understanding from Loretta's meeting is that only the South African archbishop would have a speaking role during the POTUS event, and that the others would only interact with the President if there's some kind of receiving line. The entire group would also participate in a religious leaders conference on AIDS at USAID and an inter-denominational service led by Andy Young.

A CONSENSUS FROM CONSCIENCE: REVEALING THE ROLE OF FAITH IN RESPONSE TO AIDS
White House World AIDS Day Summit 2000
November 30 - December 1, 2000

Speakers and Domestic Invitees List

1. Speakers

Stephen L. Carter, J.D.
William Nelson Cromwell Professor of Law
Yale University
New Haven, CT 06520
Tel: 203-432-4830
Fax: 203-243-4871

Ambassador Andrew Young
GoodWorks International, LLC
303 Peachtree St NE Suite 4420
Atlanta, GA 30308 USA
telephone: 404.524.5700
fax: 404.527.3827

Elie Wiesel
The Elie Wiesel Foundation for Humanity
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Rollins School of Public Health
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Tel: 404-727-1038
Fax: 404-727-8436

2. US Denominational and Other Religious Leaders

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Minneapolis, MN 55405
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Fax: 612-377-6630

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Rainbow/PUSH Coalition
208 S. LaSalle Street
Suite 1277
Chicago, IL 60604
Tel: 773-373-3366
Fax: 773-373-3571
Fax: 202-728-1192 (Lydia Watts)

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Founder
The King Center
449 Auburn Avenue
Atlanta, GA 30312
Tel: 404-526-8900
Fax: 404-524-7245

The Reverend Dr. Robert Franklin
President
Interdenominational Theological Center
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Tel: 404-527-7702
Fax: 404-527-7770

The Reverend Dr. Leon Sullivan
Chairman
Peoples Investment Fund for Africa
5040 East Shea Blvd.
Phoenix, AZ 85254-4610
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Fax: 602-443-1824

The Most Reverend Frank Tracy Griswold

Presiding Bishop and Primate
The Episcopal Church, USA
Episcopal Church Center
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Fax: 212-490-3298

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The Reverend Clifton Kirkpatrick
Stated Clerk
Presbyterian Church USA
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Louisville, KY 40202
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Fax: 502-569-5018

Sullivan Robinson
The Congress of National Black Churches
1225 Eye Street, N.W., Suite 750
Washington, DC 20005
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Bishop Felton E. May
Superintendent
Washington Baltimore Conference
United Methodist Church
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Fax: 410-309-9436

The Reverend Richard Cizik
National Association for Evangelicals
Office for Governmental Affairs
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Washington, DC 20036
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Fax: 202-842-0392

The Reverend William Shaw
National Baptist Convention
Fax: 215-474-3332

The Right Reverend Vashti McKenzie
Presidng Prelate, 18th Episcopal District
African Methodist Episcopal Church
South Africa
Ph: 266-310-548
Fax: 266-320-869
Also Fax Ms. Travis:410-869-9160

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Starrting School for the Ministry
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Berkeley, CA 94709
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Fax: 510-845-6273

The Reverend Altagracia Perez, S.T.M.
Church of Saint Phillip the Evangelist
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Los Angeles, CA 90011
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Fax: 323-232-0018

The Reverend Joseph Hough
President
Union Theological Seminary
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Fax: 212-280-1416

The Reverend Chandler Owens

The Reverend Canon Ted Karpf
Episcopal Diocese of Washington
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Mount St. Alban
Washington, DC 20016
202-537-6531
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tkarpf@cathedral.org

The Reverend Robert Vitello
U.S. Catholic Conference
Catholic Campaign for Human Development
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Ph: 202-541-3367
Fax: 202-541-3329

The Reverend Sherman Hicks
First Trinity Lutheran Church
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Dr. Sayyid Syeed
General Secretary
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FAX 317-839-1840

The Reverend Kenneth Prunty
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303-465-9250
(no fax)

Bishop P.D. Jakes
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Dallas, TX 75236
214-331-0954
FAX 214-333-6497

3. Faith-Based Development Organization Representatives

3.a. Denominational Development Organizations

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President
Adventist Development and Relief Agency
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Silver Spring, MD 20904
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FAX 301-680-6370

Mr. Iqbal Noor Ali
Chief Executive Officer
Aga Khan Foundation USA
1901 L Street NW Suite 700
Washington, DC 20036
202-293-2537
FAX 202-785-1752

The Right Reverend John Ricard
Bishop of Pensacola and Chairman, Catholic Relief Services
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Pensacola, FL 32522
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FAX 850-436-6424

Sister Ann Duggan
AIDS Coordinator
Catholic Relief Services
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FAX 410-234-3178

Sandra Swan
Executive Director, Episcopal Relief and Development
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FAX 212-983-6377

Susanne Riveles, PhD
Director, Africa Campaign, Lutheran World Relief
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Baltimore, MD 21230-3850
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Fax 410-230-2882

Captain Ian Campbell
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International Headquarters
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FAX 011-[44] 20 7236 4981
011-44-207-332-8080
FAX 011-44-207-

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General Board of Global Ministries, United Methodist Church
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(212) 870-3606
FAX (212) 870-3748

Marian McClure
Director Worldwide Ministries Division
Presbyterian Church, USA
100 Witherspoon Street
Louisville, KY 40202
Ph: (502) 569-5000
Fax: 502-569-8039

3.b. Non-denominational/Interfaith Development Organizations (alphabetically by *organization* name)

Ted Barnett, Ed.D.
US Director
Africa Inland Mission
P. O. Box 178, Pearl River, NY 10965
Tel 914-735-4014
Fax 914-

Church World Service

Paul Derstine
President
Interchurch Medical Assistance
College Avenue Box 429
New Windsor, MD 21776
410-635-8720
FAX 410-635-8726

Michael Nyenhuis
President and CEO
Medical Assistance Programs (MAP) International
P.O. Box 215000

Brunswick, GA 31521-5000
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912-280-6633
FAX 912-265-6170

The Reverend Franklin Graham
Chief Executive Officer and Chairman of the Board
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FAX 828-262-0836

Richard Stearns
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FAX 253-815-3447
email rstearns@worldvision,org

4. US AIDS Leaders

Your list

5. Others

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CDC National Prevention Information Center
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Pernessa C. Seele

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212-614-0057

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Fax: 310-206-4310

The Honorable Imam W. Deen Mohammed
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Calumet City, IL 60409

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A Consensus from Conscience: Revealing the Role of Faith in Response to AIDS
White House World AIDS Day Summit 2000
November 30 – December 1, 2000
Washington, DC

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Mr. Jean Sossaminou
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Father Orlando Navarro
San Jose, **Costa Rica**
Ph: 506-219-6531
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Email: cecoders@sol.racsa.co.cr

AUG.15.2000 4:29PM DOD OSD/P ISA AFR

Nora Dempsey

Approved 15/8/00 BMC

DRAFT DOD TALKING POINTS FOR POTUS TRIP TO NIGERIA

- I am pleased to announce that the USG will send a Defense team to Abuja in September to begin planning for Nigerian military participation in our LIFE program.

- The thrust of our military programs is in the areas of prevention, training and education assistance, designed specifically to reduce the HIV prevalence rate in the Nigerian defense forces.

- In addition, our Department of Defense, in conjunction with other federal agencies, will work hard to extend existing international programs into the Nigerian Defense Force including support to family members, hospice care and demobilized forces.

OPTIONAL FORM 99 (7-90)

FAX TRANSMITTAL # of pages ► 1

To Ken Bernard	From D. Hamon
Dept./Agency NSC	Phone #
Fax # 202 456 9390	Fax #

NSN 7540-01-317-7368 5099-101 GENERAL SERVICES ADMINISTRATION

U.S. Department of Labor

FAX TRANSMISSION

DEPUTY UNDER SECRETARY FOR INTERNATIONAL LABOR AFFAIRS

200 Constitution Ave, N.W.
Washington, D.C. 20210
Telephone: (202) 693-4770
Facsimile: (202) 693-4780

To: Lauren Tabak Date: 8/4/00

Fax Number: 456 9260 Number of Pages 6 (Including Cover Sheet)

From: MacArthur DeShazer

Subject:

COMMENTS:
the revised deliverable event sheets are attached, including the HIV/AIDS piece. Mac DeShazer will be the DOL representative at NSC Nigeria prep meetings.
All deliverables are funded out of DOL's current or FY 2001 funds.

HIV/AIDS - Lagos or Kano

U.S. DEPT. OF LABOR POTUS NIGERIA VISIT
RECOMMENDATION FOR HIV DELIVERABLE

1. Theme: Workplace-based HIV/AIDS Education and Prevention

2. Deliverable: Announcement of a $500,000 USDOL project to initiate workplace-based HIV/AIDS education and prevention, working with Nigerian labor unions, employers, and the Ministry of Labor.

- Although official estimates estimate Nigeria's HIV seropositivity rate at 5.4%, some health experts put the rate at double that figure. Some areas in Nigeria are already showing 21% seropositivity rates in pregnant women. Intervention in Nigeria's HIV/AIDS epidemic at this critical, early stage could help prevent levels from soaring to those rates now seem in southern Africa, which could have serious repercussions for the entire west African region.

- President Obasanjo has recently identified the need for stronger protection against discrimination in the workplace based on HIV seropositivity. This signals a high-level awareness of and commitment to the crisis and to the importance of this particular aspect of the problem..

- Fear of discrimination and social stigmatization are among the most serious obstacles to affecting behavior change pertaining to HIV. The workplace is one of the most powerful platforms from which one can work to confront the stigma issues, by helping ensure financial and social stability to individuals with AIDS. It is also an ideal site from which to perform education efforts for at-risk adults.

- Trade unions are among the more robust elements of civil society in Nigeria, and can provide a strong foundation for developing a program. This also offers an opportunity to partner with employers, giving the program sustainability; collaboration with the Ministry of Labor will afford the chance to help build capacity in one of Nigeria's neglected and troubled government institutions.

3. Event: The President will visit an apparel assembly plant to announce the launching of a workpace-based HIV/AIDS education and prevention project in Nigeria. POTUS will meet with labor leaders, employers representatives, Ministry of Labor officials, and representatives of the Nigerian Network of Persons Living with HIV/AIDS. The President will acknowledge in his remarks the critical need for partnerships between unions and employers, public and private sector, and Nigerian and international institutions to combat HIV/AIDS. He will discuss workplace's ability to become a powerful tool for fighting discrimination and stigma, and for furthering education efforts. The apparel plant will also serve as an effective visual backdrop for the recently passed Africa Growth and Opportunity Act (AGOA), which stressed apparel production. The project will have the opportunity to connect with ongoing projects of USAID on HIV in Nigeria, and address linkages between HIV and trade, as spelled out in the AGOA.

4. Location: Unionized apparel assembly plant in Kano.

5. Time Needed for the Event: 45 minutes

6. Funding: $500,000 allocated against DOL's FY2001 bilateral funding, if approved.

7. Contact: MacArthur DeShazer, Associate Deputy Under Secretary, Bureau of International Labor Affairs, U.S. Dept. of Labor, phone: 202-693-4770; fax: 202-693-4780

U.S. DEPARTMENT OF LABOR DELIVERABLE
Nigerian Labor Exchange Program

1. **Theme: Nigerian Labor Exchange Program:**

2. **Deliverable**: Announcement of a $500,000 Labor Exchange program aimed at assisting the Government of Nigeria and the Lagos State Government establish effective and efficient Labor Exchange services in Lagos wthat will serve as a model for the improvement of employment services country wide, as well as provide employment services in Lagos on a pilot basis.

3. **Event: No specific event**

4. **Location: Not applicable**

5. **Time needed for event:** Include in POTUS remarks

6. **Contact**: MacArthur DeShazer, Associate Deputy Under Secretary, Bureau of International Labor Affairs, U.S. Department of Labor, Phone: 202-693-4770; Fax: 202-693-4780

U.S. DEPARTMENT OF LABOR DELIVERABLE
Veterans Employment Services

1. **Theme:** **Veterans Employment Services:** To assist the Government of Nigeria establish effective and efficient programs that help ease the transition of veterans from the uniformed services to appropriate employment in the civilian workforce.

2. **Deliverable**: Announcement of a $300,000 (DOL bilateral funds)Veterans Employment Services program with the Government of Nigeria to accomplish the following:

- Identify cost-effective and efficient strategies to prepare depaarting service members for civilian employment.
- Establish the Nigerian Armed Forces Resettlement Center at Oshodi as a model veterans' outplacement center.
- Assist with designing a realistically scaled outplacement service – in addition to the Resettlement Center – to assist departing service members find civilian employment.
- Assist in development of a strategy for periodic assessment of Resettlement Center services as to effectiveness, efficiency, continued need and alternatives such as outsourcing.
-

3. **Event: No specific event**

4. **Location: Not applicable**

5. **Time needed for event:** Include in POTUS remarks

6. **Contact**: MacArthur DeShazer, Associate Deputy Under Secretary, Bureau of International Affairs, U.S. Department of Labor, Phone: 202-693-4770; Fax: 202-693-4780

U.S. DEPARTMENT OF LABOR DELIVERABLE
Child Labor

1. **Theme: National Program to Eliminate the Worst Forms of Child Labor:** The program brings Nigeria, for the first time, into the International Labor Organization's International Program on the Elimination of Child Labor (IPEC) to which the U.S. Government contributed $30 million each year for the past two years. Its goals are to strengthening the capacity of the government, non-governmental organizations, and workers' and employers organizations to combat child labor; implementing direct action pilot projects; and increasing public awareness about the hazards of child labor.

2. **Deliverable**: Announcement of a $1 million National Program to Eliminate the Worst Forms of Child Labor.

- The Nigerian First Lady, Ms. Stella Obasanjo is the Honorary Chair of the National Program to Eliminate the Worst Forms of Child Labor. Late last year, she agreed to accept this position during a dialogue with Labor Secretary Alexis Herman. A Memorandum of Understanding (MOU) signing ceremony for this program between the Government of Nigeria and the International Labor Organization/IPEC officials will take place August 8, 2000, in Abuja, Nigeria. The plan of action calls for removal of approximately 3000 children from work and provided with educational opportunities in pilot projects.

- The funds noted above include $718,928 for the National Program to Eliminate Child Labor in Nigeria and $282,613 for a statistical program aimed at generating reliable data on child labor which can be used to develop effective interventions against child labor in Nigeria and to build the national capacity to conduct child labor surveys at regular intervals in the future.

- The project was approved in December 1999, Project Agreement between ILO and the Federal Office of Statistics was signed in January 2000. Preliminary preparatory activities started immediately.

- The pilot test for the Statistical Program was conducted from May 2, - June 2000.

3. **Event: No specific event**

4. **Location: Abuja, Nigeria**

5. **Time needed for event:** Include in POTUS remarks.

6. Contact: MacArthur DeShazer, Associate Deputy Under Secretary, Bureau of International Labor Affairs, U.S. Department of Labor, Phone: 202-693-4770, Fax: 202-693-4780

U.S. DEPARTMENT OF LABOR DELIVERABLE
Industrial Relations

1. **Theme:** **Industrial Relations:** To promote democratic trade unionism, collective bargaining, and conflict resolution in Nigeria

2. **Deliverable**: Announcement of a two year (September 2000 - August 2002), $2 million project to improve the state of industrial relations in Nigeria through training trade unions and employers in relevant labor laws, promotion of collective bargaining, conflict prevention and dispute resolution, and the strengthening of executive and judicial systems responsible for administering national labor law. (DOL/ILAB 1999 bilateral funds that will be obligated in September)

- The prevailing democratic environment in Nigeria provides a unique opportunity to underpin the institutions and processes of industrial relations which have deteriorated and became dysfunctional during the long military dictatorship. This requires measures to help the social partners in rebuilding their organizations and in strengthening their capacity to consult and negotiate agreements, and to resolve disputes.

- Project conducted in collaboration with the International Labor Organization

3. **Event: No specific event**

4. **Location: Not applicable**

5. **Time needed for event:** Include

6. **USAID will add a bullet to the above deliverable -- not yet received by confirmed with Jennifer Winsor!!**

7. MacArthur DeShazer, Associate Deputy Under Secretary, Bureau of International Labor Affairs, U.S. Department of Labor, Phone: :202-693-4770; Fax: 202-693-4780

Nora

FYI

Colby

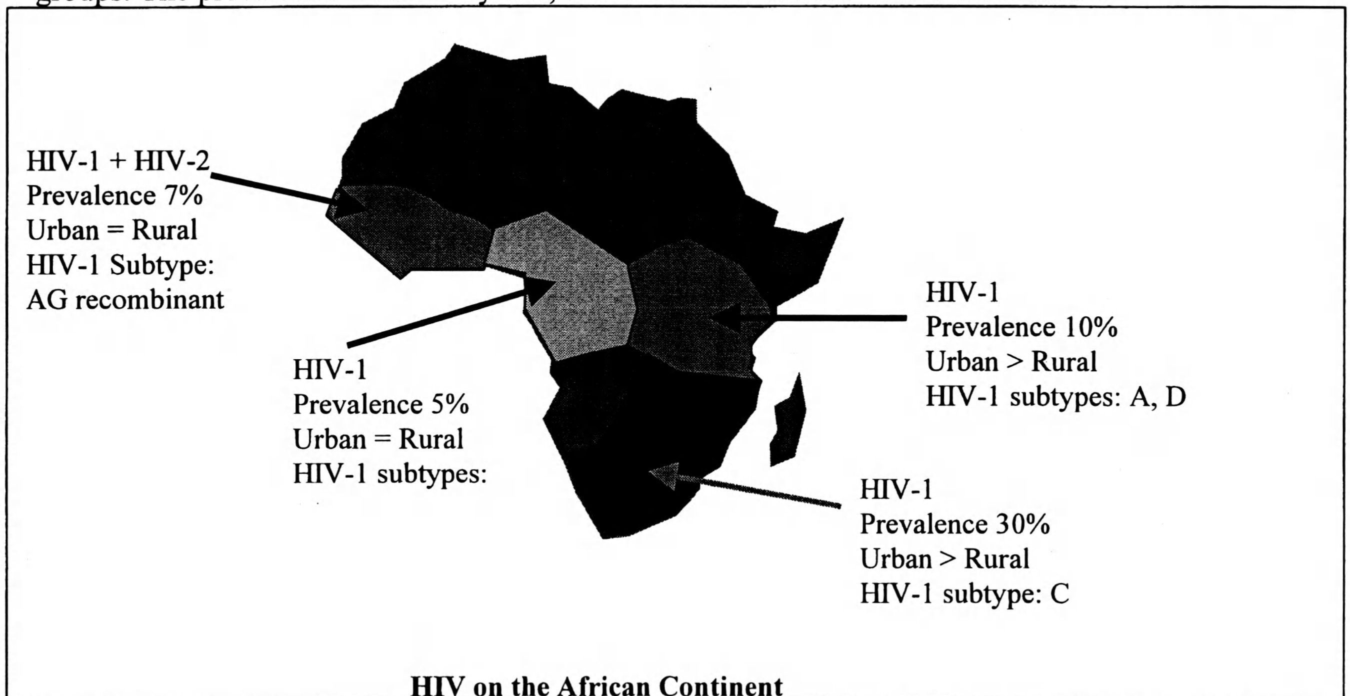
hold copy
for trip
book prep

DoD Non-Paper
Proposed DoD Prevention Activities for African Military and Uniformed Services

BACKGROUND

The AIDS epidemic on the African continent is remarkably complex. HIV incidence and prevalence, the demographics of populations at risk, risk behaviors, the rural vs. urban distribution of HIV, and access to basic education/prevention activities all vary regionally and country by country. Moreover, the mixture of HIV types, groups, subtypes, and recombinants varies widely across Africa. A regional, and sometimes a country-specific, approach to primary AIDS prevention is required.

In East Africa, the HIV-1 epidemic was already established by the 1980's and is centered around population centers and routes of commerce. HIV-1 subtypes A, C, and D and their recombinants predominate. The prevalence in most of East Africa has been relatively stable in the last 15 years. In much of Southern Africa, the largely HIV-1 subtype C epidemic is only about 10 years old, but has achieved a high prevalence in a short time, largely centered in urban areas. In West Africa, HIV-2 has been present for a long time, but the HIV-1 epidemic, mostly due to an A/G recombinant IbNG, started more recently. Prevention in that region must entail consideration of both types of HIV. In West Central Africa all of the subtypes of HIV-1 are present in the region, as well as the 'O' and 'N' groups. The prevalence is relatively low, and not dissimilar in rural and urban areas.



HIV on the African Continent

intervention in African military populations. It has been demonstrated that assessment of knowledge, attitudes, and behaviors, coupled with serial prevalence or incidence measurements, can be done while maintaining confidentiality and with a high level of voluntary participation. The U.S. military population is exposed to multiple HIV subtypes while on deployment, in response rapid diagnosis of HIV subtypes have already

been developed. There are a number of factors contributing to HIV risk. These include travel away from home base, alcohol use, and economic means to use commercial sex workers. Assessment of these components of HIV risk in African military populations will develop the regional profile to design and guide prevention activities.

DEFINITIONS AND PERFORMANCE MEASURES

1. Regional specific military-based education.

Based on findings of the regional diversity of AIDS in Africa and through work with UNAIDS, regional scientists, and African militaries, military-based education will be directed to four specific African regions: East, South, West, and West-Central, respectively. The approach will proceed by stages:

- assessment of HIV prevalence and risk behaviors
- development of a regional prevention plan
- implementation through training and development of infrastructure
- evaluation of the effect of prevention
- refinement and incorporation into the military culture for enduring impact

We will build on the unique DoD triservice military education programs developed to prevent alcohol abuse and STDs, as well as the region-specific HIV prevention work by NGOs and USAID. Anonymous serosurveys with risk behavior data collection will begin as soon as feasible (see attached questionnaire developed by the Naval Research Unit in San Diego (NHRC) and utilized by the Navy, which has been expanded to all services). Current educational modules created by the NHRC and Johns Hopkins University (JHU) will be culturally adapted to the targeted areas in Africa. This group education module, focusing on altering behavior, will be instituted.

The initial round of serosurveys and risk behavior assessment will take a minimum of six months. A "train the trainer" approach that has been very successful within the U.S. Air Force will be used. This training can occur simultaneously within the different regions and will be completed within three months. All of these programs will be coordinated with similar USAID activities. For example, education concerning condoms, counseling, and testing of general populations.

The trained educators will then intensively educate specifically selected military units where anonymous serosurveys have been completed within the first round. Post education serosurveys with risk behavior assessment will again be completed and compared with the original information to assess impact.

In other areas of the world where this approach has been successfully implemented, i.e. SE Asia, incidence markedly declined and upon release from the military these individuals became peer educators within their villages, expanding the impact of the original investment. The same scenario is visualized for this project, which is expected to make a substantial impact on reducing the impact of AIDS in African militaries.

In addition to assessment of HIV seroprevalence, selected serum samples will be utilized for determinations of HIV type, group, and subtype. Because the distribution of HIV in different regions and populations group is incompletely known, this will provide essential information characterizing the epidemic in African militaries.

This project is expected to contribute to long-term and sustained HIV prevention in Africa. The impact of HIV-1 subtype on clinical progression, transmission, and eventual vaccine efficacy is largely unknown. Assessment of HIV-1 subtypes in African military populations, with opportunity for follow-up, will permit an evaluation of these factors in many different settings, ranging from a virtually single-subtype epidemic in Southern Africa to a highly complex mixture of subtypes and recombinants in West Central Africa. Prevention activities can be focussed, not only on individuals at high risk, but also on regions and populations where the particular subtypes or mixtures of subtypes present the greatest challenge to prevention.

2. Enhanced military education of African UN Peace-Keeper forces.

African military personnel deployed far from their home base for long periods in conjunction with UN peace-keeping activities may experience a different HIV risk profile than soldiers remaining at home. In conjunction with the ongoing UN peace-keeping project to combat HIV/AIDS, COL Peter Leenijes coordinated with the Ford Foundation, the Civil Military Alliance, and the U.S. Military HIV Research Program to develop a special intervention program targeted to the African military UN peace-keepers. The program was patterned on one currently being piloted through the South African Army field units. The current project involves five specific curriculum modules:

- Defining HIV and its impact in the military
- HIV Prevention
- Substance Abuse, HIV, STDs
- Risk Assessment and Prevention Strategies
- Course Summary

AGENCIES ACTIVITIES

1. Regional specific military-based education.

The DoD, through the U.S. Military HIV Research Program, has been developing new educational modules specifically focusing on unique, military-associated risks. These new modules were developed after an extensive highly confidential behavior survey of new triservice military seroconverter study and an expansive assessment of HIV education and prevention needs in the U.S. military. These new modules are undergoing evaluation in a large Naval population overseas. Additional HIV/AIDS educational modules for 16-20 year olds developed by JHU are being adapted for evaluation within the army recruit population. A modification of these modules will be utilized for the initial assessment of African troops, after coordination with African militaries and USAID groups, and NGOs working in the region. The U.S. Military HIV Research Program already has ongoing research support and military connection in West Africa - Senegal and Cameroon, East Africa- Uganda, Tanzania, and Kenya, and through our joint UN effort in South Africa.

2. Enhanced military education of African UN Peace-keeper forces.

The UN Peace-keeping educational initiative is already a coordinated effort between the UN Department of Peace-Keeping Operations and the Civil-Military Alliance, which has U.S. military support through LTC Craig Hendrix, USAF ret. For the past five years, William Lyerly - USAID, Manual Carballo - International Center for Migration and Health, and Peter Gordan - UN HIV and Development Programme have instituted this initiative. The curriculum developers were Donna Ruscavage and Paul Purnell of the U.S. Military HIV Research Program.

COUNTRIES

DoD recommends utilizing the U.S. military's current education and prevention programs and instituting new research within the regions and countries noted:

First Tranche: Nigeria, Kenya, South Africa, Botswana, and Senegal

Second Tranche: Benin, Mali, Malawi, Ghana, Uganda, Zimbabwe and Ethiopia

Summary of UV Waterworks Demonstrations Around the World

General Background

In economically deprived areas, waterborne diseases lead to illnesses and sometimes even death, especially in children. The unavailability or excessive cost of fuel prevents many families from boiling their water for disinfection before drinking it. A device for water disinfection was developed by DOE at the Lawrence Berkeley National Laboratory which allows water to be disinfected for much less energy than it would take to boil it.

This device, called Ultra-Violet Waterworks (UVWw) uses ultraviolet light to disable viruses, bacteria, and protozoa. It requires only 40 watts of electricity to disinfect the daily needs of 1000 people and was specifically designed to be inexpensive and low maintenance for rural village applications in the developing world. The device does not require a pressurized water source (it can work with a hand held pump and a surge tank) and can operate powered by photovoltaics, without access to grid electricity.

In 1996, researchers at Lawrence Berkeley National Laboratory licensed the system to Water Health International (WHI) in Napa, California. Water Health international holds an exclusive world wide license for the device (except for in India) and pays a 3.5% royalty on all sales, except those to the Federal Government, to the Lawrence Berkeley National Laboratory. The latest model can provide 10 liters of clean water daily to 1000 people at 10 cents per year per person. An individual device sells for about $620. Larger devices are available.

South Africa

Under the Gore-Mbeki Binational Commission, the Department of Energy's Lawrence Berkeley National Laboratory worked with the South African Center for Essential Community Services to conduct a field test of UVWw at the "Lily of the Valley" AIDS clinic outside of Durban. This clinic is a hospice for abandoned infants with the HIV antibody. For infants infected with the antibody, clean water can mean the difference between life and death. At the hospice, the untreated water was contaminated with 4000 microorganisms such as E.coli per deciliter, while none were detectable after passing the water through the device.

A solar-powered UV Waterworks demonstration system was installed in 1998 at the Greenock Clinic, a rural health clinic located near Dundee, KwaZulu-Natal. The clinic sees approximately 40 patients per day, most of them children complaining of diarrhea caused by contaminated water. The clinic's own groundwater supply has been contaminated by nearby pit latrines but requires no pre-filtration before UV treatment.

This installation was made possible under a grant from the U.S. Department of Energy to the Lawrence Berkeley National Laboratory, using UV Waterworks units donated by WaterHealth International.

Philippines

WHI's Philippines distributor has established 37 "Aqua Sure" water stations in urban areas and 30 community water centers in rural areas of the Philippines. At these installations, people without access to reliable drinking water can buy water (which is treated by UV Waterworks™ plus pre-filters) for one-third the cost they are paying for bottled water.

Approximately 50,000 people are now being served daily by UV Waterworks™-treated water in the Philippines. In addition, the Rotary Club has allotted funds for nine Philippine public schools to be outfitted with community water centers.

Mexico

WHI installed its first integrated community water system near Acapulco in Zihuatenejo (Guerrero State), Mexico in late 1998. The system can provide clean water for 2,000 people daily. It includes sand and roughing filters to remove turbidity and cysts, solar panels for its electrical requirements, and UV Waterworks for treatment of bacterial and viral contamination WHI recently installed60 smaller-scale systems in rural clinics throughout Guerrero. An additional 40 systems will be installed in early2000. Two non-profit organizations - A Cup of Water and the Clearwater Project - will install a community water disinfection system at Tunzingo, Guerrero, Mexico, in early 2000.

Bangladesh

In areas throughout Bangladesh where boreholes are heavily contaminated with arsenic, WHI's water disinfection systems provide an immediate alternative of switching to surface water as a source of clean drinking water. WHI installed its first Bangladesh demonstration unit in May 1999 with the support of Energy, which made a gift of WHI's equipment to the people of Bangladesh. The initial demonstration unit is a compact water station that includes four mechanical pre-filters to remove large particles, fine turbidity and cysts, a carbon filter to remove dissolved chemical contaminants, and a UV Waterworks unit to treat bacterial and viral contamination. The station can provide water for approximately 2,000 people daily.

WHI hopes to install additional community water systems in rural areas throughout Bangladesh in 2000. In doing so, WHI will work closely with the Bangladesh government, international agencies and respected Bangladeshi NGOs. In urban areas, Golden Fair Trading Company (WHI's agent in Bangladesh) is commercially marketing WHI's products.

Nigeria

In Nigeria, USDOE installed one unit outside of Abuja that Secretary Richardson dedicated, and DOE (with USAID) had hoped to deploy thousands of similiar units in villages around the country. The whole program was dependent on USAID's efforts at organizing communities on the local level to be able to manage the operation and maintenance of simple community projects , like the UV waterworks. USAID's efforts at creating community level political entities have not met with the success they had hoped for, in spite of a major effort over the past two years, so they never felt it would be a good investment to provide communities with the waterworks, as they would be vandalized, stolen, or broken for lack of maintenance in a very short time. Unfortunately, this is what happened to the one unit installed in what is really a suburb of Abuja. The local chief took it over for his own use, some small parts broke, and the system was kaput in a very short time.

India

UV Waterworks technology was field tested in India and in 1996, Lawrence Berkeley Laboratory granted a license for its manufacture and sale in India to Urminus Industries in Bombay, which manufactures the outer shell of aluminum (as opposed to thermoplastics used by Waterworks International elsewhere in the world).

Possible Talking Points for
USG Meeting on AIDS
Vice President's Ceremonial Office
Friday, July 21,2000
1:15 p.m.

- The Department of Energy was asked to come to this meeting today to discuss UV waterworks technology and its potential to be mixed with infant formula to combat AIDs transmission through mother's milk. We believe the technology has excellent potential but the Department of Energy does not have the funds to implement the technology.

- As you know, millions of South Africans do not have access to safe drinking water. In economically deprived areas, waterborne diseases lead to illnesses and sometimes even death, especially in children. The unavailability or excessive cost of fuel prevents many families from boiling their water for disinfection before drinking it.

- A device for water disinfection was developed by DOE at the Lawrence Berkeley National Laboratory which allows water to be disinfected for much less energy than it would take to boil it.

- This device, called Ultra-Violet Waterworks (UVWw) uses ultraviolet light to disable viruses, bacteria, and protozoa. It requires only 40 watts of electricity to disinfect the daily needs of 1000 people and was specifically designed to be inexpensive and low maintenance for rural village applications in the developing world.

- The device does not require a pressurized water source (it can work with a hand held pump and a surge tank) and can operate powered by photovoltaics, without access to grid electricity. The latest model can provide 10 liters of clean water daily to 1000 people at 10 cents per year per person. An individual device sells for about $620.

- Under the Gore-Mbeki Binational Commission, the Department of Energy's Lawrence Berkeley National Laboratory worked with the South African Center for Essential Community Services to organize a field test of UVWw at the "Lily of the Valley" AIDS clinic outside of Durban. This clinic is a hospice for abandoned infants with the HIV antibody. For infants infected with the antibody, clean water can mean the difference between life and death. The biweekly monitoring of the unit indicated adequate performance with no detectable coliform bacteria in the water, reduced from 4000 microorganisms per deciliter.

- A solar-powered UV Waterworks demonstration system was installed in 1998 at the Greenock Clinic, a rural health clinic located near Dundee, KwaZulu-Natal. The clinic sees approximately 40 patients per day, most of them children complaining of diarrhea caused by contaminated water. The site test is ongoing We have been struggling a bit with the second site, as we have encountered vandalism of some outdoor components of the PV-powered system, and some problems with the

reporting of the bacterial tests of the water quality. Researchers at LBNL visited the site in February, 200 and report that they believe that these problems have been now solved.

- In 1996, researchers at LBNL licensed their UV Waterworks disinfection system to WaterHealth International in Napa, California. WaterHealth International holds an exclusive worldwide license for the device and pays the government a 3.5% royalty. A U.S. government entity purchasing UV waterworks devices pays no royalty charge.

Potential for Distribution

- We examined three ideas for broad implementation of the UV Waterworks system in Africa.

1. **USAID / Private Foundation funding:** UV waterworks system could be funded through grants to rural organizations. This costly on a broad scale but could be used to demonstrate the benefits of the technology and as a public relations effort to gain rural population buy-in.

2. **Micro credit/Franchise sales:** With a micro-credit loan program, local water sales entrpreneurs could sell purified water and recover the cost to the equipment as well as enhance economic growth in the community.

3. **Private Industry sponsorship.** The Department of Energy has been approached by the pharmaceutical industry_regarding cooperation between UV Waterworks technology and drugs for combating AIDS. We plan to follow up with them to discuss this idea further.

Closing

- We are eager to work with other interested agencies to bring UV waterworks technology to bear on meeting this need.

- I have copies of our initial memo for Leon Fuerth (with a technology brochure) and a summary of world wide demonstrations of the device.

U.S. DEPARTMENT OF ENERGY
OFFICE OF INTERNATIONAL AFFAIRS

OFFICE OF AFRICAN AND AMERICAN AFFAIRS
1000 INDEPENDENCE AVENUE, SW
WASHINGTON, DC 20585
202/586-6140 (PHONE)
202/586-0013 (FAX)

FAX COVER SHEET

TO: Jim Babbitt	FROM: Andrea Lockwood
COMPANY:	DATE: 7/14
FAX NUMBER: 456-9500	TOTAL NO. OF PAGES INCLUDING COVER: 7
PHONE NUMBER:	SENDER'S PHONE NUMBER: 586-2518

RE: Request for information on UVWaterworks for Leon Fuerth

Department of Energy
Washington, DC 20585

MEMORANDUM FOR **Leon Fuerth, Senior Foreign Policy Advisor to the Vice President**

FROM: David Goldwyn, Assistant Secretary
Office of International Affairs

SUBJECT: UV Waterworks Technology: Gore-Mbeki Binational Commission Experience and Potential Applications in AIDS battle

Issue

You requested a brief backgrounder on the UV Waterworks technology that had been field tested in South Africa under the auspices of the Gore-Mbeki Binational Comission and the potential for its use in combining clean water with powdered infant formula to prevent the transmission of AIDS to infants through mother's milk.

We believe the technology has excellent potential and will examine some proposals for funding in this paper.

Background

Millions of South Africans do not have access to safe drinking water. In economically deprived areas, waterborne diseases lead to illnesses and sometimes even death, especially in children. The unavailability or excessive cost of fuel prevents many families from boiling their water for disinfection before drinking it. A device for water disinfection was developed by DOE at the Lawrence Berkeley National Laboratory which allows water to be disinfected for much less energy than it would take to boil it.

This device, called Ultra-Violet Waterworks (UVWw) uses ultraviolet light to disable viruses, bacteria, and protozoa. It requires only 40 watts of electricity to disinfect the daily needs of 1000 people and was specifically designed to be inexpensive and low maintenance for rural village applications in the developing world. The device does not require a pressurized water source (it can work with a hand held pump and a surge tank) and can operate powered by photovoltaics, without access to grid electricity. The latest model can provide 10 liters of clean water daily to 1000 people at 10 cents per year per person. An individual device sells for about $620.

Under the Gore-Mbeki Binational Commission, the Department of Energy's Lawrence Berkeley National Laboratory worked with the South African Center for Essential Community Services to organize a field test of UVWw at the "Lily of the Valley" AIDS clinic outside of Durban. This clinic is a hospice for abandoned infants with the HIV

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antibody. For infants infected with the antibody, clean water can mean the difference between life and death. A team from LBNL was in South Africa from July 19 to August 7, 1997, to set up and begin monitoring the performance of the UVWw system. The biweekly monitoring of the unit indicated adequate performance with no detectable coliform bacteria in the water.

Following this field test and field tests in India in 1996, researchers at LBNL licensed their UV Waterworks disinfection system to WaterHealth International in Napa, California. WaterHealth International holds an exclusive worldwide license for the device.

Potential for Distribution

We examined three ideas for broad implementation of the UV Waterworks system in Africa.

1. **USAID / Private Foundation funding:** UV waterworks system could be funded through grants to rural organizations. This is costly on a broad scale but could be used to demonstrate the benefits of the technology. This could also drive a public relations effort to gain rural population buy-in.

2. **Micro credit/Franchise sales:** With a micro-credit loan program, local water salesmen/entrepreneurs could sell purified water and recover the cost to the equipment as well as enhance economic growth in the community.

3. **Private Industry sponsorship.** The Department of Energy has been approached by the pharmaceutical industry regarding cooperation between proponents of UV Waterworks technology and drug manufacturers interested in combating AIDS. We plan to follow up with them to discuss this idea further.

WATERHEALTH INTERNATIONAL, INC.

1700 Soscol Avenue, Suite 5
Napa, California 94559 U.S.A.

For more information
contact us at:

Phone: 707-252-9092
Fax: 707-252-1514
E-mail:
info@waterhealth.com
Web site:
www.waterhealth.com

UV WATERWORKS™

RELIABLE, AFFORDABLE WATER DISINFECTION

WATER QUALITY
ASSOCIATION
MEMBER

WATERHEALTH INTERNATIONAL, INC.

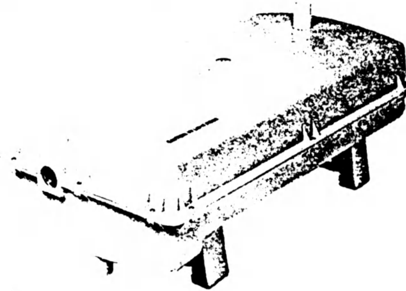
WaterHealth International, Inc. holds the worldwide patent rights (except India) for UV Waterworks. UV Waterworks was developed by and patent rights were obtained from the Lawrence Berkeley National Laboratory, Berkeley, California.

2/98

UV WATERWORKS

SAFE DRINKING WATER FOR SINGLE HOMES OR ENTIRE COMMUNITIES

UV Waterworks is an efficient, affordable water disinfection device that uses ultraviolet light to quickly and reliably disable bacteria and viruses in drinking water, making it safe to drink. Low purchase price, simple operation and low operating cost make UV Waterworks practical and affordable for a wide range of uses, from rural communities in developing nations to individual residences in developed countries that lack access to centralized water disinfection.



RELIABLY DISINFECTS 1,000 LITERS OF WATER FOR LESS THAN 5 CENTS

With no moving parts and requiring only 40 watts of power, UV Waterworks reliably disinfects 4 gallons of water (15 liters) per minute. That's enough to serve 500-1,500 people if used for drinking water and cooking at low usage rates, or up to 150 homes at higher usage rates.

PROVEN GERMICIDAL EFFECTIVENESS

UV Waterworks contains a germicidal ultraviolet (UV) lamp positioned over a shallow water pan. Water flows through the unit by gravity, staying in the chamber 12 seconds to ensure adequate disinfection. Delivering a UV dosage of over 80,000 microwatt-seconds per cm^2, UV Waterworks disables 99.995% of water-borne bacteria and viruses.

* More often if the water contains chemicals that create a film on the water pan or a lot of solid matter.

** In the Ultra model the UV meter and solenoid valve must be replaced periodically.

EASY SET UP, LOW MAINTENANCE

UV Waterworks' small size, light weight and simple gravity-feed operation mean that it can be installed virtually anywhere there is a water supply and electricity. Maintenance consists only of cleaning the water pan with a damp cloth once every six months*, replacing the UV lamp once a year, and replacing the ballast at least every ten years.**

OTHER BENEFITS INCLUDE:

- **UV Waterworks uses no chemicals. Imparts no taste or odor to water; has no risk of overdose.**
- **Does not require pressurized water to work.**
- **Costs less than comparable systems.**
- **Eliminates the need to purchase fuel or gather wood to boil and purify water.**
- **Suitable for a wide range of uses, including: rural communities, single residences with wells, farms, hospitals, and more.**
- **Easily powered by a car battery, a bicycle generator, wind, solar cells or a small hydroelectric source.**

Discover Magazine's Award for Technological Innovation (Environment Category)

Popular Science Magazine's Best of What's New Award

ANSWERS TO YOUR QUESTIONS ABOUT UV WATERWORKS

Q. HOW SAFE IS ULTRAVIOLET DISINFECTION?

A. EXTREMELY SAFE.

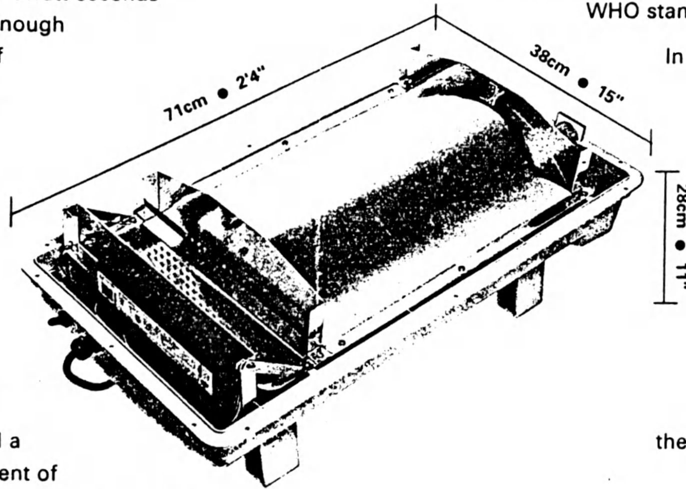
Rapid and inexpensive, UV light is a World Health Organization-approved method of disinfecting drinking water.[1] A UV dosage of 38,000 microwatt-seconds per square centimeter (cm^2) disables the most virulent bacteria. Typical UV systems provide a dosage of 25,000-35,000 microwatt-seconds per cm^2.

UV Waterworks, however, delivers a minimum dosage of 80,000 microwatt-seconds per cm^2, more than enough to disable 99.995% of waterborne bacteria and viruses. UV disinfection is not generally recommended for long-term storage of water. UV Waterworks effectively disinfects water with up to 20 NTUs of turbidity and a UV extinction coefficient of .25/cm or lower. Turbidity can be reduced with a settling tank, sand filter or other type of filter.

Q. HAS UV WATERWORKS BEEN PROVEN UNDER CONTROLLED CONDITIONS?

A. YES.

Tests were conducted by the Lawrence Berkeley National Laboratory using World Health Organization (WHO) protocols. These demonstrated that when concentrations of colony-forming units of E. coli per 100 ml of water were more than 100,000 at the inlet of UV Waterworks, the concentration at the outlet was less than one, thus meeting the WHO standard for drinking water.



In separate tests, tap water with no residual chlorine was spiked with high concentrations of the infectious waterborne pathogens listed below. UV Waterworks effectively disabled all of the pathogens.

[1] Guidelines for Drinking Water Quality, vol. 1, World Health Organization, Geneva, Switzerland, 1993, p. 135.

Q. HAVE FIELD TESTS PROVEN EFFECTIVE?

A. AGAIN, YES.

Weekly tests of UV Waterworks conducted over five months in several Philippine communities demonstrated that highly polluted water (run through a two-micron filter to remove solid matter) contained no measurable trace of bacteria or viruses after being treated by UV Waterworks.

UV Waterworks successfully treated contaminated ground water from a borehole at a children's clinic near Durban, South Africa. The water contains "wild" (as opposed to "laboratory") strains of bacteria, which are more resistant to UV treatment than clean water dosed with pure cultures of the same organisms.

Results: Before entering the UV Waterworks unit, the South African water contained an average of 3,000 colony-forming units per 100 ml of water, including 200 fecal coliforms per 100 ml. Water leaving the UV Waterworks unit contained no detectable coliforms (including E. coli) or other Enterobacteriaceae.

In addition, extensive tests by the National Water Commission of Mexico confirmed UV Waterworks' effectiveness.

SPECIFICATIONS

- **Maximum Flow Rate:** 15 liters (4 gallons) per minute
- **People Served:** 500-1,500 per unit (if used primarily for drinking water and cooking at low usage rates), or up to 150 homes (at typical U.S. water usage rates)
- **Cost per 1000 liters (one ton of water):** 4 cents U.S.
- **UV Dosage:** Exceeds 80,000 microwatt-seconds per cm^2 (more than enough to disable 99.995% of waterborne bacteria and viruses)
- **Power Consumption:** 40 watts (UVW Standard), 60 watts (UVW Ultra)
- **Voltage:** 120V AC, 220V AC or 12V DC
- **Length:** 71 centimeters (2 feet, 4 inches)
- **Width:** 38 centimeters (15 inches)
- **Height:** 28 centimeters (11 inches)
- **Weight:** 7 kilograms (15 pounds)

Note: UV Waterworks under standard operation does not treat parasites or micro-organism cysts with protective coverings such as Cryptosporidium and Giardia. Such organisms are effectively removed by a flocculating agent, settling tank or sand filter.

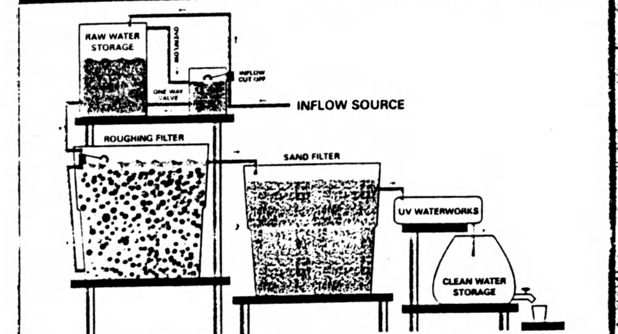
PATHOGENS TESTED AGAINST

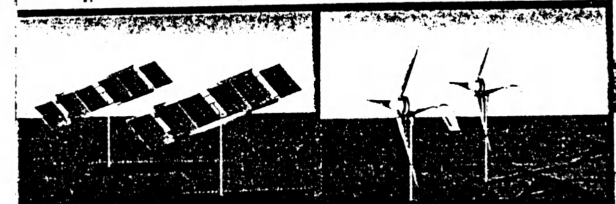
- ***Escherichia coli*** (ATCC-10148)
- ***Salmonella typhi*** (NCTC-786)
- ***Vibrio cholerae*** (569 Inaba)
- ***Streptococcus faecalis*** (water isolate)
- ***Clostridium welchii*** (water isolate)
- ***Shigella dysenteriae*** (clinical isolate)
- ***Proteus vulgaris*** (clinical isolate)
- ***Klebsiella aerogenes*** (water isolate)
- ***Enterobacter cloacae*** (clinical isolate)
- ***Pseudomonas aeruginosa*** (Immunotype IV)

ADDITIONAL EQUIPMENT & SERVICES

WaterHealth International, Inc. offers the following equipment and services at additional cost. See product literature for more information.

- **Spare parts:**
  UV lamp and 120V AC, 220V AC or 12V DC ballast.
- **Pressure control and water shutoff system:**
  adjusts water flow from pressure source and controls water level in clean water storage tank.
- **Sand and roughing filters:**
  filter out turbidity and larger pathogens not effectively treated by UV Waterworks (e.g., Giardia, Cryptosporidium, amoebae and worms).





- **Wind, solar or small hydroelectric power packages:**
  wind turbines, solar panels and small hydroelectric power packages to operate UV Waterworks.
- **Installation and maintenance services:**
  engineering information for installation of units and associated equipment.
- **Community education materials to assist communities to use the system properly.**

UV light brings cheap, clean water to HIV babies

Near Durban, South Africa, an inexpensive ultraviolet disinfection system is providing very clean drinking water for abandoned infants with the HIV antibody. Not all of these babies are infected with the virus, but for the fraction that are, disinfected water can mean the difference between life and death.

The system takes advantage of the germicidal property of UV light, which only recently has been harnessed effectively enough to work in a community with a low level of technology. Following field tests in rural Indian villages (see *Biophotonics International*, March/April 1996, p. 30), researchers at Lawrence Berkeley National Laboratory in Calif., licensed their redesigned UV Waterworks disinfection system to WaterHealth International in Napa, Calif. With an exclusive worldwide license (except in India, where it is sold by Urminus Industries Ltd. of Bombay), WaterHealth is selling production models in developing countries including Mexico, Haiti, the Philippines, Uruguay, Brazil, Nepal and Bangladesh.

Berkeley physicist Ashok Gadgil and his group invented the system in response to a 1993 Indian outbreak of cholera. Based on the initial field tests and with new support, the Berkeley researchers re-engineered the system to be less costly and more compact, said Gadgil. A field test of the new design is in progress at the Lily of the Valley HIV-Hospice in South Africa.

Other methods impractical

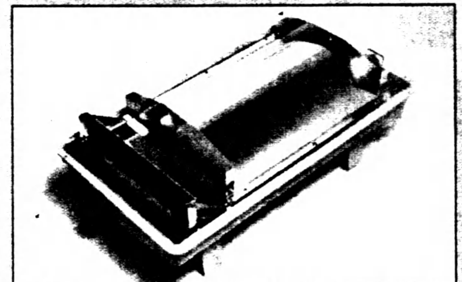
The two most common water disinfection methods are boiling and chlorination. Chlorine treats a broader range of organisms than UV and offers residual protection until it evaporates, but chlorination can be expensive and requires skilled maintenance as well as a supply of potentially hazardous chlorine. Boiling provides no residual protection against recontamination, such as from dipping a soiled hand or pot into the cistern. Typically done over a biomass cookstove, boiling is the most effective treatment but is slow and labor-intensive, and can use as much as 20,000 times more energy than efficient UV treatment.

The simplicity, low cost and speed of UV disinfection justifies its use in less technological communities, despite the following limitations: UV light cannot treat nonbiological pollution nor the parasites *Giardia* and *Cryptosporidium*, and its disinfectant action offers no residual effect, leaving it susceptible to recontamination. However, simple mechanical devices such as a 10,000-lb sand-based roughing filter can remove the larger parasites and other floating particles from the water, said Elwyn Ewald, president and CEO of WaterHealth. Collecting the disinfected water in closed containers can minimize the risk of recontamination.

Other UV-based systems were impractical in the developing world because they require a pressurized water source. (These communities tend to use surface or hand-pumped water that is not pressurized.) In addition, because other systems submerge the UV bulb in the water, biological and chemical deposits accumulate on the bulb's protective sleeve and necessitate frequent cleaning by trained personnel.

With the UV disinfection system on the outside kitchen wall, clean water becomes available at the sink inside. Durban Metro Water plumbers and a Berkeley lab researcher installed a manufacturing prototype at an HIV hospice for a 1-year field test starting in August 1997. Courtesy of A. Gadgil.

Researchers hope to improve the water quality in developing communities permanently. Therefore, in addition to sampling the water, field tests address social factors such as community acceptance, education about sanitary practices, and local maintenance and management. Courtesy of A. Gadgil.



The plastic exterior of the production model protects it from the environment in hot as well as cold climates. WaterHealth is looking into field testing the unit in native communities in Alaska where clean unsalted water is scarce. Courtesy of WaterHealth International.

SPECIAL DOUBLE ISSUE

U.S.News & WORLD REPORT

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Outlook '97

20 WAYS TO SAVE THE WORLD

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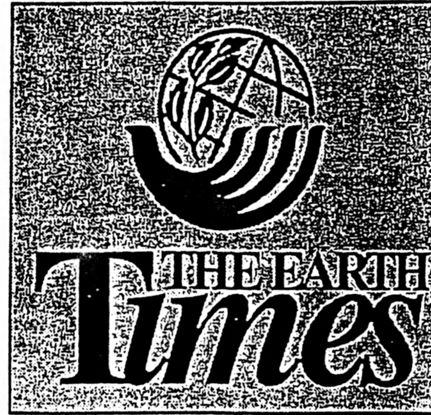
Toxic Fame, Failed Predictions, Buzzwords and the Year in Pictures, 1996

KEEP ON SALE UNTIL JAN. 31, 1997

EDITORIAL

A test for market forces: Clean water and UV light



By Paula DiPerna

Recently, at a resort hotel on a water-short island, few people seemed concerned about water. The hotel went only so far as to discreetly place a small card near the sink that said, "Help us by keeping water use in mind." Meanwhile, in the restaurant, eager waiters kept topping up large glasses of iced drinking water almost the moment after a diner had taken a sip. Water shortages don't seem to mean a thing anywhere the affluent gather.

Yet severe water scarcities are among the most worrying trends for the future. The United Nations Industrial Organization (UNIDO) suggests that 1995's industrial water use could double by the year 2025, causing a four-fold increase in the pollution load on the world's fresh water.

At the same time, water-use inefficiencies persist, despite trends toward privatizing water services, and the world's poor people still cannot imagine the day when

clean water will be readily available to them, let alone to be taken for granted.

An encouraging sign is emerging currently on the water front, as a new technology developed over three years by a research team headed by innovative physicist, Ashok J. Gadgil of the Lawrence Berkeley National Laboratory, moves toward mass commercial application and, one hopes, closer to the people who need it most.

Gadgil held audiences rapt in June 1996, at the Habitat II conference in Istanbul, with his description of a gravity-driven water purification unit that uses ultra-violet (UV) light to remove bacteria and viruses from water to make it safe to use and drink. The costs were below negligible—roughly two cents per metric ton or about seven cents a year to disinfect one year's drinking supply for one adult.

• • •

Gadgil's apparatus seemed to hold out a promising solution so accessible and affordable, one would expect to soon find the UV units in every community lacking potable water around the world. Customers would hardly seem to be lacking. But, in a world focused on private sector forces as the solution for development, commercial viability of such new technologies has to be established, and customers must have enough money to buy.

A small group of investors who had heard of Gadgil's work have formed a for-profit company, WaterHealth International, with an initial capitalization of US$300,000, and successfully negotiated a licensing and royalty agreement with the Livermore Laboratory for the rights to manufacture and market the UV water units worldwide, except in India, where a different firm was granted the rights. According to WaterHealth, a unit can purify water to meet the daily drinking and other potable water needs of 500 to 1,500 people in developing countries.

The unit requires only 40 watts of electricity to light the needed UV bulb, which means the water unit can run on a car battery or bicycle-pump generator. Where even such rudimentary power sources are lacking, separate power packs can be added to the water unit to harness solar or wind power, for $600 to $1,200 additional cost per unit, depending on local conditions. The power packs even generate surplus power that could be put to other uses.

This all means that about 1,000 people can have their daily water needs met, plus pick up some extra electrical power, for not more than $2,000 in initial investment, with very low maintenance thereafter for the 15-year life of the unit. This is a cost roughly equivalent to a 10-day stay for one person in the hotel where water conservation seemed a mere footnote.

WaterHealth says the first UV units will be ready to ship this fall, and it has begun to establish networks of local retail distributors around the world, including micro-enterprises using micro-credit loans. But what can insure that the units will be priced at the retail level cheaply enough to be accessible to the rural poor, yet high enough to return a profit to permit continued mass production? Will governments be sufficiently motivated to meet their people's water health needs to buy and install the units if a community is too poor itself to do so? Or will governments shun this too as "subsidy"?

In short, will such an apparently appropriate and affordable technology get into the hands that need it most, especially since Gadgil himself is acutely mindful of the development needs of the poor.

The UV technology involved has gone from concept to practice, production and international outreach in just a few years—nearly record time—presumably because its viability seems a given. Thus, this relatively simple and inexpensive device offers a true chance for profitability demands and human needs to be met together. The test will be as clear as water.

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SACECS

Newsletter of the South African Centre for Essential Community Services

SUCCESS

issue no. 1 april 1998

contents

Seeking solutions

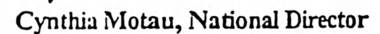
The work of the South African Centre for Essential Services (SACECS) has rapidly developed since the Centre's foundation in 1996 under a collaborative agreement between ESKOM and US-based EPRI.

SACECS endeavours to develop, demonstrate and utilise appropriate technologies to support the needs of communities in meeting their environmental challenges by creating opportunities for economic growth, development and social well-being.

This is the first issue of a quarterly newsletter planned by SACECS. Our objective is to continue to promote and market SACECS' activities and projects, and explore management strategies that will strengthen the synergy between ourselves, water utilities and the health care industries.

We are particularly proud of the solid relationships we have established with the MRC, WRC, FRD, CSIR, Umgeni Water, Rand Water and the Department of Water Affairs and Forestry in addressing issues of mutual concern.

By continuing with the strengthening of collaboration with critical stakeholders, we hope to be able to more efficiently and effectively influence national and regional government on social change and upliftment of communities.



Cynthia Motau, National Director

mechanical engineering

VOL.119/NO.7 JULY 1997

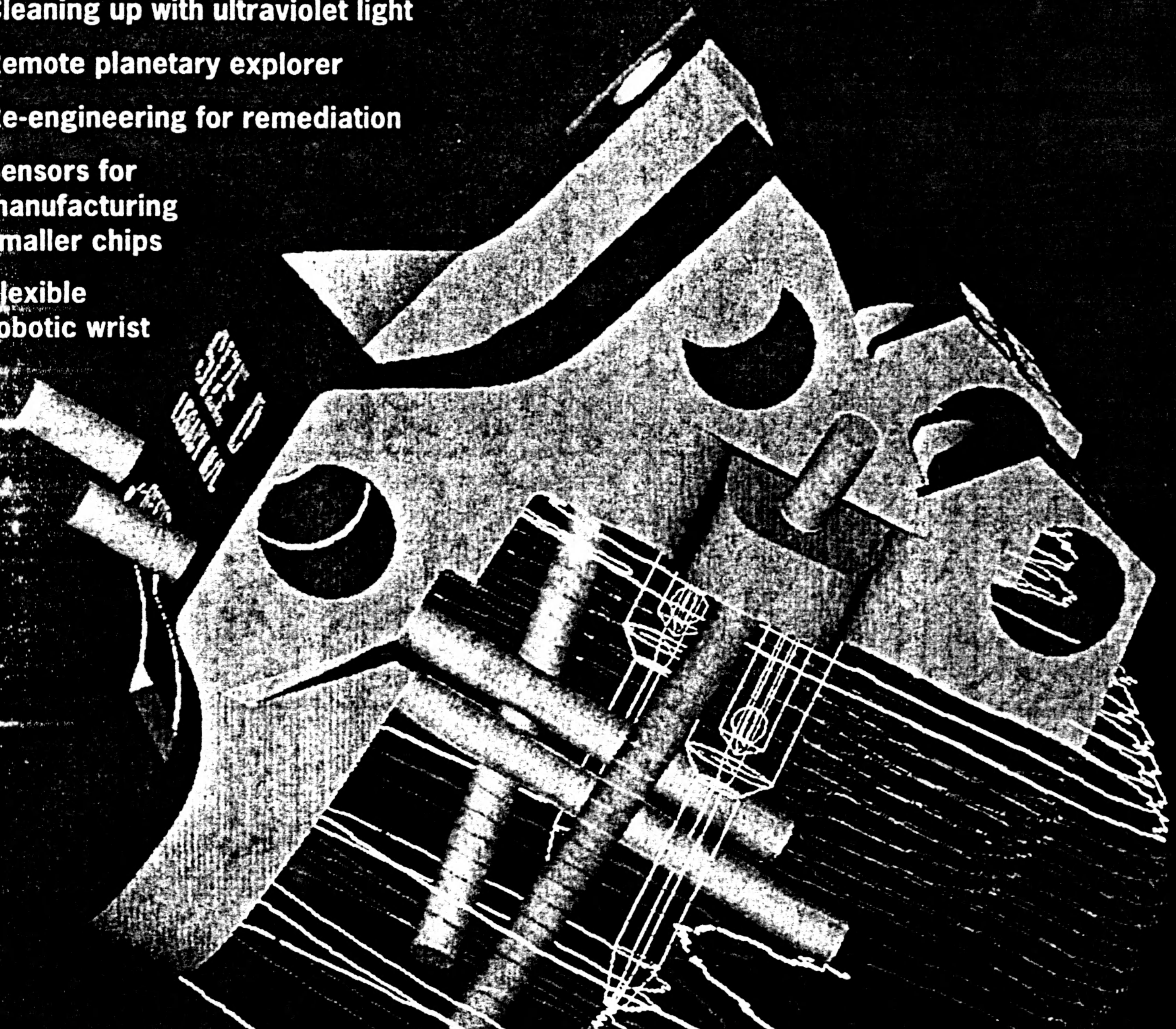
Cleaning up with ultraviolet light

Remote planetary explorer

Re-engineering for remediation

Sensors for manufacturing smaller chips

Flexible robotic wrist



Customizing Biomechanical Parts

ULTRAVIOLET LIGHT HAS a proven track record of killing bacteria and viruses found in municipal wastewater. In addition, environmental concerns over the use of chemical disinfectants, coupled with improvements in ultraviolet-lighting technology, have led to the development of UV systems that treat spent metalworking fluids in the industrialized world; disinfect drinking water in developing countries; and clean aquaculture water, ballast water, and hospital air everywhere.

Typically, chlorine gas or liquid is injected by a high-speed inductor directly into wastewater to kill bacteria before the water is discharged. "The main advantage UV has over standard disinfection techniques is that the light-based system eliminates the transport and use of chlorine," said George Tchobanoglous, professor emeritus of civil and environmental engineering at the University of California, Davis. "Even though the water is dechlorinated by the addition of other chemical compounds such as sulfur dioxide, residues of these toxic compounds remain in the water, which is a matter of increasing concern." Tchobanoglous chaired a committee of academic, industrial, and environmental consultants who drafted guidelines on UV disinfection for California in 1994.

Another factor leading municipalities to reconsider chlorination is its increased cost due to the national *Uniform Fire Code* adopted in 1993. This specifies double containment of stored chlorine and chemical scrubbers in case of leaks—both of which are expensive propositions.

"There are no residuals left by UV-light systems, whose effectiveness has been improved with the development of more-intense ultraviolet lamps. Now, one lamp can do the work of 20," Tchobanoglous said.

REPLACING CHLORINATION

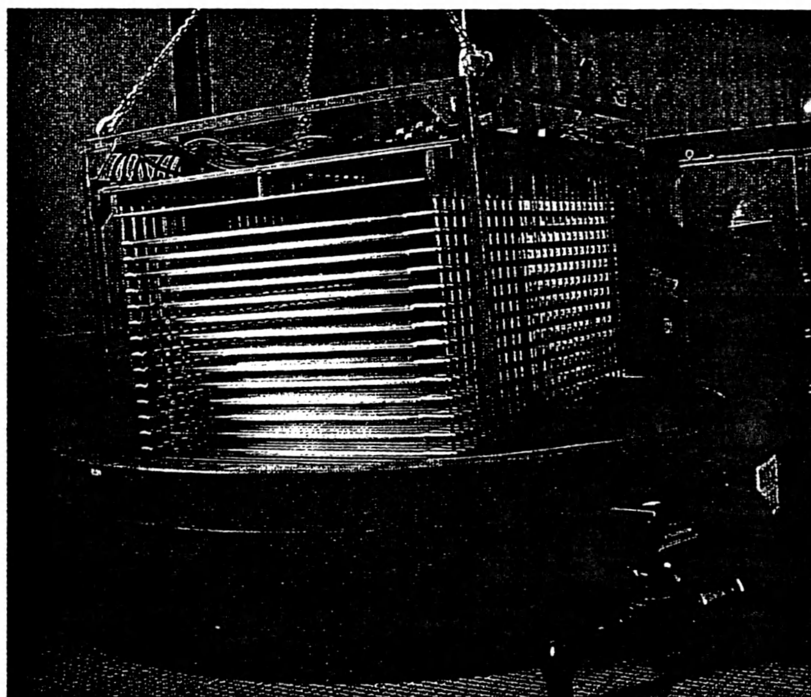
Only about 5 percent of American wastewater is currently treated by UV before being discharged, but the Electric Power Research Institute (EPRI) in Palo Alto, Calif., expects that figure to grow to 25 percent within 10 years.

The Central Contra Costa Sanitary District (CCCSD) in Martinez, Calif., is an example of UV's growing acceptance by U.S. municipalities. The district's treatment plant, located 45 miles from San Francisco, treats approximately 40 million gallons of wastewater per day before discharging it into Suisun Bay and San Francisco Bay. The plant's old treatment system, dating from the early 1970s, involved adding 3,500 pounds of chlorine daily, along with 2,400 pounds of sulfur dioxide per day to neutralize the chlorine.

Triton Thalassic Technologies designed a specialized ultraviolet geometry, gas combination, and fluid dynamics that enable its UV technology to emit a monochromatic wavelength that kills bacteria in machining fluids without damaging the fatty acids that provide the fluids' performance characteristics.

CCCSD reconsidered its chlorination strategy in 1990, when community groups expressed concern about the possible accidental discharge of chlorine gas into the air. In addition, provisions of the Clear Air Act required limiting worker exposure to chlorine fumes, and provisions of the looming fire code specified the installation of an expensive leak-containment system to prevent such discharges.

In 1991 CCCSD plant management compared the costs of continuing to use chlorine treatment with those of three other disinfection strategies: hypochlorite, ozone, or UV treatment. Hypochlorite cost about twice as much as chlorine on an annualized basis and ozonation was even more expensive, but three UV systems were comparable to the cost of chlorination and dechlorination. An additional factor favoring UV treatment was an unused concrete denitrification channel in which lamps could be installed.



Water authorities are replacing chlorination by using banks of UV lamps, shown here being cleaned of sediment, to disinfect municipal wastewater.

A large-scale pilot plant capable of treating less than 1 million gallons per day was built on-site by Los Angeles–based Montgomery Watson and CCCSD in 1992. It demonstrated that UV was just as effective as chlorination in killing bacteria and slightly more effective in destroying viruses found in the Martinez plant's wastewater. It also showed the lamps would need to be cleaned of fouling every two to four weeks.

Montgomery Watson designed the UV system, which was installed in October 1996. Water is piped to a treatment channel that is covered by a clear plastic lid to reduce algae growth. Eighteen banks of low-pressure mercury ultraviolet lamps made by Bailey-Fischer & Porter Co. in Warminster, Pa., line the sides of the chan-

Beams from these louvered UV lamps draw in tuberculosis germs by air convection, thus preventing the disease's spread in hospitals and homeless shelters.

the ammonia produced by fish breeding. T³I is working closely with the Biotechnology Center at the University of Connecticut in Storrs, anticipating a state-funded project to adapt its UV technology to treating aquaculture water. Ressler said his company will be field-testing FASTAC in tilapia, flounder, and salmon aquaculture facilities this fall.

T³I originally aimed its UV technology at dealing with industrial-plant zebra mussel fouling and treating contaminated ballast water discharged by cargo ships and tankers, and it has continued to develop these applications. Discharged ballast water has introduced nonindigenous species into countries, including the United States, where they have no natural enemies. As a result, these foreign creatures often proliferate to the point where they pose an environmental and economic problem. The best-known example is the zebra mussels that have clogged industrial and power-plant intakes along the Great Lakes (see "Power Plant Pest," Input/Output, March 1991).

T³I was first approached by its automotive client when it presented its UV technology as an alternative to using chemical biocides to kill the zebra mussel at the Zebra Mussel Conference in February 1995, according to Ressler. Since that time, a congressional task force supporting the National Invasive Species Act and the United Nations' International Maritime Organization have become interested in using FASTAC in conjunction with prefiltration to kill virtually all the microorganisms in ballast water without using chemical biocides.

Ressler's company is in the design phase, and is lab-testing a FASTAC system to serve the typical commercial freighter plying the Pacific Ocean between the United States and the Far East. "The prototype system can treat the required 4,000-gallon-per-minute loading and discharge flow rates through a 12-inch-diameter pipe, and we can easily scale up the system for larger vessels," Ressler said.

Saving Lives in Developing Countries

In developing nations, 400 children under five years old die every hour from diarrheal diseases, including cholera and typhoid, that are transmitted by contaminated drinking water. Although UV treatment can kill these waterborne pathogens, such systems are often too expensive for third-world villages. Scientists at the Lawrence Berkeley National Laboratory in Berkeley, Calif., developed UV Waterworks, an inexpensive, low-maintenance UV treatment system specifically geared for developing nations (see "Cleaning Water with Light," News & Notes, August 1996).

The Berkeley design team was led by Ashok Gadgil, an ASME member and a physicist at Berkeley. "There was a lot of mechanical engineering involved in designing the UV Waterworks system," Gadgil said. "For example, we performed radiometrics calculations to ensure that the proper light intensity is maintained. We also analyzed the hydrodynamics of the flow to prevent a wide distribution of residence time for water flowing under the lamp. This ensures high efficiency."

UV Waterworks can be connected to the pumps common to most villages in developing countries in two ways. In the case of hand pumps, the unit is connected to a surge tank, typically holding 30 liters, that collects water from the pump. For electrical borehole pumps, the disinfecting unit is connected to a tank mounted on a small pedestal.

Water from either tank enters a stainless-steel chamber, and is bathed by UV light at 254 nanometers—the optimum frequency for killing bacteria—emitted by a single 36-watt standard mercury-vapor lamp positioned above the water without contacting it. This eliminates the need for and expense of the UV-transparent sleeve used on

AIDS in Africa is a Serious Crisis

But Opportunities Exist for Helping to Save Millions of Lives

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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NATIONAL SECURITY COUNCIL

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Chris Keenan at
(202) 456-9394

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

Date: May 2, 2000 **Pages to follow:** 15

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[001a]

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001b. memo	Kenneth Bernard and Sandra Thurman to Leon Fuerth, et al., re: Interagency Working Group on the Global AIDS Crisis [partial] [10 U.S.C. 424] (0 page)		P3/b(3)

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NATIONAL SECURITY COUNCIL
WASHINGTON, D.C. 20504

May 1, 2000

MEMORANDUM FOR

MR. LEON FUERTH
Assistant to the Vice President for National Security Affairs

MR. FRANK E. LOY
Under Secretary for Gobal Affairs
Department of State

DR. SUSAN E. RICE
Assistant Secretary for African Affairs
Department of State

RANDOLPH P. EDDY
Senior Policy Advisor to the U.S. Representative to the United Nations

MR. TIMOTHY GEITHNER
Under Secretary for International Affairs
Department of the Treasury

DR. SUE BAILEY
Assistant Secretary of Defense for Health Affairs
Department of Defense

P3/(b)(3)

MR. ALAN BOWSER
Deputy Assistant Secretary for Basic Industries
Department of Commerce

MR. MARK L. SCHNEIDER
Director
Peace Corps

MR. MACARTHUR DESHAZER
Associate Deputy Under Secretary, Bureau of International Labor Affairs
Department of Labor

DR. DAVID SATCHER
Assistant Secretary for Health and Surgeon General
Department of Health and Human Services

MS. BARBARA TURNER
Assistant Administrator
Bureau for Global Programs, Field Support and Research
Agency for International Development

P3/(b)(3) [001b]

MR. JOSEPH PAPOVICH
Assistant USTR for Services, Investments and Intellectual Property Rights
U.S. Trade Representative

MR. ROBERT D. KYLE
Associate Director for National Security and International Affairs
Office of Management and Budget

FROM: Kenneth W. Bernard, National Security Council
Sandra Thurman, Office of National AIDS Policy

SUBJECT: Interagency Working Group on the Global AIDS Crisis

Attached please find the final IWG document on expanding the U.S. role in controlling the international HIV/AIDS epidemic. It includes a summary list of "next steps," and is the result of two large interagency meetings in February and March, and five smaller issue-oriented subgroup sessions. The first two drafts of the document were circulated and attempts have been made to incorporate all suggested changes.

Note that many of the suggestions are aspirational (therefore, some may require additional resources). While the IWG reached consensus that the ideas are good ones, agencies should be careful to adhere to departmental and Administration budget priorities and processes.

The consensus document is not intended to be static, but rather an ongoing attempt to ramp up the USG response to the HIV/AIDS crisis. A number of issues and actions raised by the IWG will be further discussed in the Deputies and Principals Committee process.

The IWG will meet again in June, prior to the International AIDS Conference in Durban, to document progress on each of the action items outlined in the consensus document. The lead agencies will coordinate input into this process.

Please note that designation of agency "leads" (in parentheses after action items) is not intended to be exclusive. Those listed are requested to inform and coordinate with all relevant agencies. They will be asked to report to the IWG on USG agency-wide follow-up on progress on each action item.

Attachment

NATIONAL SECURITY COUNCIL
WASHINGTON, D.C. 20504

April 28, 2000

U.S. GOVERNMENT USE ONLY

INTERAGENCY WORKING GROUP CONSENSUS PAPER

SUBJECT: Expanded United States Role in the Global HIV/AIDS Crisis

Background

Extent of the Problem: The human toll of AIDS is staggering. Fifty million people worldwide have been infected with the HIV virus; 33.6 million are now living with HIV/AIDS, and annual AIDS-related fatalities hit a record 2.6 million last year. Ninety-five percent of all cases are in the developing world. AIDS is now the leading cause of death in Africa and fourth in the world. In at least five African countries, over 20 percent of adults are HIV-positive. And the highest rates of new infections are often among young women who will soon be mothers.

Other parts of the world are going down the same road as Africa. Infection rates in Asia are climbing rapidly, with several countries, especially India, on the brink of a large-scale expansion of the epidemic and needing to take action immediately to forestall the disaster that Africa has suffered. Parts of Latin America and the Caribbean also show high and rising rates of infection. And the former Soviet Union countries and Eastern Europe are vulnerable as well, with Russia experiencing the highest increase in infection rates in the world last year.

AIDS as an economic and security issue: On January 10, under the leadership of Vice President Gore, the United Nations Security Council held a daylong session on the global threat posed by HIV/AIDS. This event was the first time the Security Council considered a health issue. The session reinforced what we have stated repeatedly, that AIDS is much more than a health or humanitarian issue -- it is a development issue, a trade issue, and a key stability and security issue.

At the Security Council meeting, Secretary General Kofi Annan said that the "high rate of infection among police and armed

forces has left many African countries ill-equipped to face security threats." World Bank President James Wolfensohn added: "We're losing teachers faster than we can replace them. We're losing judges, lawyers, government officials, and persons in the military. Unless we act, there will surely be continued instability on the continent."

USG International HIV/AIDS programs: The U.S. Government remains the world leader in responding to the global pandemic of AIDS. Current USG activities emphasize enhanced financial and political commitment, primary prevention, improving community and home based care and treatment, caring for children affected by HIV/AIDS, health infrastructure development, biomedical and behavioral research and training, and multisectoral efforts from the grass roots to the international level that reduce the impact of AIDS. Since 1986, USAID has dedicated over $1.2 billion to mitigate the epidemic. In FY 2000, we contributed four times as much as the next largest donor. But we will need to spend more -- much more.

During the Security Council meeting, the Vice President outlined Phase II of our LIFE Initiative (Leadership and Investment in Fighting an Epidemic), the enhanced global AIDS effort which was launched last year with a budget amendment for a $100 million increase in our global AIDS program. Congress appropriated the funding; bringing our FY2000 global AIDS prevention and care program to $225 million -- nearly two thirds of which will go to Africa. The FY2001 budget includes an additional $100 million increase in our global AIDS effort (for a total of $325 million, excluding research) which will be targeted to: prevention; basic care and treatment; support for orphans; and health infrastructure development, and implemented by USAID, HHS (CDC), DOL and DOD.

Many other agencies are contributing to the USG efforts. For example, in mobilizing human resources, the Peace Corps is training all new volunteers in HIV/AIDS prevention and education strategies. There are currently over 6000 Peace Corps volunteers globally, and more than 2,400 in Africa alone, many having primary assignments in HIV/AIDS work. In addition, a cadre of experienced "Crisis Corps Volunteers" is now being selected to work directly with HIV/AIDS in countries with high HIV/AIDS prevalence.

And NIH is spending over $1.8 billion annually on AIDS research, with over $200 million each year in the search for a vaccine.

Extent of financial needs -- the example of Africa: UNAIDS estimates that it will take at least a $1 billion HIV prevention program in Africa to stem the rising tide of infection, including mother-to-child transmission. In 1999, all host governments and donors spent less than one third that amount on prevention, and very little in the military context. In addition, UNAIDS believes that it would cost an additional $1 billion to begin to bring basic medical care and treatment to the 24 million people in Africa already living with AIDS. At present, spending is less than one tenth that amount, with only 1-5 percent of those who are sick receiving even the most basic antibiotics and treatment for opportunistic infections. The total expenditure from all sources for HIV/AIDS prevention and care in the average sub-Saharan African country is only $5-20 million per year.

The Interagency Process

With the growing concern that the U.S. Government needed to further increase its efforts to deal with the AIDS crisis, an interagency working group (IWG) was convened under the co-chair of Sandra Thurman, Director, Office of National AIDS Policy (ONAP), and Kenneth Bernard, Special Advisor, National Security Council. The first meeting was held on February 8, 2000, and included representation from State (including USUN), USAID, Defense, Joint Staff, Treasury, Commerce, CIA, DOL, DIA, HHS (including NIH and CDC), Office of the Vice President, OMB, USTR, NEC, NSC and OSTP. Issue oriented IWG subgroups were formed to develop recommendations for enhanced USG action. They included 1) budget and legislation, 2) diplomacy and public awareness, 3) security, 4) economics, trade and finance, and 5) prevention and care.

An ongoing process: This consensus document, drafted with input from all listed agencies and IWG subgroups(with the addition of Peace Corps), is not intended to be static, but rather an ongoing attempt to ramp up the USG response to the HIV/AIDS crisis. A number of the following issues and actions raised by the IWG will require further discussion at the departmental level as well as in the Deputies and Principals Committee process.

The IWG, co-chaired by NSC and ONAP, will meet again in June, prior to the International AIDS Conference in Durban, to document progress on each of the action items outlined in the consensus document. It will then reconvene periodically

thereafter. Decisions on outstanding issues will be referred to Deputies or Principals as needed.

Strategic framework for action

To ensure that the United States continues its leadership role in combating HIV/AIDS, the IWG recommended that new USG activities be considered in the context of four overall objectives:

- Mobilizing an enhanced and coordinated United States Government response, and maximizing its leadership and effectiveness in the international battle to reduce HIV transmission and care for those who are sick.
- Enhancing political commitment by national governments to combat HIV/AIDS as a national and international priority, including mobilizing and leveraging increased internal national budget resources.
- Leveraging an enhanced response from other bilateral donors and multilateral institutions through a U.S.-lead international cooperative effort.
- Leveraging an enhanced response from the private sector in the United States, including corporations, foundations, religious institutions and non-governmental organizations.

Issues and Actions

(Note: Agencies in parentheses below are not the only agencies to be involved in listed issues or initiatives. They are, however, tasked with responsibility for convening discussion or planning groups as necessary and acting as rapporteurs for the specified issues at IWG meetings.)

1. Budget and legislation

During this session of Congress, more than ten global AIDS initiatives have been introduced. Committees of jurisdiction in both chambers have favorably reported global AIDS legislation ranging from $510 million for FY2001 in the Senate to $1 billion over 5 years in the House. Ideas vary from enhancing existing bilateral efforts through USAID to creating a new multilateral AIDS Trust Fund at the World Bank. Currently, there seems to be considerable momentum on the Hill for moving a global AIDS

initiative either freestanding or as part of the Foreign Assistance or African Trade bills.

- Pending authorizing legislation should support or enhance the Administration's goal of securing an additional $100 million for the expansion of our current global AIDS initiative. Outcomes and strategic USG goals should define which legislative mechanisms and pending bills we should support.

- The Administration would proactively work with Congress to craft HIV/AIDS legislation that bolsters and helps launch international leadership initiatives and do not undermine other vital antipoverty/AIDS priorities such as HIPC.

- ONAP and WH legislative affairs will coordinate Administration response to the authorization bills, and take a proactive approach to the appropriations debate so as to maximize FY2001 funding of global AIDS activities. (ONAP)

2. ***Diplomacy and awareness***

The Department of State has aggressively increased its diplomatic outreach and education efforts, including the Secretary's 1999 International Response to HIV/AIDS and recent cables (State 34645, State 58033) to diplomatic posts calling for a dramatic increase in Embassy engagement with host countries.

- Strengthen U.S. diplomatic efforts

  ✓ Advance the concept, suggested by USUN, of having countries name Presidential Envoys for AIDS Control (PEACs). Each concerned country would name a senior envoy that would meet, debate, and help coordinate international efforts to deal with the thornier problems of the epidemic. Meetings of PEACs would provide a forum for discussion of issues needing international action, such as drug availability in poor countries, and making recommendations for innovative actions. (ONAP, State)

  ✓ Target USG efforts at the countries most at risk and target leadership in countries already heavily infected. (State, USAID)

- ✓ Broaden diplomatic efforts to include regions other than Africa, including Asia and the Newly Independent States. (State)

- ✓ Highlight and actively implement in other at-risk countries the successful national AIDS programs in Uganda, Thailand and Senegal. (USAID, State)

- ✓ Develop a high-profile communications strategy for public diplomacy on HIV/AIDS control. (State)

- ✓ Develop at each Embassy a comprehensive HIV/AIDS action plan and integrate it into work and reporting requirements and resource allocation. (State)

- ✓ Establish required HIV/AIDS briefings for appropriate DOS Bureau personnel, including new Chiefs of Mission, Ambassadors, DCMs and others in Washington or in regional meetings. (State)

- ✓ Provide diplomatic posts with sufficient epidemiological and best-practices information through a dedicated DOS AIDS information officer, or through USAID missions. (State, USAID)

- Persuade foreign leaders of the profound effect of AIDS on their national security in terms of impact on political stability, economic growth, and civil society (NSC, State).

  - ✓ Provide leaders with briefs and analyses on AIDS in their regions. (State, USAID, DOC)

  - ✓ Issue new demarches on the security and health aspects of AIDS to be carried by the Ambassador to the head of state. (State)

- Develop innovative sustainable policies in partnership with other U.S. agencies, international organizations and entities. (State)

  - ✓ Increase involvement with the U.S. and foreign business communities on HIV/AIDS, including information dissemination and worker education. (DOC, USTR, USAID)

  - ✓ Work with the G-8, multilateral development banks and others to move basic health care, including AIDS prevention

and control, to the top of the finance and debt reduction agendas. (Treasury)

✓ Collaborate with WHO, UNAIDS and other UN agencies to develop more effective prevention, awareness and treatment programs. (HHS, USAID, State)

- Make international health and scientific collaboration on HIV/AIDS a priority in science and technology programs facilitated by the State Department. (State, HHS)

3. ***Security***

This year, the NIC, CIA and DIA have all produced excellent intelligence products on the impact of AIDS on the security, stability and economies of the hardest hit nations. DoD has prepared U.S. military education and training materials for HIV/AIDS prevention, some of which have been adapted for UN peacekeeping forces and given to USAID for review in FY2000. These materials could be adapted for African militaries in FY2001. Funding for expanding military-to-military training for HIV/AIDS prevention is in the President's FY 2001 budget request.

- In order to advance our operational goals regarding the public health and security aspects of the epidemic, each component of the intelligence community should work to increase collection of relevant data and provide periodic updates on the extent and impact of AIDS in their specific areas of responsibility. (CIA, NSC)

- DoD has shared U.S. military specific educational modules with USAID. These education modules will be adapted for specific cultural needs. DoD has begun limited, active involvement with HIV/AIDS prevention education and training with certain African militaries and should expand these efforts as soon as possible. (DoD)

- Secretary Cohen ensures appropriate and adequate HIV/AIDS prevention, education and training for the U.S. military. It is recommended that he should, as a priority, also reinforce the need for comparable HIV/AIDS prevention, education and training in international defense forces, and for UN peacekeeping forces. (DoD, State, USUN, NSC)

- In addition to supporting the Administration's $10 million funding directly to DoD for this program in FY2001, DoD will work closely with DOS to identify FY2002-2007 International Military Education and Training (IMET) resource additions to fund (in the U.S.) HIV/AIDS professional education and prevention efforts. (DoD, State)

- All UN peacekeeping operations should effectively deal with AIDS education as an active and required responsibility. The U.S. should pursue negotiation of a UN Security Council Resolution on HIV/AIDS as a security issue, mandating HIV/AIDS prevention efforts for UN Peacekeepers. (State)

4. ***Economics, Trade and Finance***

- Multilateral

  ✓ Support UNAIDS International Partnership Against AIDS in Africa and its efforts to dramatically increase political will and action by African governments. (USAID, State)

  ✓ Actively seek support for the President's proposal that the multilateral development banks dedicate an additional $400-$900 million in concessionary loans for basic health care and systems needed to expand immunization and prevent and treat infectious diseases, including AIDS. Actively encourage the EU and the G-7 to join in this request, and request all OECD donors to increase AIDS funding at each meeting and opportunity. (Treasury, NSC, OSTP)

  ✓ Actively encourage Highly Indebted Poor Countries (HIPC) to use, as a priority, their debt service savings for poverty reduction, including HIV/AIDS prevention and care activities. USAID and Treasury should help countries prepare Poverty Reduction Strategies to include AIDS control. High priority countries either approved or being considered include, Uganda, Mauritania, Mozambique, Benin, Tanzania, and Senegal. (Treasury)

  ✓ Follow-up the DOL/AFL-CIO Trade Unionist Summit to advance HIV prevention issues at the April meeting of the ICFTU in Durban, the SADC meeting and the 13th International AIDS Conference in Durban in July. (DOL)

- ✓ Collaborate with the International Labor Organization to establish and enhance multisectoral framework for HIV/AIDS workplace education. (DOL)

• Bilateral

- ✓ Expand DOL involvement with AIDS prevention activities with other country labor unions, using $10 million FY 2001 funds. (DOL)

- ✓ Develop web sites containing workplace training manuals for HIV/AIDS to promote HIV/AIDS workplace education and prevention. (DOL, DOC)

- ✓ Establish a workplace HIV/AIDS education/training pilot project in Malawi during current fiscal year. (DOL)

• Private Sector

- ✓ Convene representatives from different industry sectors with government officials to discuss concrete suggestions to increase public/private cooperation in the battle against AIDS. Add NGOs as discussions progress. Do not limit to Africa. (OVP, DOC, HHS, Treasury)

- ✓ Expand the current USTR/HHS working group on trade and access to essential medicines. In discussions among health and trade agencies, generate a rational and forward-leaning approach to improving infrastructure and access to needed medications, while ensuring protection of intellectual property rights. Solicit input from NGOs and affected industries. Aim for mid-May delivery date for "next steps" in advance of the State visit of President Mbeki from South Africa. (ONAP, HHS, USTR, DOC, Treasury)

- ✓ Work with Congress to approve the Presidential initiative to provide a $1 billion tax credit for the sales of vaccines developed for HIV/AIDS (and other diseases such as TB and malaria that kill over 1 million annually). (Treasury, NSC, OMB)

- ✓ Increase outreach activities to foundations to raise funding of international AIDS activities. (USAID, ONAP, HHS)

✓ Work with industry to develop multimedia commercials showcasing a unified public, private, NGO, international AIDS effort. Will motivate industry participation and raise public awareness. (DOC)

✓ Implement an outreach to industry for donations of multimedia equipment for communities and grass roots organizations to promote HIV/AIDS prevention and awareness. (DOC)

✓ Select a group of high-profile U.S. and foreign personalities for public service announcements related to global AIDS issues. (ONAP)

✓ Construct a Global AIDS Internet site, "Millennium Networking Against the Global HIV/AIDS Epidemic." (USAID, HHS)

✓ Sponsor video productions, in cooperation with U.S. national filmmakers, and with the partnership of African and other national governments. Emphasize real people in real situations. (State, USAID)

✓ Initiate an "adopt-a-school" program with NGOs, religious groups and the private sector, providing funds to keep AIDS orphans in school. (ONAP)

5. ***Prevention and Care and Research***

The U.S. Government is spending, in FY 2000, over $225 million overseas for HIV/AIDS prevention and care programs alone (excluding research funding). Current USG activities emphasize primary prevention, biomedical and behavior research and training, improving community and home based care. The following recommendations are for additional emphasis and action.

- Develop a working list of what governments and donors are spending in each country on HIV/AIDS prevention, treatment and care activities to focus new efforts on needs and gaps. (USAID)

- Restate the Administration commitment to develop a preventive HIV vaccine within the next 10 years. This should emphasize developing country (Africa, India, others) participation in the critical research. (HHS, USAID)

- Initiate regular meetings co-chaired by USAID and HHS to coordinate specific strategies focusing on the delivery of prevention, medical treatment and care services to impacted communities. Expand activities and funding for treatment of opportunistic infections (such as TB and pneumonia), including increased availability of appropriate antibiotics and other medications. (USAID, HHS)

- USAID should be the lead agency for coordinating USG input into country-level HIV/AIDS activities, and will collaborate with HHS and the Department of State to develop a clear protocol to facilitate the entry of new USG partners into collaboration with individual country programs. Country-level coordination, especially where USAID or HHS do not have permanent staffs, should be part of the developed protocol. In situations where HHS/NIH are doing collaborative biomedical research, arrangements for adequate coordination with other USG agencies working in country must also be assured. (USAID, HHS)

- Quickly establish a Working Group, under the joint chair of HHS and USAID, to focus on the challenges of delivering services to reduce mother-to-infant HIV transmission. Issues include: increased access to accurate HIV testing and confidential counseling; the risk of breast feeding and safety of infant formula in low resource situations; efficacy and safety of short course anti-retroviral drugs such as Nevirapine and AZT, and concern that drug treatment may divert resources form other services. (HHS, USAID)

- Fully implement an initiative to train all 2,400 Peace Corps Volunteers in Africa in HIV/AIDS prevention and awareness techniques, and field teams of experienced former Peace Corps Volunteers to assist on critical AIDS projects. (Peace Corps).

- Highlight and actively implement in other countries the successful Peace Corps AIDS projects in Malawi, Thailand and Senegal. (Peace Corps).

- NIH, CDC and others should establish centers of excellence in international settings that will support basic research and long-term cohort studies; serve as locations for studies of efficacy of biomedical and behavioral prevention interventions, including Phase I, II, and III vaccine trials as well as trials of topical microbicides; function as training centers for investigators from throughout the region;

and provide bridges to services. The centers should provide an environment for the development of true and equal partnerships between the U.S. and foreign investigators. (HHS)

- Call for consistent Administration messages on the need to empower women to reduce their vulnerability. Consider a major initiative to accelerate microbicide development. (HHS, USAID, State)

- Call for the Administration to make a statement to more fully involve the faith communities, both here and abroad, with prevention efforts and patient care. (ONAP)

- Because global TB, now exacerbated by HIV/AIDS, is the leading cause of death in the developing world, pledge increasing support to the international "Stop TB" initiative. (HHS, USAID)

- Endorse community-based approaches to support children and their families affected by AID (especially avoiding dependence on orphanages). (ONAP, USAID, Peace Corps).

- Consult with Congress on extending the "notwithstanding" provisions of the Foreign Assistance Act, Section 522, (Child Survival, AIDS and other activities) to include an exemption from the "Buy America Act" (Section 604) to allow procurement of critical HIV/AIDS pharmaceuticals and other selected commodities. (OMB, USAID)

USG Coordination of International AIDS Activities

Commending the work of the Office of National AIDS Policy (ONAP) in our global efforts, the Interagency Working Group recommended that ONAP retain the USG focus for international HIV/AIDS coordination. However, that office currently has insufficient personnel resources to fully staff its international as well as domestic responsibilities.

Therefore it is recommended that ONAP be expanded to include a Deputy for International Affairs to cover the broad coordination of USG activities related to the global epidemic.

The Deputy Director for International Affairs, to complement ONAP's interagency responsibilities, would be designated to coordinate USG international activities for that office, and, in

doing so, maintain a close working relationship with National Security Council senior staff, especially the senior health advisor to the Assistant to the President for National Security Affairs.

Nora

Worth passing to Sandy T? (Believe we should not add to @Africa scheduling pile right now, but looks good)

NATIONAL INSTITUTES OF HEALTH
COMMITMENT TO INTERNATIONAL AIDS RESEARCH

NIH AIDS Research Program and Budget

- The conduct of research is a critical component of a comprehensive strategy to improve the international response to HIV. Even resource-poor nations can make long-term commitments to participate in research, through collaboration with partners in industrialized nations.

- The National Institutes of Health (NIH) represents the largest single public investment in AIDS research in the world. It supports a comprehensive program of basic, clinical, and behavioral research on HIV infection and its associated opportunistic infections and malignancies.

- Half of the total $2 billion NIH AIDS research budget supports basic research that benefits all HIV-infected individuals, including those in developing countries. Of the remaining half, NIH conducts and supports AIDS research that has important specific international benefits. Some of this research is taking place in international research sites.

- NIH collaborates with UNAIDS, host country governments, and in-country scientists in prevention research and preparation for efficacy trials. Sites have been established in Uganda, South Africa, Haiti, Malawi, Thailand, India, Zimbabwe, Zambia, Trinidad and Tobago, Brazil, and Kenya.

- NIH will significantly increase its investments in this area in FY 2001. The major areas of the NIH AIDS research program of benefit to the international community include:

    - Vaccine Research
    - Development of Topical Microbicides
    - Prevention of Disease Transmission and Disease Progression
    - Research on Women and AIDS
    - Prevention and Treatment of HIV Infection in Children
    - Prevention and Treatment of Opportunistic Infections, including Tuberculosis
    - Capacity Building and Training of Foreign Scientists
    - Research Collaboration
    - Private Sector/Foundation/NGO Support

Vaccine Research

- The toll of the epidemic in developing countries where therapeutic and prevention interventions are unavailable or unaffordable, as well as in industrialized parts of the world, dictates the important emphasis on vaccine development.

- NIH spending for AIDS vaccine research has increased 100% since FY 1995.

- <u>President's Vaccine Initiative:</u> The President has made the discovery of an AIDS vaccine a national research priority. A safe and effective vaccine is the critical missing element in our armamentarium for the prevention of HIV and ultimate control of the pandemic, and remains one of the highest research priorities. A new Vaccine Research Center has been established at the NIH.

- <u>G-8 Initiative:</u> At the Summit meetings of the G-8 nations for the past two years, we have agreed to work to devote appropriate resources to the quest for an AIDS vaccine. NIH has also pledged to work with other G-8 nations on vaccine research efforts.

- In recognition of the need to develop vaccines that are efficacious against a variety of strains found around the world, NIH supports studies analyzing genetic and antigenic variation of HIV and targeted toward eliciting cross-reactive immune responses.

- Vaccine Clinical Trials:

  - The NIH AIDS Vaccine Evaluation Group, consisting of 6 U.S. sites, is evaluating potential HIV vaccines in phase I and II clinical trials. To date, more than 46 trials with 24 different vaccine candidates and adjuvants have been conducted.

  - In preparation for Phase III efficacy trials, NIH supports the HIV Vaccine Trials Network, a domestic and international network of sites that are currently identifying the cohorts of populations at risk for HIV infection and building the infrastructure necessary to conduct large-scale efficacy trials of potential HIV vaccine candidates when they become available. These efforts involve strengthening in-country research capacity. Awards will be made shortly, including sites in developing countries.

- The changes that have been implemented in this area over the past few years, and the scientific advances that have been achieved, have enormous potential significance, not only for AIDS but for other diseases as well, as progress made in the development of an AIDS vaccine will certainly have implications for vaccines against other life-threatening illnesses.

Development of Topical Microbicides

- The development of safe, effective and acceptable topical microbicides is a global need to protect women around the world from sexual transmission of HIV infection. The Secretary has made this a high priority for U.S. government-supported research.

- NIH sponsors a comprehensive biomedical and behavioral program for the discovery, development, preclinical testing, and clinical evaluation of topical microbicides and other female-controlled barrier methods for prevention of HIV transmission.

- NIH plans to expand its Topical Microbicide Program Projects involving multidisciplinary research to develop and test new agents and will expand contracts and grants for developing and testing spermicidal and non-spermicidal microbicides and other female-controlled barrier methods.

Prevention of Disease Transmission and Disease Progression

- NIH-sponsored programs target studies on factors related to transmission of HIV and the pathogenic mechanisms associated with HIV disease progression through a number of studies in Africa, Asia, and Latin America. These studies focus on the biologic determinants of infectiousness and susceptibility.

- NIH sponsors an extensive biomedical and behavioral research program for the discovery, development, preclinical testing, and clinical evaluation of interventions to prevent HIV transmission, slow disease progression, and limit disease mortality. These intervention programs include the development of topical microbicides and other barrier methods, sexual and drug-using behavioral interventions, strategies to reduce perinatal transmission, and prevention of sexually transmitted diseases.

- The Prevention Trials Network is designed to conduct research on promising and innovative biomedical/behavioral strategies for the prevention or reduction of HIV transmission among at risk adult and infant populations. The research will include: (1) evaluation of a broad range of interventions designed to reduce adult and perinatal transmission of HIV; (2) basic laboratory studies which address viral and host factors related to risk of transmission, mechanisms of transmission and/or modes of action of successful prevention strategies; and (3) testing of microbicides. The network will include sites in developing nations.

- Blood safety: In FY 2001, NIH will initiate a new program targeting the development and evaluation of effective, low cost, and reliable assay systems and inactivation processes to improve the safety of blood supplies in low resource, developing countries.

Research on Women and AIDS

- A number of studies specifically examine complications of HIV disease that are unique to or more prevalent in women than in men. A critical area of concern is the impact of HIV on cervical cancer, as co-infection with human papilloma virus (HPV) is common in HIV-infected women. For example, a study in Africa is examining the natural history of cervical neoplasia in women infected with HIV-1 and HIV-1 and the role of HPV as a risk factor.

- An NIH multi-site international trial is investigating whether women who use hormonal contraceptives are at increase risk for sexual acquisition of HIV. Other studies are planned to examine the possible effects of hormones on infectiousness and disease progression.

Prevention and Treatment of HIV Infection in Children

- Preventing transmission from HIV-infected mother to child is a priority of NIH intervention research. Initiation of treatment with zidovudine prior to birth, during delivery, and to the infant has significantly reduced the incidence of maternal-fetal HIV transmission in the United States. However, this protocol is not easily applied in developing countries because of cost factors and lack of health care infrastructure. Simpler and less expensive antiretroviral regimens for interruption of vertical transmission are being tested by NIH.

- To reduce transmission further, NIH research is pursuing studies to better understand the timing, mechanisms, and risk factors of perinatal transmission; whether specific strains are more likely transmitted; and the role of co-infection and other factors.

- **Nevirapine Study**: Clinical findings from an NIH trial in Uganda demonstrated that a single oral dose of nevirapine at the onset of labor to the HIV-infected woman and a single dose of oral nevirapine to her infant within 72 hours of birth reduced the risk of maternal-infant HIV transmission by nearly 50 percent. This simplified, low-cost regimen ($4) has significant international implications, since it may be a viable way of decreasing perinatal transmission in developing nations.

- **Breast Feeding**: A recent NIH-sponsored study showed that risk of HIV transmission through breast feeding is highest during the first few months of life. This finding and other ongoing studies will provide important information on the timing, risk factors, and potential approaches to block this mode of HIV transmission.

- **Caesarean Sections:** While initial studies have demonstrated the potential benefits of caesarean sections in reducing the risk of perinatal transmission, further studies are needed to assess the benefits against the risk of these surgical procedures on the infected woman and the potential applicability of this procedure in developing nations.

Prevention and Treatment of Opportunistic Infections

- Tuberculosis (TB) represents the most common human infection in the world and is the attributable cause of one-third of all adult deaths in developing nations. HIV infection confers the greatest known risk for the development of TB, both the reactivation of latent infection and progression to primary disease, and UNAIDS estimates that approximately 30% of all AIDS deaths result directly from tuberculosis. Particularly ominous is the emergence of multidrug resistance.

- In collaboration with the government of Uganda, NIH has made significant progress toward practical and affordable prevention measures to reduce the burden of tuberculosis. NIH-supported scientists in Thailand are studying risk factors for infection with *Penicillium marneffei*, a newly-described fungal infection that is the major OI in Thailand and potentially in other Asian nations.

Capacity Building, Training of Scientists an Information Dissemination

- It is critical to the success of international studies that foreign scientists be full and equal partners in the design and conduct of collaborative studies and that they have full responsibility for the conduct of studies in-country.

- To help build capacity in developing countries, the NIH funds the AIDS International Training and Research Program (AITRP). The AITRP provides research training to foreign scientists through grants to U.S. universities. The program has provided training in the U.S. for scientists from developing countries in Africa, Asia, and Latin America, and training courses have been conducted in 60 countries. Pilot studies will be launched in FY 2000 to reduce HIV transmission through improving the blood supply in developing nations.

- NIH-supported HIV-related research helps to build laboratory capacity in developing countries where the research is conducted through purchase of laboratory equipment and transfer of research technology.

- The translation of research results into effective prevention programs and improved patient care is a high priority. NIH is continuing efforts to assure that research results relate to the cultural, social, and economic contexts of developing countries.

Research Collaboration

- NIH has established the International AIDS Research Collaborating Committee. The goal of the Committee is to assist in (1) enhancing and promoting international collaboration in HIV research; (2) developing a coordinated international HIV research effort, including biomedical, behavioral, and social science studies; and (3) providing a forum for international exchange. Its membership includes the NIH, other government agencies and departments that conduct and support international research on HIV/AIDS, agencies involved in the implementation and dissemination of the results of such research, and international organizations such as UNAIDS and the World Bank.

- The development of international collaborations for tracking the natural history and epidemiology of infectious diseases and for obtaining and identifying variants of infectious agents from different geographic regions helped expedite research on AIDS. This experience, and the collaborations established, will be of great value as new epidemic diseases emerge in the future.

To be released after -

Final Draft 26/Jan 8:00 pm

January 27, 2000

President Clinton Unveils Millennium Initiative to Promote Delivery of Existing Vaccines in Developing Countries and Accelerate Development of New Vaccines

In his State of the Union address, President Clinton will call for concerted international action to combat infectious diseases in developing countries. These diseases cause almost half of all deaths worldwide of people under age 45, killing over eight million children each year and orphaning millions more.

The President committed the United States to addressing this terrible problem in his September speech to the United Nations General Assembly. Now the President is asking for foundations, pharmaceutical companies, international agencies, and other governments to join us in this task, and he is announcing these specific elements of his Millennium Initiative:

- **A new financial commitment to purchase and deliver existing vaccines in poor countries.** As Vice President Gore told the U. N. Security Council earlier this month, the Administration's FY 2001 budget will include **a proposed $50 million contribution to the vaccine purchase fund of the Global Alliance for Vaccines and Immunization (GAVI).**

- **Increased investments in health in developing countries. The President is calling on the World Bank and other multilateral development banks to dedicate an additional $400 million to $900 million annually of their low-interest-rate loans to expand immunization, prevent and treat infectious diseases, and build effective delivery systems for other basic health services.** These investments are as central to economic progress as investments in education and physical infrastructure, and they would build on the new focus on basic health services that we have supported as part of the Highly Indebted Poor Countries (HIPC) debt initiative. This proposed shift in existing resources does not require additional U.S. budget expenditures.

- **A significant increase in basic research on diseases that affect developing nations.** The Administration's FY 2001 budget for the National Institutes of Health includes **a sharp step-up in research critical to the development of vaccines for malaria, tuberculosis, and HIV/AIDS.**

- **A new tax credit for sales of vaccines for malaria, tuberculosis, and HIV/AIDS to accelerate the invention and production of these vaccines.** Because developing countries often cannot afford to buy vaccines, the market provides little incentive for pharmaceutical companies to develop vaccines for diseases that disproportionately affect those countries. This tax credit would provide such an incentive, because **every dollar paid by a qualifying organization to buy a qualifying vaccine would be matched by a dollar of tax credits – representing up to $1 billion of additional funding for future vaccine purchases.** The President is calling on other governments to make similar purchase commitments, so that we can ensure a future market for these critically needed vaccines.

5-10% of IDA money.

doesn't require a bill: does NOT require new $ (no Congress)

Davos speech.

a way to get around dumping drugs on countries which don

Leach bill

billions of IDA loans for AIDS.

pharmaceutical + biotech companies

a Billion dollar tax credit.

to anyone who develops or a government or an NGO.

only thing in State of the Union

Jeff Sachs. Tim Geitner @ Treasury came up of this — Summers approved this.

POLICY RATIONALE AND ADDITIONAL EXPLANATION

Infectious Diseases Pose a Mounting Social and Economic Burden on Developing Countries – And a Threat to Our Health As Well.

- More than eight million children die each year of centuries-old diseases like malaria, tuberculosis, and respiratory and diarrheal diseases. Deaths from the modern scourge of AIDS are climbing rapidly. Altogether, as many children die of infectious diseases each year as the total number of combatants who perished in World War I.

- In an interconnected and highly mobile world, health crises in other countries are a threat to everyone. We have seen this with HIV/AIDS, with the resurfacing of tuberculosis, and with the outbreak last year of West Nile encephalitis in New York. According to the Global Health Council, during the past 50 years, at least five times as many Americans have died from communicable diseases that have come from the developing world than have died in military conflicts.

Vaccines Are One of the Most Cost-Effective Ways to Improve the Well-Being and Productivity of the Poorest Countries – And Medicines and Other Basic Health Services Are a Necessary Complement.

- It costs about $17 to immunize a child, but millions of children die each year of diseases that could be prevented by existing vaccines. Indeed, children in developing nations are 10 times more likely to die of a vaccine-preventable disease than children in developed nations. And these tragedies occur in spite of the enormous efforts of UNICEF and others to vaccinate children, which save 3 million lives each year.

- Highly effective vaccines do not yet exist for malaria, TB and AIDS, which take over 5 million lives each year. But developed nations have the scientific and technological capacity to make new vaccines possible. For example, recent work on genetic sequencing, including the human genome, will open vast possibilities.

- Another health investment with very high returns is simple preventive and curative services. Providing this basic health care together with vaccines would save millions of lives each year.

A $50 Million Contribution to GAVI to Buy Vaccines For Children – Which Will Save Lives Now and Create Confidence that a Market for New Vaccines Will Exist in the Future.

- GAVI, the Global Alliance for Vaccines and Immunization, was formed as a collaborative effort of UNICEF, the World Health Organization (WHO), the World Bank, private foundations, bilateral aid agencies (including the U.S. Agency for International Development), industry representatives, and developing countries. GAVI established the "Global Fund for Children's Vaccines" with an initial grant of $750 million over 5

years from the Bill and Melinda Gates Foundation. The formal launch of GAVI, and the official announcement of the Gates gift, will occur shortly in Davos, Switzerland.

- A U.S. contribution will help to purchase vaccines for Hepatitis B, Haemophilus Influenzae B (Hib), and Yellow Fever, along with related safe delivery equipment such as auto-destruct syringes. To ensure that GAVI's vaccine purchases complement, rather than replace, existing vaccination efforts, they will be conditional on a country achieving 50 percent coverage of the DTP (diptheria-tetanus-pertussis) vaccine, which is included along with measles and polio in the existing EPI (Expanded Program for Immunization).

- A U.S. contribution will hopefully catalyze significant contributions from other countries and foundations. It will also add crucial credibility to the international community's commitment to provide a market for new vaccines when they are developed.

We Must Shift Existing International Resources Toward Building Health Infrastructure in Poor Countries That Can Deliver Vaccines and Medicines and Provide Essential Basic Health Services.

- The World Bank and other multilateral development banks (MDBs, such as the African Development Fund) lend money on highly favorable terms to the world's poorest countries. Today, roughly $1 billion to $1-1/2 billion of this so-called "concessional funding" is devoted to health care each year. The Administration proposes to increase that amount by $400 million to $900 million per year, with a focus on:
  - immunization;
  - prevention of diseases using basic measures such as information and condoms for AIDS, treated bed nets for malaria, and stronger systems for containing TB;
  - treatment of diseases, including common respiratory and diarrheal infections; and
  - more effective provision of basic health care.

- The Administration is exploring ways to use the HIPC debt reform to support this part of the Millennium Initiative. One possibility is to make an increase in vaccination rates one of the performance targets monitored in the HIPC progress reports. This could be accompanied by debtor countries' agreements to include specific improvements in vaccine delivery systems as priority uses of debt relief proceeds. We also expect that all Poverty Reduction Strategy Papers that are prepared for HIPC candidates will discuss the adequacy of budget resources and suggested policy reforms devoted to basic health care.

- This re-direction of resources supports the Administration's overall strategy for global development, which emphasizes poverty reduction and gives a central role to "global public goods" – like health or the environment – in which positive actions taken in one country benefit other countries as well. To meet this objective, these funds should not come from spending on other basic social programs, such as education and health care.

- This aspect of the Millennium Initiative does not require a new budgetary commitment by the United States (or other donor countries). However, the U.S. ability to influence the direction of MDB lending and the use of HIPC proceeds depends crucially on meeting our existing commitments to these aid programs. We will work with other G-8 finance and development ministries to refine this proposal.

- A conservative estimate suggests that if basic health care including immunization were made broadly available, up to 2 million children's lives could be saved each year.

Higher Funding for Basic Scientific Research Through the National Institutes of Health (NIH) and Elsewhere Will Hasten the Development of Vaccines for Malaria, TB, and AIDS.

- The Administration's FY 2001 budget for NIH includes a significant increase in research critical to creating vaccines for these diseases. For malaria and TB, this increase will build on recent advances in the genetic sequencing of these diseases, which have set the stage for major breakthroughs in vaccine development.

- Funding for NIH malaria vaccine research will increase by 20 percent over the FY 2000 level. Future research will range from pre-clinical studies aimed at improving our understanding of the malaria parasite, through the development of vaccine candidates, to clinical trials judging vaccine efficacy and safety. NIH will also expand its collaboration with scientists in malaria-endemic regions, especially in Africa, to strengthen those regions' capacity for conducting clinical trials of malaria vaccines in the future.

- NIH research on a tuberculosis vaccine will receive 50 percent more funding than in FY 2000 and nearly double the FY 1999 level. NIH will focus on studying the body's defense mechanisms against TB, and developing and studying TB vaccine candidates. Through its Tuberculosis Research Unit, NIH supports an international multi-disciplinary team to translate advances in basic research into new tools for fighting TB.

- NIH funding for AIDS vaccine research will increase substantially in FY 2001 and will have more than doubled since FY 1997. These additional resources will allow NIH to accelerate basic research on developing vaccine candidates and to significantly expand testing of potential vaccine candidates in both developing and developed countries. The new Vaccine Research Center on the NIH campus, which will be occupied this summer, will receive a sizeable increase in funding for the development and pre-clinical testing of HIV vaccine candidates.

- The Administration is providing strong support for the path-breaking research on infectious diseases being conducted by U.S. military scientists, including the opening (in October 1999) of the Walter Reed Army Institute of Research/Naval Medical Research Center. Working in close collaboration with scientists worldwide, military scientists have developed and tested successful vaccines against Japanese encephalitis and hepatitis A –

and they are working to create vaccines and medicines to protect service people, travelers, and millions of others from malaria, HIV/AIDS, and other infectious diseases.

A New Tax Credit Would Effectively Provide Up to $1 Billion for Future Vaccine Purchases, Speeding the Invention and Production of New Vaccines.

- Current tax law provides substantial incentives for pharmaceutical research and development, including the research and experimentation (R&E) tax credit, the orphan drug tax credit, and an enhanced deduction for charitable contributions of certain products. Nonetheless, pharmaceutical companies may be reluctant to invest in developing vaccines for diseases that primarily afflict people in poor countries, because little or no paying market exists in those countries.

- Under the proposal, the seller of a qualified vaccine could claim a tax credit equal to 100 percent of the amount paid by a qualifying organization that received a "credit allocation" by the U.S. Agency for International Development (AID). The tax credit would match the qualified organizations' expenditures dollar-for-dollar, thereby doubling their purchasing power. A qualifying vaccine would be a new vaccine that received FDA approval for use against malaria, tuberculosis, HIV/AIDS, or any infectious disease that causes over 1 million deaths annually worldwide.

- For 2002 through 2010, AID could designate up to $1 billion of vaccine sales as eligible for the credit. This tax credit would be limited to new vaccines developed to fight these terrible diseases. The credit would provide a specific and credible commitment to purchase future vaccines at reasonable prices. Together with similar commitments from foundations and other governments, it would provide a critical and powerful incentive to accelerate vaccine research and development.

IDA acct.
IDA Loans
Leach bill. } — prevention + infrastructure

Seth Berkeley.
Eye Abbey.

expanding HIPC. . Bank.

+ Kerfluffle.

AFRICARE ½ budget
Carl. for Africa – almost
Ron is going to be the chair of the Presidents AIDS council.
Dellums

OFFICE OF NATIONAL AIDS POLICY
EXECUTIVE OFFICE OF THE PRESIDENT
THE WHITE HOUSE

FACSIMILE TRANSMITTAL SHEET

TO: Nora	FROM: Cheryl
COMPANY:	DATE:
FAX NUMBER: 6-9260	TOTAL NO. OF PAGES INCLUDING COVER: 3
PHONE NUMBER:	
RE:	

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

Hi Nora. Sandy wanted your thoughts on this. Pls. call me when you have a minute.

Thanks!

Cheryl (6-2959

Gayle — I told ONAP just to have the regional A.I.D. person (who works on AIDS) to look into this.

— N.

736 Jackson Place
Washington, DC 20503
(202) 456-2437
(202) 456-2438 (fax)

Note the Logo. cooool, no? (I'm sure he thinks so!)

JC WILSON INTERNATIONAL VENTURES CORP
AMBASSADOR JOSEPH C. WILSON, IV

May 3, 2000

Ms Sandra Thurman
Director, Office of National AIDS Policy
The White House
1600 Pennsylvania Ave. NW
Washington DC, 20500

Dear Sandy,

I was heartened to read about the decision to declare AIDS a threat to the United States National Security. Congratulations on everything you have done to focus attention on this serious issue. After close to twenty-five years in Africa and working on African Affairs, including with Jonathan Mann when he was in Kinshasa, I know, and have reported on, the enormous devastation wreaked on African societies by the disease. While many millions have already died or will die, it is never too late to fight for future generations. I would like to be helpful in that fight, having lost too many African friends to AIDS.

When I was in Gabon, Central Africa as U.S. Ambassador, I tried to interest CDC and NIH in a world class medical research center in Franceville, constructed and staffed by international experts for the purpose of studying low fertility rates in Central Africa, and especially Gabon. The center, called the "Centre International de Recherche Medicale de Franceville" (CIRMF), also studied Hepatitis C, Ebola, Malaria and of course, AIDS. There were exchanges with but funding constraints and other higher priorities limited them, and they may have been phased since my departure in 1995.

Gabonese President Omar Bongo called me yesterday morning to support the President's announcement and offered to put CIRMF at the disposal of efforts learn more about, and to find a cure for, HIV/AIDS. I was impressed by his willingness to step forward on such a sensitive issue in Africa and I promised to do what I could to make the offer known to the appropriate American authorities, even though I am no longer in government. President Bongo will be meeting with the American Ambassador within the next few days to convey officially his offer, but I wanted to make you aware of his pledge in the hopes that you will find a way to take advantage of his initiative.

1717 Pennsylvania Avenue, NW. Suite 300. Washington, DC 20006 Telephone 202.887.6171 Facsimile 202.887.6786
Cellular 202.256.0536 E-Mail joewilson@rockcreekcorp.com

It is important to support African leadership on the HIV/AIDS, and to encourage African participation in the search for a cure. It is also important, as we have seen from the Mbeki letter, that there be constant dialogue between our scientists and politicians to ensure common understanding of the threat we all face. I hope that the U.S. government will respond positively to President Bongo's offer. We need all the help we can get. Please do not hesitate to contact me if I can be of assistance.

Sincerely yours, and warmest regards,

Joseph C. Wilson, IV

gov. is using

- Democracy is a myth

Terrible press. Flawed election.

- Land Reform is a manufactured crisis

IFES →

DRAFT

June 2, 2000

DECLASSIFIED
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KBH 8/19/2022

INFORMATION

MEMORANDUM FOR SECRETARY SHALALA
SANDRA THURMAN

FROM: KENNETH BERNARD

SUBJECT: French Proposal for a Conference on Access to HIV/AIDS Drugs

Background: The French Government has been pushing for a tripartite conference on "Access to HIV/AIDS Drugs" as a way to "improve access to the latest treatments for infected populations in the South." They originally wanted this French-hosted event to be held in a Francophone African country and include government and NGO representatives from donor and developing countries as well as the pharmaceutical industry. After much acrimonious discussion at the UNAIDS Program Coordinating Board last week, we understand they may be reformulating their proposal. The French are considering the whether the meeting to discuss drug access be broadened to include "access to care," and whether it would be done under UN auspices.

This meeting is a very important diplomatic goal for France. It will be a focus during their term in the Presidency of the EU this year. France's Ambassadors in New York and Washington as well as its Development and Health Ministers have all lobbied for the U.S. to sign-on to the idea as cosponsors. Dr. Michel Lavollay from the French Embassy in Washington is working full time to move the meeting concept forward. France likely will try to get both the International AIDS Conference in Durban and the G-8 Summit to endorse the meeting.

Other country views: At the recent UNAIDS Board meeting in Geneva, Germany, Norway, Finland, and especially Sweden and South Africa (speaking for the SADC) vehemently opposed the French conference proposal, arguing that it was premature and too focused on drugs and not on important infrastructure and the continuum of care issues. If the meeting were to be done they argued, it should be within the UN system. They proposed a "contact group" of governments and NGOs convened by UNAIDS and

its Cosponsors, to deal more broadly with care, drug access, and infrastructure as an alternative to the French proposal.

U.S. Position: In numerous working level discussions with the French, we have been very cautious about support for a meeting to deal specifically with "access to HIV/AIDS drugs," asking for more information without stating we would either fully support or formally object to the meeting. However, USG does support, and is working for, substantially increased emphasis on care and treatment (including pharmaceutical access) to complement prevention activities in developing countries.

While the proposed meeting could potentially have some utility, we agree with the UNAIDS Board discussion that before we have a global session dedicated to finding solutions to HIV/AIDS care issues, there should be regional buy-in and preparatory meetings to define questions, goals and solutions. If a conference is held, it could be led by the French, but it would be best done under the auspices of UNAIDS and its Cosponsors.

Talking Points (for the French MOH)

- We appreciate France's interest in dealing with the critical issue of care and treatment of HIV/AIDS - a sector that has been somewhat neglected in our focus on prevention.

- Drug availability and affordability are a critical components of providing care for those with HIV/AIDS, but must be viewed in the broader context of health infrastructure including HIV counseling and testing, provision of palliative and basic medical care including treatment of opportunistic infections like TB, support of community based clinics and training of health care workers.

- Any proposed Conference would have to include the broad range of care issues and be well coordinated with all interested parties. It would be difficult to see how that could be done before next year. We would also want to see the context and plans for a broadened conference before indicating our level of support.

- What do the French think of suggestions at the UNAIDS Program Coordinating Board by the Swedes and South Africans for modifying the French Conference idea - moving it to a UN institution? And the idea of a more permanent "contact group" to grapple with the drug issues?

- We would be interested to know how you will respond to what appears to be a strong negative reaction to the conference by the South Africans [NB. who were speaking also for the Southern African Development Committee - SADC].

- We are encouraged by the recent announcement by five major pharmaceutical companies to begin negotiations with developing countries to work out price structures that will make anti-retrovirals more affordable to those who need them.

- President Clinton recently signed an Executive Order allowing African countries to more easily obtain needed pharmaceuticals. The Order states that the US will not object to parallel importing or compulsory licensing of needed HIV/AIDS drugs, as long as the country follows TRIPS guidelines.

- The biggest need (for both prevention and care) in Africa right now is funding. there is a $2.5 billion annual gap between resources and needs. We are planning to call on the G-8 in Okinawa to redouble investments in international AIDS activities.

NORA
GAYLE

NAME	AGENCY	PHONE	FAX
Alex Ross	USAID	219-0476	219-0507
Mary Knox	USAID	712-0978	216-3394
Sandy Thurman	ONAP	456-2959	456-2439
Nora Dempsey	NSC	456-9261	456-9260
Ken Bernard	NSC	456-9298	456-9390
Laura Efros	NSC	456-6065	456-6028
Joyce Holfeld	USAID	712-4727	216-3394
Hal Shapiro	NEC	456-5905	456-2223
Hoyt Yee	NSC	456-9156	456-9150
Alicia Robinson	DOC	482-5418	482-5198
Jason Buntin	STR	395-9564	395-3974
Donna DiPaola	STR	395-6864	395-3891
Barbara Holloway	TREAS	622-0098	622-0218
Amar Bhat	NIH	301-496-4784	301-480-3414
Sharon Hyrnkow	NIH	301-496-1415	301-402-2173

Total pages - 4

Attached is the latest negotiated version of the text of the joint statement. It was shared with the EU on May 23. The EU has now posted this draft for comment with its member states and has given them until May 25, 5 PM Brussels time, to make comments. We have proposed that there will be a telephone conference at 10 AM on Friday to try to close any differences on text. Ken Bernard, Laura Efros, and Dick Morford will be in the chair. (This time works for the EU but has not been confirmed.)

I must have any comments and final suggestions by 5PM on Thursday. We can then raise them with the EU in the audio conference.

If you are interested in attending please me know. Thanks

Ray Walser
Tel-202- 647-1605
Fax - 202-647-9959

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

May 24, 2000 (Please discard previous texts)

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

We, the U.S. and EU, reiterate our commitment to combat HIV/AIDS, tuberculosis and malaria. Together with other countries and international organizations, we are already making a major effort. But the scale of the problem requires new mechanisms to mobilize international opinion and resources and to take appropriate actions to assist African countries. We welcome the work done in the UN Security Council during the January 2000 U.S. Presidency. In the Cairo Declaration and Action Plan of April 2000, the EU and African leaders pledged their commitment to pursue further action in this field. The renewal of the ACP-EU Partnership Agreement in June 2000 also highlights the need to work with African, Caribbean and Pacific Partners on a comprehensive approach in the context of poverty reduction. We are looking forward to G-8 initiatives on infectious diseases and poverty at the upcoming Summit in Okinawa.

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

International partnerships

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

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

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

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

Public awareness

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

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

Drugs and vaccines

- Together with developing country partners and with industry, we will strengthen our research and development cooperation in the fight against

these poverty-related diseases. In this respect, we call for enlarged partnerships aimed at speeding up research and development. We will explore new methods of evaluating needed drugs and vaccines, including strengthening capacity and training in those countries most impacted by these diseases.

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

- We will support international coordination initiatives, such as the Global Alliance for Vaccines and Immunization (GAVI), the Multilateral Initiative on Malaria and the EU-ACP West African Vaccine Independence Initiative, which encourage partnerships and international collaboration in the development of affordable drugs and vaccines.

Resources

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

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

- We will support governments that undertake to improve their heath systems with resources made available under the HIPC debt relief initiative and through the implementation of the Poverty Reduction Strategies developed in consultation with civil society and international donors.

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

OFFICE OF NATIONAL AIDS POLICY

EXECUTIVE OFFICE OF THE PRESIDENT

THE WHITE HOUSE

FACSIMILE TRANSMITTAL SHEET

TO: Nora Dempsey

FROM: Cheryl Barrette

COMPANY:

DATE:

FAX NUMBER: 6-9260

TOTAL NO. OF PAGES INCLUDING COVER:

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RE:

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

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the National Association of People with AIDS

1413 K Street, NW
Washington, DC
20005-3442
202-898-0414
FAX 202-898-0435
www.napwa.org

Mr. Henry DuToit
Embassy of South Africa
3051 Massachusetts Avenue, NW
Washington, DC 20008
202-232-0910

Dear Mr. DuToit,

I am pleased to learn of President Mbeki's plans to convene an international panel of experts to advise the Government of South Africa on HIV/AIDS issues. As a person living with HIV who serves in this country on President Clinton's Presidential Advisory Council on HIV/AIDS, I know the potential value of such an advisory body.

Various lists of names of people to serve on this panel have been in circulation, bringing together a variety of backgrounds and viewpoints. I would like to offer an unsolicited list of other names for your consideration should your government have the opportunity to appoint additional people to this important panel.

1.) Dr. Marsha Lillie-Blanton, who serves as Vice-President for Health Policy at the Kaiser Family Foundation. Dr. Lillie-Blanton has extensive experience in issues of health care financing and health care delivery systems, with a particular focus on the needs of minority populations. She can be reached at 650-854-9400.

P6/(b)(6)

[003]

3.) Dr. Mark Smith, President of the California Health Foundation, is an African-American physician with more than a decade of experience in HIV/AIDS clinical, policy and funding issues. He can be reached at 510-238-1040.

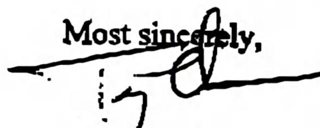
P6/(b)(6)

5.) Finally, I am disappointed that none of the lists I have seen have included the names of any people known to be living with HIV/AIDS. In this country, we have benefitted greatly from including infected people in all levels of decision-making around HIV/AIDS, ensuring that decisions are relevant to the lives of those most impacted by this epidemic. I strongly urge your government to identify

one or more South Africans living with HIV/AIDS to include on this important panel. Should you seek assistance in that matter, I would be very happy to help in any way I or my organization can.

Thank you for you attention on this important matter. Please do not hesitate to contact me directly if I can be of any assistance.

Most sincerely,



Terje Anderson
Executive Director

Department of Health

#2

Memo

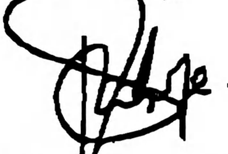
To: Dr Helene Gayle
From: Ray Mabope
CC: 091-404-639-8600
Date: 04/26/00
Re: International AIDS Panel

Dear Helene Gayle

Find attached herewith a letter of invitation from the President of South Africa, Mr Thabo Mbeki, in which he invites you to participate in the International AIDS Panel.

I would appreciate it very much if you could confirm with me your acceptance of the invitation as soon as possible.

Yours truly,



RAY MABOPE

Chief Director: National Health Systems, National Department of Health

Tel +27-12-312-0497 Mobile 072-82-458-8263 Fax +27-12-325-8721
072-45 88 26 3

E-mail: mabopr@hltrsa2.pwv.gov.za

April 24, 2000.

Sir/Madam,

In its report on the "Global Situation of the HIV/AIDS pandemic, end 1999", the WHO says:

" Of the 5.6 million people infected with HIV in 1999, 3.8 million live in Sub-Saharan Africa, the hardest-hit region. There were an estimated 2.2 million HIV/AIDS deaths in the region during 1999 (85% of the global total), even though only one-tenth of the world population lives there. In addition, there are now more women than men among the 22.3 million adults and 1 million children estimated to be living with HIV/AIDS in sub-Saharan Africa."

Clearly, this represents a major catastrophe for our country as well, as it falls within what the WHO (and UNAIDS) describe as the hardest-hit region.

Because of this, our Government took the decision that it was necessary to respond to this situation in an urgent and comprehensive manner, using all means at its disposal.

As we were investigating these means, while simultaneously working to implement measures already advised by the WHO and UNAIDS, we became aware that there was a considerable amount of disagreement among scientists about a whole variety of matters relating to HIV/AIDS.

The issues at stake are directly relevant to the comprehensive response we seek to make.

At the centre of these are such questions as:

- what causes the immune deficiency which leads to death from AIDS?
- what is the most efficacious response to this cause or causes?
- why is HIV/AIDS in sub-Saharan Africa heterosexually transmitted while in the Western world it is said to be largely homosexually transmitted? and,
- what is the efficacy of anti-retroviral drugs against HIV/AIDS?

It seemed to us that we need to be as certain as we can be with regard to these and other matters, bearing in mind the level and extent of scientific knowledge at this point in time.

We believe that this is a critical and necessary condition for us to undertake the urgent and comprehensive response of which we have spoken.

We are also aware of the fact that many others on our Continent are also preoccupied with this issue in the same way that we are, precisely because together, we are concerned that we should save the lives of the millions of Africans who, it is said, are destined to die.

For these reasons, we have taken the initiative to convene an international panel of scientists openly to discuss all the matters in contention.

We have tried to ensure that this panel includes all points of view in the debate and is constituted of eminent world scientists.

Accordingly, on behalf of the South African Government, I am privileged to extend an invitation to you to participate in this panel.

It is proposed that the first interaction of the panel should take place in South Africa on the 6-7 May, 2000.

I also attach a list of other people who have been invited to join the panel, the majority of whom have already confirmed their availability.

The South African Government will, of course, meet your travelling, hotel and other costs arising from your participation in the panel.

Our Director General of Health will contact you immediately with regard to all other matters relevant to the work of the panel, including the terms of reference, proposed procedures during the discussions etc.

I am greatly encouraged that we can count on your support in the common fight to save particularly our Continent and its peoples from the scourge of AIDS.

Yours sincerely,

THABO MBEKI.
President
Republic of South Africa.

Dear Esteemed Panelist

RE: SOUTH AFRICAN PRESIDETIAL AIDS ADVISORY PANEL

1. **WELCOME**

1.1 We wish to express our heartfelt gratitude to you for accepting the invitation to participate in the above panel and attending the inaugural meeting of the panel in South Africa on 6 & 7 May, 2000.

1.2 We wish you a pleasant journey to the sunny skies of South Africa. We are looking forward to benefit from your contributions during the panel discussion.

1.3 In your letter of invitation the President indicated that you shall receive a letter from me covering some matters relevant to the work of the panel. This communication addresses some of these areas.

2. **PANELISTS**

Herewith is the list of participants who have confirmed their participation at the meeting of 6 & 7 May 2000, as of today. We continue to receive other confirmation.

2.1 Prof Salim Abdool-Karim
2.2 Dr Bialy, Harvey
2.3 Dr deHarven, Etienne
2.4 Prof Duesberg, Peter
2.5 Dr Fiala, Christian
2.6 Dr Gayle, Helene
2.7 Dr Giraldo, Roberto
2.8 Dr Herxheimer, Andrew
2.9 Dr Koehnlein, Klaus
2.10 Dr Kothari, R
2.11 Dr Lane, Clifford
2.12 Prof Makgoba, Malegapuru W
2.13 Dr Mhlongo, Sam
2.14 Prof Montagnier, Luc

2.15 Dr Mugerwa, Roy
2.16 Dr Owen, Stephen [Facilitator-in-Chief]
2.17 Dr Paranjape
2.18 Dr Perez, George
2.19 Prof Prozesky, Wally
2.20 Prof Rasnick, David
2.21 Dr Scondras, Dave
2.22 Dr Sonnabend, Joseph
2.23 Dr Stein, Zena
2.24 Dr Stewart, Gordon
2.25 Prof Ephraim Mokgokong [Facilitator]
2.26 Dr Zuniga, Jose M

3. TERMS OF REFERENCE

The terms of reference broadly are:

3.1 Evidence of viral aetiology of HIV and related concerns about pathogenesis and diagnosis. This naturally will deal with such questions as:

a. What causes the immune deficiency which leads to death from AIDS?

b. What is the most efficacious response to this cause or causes?

c. Why is HIV/AIDS in Sub-Saharan Africa heterosexually transmitted while in the western world it is said to be largely homosexually transmitted?

3.2 What is the role of therapeutic interventions in the context of developing countries? This should cover such areas as:

a. What therapeutic interventions are appropriate in developing countries:

- In patients with AIDS
- In HIV positive patients
- In the prevention of mother to child transmission

- In the prevention of HIV transmission following occupational injury
- In preventing HIV transmission following rape.

3.3 Therapeutic prevention of HIV/AIDS.

a. The discussions above should be underpinned by considerations of the social and economic context, especially poverty and other prevalent co-existing diseases and the infrastructural realities of developing countries.

4. FORMAT OF THE MEETING

4.1 The meeting will commence at 08:00 on Saturday, 6 May 2000, and end on Sunday, 7 May 2000, at approximately 16:00.

4.2 The South African government will welcome the participants.

4.3 The Facilitator will take over and provide each participant an opportunity to make a brief input. This will be followed by an extraction and distillation of the issues to be discussed by the panel and a proposal on the work programme for the two days from the facilitators.

4.4 Prof Stephen Owen has been nominated as the facilitator-in-Chief. Two co-Facilitators will assist him. A secretariat will be in attendance to assist the facilitators and participants to document the proceedings of the meeting.

4.5 A draft summary of proceedings will be presented at the end of the meeting on Sunday. This will be followed by a detailed summary that will inform an internet discussion that will follow over a period of 6 weeks thereafter.

4.6 You will also be invited to recommend names of people to participate in the closed Internet discussion.

4.7 Finally, there will be a concluding meeting in South Africa in late June/early July [dates still to be negotiated].

5. COMMUNICATION

5.1 It is proposed that a media conference be held by the facilitators at the end of the meeting to communicate the progress made by the panel during the two-day meeting.

5.2 The South African Broadcasting Corporation [SABC] has approached the South African government with a view to do a live broadcast of the proceedings of the meeting. The government has indicated to the SABC that it would seek the permission of the panelists before acceding to their request. You are therefore requested to indicate your opinion on this matter by Tuesday, 2 May 2000, and to provide guidance regarding your preference. If, however, it is the view of some panelists that the media should not do a live broadcast of the proceeding, the request from the South African Broadcasting Corporation will be turned down without further discussion.

6. TRAVEL ARRANGEMENTS

6.1 We propose that panelists should plan to be in South Africa on Friday, 5th May, in order to start at 08:00 on Saturday. The South African government will pay or reimburse participants for a return business class flight to and from Johannesburg.

6.2 We have appointed Reynolds Travel as our travel agent to facilitate the flight arrangements and airport/hotel transfers for all the panelists. Please feel free to reach Mary Reynolds directly at maryr.saaccreynoldstravel@galileosa.co.za We have furnished Reynolds Travel with a list of all the participants who will be attending the meeting of the 6 & 7 May.

6.3 For those who need to be reimbursed for airline tickets already purchased, please contact Mrs Hannekie Botha at

hannekie@nrf.ac.za and she will make arrangements for the monies to be paid into your credit card.

7. **ACCOMMODATION**

7.1 We have booked all the participants at the Sheraton Hotel in Pretoria.

7.2 Reynolds Travel is also responsible for booking your hotel accommodation. They will provide you with the relevant information in this regard as soon as possible.

8. **TRANSPORT**

8.1 Reynolds Travel will also meet you at the airport and transport you to the Sheraton Hotel in Pretoria. Pretoria is approximately 50 kilometers away from the Johannesburg International Airport.

9. **MEETING VENUE**

9.1 The meeting will be held at the Sheraton Hotel in Pretoria where you will also be accommodated. Please let us know beforehand whether you will need any special equipment or facilities during the meeting.

10. **HONORARIUM**

10.1 An honorarium of R2,500.00 for each of the 2 days will be offered to each of the panelists.

Yours Sincerely
DR AYANDA NTSALUBA
Director General
Department of Health
Republic of South Africa
P.S. Please direct all inquiries to Mr Ray Mabope
END!

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Sunday April 30 8:10 PM ET

AIDS Threat Designation Defended

WASHINGTON (AP) - Clinton administration officials Sunday defended their decision to classify AIDS as a threat to national security - a designation aimed at garnering more attention and funding toward combating the disease worldwide.

Sandy Thurman, director of the White House Office of National AIDS Policy, said AIDS has become such an epidemic that, in years to come, it threatens to destabilize nations and the economies of whole continents.

``We have to respond to this because we've never seen a crisis like HIV and AIDS globally," Thurman said. ``We're beginning to understand that this epidemic, not only has health implications, but has implications as a fundamental development issue, an economic issue and a stability and security issue."

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Senate Majority Leader Trent Lott, in an appearance earlier in the day, said he does not believe AIDS is a national security threat.

``I guess this is just the president trying to make an appeal to, you know, certain groups," Lott, R-Miss., told ``Fox News Sunday." ``I don't view that as a national security threat, not to our national security interests, no."

Thurman countered that a report earlier this year from the National Intelligence Council indicates that the disease is ``sweeping the globe," posing a crisis in Africa today and threatening India and newly independent nations of the former Soviet Union in the future.

``With the logistical expertise that the national security community brings, with the diplomatic expertise that is necessary to sort of pave the road for leaders around the world to respond to this epidemic, this gives us a whole new ability to respond to AIDS like we would respond to any other international threat," Thurman said.

The White House, in raising the status of AIDS, has creating an interagency working group. The Clinton administration has designated

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Full Coverage

See a Yahoo! special report on **AIDS - HIV News**

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- U.S. Reportedly Calls AIDS National Security Threat - Reuters (Apr 30, 2000)
- AIDS Is Declared Threat to Security - Washington Post (Apr 30, 2000)
- AIDS deaths rise 15 percent in Miami-Dade County - Miami Herald (Apr 27, 2000)
- Lost years in the life of AIDS let polio vaccine off the hook - The Telegraph (Apr 26, 2000)

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Related Web Sites

- World AIDS Campaign: Listen, Learn, Live! - focusing on the AIDS and how it affects Children and Young People. Find out what you can do, and get statistics and background documents. From UNAIDS.
- AIDS Education Global Information System (AEGIS) - includes a searchable news archive, prevention information, a law library, information on treatment options and living with HIV.
- AIDS101.com - with news, basic information, origins, social impact of the disease, and biology.

interagency working group. The Clinton administration has designated about $325 million to fighting the disease worldwide this year, most of it going to Africa, and the president wants an additional $100 million for fiscal 2001, Thurman said.

She said a large focus of the effort would be on finding a vaccine.

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Earlier Stories

- Report: AIDS Designated a Threat (April 30)

biology.

- HIV/AIDS Treatment Information Service (ATIS) - information on federally approved treatments for HIV infection, treatment-related publications, and links to other treatment-related sites.
- Johns Hopkins AIDS Service - with publications, resources, prevention and treatment information.

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Opinion & Editorials

- Older age is no protection against AIDS - Detroit Free Press (Apr 21, 2000)
- Arresting AIDS -- Coburn's Idea: Focus First on HIV - Oklahoman (Mar 30, 2000)
- Rape victims - Dallas Morning News (Mar 7, 2000)

Magazine Articles

- Flirting With PseudoScience - Village Voice (Mar 14, 2000)
- Foo Fighters, HIV Deniers - Mother Jones (Feb 25, 2000)
- When Did AIDS Begin? - Time (Feb 14, 2000)

Audio

- Death of Singer Sparks Controversy Over AIDS and Privacy - NPR (Mar 1, 2000)

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- CDC: Minorities represent more than half of new AIDS cases among gay men - CNN (Jan 14, 2000)
- "Some cultural attitudes have to change" - BBC (Dec 1, 1999)

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April 27, 2000

GLOBAL AIDS CRISIS

Background: *The human toll of AIDS is staggering. Fifty million people worldwide have been infected with the HIV virus; 33.6 million are now living with HIV/AIDS, and annual AIDS-related fatalities hit a record 2.6 million last year. Ninety-five percent of all cases are in the developing world. AIDS is now the leading cause of death in Africa and fourth in the world. In at least five African countries, over 20 percent of adults are HIV-positive. And the highest rates of new infections are often among young women who will soon be mothers.*

On January 10, the United Nations Security Council held a daylong session on the global threat posed by HIV/AIDS. This event was the first time the Security Council considered a health issue. The session reinforced what we have stated repeatedly, that AIDS is much more than a health or humanitarian issue -- it is a development issue, a trade issue, and a key stability and security issue.

The U.S. government remains the world leader in responding to the global pandemic of AIDS. Current USG activities emphasize enhanced financial and political commitment, primary prevention, improving community and home based care and treatment, caring for children affected by HIV/AIDS, health infrastructure development, biomedical and behavioral research and training, and multisectoral efforts from the grass roots to the international level that reduce the impact of AIDS.

Challenges for the next ten Months:

- Dramatically increase international spending for HIV/AIDS prevention and patient care and treatment. The average sub-Saharan African country has only $5-20 million from all sources to spend on AIDS prevention and care – a ludicrously insufficient amount.

  - We intend to push for new initiatives to increase the accessibility of drugs to those in Africa who need them most, and to find a way to help countries decrease mother-to-child transmission of AIDS.

- Enhance political commitment by national governments to combat HIV/AIDS as a national and international priority, including

mobilizing and leveraging increased internal national budget resources.

- The President's joint statement with India on HIV/AIDS, and India's recent IDA loan to fund AIDS activities are good examples of the leadership needed.

- We will be joining the SADC....... **FILL IN PLEASE**

- Leveraging an enhanced response from other bilateral donors and multilateral institutions through a U.S.-lead international cooperative effort.

- At the US-EU Summit next month, we will be joining the EU in promoting new initiatives to increase activities to combat the epidemic, especially in Africa.

  - The Japanese have indicated that HIV/AIDS will be a major agenda item on the G-8 meeting in Okinawa in July. The U.S. will be joining our G-8 partners in pushing for increased international funding of AIDS efforts.

- Leveraging an enhanced response from the private sector in the United States, including corporations, foundations, religious institutions and non-governmental organizations.

Questions and Answers

Did South African President Mbeki send a letter to the President regarding the AIDS epidemic in his country? What did he say? Do we think that he is espousing a dangerous course of action that has been scientifically discredited? Has the President responded?

- South African President Thabo Mbeki has written to the President. The President has not yet responded. This was a private communication between two leaders and I don't want to comment specifically on the contents of the letter.

- There is no question that President Mbeki understands the depth of the health crisis facing much of Africa, including his own country. South Africa is doing a great deal, including appointing a senior government task force, an AIDS council between the public and private sector, and a country-wide education campaign.

- We recognize that the AIDS epidemic in Africa, including South Africa, is manifesting itself in different ways than it has in the United States. They are doing everything within their capacity to deal with this crisis. They don't have the same health care infrastructure that we do, for example, which means that in addition to what the South African government is

already doing, they also need to look at additional approaches relevant to specific conditions in Africa. Do we agree with the views of every expert he's consulted? No, we don't and we have communicated that to the South African government. But we do agree with his premise that more has to be done globally, and more needs to be done in Africa.

- We have to keep in mind the limited resources Africa has to deal with this. Our estimates are that in some African countries, like Uganda, treating every infected individual would cost more than ten times the national budget.

- There is no question that AIDS threatens the economic, political and social progress that Africa has made. That's the reason the Vice President and Ambassador Holbrooke put this issue front and center in the United Nations Security Council in January, and why we have an interagency working group studying how we can help Africa confront this major challenge.

Is Mbeki coming to the US on an official visit?

- We have not yet made an official announcement.

Will HIV/AIDS be on the agenda?

- Of course, as will a number of other issues of common concern to the United States and South Africa.

How much is the USG spending on AIDS, especially in Africa? Should we be doing more?

- Since 1986, USAID has dedicated over $1.2 billion to mitigate the epidemic. For FY 2000, Congress appropriated funding for our global AIDS prevention and care program of $225 million – four times as much as the next largest donor. And nearly two thirds will go to Africa. The FY2001 budget request includes an additional $100 million increase in our global AIDS effort (for a total of $325 million, excluding research) which will be targeted to: prevention; basic care and treatment; support for orphans; and health infrastructure development, and implemented by USAID, HHS (CDC), DOL and DOD. In addition, NIH is spending over $1.8 billion annually on AIDS research, with over $200 million each year in the search for a vaccine.

- Yes, we – and all concerned countries – should be doing more. The USG is now engaged in an interagency process to identify and refine a series of new initiatives and partnerships to deal with the critical issues, especially leadership, public awareness, increasing accessibility to drugs in poor countries, and prevention of mother/child transmission.

- The President plans to discuss what more the international community can do on this critical issue at the U.S.-EU Summit next month in Lisbon, and with the G-8 in Okinawa. Ongoing discussions with James Wolflensohn at the World Bank indicate that the mulitlateral development banks are willing to make substantial funds available to eligible countries to

meet the prevention, treatment and care requirements of eligible countries. This will complement the Cologne debt initiative agreement last year in which, for the first time, we agreed with our G-7 partners to encourage debt relief for the HIPC countries with the funds to be used for social and health programs such as AIDS control.