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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. report	Re: [Zimbabwe] (4 pages)	11/13/1998	P1/b(1)
<del>002. note</del>	<del>Handwritten notes from meeting with Sandy Thurman (2 pages)</del>	<del>04/09/1999</del>	<del>P1/b(1)</del> KBH 10/21/2024
003. report	Re: Africa's Growing AIDS Crisis (2 pages) <i>Partial release - KBH 10/21/2024</i>	09/03/1999	P1/b(1)
<del>004. briefing paper</del>	<del>Re: [Intellectual Property Rights] (3 pages)</del>	<del>08/31/1999</del>	<del>P1/b(1)</del> KBH 10/21/2024

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WASHINGTON, DC 20230

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**AIDS Cuts Life Expectancy in Many African Countries,  
Census Bureau Notes in World Population Profile**

AIDS has cut life expectancy by four years in Nigeria, 18 years in Kenya and 26 years in Zimbabwe -- only a few of the countries where mortality from the disease is having a major demographic impact, the Commerce Department's Census Bureau reported today.

"AIDS results in higher mortality rates in childhood, as well as among young adults where mortality otherwise is low," said Karen Stanecki, a contributing author of the Census Bureau's new report, World Population Profile: 1998. "As a result, AIDS deaths will have a larger impact on life expectancies than on some other demographic indicators in these nations."

The Census Bureau assessment shows 21 countries in Sub-Saharan Africa are significantly affected by AIDS. According to the report, HIV/AIDS epidemics continue to spread in Sub-Saharan Africa, particularly in Botswana and South Africa. Other severely affected countries include Namibia, Swaziland, Zambia and Zimbabwe, where 18 to 25 percent of all adults are HIV-positive.

Seven developing countries in Asia and Latin America also are significantly affected -- Guyana, Burma, Haiti, Cambodia, Honduras, Brazil and Thailand.

In addition to the update on AIDS mortality worldwide, World Population Profile: 1998 provides a comprehensive picture of population size and growth, fertility and mortality levels, and age structure in 227 countries and territories during the next quarter century.

The report also examines trends in family planning likely to play a key role in determining fertility and natural population increases during the coming decades.

Other points from the report:

- The world population will reach 6 billion in 1999.

- Between 1998 and 2025, the world's elderly population (age 65 and over) will more than double while the world's young (under age 15) will grow by only 6 percent.
- Early in the next century, international migration will become more of a critical variable in population growth in the United States and other developed countries, where the balance of births and deaths will otherwise lead to a stable or decreasing population.
- About 96 percent of world population increase now occurs in the developing regions of Africa, Asia and Latin America.
- A child born in Latin America or Asia can expect to live between seven and 13 fewer years, on average, than one born in North America or Western Europe.
- An estimated 120 million married women in the world's developing regions have an "unmet need" for contraceptive services and products, meaning they would like to regulate their fertility but currently are not using any means of contraception.

Data in the report are from the Census Bureau's International Data Base, HIV/AIDS Surveillance Data Base and unpublished tables.



AIDS

FACSIMILE

OFFICE OF NATIONAL AIDS POLICY  
EXECUTIVE OFFICE OF THE PRESIDENT

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Michael Skowitz

DATE:

July 15, 1998/4:06 PM Eastern

PAGES:

(Including cover sheet) 10

COMMENTS:

## THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release

December 1, 1998

**REMARKS BY THE PRESIDENT  
AT WORLD AIDS DAY EVENT**Room 450  
Old Executive Office Building

THE PRESIDENT: Thank you, Amy, for your magnificent remarks and the power of your example. Thank you, Cynthia, for coming to this big, scary crowd. (Laughter.) She was nervous. I said, well, look at the bright side -- at least you got out of school for a day. (Laughter.)

I thank the other children who are here with us. And I want to thank all the members of our administration who have helped so much in this cause -- Secretary Albright; Brian Atwood; Dr. Satcher; our AIDS Policy Director, Sandy Thurman; members of the Council on HIV and AIDS. We're glad to have Nafis Sadik here, the Director of the U.N. Population Fund. Richard Socaridies from the White House, I thank you and all the other members of the administration. And I, too, want to join in expressing my appreciation to the members of Congress who Brian mentioned for their support for AIDS funding.

But I especially want to thank Amy for being here and reminding us of what this is all about. When she was speaking my mind wandered back to an incident that occurred when I was running for President in 1992. Some of you have heard me say this before, but I was in Cedar Rapids, Iowa, a place largely known for its enormous percentage of Czech and Slovak citizens. And there was in the crowd at this rally where I was speaking a woman who was either Czech or Slovak, probably, holding an African American baby. And I said, whose baby is this? She said, this is my baby. And I said, where is this baby from? She said, Florida, I got her from Florida. (Laughter.)

And it was October in Cedar Rapids and she should have been in Florida, probably. (Laughter.) She said, this baby was born with AIDS and abandoned and no one would take this baby. This woman had her marriage had dissolved, she was raising her own children alone. But because she heard about children like this wonderful little girl, she adopted this baby.

And every year since, about once a year, I see this young child. I've watched her grow up now and I'm happy to tell you that six years later she's still alive and doing pretty well. She comes to the NIH for regular check-ups and she comes by the White House to see her friend. And every time I see Jimiya I am reminded of what this whole thing is about.

And I think I should tell you one other thing. When Amy was standing up here with me and I was telling her what a fine job she did, she said, I'm so glad that Cynthia could be here, and that I

could say Carla's name in your presence.

This is, I think, very important for people who have not been touched in some personal way -- who have never been at the bedside of a dying friend, who have never looked into the eyes of a child orphaned by AIDS or infected with HIV -- to understand. And I believe, always, that if somehow we could reach to the heart of people, we would always do better in dealing with problems, for our mind always conjures a million excuses in dealing with any great difficulty.

Let me begin, even in this traumatic moment, to say we have a lot to celebrate on this AIDS Day. We celebrate the example of Amy and Cynthia. Just think, a decade ago people really believed that AIDS was unstoppable; the diagnosis was a virtual death sentence; there was an enormous amount of ignorance and prejudice and fear about HIV transmission. Most of us knew people who couldn't get into apartment houses or were being kicked out or otherwise -- their children couldn't be in school because of fears that people had about it.

Every day, for people who had HIV or AIDS and their families -- every day was a struggle a decade ago. A struggle for basic information, for treatment, for funding, and all too often, for simple compassion.

For six years, thanks to many of you, we have worked hard to change this picture -- and so have tens of thousands of other people across our country and across the globe. We've worked hard to draw attention to AIDS and to better direct our resources by creating the Office of National AIDS Policy and the President's Council on HIV and AIDS. We had the first ever White House conference on AIDS. We helped to ensure that people with HIV and AIDS cannot be denied health benefits for preexisting conditions. We accelerated the approval of more than a dozen new AIDS drugs, helping hundreds of thousands of people with AIDS to live longer and more productive lives.

Working together with members of both parties in the Congress, we increased our investment in AIDS research to an historic \$1.8 billion. This year we secured \$262 million in new funding for the Ryan White CARE Act, providing medical treatment, medication, even transportation to families coping with AIDS. This October we declared that AIDS had reached crisis proportions in the African American, Hispanic American and other minority communities, and fought for \$156 million initiative to address that. Today the Vice President is announcing \$200 million in new grants for communities around the country to provide housing for people with AIDS.

The results of these and other efforts have been remarkable. For the first time since the epidemic began, the number of Americans diagnosed with AIDS has begun to decline. For the first time, deaths due to AIDS in the United States have declined. For the first time, therefore, there is hope that we can actually defeat AIDS.

But all around us there is, as we have heard from all the previous speakers, fresh evidence that the epidemic is far from over, our work is far from finished, that there are rising numbers of AIDS in countries like Zimbabwe, where 11 men, women, and children become infected every minute of every day. There are still too many children orphaned by AIDS, tens of thousands

here in America, tens of millions in developing nations around the world.

And when so many people are suffering, and with HIV transmission disproportionately high, still, among our own young people here in America, it's all right to celebrate our progress, but we cannot rest until we have actually put a stop to AIDS. I believe we can do it -- by developing a vaccine, by increasing our investment in other forms of research, by improving our care for those who are infected and our support for their families.

Last year at Morgan State University, I declared that we should redouble our efforts to develop an AIDS vaccine within a decade. Today I am pleased to announce a \$200 million investment in cutting edge research at the NIH to develop a vaccine. That's a 33 percent increase over last year. With this historic investment, we are one step closer to putting an end to the epidemic for all people.

I'm also pleased to say that there will be more than \$160 million for other new research critical to fighting AIDS around the world, from new strategies to prevent and treat AIDS in children, to new clinical trials to reduce transmission.

And as hard as we are working to stop the spread of AIDS we cannot forget our profound obligation for the heartbreaking youngest victims of the disease -- the orphaned children left in its wake. Around the world, as we have heard, millions of children have lost their parents. Their number is expected to rise to 40 million over the next 10 to 15 years. Some of them are free of AIDS, others are not. But sick or well, too many are left without parents to protect them, to teach them right from wrong, to guide them through life and make them believe that they can live their lives to the fullest.

We cannot restore to them all they have lost, but we can give them a future -- a foster family, enough food to eat, medical care, a chance to make the most of their lives by helping them to stay in school. Today, through Mr. Atwood's agency, we are committing another \$10 million in emergency relief that will, though seemingly a small amount, actually make a huge difference for many thousands of children in need around the world.

**I'm also directing Sandy Thurman to lead a fact-finding mission to Africa, where 90 percent of the AIDS orphans live. Following the mission she will report back to me with recommendations on what more we can do to help these children and give them something not only to live for, but to hope for.**

Eleven years ago, on the first World AIDS Day, we vowed to put an end to the AIDS epidemic. Eleven years from now, I hope we can say that the steps we took today made that end come about. If it happens, it will be in no small measure because of people like you in this room, by your unfailing, passionate devotion to this cause -- a cause we see most clearly expressed in the two people sitting right behind me.

Thank you all, and God blcss you. (Applause.)



**Secretary of State Madeleine K. Albright**  
Remarks at World AIDS Day 1998, The White House  
Washington, D.C., December 1, 1998  
As released by the Office of the Spokesman  
U.S. Department of State

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Mr. President, Brian Atwood, Amy Slemmer of Mothers' Voices Against AIDS, Carol Bellamy of UNICEF, Nafis Sadik of the UN Population Fund, distinguished colleagues, guests and friends. I am pleased to participate in this program but saddened by its necessity.

For today we observe World AIDS day for the eleventh time. And we can expect many more.

I look around this room and I see many valiant members of the global network that is fighting the causes and consequences of HIV/AIDS. That network is strong and deeply motivated; it is growing; it is active almost everywhere; but it is not yet winning the war against this disease of awful and shattering power.

Thirty-three million people are now infected with HIV. And up to forty million children will be orphaned by AIDS by the end of the next decade.

It is a deep human tragedy that 90 percent of AIDS orphans live in sub-saharan Africa. But this highly mobile disease has migrated to every corner of the earth.

So directly or indirectly, HIV/AIDS threatens us all -- whether as individuals, as family, friends and neighbors, or as members of the global community.

For we cannot build dynamic economies where one in five or even one in twenty adults is being struck down. We cannot create vibrant democratic institutions where communities are preoccupied with suffering and sorrow. We cannot count on stability where the ranks of military and political leadership are decimated. And we cannot expect a strong sense of social responsibility in the young where too many children have no parents.

All this is why fighting HIV/AIDS, and helping its victims, is a foreign policy imperative.

Soon, I will be releasing a report entitled the 1999 U.S. International Response to HIV/AIDS. This is an interagency effort to document the full range of U.S. resources engaged in the struggle against AIDS. We will use it to launch a diplomatic initiative designed to mobilize and energize others around the world -- both from the top down and the bottom up -- so that international organizations, governments and grassroots reinforce each other and pull in the same direction.

If we are to make progress, governments must understand what you and your overseas

counterparts already understand. And that is that HIV/AIDS cannot be denied or ignored or patronized or put off until tomorrow.

This is an urgent, deadly, global threat. It cannot be appeased; it must be confronted.

And as Secretary of State, I will do all I can to see that this imperative is raised as a matter of international security, at the highest levels, at every opportunity, in every region, on every continent.

On this day of special dedication, let us vow to work together across all lines of profession, culture and national borders so that we may bring closer the day when nations and people everywhere are aware of the dangers of this disease; all act to prevent its spread; all afflicted are helped and their human rights respected; and none rest until HIV/AIDS is conquered or controlled.

Thank you. And now I'd like to introduce the head of the agency whose employees have long been on the front lines of this fight, my good friend, the Administrator of the Agency for International Development, Brian Atwood.

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## THE WHITE HOUSE

## Office of the Press Secretary

For Immediate Release

December 1, 1998

PRESIDENT CLINTON COMMEMORATES WORLD AIDS DAY  
BY UNVEILING NEW STEPS TO ADDRESS THE  
GROWING CRISIS OF CHILDREN ORPHANED BY AIDS

December 1, 1998

Today, President Clinton will join Secretary of State Madeleine Albright and Brian Atwood, Administrator of the U.S. Agency for International Development (USAID), to commemorate World AIDS Day by launching a series of new initiatives to address the growing crisis of HIV/AIDS around the world, particularly the millions of children orphaned by AIDS. The President will unveil historic increases in funding for research at the National Institutes of Health (NIH) designed to develop an effective AIDS vaccine and prevention strategies to help address the problem of HIV/AIDS throughout the world. He will announce new emergency funding from USAID to support international AIDS orphan programs. In addition, he will direct his AIDS policy advisor, Sandra Thurman, to lead a delegation to Sub-Saharan Africa to assess the growing problem of AIDS orphans and recommend new strategies for responding to the crisis.

USAID projects that up to 40 million children will be orphaned by HIV/AIDS by the year 2010, over 90 percent of whom live in developing countries with few resources to provide for their care and support. Over 33 million people around the world are now living with HIV or AIDS, with another 5.8 million becoming infected every year. As with so many epidemics, children and young people bear much of the terrible burden of AIDS. In the United States, as many as 80,000 children already have been orphaned by AIDS.

Increases in funding by the National Institutes of Health for research to prevent and treat HIV around the world. The National Institutes of Health will undertake the largest single public investment in AIDS research in the world by supporting a comprehensive program of basic, clinical, and behavioral research on HIV infection and its related illnesses. This program will include:

\$200 million -- a 33 percent increase from last year's funding -- for research on AIDS vaccines to prevent transmission around the world. The development of a safe and effective AIDS vaccine is critical to stemming the growing problem of HIV/AIDS and AIDS orphans internationally. The President will announce that NIH will dedicate \$200 million to vaccine research in Fiscal Year (FY) 1999, a \$47 million or 33 percent increase over FY 1998 and an 100 percent increase over FY 1995. This investment is critical in meeting the President's challenge to develop an effective AIDS vaccine.

\$164 million for other research critical to addressing the

HIV/AIDS epidemic around the world. The President also will announce that NIH will invest \$164 million in FY1999, a \$38 million increase over last year, in critical research projects aimed at reducing the number of AIDS orphans by preventing and treating HIV/AIDS internationally. These projects will include: a new prevention trials network to reduce adult and perinatal transmission of HIV/AIDS; new strategies to prevent and treat HIV infection in children; funding to train more foreign scientists to collaborate on this epidemic; research on the prevention and treatment of the opportunistic infections, such as tuberculosis, that commonly kill people with HIV/AIDS; and research on topical microbicides and other female-controlled barrier methods of HIV prevention.

\$10 million in USAID emergency relief funding to provide support for AIDS orphans. USAID will make available \$10 million in emergency funding to support community-based efforts for orphans in the countries most affected by this problem. These efforts will include training and support for foster families, initiatives to keep children in school, vocational training, and nutritional enhancements. In addition, USAID will take steps to help prevent the spread of HIV from mothers to children and to improve medical care for children already infected with HIV.

AIDS Policy Advisor Sandra Thurman to lead fact-finding delegation to raise awareness and make recommendations to address growing problem of AIDS orphans. President Clinton will ask Sandra Thurman, Director of the Office of National AIDS Policy, to lead a fact-finding delegation early next year to Sub-Saharan Africa, where 90 percent of AIDS orphans reside. The delegation will include representatives from key Congressional offices. Its goal will be to raise awareness of this emerging problem and to develop recommendations for action.

New steps to address the continued needs of those living with HIV/AIDS in the United States. While the problem of HIV/AIDS is particularly acute internationally, the President will underscore the impact of HIV/AIDS on families in this country as well. The President will highlight an announcement today by Vice President Gore of more than \$200 million in funds this year for the Housing Opportunities for People With AIDS (HOPWA) program to prevent individuals affected by HIV/AIDS and their families from becoming homeless. The Vice President will announce these grants at a meeting with local community leaders who provide housing and other support services for people living with HIV/AIDS and with several individuals and families who have benefited from these services.

A solid record of achievement in HIV/AIDS. Today's announcements build on a deep and ongoing commitment by the Clinton Administration to respond to the AIDS crisis both in the United States and across the world. The Administration has fought for other critical investments in HIV/AIDS. This year alone, the President:

Declared HIV/AIDS in racial and ethnic minority communities to be a severe and ongoing health care crisis and unveiled a new \$156 million initiative to address this problem. This initiative included crisis response teams, enhanced prevention efforts, and assistance in accessing state-of-the-art therapies.

Worked with Congress to secure historic increases in a wide range of effective HIV/AIDS programs. Increases this year alone include: a \$262 million increase in the Ryan White CARE Act; a 12 percent increase in AIDS research funding at the NIH, totaling nearly \$1.8 billion; a \$32 million increase for HIV prevention programs at the Centers for Disease Control and Prevention; and a \$21 million increase in the Housing Opportunities for People With AIDS (HOPWA) program at HUD.

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AIDS in Africa:

- o White House AIDS Coordinator Sandy Thurman is planning a visit to sub-Saharan Africa in January. OASIA will be working with NSC to be supportive and to see whether, for example, there are additional steps the MDBs might take to address the problem.
- o A recent UN report calls Africa the epicenter of the global AIDS epidemic and makes clear that Thurman's trip is timely. The figures are horrifying enough in terms of health policy, but demonstrate graphically that this is a development disaster as well.
- o Of six million new HIV infections in the past year, over two-thirds were in Africa – most of them among economically-active groups. In the hardest-hit countries of Botswana, Namibia, Swaziland, and Zimbabwe, 20 to 26 percent of adults are HIV-positive or have AIDS. If the infection continues to spread at current rates, Zimbabwe's population growth could reach zero as early as 2002 and life expectancy in South Africa could fall from the present 68 years to 48 years in the next decade. By 2005, South African businesses could be paying out AIDS-related employee benefits equivalent to 19% of salaries, compared to 7% in 1995. Since the onset of the epidemic, 83% of global AIDS deaths have been in Africa and 95 percent of the world's AIDS orphans are African.
- o The reasons for these trends include popular disdain for condoms, slow or inadequate public awareness campaigns, and (especially in southern Africa) mass migrations of men to the cities in search of jobs, frequently leading both husbands and wives to seek out new partners. Where these problems have been vigorously addressed, as in Uganda, infection rates among the most vulnerable groups have fallen from 30 to 10% in just five years.

FINANCIAL TIMES WEDNESDAY NOVEMBER 25 1998

## INTERNATIONAL

UN REPORT SUB-SAHARAN AFRICA SEEN AS 'GLOBAL EPICENTRE OF AIDS EPIDEMIC'

## HIV infects 6m people in a year

By Clive Cookson,  
Science Editor, in London

Almost 6m people have been infected with HIV over the past year, the United Nations said yesterday in its annual update on the Aids epidemic. Half of the new infections are in the 15 to 24 age group, and two thirds are in Africa.

According to UNAids, the joint UN programme on the disease, 2.5m people died of Aids this year and the total number living with HIV rose to 33.4m.

"Two decades into the Aids epidemic, we know better than ever about prevention - how to persuade people to protect themselves, make sure they have the necessary skills and back-up, and remove social and economic barriers to effective prevention," said Peter Piot, UNAids director. "Every one of these new HIV infections represents a prevention failure, our collective failure."

Dr Piot and Clare Short, the UK international development secretary, told a news conference in London that greater availability of condoms was essential to prevent infection.

Adults and children newly infected with HIV/Aids during 1998

Total 5.8m

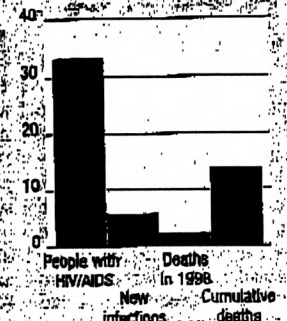


Source: UNAids, WHO

Adults and children

1998 global estimates

Million



and the virus "is clearly beginning to spread in earnest through the vast populations of India and China".

In Europe and north America new anti-HIV drug combinations - far too expensive for widespread use in developing countries - have cut the Aids death rate sharply. The number dying in the US has fallen by two-thirds in two years.

But the rate of new HIV infection in Europe and North America has remained fairly constant at about 75,000 per year over the past decade, as people persist with risky behaviour - unprotected sex and, particularly in southern Europe, sharing needles for illegal drug injections.

As a result, the number of people living with HIV is increasing steadily. Aids Care Education & Training (ACET), a UK charity, says British deaths from the disease fell from 1,276 in 1992 to 381 in 1997 and possibly as few as 250 this year, while the number infected increased from 12,000 to 20,000. ACET estimates that by 2002 there will be 30,000 people with HIV and their treatment will cost £300m (\$500m) a year.

"It needs to become as easy to get hold of a condom in a poor country as a Coca-Cola," Ms Short said. "If Coca-Cola can be everywhere throughout the poorest countries, then so can condoms."

Her appeal was supported by Bill Roedy, president of MTV, the international music channel. Yesterday he joined Ronaldo, the Brazilian football star, as a UNAids "ambassador".

Mr Roedy said he would spread the HIV prevention message prominently in media aimed at young people, including MTV.

"We try to use the influence of pop culture to

deliver a message," he said. "Quite simply, condoms are cool and using them is cooler. We want to make it trendy, hip and cool to use condoms."

The UNAids report, released ahead of World Aids Day next Tuesday, shows that sub-Saharan Africa is the "global epicentre of Aids". The epidemic is spreading most rapidly in the continent's southern-most countries, where 20 to 26 per cent of adults are infected.

In this region, Aids is "an urgent and massive threat to development," the report says. Children born in Botswana early in the next

century will have an average life expectancy of just over 40 years; in the absence of Aids, they could have expected to live to 70.

Yet there are bright spots, even in Africa. One is Uganda, which was hit hard earlier in the epidemic but is now showing signs of recovery through a vigorous prevention campaign. The proportion of urban Ugandans in the 20-25 age range with HIV has fallen from 30 per cent to 10 per cent over the past five years, Dr Piot says.

Asian infection rates are still far lower than in Africa but UNAids says more than 7m Asians are HIV positive

# Spread of AIDS in S. Africa Could Lower Life Expectancy

By LYNNE DUKE  
Washington Post Foreign Service

JOHANNESBURG, Dec. 1—As the startling spread of AIDS in Africa continues to thwart the continent's development, South Africa—the region's economic powerhouse—is showing such rapid AIDS growth that overall life expectancy here could fall by nearly a

third over the next decade.

About 14 percent of South Africa's 32 million people are infected with the human immunodeficiency virus (HIV), which causes AIDS, and 1,500 more are diagnosed with the virus each day, according to government statistics. If the virus's spread continues unabated, South Africa's overall life expectancy could fall from about 68 years to 48

years in the first decade of the new millennium, according to government and U.N. statistics.

Long sheltered from AIDS because of its international isolation under apartheid, South Africa's post-apartheid AIDS rate now is helping to fuel southern Africa's dubious distinction as the center of the global AIDS epidemic.

Most of the countries hit hardest by AIDS are in southern Africa, notably Botswana, Namibia, Zimbabwe and Swaziland. Between 20 and 26 percent of adults in those countries are infected with HIV or have AIDS.

"We now know that despite these already very high levels of HIV infection, the worst is still to come in southern Africa," said Peter Piot, executive director of the Joint United Nations Program on HIV/AIDS, which marked World AIDS Day today in South Africa for the first time. "The region is facing a human disaster on a scale it has never seen before."

South Africa is rapidly catching up with its neighbors: Of the 1.4 million people between the ages of 15 and 49 who were infected with HIV this year in nine southern African countries, slightly more than 50 percent were in South Africa.

Health experts attribute the rapid increase of AIDS in South Africa to a variety of factors, ranging from grass-roots disdain for condoms, to slow-off-the-mark public awareness campaigns, to migrant labor patterns both inside South Africa and between it and neighboring countries.

For decades, rural South African men have migrated to cities for work leaving families behind and often taking up new sexual partners. In addition, some rural women left behind take up secret partners as well. On top of these trends, South Africa's post-apartheid openness has made for a degree of cross-border traffic unheard of when international sanctions against the old white-minority regime ensured the country's isolation.

"There's an interaction between all these countries because of migration patterns," Piot said.

As sudden as South Africa's problem is, the plague of AIDS in Africa is an old one. Since the first AIDS deaths were recorded in the 1980s, 83 percent of the world's AIDS deaths have been in sub-Saharan Africa, and 95 percent of the world's AIDS orphans are African. This year, 70 percent of the world's newly infected people are in this sub-Saharan region.

As devastating as the epidemic's immediate effect has been in human terms, its economic repercussions promise a long-term erosion or thwarting of development. Economists say that growth rates are hampered in hard-hit countries because of the public and private expenditures necessitated by the epidemic. The United Nations estimates that by 2005, South African businesses will be paying out AIDS-related employee benefits equivalent to 19 percent of salaries, up from 7 percent in 1995.

"Whether measured against the yardstick of falling life expectancy, deteriorating household income, overburdened health systems, child deaths, orphanhood or bottom-line losses to business, AIDS has never posed a bigger threat to development," the U.N. AIDS program says.

Alarmed South African officials, fearing their efforts to improve the lot of this long-oppressed society are in peril, are speaking about AIDS and sex and morality in more blunt terms than ever before. Today President Nelson Mandela even called for condom use.

"Although AIDS has been part of our lives for 15 years or more, we have kept silent about its true presence in our midst. We have too often spoken of it as someone else's problem," Mandela said as his cabinet ministers were fanning out around the country to deliver similar messages.

Piot hailed South Africa's aggressive new public awareness campaign but said that "yes, it could have come earlier, that's for sure."

Little high-level public attention was paid to AIDS immediately after Mandela's government came to power four years ago—in part because of its huge post-apartheid agenda. And several policies that eventually were adopted have misfired, sparking controversy.

For instance, the government mounted a \$3 million campaign to stage an anti-AIDS musical in 1996, but the project was mired in allegations of corruption after it was revealed that proper procedures were not followed in the awarding of the contract, which went to a friend of Health Minister Nkososana Zuma. More recently, Zuma's ministry has taken heavy criticism from AIDS activists angered at the cancellation of a pilot study to give pregnant women AZT, a drug used in the treatment of AIDS. The government said the pilot was not cost-effective.

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### 360° Pure Cutlass.

December 4, 1998

DEAD ZONES: THE BURDEN OF SHAME

## AIDS Is Everywhere, but the Africans Look Away



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By SUZANNE DALEY

**D**URBAN, South Africa -- Mercy Makhalemele found out she was HIV-positive when she was pregnant with her second child. She was 23, had been married for five years, and was faithful to her husband. She cried all the way home from the prenatal clinic, but was too afraid to tell anyone for nearly a year.

When she finally did tell her husband, he beat her to the ground, knocking her against a lighted stove and badly burning her wrist, she said. Then he threw her out of the house, refusing to believe that he had given her the virus. The next day, he went to the shoe store she managed. With everyone watching, he shouted at her to collect all her things, he would have nothing to do with someone with HIV, the virus that causes AIDS.

Her employers dismissed her that afternoon.

"My story," she told a women's group gathered for a luncheon in Durban recently, "is not just my story. If you talk to other women, you will hear 90 percent the same. It will not be 50 different stories. Rejecting us is not going to solve the problem of this disease. It's just going to cause stress. So please, just accept us."

Across sub-Saharan Africa, the AIDS epidemic is everywhere. In several countries, one out of four people are now infected with the virus and will probably die within 10 years. The disease is flooding hospitals, changing the face of work places and producing hundreds of thousands of orphans. But go to a village and ask if anyone is suffering from AIDS and the answer will likely be no, there is only malaria or tuberculosis or diarrhea.

It is hard to find anyone who publicly admits to being HIV-positive. Many go to

## AIDS Is Everywhere, but the Africans Look Away

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their graves with their secret, so great is the stigma attached to AIDS. Discrimination against people with HIV exists to some degree in most countries around the world. But experts say the problem is particularly severe in Africa, where little has been done to study or attack the stigma.

The shame that people feel and the treatment they suffer at the hands of their communities has far-reaching consequences for efforts to fight the spread of the virus and treat the sick, experts say. For one thing, it keeps people from wanting to find out whether they have AIDS, and it encourages even those who know they are HIV-positive to act as everyone else does, and perhaps even spread the disease.

For instance, a mother who is trying to hide her HIV status may be unwilling to try infant formula to help prevent transmission to her child if other mothers in her village are breast-feeding.

Fear of discovery can also keep people from seeking services of any sort. In South Africa, facilities earmarked for AIDS patients often stand virtually empty even though the help they offer is desperately needed.

In Richard's Bay, on the coast north of Durban, the town's six largest employers have converted an old farmhouse into a nine-bed AIDS hospice open to any of their 10,000 employees, many of whom live in shacks. The building is surrounded by flowering gardens and services include counseling for families, free meals and visits with traditional healers if they are wanted. But despite a local HIV infection rate estimated at 30 percent, the compound is rarely used.

"It's such a huge disgrace to be diagnosed with HIV/AIDS that people will suffer all sorts of discomforts rather than associate with a facility that is clearly known to be for people with AIDS," said Jenny Rogers, who designed the hospice.

Those people who do come forward, even to tell their families, face daunting prejudice. In some rare cases, they have been stoned. But most often they are simply rejected by their families or isolated, their utensils and bedclothes kept separate from everyone else's, their needs suddenly last on the list. Some are thrown out of their churches and hounded from their homes.

As Ms. Makhalemele was making her plea for tolerance, a 19-year-old boy was alone in a Durban hospital suffering from tuberculosis. A few weeks before, she had taken her pitch to the boy's rural village and, inspired by her courage, the young man had told his neighbors that he too was HIV-positive. Later that day, his neighbors had gathered around his house and, hissing and pointing, had forced him to leave. His horrified family also wanted nothing to do with him, though efforts at reconciliation were under way.

Some experts also argue that the isolation that AIDS victims experience can even hurt their family or community economically.

"You have perfectly normal people who cannot continue to contribute to society anymore," said Jean Louis Lamboray, a policy adviser for UNAIDS, the United Nations agency that deals with AIDS. "If they have a shop, they lose their customers, they lose their suppliers and soon they are out of business. That's the typical story, 1,200 times over."

While the way people with AIDS are treated varies from country to country across the continent, the discrimination seems to be somewhat worse in southern Africa, which has among the world's fastest rising rates of infection but few effective AIDS programs.

Yet even to the north in Uganda, which is often held up as a model country because it has an aggressive AIDS education and prevention campaign, secrecy remains an issue. A 1993-4 survey of more than 700 clients who had been in counseling sessions at an AIDS services group found that more than 60 percent had not told their spouse or regular partner. The clients urged the organization to find an out-of-the-way location so that people could attend without being identified. Experts say that discrimination continues even now.

A 1997 study in the southern African country of Zimbabwe found that only one out of 10 people caring for someone with AIDS was willing to admit that they were nursing someone with the disease. Patients themselves were only slightly more likely to reveal their status. Sixty-five percent had told no one.

In South Africa, Peter Busse, head of the National Association of People Living With AIDS, estimates that fewer than 100 of the country's three million HIV-infected people are completely open about it. "When something like World AIDS Day comes around, we have trouble finding 20 people to go on television and radio shows," he said.

Experts say that lack of education about the disease, superstition and conservative religious beliefs all contribute to the discrimination people with Aids face. But some experts say that Aids arouses such passionate responses because it encompasses two subjects that are highly taboo in many parts of Africa: sex and death.

"We are a culture that knows about death, but we don't discuss it," said Noerine Kaleeba, who works for UNAIDS helping communities develop AIDS programs. "We don't discuss sex either. With us, you can have sex as long as you don't let us know. There is a whole language for discussing sex, but it is very subtle -- a child could be in the room and would never know that is what you are talking about it. But a person who has AIDS, every time you look at this person you must confront sex and death. These are the things that make it too difficult to handle."

Mrs. Kaleeba argues that to some degree, however, the stigma is self-imposed. The fear is sometimes greater than it should be and counseling can go a long way to helping families accept those that are infected.

Many AIDS sufferers complain that church groups are often leading the charge in isolating those with HIV. Even before she was diagnosed with the virus, Musa Njoko was asked to leave her church choir in a township on the outskirts of Durban. She had swollen glands and asthma and people were whispering about her having "the Big A," she said. But since she had only had two boyfriends, she did not believe it was possible. For weeks after she was diagnosed she did not leave the house. Church members came to visit but would not enter her room.

Ms. Njoko says that people still call saying that she is bringing shame on her family for speaking out about the disease: "They say isn't it enough that you have AIDS, do you have to damage your family too?"

Ernest Saila, who has been hired to work for a UNAIDS program that sends HIV sufferers to work in various companies to teach and counsel about AIDS, says that he is often hounded when he is at home with his family near Bloomfontein. His mother remains furious at him for going public about his condition. She allows him to stay home, but refuses to give him any money. "She says food is

## AIDS Is Everywhere, but the Africans Look Away

enough for you," he said. "The rest belongs to the other kids."

When Mrs. Makhalemele gave birth to her daughter in 1994, none of the midwives would sew her up. Four hours went by before an aunt, also a nurse in the hospital, who came by to visit, read her chart and did the work. The aunt did not know, however, that Mrs. Makhalemele still had dressing inside of her and a massive infection followed.

Ms. Makhalemele told her husband she was HIV-positive largely because her baby daughter was so sick she felt she needed to be honest with him. After he threw her out, it was the child's pediatrician who took her in, giving her work as a maid. Though she was grateful, she was also humiliated.

"I did not want to become a maid," Ms. Makhalemele said. "It was not my dream. I had to swallow my pride. I needed money for formula."

A few months later, her husband got sick and a blood test showed he was HIV-positive. It was only then that he admitted that he had infected her and wanted her back.

Since then, both he and her daughter have died. Mrs. Makhalemele is now employed by the National Association of People Living with HIV/AIDS to go around the country talking to people in a campaign to promote "disclosure and acceptance."

But she is not advocating what she calls "reckless" disclosure. When she spoke to the women's group recently, she was accompanied by a shy young woman named Princess who is also HIV-positive and wants to volunteer with Ms. Makhalemele's campaign. But her boyfriend has threatened to kill her if she goes public. He already has a new girlfriend and does not want her to know about his HIV status.

Ms. Makhalemele is counseling Princess to go slowly. She recently stopped more than a dozen young people from taking part in an AIDS awareness television show because she felt they did not truly understand the consequences of going public.

"It is not for everyone," she said. "It is a very serious thing to do."



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Lester R. Brown

# AIDS' Tragic Toll

When the United Nations' demographers released their biennial update of world population projections on Oct. 28, they shocked the world. The projections were substantially lower, partly because of the devastating toll of AIDS. The massive rise in deaths now in prospect in many countries marks a tragic new development in world demography.

These projections are the first to use the World Health Organization's new data on HIV infection rates. In some countries in sub-Saharan Africa, a staggering one-fifth to one-fourth of the adult population is HIV-positive. In Zimbabwe, it is 26 percent; Botswana 25 percent; and in Namibia, Swaziland and Zambia it is 18 to 20 percent.

Barring a medical miracle, these countries will lose one-fifth or more of their adult population to AIDS within the next decade. To find a precedent for such a potentially devastating loss of life from an infectious disease, we have to go back to the decimation of New World Indian communities by the introduction of smallpox in the 16th century or to the bubonic plague that claimed roughly a third of Europe's population during the 14th century.

While industrial countries have been able to hold HIV infection rates among the adult population under one percent, in developing countries they are soaring. After several decades of relentless rapid population growth, these countries are showing signs of demographic fatigue as they struggle with the simultaneous challenge of educating growing numbers of children, creating jobs for swelling ranks of young job seekers and dealing with the environmental effects of population growth. When a major new threat arises, such as AIDS, governments often cannot muster the leadership energy and fiscal resources to cope.

Social problems routinely man-



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aged in industrial societies are becoming full-scale humanitarian crises in many developing ones. As a result, some of the latter are now headed for population stability or even decline in a matter of years, not because of falling birthrates but because of fast-rising death rates. Rising AIDS fatalities could bring Zimbabwe's population growth to a halt as early as 2002. Life expectancy in Botswana is projected to drop from the historic high of 61 years in 1990 to 47 years in 2000.

In addition to adult deaths from AIDS, some 80 percent of infants born to HIV-positive mothers are born with the virus. Their life expectancy is two years. The epidemic is also creating a new population subset—AIDS orphans. Already numbering 7.8 million in sub-Saharan Africa, their ranks are growing fast.

The social and economic effects of the HIV epidemic are just starting to materialize. In contrast to most potentially fatal infectious diseases, AIDS takes its toll not so much among the very young and the elderly but among the young professionals—the very engineers, agronomists and teachers needed to develop the economy. Indeed, the precipitous drop in many countries in life expectancy, the sentinel indicator of economic development, could erase half a century of progress almost overnight. (See "Beyond Malthus" at [www.worldwatch.com](http://www.worldwatch.com).)

Two lessons are to be learned from this epidemic. One, the key to controlling it is to jump on the disease early before it spirals out of

control. Two, population growth must be slowed before even more governments are overwhelmed by demographic fatigue.

Two countries, Thailand and Uganda, have succeeded in curbing the spread of the virus. In both countries, the epidemic was treated as an emergency. In Uganda, President Yoweri Museveni led the effort that enabled his country, probably the one where the disease originated, to stem the tide. In both countries, an intense educational effort accompanied by the free distribution of condoms played an important role.

Family planning programs and the distribution of condoms are keys to controlling the spread of HIV infections. Ironically, just days before the United Nations released the new projections, a little-noticed amendment—inserted into the budget at the last minute by the congressional leadership—cut off all funding for the U.N. Population Fund, the principal source of international family planning assistance. Congress, mired in the quicksand of antiabortion politics, is depriving developing countries of the assistance they need. The HIV epidemic should be seen for what it is—an international emergency of epic proportions, one that could claim more lives in the early years of the next century than World War II did. Any decision to withhold assistance in controlling it should not be taken lightly.

The writer is president of the Worldwatch Institute.

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Dec  
1998

Sutphen, Mona K.

Boyle / Ema

AIDS

Ken -

From: Bernard, Kenneth W.  
Sent: Friday, December 18, 1998 6:41 PM  
To: @NSA - Natl Security Advisor  
Cc: @RUSSIA - Russia/Ukraine; @AFRICA - African Affairs; @HEALTH - International Health Affairs  
Subject: Followup to POTUS/polio meeting [UNCLASSIFIED]

Please call Mr. Jacy. Following up from his meeting w/ POTUS. at POTUS's request. know that POTUS discussed Russia/polio.

PLEASE PASS TO SRB

From: Ken Bernard and Carlos Pascual

**Issue:** In the Dec. 11 meeting between POTUS and James Lacy, head of Rotary International, POTUS raised the topic of health in Russia, encouraging Lacy to focus attention on polio eradication there, and asked you to look into helping Rotary's health outreach program expand into polio efforts in Russia.

**Summary:** Russia has virtually eradicated polio. Because polio eradication efforts remain critical for sub-Saharan Africa and South Asia, we suggest that we focus our polio efforts with Rotary to countries in those regions. In Russia, we suggest focusing our limited health funds on TB, a key public health threat and an issue on which the VP and First Lady are already engaged.

**Russia and polio:** Russia has not reported a case of polio for two years. In the rest of the NIS, only Tajikistan has reported a case recently (in 1997). Immunization rates there are over 90 percent, but populations are still potentially at risk from polio imported across the border from Afghanistan .

**Russia and TB:** The number of cases of TB in Russia has more than doubled in the past six years. Of even greater significance is the rapid development of multidrug resistant TB, which increases the cost of treatment from \$30 per case to \$3,000 and sometimes can't be treated at all. TB rates in Russian prisons, a breeding ground for drug resistance, are 20-30 times higher than in the general population.

The VP's Binational Commission started a TB initiative last year. In October, the First Lady hosted a meeting on the TB problem, attended by World Bank President James Wolfensohn, W.H.O. Director General Gro Brundtland, Secretary Shalala, Brian Atwood, U/S Frank Loy, and George Soros. Consensus was reached that international TB control efforts must be accelerated, especially in Russia, under the overall direction of W.H.O. A team from CDC, USAID and W.H.O. subsequently went to Russia to design pilot programs for TB control. The interagency is now working to put together a USG strategy for dealing with TB in Russia, primarily under the political umbrella of the Gore-Primakov Commission, and we will collaborate with the EU, G-8, W.H.O. and the private sector in developing the international response.

**Global Context of Polio:** Polio is targeted for worldwide eradication by 2000. Unfortunately, that date is unlikely to be met, but with enough support, complete eradication should be attainable within a few more years. Massive worldwide immunization efforts have dramatically reduced cases from 35,000 in 1988 to only

See if there is some joint initiative we could work on. Then, 1-2 p memo to update POTUS. @

Not really where problem is. Russia/TB. What are they doing in Asia? Africa? Can US be of help? @

about 5,000 last year. The western Hemisphere, the Pacific, and Europe (sans Turkey) are now polio-free. Most polio cases are now reported from sub-Saharan Africa (especially DROC, Ethiopia, Nigeria), and South Asia (especially India, Pakistan and Bangladesh).

The US spends \$270 million each year immunizing our children for a disease that no longer exists here, but could be imported. Worldwide polio eradication would save the U.S. that sum each year in perpetuity.

Rotary has spent \$200 million thus far on worldwide polio eradication efforts, and plans on raising \$200 million more. "Rotary International" is focusing almost exclusively on polio as its international health outreach issue in order to financially focus its health efforts. The U.S. spent \$75 million on polio eradication in 1998 alone, and the issue has strong bipartisan support (Leahy, Porter, Bumpers, Specter).

### **Suggested next steps:**

- Given Rotary, Congressional and POTUS interest in polio, we should suggest focusing on South Asia (great issue for the POTUS trip, if it occurs) and Africa, especially areas of military conflict and civil unrest. A letter from the President to Mr. Lacy outlining the U.S. commitment and partnership with Rotary in these areas would be useful.
- In Russia, Rotary could be encouraged to join the efforts for TB control in Russia as part of their international outreach there. Under the general political coordination of the Gore-Primakov commission, we are pushing for a concerted public/private sector international effort to control TB in Russia.

Concurrence: Gayle Smith, Jason Greer, Rick Saunders

AIDS

# AIDS IN THE THIRD WORLD

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## A global disaster

PIETERMARITZBURG, HARARE, KAMPALA

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

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

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

Since HIV was first identified in the 1970s, over 47m people have been infected, of whom 14m have died. Last year saw the biggest annual death toll yet: 2.5m. The disease now ranks fourth among the world's big killers, after respiratory infections,

diarrhoeal disorders and tuberculosis. It now claims many more lives each year than malaria, a growing menace, and is still nowhere near its peak. If India, China and other Asian countries do not take it seriously, the number of infections could reach "a new order of magnitude", says Peter Piot, head of the UN's AIDS programme.

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

AIDS was already devastating Africa.

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

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

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

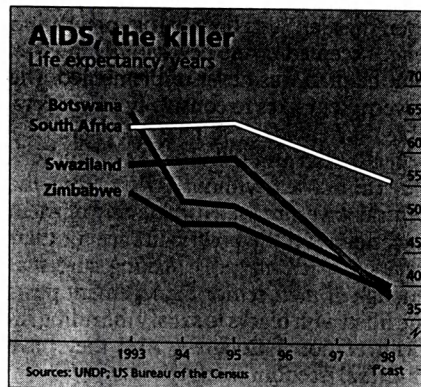
No one knows what AIDS will do to poor countries' economies, for nowhere has the epidemic run its course. An optimistic assessment, by Alan Whiteside of the University of Natal, suggests that the effect of AIDS on measurable GDP will be slight. Even at high prevalence, Mr Whiteside thinks it will slow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

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

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

### The cost of the disease

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



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

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

In the public sector, where pensions and health benefits are often more gener-

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

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

### Obstacles to prevention

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

- Sex is fun... Many feel that condoms make it less so. Zimbabweans ask: "Would you eat a sweet with its wrapper on?"

- ... and discussion of it often taboo. In Kenya, Christian and Islamic groups have publicly burned anti-AIDS leaflets and condoms, as a protest against what they see as the encouragement of promiscuity. A study in Thailand found that infected women were only a fifth as likely to have discussed sex openly with their partners as were uninfected women.

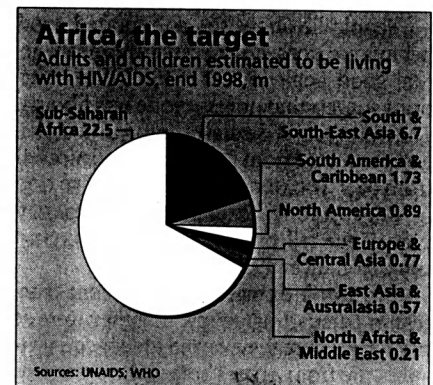
- Myths abound. Some young African women believe that without regular infusions of sperm, they will not grow up to be beautiful. Ugandan men use this myth to seduce schoolgirls. In much of southern Africa, HIV-infected men believe that they can rid themselves of the virus by passing it on to a virgin.

- Poverty. Those who cannot afford television find other ways of passing the evening. People cannot afford antibiotics, so the untreated sores from STDs provide easy openings for HIV.

- Migrant labour. Since wages are much higher in South Africa than in the surrounding region, outsiders flock in to find work. Migrant miners (including South Africans forced to live far from their homes) spend most of the year in single-sex dormitories surrounded by prostitutes. Living with a one-in-40 chance of being killed by a rockfall, they are inured to risk. When they go home, they often infect their wives.

- War. Refugees, whether from genocide in Rwanda or state persecution in Myanmar, spread HIV as they flee. Soldiers, with their regular pay and disdain for risk, are more likely than civilians to contract HIV from prostitutes. When they go to war, they infect others. In Africa the problem is dire. In Congo, where no fewer than seven armies are embroiled, the government has accused Ugandan troops (which are helping the Congolese rebels) of deliberately spreading AIDS. Unlikely, but with estimated HIV prevalence in the seven armies ranging from 50% for the Angolans to an incredible 80% for the Zimbabweans, the effect is much the same.

- Sexism. In most poor countries, it is hard for a woman to ask her partner to use a condom. Wives who insist risk being beaten



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

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

### How to fight the virus

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

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

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

## AIDS IN THE THIRD WORLD

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

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

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

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

Second, Uganda. Thailand shows what is possible in a well-educated, fairly prosperous country. Uganda shows that there is hope even for countries that are poor and

barely literate. President Yoweri Museveni recognised the threat shortly after becoming president in 1986, and deluged the country with anti-AIDS warnings.

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

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

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

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

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

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

### How to dither and die

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

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

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

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

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



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## AIDS in pandemic proportions

AIDS has taken on pandemic proportions in Southern Africa, causing not only human suffering but posing a real threat to the economies of the region. At a recent AIDS summit in Pretoria, Deputy President Thabo Mbeki described AIDS as the most serious crisis yet to face South Africa—"one that threatens not only to damage the fabric of society but to cripple the economy."

By allowing AIDS to spread at its current alarming rate, South Africa faced the danger that half of the country's youth would not reach adulthood, Mbeki cautioned. Their education would be wasted and the economy would shrink. There would be a large number of sick people whom the healthy would not be able to support. Also private enterprise has expressed fears that at the current rate of infection the country's work force would become increasingly unreliable and costly.

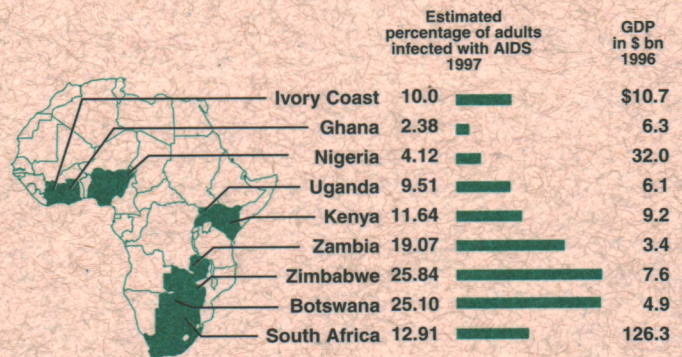
Since 1981, when aids was first diagnosed, 47 million people worldwide have become infected and 14 million have died. AIDS now kills more people than any other infection, ahead of malaria, which caused 1 million deaths last year. Tuberculosis is third with thirty percent of these deaths involving people who were already infected with the HIV virus.

According to a recent UN report, AIDS virus infections worldwide have risen by 10 percent over the past year showing a disturbing lack of progress in prevention. Overall the number of people infected with HIV, the AIDS virus, rose by 5.8 million to 33.4 million from 27.6 million. All but 5 percent of the infections occurred in Asia, Africa and Eastern Europe.

The ravages of malaria, once considered the major scourge of Africa, pale in comparison with the devastation currently caused by AIDS. Sub-Saharan Africa alone accounts for 22.5 mil-

continued on page 3

### The African Aids Epidemic



Sources: UNAIDS, World Bank, New York Times



## SA Analysis & Advice

*From the publisher's desk*

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## Analogy of experience

"We know nothing of what will happen in future, but by the analogy of experience." These words of wisdom spoken by Abraham Lincoln 160 years ago should bring some comfort to those in our midst who seem to fear for the future of South Africa as well as that of its neighbors on the continent who rely on its political stability and economic prosperity for their own well-being.

During the past year the South African economy like most others, with the notable exception of the United States, has experienced a sharp downturn in the wake of the turbulence in Asia. However, by holding steadfast to its preset prudent fiscal course, the South African government has prevented a series of setbacks from developing into a full-blown crisis. By refusing to cave in to domestic demands for a return to the protective measures and controls of the past, South Africa has shown itself to be a responsible and mature member of the global economy.

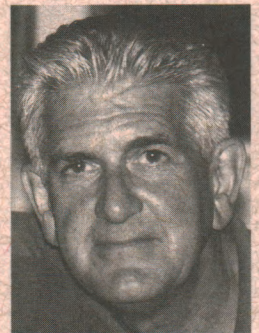
Not surprisingly, Moody's, in maintaining South Africa's investment grade sovereign credit rating, cited its confidence in the competence and resolve of South Africa's leadership as a major factor. The ANC has consistently staved off strong pressures on the part of its trade union and Communist alliance partners to abandon sound economic principles for the sake of political gain.

If the South African government in this new year could apply itself equally well to combating crime, fighting Aids, reducing unemployment and the like, the country's outlook-according-to-Moody's might well move from "stable" to "excellent." Of course, given the enormity of these problems, everyone understands that it would be unrealistic to expect dramatic results in the short or even medium-term. Yet, real progress has to be made.

The mastermind behind South Africa's macroeconomic plan, Deputy President Thabo Mbeki, will take over officially from President Nelson Mandela towards the middle of this year. This is in reality a mere formality. Mandela himself has admitted that Mbeki has in a *de facto* sense run the country for several years.

Therefore the future of South Africa can indeed, in the words of Lincoln, be measured by an analogy of past experience. This in itself should be reassuring to foreign investors.

Publisher



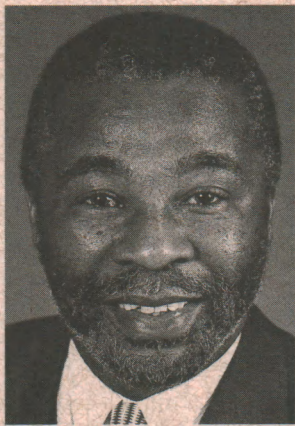
# AIDS

*Continued from page 1*

lion of the 33.4 million cases of HIV infection worldwide. The four countries with the highest infection rates all share borders with South Africa—Botswana, Zimbabwe, Namibia and Swaziland. All of them have recorded an infection rate of 20 to 26 percent of people 15 to 39 years old.

If the spread of AIDS continues at its current rate in Zimbabwe it is expected to reduce its population growth rate to zero in four years, down from its current 2.2 percent per year. According to the local UN Development Program representative 1.5 million out of 11 million Zimbabweans are already infected with the HIV virus and 500 are dying of the disease every week. The HIV infection rate in the age group 15 to 45 is estimated to have reached a shocking 30 percent level.

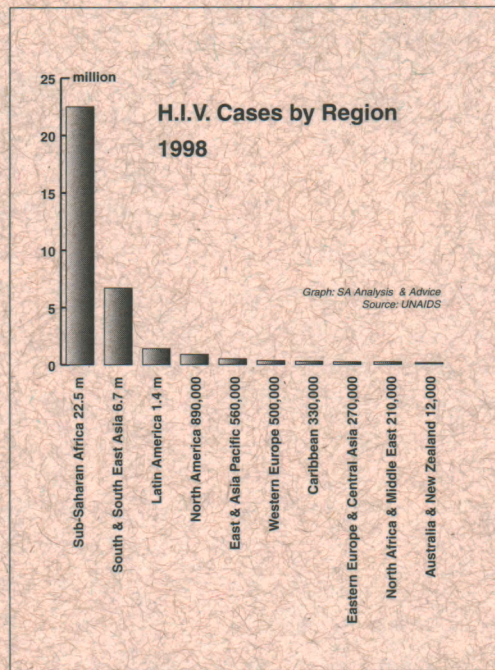
More than 3 million South Africans have the disease. An estimated 1,500 new infections occur daily. As elsewhere on the continent, the disease shows its devastating effect mostly among educated urban professionals who should be underpinning the nation's proposed economic expansion. The full extent of the damage is difficult to gauge as it is impossible to estimate how much in potential business, academic and administrative talent is buried in an early grave as a result of the disease.



*Thabo Mbeki*

At the recent Pretoria AIDS summit, attended by 200 leaders of South African society, it was revealed that about 150,000 of South Africa's 1 million civil servants have tested HIV positive. The key message was that AIDS was no longer just a health problem, but had the potential to devastate economic and social reforms and had to be tackled on all fronts. The financial and social implications are enormous over the medium and long term. It also impacts on crime prevention and security with an estimated 33,000, (or one quarter) of the South African police suffering from AIDS.

In South African mines where one sick operator can cripple a whole drill crew, some shafts are reporting a 25 percent HIV infection rate and an even higher incidence of tuberculosis, which thrives on AIDS-weakened immune systems. Companies are re-



luctant to talk about AIDS in their work force and some are even prone to hiding the severity of the problem from their shareholders, but it is apparent that AIDS is eroding corporate profits in many instances.

The South African government has been severely criticized for its lack of direction and strategy in facing up to the AIDS menace. Mark Heywood of the Aids Law Project has accused the state had for having "failed horribly" and having been "terribly negligent" in allowing the infection rate to escalate by 2 million in four years. Others have accused Health Minister Nkosazana Zuma's department

of bungling the AIDS prevention effort by squandering millions on an ill-conceived AIDS awareness play, *Sarafina 2*, which has led to two separate commissions of inquiry.

Recently the South African authorities promised to revamp its youth education program while apparently hoping, as the rest of the world does, for some miracle cure to emerge sometime soon. This approach seems in line with a plan promoted on the UN's World AIDS Day last December 1, to "harness the power of youth" for the prevention of further HIV infections. Young people, the argument goes, are more likely to practice abstinence or safer sex than adults, if they had the information to do so. Senegal is cited as one country where this strategy worked. As a result of an intensive educational program, the UN claims, in 1997 40 percent of women under 25 and 65 percent of men in Senegal used condoms in non-monogamous sexual relations in contrast to fewer than 5 percent for both sexes at the start of the decade.

In launching South Africa's "nationwide partnership against AIDS," Mr. Mbeki urged the nation to change the way they lived and loved, appealing to young people to abstain from sex for as long as possible. "If you decide to engage in sex, use a condom." Mbeki also appealed to men and women to be faithful to each other, and if they weren't, to use condoms. "The power to defeat the spread of HIV/AIDS lies in our partnership—as youth, as women and men, as business people, as workers, as religious people, as parents and teachers, as students, as healers, as farmers and

*continued on next page*

## Upcoming

### Summit on Africa

The Washington-based Corporate Council on Africa (CCA) will hold its 1999 *Attracting Capital to Africa Summit* in Houston, Texas, from April 24-28. This event is the second in a series of biannual summits by the nonpartisan, nonprofit organization under the direction of top-level US personalities with a special interest in the continent. Membership of the CCA includes most major US corporations with business interests in the continent.

Apart from other ongoing activities, these summits are designed to bring together the leadership of Africa with key US decision makers and investors. Workshop sessions and issue-specific roundtables allow participants to engage in direct dialogue on commercial relations between the United States and Africa.

Former Assistant Secretary for African Affairs, Dr. Chester Crocker, who is a member of the CCA board, describes the summit as both a "retreat" and a conference which leaves ample opportunity for networking and side meetings.

Judging by the first summit at Chantilly, Virginia, participants might once again expect in Houston to rub shoulders with a Who's Who list of decision makers on both sides of the Atlantic. Enquiries should be directed at the CCA at telephone 202-835-1115 or fax 202-835-1117.



First Lady Hillary Clinton in conversation at the 1997 Summit with Co-Chairman Donald Fites, CEO of Caterpillar (on the right) and Ambassador Andrew Young, a founding member of the Corporate Council on Africa.

## AIDS

*Continued from previous page*

farm workers, as the unemployed and the professionals, as the rich and the poor—in fact, all of us.”

He urged South Africans to spread the message. “Every day, every night—wherever we are — we shall let our families, friends and peers know that they can save themselves and save the nation by changing the way we live and how we love. We shall use every opportunity openly to discuss the issue of AIDS.”

Donald McNeil, the Johannesburg correspondent of the *New York Times*, pointed out that it might be hard for Westerners “used to a system in which insurers and governments pay for top-quality medical care” to grasp the kinds of cuts already being made in Southern Africa. “Never mind \$15,000 AIDS cocktails and costly cures for rare brain infections. Companies that once calmly paid for coffins, hearses and funeral meals for employees are now begrudging even that.”

According to McNeil most African countries have annual health budgets of less than \$6 per citizen. Zimbabwe, for example, allocated \$3.68 per person in 1995, while the hospitalization of a privately insured AIDS patient that year cost \$18,000. Even relatively rich South Africa was compelled to discontinue \$80 courses of AZT administered routinely to pregnant and nursing women to prevent transmission of the AIDS virus to their children. The World Bank points out that the \$15,000 per year protease inhibitor cocktail of drugs that helps to prolong a single life in America equals the money spent on the education of 400 children in African schools.

Worker health insurance is rare and laborers have to rely largely on clinics at mines, factories or on farms. Small companies cope by simply dismissing sick workers while rich ones are compelled to cap their health benefits. Even Eskom, the giant South African power company known for its generous benefits, recently had to cut its medical benefits for HIV-infected employees from \$18,000 a year to \$2,600. Insurance companies routinely try to protect themselves by writing policies that require repeated blood tests.

Some experts insist that while educational programs might inhibit the spread of the virus, it is evident that only an affordable cure will save Africa from suffering the same fate as Europe in the 14th century when nearly a third of its population perished in the bubonic plague or in what is commonly referred to as the Black Death. In the meantime the AIDS toll, not only in lives and human suffering but in real economic terms, is something that emerging Africa bent on making the renaissance a reality, can ill afford.

HIV/AIDS

Zim / s. Africa

UNCLASSIFIED

AID 10/23/98

DIR:RMDEPP

PHNO/PRETORIA:KYAMASHITA

1.PHNO:RR, 2.MALAWI:JL, 3.ZAMBIA:RC, 4.ZAMBIA:WN

AID

RMD \_\_\_  
KY \_\_\_  
JL \_\_\_  
RR \_\_\_  
RC/WN \_\_\_

- AMEMBASSY HARARE
- AMEMBASSY PRETORIA
- AMEMBASSY LUSAKA
- AMEMBASSY LILONGWE
- SECSTATE WASHDC
- INFO AMEMBASSY ADDIS ABABA
- AMEMBASSY ANTANARIVO
- AMEMBASSY ACCRA
- AMEMBASSY BAMAKO
- AMEMBASSY CONAKRY
- AMEMBASSY COTE DIVOIRE
- AMEMBASSY COTONOU
- AMEMBASSY DAKAR
- AMEMBASSY DAR ES SALAM
- AMEMBASSY KAMPALA
- AMEMBASSY LAGOS
- AMEMBASSY MOZAMBIQUE
- AMEMBASSY NAIROBI
- AMEMBASSY WINDHOEK
- CDC ATALANTA

AIDAC

FOR AID/W, AA/AFR, AFR/SD, AFR/SA, G/PHN  
USAID AND REDSO FOR PHN OFFICERS  
CDC FOR NCHSTP

*bennenia: please find these addresses for the slug line:  
eds at ibrd and imf,nih*

SUBJECT: STORM WARNING: USAID STAFF REVIEW SOUTHERN AFRICA'S  
RESPONSE TO THE HIV/AIDS CRISIS.

1. SUMMARY. THE HIV/AIDS EPIDEMIC IN SOUTHERN AFRICA IS  
EXTREMELY SERIOUS AND GETTING WORSE. THE SOCIAL AND ECONOMIC  
IMPACTS OF THE EPIDEMIC ARE PERVASIVE. USAID INVESTMENTS IN  
ADDRESSING THE ISSUE ARE CONSIDERABLE BUT RESULTS HAVE BEEN  
DISAPPOINTING. THERE HAVE BEEN SUCCESSFUL INTERVENTIONS WHICH  
HAVE MADE A DIFFERENCE BUT MUCH REMAINS TO BE DONE.

2. THIS CABLE REPORTS ON A RECENT MEETING OF REGIONALLY BASED  
USAID HEALTH PROFESSIONALS. THEY REVIEWED THE CURRENT STATE OF  
THE CRISIS, SHARED EXPERIENCES AND RECOMMENDED SEVERAL ACTIONS TO  
ENHANCE THE EFFECTIVENESS OF USAID'S PROGRAM. END SUMMARY.

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BACKGROUND  
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3. USAID MISSION DIRECTORS FROM ZAMBIA AND ZIMBABWE AND PHN OFFICERS FROM MALAWI, SOUTH AFRICA, ZAMBIA, AND ZIMBABWE MET IN HARARE ON FRIDAY, OCTOBER 16 FOR REGIONAL CONSULTATIONS ON HIV/AIDS. THIS MEETING WAS CALLED IN RESPONSE TO CONCERNS EXPRESSED BY R4 REVIEWERS IN WASHINGTON ABOUT THE EFFECTIVENESS OF USAID'S INVESTMENTS IN THE HIV/AIDS ARENA.

4. THE FOCUS OF THE CONSULTATION WAS THREEFOLD: 1) TO SHARE HIV/AIDS AND STD COUNTRY EXPERIENCES; 2) TO EXPLORE POSSIBLE REGIONAL COLLABORATION; AND 3) TO PROVIDE INPUT TO THE AFRICA BUREAU MISSION DIRECTOR'S CONFERENCE IN WASHINGTON. THE ONE DAY MEETING WAS HIGHLY PRODUCTIVE AND INFORMATIVE.

5. POSSIBLE AREAS FOR REGIONAL COLLABORATION WERE IDENTIFIED IN TWO BROAD AREAS. FIRST, AREAS WHERE ACTIVITIES HAD NOT BEEN CARRIED OUT BEFORE, SUCH AS PROGRAMS FOR CROSS BORDER POPULATIONS, GREATER LINKAGES WITH THE SOUTH AFRICA DEVELOPMENT COMMUNITY (SADC), AND PROGRAMS FOR MIGRANT WORKERS WITHIN THE REGION. SECOND, AREAS WHERE BILATERAL PROGRAMS ARE ALREADY ENGAGED BUT COULD BENEFIT FROM GREATER REGIONAL COOPERATION, SUCH AS ADVOCACY AND POLICY DIALOGUE - ESPECIALLY TAKING ADVANTAGE OF KEY ACTOR LINKAGES, SUCH AS LABOR TO LABOR, BUSINESS TO BUSINESS, POLITICIAN TO POLITICIAN, NGO TO NGO; COMMUNICATIONS PROGRAMS, SUCH AS MASS MEDIA ADVERTISING; REGIONAL MONITORING AND EVALUATION METHODS, INCLUDING SURVEILLANCE, GREATER SHARING OF BEST PRACTICES, AND GREATER INVOLVEMENT WITH OTHER DONORS.

6. NEXT STEPS INCLUDE ENGAGING KEY PARTNERS TO IDENTIFY SPECIFIC ACTIVITIES WHICH CAN BE STARTED; CONSULTATIONS WITH USAID/W ON A NUMBER OF TECHNICAL AND PROCEDURAL MATTERS.

7. PARTICIPANTS WISH TO ACKNOWLEDGE EXCELLENT SUPPORT FOR THESE MEETINGS BY USAID/HARARE AND FROM THE U.S. AMBASSADOR TO ZIMBABWE, THE HON. TOM MCDONALD.

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THE PROBLEM IS GETTING WORSE: SOME STATISTICS  
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8. ON A PROPORTIONAL BASIS, THE HIV/AIDS EPIDEMIC HAS HIT THE SOUTHERN AFRICA REGION HARDER THAN ANYWHERE ELSE IN THE WORLD. RECENT ESTIMATES OF PREVALENCE ARE 20.3% IN ZIMBABWE, 19.9% IN ZAMBIA, 16% IN SOUTH AFRICA, AND 13% IN MALAWI. IN ALL COUNTRIES, THE YOUNG ADULT POPULATION AND WOMEN OF REPRODUCTIVE AGE ARE AMONG THE MOST VULNERABLE GROUPS. FEMALES AGED 15-24 ARE FOUR TO SIX TIMES MORE LIKELY TO BE INFECTED THAN MALES OF THE SAME AGE.

9. THE IMPACT OF THE PANDEMIC IN THE REGION IS SEVERE: ALL COUNTRIES ARE SEEING DRAMATIC DECLINES IN LIFE EXPECTANCY; INCREASING NUMBER OF PREMATURE DEATHS IN THE ECONOMICALLY PRODUCTIVE ADULT POPULATIONS; LARGE INCREASES IN ORPHANED CHILDREN; AND A SIGNIFICANT NUMBER OF HIV-INFECTED CHILDREN LEADING TO RISING INFANT AND CHILD MORTALITY RATES.

10. MOREOVER, THERE ARE NO SIGNS THAT THE EPIDEMIC HAS PEAKED. PROJECTIONS INDICATE THAT THE NUMBER OF HIV/AIDS CASES WILL DOUBLE IN ONLY 24-36 MONTHS IN EACH COUNTRY. IN ALL COUNTRIES, A CONCURRENT TB EPIDEMIC HAS FURTHER TAXED BELEAGUERED HEALTH SYSTEMS.

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#### PARTICIPANTS

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11. AGAINST THIS BACKDROP, PHN OFFICERS FROM SOUTHERN AFRICA MET FOR ONE DAY TO DISCUSS COMMON CONSTRAINTS, SHARE LESSONS, AND CONSIDER OPTIONS FOR REGIONAL INITIATIVES WHICH WILL ENHANCE SPECIFIC COUNTRY PROGRAMS. IN ATTENDANCE AT THIS MEETING WERE JOAN LA ROSA FROM MALAWI, KEN YAMASHITA FROM SOUTH AFRICA, ROBERT CLAY AND PAUL ZEITZ FROM ZAMBIA, AND ROXANA ROGERS AND PATRICK OSEWE FROM ZIMBABWE. THE MISSION DIRECTOR FROM USAID/ZAMBIA, WALTER NORTH, AND FROM USAID/ZIMBABWE, ROSE MARIE DEPP, ALSO JOINED IN THIS DAY LONG DELIBERATION.

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#### COMMON CHALLENGES

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12. THE COUNTRY PROGRAMS HIGHLIGHTED A NUMBER OF COMMON CONSTRAINTS AND A VARIETY OF INNOVATIVE STRATEGIES TO OVERCOME THESE CONSTRAINTS. THE MAJOR COMMON CONSTRAINTS INCLUDED: 1) LACK OF POLITICAL LEADERSHIP. IN EVERY COUNTRY THE POLITICAL LEADERSHIP HAS BEEN RELUCTANT TO PUBLICLY ADDRESS THE ISSUE OF HIV/AIDS. AN EXCEPTION IS SOUTH AFRICA, WHERE RECENTLY THE DEPUTY PRESIDENT LAUNCHED A NATIONAL PARTNERSHIP AGAINST AIDS CAMPAIGN; 2) WEAK MINISTRIES OF HEALTH. IN EVERY COUNTRY, MINISTRIES OF HEALTH ARE STRAPPED BY LIMITED FINANCIAL AND TRAINED HUMAN RESOURCES. THEY ARE THEREFORE UNABLE TO MOUNT EFFECTIVE PROGRAMS TO COUNTER THE EPIDEMIC. 3) ECONOMIC DOWNTURN. WEAK PUBLIC SECTOR ENTITIES ARE FURTHER HAMPERED BY A REGIONAL DOWNTURN IN ECONOMIC PROGRESS, RESULTING IN REDUCED PUBLIC SECTOR BUDGETS; 4) AWARENESS/BEHAVIOR GAP. IN ALL COUNTRIES, THERE IS CONSIDERABLE AWARENESS IN THE POPULATION OF HIV/AIDS AND HOW TO PREVENT THE INFECTION, YET THERE IS NOT CONSISTENT EVIDENCE OF CORRESPONDING CHANGE IN BEHAVIOR AMONG INDIVIDUALS.

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#### SOME HOPEFUL SIGNS

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13. IN SPITE OF THESE CONSTRAINTS, THERE ARE MANY INNOVATIVE AND SUCCESSFUL INTERVENTIONS THAT ARE TAKING PLACE.

A) IN MALAWI, THE COPE PROJECT IS BEING IMPLEMENTED BY SAVE THE CHILDREN (USA) WHICH ASSISTS RURAL COMMUNITIES TO IDENTIFY AND ADDRESS THE IMPACT OF AIDS ON VILLAGES BY IDENTIFYING ORPHANS AND GETTING THEM BACK INTO SCHOOLS, PROVIDING TRAINING IN CARING FOR THE SICK, PROMOTING AIDS PREVENTION AND INCOME GENERATING

ACTIVITIES. PROJECT STAFF INITIATE ACTIVITIES TO MOBILIZE COMMUNITY AND VILLAGE AIDS COORDINATING COMMITTEES AND THEN MOVE ON TO OTHER COMMUNITIES. EVALUATION RESULTS SHOW THAT COMMITTEES ARE CONTINUING THEIR WORK LONG AFTER COPE PROJECT STAFF HAVE GONE.

B) IN ZIMBABWE, CONDOM SOCIAL MARKETING PROGRAMS RESULTED IN SALES OF OVER 3 MILLION MALE CONDOMS AND 83 THOUSAND FEMALE CONDOMS BY JULY OF 1998 -- EXCEEDING THE TARGET AND COMPLEMENTING ANNUAL DISTRIBUTION IN MOH CLINICS OF OVER 40 MILLION CONDOMS. AN INNOVATIVE VOLUNTEER COUNSELLING AND TESTING PROGRAM IS BEING LAUNCHED THAT EXPECTS TO INCREASE AWARENESS AND WILL REDUCE HIGH RISK BEHAVIOR; ALSO AT THE PROVINCIAL LEVEL, THE CHAIRMAN OF THE RULING PARTY AND SEVERAL CABINET MINISTERS LAUNCHED A PROVINCIAL HIV/AIDS AWARENESS CAMPAIGN INDICATING INCREASING INVOLVEMENT ON THE PART OF SOME POLITICAL LEADERS.

C) IN ZAMBIA, CONDOMS ARE BEING SUCCESSFULLY SOCIALLY MARKETED THROUGH OUT ZAMBIA, WITH SALES REACHING 7 MILLION ANNUALLY. IN 1997, A SOCIALLY MARKETED FEMALE CONDOM WAS LAUNCHED. AN INNOVATIVE MULTISECTORAL APPROACH AT THE DISTRICT AND COMMUNITY LEVELS HAS LED TO IMPROVEMENTS IN PREVENTION ACTIVITIES, INCLUDING REDUCTIONS IN UNSAFE TRADITIONAL PRACTICES; EXPANDED YOUTH AND INTERFAITH PROGRAMS; AND EXPANDED ACCESS TO COMMUNITY CARE AND SUPPORT SERVICES FOR AIDS PATIENTS AND ORPHANED/VULNERABLE CHILDREN.

D) IN SOUTH AFRICA, PROGRAMS WITH TRADE UNIONS HAVE RESULTED IN THE ESTABLISHMENT OF A COMMON POSITION AMONG ALL TRADE UNIONS ON HIV/AIDS IN THE WORKPLACE, AND AWARENESS AND SERVICE DELIVERY IN MINING COMMUNITIES HAS LED TO REDUCTIONS IN THE INCIDENCE OF STDs. THE RECENT LAUNCHING BY THE DEPUTY PRESIDENT OF THE PARTNERSHIPS AGAINST AIDS CAMPAIGN HAS RESULTED IN PUBLIC COMMITMENTS BY LABOR, BUSINESS, NGO, RELIGION, AND ALL PUBLIC MINISTRIES TO JOIN FORCES TO COMBAT THE DISEASE.

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REGIONAL ISSUES  
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14. IN MOVING FROM COUNTRY SPECIFIC PROGRAMS TO REGIONAL ISSUES, THE GROUP IDENTIFIED TWO BROAD AREAS WHICH WERE CURRENTLY NOT BEING ADDRESSED: CROSS BORDER ISSUES AND GREATER REGIONAL SHARING OF COUNTRY EXPERIENCES.

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CROSS BORDER ISSUES  
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15. CROSS BORDER ISSUES. SOME EXAMPLES IDENTIFIED INCLUDE:

A) THERE IS SIGNIFICANT COMMERCIAL MOVEMENT ACROSS ALL COUNTRIES OF THE REGION. THE TRANSPORTATION, ESPECIALLY TRUCKING, INDUSTRY HAS IDENTIFIED STDs AND HIV/AIDS AS A SIGNIFICANT PROBLEM.

B) MIGRANT LABOR. INDEED, THE GROUP COMMENTED THAT THE COMMON WISDOM IN ZIMBABWE WAS THAT MIGRANT WORKERS WOULD GO TO SOUTH AFRICA, GET INFECTED, AND BRING IT HOME, WHILE IN SOUTH AFRICA, IT IS FREQUENTLY SAID THAT WORKERS FROM ZIMBABWE ARE ALREADY INFECTED AND BRING THE INFECTION TO SOUTH AFRICA. THESE KINDS OF PASSIVE POSTURES LEAD TO INDIFFERENCE AT BEST, AND POTENTIALLY SERIOUS REGIONAL FRICTIONS AT WORST.

C) ENGAGEMENT OF REGIONAL ENTITIES, SUCH AS THE SOUTH AFRICAN DEVELOPMENT COUNCIL (SADC). IT WAS COMMENTED THAT SADC IS IN THE PROCESS OF DEVELOPING A "CODE OF CONDUCT" WITH RESPECT TO HIV/AIDS, THAT WOULD COVER ALL SADC COUNTRIES. SADC COUNTRIES ROUTINELY MEET AT THE HIGHEST LEVELS TO DISCUSS MATTERS OF INTEREST, BUT HAVE DONE RELATIVELY LITTLE WITH RESPECT TO HIV/AIDS.

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SHARING COUNTRY EXPERIENCES REGIONALLY  
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16. SHARING OF COUNTRY EXPERIENCES. SOME EXAMPLES IDENTIFIED INCLUDE:

A) IN ORDER TO IMPROVE THE POLICY ENVIRONMENT, IT WOULD BE BENEFICIAL TO HAVE DIRECT PARTNERSHIPS, SUCH AS LABOR TO LABOR, BUSINESS TO BUSINESS, POLITICIAN TO POLITICIAN, NGO TO NGO, UNIVERSITY TO UNIVERSITY - ON MATTERS OF COMMON INTEREST. THIS IN TURN COULD BE THE CATALYST FOR INCREASED ADVOCACY SKILLS AND STRATEGIES.

B) IN COMMUNICATIONS (ESPECIALLY MASS MEDIA COMMUNICATIONS), COMMON MESSAGES COULD BE CREATED AND LEVERAGED ON A REGIONAL LEVEL TO KEY MEDIA, SUCH AS TELEVISION AND MAJOR RADIO STATIONS.

C) TAKE BEST PRACTICES, LESSONS LEARNED, AND PILOT PROJECTS, AND REPLICATE THEM AS APPROPRIATE IN OTHER COUNTRIES.

D) IMPROVE DONOR COORDINATION, FOLLOWING THE EXCELLENT COORDINATION EFFORTS IN MALAWI.

E) FINALLY, MONITORING AND EVALUATION, INCLUDING SURVEILLANCE, COULD BE STRENGTHENED AND REPLICATED ACROSS THE REGION IN ORDER TO OBTAIN IMPROVED AND COMPARABLE INFORMATION.

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SOME CONCRETE PROPOSALS  
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17. THE NEXT STEPS WILL BE TO BEGIN IDENTIFYING SPECIFIC ACTIVITIES WHICH CAN BE CARRIED OUT AT THE REGIONAL LEVEL. FOR EXAMPLE:

A) USAID-HIVNET COLLABORATION: HIV/AIDS RESEARCH INSTITUTIONS IN ZIMBABWE, ZAMBIA, SOUTH AFRICA, AND MALAWI HAVE ALL BEEN SELECTED

AS COLLABORATING CENTERS WITH THE NATIONAL INSTITUTES OF HEALTH (NIH) FUNDED HIVNET PROGRAM. HIVNET IMPLEMENTORS HAVE BEEN CONTACTING USAID OFFICIALS IN SEVERAL COUNTRIES LOOKING FOR OPPORTUNITIES FOR TECHNICAL AND OPERATIONAL COLLABORATION BETWEEN USAID PROJECTS AND HIVNET ACTIVITIES. THE MEETING RECOMMENDED THAT A JOINT CONSULTATION SHOULD BE PLANNED BETWEEN USAID MISSIONS AND HIVNET TO IDENTIFY OPPORTUNITIES FOR COLLABORATION.

B) THE DEVELOPMENT OF REGIONAL IMPLEMENTATION STRATEGIES TO ADDRESS TRUCKING ROUTE CROSS BORDER TRANSMISSION, MASS MEDIA COMMUNICATION STRATEGIES, AND ADVOCACY ACTIVITIES. THIS WOULD REQUIRE FOLLOW UP DISCUSSIONS WITH KEY COOPERATING AGENCIES, INCLUDING POPULATION SERVICES INTERNATIONAL, JOHNS HOPKINS UNIVERSITY POPULATION COMMUNICATION SERVICES, AND THE POLICY PROJECT. THE MEETING RECOMMENDED THAT A COOPERATING AGENCYS' MEETING BE PLANNED WHERE SPECIFIC ACTIVITIES COULD BE IDENTIFIED.

C) THE BURDEN OF ORPHANED AND VULNERABLE CHILDREN AFFECTING ALL COUNTRIES OF THE REGION. MALAWI AND ZAMBIA HAVE INITIATED INNOVATIVE COMMUNITY BASED RESPONSES WITH SUPPORT FROM THE DISPLACED CHILDREN AND ORPHANS FUND (DCOF) MANAGED BY THE GLOBAL BUREAU. THE MEETING RECOMMENDED THAT CONSIDERATION SHOULD BE GIVEN FOR THE EXPANSION OF DCOF FUNDED ACTIVITIES IN OTHER COUNTRIES OF THE REGION AND EXPANDING THE SHARING OF LESSONS LEARNED AND BEST PRACTICES.

D) IN SEPTEMBER 1999 ZAMBIA WILL BE THE HOST OF THE XITH INTERNATIONAL CONFERENCE ON AIDS AND STDS IN AFRICA, AND IN 2000 SOUTH AFRICA WILL BE THE HOST OF THE INTERNATIONAL HIV-AIDS CONFERENCE. THESE CONFERENCES PROVIDE AN OPPORTUNITY FOR USAID AND COOPERATING AGENCIES TO PARTICIPATE, LEARN, AND INFLUENCE IMPLEMENTATION STRATEGIES THAT ARE BEING DEVELOPED BY AFRICAN NATIONS. THE MEETING RECOMMENDED THAT THESE CONFERENCES BE UTILIZED TO THEIR MAXIMUM ADVANTAGE FOR REGIONAL NETWORKING AND DISSEMINATION OF LESSONS LEARNED.

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INPUT FOR THE AFRICA BUREAU'S DIRECTORS' MEETING  
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18. AS INPUT TO THE UPCOMING AFRICA BUREAU MISSION DIRECTORS CONFERENCE, THE GROUP REQUESTS THAT THE FOLLOWING ISSUES BE ADDRESSED:

A) THE GROUP WAS UNANIMOUS IN AGREEING THAT THIS TYPE OF ON THE GROUND CONSULTATION BETWEEN PROFESSIONALS WAS MORE COST EFFECTIVE, USER FRIENDLY AND INFORMATIVE THAN THE PROLONGED R4 PROCESS. IT WAS AN OPEN AND EFFECTIVE INTERCHANGE ON SUCCESSES, CHALLENGES, AND CONSTRAINTS BEING FACED IN THE SECTOR. IN ADDITION SUCH MEETINGS ARE IMPORTANT FOR SHARING INFORMATION AND LESSONS LEARNED. THIS CAN HELP PREVENT DUPLICATION OF EFFORTS THAT HAVE BEEN UNSUCCESSFUL ELSEWHERE.

B) THE GROUP RECOMMENDED THAT, AT THE DAC LEVEL AND IN FORA WITH

MULTILATERALS, THERE IS A NEED TO INSIST (1) ON THE PRIORITY OF HIV/AIDS IN SOUTHERN AFRICA AND (2) THAT MULTILATERALS TAKE A MORE PROACTIVE ROLE IN COORDINATING BILATERAL AS WELL AS MULTILATERAL ASSISTANCE. HIV/AIDS DONOR COORDINATION HAS BEEN SPORADIC IN ALL THESE COUNTRIES DESPITE THE SIGNIFICANT GAINS ACCRUED BY INFORMATION SHARING. IN GENERAL, USAID PHN OFFICERS LEARN ABOUT OTHER DONOR PROGRAMS ON AN AD HOC BASIS. THE STRIKING EXCEPTION TO THIS IS MALAWI WHERE UNAIDS HAS PLAYED AN ACTIVE ROLE IN BRINGING DONORS TOGETHER ON A REGULAR BASIS FOR DISCUSSION AND COLLABORATION -- CLEARLY REPRESENTING A BEST PRACTICE EXAMPLE.

C) THE GROUP NOTED THAT: (1) THE PROPOSED ACTIVITIES CAN BE CARRIED OUT WITH EXISTING FUNDS OR LIMITED ADDITIONAL FUNDS, THOUGH THERE MAY BE EXCEPTIONS; (2) FURTHER REGIONAL DIALOGUE WAS NEEDED TO FLESH OUT THE IDEAS AND CONSIDER THE RESOURCE IMPLICATIONS; AND (3) REGIONAL FLEXIBILITY AND WASHINGTON SUPPORT WOULD BE CRITICAL AS WE MOVE TO THE NEXT PHASE OF PROPOSING SPECIFIC ACTIVITIES.

D) THE GROUP RAISED QUESTIONS ABOUT HOW TO ENGAGE NON PRESENCE COUNTRIES. BOTSWANA IN PARTICULAR IS A CONCERN FOR ANY REGIONAL APPROACH. HIV PREVALENCE IN BOTSWANA IS ONE OF THE HIGHEST IN THE WORLD, AND THE EPIDEMIC IS CLOSELY LINKED TO THE EPIDEMICS IN SOUTH AFRICA AND ZIMBABWE. MIGRANT WORKERS IN BOTH COUNTRIES TRAVEL TO AND FROM BOTSWANA, AND TRUCKS TRAVELLING NORTH OR SOUTH PASS THROUGH BOTSWANA. THE LACK OF A USAID BILATERAL PRESENCE COULD UNDERMINE ANY REGIONAL EFFORT THAT SOUGHT TO TARGET REGIONAL MIGRANT LABOR OR TRANSPORTATION INDUSTRIES.

E) THE GROUP NOTED OUTSTANDING TECHNICAL ISSUES WHICH SHOULD BE CONSIDERED AS PRIORITIES FOR USAID/WASHINGTON INVOLVEMENT. THESE INCLUDE: (1) PRIORITIZATION AND DELIVERY OF COST EFFECTIVE HIV/AIDS INTERVENTIONS IN DECENTRALIZED HEALTH CARE SYSTEMS, WITH LIMITED AND SHRINKING RESOURCES; (2) THE IMPACT OF HIV/AIDS ON REVERSING GAINS IN CHILD SURVIVAL; (3) ISSUES RELATED TO REDUCTION OF MATERNAL TO CHILD TRANSMISSION, INCLUDING HIV AND BREASTFEEDING ISSUES; AND (4) BEST PRACTICES FOR SUPPORTING COMMUNITY BASED ORPHAN/VULNERABLE CHILDREN INTERVENTIONS, INCLUDING MONITORING AND EVALUATION.

19. THE GROUP ACKNOWLEDGES AND WISHES TO THANK USAID HARARE FOR THE EXCELLENT LOGISTICAL SUPPORT IT PROVIDED. THE GROUP ALSO GREATLY APPRECIATED THE PARTICIPATION OF THE U.S. AMBASSADOR TO ZIMBABWE, THE HON. TOM MCDONALD, WHO TOOK THE TIME TO MEET WITH THE GROUP, AND WHO SUGGESTED THAT AN AMBASSADORIAL LEVEL MEETING MIGHT BE APPROPRIATE AT SOME LATER DATE, ONCE CONCRETE PROPOSALS HAVE BEEN DEVELOPED. MCDONALD##

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Cc: William A. Jeffers@AFR.SA@AIDW  
Bcc:  
From: Rose Marie Depp@DIR@HARARE  
Subject: AIDS Meeting of Last Friday and Amb McDonald Follow-up  
Date: Monday, October 19, 1998 16:01:12 GMT  
Attach:  
Certify: N  
Forwarded by:

MD  
Copy

AIDS

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Amb McDonald just called me to discuss follow-up to last Friday's meeting of USAID Southern Africa Technical HIV/AIDS officers.

He called Krueger (but he was out) and Render called him on another matter and he discussed the AIDS meeting with her. He expects to touch base w/ Shippey as well. He didn't mention Joseph but my presumption is that he'll contact him as well.

He wants to pursue the idea of bringing together Ambassadors and USAID MDs and suggested early next year.

Hopefully, I bought us some time reporting that a cable is in the works w/ about a half dozen ideas. The next step (I think) is that the tech folks get together again to explore more in depth a couple of the ideas and to discuss the implementation details and resources implications of putting something concrete together. I suggested that after this is done that it might be appropriate to bring together the Amb level, but that before Amb McDonald invites his counterparts to Harare for a conference that we would want to be sure we had something solid to work from. He understood this and suggested that rather than January perhaps later in the first quarter.

I also said that Walter and I had to talk to our counterparts at the upcoming MD conference(s) and make sure USAID leadership is on board. Ed, we explained that there is no bilateral mission in Botswana and no regional HIV programming. Amb McDonald understands that but wants to exploit Krueger's SADC "hat." Bill J and Carol P will be interested in the results of this meeting and hopefully will have guidance and suggestions re future steps. Bill J. told me that it is on the agenda for the Southern Afr sessions.

Amb McDonald also suggested that he and Krueger in some future visit to Washington visit the Hill (he mentioned Pelosi because Clay mentioned her and Amb McD knows her) to try and seek funding. I suggested that this is premature as well and that financial resources may not be the constraint here.

In closing, I saw Ken's suggestion for a December meeting. Am interested in others' reaction. This does start to get into holiday time, but I don't oppose the suggestion. We also need to touch base w/ Mozambique and Tanzania to see if they plan on participating in future meetings. I assume that they do and that this time it was just a scheduling constraint, but perhaps the organizers can clarify this point for me.

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## DISCUSSION PAPER ON REGIONAL COLLABORATION

Following our successful one day HIV/AIDS meeting last Friday, I visited the SADC and WHO libraries to get more information on regional collaboration. I also had a chance to discuss regional HIV/AIDS activities with the Coordinator -- Commonwealth Health Secretariat for East Central and Southern Africa (ECSA), Grace Osewe who is assisting ECSA to develop its strategic plan for the next five years, and officials from WHO headquarters who were attending the just ended obstetrics and gynecology conference in Harare.

I have tried to summarize the literature search, discussions and inputs from last Friday's meeting. I hope that you will find the document useful in preparation for the Directors meeting.

I have conveniently categorized regional issues under four main areas:

1. Identification of similarities that constitute a common framework i.e. common constraints. For example, despite the good road network in the region, there is no regional communication strategy, and in most of the countries, there has been no comprehensive national HIV/AIDS communication strategy. The information, education and communication messages are being disseminated in a very sporadic manner and has not included different races in the countries or paid sufficient attention to the crucial and significant differences between the rich and poor, rural and urban, traditional and non-traditional groups.
2. Sharing of lessons learned, which revolves around availability and access to information in a form that can be easily understood and applied. For example, the national policy document in Zimbabwe, supported by USAID, deals with issues such as mandatory testing, discrimination, children and youth, wilful transmission, commercial sex workers, condoms in prison and gender. Many policy documents from SADC countries are silent on several of these issues. Zimbabwe's experience in handling these issues should therefore provide useful lessons for other countries in the region.
3. Issues that lend themselves to regional collaboration, i.e. collaboration on problems that affect a significant part of the region, or adoption of a regional approach to local problems based on successful interventions in other areas.
4. Regional resources that can be mobilized, e.g. regional donor collaboration, potential centers of excellence in specific and/or highly relevant areas such as policy and advocacy, or highly successful activities such Voluntary HIV Counseling & Testing (VCT).

### **Potential areas of opportunity:**

▶ The major constraint in the region is lack of political leadership -- most politicians in the region are still quite reluctant to publicly address issues pertaining to HIV/AIDS, except in Uganda, and to a smaller extent in Kenya. It is only recently that leaders in South Africa and Zimbabwe have begun to discuss the impact of HIV/AIDS on their population. In South Africa the deputy President launched the national partnership against HIV/AIDS campaign, while in Zimbabwe the ruling party chairman and several cabinet ministers launched the Provincial HIV/AIDS Awareness Campaign, and directed provincial governors to replicate the initiative in other provinces. In most countries however, the leadership is still not talking about HIV/AIDS despite its devastating impact on the economy. Consequently, progressive countries can share experiences with those that are still lagging behind. For example, the recent openness in Zimbabwe came after a study tour to Uganda by several cabinet ministers.

▶ HIV program managers are concerned that despite many years of intervention, and correspondingly high levels of awareness, there is very limited behavior change and are looking for newer approaches. A new initiative, appropriately termed 'Beyond Awareness', has been launched in South Africa and Zimbabwe. It is designed to target issues that impede behavior change by mobilizing political, business, religious, educational and traditional leaders at the national, provincial, district and community levels to openly speak out about HIV/AIDS. The leaders are encouraged to address behaviors that facilitate transmission such as wife inheritance, infected males having sex with virgins as a form of treatment, heavy alcohol consumption, etc. Zambia has a district multi-sectoral approach that has led to improved education and communication activities at the grassroots.

▶ Recent studies from Eastern Africa (Uganda, Kenya, Tanzania and Rwanda) indicate that Voluntary Counseling and Testing (VCT) is more effective in reducing high risk sexual behavior among men and women compared to general health information. Although USAID continues to support dissemination of untargeted general health information in some countries of the region, the strategy may have limited usefulness in high HIV-prevalence countries where levels of awareness are approaching 100%. Consequently, we should consider making investments in new strategies such as VCT which are more appropriate for mature epidemics. Uganda has had a very successful VCT program upon which a regional framework to share lessons learned can be established.

▶ Partly due to the successful national launch of female condom in Zimbabwe, it is being marketed in South Africa and Zambia and other countries in the region are also interested. It is critical to discuss at a regional level whether the female condom, an expensive barrier method, is a viable option for a

significant number of men and women in the region, and if that is the case, explore with other partners how it can be made more available and accessible.

► Orphans are emerging as a problem in the region, and no single country has developed a national strategy to address it. Malawi and Uganda have some relatively successful local strategies that could be expanded and shared with other countries.

**Potential forms of collaboration:**

► Linkages with regional economic blocks such as Southern Africa Development Community (SADC), and Community Market for East Central and Southern Africa (COMESA) as a catalyst for increased policy and advocacy. Both organizations have included HIV/AIDS in their programs of work, and SADC for example has plans to develop joint regional activities in research, capacity building, and IEC material development among other areas. The two organizations have deep economic and political roots in the region thus providing an excellent entry point.

► Strengthening existing regional networks to facilitate sharing of HIV/AIDS experiences among similar institutions such as: NACPs, Research institutions, NGOs involved in similar activities, Policy organs such as trade unions, large industry concerns such as mining, commercial farming, and donor agencies.

► Identification of partners already working in most of the countries to discuss potential areas of collaboration e.g. Futures Group in Advocacy.

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Cc: Christopher Milligan@SO2  
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From: William Martin@RMIS@Harare  
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Date: Monday, October 19, 1998 16:40:55 GMT  
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Certify: N  
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MT  
CMB

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Data are all over the place. But here is something in writing on the BUCEN report on Zimbabwe. Marowa is in a difficult position. We need to be VERY careful in how WE use the BUCEN estimates given the numbers that Marowa seems to be using (at least for now). Bill

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Original Text

From Scott Allen@EDIT@GABORONE, on 10/19/98 9:40 AM:  
To: Christopher Edwards@PROG@GABORONE, Hope Sukin@AFR.SD@AIDW, Lovemore Bingandadi@EDIT@GABORONE, Oliver Chapeyama@ADNR@GABORONE, Ozias Tungwarara@ADNR@GABORONE, Patricia L. Jordan@AFR.SA@AIDW, Sanath K Reddy@PROG@GABORONE  
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The following article on a U.S. Census Bureau forecast of AIDS in Zimbabwe was in today's electronic edition of WOZA (South Africa). If the projections are accurate, apart from the terrible toll on human lives, the economic consequences will be devastating. Lester Brown of Worldwatch estimates that Zimbabwe's population will stop growing and begin declining in four years. UN estimates of AIDS prevalence for some of the countries in the Southern African region include:

Zimbabwe:	25%
Botswana:	29%
Namibia:	20%
Zambia:	19%
Swaziland:	18%.

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October 19, 1998

AIDS in Zimbabwe: only one in three 15 year olds will reach 31, says study

A demographic holocaust in Zimbabwe, caused by AIDS, has been forecast by the United States Census Bureau.

Commenting that the life expectancy of Zimbabwean babies being born today is already down to just over 40 years, compared to just over 60 years a decade ago, the bureau says life expectancy for babies born in 2010 could be as low as 30 years.

The organisation says that Africa, and Zimbabwe in particular, is returning to a pre-colonial situation, when high birth rates were accompanied by high death rates from diseases resulting in low population.

Dr Evaristo Marowa, co-ordinator of Zimbabwe's National AIDS Control Programme (NACP), told The Standard that he could not confirm the American projections, but said political and community leaders must make a coordinated effort to stop the "terrible and unacceptable drop in life expectancy".

His organisation's own research set the life expectancy of children being born in 2000 at 50 years.

Helen Jackson, the director of the Southern Africa AIDS Information Dissemination Service (SafAIDS), explained that different models estimate a decline in the life expectancy in this country by between 20 and 30 years over the next 15 years.

Quoting statistics formulated by Zimbabwe-based epidemiologist, David Wilson, Jackson noted that only one in three 15-year-olds alive today are expected to reach their 31st birthdays.

She said that current deaths by AIDS had reached between 750-800 a week, and that HIV and AIDS related illnesses had become a leading cause of hospital admissions.

Jackson, however, cautioned people when relating to these figures, saying that "the trends are more important than the absolutes".

The AIDS Counselling Trust reports an increase in the estimated number of HIV cases from 119 in 1989, to 1,2 million in 1998, and an estimated three-quarter of a million AIDS orphans.

Dr Marowa, of the NACP, confirmed that the decline in the life expectancy of Zimbabwean adults had the potential to negate any strides made towards social development.

He said that decline in the country's life expectancy was likely to continue unless all money and resources available to combat the epidemic were "translated into meaningful action" by the authorities.

Another Zimbabwean organisation, the Community Working Group on Health (CWGH), estimates that "households will spend Z\$887 million around AIDS deaths alone, leading to a 61% loss in rural production . . . ."

While the group did not suggest a time-frame for this predicted expenditure by afflicted families, they nevertheless criticised the current \$3,5 billion budget

allocation made to the health sector as inadequate.

In a press release on Friday, the group said that "the minimal proportional increase to the already underfunded health sector and the absolute level of per capita funding is pitifully inadequate".

The CWGH, whose members include local and international civic organisations, suggest in their summary position on the budget that reallocations be made from those given to other ministries "including foreign affairs, defence, and other areas of government administration".

Increased budgetary allocations should "be directed towards preventive health and primary care clinic/district hospital services", noted the group.

The group recommended the budget take into account a minimum per capita allocation of Z\$540 "in order to finance essential services and activities".

The group cited taxation as the "most equitable" means of financing health services, and thus recommended that both preventive services and agreed levels of basic curative services for all citizens should be financed through "increased allocations" of tax revenue. from MISAnet/The Standard

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**BRIEFING PAPER FOR AMBASSADOR MCDONALD'S 9/21/98 MEETING  
WITH SECRETARY OF HEALTH AND HUMAN SERVICES**

**What is the extent of the HIV/AIDS problem in Zimbabwe?**

- **HIV prevalence:**
  - Estimated 20.3% adult prevalence in 1996
  - Highest in the world, according to UNAIDS
  - No signs yet that the epidemic is peaking
  
- **HIV transmission :**
  - Estimated 93% of cases are sexually transmitted
  - Estimated 7% transmitted from mother to child
  - Very few cases are transmitted by other means
  
- **AIDS distribution:**
  - More than 70% of reported cases are among adults between 20 and 49
  - More males than females infected but this difference is decreasing
  - Females 15-19 years are five times more likely to be infected than males of the same age
  
- **Social impact of AIDS:**
  - Estimated 1,100,000 orphans by the year 2005
  - Child & infant mortality is increasing, largely attributable to the epidemic
  - Exploding, costly TB epidemic is associated with the HIV epidemic: 550% increase in reported TB cases 1985 - 1995
  - Women are particularly affected because they
    - (1) have a higher risk of infection because of anatomical differences;
    - (2) culturally cannot insist on protection;
    - (3) become care givers, forfeiting income generating activities;
    - (4) drop out of school when parents are infected by AIDS
  
- **Economic impact**
  - High household costs due to expense of caring for sick family member and loss of earnings when they stay at home to provide care
  - At the firm-level, there is a loss of trained personnel, absenteeism, high death benefits pay-outs with some firms training two recruits for one job
  - The cost of AIDS is reducing GDP per capita
  
- **Zimbabwean response to the epidemic**
  - Universal awareness has not led to levels of behavior change required to make a significant impact on the epidemic
  - Lack of high level commitment; leaders either do not perceive AIDS as a grave problem facing the nation or ignore the gravity of the problem

-Ministry of Health has limited capacity to provide services as it is hard hit by overall economic downturn

### **What is USAID/ZIMBABWE doing in response?**

- **Condom social (private sector) marketing program**
  - Complements public sector distribution program
  - Includes male and female condoms (the "contraceptive sheath")
  - Done in collaboration with British Government
- **Policy awareness/development activities**
  - Tools to increase commitment to fighting epidemic at top and grass roots levels (e.g., presentations, booklets, models, etc.)
  - Support for development of a national AIDS policy and its dissemination
- **Voluntary HIV counseling and testing (VCT) activity**
  - VCT has proved effective in promoting behavior change in other countries
  - Currently very few testing sites in Zimbabwe
  - New activity in design stage and showing promise
  - Strong support and collaboration with GOZ
- **NGO strengthening project**
  - NGO capacity to implement HIV/AIDS programs is being strengthened
  - NGOs are acquiring business skills (marketing, financial and personnel management)
  - NGOs trained under this program will mentor other smaller, newer NGOs
- **Beyond Awareness Campaign**
  - Technical assistance to the Ministry of Information and Ministry of Health to conduct a communications campaign to move "beyond awareness" to behavior change

**Background on USAID-HHS Cooperation** - (This information is provided for your information only.) USAID works closely with the Centers for Disease Control (CDC), an agency of HHS. CDC helps USAID implement programs around the World and conducts research that is of direct relevance to assistance programs. CDC also loans staff to USAID and many of USAID's health advisors are either recruited by CDC on behalf of USAID or have prior work experience with CDC (for example, Dr. Patrick Osewe was an employee of CDC prior to joining USAID).

While HHS has an international health division, Congress has historically insisted that funding for international programs be appropriated in the International Affairs Account (Account 150) and has thus resisted efforts of domestic agencies to seek direct appropriations to conduct assistance programs. The vast majority of HHS

funding for such programs is provided by USAID to HHS, usually CDC, through inter-agency agreements. The exception is funding for international research that is conducted by the agencies of HHS (such as the National Institutes of Health). The Embassy is frequently requested to approve travel to Zimbabwe for HHS personnel who are involved in its research activities. Because USAID has technical health staff, the Embassy coordinates such clearances with USAID as it knows the actors better and has information on the Government of Zimbabwe procedures.

**You could ask for the Secretary's support in the following ways:**

- Request her support and voice in inter-agency fora to describe the gravity of the AIDS epidemic in Zimbabwe. On the surface the social-economic indicators for Zimbabwe look good in comparison to other African countries; however, the AIDS epidemic threatens progress and we expect a decline in these indicators when the next Demographic Health Survey is conducted in about a year's time. The economic impact of the epidemic on the hope for a democratic and peaceful transition to the post-Mugabe era is an increasingly important factor that will affect the future. There are regional implications especially with respect to the food security, the movement of people and the obvious implications for regional neighbors.
- If the Secretary agrees to visit Zimbabwe, you might suggest the following:
  - meetings with senior officials to encourage a high level policy dialogue concerning the impact of the epidemic, the importance of leadership in discussing the disease and encouraging behavior change; and
  - hosting a meeting of high level delegates from neighboring countries to discuss the epidemic and its impact and cooperative efforts to tackle the problems of mutual interest.
- You might suggest that the researchers from HHS agencies do a better job assuring liaison with USAID. There has been at least one case since your arrival when the Embassy requested that the researcher contact USAID; however, she did not, even though we learned from counterparts that the researcher had been in-country. Because our host-country counterparts do not always make a distinction among USG agencies, it creates confusion when all parties are not fully informed of other agencies' activities. This is particularly important given the cultural and political sensitivities that surround research conducted on foreign citizens that is potentially of greater benefit to Americans than to Zimbabweans.

Briefing Paper on HIV/AIDS in Zimbabwe for 9/22 Meeting between U.S.  
Ambassador to Zimbabwe and HHS Secretary:  
9/21/98: DCohn:o:\sapub\zimbabwe\ aids\hhsamb.brf

<u>Clearances:</u>	<u>Name</u>	<u>Date</u>
USAID/Zimbabwe:	RMDepp	9/21
AFR/SA:	RCohn	9/21
G/PHN/HN/HIV:	PDelay	9/21
A-AA/AFR:	CPeasley	9/21

HTV / MDS

Sydney Thurman

Barbara Lee  
Shaeta Jackson Lee  
Kathryn Kilpatrick

Helms staff  
Hatch staff  
Kennedy staff

4/19/99

→ Nancy C-F issue

Star the pot

• Economic Impact

~ huge disincentive to invest

~ BP VP in Zambia -

doing planning sessions  
on how to deal  
w/ this

SAfrica

infant mortality x 2

child " x 3

5,500 funerals/day

20 yr life exp ↓ in 5 yrs

went to

SAP  
Bots  
Uganda  
Zambia

AAA Summit  
IS GOING

EXPLORE ON NEXT TRIP

- mining
- military
- other industries

South Africa - denial is enormous

- 2nd fastest rising in world (behind Zimbabwe)

- official rate 40% in S. Africa Armed forces

Zimbabwe - 80% " of infection in armed forces

- highest rate of infection in the world

USDD > our guys @ risk if we don't do this - we work w/ them  
too much

- basic training on precautions ← [DISASTER PREPAREDNESS  
PIECE OF SADC-FORUM]

→ DEBRIEF BY S. THURMAN

Surg. Gen, NHS, AID, State, Commerce, Treasury, DOD, Labor, JJ

Shalala

Peace Corps

child labor/sex workers

Public  
Private  
Partnership

→ Seilim/Salim @ OAU Summit

CCF

Leri | Exam | Chemm | Pharma

Bob Silver → POTS  
O MONEY

(BLUE RAIN)

DISASTER PREPAREDNESS

- prophylaxis on sight?
- equipment on site?
- do disaster teams understand transmission?

INITIATIVE ON AFRICA → HIV/AIDS → GIVE IT A NAME

↓  
AIDS  
SIDA

Peace Corps

WB - % of spending on HIV/AIDS

FLORUS ← CHILD SOLDIERS / CHILD ORPHANS ←

5 PRONGED APPROACH

① LEADERSHIP - military  
- economy

COVIN OWEN  
RUBIN

② WOMEN - women's rights  
children's rights

FLORUS  
↓  
Melanne

Andy Young  
Desmond Tutu

③ PRIVATE PUBLIC  
Partnership

JWFE  
Pele  
Magic Johnson  
NIKE  
Reebok

④ Education Links  
Students - Univ. Campaign

⑤ Churches

**Battenfield, Pat A.**

---

**From:** Barks-Ruggles, Erica  
**Sent:** Wednesday, April 21, 1999 5:27 PM  
**To:** Bernard, Kenneth W.; Babbitt, James F.  
**Cc:** @AFRICA - African Affairs  
**Subject:** HIV/AIDS guidance [UNCLASSIFIED]

With Sandy Thurman's changes, here is the guidance. I will get the final number tomorrow morning. USTR will get us clearance tomorrow morning. Article in USA Today will not run until the first week in May. Ralph Nader apparently had a fizzle a bit on the Hill. Will, again, try to get a better sense of this in the morning. I am faxing this to AF/S as a draft for them to start getting clearance from their building so it can go out to Pretoria by COB tomorrow.



HIVguidance.doc

## HIV/AIDS Crisis in Africa and U.S. Response

**The U.S. is accused by Ralph Nader and others of preventing access to medicines to combat HIV/AIDS in Africa. Mr. Nader states that U.S. – and specifically the Vice President's - support for pharmaceutical companies' complaints against the South African Government's efforts to make drugs more affordable has deprived thousands of needed treatments. What is your response to this?**

- The United States government, particularly the President, the First Lady and the Vice President have taken an active role in publicizing the AIDS crisis in Africa, and in ensuring that the U.S. strongly supports African efforts to combat the disease.
- This Administration has done more than any previous Administration to fight the scourge of HIV/AIDS both here at home and abroad. We have accomplished much, but much more still needs to be done.
- This is especially important as 70% of the 34 million people living with HIV/AIDS live in sub-Saharan Africa, and 11.5 million out of the 14 million deaths caused by HIV/AIDS have occurred in sub-Saharan Africa. Since 1986, the United States has spent \$ \_\_\_\_ million to control the spread of HIV/AIDS. More than 50% of those funds have been dedicated to sub-Saharan Africa. Since the early 1990s, the U.S. has been the lead donor to the UNAIDS Program, contributing more than 25% of the budget and 48% of overall development assistance devoted to HIV care and prevention in the developing world.
- This year the United States will spend \$76 million to combat HIV/AIDS in sub-Saharan Africa, including \$7 million alone for AIDS orphans and infected children. This represents a trebling of our assistance since 1992.
- We applaud recent efforts by many of Africa's leaders, including those of President Mandela, South Africa's Deputy President Mbeki, Ghana's President Rawlings, Namibia's President Nujoma, Zambia's President Chiluba and many others to publicize the dangers of HIV/AIDS and the need for a united and concerted effort by communities to prevent its further spread and support those already infected.

- In South Africa, we share a mutual goal with the government to bring better health care to the people of South Africa, including those suffering as a result of HIV/AIDS. We believe this goal can be achieved while promoting effective and adequate patent protections for pharmaceutical products. With a shared commitment to improve health care and provide intellectual property protections we are continuing our efforts to find common ground on our differences.
- That said, we do have concerns with provisions of South Africa's Medicines Act, which may grant the Minister of Health broad discretion to authorize parallel importing of pharmaceutical products in a manner inconsistent with international trade agreements. The lack of definition provided in the Act may also grant authority to undermine other patent rights with respect to pharmaceuticals.
- We believe that commercial incentives to market pharmaceutical products are necessary, if we expect private industry to support continued research and the introduction of new, more effective pharmaceuticals. We will continue to work with the AIDS community and people living with AIDS both here and abroad to find ways to expand access to treatment. We will also continue to work in a sense of partnership with the South African government to resolve our outstanding differences related to intellectual property rights protections and the Medicines Act.
- The United States continues to be a leading donor in the fight against HIV/AIDS in some of the worst hit countries on the continent. For example, from 1986-1998, through USAID funding, the U.S. government contributed over \$46 million to fund counseling, testing, education, prevention, and treatment programs in Uganda. This is more than  $\frac{1}{4}$  of the total donor contributions to Uganda's aggressive and successful effort to slow the increase in HIV infection rates.
- In South Africa, the United States, through USAID recently committed to fund a \$10 million five-year program to support the South African government and local NGOs efforts to fight HIV/AIDS. We are seeking to expand these resources through public-private partnerships.

January 22, 1999

MEMORANDUM FOR TODD SUMMERS  
Deputy Director  
Office of National AIDS Policy

SUBJECT: Foreign Travel Approval

This memorandum is to confirm that the following foreign travel request has been approved.

Sandra Thurman  
Director  
Office of National AIDS Policy

January 22 - February 7, 1999

South Africa  
Zimbabwe  
Zambia  
Uganda

  
Glyn T. Davies  
Executive Secretary

DEPARTMENT OF STATE  
EXECUTIVE SECRETARIAT  
TRANSMITTAL FORM

S/S 9901146  
Date 1/22/99

For: Mr. Glyn T. Davies  
Executive Secretary  
National Security Affairs  
The White House  
Washington, DC 20500

Reference:

To: Glyn T. Davies

From: Kristie A. Kenney

Date: 1/22/99

Subject: Foreign Travel Request for Sandra Thurman, Director of the Office of National AIDS Policy

WH Referral Dated: 1/21/99

NSCS ID# (if any): 9901146 990425

The attached item was sent directly to the Department of State.

ACTION TAKEN:

- A draft reply is attached.
- A draft reply will be forwarded.
- A translation is attached.
- An information copy of a direct reply is attached.
- We believe no response is necessary for the reason cited below.
- The Department of State has no objection to the proposed travel.
- Other (see remarks).

REMARKS:

*Kristie A. Kenney*

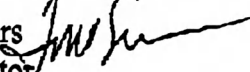
Kristie A. Kenney  
Executive Secretary

9901146

THE WHITE HOUSE  
WASHINGTON

Unclassified

MEMORANDUM FOR EXECUTIVE SECRETARY, NSC

From: Todd Summers   
Deputy Director  
Office of National AIDS Policy

#0425

Date: January 21, 1999

Re: Official Foreign Travel of Sandra Thurman

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On December 1, 1998, the President announced \$10 million in US emergency relief funding to help identify effective policies and programs for children orphaned by AIDS, and to begin to build support for community-based responses that strengthen families, villages, and youth themselves.

As a first step in this process, Ms. Thurman will lead a small delegation with expertise in HIV, children, government, business, and public relations to sub-Saharan Africa. Ms. Thurman and the delegation will visit programs as well as meet with high-ranking government officials, non-governmental organizations, and individuals and families living with HIV and AIDS in South Africa, Zambia, Zimbabwe, and Uganda. Tentative arrangements have been made for Ms. Thurman to meet with the President of Zambia (at his request).

The purpose of this initial trip is to assess realities, identify strategic opportunities, and plan for a larger fact-finding mission to take place in early April. The April fact-finding mission will, as directed by the President, include key congressional members. Following this assessment phase, Director Thurman will make recommendations for action to the President.

Ms. Thurman and her staff have been working with the Africa Bureau at the Department of State, and with NSC staff (including Gayle Smith, Erica Barks-Ruggles, and Ken Bernard).

Please let me know if you have any concerns about this trip. I can be reached at 6-2444. Thank you.

9901146

# NATIONAL SECURITY COUNCIL

## FAX COVER SHEET

<b>NATIONAL SECURITY COUNCIL</b>	<b>From: June Bartlett To: Barbara Hamrick/Saadia Sarkis Agency: State/ExecSec Fax Number: (202) 647-1533</b>
17th & Penn, N.W. Washington, D.C. 20504	<b>Date/Time: January 21, 1999 No. of pages to follow: One</b>
Did you get a complete, clear transmission? If not, please call:	<b>Message: Barb: Per my voice mail, attached is the foreign travel request from a White House office. Hand delivered earlier this evening. Please note that traveler departs tomorrow, Friday (early evening). Would appreciate your assistance in obtaining State's approval, if at all possible by early p.m., Friday. Also note that traveler has been working Africa Bureau. THANKS - JUNE BARTLETT</b>
(202) 456-9461	

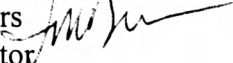
*June*

0425

THE WHITE HOUSE  
WASHINGTON

Unclassified

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Deputy Director  
Office of National AIDS Policy

Date: January 21, 1999

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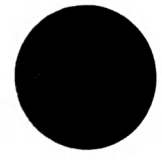
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\*\*\*\*\*  
\*\*\* TX REPORT \*\*\*  
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TRANSMISSION OK

TX/RX NO	1462	
CONNECTION TEL		96471533
CONNECTION ID	SSS	
ST. TIME	01/21 19:28	
USAGE T	01'20	
PGS.	2	
RESULT	OK	



# NATIONAL SECURITY COUNCIL

## FAX COVER SHEET

**NATIONAL  
SECURITY  
COUNCIL**

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

**From: June Bartlett**

**To: Barbara Hamrick/Saadia Sarkis**

**Agency: State/ExecSec**

**Fax Number: (202) 647-1533**

**Date/Time: January 21, 1999**

**No. of pages to follow: One**

**Message: Barb: Per my voice mail, attached is the foreign travel request from a White House office. Hand delivered earlier this evening. Please note**

Did you get a complete, clear transmission? If not,

NATIONAL SECURITY COUNCIL

FAX COVER SHEET

<p><b>NATIONAL SECURITY COUNCIL</b></p>	<p><b>From: June Bartlett</b> <b>To: Barbara Hamrick/Saadia Sarkis</b> <b>Agency: State/ExecSec</b> <b>Fax Number: (202) 647-1533</b> <b>Date/Time: January 21, 1999</b> <b>No. of pages to follow: One</b> <b>Message: Barb: Per my voice mail, attached is the foreign travel request from a White House office. Hand delivered earlier this evening. Please note that traveler departs tomorrow, Friday (early evening). Would appreciate your assistance in obtaining State's approval, if at all possible by early p.m., Friday. Also note that traveler has been working Africa Bureau. THANKS – JUNE BARTLETT</b></p>
<p>17th &amp; Penn, N.W. Washington, D.C. 20504</p>	
<p>Did you get a complete, clear transmission? If not, please call:</p>	
<p>(202) 456-9461</p>	



**Bartlett, L. June**

---

**From:** Bartlett, L. June  
**Sent:** Thursday, January 21, 1999 6:32 PM  
**To:** Smith, Gayle E.  
**Cc:** @AFRICA - African Affairs; @CROSS - Cross Hatches  
**Subject:** RE: Thurman travel [UNCLASSIFIED]

#0425

THANKS!

June

-----Original Message-----

**From:** Smith, Gayle E.  
**Sent:** Thursday, January 21, 1999 6:28 PM  
**To:** Bartlett, L. June  
**Cc:** @AFRICA - African Affairs  
**Subject:** Thurman travel [UNCLASSIFIED]

We concur with Thurman travel to Africa as per memo faxed to us.

\*\*\*\*\*  
\*\*\* TX REPORT \*\*\*  
\*\*\*\*\*

TRANSMISSION OK

TX/RX NO 1461  
CONNECTION TEL 69260  
CONNECTION ID AFRICAN AFFAIRS  
ST. TIME 01/21 19:19  
USAGE T 00'52  
PGS. 1  
RESULT OK

THE WHITE HOUSE  
WASHINGTON

Unclassified

MEMORANDUM FOR EXECUTIVE SECRETARY, NSC

From: Todd Summers *TSum*  
Deputy Director  
Office of National AIDS Policy

Date: January 21, 1999

Re: Official Foreign Travel of Sandra Thurman

*1-21-99  
Gayle -  
Here is  
travel  
request -  
if you  
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review  
& approve  
by early  
PM -  
Thanks  
June*

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THE WHITE HOUSE  
WASHINGTON

Unclassified

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Deputy Director  
Office of National AIDS Policy

Date: January 21, 1999

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Please let me know if you have any concerns about this trip. I can be reached at 6-2444. Thank you.

TO: DAVIES

FROM: SUMMERS, T

DOC DATE: 22 JAN 99  
SOURCE REF:

KEYWORDS: SOUTH AFRICA  
ZAMBIA  
FOREIGN TRAVEL

ZIMBABWE  
UGANDA

PERSONS: DURHAM, S

SUBJECT: NOTIFICATION OF FORN TRAVEL BY SUMMERS TO SOUTH AFRICA / ZIMBABWE  
ZAMBIA / UGANDA / ON 22 JAN - 7 FEB 99

---

ACTION: CONCURRENCE TO EXEC SECRETARY DUE DATE: 28 JAN 99 STATUS: S

STAFF OFFICER: BARKS-RUGGLES

LOGREF:

FILES: WH

NSCP:

CODES:

---

D O C U M E N T D I S T R I B U T I O N

FOR ACTION  
BARKS-RUGGLES

FOR CONCURRENCE  
PRENDERGAST  
STATE

FOR INFO  
RUDMAN  
SANDERS  
SCHWARTZ  
SMITH, G

COMMENTS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DISPATCHED BY \_\_\_\_\_ DATE \_\_\_\_\_ BY HAND W/ATTCH

OPENED BY: NSGP

CLOSED BY:

DOC 1 OF 1

THE WHITE HOUSE  
WASHINGTON

Unclassified

MEMORANDUM FOR EXECUTIVE SECRETARY, NSC

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Office of National AIDS Policy

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June*

*Done  
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HIV/AIDS



# THE AFRICA-AMERICA INSTITUTE

AAI • UNITED FOR LEARNING AND LEADERSHIP

**MORA MCLEAN**  
PRESIDENT

**HEADQUARTERS**

380 Lexington Ave, 42nd Floor  
New York, NY 10168-4298  
Phone: 212-949-5666  
Fax: 212-682-6174  
E-Mail: [aainy@aaionline.org](mailto:aainy@aaionline.org)

**VIA FAX NO: (212) 556-3622**

December 16, 1998

**WASHINGTON D.C.**

1625 Massachusetts Ave, N.W.  
Washington, DC 20036  
Phone: 202-667-5636  
Fax: 202-265-6332

Letters to the Editor  
The New York Times  
229 West 43<sup>rd</sup> Street  
New York, NY 10036

**REPRESENTATIVES IN:**

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- Burkina Faso
- Congo
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- Mali
- Mozambique
- Namibia
- Nigeria
- Senegal
- Sierra Leone
- South Africa
- Tanzania
- Zambia
- Zimbabwe

**To the Editor:**

The Times' occasional series on AIDS in Africa (most recent installment, front page, December 16) has amply documented the alarming spread of HIV/AIDS on the continent and the myriad social, economic, and cultural challenges posed by the disease. Unfortunately, it has also left the impression that Africans are failing to address the AIDS epidemic and that there is little to do but to despair.

The African reality is much different. As documented by the Joint United Nations Program on HIV/AIDS (UNAIDS), African countries are among those with the most pro-active and far-reaching programs to combat AIDS, as well as those hardest hit by the epidemic. Uganda, whose model anti-AIDS program has been mentioned only in passing in the series, is but one example. UNAIDS also cites the efforts of Zambia, Senegal, and Madagascar, where government and private organizations have taken creative, effective approaches to the prevention and treatment of AIDS.

Several articles in the series have addressed the stigmatization of AIDS in much of Africa. This is indeed a serious problem, but it is important to put the issue in context. There is nothing unique about the misinformation and denial reflected in many Africans' view of AIDS. After all, it was not so long ago that a young American boy, Ryan White, was forced to leave his school in Indiana because of his community's fear of the HIV virus he had contracted. If Americans are now a bit more enlightened on the topic it is only because of a massive public information campaign over the last several years.

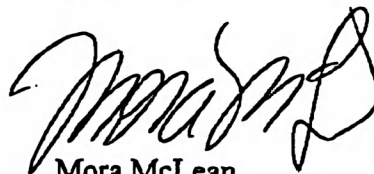
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- Ted Smyth
- Maurice Tempelman

Moreover, several African governments are tackling the stigmatization problem head on. For example, South African Deputy President Thabo Mbeki addressed the nation in October, acknowledging the silence and denial that had marked South African society's approach to AIDS and calling for abstinence, fidelity, condom use, and a caring, non-discriminatory attitude to those stricken by HIV/AIDS. The speech was televised nationally and many firms stopped work to allow their employees to listen to it. Yet this significant event went unreported in the Times.

American readers are all too familiar with news reports of the many daunting challenges African countries face. What they hear all too little about is the valiant efforts of many Africans to take their destiny into their own hands and confront these problems.

Sincerely,

A handwritten signature in black ink, appearing to read 'Mora McLean', written in a cursive style.

Mora McLean  
President

# The New York Times

SATURDAY, DECEMBER 19, 1998

## Fighting AIDS in Africa

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To the Editor:

Your Dec. 16 front-page article on AIDS in Africa and others in your series on the disease document the alarming spread of the virus, but might leave the impression that Africans are failing to address the epidemic. As documented by a United Nations program (UNAIDS), African countries have some of the most far-reaching programs to combat the virus.

Uganda's, which you mentioned, is one example. The U.N. also cites Zambia, Senegal and Madagascar.

There is nothing unique about the misinformation and denial in Africa. It was not so long ago that Ryan White was forced to leave his school because of his Indiana community's fear of the virus.

MORA MCLEAN

New York, Dec. 16, 1998

*The writer is president of the Africa-America Institute.*

# Withdrawal/Redaction Marker

## Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003. report	Re: Africa's Growing AIDS Crisis [partial] (2 pages)	09/03/1999	P1/b(1)

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**COLLECTION:**

Clinton Presidential Records  
National Security Council  
African Affairs (Smith, Gayle/Barks-Ruggles, Erica/Sanders, Robin/Rice, Susan/Dempsey, Nora et al.)  
OA/Box Number: 2853

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**FOLDER TITLE:**

AIDS, 1 of 2 [Africa] [3]

2007-1550-F  
ke2009

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

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

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

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

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

CONFIDENTIAL

6.2(d)

3 September 1999

### Africa's Growing AIDS Crisis (U)

Sub-Saharan Africa is clearly bearing the brunt of the pandemic. Of the 30.6 million globally-recorded cases of HIV/AIDS in 1997, 69 percent were in Sub-Saharan Africa,

E.O. 12958 1.4(c)

- Eastern and southern Africa have the highest HIV infection rates at 10 to 30 percent respectively, but prevalence is increasing in west Africa. In Cote d'Ivoire, for example, [1.4(c)] about 10 percent of the adult population is now HIV positive.
- Infection rates appear to be increasing in South Africa, Zimbabwe, and Botswana. By 2010, the US Census Bureau projects that life expectancy in these countries will be as low as the 30s—half of the projected life expectancy without AIDS.

6.2(d)

We estimate that, in South Africa, AIDS it will become the number-one cause of death by 2001 and infect over 38 percent of the adult population by 2010.

- Twenty percent of South Africa's adult population is currently infected with HIV, according to US Census Bureau projections [1.4(c)] [1.4(c)] South African Government statistics report that 1,500 new cases are diagnosed daily. [6.2(d)]

Government efforts to deal with the growing problem have been limited, and there is no evidence that they are having any effect halting the disease's spread. Steps taken include strong public statements by key leaders and the provision of free condoms.

- In October 1998, then-Deputy President Mbeki called for abstinence, fidelity, and condom use

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on national television and urged a caring, non-discriminatory attitude to those already infected with or affected by HIV.

- Then-President Mandela reiterated this message in a December 1998 speech in KwaZulu-Natal, the most heavily HIV-infected province. 6.2(d)

The government, however, has not established a policy for treating people with AIDS. Although South Africa has access to western HIV/AIDS treatments, the expense of AZT and other drugs makes their use impractical.

- A South African think tank estimated in 1991 that per patient costs ranged from \$1,070-\$2,026 per year—South Africans' average annual income is \$5,400
- With 20 percent of South Africa's 23.5 million adults (15-49 years old) infected, a full treatment program would cost \$5.0-9.5 billion in 1999 alone, greater than Pretoria's total 1999 health care budget.

In contrast to the rest of the continent, Uganda has made measurable gains in fighting HIV/AIDS, recording a steady decline in infection rates since 1992. South Africa may seek to emulate the "best practices" employed by Kampala; newly appointed Health Minister Tshabalala-Msimang has already visited Uganda and discussed HIV/AIDS programs. Such best practices would include:

- Unusually strong leadership by Ugandan President Museveni, who has staged a public relations campaign enlisting the population to fight the disease as a national duty.
- A vigorous voluntary testing, counseling and prevention program instituted in cooperation with donor organizations and governments.
- Effective use of radio, print media, and other outlets to persuade people to change their behavior. These efforts have been particularly effective among youth.
- The program's reputation for efficiency, unmarred by the allegations of mismanagement plaguing South Africa's program. 6.2(d)

FILE

## **HIV/AIDS Leadership Meeting**

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

### **Overview and scope of the problem**

#### **Brief outline of the Administration's new Global AIDS Initiative**

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

#### **Open discussion by key stakeholders**

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

#### **Next steps**

**AIDS Convening  
September 7, 1999**

***Participants List***

**Administration**

First Lady Hillary Rodham Clinton

Secretary Donna Shalala  
Department of Health and Human Services

The Honorable David Satcher  
Surgeon General

Secretary Lawrence Summers  
Department of the Treasury

Administrator Brady Anderson  
US Agency for International Development

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

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

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

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

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

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

### **Multinational Organizations**

Mr. James Wolfensohn  
President  
World Bank

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

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


### **Foundations**

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

Mr. Aryeh Neier  
President Soros Foundations Network  
Open Society Institute

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

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

 Dr. Drew Altman  
President and CEO  
Kaiser Family Foundation

## **Corporations/Others**

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

Mr. Robert Johnson  
Chairman and CEO  
Black Entertainment Television

## **Observers**

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

Paul Delay  
Agency for International Development

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

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

Ms. Debrework Zewdie  
Lead Specialist, Population  
The World Bank

Timothy Geithner  
Under Secretary for International Affairs  
Department of the Treasury

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

Ms. Debrah Lee  
President and COO  
Black Entertainment Television

Mr. Ken Weg  
Vice Chairman  
Bristol Myers Squibb

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

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

Mr. Paul Boneberg  
Director  
Global AIDS Action Network

Ms. Marsha Martin  
Special Assistant to the Secretary  
Department of Health and Human Services

Ms. Diane Graham  
Special Assistant for Global Affairs  
State Department

Ambassador Nancy Powell  
Principal Deputy Assistant Secretary for African Affairs  
State Department

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

## **Script:**

Location: Roosevelt Room 10:30am September 7, 1999

### Press enters

#### • **Welcome**

- **Opening remarks by the First Lady**, including introductions (see above)

### Press departs

- **Introduce Dr. Peter Piot**, Executive Director, Joint UN program on HIV/AIDS in Geneva: For brief overview of epidemic and the specific challenges we face as we move into the next century.

- **Call on Donna Shalala** for her thoughts on where we need to go in the health sector

- **Call on Lawrence Summers** for his thoughts on where we need to go in the international financial sector

- **Call on James Wolfensohn** for his thoughts on directions for the International Financial Institutions

- **Follow on with open discussion with foundations and corporations and others**

#### **Issues -- Incorporating AIDS into specific sector portfolios:**

- Prevention activities. Engagement of leadership. Stigma reduction. Education. Mother to child transmission prevention.
- Care and treatment. Provision of basic medical care., including treatment of TB and other opportunistic infections.
- Infrastructure development, including financing and debt relief

- **Next Steps**

1. Foundation meeting called by MacArthur Foundation. Could they take a leadership role with other foundations?
2. Business Leader's meeting coordinated by VP and Commerce. Could Bristol Myers have a role in helping with pharmaceutical companies?
3. Could BET help organize a communications forum to discuss increased AIDS

activities internationally?

5. Follow on the Cologne Initiative: Demonstration project in Africa on Debt for AIDS prevention activities.
  6. New UN activities
  7. Other (as come up in the open discussion).
- Close.

703/548-4407

Opening Remarks HRC

- Welcome -- and thank you all for coming to what I hope will be a very interesting and productive discussion. We are very pleased to be joined this morning by many leaders from the Administration, international organizations, foundations, businesses, and the AIDS community. Their presence is a testament to the impact the AIDS pandemic has on every sector of society -- and to the responsibility we all have to end it.
- It is my hope that this meeting will lead to new initiatives, new resources, new thinking, and new partnerships to fight -- and ultimately win -- the war against HIV/AIDS in Africa and around the world.
- Because every day, we are reminded of the breakthroughs we've had in this fight-- from drug therapies that are improving life to campaigns that are empowering people to prevent the disease. We know what works. But, we are also reminded time and again of the people left behind -- and the sheer enormity of the challenge that remains.
- Just a week ago in Atlanta, we heard that the rate of HIV infections is no longer declining in the U.S. And, as you know, every day, AIDS claims the lives of more than 5,500 men, women, and children in Africa. In the next few years, that number will more than double. The AIDS epidemic in Africa is a crisis of biblical proportions. We are facing an emergency. And what we see in Africa today, we will likely see one day in India, in Southeast Asia, and the Newly Independent States if we don't act now.
- As I have been privileged to travel all over the world, I have seen firsthand what can be accomplished when leaders and citizens alike decide to tackle this tragedy from every angle.
- In Uganda, I went to the AIDS Information Center and saw billboards everywhere I went educating people to protect themselves against AIDS. It was all part of the campaign being waged by President Museveni and citizens throughout Uganda. I remember the song some of them sang: Ugandans are fighting to ensure that AIDS cannot win. Well, it's working. In 1992, 17 percent of sexually active teenage girls in Uganda were HIV positive. By the end of 1998 the rate was about six percent -- that's almost a two-thirds reduction.

- That example was on the minds of the African health ministers who came together last week at a W.H.O. meeting in Namibia. They declared war on HIV/AIDS and made a commitment to wage intensive campaigns to stop the devastation it is causing for their citizens and countries. And we must work hand in hand with them.
- Because AIDS is not somebody else's problem. And it is certainly not just a public health challenge that we can put in a box and ask our scientists and health care professionals to meet alone. Our work against AIDS must be part of our overall development efforts -- especially those affecting women and children.
- Because as we speak, the AIDS epidemic in Africa is turning back the clock on the steady development we've seen over the past few decades. It is undermining economies, trade, civil society, stability, and decreasing life expectancy by up to 20 years in some countries. And it is turning millions of children into orphans. How will they be able to build Africa in the future...when they are being left without a future today?
- I know that the people in this room have made great progress in the battle against AIDS. But, as you know better than anyone, the challenge before us is far greater than the collective actions taken so far. And that's why this meeting -- and the leadership of the organizations and sectors you represent -- is so important.
- We are pleased to be joined by so many key leaders of our Administration, who have worked on this problem from every perspective -- health, financial, international, and development. They include the Secretary of Health and Human Services, Donna Shalala; the Secretary of the Treasury Larry Summers; USAID Administrator Brady Anderson; our Surgeon General David Satcher; Undersecretary of State, Frank Loy; and the Director of the White House Office of National AIDS Policy, Sandy Thurman.
- As many of you know, this Administration has asked for an additional \$100 million next year to fight the global battle against AIDS. This is the largest increase ever in the international AIDS budget. And it would allow us to more than double our efforts in sub-Saharan Africa.

- We are also joined by representatives of our multilateral organizations, including Jim Wolfenson and Jan Piercy from the World Bank and Peter Piot from UNAIDS. [When we hear Dr. Piot talk about the work that UN agencies are doing to combat AIDS around the world, we are reminded of yet one more reason why it is so important that we support the United Nations and pay our dues.]
- We are also very fortunate to have with us some of the non-governmental organizations who serve on the frontlines. I want to thank the National Association of People with AIDS and the Global AIDS Action Network for being here.
- And we are also joined by representatives of the foundation community who have provided great leadership in the fight against HIV/AIDS. I want to thank the Rockefeller Foundation, the Gates Foundation, and the Open Society Institute for their generous contributions. I also want to thank the Kaiser Family Foundation, which comes here with a new commitment to match funding dedicated to preventing AIDS among adolescents in South Africa. And I want to thank the MacArthur Foundation, which will be bringing foundations together at the end of this year to discuss even more ways they can meet this challenge.
- We are also joined by Black Entertainment Television and Bristol Myers Squibb, who are not only making great contributions themselves. They are reminding us of the role that the media, the pharmaceutical companies – and indeed all businesses – can play.
- [Add Cologne announcement if we get it resolved]
- There are millions of people in Africa and all over the world whose lives and futures we could save – if only we find the will and the way. So, I hope that over the next hour or so we will think creatively about the ways that we can work together to finally win this war.
- In this room, there are leaders who have dedicated their hearts and souls and resources to this fight. But, just imagine what we could accomplish if, over the next few years, we could bring to this table every government leader, every foundation, every business, every NGO, every multilateral organization, and every citizen.

- We will never give up until the day when we meet our ultimate goal and find a cure that reaches every single man, woman, and child on this planet. But, until then, we must do everything in our power to prevent HIV and heal those it strikes in Africa and all over the world.
- I hope that this meeting is the first of many steps we will take over the next few years to make that possible.

August 4, 1999

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

Dear John:

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

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

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

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

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

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

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

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

Sincerely yours,

Hillary Rodham Clinton

# **AIDS in Africa is a Serious Crisis**

But Opportunities Exist for Helping to Save Millions of Lives

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## **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 37 years. 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.

September 3, 1999

## MEMORANDUM TO THE FIRST LADY

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

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

---

### Summary

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

### Background

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

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

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

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

- **Business Leaders Meeting** - The Department of Commerce will facilitate a meeting of business leaders active in Africa to encourage them to increase their efforts in the battle against AIDS. This is tentatively scheduled for early November and the Vice President has expressed interest in participating.
- **Labor Leaders Meeting** - The Department of Labor, led by Secretary Herman, and the AFL-CIO will co-host a meeting of US and African labor leaders to determine ways to expand existing programs which use trade unions to provide outreach and HIV/AIDS education (Note: In many parts of South Africa one in four mine workers in HIV-positive).
- **Religious Leaders Summit** - The Office of National AIDS Policy will facilitate a meeting of African, American and other religious leaders to discuss ways to more effectively engage communities of faith in the fight against AIDS. Several prominent religious leaders have tentatively committed to participate including Reverends Jesse Jackson, Leon Sullivan, Andrew Young and Archbishop Desmond Tutu.
- **UN Conference on Children Orphaned by AIDS** - On December 1, 1999 (World AIDS Day), the United Nations in conjunction with the National Black Leadership Commission on AIDS (chaired by David Dinkins), The White House Office of National AIDS Policy, The Magic Johnson Foundation and a variety of NGO's will hold a conference to focus attention on the growing number of children orphaned by AIDS. You have been asked to deliver a keynote address.

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

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

**SENSITIVE**

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

South Africa  
Intellectual Property Rights

ISSUE:

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

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

BACKGROUND:

Actions by the Administration

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

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

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

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

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

### Congress

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

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

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

### U.S. Policy

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

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

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

### Compulsory Licensing

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

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

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

### Parallel Imports

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