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Folder Title:

Global AIDS Issues [1]

Staff Office-Individual:

International Health Affairs-Bernard, Kenneth

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Withdrawal/Redaction Sheet

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. email	From Kenneth Bernard, re: Note to Sandy (3 pages)	07/27/2000	P1/b(1), P6/b(6) KBH 10/21/2024
002. memo	John Duncan to Gene Sperling, re: G-8 Update (3 pages)	10/22/2000	P1/b(1) KBH 10/21/2024

COLLECTION:

Clinton Presidential Records
National Security Council
International Health Affairs (Bernard, Kenneth)
OA/Box Number: 3646

FOLDER TITLE:

Global AIDS Issues [1]

2007-1550-F
ke2034

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]

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

RR. Document will be reviewed upon request.

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

- b(1) National security classified information [(b)(1) of the FOIA]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
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13 July
1000
A.M.

G-8 MORNING SESSION:
TOWARD A 21ST CENTURY OF GREATER PROSPERITY

TOPIC 3a: INFECTIOUS DISEASES/VACCINES
TALKING POINTS

- Moral, economic, and security imperative for strong, concerted G-8 action. In Africa, Asia, and many parts of the world, AIDS, malaria, and tuberculosis kill not only people, but hope for progress. Now seeing hard-fought gains in economic development, stability and security being lost.
- In Africa, where 70 percent of all the world's AIDS cases exist, some companies hire two employees for every job on the assumption that one of them will die of AIDS.
- Zambia lost 1300 teachers in 1998 - equivalent to two-thirds of all the new teachers trained.
- In Botswana, Zimbabwe, and South Africa, one half of all 15-year-olds will eventually die of AIDS, and within two years, total population will actually decline in all three countries.
- Worldwide, 44 million children will be orphaned as a result of AIDS during the next decade.
- And today, 3 million children still die from diseases preventable with vaccines we already have, and over 5 million children and adults die from diseases like malaria, TB and AIDS for which vaccines must be developed.
- Leaders of hardest hit countries must step up, but, as largest donors and leading vaccine and drug producers, some things only we can do.
- Must commit new resources. U.S. doubled bilateral assistance for AIDS over the past two years; this year, asked Congress for over \$325 million, increased assistance for malaria and TB to \$50 million. Should credit G-8 members who have increased resources; urge others to meet challenge/obligation.
- Encouraged by the expansion of new partnerships among governments, foundations and pharmaceutical industry to expand

care and treatment of HIV infected persons, including making needed anti-AIDS drugs more available.

- Must keep up pressure on MDBs to shift resources toward basic health care. Commend Wolfensohn for announcement that World Bank will triple low-interest lending for infectious diseases next year. Reiterate importance of using resources freed up by HIPC debt relief initiative for health and other poverty programs.
- For long term, must address market failure for vaccines and drugs for diseases of poor countries; G-8 uniquely capable. U.S. called for \$1 billion tax credit and \$50 million for global purchase fund to speed development of vaccines for AIDS, malaria, TB. Others should work within own systems to create mechanisms, like tax credits, to provide incentives to industry.

(If raised)

- Need to strike balance between making HIV/AIDS drugs more affordable and protecting IPR.

Bernard, Kenneth W. (HEALTH)

From: Bernard, Kenneth W. (HEALTH)
Sent: Thursday, July 27, 2000 12:08 PM
To: Bernard, Kenneth W. (HEALTH); Keenan, Josefine (Chris) (HEALTH)
Subject: FW: Note to Sandy [CONFIDENTIAL]

**DECLASSIFIED
PER E.O. 13526**

2017-0739-m (3.06)
KBH 10/2/2023

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

From: Bernard, Kenneth W. (HEALTH)
Sent: Thursday, July 27, 2000 12:04 PM
To: Siberell, Justin H. (NSA)
Subject: Note to Sandy [CONFIDENTIAL]

Justin, Pls pass to Sandy. --Thanks, Ken Bernard

Sandy,

I haven't bothered you in a while, as you have been otherwise occupied with more important affairs of state. However, now that we are closing in on the end of the administration, I would like to briefly outline where we are on a few global health issues, and ask for your input on what we can do in the few months left to close some loops.

Note: When we first talked after Donna sent me over here two years ago, you gave me three pieces of advice:

1) Reach out to the other EOP offices. Developed have good and ongoing working relationships with Leon, Lael and Gene, Melanne, Neal Lane, Chris Jennings, Sandy Thurman, Maria Echeveste, and David Beier, among others. You were right. Invaluable and necessary. 2) Pick an initiative and make it happen. The President's "Millennium Vaccine Initiative" we put together for his UNGA speech last September has done better than anyone expected - the G-8 communiqué virtually endorses our priorities (AIDS, malaria and TB), and 3) make sure the next NSA asks, "who's doing health?" If Al Gore is elected, we are cool. If not.....

Selected Issues (comments, suggestions SVP):

- **Vaccine Initiative:** We got a 20% funding increase for NIH basic vaccine research, \$37-50 million for the Global Alliance on Vaccines (and Tim Geithner from Treasury even went to their Board meeting), an increase in World Bank lending for AIDS, TB and malaria from \$200 to \$700 million, and significant buy-in from industry (as a result of the President's March meeting). We still need to ensure that Larry Summers' proposed \$1 billion tax credit for the sale of vaccines is acted on by Congress this year.
- **AIDS:** A lot of mileage from Bart Gellman's story about "AIDS as national security threat," although calling it an "international security threat" probably makes better sense. I

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001. email	From Kenneth Bernard, re: Note to Sandy [partial] (1 page)	07/27/2000	P6/b(6)
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recently did a NY session for the CFR followed within several months by another with Holbrooke and Shalala. Tremendous bipartisan support for increasing funding for AIDS (and TB), especially in Africa. Frist/Helms bill just authorized \$600 million over two years for AIDS and 120 million for TB. Appropriators still discussing, but looks good for the President's request (so far) in the end-game. Got our \$10 million in the DoD appropriation for mil-mil AIDS-prevention training of African troops (this is good. Nigeria, among many others, has formally requested assistance).

- **AIDS, cont'd:** Leon is seized with the AIDS issue, especially the development of a USG "battle plan" and a new initiative to reduce mother-to-child transmission, especially in South Africa. Sandy Thurman has not been very helpful with the co-chaired ONAP/NSC interagency meetings on AIDS. Attempts to run IWG/deputies process has been stalled by her frequent travel and lack of any office backup in her absence. Clearly the IWG/deputies process does not fit in well with her personal style and working preferences.
- **PEAC:** The "Presidential Envoy for AIDS Cooperation" issue remains difficult and mired in personal agenda conflicts. The PEAC idea is a good one. (b)(6) [001]
[REDACTED]
[REDACTED]
[REDACTED] We should make every attempt to work something out one way or the other with Madeleine and Podesta in time to possibly discuss in Nigeria with Obasanjo, and/or at the Millennium Summit in NY in September. This call is above my pay grade.
- **Nigeria trip:** Obasanjo has been a leader and outspoken proponent of disease control as a necessary prerequisite to development and increased economic productivity. He has hosted an African leaders summit on malaria, and told Larry Summers he wanted to do the same for AIDS. Could help with the Mbeki problem. Lots we can do emphasizing his leadership during the President's trip, and we have several good events involving foundation/private sector links are being proposed.
- **G-8 and US-EU Summit:** The G-8 Communiqué makes some significant steps forward from the Lisbon Statement on infectious diseases - it actually sets targets for reducing the three diseases the President is pushing as high priorities for international action: AIDS, TB, and malaria. The international community is now reading from the same page - ours. However, despite Canada, UK, Japanese and World Bank resource commitments, we need to continue to push France, who, as EU President, can direct substantial funding from the EC. Both Japan (for G-8) and France (for EU) will be hosting meetings in a few months to implement the promises of the Summits. Could happen.
- **EC Commissioners Chris Patten and Poul Nielson,** in parallel with Madeleine Albright, will be sending letters to our Ambassadors and heads of delegations in Africa directing them to work together with African leaders and private sector partners to intensify joint actions on AIDS, TB and malaria. Will especially emphasizing public diplomacy and

awareness efforts. A useful result of my recent trip to Brussels to push on the Commission.

- **Anthrax Vaccine/DoD:** (I've talked with Don about this) Vaccine shortfalls have necessarily required emergency modification of the "immunize everyone" policy of DoD. The issue has shined a spotlight on DoD's shaky decision to go for single-source private sector providers of BW vaccines. In a 180 degree turnaround, prompted by some probing congressional questioning, DoD is now fully supportive of constructing a government owned-contractor operated vaccine production facility for BW and other orphan vaccines for military and civilian defensive purposes. Dick Clarke and I pushed for this a year ago, but without an good example of a clear failure of their current system, could not convince DoD to consider alternatives. Hallelujah.
- **Kosovo - psychosocial needs:** State/USAID have implemented a wide-ranging set of programs to respond to the IRC psychosocial needs-assessment briefed to you last September. Greg and I will be sending you an update on these activities in a few days.
- **Civilian Biodefense:** At our request, HHS and CDC are in the final stages of installing crypto equipment so they may participate in emergency SVTS meetings with the IC, WH and others if there is a suspicion of offensive use of a biologic weapon. We will also be setting up routine SVTS meetings between CIA, DIA and CDC to share information and concerns related to foreign government development of BW and chemical agents. Work to develop new drugs to defend against smallpox are well underway at the CDC high-containment lab. Comparable US-monitored and funded studies are in planning stages in Russia.

--Ken Bernard

September 4, 2000

To Sandy, Don, Mara:

From: Ken Bernard

Subject: POTUS comment on Laurie Garrett's book

Issue: Pulitzer prize-winning author Laurie Garrett sent copies of her new book "Betrayal of Trust: The Collapse of Global Public Health" to the President and Sid Blumenthal. (note: her last book, "The Coming Plague" was a NYT bestseller about the new disease threats like AIDS and Ebola.)

Sid discussed the book with the President. POTUS then did a hand-written note to Laurie saying, "I have tried to help on this, but it's obvious that we need to do more -- much more." He also wrote a note to you and Chris Jennings saying, "I wish we could do more on this." You have asked for my thoughts.

Background: Laurie says that governments and the health sector are not coming to terms with globalization and its impact on health -- the lack of appropriate focus on public health and global public goods is killing people and hobbling global development. She presents, in 750 pages of footnoted detail, a whole series of examples related to food safety, bioterrorism, aging populations, managed care, drug access etc. Much domestic, but internationally she argues:

- Western models of individualized patient-oriented high-tech medicine fail to deal with the basic essentials of public health in poor countries: clean water, uncontaminated food, decent housing, clean air, appropriate sanitation, control of epidemics, access to maternal and child care, and an educated population that can make rational choices affecting their health.
- The high tech health revolution is of no benefit to the majority of the world's population because new treatments and technologies are unaffordable and don't tend to basic public health needs.
- The innovations that would be useful, such as vaccines for malaria and TB, etc, have not been pursued because they are not immediately profitable.
- Ill-prepared public health systems are collapsing at times of social stress. Russia is a classic example, with life expectancy falling and drug-resistant TB raging out of control.

A personal digression:

- In 1981, Rene Dubos, wrote, "Think globally, act locally."
- Hanging in Dick Clarke's office is a sign that says, "Think globally, act globally."
- Laurie exhorts us to go one step further: act globally to protect public health locally.

Clearly, the first is becoming historical commentary, the second is now 21st century dogma, and we are beginning to embrace the third. For the U.S. to further expand our security and economic

prosperity, it is in our self-interest to attend to the basic public health and education needs of the global community -- not just our own citizens.

In "the Lexus and the Olive Tree," Tom Friedman, perhaps prophetically, invented a new disease: "Microchip Immune Deficiency Syndrome." It shadows Laurie's criticisms of the Western health community. Usurping the "AIDS" acronym could be accidental -- but it has a real ring of truth.

"MIDS: A disease that can afflict any bloated, overweight, sclerotic system in the post-Cold War era. MIDS is usually contracted by countries and companies that fail to inoculate themselves against changes brought about by the microchip, and the democratization of technology, finance and information -- which created a much faster, more open and more complex marketplace, with a whole new set of efficiencies. The symptoms of MIDS appear when a country or company exhibits a consistent inability to increase productivity, wages, living standards, knowledge use and competitiveness, and becomes too slow to respond the challenges of the Fast World. . . .MIDS can be fatal to those companies and countries that do not get appropriate treatment in time."

What "new" have we done internationally? I won't go into the broad range of USAID and other USG programs on education, housing, clean water, etc, but related to the President's clear interest in infectious disease threats disproportionately affecting health in the poorest nations, he:

Signed the Global AIDS and Tuberculosis Relief Act of 2000; asked Congress for an increase of \$100 million -- to \$342 million -- for international AIDS prevention and care in FY 2001; signed an Executive Order to help make HIV/AIDS-related drugs and medical technologies more affordable and accessible in beneficiary sub-Saharan African countries; announced the Millennium Vaccine Initiative to accelerate the development of malaria, TB, and AIDS vaccines and held a White House meeting on developing public/private partnerships to engage industry, foundations, the UN and the research community in the initiative; met with Bill Gates and others, expanding the concept of the "digital divide" to the "health divide"; made global infectious diseases a top priority at the U.S.-European Union Summit in Portugal and the G-8 Summit in Okinawa; has taken a global leadership position on debt relief, especially for HIPC countries; and during recent trips to Nigeria and India, focused on leadership and resources for public health development.

Can we "do more?" Four months is not much time. But never has there been such a universal call for trying to narrow the disparity between those countries most benefiting from globalization of markets and technology and the 1.5 billion people still living on less than \$1/day. With growing evidence of a direct link between health status and economic development, there are both practical and moral imperatives for the world community to enact systems that secure the benefits of medical science for all people.

1) Continue to use each international forum (Millennium Summit, trip to Vietnam etc,) to reinforce the G-8 communiqué language on our infectious disease/AIDS and health infrastructure development.

2) In the 2001 budget endgame, place a high priority on the \$1 billion tax credit for the sale of malaria, TB and AIDS vaccines. This innovative idea is forging new ground -- other countries are watching closely. And debt relief is key -- improved infrastructure must be primarily funded by countries themselves if lasting change is to occur.

3) The EC will be finalizing a major funded initiative in September aimed at health sector infrastructure development for Africa. We should use the December US-EU Summit to join the French with a strong complementary plan to leverage health resources for developing countries.

4) Most importantly, the President could step beyond his EO on AIDS drugs for Africa. The lack of affordable drugs, especially in Africa, has focused world attention on the downside of globalization. There are a number of good ideas for moving forward: tiered pricing plans; social venture, World Bank, or revolving drug purchase funds; building developing country production capacity; tax credits; patent exchange and roaming market exclusivity, and many others. Any initiative would require careful in-house discussion with Chris and others to consider domestic and trade policy overlap, especially to avoid interference with the Medicare drug plan negotiations.

A major President address could lay down a marker for the next administration, and outline an aggressive international initiative to help provide increased access to affordable and needed drugs. The French would applaud (Chirac has been urging us to join them on this for months), and we could do nothing more important for our developing country allies.

"Protecting health and the environment are central American interests. Epidemics and climate change know no borders. . . .efforts to make medicines more widely available should be a high priority for Washington." ("America in the World" NYT editorial, Aug 7, 2000)

Current and future U.S. government spending on global AIDS, malaria, and TB

	<u>Fiscal year 2000</u>	<u>Fiscal year 2001</u>
AIDS		
-- assistance	\$244 million	\$460 million (pending final budget decision)
-- research	~\$2 billion	\$2.1 billion (pending final budget decision)
malaria		
-- assistance	\$27 million	\$50 million
-- research	\$51.5 million	\$55.5 million (pending final budget decision)
TB		
-- assistance	\$15 million	\$60 million (pending final budget decision)
-- research	\$81.7 million	\$86.8 million (pending final budget decision)

For Chair

Chair's Summary Okinawa International Conference on Infectious Diseases

Introduction

1. Infectious Diseases: A Key to Poverty Reduction and Human Security

Good health is the key to prosperity. While better health contributes to poverty reduction, growth and human security, poor health both drives and is driven by poverty. Infectious and parasitic diseases, notably HIV/AIDS, Tuberculosis (TB), and malaria, are now the world's major killers of children and young adults,¹ causing more than 13 million deaths a year. Most of them occur in developing countries, where the least money is spent on health care.

Infectious and parasitic diseases undermine societal structures, health systems and national economies. Calculations remain imprecise, but it is certain that the full economic costs of infectious diseases have been under-estimated. Recent studies suggest that those countries where 10 per cent of the population is affected by HIV/AIDS stand to lose up to one percentage point of GDP per year. Malaria, too, continues to undermine economic performance, diminishing potential growth by up to 1 per cent per year. The economic costs of TB could amount to more than \$12 billion per year. Taken together, the costs in terms of human security, economic growth and development are staggering. The case for more rapid, sustained and concerted action is overwhelming.

Two decades of addressing the HIV/AIDS epidemic have demonstrated that the disease cannot be brought under control if we tackle it in conventional public health terms: HIV/AIDS has become a development issue, and, as recognized by the UN Security Council, an issue of human security. It requires action across the whole of society. The response to HIV/AIDS has succeeded in becoming political and social: there are important lessons to be learned from this in addressing TB, malaria and other infectious diseases.

2. Challenges and Opportunities for Global Actions

As stated above, major infectious and parasitic diseases increase poverty and seriously affect development. Health systems in developing countries often lack resources to provide even basic care and hardly reach the most affected individuals. Moreover, vulnerability to infectious diseases is increased by certain personal and social factors, including gender inequality, lack of safe water, social exclusion, displacement due to war, that are exacerbated by poverty. This situation is often aggravated by the lack of knowledge, skills and resources at the family level necessary for the prevention and care of infectious diseases. Finally, infectious diseases often cross national borders, and the failure of control measures may put global health at risk.

During the past years, significant progress has been made in fighting infectious diseases as a major health challenge against poverty. These initiatives include International Partnership against AIDS in Africa (IPAA), Stop TB Initiative, Roll Back Malaria (RBM), Multilateral Initiative on Malaria (MIM), Global Alliance for Vaccine and Immunization (GAVI) and International AIDS Vaccine Initiative (IAVI).

Here in Okinawa, the G8 leaders agreed to demonstrate their resolution to step up this fight and set out the following three numerical targets for HIV/AIDS, TB and malaria:

- Reduce the number of HIV/AIDS-infected young people by 25 per cent by 2010;
- Reduce TB deaths and prevalence of the disease by 50 per cent by 2010; and
- Reduce the burden of disease associated with malaria by 50 per cent by 2010.

¹ Children and young adults implies ages from 0 to 44 years old. World Health Organization. 1999. *Removing Obstacles to Health Development*

To deliver these targets, the leaders committed themselves to fostering a new and innovative partnership with governments, the World Health Organization (WHO) as well as other international organizations, industry, academic institutions, foundations and other relevant actors in civil society.

Hence we, the stakeholders of this partnership, gathered to shape a concrete action plan to fulfill the leaders' commitment, by defining the operations of this new partnership, the area of priority and the timetable for action.

The challenges identified for the partnership to reach the 2010 targets include:

- **The challenge of finance:** Developing countries cannot reduce the negative social and economic impact of the diseases associated with poverty with current levels of spending. Achieving the targets that have been set will require an intensive effort over many years, and additional funds over and above resources already pledged or obligated. We recognize the responsibility of using existing and additional resources to maximize the impact in the fight against the major infectious diseases.
- **The challenge of scale:** While many effective interventions exist, they are accessible to the few rather than the many. Reaching people that suffer disproportionately from, or that are at greatest risk of, these conditions (particularly women and children) calls for effective action that builds basic health care systems deliverable to all.
- **The challenge of new ways working:** The challenge is not to add yet another new initiative, but to bring together existing endeavors in a more coherent and accelerated way. The approach adopted needs to be based on country leadership. It is increasingly clear that the public sector alone has not responded, and cannot respond, to the challenges outlined in this Summary. Finding ways of tapping the energy, entrepreneurial spirit and innovation of the private and voluntary sectors are critical to success.
- **The challenge of health and development:** We will not succeed in achieving the targets – particularly the HIV/AIDS target – if we fail to act from a broad developmental perspective. Behavioral change needs to be understood in a social, political and economic context. Reducing people's overall vulnerability to infectious disease is as important as reducing the factors – such as unsafe sex – that put them at immediate risk.

Principles for Operation of the New Partnership

The new partnership tackling the major infectious and parasitic diseases mentioned in the Okinawa Summit will facilitate developing global actions for poverty reduction and human security through infectious disease control, and reducing the illness and premature mortality suffered by the poor. This global movement for infectious disease control will encompass actions undertaken by a wide range of organizations and institutions, including governments, bilateral and multilateral donors, industry, academic institutions, NGOs, and other development partners. The partnership will be underpinned by core values, including 1) commitment and ownership, 2) accountability and impact, 3) people centered, and 4) international public goods.

- **Commitment and Ownership:** An international commitment to taking concrete actions and mobilizing resources is required to tackle infectious diseases. Tackling the major infectious diseases requires country level commitment, political leadership and country level and specific processes to define priorities. National governments of developing countries will be the stewards in the fight against infectious diseases, ensuring the development of appropriate policy frameworks to define priorities. Developing countries must support the development of the public health and scientific infrastructure, particularly human resource capacity building, to sustain and expand on the initial investments made by the donor community.

- **Accountability and Impact:** Both the global community and the national governments need to be held accountable to all development partners and their people for their actions in the fight against infectious diseases. This will be achieved if the success of the partnership is measured by its outcomes.
- **People Centered:** The partnership will depend upon national human resources and experience that are adequately trained, motivated and supported. The partnership must empower poor people and communities to both demand and have greater control for their own health. State and non-state health systems need to become more responsive to the needs of the poor.
- **International Public Goods:** International Public Goods (IPGs) may be defined as development resources capable of generating positive externalities that have a transnational reach.² Considering those resources as the means to achieve specific goals, IPGs include information, knowledge and technology such as drugs and vaccines for major infectious diseases. The partnership will work together to deliver these International Public Goods such as vaccines for HIV and malaria and new drugs for infectious diseases. This will require increased incentives to promote research and development in these IPGs and substantive support of capacity building for research and development work in developing countries and regions.

Priorities in Tackling the Major Infectious Diseases

1. The New Partnership

Investing in infectious disease control and research contributes to economic growth through reducing illness itself and premature deaths. Based on this premise, the G8 leaders are committed to meeting three global targets in relation to HIV/AIDS, TB, and malaria. Achieving these goals requires accelerated and concerted efforts of all development partners.

There are already existing global partnerships to fight against major infectious diseases, including International Partnership against AIDS in Africa (IPAA), Stop TB Initiative, Roll Back Malaria, Global Alliance for Vaccine and Immunization (GAVI), Multilateral Initiative on Malaria (MIM) and International AIDS Vaccine Initiative (IAVI). Many of us are involved in some or most of these initiatives. On the other hand, both bilateral and multilateral donors, NGOs, civil societies, and the private sector, embracing the same overall goals but taking varied approaches, have also been fighting infectious diseases on their own or in conjunction with some development partners. To optimize the impact of those efforts, we must develop dynamic mechanisms that enable a wide range of partnerships to effectively function at country, regional, and global levels.

(1) At Country Level

Partnership at the country level provides mechanisms for all relevant parties to come together, in principle under the leadership of the concerned government, to support national strategies against infectious diseases, in the context of poverty reduction strategies and through health systems development. Such partnerships can improve communication among all stakeholders, channel and mobilize resources, stimulate demand, ensure access to goods and services for every intended destination, and strengthen local research infrastructures.

To achieve sustainable improvements in the health outcomes of the poor, it is essential that national poverty reduction strategies and health sector programs incorporate infectious disease control

² Marco Ferroni. 2000. *Reforming Foreign Aid: The Role of International Public Goods*. OED Working paper Series No.4. World Bank.

measures that are tailored to specific country contexts. There are a number of mechanisms that are important in this regard, including the country-driven Poverty Reduction Strategy Papers (PRSPs) and Sector-Wide Approaches (SWAPs) to health sector development. We recognize the importance of these types of mechanisms to ensure developing country ownership. Through broad-based efforts, governments and donors can share information and objectives and coordinate action as appropriate towards a set of shared objectives that are fully owned by all development partners.

The ownership and commitment of a concerned government are the keys in the fight against infectious diseases. In those countries where development partners are already working within a government-led health policy, we will support the existing development processes. In order to increase the ownership of partner developing countries, we recognize the importance of supporting capacity building of governments through human resource development and institutional building. In those countries where the government devotes insufficient resources to addressing health sector problems, the partnership at the country level works on mobilizing political will through dialogue, to ensure the government takes effective infectious disease control measures.

Effective and equitable health systems are essential. Capacity-building at all levels will be required to ensure overall government stewardship, to promote fair financing and to increase the responsiveness of health systems to the needs of poor people. A key issue in relation to infectious diseases, however, is to stimulate demand for, and promote equitable services on a massive scale, while at the same time ensuring that poor people have better access to affordable services, commodities, and the information they need to improve the effectiveness of health interventions. This will demand appropriate attention to the response of communities.

Without the full and equal participation of the community, it will be impossible to develop and support preventive actions and provide sufficient care to those infected and affected by infectious diseases. In this respect, mobilizing existing resources within local communities deserves careful attention. Also, from the viewpoint of over all development, it is necessary to incorporate infectious disease control in holistic community development programs. At this point, the importance of improving public health and health systems at the community level, universal distribution of basic education, securing safe water, and gender equality in addressing the challenges of infectious diseases cannot be overemphasized. Furthermore, cultural, economic, and social environment should be taken into account in fight against infectious diseases.

NGOs, through their grass-root experiences, often have intimate knowledge of the countries concerned and know-how to directly assist the most seriously affected individuals, families and communities, whom public service often fails to reach, in planning and implementing community-based prevention and care activities. We encourage dialogue between NGOs and the public sector in the context of the dynamic mechanisms of the partnership at the country level so that they complement one another and make the most of each other's comparative advantages in tackling challenges of infectious diseases. Strengthened partnership among NGOs themselves is also encouraged, and we will focus on collaborating efforts between local and international NGOs to address the challenge of infectious diseases. Moreover, recognizing the importance of the roles that local NGOs play in the field of infectious disease control, we encourage donors to further support those local NGOs.

The growing importance of public-private partnership is evident at the country level. Local private sector involvement complements public sector efforts in improving access to and affordability of health goods and services.

(2) At Regional Level

Regional partnership is intended to share resources within a region, including human resources, technology and knowledge, and to address cross-border issues that require regional responses. Such partnership functions through mechanisms that promote improved surveillance systems, regular

stock-taking and monitoring performance at the regional level. The G8 members will take part in regional reviews through already established fora such as African Development Forum, ASEAN, SAARC, and SADC, on a regular basis in relation to the above functions.

"South-South" Cooperation is integral to the response to the infectious diseases and is at the root of good partnership and effective collaboration. When international partnership is mobilized in the form of South-South cooperation, the reward could be enormous and highly cost-effective. It can be used in planning, mobilization, partnership building and capacity building. This potential has not been fully tapped, however. South-South cooperation must be encouraged to share experiences and best practices among developing countries within a region. In addition, greater efforts need to be made to establish effective information systems, or "clearinghouses," that accumulate and distribute such information. Inter-country networking has proven very effective in developing appropriate operational strategies, strengthening technical capacities and monitoring progress for HIV/AIDS and malaria control in the Mekong region. Countries are encouraged to make use of the Internet and other electronic resources to share epidemiological data and research results.

(3) At Global Level

At the global level, there is a need for effective partnership mechanisms to achieve the objectives, including improving access to goods and services at the country level; increasing cooperation between developed and developing country research institutions, industry, and academia for the development of new infectious diseases prevention and treatment strategies; improving the affordability of essential drugs; increasing training of in-country personnel in laboratory and research techniques; and mobilizing international commitment.

In particular, inadequate access to affordable health commodities and drugs is a major problem in developing countries, especially among the poor. Improving the access and affordability requires global responses, especially to ensure that local health infrastructures and systems are improved so that commodities and drugs not only reach those who need them, but are used safely and effectively. Other issues that must be addressed include the cost of drugs, tariffs, taxation, distribution, and marketing. There is also an urgent need for innovative mechanisms that enhance the global partnership between the public and private sectors to address this challenge. We applaud recent announcements by countries and pharmaceutical companies to make more affordable those drugs and treatments necessary to treat HIV/AIDS and other diseases. Such partnerships should seek to expand their practices of making necessary drugs affordable to the poorest countries, and all partners should evaluate innovative new solutions to increase access to affordable drugs and commodities.

We are encouraged to participate in ongoing international partnerships such as UNAIDS, IPAA, STOP TB Initiative, RBM, MIM, GAVI, IAVI, and to use these fora as opportunities to share information, review ongoing initiatives, and identify unmet needs. At the Cologne Summit last year, the G8, expressing its concern over the spread of HIV/AIDS and other infectious and parasitic diseases, agreed to providing continuous support to those global initiatives led by UN agencies in the fight against infectious diseases. Recently, the UN General Assembly has Decided to convene HIV/AIDS special session from 25 to 27 June 2001 to address the challenge of, and secure a global commitment to combat the epidemic.

To combat the global challenge of infectious diseases, it is essential to collaborate with international organizations through effective global partnership mechanisms. Those international organizations, including UN agencies and Multilateral Development Banks (MDBs), working closely with other development partners, are expected to contribute to monitoring and evaluation at the global level, as well as to collecting, accumulating, analyzing and disseminating best practices world-wide.

The World Bank and the Regional Development Banks also play major roles in partnerships at regional and global levels. We call on them to expand their assistance in infectious disease control with other development partners through lending and policy dialogue at the country level. We also

welcome their innovative initiatives and approaches for targeting resources toward regional and global public goods. We encourage the MDBs to support the development of in-country laboratory capabilities, training and research, in order to ensure a long-term commitment to disease control and prevention.

2. Improvement of Availability of International Public Goods

(1) Research and Development of International Public Goods

Basic research on infectious diseases provides the foundation on which diagnostics, vaccines, biomedical and behavioral preventive interventions, and therapeutics may be developed. Important international public goods in the fight against infectious diseases include the development and use of vaccines and drugs, appropriate methods of treatment, and health commodities necessary for controlling these diseases such as male and female condoms, testing kits, and microbicides. Further research is necessary to develop cost-effective and socially acceptable methods for detecting and preventing the spread of infectious diseases. Additional needs include research to identify sustainable approaches to managing infected patients and operational research to determine how best to implement newly identified interventions.

In order to increase the availability and affordability of these international public goods for all affected people, stronger partnership at the global level to support research and development of these international public goods is urgently needed. The private sector has an enormous capability for the research and development of international public goods, and should be encouraged to use this potential further through cooperative initiatives with the public sector. Exemplifying such public-private initiatives are the International AIDS Vaccine Initiative (IAVI) and GAVI.

The private sector has difficulties in obtaining financing or justifying investment in the research and development of global public goods that do not have an assured market and lack protection. Uncertainties in marketing the developed products are another deterrent. Most demand for international public goods arises in developing countries, where the market size is not large enough to motivate the private sector to increase their investment for the research and development.

We are committed to increasing our support at the global level for the research and development of the international public goods such as AIDS vaccines; treatment drugs of AIDS, TB and malaria; microbicides; and other health commodities. Measures include the creation of enabling circumstances, such as tax credits, purchase funds and other creative means to promote the investment in, and financing of, such research and development by private industry. Furthermore, the G8 and MDBs could consider providing financial and other incentives.

Additionally, cooperation between the public and private sectors in research on marketing the international public goods should be advanced. Initiatives to accommodate bulk procurements for these goods are cited as one of the measures.

(2) Information and Knowledge as International Public Goods

The nature of infectious diseases crossing over national boundaries requires countries to cooperate in monitoring and detecting the spread of disease, and to share epidemiological data. Research efforts to understand the underlying ecological and biological mechanisms that lead to the emergence and transmission of infectious diseases are also needed. Such information is one of the international public goods. Efforts to raise the accuracy of information and achieve the appropriate timing for collecting and sharing information are necessary. We support the cooperation among concerned research funders and bilateral and multilateral donors, as a means of strengthening existing international surveillance systems.

Governments, donors, NGOs, and academic and private sectors have experienced success in their

pilot behavioral interventions and mobilization of societies against infectious diseases. The factors for such success, however, have yet to be thoroughly analyzed, and the lessons extracted from the analysis that has been done have not been fully disseminated, either. We promote research about innovative approaches and best practices and support establishing the function of clearinghouses of information on these approaches and practices.

Continuation of Support for Other Health Priorities

While there is a growing concern over the three major infectious diseases, HIV/AIDS, TB, and malaria, as key health challenges, it is also important to recognize that other health conditions, notably childhood infectious diseases such as pneumonia, diarrhea and measles, are often cited as health priorities among the poorest populations. At the Okinawa Summit, the G8 leaders acknowledged that, together with the international community, they have successfully arrived at the final stage of polio and guinea worm eradication and have begun to control onchocerciasis. Remarkable progress has been made in the fight against polio and some areas of parasitic diseases in the past decades. In the meantime, continuous efforts have yet to be made in those areas as health priorities.

Polio is now endemic only in parts of sub-Saharan Africa and the Indian sub-continent. The global target was set to certify the world as polio-free by 2005. Accelerated efforts are needed for the final battle to wipe out polio. It is estimated that the total external financial support needed through 2005 is US \$1 billion.

The accelerated efforts to wipe out polio focus more on geographical priority areas. They include the countries and areas affected by conflict where eradication activities started relatively late, and those with large and dense populations and intense virus transmission. In addition, the growing importance of extending polio control measures to reach the remotest areas in the endemic countries is recognized.

Notably, schistosomiasis and soil-transmitted helminths represent more than 55 percent of the disease burden due to tropical diseases, excluding malaria. Most morbidity is seen in children, ranging from malnutrition, anemia, growth retardation, and cognitive impairment. Moreover, schistosomiasis and soil-transmitted helminth infections are more prevalent among the poorest populations in the least-developed countries. Towards this effect, it is necessary to scale up the control measures for reducing the impact of schistosomiasis and soil-transmitted helminth infections. We recognize the importance on the four strategies in fighting against parasitic diseases that were identified in the recommendation to the Birmingham Summit (Hashimoto Initiative).

School health programs have been recognized as important efforts to fight against health challenges in developing countries. These programs can simultaneously contribute to reducing common health problems including the above parasitic diseases, increasing the efficiency of the education system and advancing public health development.³

Confronting Three Major Infectious and Parasitic Diseases: Commitment in Okinawa

1. HIV/AIDS

(1) Current Situation

³ There is a partnership initiative called the International School Health Initiative (ISHI). ISHI is an action-oriented partnership that focuses specifically on promoting the quality of school health and nutrition programs. Partners include MDBs such as the World Bank, the UN-agencies such as WHO and PAHO, major bilateral agencies such as USAID, and international NGOs such as Save the Children and the Partnership for Child Development (PCD), the leading technical NGO working in this area (which is partially-financed by the World Bank).

- Over 36 million people are living with HIV/AIDS in the year 2000 – over 50 per cent more than projections made in 1991 on the basis of data then available.
- The number of newly infected people in the year 2000 is estimated at 5.3 million; over 20 million people have died from AIDS since the start of the epidemic.
- 95 per cent of all HIV infections are in developing countries, causing a dramatic reduction in growth and having a severe impact on the most vulnerable groups, including the poor, children and women.
- So far, the AIDS epidemic has claimed the lives of 4.3 million children. Another 1.4 million children are living with AIDS today. Worldwide, one in ten of those newly infected in 2000 was a child.
- There have been over 13 million children orphaned because of AIDS, most of them in Sub-Saharan Africa.
- Sub-Saharan Africa is the worst affected continent. There, more than 25 million people are now living with HIV/AIDS, with 3.8 million new infections in 2000.
- In China and India, which account for around 36 per cent of the world's population, even the low HIV prevalence rate means that a huge number of people are living with the virus.
- HIV/AIDS is having a dramatic effect on economic growth and has reduced life expectancy in some countries. In particular, in most of sub-Sahara African countries, it is significantly undermining the achievement of decades of development efforts. The scale of the HIV/AIDS epidemic is now far greater than a decade ago. It has become a threat to human security.

(2) Future Target

At the Okinawa Summit, G8 members endorsed the global target:

Reduce the number of HIV/AIDS infected young people by 25 per cent by 2010 (UN Secretary General Report to the General Assembly on 27 March 2000).

(3) Priority Areas

There are three core priorities in the fight against HIV/AIDS: (1) preventing the spread of HIV/AIDS, (2) providing care and support to those infected and affected by HIV/AIDS, and (3) enhancing research and development for international public goods.

a. Preventing the spread of HIV

We should continue to focus on the preventive measures that have proven to be effective. Those include:

- Promotion of healthy and safer sexual behaviors, especially among young people;
- Ready access to the essential commodities for prevention;⁴
- Prevention of mother to child transmission especially in countries and regions where prevalence of HIV infection among pregnant women is high;
- Voluntary counseling and testing;
- Treatment of STI (Sexually Transmitted Infection);
- Control measures for those most at risk for HIV;
- Safe blood transfusion; and
- Prevention of transmission related to substance abuse.

Among the above, increasing emphasis will be placed on the prevention of mother-to-child transmission as part of a comprehensive prevention package. A recent expert meeting at WHO Geneva has confirmed the safety and effectiveness of antiretroviral (ARV) regimens that prevent HIV transmission from mother to child and recommended their use on a large scale. Research is underway on strategies for feeding of infants born to HIV+ mothers.

⁴ The essential commodities for preventing HIV/AIDS are 1) male and female condoms, 2) testing kits for voluntary counseling and testing, 3) drugs for treating sexually transmitted infections, 4) commodities for strengthening blood banks eg HIV test kits, 5) drugs for preventing mother to child transmission and diagnostic tests. UNAIDS. 2000. *HIV/AIDS commodity security for Sub-Saharan Africa*.

We believe that those interventions will not be successful unless they are implemented with an understanding of the social and economic factors that determine both behavior and the response to the epidemic. Thus, priority should be given to efforts that address social stigma/disclosure issues, alcohol and drug use, role of the family and non-formal health care, development and testing of educational materials, and social acceptability of interventions, including vaccines, barrier technologies, and voluntary counseling and testing.

b. Providing care and support to those infected and affected by HIV/AIDS

While prevention must remain a priority, there is a need to plan for and mitigate the impact of the epidemic. Priorities in this area include:

- Strengthened health system to ensure people with HIV/AIDS with access to care and treatment;
- Sustainable supply of essential commodities for care and support⁵ including opportunistic infections control caused by HIV infection; and
- Social support for those affected by the disease such as AIDS orphans.

Alleviating the social impact of HIV/AIDS solicits community involvement in social support for those affected by the epidemic.

Increasing attention is placed on the recent initiative for public-private partnership by countries, pharmaceutical companies, and international foundation to make AIDS care and treatment more accessible through a comprehensive care and treatment package. This approach includes the effective and sustainable provision of affordable antiretrovirals, provision of AIDS care and treatment, and human resource development making use of existing health systems in developing countries.

c. Enhancing research and development for international public goods

We encourage the promotion of research and development of international public goods, including, particularly:

- HIV/AIDS preventive vaccines that are safe, effective, affordable, and appropriate for use in resource-poor settings;
- HIV/AIDS prevention products, especially microbicides;
- HIV/AIDS treatment products and regimens appropriate that are safe, effective, and affordable for use in resource-poor settings, especially for the prevention of maternal-infant transmission and the prevention and management of opportunistic infections (e.g., tuberculosis and cryptococcosis); and
- Enhanced epidemiologic research to identify at-risk populations and evaluate the effectiveness of education and prevention programs.

Among the above, we recognize urgent needs for and put the most emphasis on the development of HIV/AIDS vaccines.

(4) Time Table for Actions

In June 1999, the ICPD+5 United Nations General Assembly Special Session (UNGASS) set a new internationally agreed target for addressing HIV/AIDS, and governments, UNAIDS and donors have been called upon to take the steps necessary to ensure that, by 2005:

⁵ The essential commodities for care and support are 1) basic drugs for palliative care and treatment for pneumonia, diarrhoea, oesophageal thrush, oral thrush, vaginal candidiasis and pulmonary tuberculosis, 2) drugs to prevent infection using cotrimoxazole prophylaxis for symptomatic HIV positive people. UNAIDS. 2000. *HIV/AIDS commodity security for Sub-Saharan Africa*.

- At least 90 per cent of young men and women aged 15 - 24 have access to information and skills required to reduce their vulnerability to HIV infection;
- HIV incidence in 15 - 24 year-olds is reduced by 25 per cent in the most affected countries.

Source: UNAIDS. 2000. *The International Partnership against AIDS in Africa: A Framework for Action*

2. Tuberculosis

(1) Current Situation

- One third of the global population is infected with TB.
- 8 million people develop active TB every year.
- TB causes nearly 2 million deaths annually.
- Over 90% of cases and deaths are in developing countries.
- 22 countries together account for 80% of global TB burden.
- Economic costs to the poor is estimated to be \$12 billion per year.
- A person with TB loses on average 20-30% of annual income.
- HIV and spread of drug resistance threaten TB control. TB is the leading cause of death in people with HIV/AIDS. Multi drug resistant TB is increasing in many countries, due to poor treatment practices.
- TB in children is increasing and poses diagnostic problems especially in the context of high HIV prevalence.
- The proportion of people treated in DOTS⁶ programs has increased from 1% in 1991 to 21% in 1998. At this rate the global target to treat 70% of people with infectious TB in DOTS programs will not be reached until 2012.

(2) Future Target

At the Okinawa Summit, G8 members endorsed the global target:

Reduce TB death and prevalence of the disease by 50 per cent by 2010 (WHO Stop TB Initiative).

(3) Priority Areas

The immediate priority is to expand Directly Observed Therapy, Short-course (DOTS) strategy⁷ of TB control for a wider population. The expansion of the strategy and its effective use require:

- Government commitment to give high priority to TB control;
- Strengthened health system to ensure every person with TB has access to treatment and cure; and
- Sustainable supply of anti-TB drugs with good quality and improved access to drugs in countries most impacted by the TB epidemic.

As the long-term priority, research should also be encouraged to develop new or improved international public goods, particularly:

- Rapid, inexpensive, diagnostic tests that are sensitive and specific for the diagnosis of *Mycobacterium tuberculosis*;
- New or improved anti-tuberculosis drugs and/or combination drug regimens that are effective in the treatment of *Mycobacterium tuberculosis*, especially multi-drug resistant tuberculosis;
- A safe, effective, affordable tuberculosis vaccine; and
- Enhanced epidemiologic research to identify at-risk populations and evaluate the effectiveness of education, treatment, and prevention programs.

⁶ DOTS, the internationally recommended strategy to control TB, is a package to ensure accurate diagnosis and successful treatment of people with TB.

⁷ DOTS strategy has five key components: 1) Governments commitment to sustained TB control activities, 2) Case detection by sputum smear microscopy, 3) Standardized treatment regimen of six to eight months, 4) A regular, uninterrupted supply of all essential anti-TB drugs, 5) A standardized recording and reporting system.

(4) Time Table for Actions

Operational Targets:

- 70 per cent of people with infectious TB will be diagnosed, and 85 per cent cured, by the year 2005.

Research and Development Milestones:

- An effective strategy to reduce the impact of HIV-related TB will be developed by 2005.
- An improved test for diagnosis of TB disease will be introduced by 2005.
- An improved TB drug to shorten the course of treatment will be developed by 2010.
- An improved TB vaccine will be introduced by 2020.

For 22 High Burden Countries

- Develop five-year plans by November 2001.
- Review programs every 2-3 years.

Based on *Tuberculosis: accelerated action for poverty alleviation, Draft, 19/10/2000* (submitted by WHO for the preparation of the Okinawa International Conference for Infectious Diseases)

3. Malaria

(1) Current Situation

- 40 per cent of the world's population is at risk of malaria.
- From 300 to 500 million people suffer from malaria each year.
- Malaria kills at least 1 million people each year.
- More than 90% of the episodes of clinical illness due to malaria and 90% of the deaths occur in Africa, mainly among young children.
- The number of people dying from malaria has been increasing over the past two decades.
- The deterioration and failure of health systems, growing drug and insecticide resistance, environmental changes and human migration which have led to an increase in epidemics all contribute to the worsening global malaria problem.
- Malaria has slowed economic growth in African countries by 1.3 percent per year; as a result of the compounded effect over 35 years, the GDP for African countries is now up to 32 percent lower than it would have been in the absence of malaria.

(2) Future Target

At the Okinawa Summit, G8 members endorsed the global target:

Reduce the burden of disease associated with malaria by 50 per cent by 2010 (Roll Back Malaria).

(3) Priority Areas

It is recognized that the priorities in malaria control today are:

- Rapid diagnosis and effective treatment both at family and community levels for uncomplicated cases and in public and private health facilities for more serious cases;
- Prevention through use of insecticide-treated bednets;
- Providing malaria prevention and treatment to pregnant women;
- Early detection of malaria outbreaks and effective and prompt response; and
- Development of new or improved methods to control malaria transmission and prevent disease, including drugs, vector control strategies and vaccines. In view of the increasing levels of parasite resistance to antimalarial drugs currently in use, there is an urgent need to optimize the use of existing drugs and to develop new antimalarial compounds.

In addition, we also support the new multi-sectoral approach to fight against malaria, which incorporates viewpoints on malaria prevention in operations of various development programs including infrastructure, agriculture, and education programs.

Research should be encouraged to develop new or improved international public goods, particularly:

- Improved diagnostic tests suitable for use in resource-poor settings;
- New or improved affordable drugs or combination therapies that are safe and effective in the chemoprophylaxis and treatment of malaria, particularly drug-resistant malaria;
- Safe, effective, affordable malaria vaccines to protect against infection (sporozoite, merozoite) and transmission (gametocyte) vaccines against falciparum and vivax malaria;
- Innovative and environmentally safe methods to control mosquito vector populations; and
- Enhanced epidemiologic research to identify epidemics and evaluate the effectiveness of education, treatment, and prevention programs.

(4) Time Table for Actions

In April 2000, Africa's heads-of-state at the Abuja Summit on Roll Back Malaria set new internationally agreed upon targets for addressing malaria in the Africa region. Governments and donors have been called upon to initiate appropriate and sustainable action to strengthen the health system to ensure that by the year 2005:

- At least 60 per cent of those suffering from malaria have prompt access to and are able to use correct, affordable and appropriate antimalarials within 24 hours of the onset of symptoms;
- At least 60 per cent of those at risk benefit from protective measures, such as insecticide treated mosquito nets; and
- At least 60 per cent of all pregnant women who are at risk of malaria have access to presumptive, intermittent treatment.

Other regions of the world affected by malaria have set similar targets for the prevention and control of malaria.

Agenda for Action: Tackling the Major Infectious Diseases

Working to the timetable requires a result-oriented agenda for actions for G8 members. Without establishing any G8 structures, the G8 commits itself to:

1. **mobilizing additional resources** for tackling infectious diseases commensurate with increases in the capacity and strength of health systems to tackle the major infectious diseases effectively.
2. **improving co-ordination** of the G8 members with governments, the UN, MDBs and other donors and civil society to ensure that international support for tackling infectious diseases unites around country-driven policies and strategies. Our support will build upon and support existing country level development policies, poverty reduction strategies, medium-term expenditure plans and sector programs fostering national government ownership.
3. increasing the **long term security of basic commodities** needed to address major infectious diseases. The partnership will aim to ensure that no country will fail to achieve its objectives of tackling these diseases through a lack of key affordable commodities.
4. ensuring necessary financial and technical support for **building capacity and strengthening national systems** to deliver appropriate interventions. In recognition of the critical role that local communities and civil society must play in slowing down the epidemics of major infectious diseases, we will seek to ensure that capacity building, nationally and locally forms a key part of international development support.
5. increasing incentives for the **development of international public goods** according to the priorities for vaccines, drugs and diagnostics set out in the Chairman's Summary.
6. **challenging the UN system** to increase its support for national capacity building, and to develop within its own membership a shared agenda and well-defined roles and responsibilities

for tackling infectious diseases.

7. **reviewing the impact** of the global and national dimensions of this new partnership and progress towards the international targets and targets set by countries. This will not duplicate monitoring towards achievement of the international development targets undertaken by the UN. These reviews will also provide an opportunity to track resource flows from G8-members and the functioning of the partnership that we have proposed. In addition, an early and broad consultations with respective developing country government is necessary for G8 on ways to carry forward this agenda in line with country-driven priorities.
8. **dynamic mechanisms**, as proposed, should bring current international initiatives (Stop TB, RBM ,GAVI etc) into the framework of this partnership with a purpose of working to achieve a common infectious disease agenda, learning from these initiatives and integrating efforts for outcome-based health systems in the public and private sectors. To this end, further work should be done to deepen our understanding of partnership mechanisms prior to Genoa.
9. encouraging and where appropriate, assisting **South-South cooperation** to address infectious diseases in various areas, inter alia human resources development and institution building, placement of experts, exchange of information and networking.

Financial Commitment by the G8

To achieve the targets endorsed by the G8, we will also seek the financial commitment from the G8 members, along with intensive efforts in the fight against infectious and parasitic diseases.

Japan: At the Kyushu-Okinawa G8 Summit, Japan announced the "Okinawa ID initiative (IDI)" for enhancing its assistance, with the target of allocating a total of US\$ 3 billion over the next 5 years, for measures against infectious and parasitic diseases (such as HIV/AIDS, TB, malaria/parasitic diseases and polio), as well as those for the improvement of public health, the development of research networks, basic education, and the access to safe water. In the framework of the IDI, Japan has accelerated its actions in these areas in this fiscal year and more than US\$ 300 million financial commitments and other various assistance have been decided and implemented as of today. To further strengthen the efforts to achieve the target, a new grant aid item on bilateral basis is under consideration in the FY2001 budget appropriation for being specifically allocated to infectious diseases as one of the priority areas. In addition, Japan decided to implement infectious disease control projects that amount to about US\$ 10 million through the "Trust Fund for Human Security" established in the United Nations to strengthen its support to the national NGO activities.

France: France has been involved in fight against infectious diseases in developing countries for a long time, both in bilateral and multilateral cooperations.

Beside support to health systems, France currently spends 100 million French francs a year on HIV/AIDS and 50 million on malaria. We should increase our fight against AIDS, through programs that will support global approach, from information to access to ARV drugs, through the International Therapeutic Solidarity Fund, including prevention and care of opportunistic infections. Support to clinical and therapeutic research in developing countries will continue.

France is the most important multilateral contributor per capita income to the European development funding. The European Union (Commission and Member States) is the first sponsor worldwide of public development assistance including to health.

In the framework of the HIPC initiative, many developing countries should benefit from poverty reduction programs that will help them in supporting their health system and fighting against infectious diseases. France should contribute to this initiative up to 10 billion euros and will help developing countries through "debt reduction and development contracts."

United States of America: In Okinawa, the U.S. committed to increasing funding for HIV/AIDS, malaria, TB and other infectious diseases that disproportionately affect the developing

world. The Fiscal Year 2001 international budget for Infectious Diseases and Child Survival is over \$1.2 billion. This reflects a near doubling of funding for international HIV/AIDS programs to \$466 million (pending final Congressional action), through a multi-agency effort, including the U.S. Agency for International Development (USAID), Centers for Diseases Control and Prevention (CDC), the Department of Labor, and the Department of Defense. This funding emphasizes prevention, education, care of those affected by AIDS, including orphans, and infrastructure development. In addition, the U.S. has nearly tripled its tuberculosis funding to \$60 million and doubled its malaria funding to \$50 million. The U.S. also anticipates providing more than \$120 million (TBD) to eradicate polio, and another \$525 million for other child survival disease programs including \$50 million for the Global Alliance on Vaccines and Immunizations (GAVI). On the research side – through the National Institutes of Health (NIH) – the U.S. is investing this year: more than \$2.1 billion on AIDS research, including more than \$260 million on the development of an AIDS vaccine; approximately \$55 million on malaria research; and \$86 million on TB research.

United Kingdom: In 1999-2000 UK spent \$488 million on tackling the health problems of the poorest. \$354 million was spent through DFID's bilateral programmes and \$134 million centrally through multilateral agencies, including the World Bank, WHO, UNAIDS and UNFPA. It is difficult to separate DFID spending according to different themes because the UK's approach is to develop long term, sustainable health systems. DFID spending on SWAPs and other health systems development initiatives contributes to the fight against the communicable diseases of the poor in a way which is difficult to measure. The following is an indicative breakdown of DFID spending for 1999-2000.

Total DFID Health Spend 1999/2000:	\$488 million
<i>Spending priorities include:</i>	
Reproductive and Sexual Health	\$84 million
Health Sector Reform/Health Care Management	\$65 million
Health Care in Unstable Areas	\$78 million
Environmental Health	\$60 million
Communicable Disease	\$131 million

In addition in the next 3 years DFID central health spending through multilateral and other channels will double, mostly due to an increased focus on communicable diseases.

Furthermore, the UK is prepared to consider additional resources for tackling infectious diseases, if the international community, and in particular the UN agencies, can demonstrate improved and better coordination at country level in support of national leadership to deliver this agenda.

The most significant increase in DFID health spending will be in response to the HIV/AIDS epidemic. In addition, the UK provides significant research and development funding into communicable disease through other developmental budgets that are not reflected here. Lastly the UK is a significant contributor to the EC European Development Fund.

Germany: Germany is committing its bilateral assistance based on country cooperation strategies agreed upon with cooperation partners annually or biannually. The volume of programs related to infectious diseases therefore highly depends on priorities set by individual countries. In the year 2000 projects which aim at strengthening the health service delivery in partner countries will reach a volume of around 250 Mio DM. This also includes Malaria and TB specific activities. AIDS related bilateral funding in developing countries increased from 35 Mio DM in 1999 to 102 Mio DM in 2000 and is expected to reach 140 Mio DM in 2001. In addition to that, Germany supports through its regular contributions the AIDS related programs of the EC and of multilateral organizations, including UNAIDS with 2,5 Mio DM in 2000 and contributions in the same order of magnitude for the coming year.

Italy: Italy is paying growing attention to health as an important outcome of development policies and programs. Italy privileges an integrated approach to health, rather than a disease oriented one.

Resources are used according to partner country's plans and priorities and mainly follow a sector wide approach.

Resources allocated for the improvement of health for the present triennium (2000-2002) sum up to about US \$ 400 millions. This includes approximately US \$30 millions specifically directed to support health systems in the fight against infectious diseases. Additional, important, however non easily quantifiable resources for health are included in "Poverty reduction programmes" and other intersectoral initiatives, voluntary contributions to UN and other multilateral organization as well as in Humanitarian interventions and NGO promoted projects with substantial ODA contributions.

Canada: In September 2000, Canada's Minister for International Cooperation, Maria Minna, announced the Canadian International Development Agency's new Framework for Social Development Priorities, that includes Health and Nutrition and HIV/AIDS. Over the next five years, Canada will double its annual funding to health, nutrition, water and sanitation programs from CA\$ 150 million to 305 million per year (total 5yr. CA\$ 1,213 million) and quadruple funding to HIV/AIDS programs from CA\$ 20 million to 80 million per year (total 5 yr. CA\$ 270 million). As part of the Social Development Priorities, CIDA is working with partners on a grant this year for the Global TB Drug Fund to procure anti-TB drugs for needy countries.

Russia: In spite of a difficult economic situation the Russian Federation within the last years was able to pay its contributions liabilities to the WHO regular budget-the sum of more than US\$ 120 million. In 1997, 1999 and 2000 the Russian Federation paid US\$500,000 a year as voluntary contributions to UNAIDS budget.

The Russian Federation is ready to:

- provide material, technological and intellectual potential of research institutions and experts for solving global tasks of infectious diseases control,
- provide training of experts in malaria diagnostics, treatment and prevention for developing countries,
- supply (as part of its annual WHO and UNAIDS contribution) diagnostic test-systems, laboratory equipment, drugs (more than 20 high quality products) to developing countries at the cost 2-2.5 times lower than average world prices.

In order to accomplish the WHO strategic plan on global poliomyelitis eradication by the year of 2005, the Russian Federation may participate in vaccine shipment campaign, supplying various international organizations with Russian polio vaccine on a for-fee basis. The vaccine is manufactured at the Chumakov Research Institute of Poliomyelitis and Viral Encephalitis of the Russian Academy of Medical Sciences. In this connection, we could additionally increase production of live polio vaccine up to 30-40 million doses per year provided that the market for this project is ensured, and continue the vaccine supply until the total eradication of poliomyelitis and the termination of polio immunization process.

European Commission: The EC is committing an average of 500-700 million Euro per year on health, aids and population, and will continue to increase this commitment year after year. This amount comes in addition to the substantial effort of debt relief through the HIPC trust fund. The EC will also make specific efforts to accelerate spending in relation to action in favour of confronting the three main diseases. In addition, the EC is committed to enhancing technical assistance for the implementation of the WTO TRIPS agreement.

The forthcoming programming exercise in developing countries and regions will take the communicable disease problems more into account and our partnership arrangements will be strengthened and improved.

Spending related to the three diseases on Research and Development out of the 5th EC R&D Framework Programme should exceed 130 million Euro by the end of 2002.

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Pages: 5 (including this cover sheet)

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Senior Policy Advisor, Office of Science and Technology Policy, Executive
Office of the President

Fax#: 456-9290(Dr. Bernard) / 456-6028(Dr. Efros)

From: Norio Tamura, First Secretary, Economic Section, Embassy of Japan

RE : Okinawa International Conference on Infectious Diseases

Dear Drs. Bernard and Efros,

The Okinawa International Conference on Infectious Diseases hosted by the Government of Japan (GOJ) will be held in Okinawa on December 7 - 8, based on the statements at the G8 Communiqué Okinawa. Please find an invitation letter from Mr. Yukio Takatsu, Director-General, Multilateral Cooperation Department, Ministry of Foreign Affairs of Japan and an explanatory note on this conference as attached.

Also, the GOJ is planning to hold the Informal Consultation with the Parties Concerned in Tokyo on November 6 in preparation for the above conference. Please refer the "Preparation Timetable for Okinawa International Conference on Infectious Diseases" as attached.

The GOJ would like the US Government to dispatch representatives to "the Okinawa International Conference on Infectious Diseases" (December 7 - 8) and "the Informal Consultation with the Parties Concerned" (November 6). I would appreciate it if you could inform me of the names and titles of participants and their business trip schedules. Please note that the GOJ will not provide air tickets and hotel charges.

If you have any comments or questions, please feel free to contact me at 202-238-6748.

Best regards.

2-1

September 28, 2000

**Explanatory Note on the Okinawa International Conference
on Infectious Diseases**

Background and Objective:

Infectious diseases such as HIV/AIDS, TB and malaria constitute serious obstacles for economic and social development in developing countries. In the G8 COMMUNIQUÉ OKINAWA 2000, adopted at the Kyushu-Okinawa Summit, G8 countries set clear targets for the fight against infectious diseases and agreed to "commit ourselves to working in strengthened partnership with governments, the World Health Organisation (WHO) and other international organizations, industry (notably pharmaceutical companies), academic institutions, NGOs and other relevant actors in civil society".

To deliver agreement on a new strategy to reach the targets, the G8 COMMUNIQUÉ OKINAWA 2000 stated that "we (the G8) will convene a conference in Japan". It would therefore be appropriate to hold in the same venue a follow-up conference on infectious diseases, one of the key agenda items of the Okinawa Summit.

The objectives of the Okinawa International Conference on Infectious Diseases are "to define the operations of this new partnership, the areas of priority and the timetable for action". Accordingly, developed and developing countries, international organizations, the private sector, NGOs and other stakeholders in the international community should work together to contribute to the eradication of infectious diseases.

Dates: December 7th and 8th, 2000**Venue:** Okinawa Convention Center, Ginowan, Okinawa**Participants (Level: Senior Officials):**

- G8 countries and the European Commission
- Non-G8 countries (India, Indonesia, the Philippines, Thailand, Brazil, Kenya, Nigeria, South Africa, Uganda)
- International organizations (WHO, UNAIDS, UNICEF, UNESCO, UNDP, UNFPA, WB)
- NGOs
- Private sector

Program:

Thursday, 7 December

Opening Session (Overview: A. Partnership among the stakeholders
B. Priority areas in international cooperation)

Lunch

Session on Theme 1 (HIV/AIDS)

Coffee Break

Session on Theme 2 (Tuberculosis)

Welcome Reception

Friday, 8 December

Session on Theme 3 (Malaria)

Session on Theme 4 (Other infectious diseases)

Lunch

Wrap-up Session

Closing Session

Preparation Timetable for
Okinawa International Conference on Infectious Diseases

- September 8** **The 1st Japanese Experts Meeting on Infectious Diseases (Tokyo)**
- A consultative meeting aiming to prepare a draft paper for discussion in the Okinawa Conference
- Early October** - Invitations will be sent to G8, developing countries afflicted by infectious diseases, relevant international organizations.
- Participants from the civil society and the private sector will be selected and invitations will be sent.
- Mid October** Inputs and suggestions from WHO, UNAIDS, UNICEF are expected to be submitted.
- October 20** **The 2nd Japanese Experts Meeting on Infectious Diseases (Tokyo)**
- Discussion will cover the suggestions from the international organizations.
- November 6** **Informal consultation with the parties concerned (Tokyo)**
- Participation from G8, EC, WHO, UNAIDS, UNICEF
- Finalize the draft paper
- December 7,8** **Conference in Okinawa**

FAX TRANSMISSION

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Date: October 17, 2000

Pages: 6 (including this cover sheet)

To: Dr. Kenneth Bernard

Senior Director for Health, National Security Council, Executive Office of
the President

Dr. Laura Efros

National Security Council, Executive Office of the President

Fax#: 456-9290

From: Norio Tamura, First Secretary, Economic Section, Embassy of Japan

RE : Okinawa International Conference on Infectious Diseases

Dear Drs. Bernard and Efros,

Based on the Japan's draft, G8, EU and international organizations (WHO, UNAIDS, UNICEF) will discuss at the "Informal Consultation with the Parties Concerned" in Tokyo on November 6 and prepare for a draft paper for the "Okinawa International Conference on Infectious Diseases" to be held in Okinawa on December 7- 8.

The Government of Japan (GOJ) is considering the whole agenda in the Okinawa International Conference and hopes that the results will be action-oriented. It is for this reason that the GOJ is considering to provide an opportunity for each G8 representative to make a presentation regarding its assistance plan for infectious diseases during the Informal Consultation with the Parties Concerned. It would be appreciated if you could send me the following materials by October 27.

- (1) US Government's foreign assistance projects on infectious diseases for the last 5 years
- (2) US Government's foreign assistance projects on infectious diseases which are implemented or planed to implement based on the G8 Communiqué Okinawa

It is necessary that the above materials include specific project contents, time, and costs. If desired, please refer to Japan's ODA for Infectious Diseases Control as attached.

Also, the GOJ will put the above materials together on one sheet of paper. It will be issued as G8's actual activities based on their commitments in the Okinawa G8 Summit just after the Okinawa International Conference on Infectious Diseases.

If you have any comments or questions, please feel free to contact me at 202-238-6748.

Best regards,

A handwritten signature in cursive script, appearing to read "N. Tamura".

Norio Tamura

Japan's ODA for Infectious Diseases Control

October, 2000
Ministry of Foreign Affairs

I. HIV/AIDS Control

1. Global Issues Initiative on Population and AIDS (GII) and Okinawa ID (Infectious Diseases) Initiative (IDI)

GII is one of Japan's individual initiatives which was announced in February 1994. This policy package is designed to provide developing countries with about a total of US\$3 billion in ODA for the area of population and HIV/AIDS during the seven-year period from FY1994-FY2000.

Japan's ODA programmes and projects on HIV/AIDS control have been implemented in the framework of GII. Japan has collaborated with US in implementing some of the HIV/AIDS projects under the "Japan-US Common Agenda".

On the occasion of Kyushu-Okinawa G8 Summit, Japan, as the presidency of the Summit and a leading donor, announced the "Okinawa ID Initiative (IDI)" for enhancing its assistance for measures against infectious and parasitic diseases with the target of allocating a total of US\$ 3 billion over the next 5 years.

2. Japan's ODA projects on HIV/AIDS control

Japan's medium-term policy on ODA, which was announced in August 1999, mentions that HIV/AIDS is one of the priority areas of Japan's ODA.

Japan's ODA on HIV/AIDS control is mainly focused on African and Asian countries. Its programmes and projects cover prevention and education, human resources development, basic research, safe blood supply, provision of medical equipment, prevention of mother-to-child transmission, care of orphans, etc..

● **Human Resource Development (including Basic Research)**

- Technical Training

- Technical training was provided to 494 new participants.

- Technical Cooperation Experts and Japan Overseas Cooperation Volunteers (JOCV)

- 17 experts and 5 JOCVs have been dispatched.

- Project-type Technical Cooperation

- Project for Strengthening of National Institute of Health Capabilities for Research and Development on AIDS and Emerging Infections Diseases (Thailand)
- Infectious Diseases Control Project (Zambia)
- Clinical Research Project of State University of Campinas (Brazil)
- The Research and Control of Infectious Diseases Project (Kenya)
- The Infectious Diseases Control Project at the Noguchi Memorial Institute for Medical Research (Ghana)

● **Prevention and Education**

- Project-type Technical Cooperation

- Project for Prevention and Control of AIDS (Thailand)
- Project for Model Development of Comprehensive HIV/AIDS Prevention and Care (Thailand)
- Project for Prevention and Control of AIDS (Philippines)

- Grant Assistance for Grassroots Projects (GGP)

- Project for AIDS Control for Women (Philippines)
- Musee Pambata STD/AIDS Information Drive & Youth Forum (Philippines)

- Living with AIDS Program (Thailand)
- Network Project for the Healing Community (Thailand)
- AIDS Counselling Project in Harare and Chitungwiza (Phase II) (Zimbabwe)
- Care and AIDS Prevention Education Project for the Provision of Education Materials on AIDS Awareness (South Africa)
- Project for Anti-AIDS Campaign and Family Planning (Haiti)
- HIV/AIDS and STD Prevention Program in the Shan State (Myanmar)
- Impact of HIV/AIDS on Elderly People (India)
- ICROSS AIDS Home Care Program in Bondo District (Kenya)
- Project for Condom Promotion for AIDS Prevention (Lao Republic)

- Community Empowerment Program

- Zambia HIV Prevention Borders Initiative (FY1999)

(Note) This program is implemented in collaboration with USAID.

● **Prevention of Mother-to-Child Transmission and Orphans Care**

- Grant Assistance for Grassroots Projects (GGP)

- Implementation Feasibility of Strategies for Prevention of Mother-to-Child Transmission of HIV (Zambia)
- The AIDS Orphans Caring Service (Zambia)
- Project for Reinforcement of Activities to Relief Patients Infected with HIV (Central Africa)

● **Improvement of Medical Facilities related to HIV/AIDS**

- Grant Aid

- Project for Improvement of Noguchi Memorial Institute for Medical Research (Ghana, FY1997 and FY1998, ¥1.26 billion)

(Note) The scope of this project also covers malaria control.

- Grant Assistance for Grassroots Projects (GGP)

- AIDS Project to Expand the Infectious Diseases Department in the Preah Pat Norodom Sihanouk Hospital in Phnom Penh (Cambodia)

- Technical Cooperation (Equipment)

- Equipment for AIDS Control and Blood Test were supplied to the Philippines, India, Pakistan, Brazil, Ghana, Kenya, Tanzania. Other equipment related to HIV/AIDS were provided to the Philippines, Uganda, Mexico, Hungary and Bulgaria. (¥395.6 million)

● **Safe Blood Supply**

- Loan Aid

- Project for Strengthening District Health in Sulawesi (Indonesia, FY1996, ¥2.231 billion)

- Grant Assistance for Grassroots Projects (GGP)

- HIV Blood Screening for Safe Blood Supply (Indonesia)

● **Others**

- Project Formulation Missions

- Project Formulation Missions related to HIV/AIDS were sent to 15 Asian and African countries.

(Note) PFM to Zambia and Bangladesh were Japan-US joint missions.

● **Contributions to UNAIDS**

Japan has been contributing to UNAIDS since its establishment. A part of its contributions has been ear-marked for vaccine development and prevention of mother-to-child transmission.

II. Tuberculosis Control

Japan's bilateral ODA programs and projects on TB control have been mainly concentrated in the Asian region.

Priority is placed on technical cooperation in making use of Japan's experiences of controlling TB after World War II.

● Human Resource Development

- Technical Training

- Japan accepted a total of 308 trainees.

- Technical Cooperation Experts

- Japan has dispatched 4 experts to Cambodia (2), Yemen and Egypt and 28 JOCVs.

- Project-type Technical Cooperation

- National Tuberculosis Control Project Phase II (Nepal)
- Tuberculosis Control Project (Philippines)
- National Tuberculosis Control Project (Cambodia)
- Tuberculosis Control Project III (Yemen)

- Grant Assistance for Grassroots Projects (GGP)

- Project for Medical Technical Assistance to the National TB Programme (Cambodia)
- TB and Leprosy Support Capacity Building Project (Zambia)

● Prevention and Treatment

- Grant Assistance for Grassroots Projects (GGP)

- TB Diagnosis Project (South Africa)
- Project for TB Prevention and Treatment in West Cape (South Africa)

● Improvement of Medical Facilities related to Tuberculosis

Japan provided grant aid in this area amounting to ¥1.12 billion (approximately US\$ 10 million) over the five year period from FY1995-FY1999.

- Grant Aid

- Project for Improvement of the Medical Equipment of the Persahabatan Hospital (Indonesia, FY1995, ¥259 million)
- Project for Improvement of the National Tuberculosis Center (Cambodia, FY2000, ¥803 million)
- In addition to the above, grant aid was provided to Afghanistan, Haiti, Yemen, Nepal and China (Tiber) from FY1977-FY1994.

- Grant Assistance for Grassroots Projects (GGP)

- Project for Providing Equipment for Respiratory Infections and Pulmonary TB (Peru)
- Project for Improving TB Ward of Al-Jumhory Hospital, Taiz (Yemen)
- Project for the Improvement of Physical Facilities of TB Hospital, Kathmandu (Nepal)
- Project for Strengthening Ward Facilities at TB Hospital (Nepal)
- Project for Constructing TB Ward at Ksut Kandal District Hospital, Kandal Province. (Cambodia)
- Project for Constructing TB Ward in the Kien Svay District Hospital, Kandal Province (Cambodia)
- Project for the Improvement of the Clinic for Prevention of TB (Colombia)
- Project for the Improvement of the Clinic for Treatment and Prevention of TB in Namangan Province (Uzbekistan)
- Project for Strengthening new Diagnosis of Lung Cancer in Communities by Mass Miniature X-Ray (Vietnam)
- Malaria and TB Control Program in Rakhine and Kachin State (Myanmar)
- TB Project (India)

● Contributions to WHO

A part of Japan's contributions to WHO has been ear-marked for TB control.

III. Malaria Control

Japan's cooperation for malaria control is extended mainly to Africa and Asia.

Japan's projects on malaria control are implemented in line with Japan's "Parasite Control Initiative" which was proposed at the Birmingham Summit in 1998 to establish centers for human resources development and research in Asia and Africa.

● Human Resource Development

- Technical Training

- Japan accepted 350 trainees mainly from Africa and Asia.

- Technical Cooperation Experts and JOCVs

- Japan has dispatched 14 experts to Asia and 29 JOCVs to Africa, Asia, the Pacific region and Central America.

- Project-type Technical Cooperation

- Project of Infectious Diseases Control (Zimbabwe)
- Project for the Asian Center for International Parasite Control (Thailand)

● Improvement of Medical Facilities related to Malaria

Japan provided Grant and Technical Assistance in this area over ¥4 billion (approximately US\$ 38 million) during the period from FY1995-FY1999.

- Grant Aid

- Project for Improvement of Health Posts and Health Centers (Ethiopia, FY1995, ¥586 million)
- Project for Construction of the Tropical Disease Center of Airjangga University (Indonesia, FY1996, ¥856 million)
- Project for Facility Improvement of EL Maarouf Hospital (Comoros, FY1996, ¥319 million)
- Project for Improvement of Noguchi Memorial Institute for Medical Research (Ghana, FY1997 and FY1998, ¥1.26 billion)
- Project for Malaria Control (the Philippines, FY1998, ¥469 million)
- Project for Malaria Control (Lao Republic, FY1998, ¥260 million)
- Project for Integrated Malaria Control Initiative (Zambia, FY1998, ¥289 million)

(Note) This project is implemented in collaboration with the US.

- Grant Assistance for Grassroots Projects (GGP)

- Donation of Mosquito Net and Insecticide (Including Olyset Net) (Madagascar)
- Efete Malaria Control Project (Vanuatu)
- Construction of Malaria Center in Khammouane Province (Lao Republic)
- Improvement of Institute of Malariology, Parasitology & Entomology (IMPE) (Lao Republic)
- Malaria and TB Control Program in Rakhine and Kachin State (Myanmar)

- Technical Cooperation (Equipment)

- Japan provided Tanzania and the Lao Republic with medical equipment and materials. (¥16.6 million)

● Contributions to WHO

A part of Japan's contributions to WHO has been ear-marked for projects assisting "Roll Back Malaria".

2001 6/8
Lester (new file)

MEMORANDUM FOR

Mr. Leon FUERTH
Assistant to the Vice
President for National Security Affairs

Mr. David BEIER
Assistant to the Vice
President for Domestic Affairs

Ms. Kristie A. KENNEY
Executive Secretary
Department of State

Mr. Neal COMSTOCK
Executive Secretary
Department of the Treasury

Col. Maria I. CRIBBS
Executive Secretary
Department of Defense

Ms. Frances F. TOWNSEND
Counsel for Intelligence Policy
Department of Justice

Mr. Eric OLSEN
Chief of Staff to the Secretary
Department of Agriculture

Ms. Amy BELLANCA
Executive Secretary
Department of Commerce

Mr. Michael GRANT
Executive Secretary
Department of Labor

Ms. Lavarne BURTON
Executive Secretary
Department of Health and
Human Services

Mr. James N. SOLIT
Director, Executive Secretariat
Department of Energy

Mr. Philip S. LINK
Director, Executive Secretariat
Department of Education

Mr. William A. NITZE
Assistant Administrator for International
Activities
Environmental Protection Agency

Ms. Carmen SURO-BREDIE
Assistant USTR for Policy Coordination
US Trade Representative

Mr. Thomas H. WOLFE
Executive Secretary
Central Intelligence Agency

Mr. Martin BAILY
Chairman
President's Council of Economic Advisors

Mr. Robert A. BRADTKE
Executive Secretary
National Security Council

Dr. Gerald EPSTEIN
Assistant Director for National Security
Office of Science and Technology Policy

Ms. Ryan CONROY
Executive Secretary
Agency for International Development

Mr. Clyde ROBINSON
Vice President and Counselor to the
Chairman
Export-Import Bank of the US

Ms. Barbara CHOW
Deputy Assistant to the President
Domestic Policy Council

Mr. John C. HOYLE
Secretary of the Commission
Nuclear Regulatory Commission

Mr. George MUNOZ
President & CEO
Overseas Private Investment Corporation

Mr. George FRAMPTON
Chairman
Council on Environmental Quality

Ms. Janet CRIST
Chief of Staff
Office of National Drug Control Policy

SUBJECT: September G-8 Sherpa Meeting: Request for Briefing Materials

G-8 Sherpas will hold their first meeting following Okinawa at the end of September in Paris. In preparation for the meeting, we request the following materials on all agenda topics requiring discussion or action for the briefing book of U.S. Sherpa, Gene Sperling.

All materials should be submitted by **OOB Monday, September 18, 2000**, cleared by all appropriate agencies. Clearances from NEC (NOTE NEW FAX NUMBER: 456-5334) and NSC staff (the appropriate regional or functional directorate) are required on all papers, prior to submission by Agencies' Executive Secretaries to the NEC. Drafters should seek these clearances as soon as possible in the drafting process. Every effort should be made to provide the papers in unclassified form. Questions regarding interagency clearance or the briefing papers should be directed to Timothy Punke at the NEC (456-5363). **Please submit final papers to Timothy Punke (223 OEOB) an electronic version on an IBM compatible disk in Word 97 format, and email a copy to timothy_punke@opd.eop.gov. Please ensure disks have been scanned for viruses.**

I. SHERPA MEETING GUIDANCE

At the Meeting, Sherpas will discuss follow-up on Okinawa and overall goals for the next G-7/8 Summit.

Papers on the topics listed below should highlight past progress, goals and work that needs to be done to achieve these goals, and particular steps that should be taken at the Meeting. In the background section, papers should cover recent developments on these issues as well as relevant G-7/8 meetings, developments since the Okinawa Summit, and the positions of all the other members of the G-7/8. Papers should not simply discuss the U.S. position on a particular topic, but must explain how it relates to the positions on the issue of other G-7/8 members, including a strategy for moving significant members to our position.

Papers should be concise (3-5 pages), and provide the following, by section:

- Description of key issue(s);

- Several key talking points in bullet form giving further detail on the positions the U.S. Sherpa should take;
- Summary of the other G-7/8 country positions;
- Several paragraphs of background. This section should reflect any development since the Okinawa Summit, as well as a brief history of the issue's evolution in the G-7/8.

In summary, the Sherpa should be able to look at a paper and understand how the position first developed, how it has evolved since then in the G-7/8, major milestones in its evolution, developments since the Okinawa Summit (including meetings, letters, etc), where the issue stands as of the time the paper was drafted, how that position corresponds with positions on the issue of other G-7/8 members (including which members we need to convert to our position and how that might be accomplished), what the ultimate U.S. goals are on the issue, and our strategy for reaching that goal. The strategy should set forth specific, concrete steps that the Sherpa should pursue.

In addition, agencies should include additional information and background reading as tabbed addenda (e.g., Memos, articles, position papers, etc.).

If all relevant issues are not adequately covered, papers will be returned to the Agency for redrafting. Given the time constraints, it is essential that papers be drafted correctly the first time.

II. <u>G-7 TOPICS</u>	<u>AGENCY LEAD</u>	<u>CLEARED BY</u>
Russia Economic Situation	Treasury	State, OVP, AID
Russia Political Situation	State	OVP, NSC
Russian Debt Situation	Treasury	State, OVP
Russian Investment Forum	State	OVP, Treasury
Chechnya	State	NSC
Nuclear Safety (Russia)	State	DOE, OVP, Treasury, NRC
Nuclear Safety (Ukraine)	State	DOE, OVP, NRC, AID, Treasury
HIPC Including countries in conflict and non-productive expenditures	Treasury	State, AID
G-7 Economic Comparison	Treasury	CEA

Economic Outlook for Asia, Latin America and Africa	Treasury	State, OVP, CEA
Financial Architecture	Treasury	State, CEA
Oil	Treasury	State, DOE, OVP, CEA
European Economic Integration Issues	Treasury	State, CEA

III. G-8 TOPICS

AGENCY LEAD

CLEARED BY

Macroeconomic Outlook for G-8 Countries	Treasury	CEA, State
Development – Universal Basic Education	State/AID	OVP, Treasury
Development -- Infectious Disease/AIDS	OSTP	State, OVP, AID, HHS, Treasury
Development -- HIPC	Treasury	State, AID
Development -- Poverty Reduction and Globalization	State	Treasury, AID
Environment, including renewable energy	State	CEQ, Treasury, EPA, AID, DOE, OVP
Information Technology Dot Force - Structure & Operation	State/OVP	Commerce, Treasury
Information Technology Development Agenda	State/OVP	AID, Treasury
International Crime, Including drugs, high-tech crime	State	DOJ, Treasury, ONDCP
E-Mail Network for Sherpas	State	NEC
Outreach -- Working with G-15, G-77 and NAM to receive their views	State	Commerce, Treasury, USTR
Conflict Prevention Econ. & Development Aspects	State	Treasury, AID

October 22, 2000

MEMORANDUM FOR GENE SPERLING

FROM: JOHN DUNCAN

RE: G-8 Update -- Letter from UK Sherpa, on HIPC, Health Conference and Dot Force

Attached is a letter from the UK Sherpa on countries in conflict, the December infectious disease conference, and the dot force. I use this letter not because it requires a response, but because it usefully raises several issues I wanted to update you on anyway. Nothing in this memorandum requires you immediate action, but we are working at lower levels on each issue as described below.

HIPC

In his letter (at Tab 1), Jeremy Heywood refers to an Attachment (at Tab 2) that sets out actual UK contacts since July, as well as planned contacts, with countries in conflict that are not on the list of 20 expected to reach the decision point by the end of 2000. The purpose of outlining the actions taken by the UK is an attempt to fulfill the commitment in the Okinawa Leaders' Statement that G-8 members should make contacts to encourage countries in conflict as soon as possible to create the conditions necessary to participate in the enhanced HIPC initiative.

Background

As you know, as a result of Treasury concerns, we refused to sign off on the proposed Japanese letter to HIPC countries in conflict. The Japanese were pressing G-8 members to send the letter prior to the World Bank/IMF Meeting in Prague in September. They argued that it was imperative to show progress on the Okinawa commitment by the time of the Bank/Fund meeting. When we did not clear the letter, the Japanese sent it under the auspices of Prime Minister Mori as PM of Japan (not on behalf of all G-8 or as this year's Chair). We had agreed to this alternative.

It is unclear what the U.S. strategy will be for following up on this Okinawa commitment. Rick and I will discuss with Treasury and get back to you with an options paper. There is nothing pressing as the British (and perhaps Japan) appear to be the only country seized with this initiative at the moment.

Health Conference

Jeremy's letter notes that his health experts remain concerned that the agenda for the Okinawa health conference in December is too narrowly defined around infectious diseases.

Background

In the Okinawa Communiqué, the G-8 countries agreed to convene a conference this Fall to coordinate infectious disease assistance and develop a strategy for reaching UN reduction targets. The proposed agenda and participant list for the December 7-8 conference is attached (at Tab 3). Also attached (at Tab 4) is a letter from the EU Sherpa, Armando Varricchio, discussing an EU “Communication” that targets major communicable diseases in the context of poverty reduction. This letter primarily addresses the role of pharmaceuticals (access, affordability and increased R & D) as discussed at a recent high-level EU Roundtable that was meant to serve both as a prelude to and an action formulating program for the December conference.

It is unclear precisely what Jeremy’s concern is with the narrow agenda, as the December conference has from the outset been targeted primarily on infectious diseases and how to meet the ambitious Okinawa targets. Laura and I will work with Jeremy’s G-8 assistant to ascertain UK concerns and will get back to you.

Dot Force

In his letter, Jeremy thanks Nogami for the carefully balanced list of dot force countries proposed by Japan in follow up to discussion at Rambouillet (at Tab 5), but suggests replacing Jordan with Egypt and Jamaica with Bolivia. He also notes that the Russian Sherpa’s list of countries and organizations for the advisory panel (at Tab 6) was well balanced and might provide a useful starting point for discussion at the first dot force meeting in early November.

Background

You have reviewed and commented on Andrei’s letter (in our response, we opposed his suggestion for 8 representatives from non-G-8 OECD countries). We received Jeremy’s letter the same day we sent out our dot force response (at Tab 7) that proposed our candidate countries for the core group and our suggestions on the makeup of the expanded advisory group. While we have proposed replacing Jamaica with Bolivia, Indonesia with Thailand and Tanzania with Egypt, we are largely in sync with the British proposal.

We have received only one G-8 response to our dot force structure letter (at Tab 8). It came from the Italians, the next G-8 chair. The Italian Sherpa, Francesco Olivieri, responded that your letter “on the dot force offers a number of points which are essential in order to iron out the final composition of the task-force.” However, Olivieri assumes the core group will have only 17 members (9 G-8 and 8 developing countries) as opposed to the 9 plus 9 formulation suggested in Nogami’s letter and agreed to in ours.

Further, Olivieri appears to reject our suggestion that we “ask GBDe, WEF, GIIC and WITSA to each send one [industry] participant,” and suggests instead that we leave it to the core group of national governments to choose the most suitable organizations to invite as members of the expanded advisory group. Our formulation was an attempt to restrict the number of organizations making up the expanded advisory group while at the same time giving the

developing country representatives an opportunity to nominate at least one industry or NGO representative. Olivieri does not address the numbers issue at all.

While Olivieri does not commit to our idea of giving a few additional international organizations observer status on the dot force, he notes the idea is “interesting, provided it serves the real purpose to liase the dot force with the relevant activities that those organizations have undertaken.” Finally, he fully shares your view rejecting the idea of a separate group of non-G-8 OECD country representatives.

Tom and Elizabeth are working with key stakeholders to determine our preferred private sector and NGO representatives, whatever the final structure of the expanded advisory group will be. We will also work with Olivieri’s assistant to ascertain if the Italians understand our concern with keeping the number of organizations on the expanded advisory group to a manageable number and if in that context they might be able to agree to our limiting proposal.

**CAMPAIGN PLAN FOR THE USG RESPONSE TO THE GLOBAL AIDS
PANDEMIC:**
05/12/00

I. Strategic Purpose: To significantly reduce worldwide HIV/AIDS transmission; improve care for those infected and affected; and reduce the associated impacts. This issue is in the foreign and strategic interest of the United States.

II. Resources Required:

Minimum financial requirement for prevention and basic care and support (FY 2000):

Sub-Saharan Africa alone: \$3 billion annually¹

For Asia, Eastern Europe/NIS, and Latin America: \$3 billion annually²

¹Of this amount, 5% of annual public sector costs should be leveraged from HIPC governments, 10% from mid-income countries; Target region: all of sub-Saharan Africa. Figures exclude US-based research efforts.

²Target region includes clusters of countries as described in section V below.

**Annual Amount Required for Africa for HIV/AIDS Prevention and Care (FY 2000) and
current spending**

	Amount needed	World Spending ¹	Shortfall	USAID ²	Other USG
Prevention	\$1.5 billion	\$300 million	\$700 million	\$	\$
Care	\$1.5 billion	\$200 million	\$1.8 billion	\$	\$
Total	\$3.0 billion	\$500 million	\$2.5 billion	\$134 million	\$34 million

¹Includes all donors and country public sector. Does not include foundations or personal out-of-pocket expenditures.

²Included in World Spending total; USAID annual funding needs in section VIII. USAID worldwide HIV spending is \$200 million in FY 2000.

Annual Amount Required for other Developing Regions (LAC, Asia, EE/NIS)

	Amount needed	World Spending ¹	Shortfall	USAID ¹	Other USG
Prevention	\$2.0 billion	\$1 billion	\$1.0 billion	\$	\$
Care	\$1.0 billion	\$0.5 billion	\$0.5 billion	\$	\$
Total	\$3.0 billion	\$1.5 billion	\$1.5 billion	\$66 million	\$1 million

¹Host country resources are more substantial in these regions. Thus the anticipated shortfalls are less.

Human and institutional resources:

1. Additional US personnel devoted to HIV/AIDS internationally. Expansion of USG agencies involved. Increased utilization of US-based expertise (NGOs, universities)
2. Significant increase in African and other national human and institutional capacity devoted to HIV/AIDS.

III. Key Trends

- 4 million new infections in Africa; 6 million worldwide; 95% of infections in the developing world. 34 million total infected in Africa.
- In past 20 years, 16.3 million deaths from HIV/AIDS (11.5 m deaths in Africa). Death toll will double in 5 to 6 years, most of it occurring in sub-Saharan Africa.

- One-third of African countries (16) have adult (15-49) HIV/AIDS prevalence rates above 10 percent. Of these, 7 countries have HIV prevalence rates above 20 percent.
- Negative population growth by 2010 in South Africa, Botswana, and Zimbabwe (-1.3, -1.3, and -0.9 respectively). Six more countries in Sub-Saharan Africa will see their population growth rates approach zero because of HIV/AIDS. Mozambique's growth rate will slow to just 0.1% per year, a twenty-fold decline in population due to HIV/AIDS.
- By 2010 over 16 million children will have lost one or both parents to HIV/AIDS in Africa.
- Prevalence rates in African militaries can be as high as 40-60%.
- By 2000, cumulative worldwide direct and indirect costs of HIV/AIDS top \$500 billion. HIV/AIDS will account for over 50% of health spending in many African countries.

IV. Result Targets:

- Reduce the expected new HIV infections over the next five years in Africa from 20 million to 10 million, and in other regions from 10 million to 7 million.
- At least 75% of HIV infected persons have access to basic care and support services. Epidemiology of HIV is complex given new infections vs. those infected that remain alive over long periods of time.

V. Strategic Approach:

Twenty years of US domestic and international experience have provided us with the approaches and tools that work: a combination of prevention, care, capacity building, multisectoral responses as well as political will, donor coordination and financing, and monitoring and evaluation.

We now need not just a quantitative increase in programs responding to the pandemic, but a true qualitative change in how we respond, what we do, who are our partners, the use of new tools, etc. We need to re-energize, scale up and rethink key strategic approaches:

The primary focus is on sub-Saharan Africa, which has generalized HIV infection throughout the adult population. This focus will recognize migration patterns and the mosaic of epidemics in different sub-regions. In Asia, Eastern Europe, the newly independent states of the former Soviet Union, and Latin America, the epidemics are concentrated in specific vulnerable populations. Our action is focused on these subpopulations and will target clusters of countries with significant cross border migration: India-Bangladesh-Nepal; Thailand, Vietnam, Cambodia, Laos; Russia-Ukraine-NIS countries-Poland-Romania; Caribbean-Guyana, Brazil. For these countries and non-focus countries, an expanded and rigorous sentinel surveillance system will monitor the epidemic and identify trends and outbreaks of transmission.

- **Primary prevention:** Essential to controlling and stopping this global scourge. Enhanced and new activities to focus on targeted vulnerable populations (e.g., youth, women, military), as well as highly used transport corridors; better access to voluntary testing and counseling (VCT), massive investments in mother to child prevention; reductions in stigma and discrimination.

- **Care and support for those infected and their families:** Focus on three points of access to infected persons: VCT, antenatal clinic attenders, and inpatients, especially those with active TB. Each of these points of access will provide the optimum way to identify HIV infected persons and to initiate care and support interventions. Each of these also will dramatically enhance our primary prevention agenda. Provide training for health workers and health care system infrastructure improvements to deliver care and support community based care programs (including food distribution). Special focus on drug procurement and distribution systems will enhance the availability and accessibility of these medications.
- **Programs addressing orphans and vulnerable children:** Provide support to community based programs assisting children and families at risk. Includes medical care, education, food, and income generation activities.
- **Capacity building:** Support building national analytical, planning and management capabilities to combat HIV/AIDS in Africa and elsewhere. Strengthen HIV/AIDS surveillance efforts, as well as national monitoring and evaluation efforts. Health system infrastructure development to assure safe and effective delivery of HIV/AIDS drugs and prevention services.
- **Enhanced multisectoral response.** Engage multiple sectors: education, agriculture, military, economic growth, microenterprise, democracy and governance, commerce, and others to launch HIV/AIDS advocacy, education, prevention and/or care programs. Specific funding is required.

VI. Key USG Actors:

USAID is the designated lead USG agency for field based action and coordination of USG agencies. Other key implementation agencies include DHHS, DOD, DOL, Treasury, USTR, the intelligence community. All other USG agencies have important roles to play, e.g., DODCommerce.

VII. Managing the Global Battle:

- US-based: restructure ONAP to manage the Federal Agency response
- Using the PEACS apparatus, engage OECD and affected countries at the highest political level.
- The US LIFE initiative and International Partnership Against AIDS in Africa (IPAA) initiatives can work together to focus on the hardest hit countries in Africa.
- Periodic NSC/ONAP convened IWG, along with executive committee to monitor US and worldwide progress.

VIII. Major Challenges that now confront us:

- **Inadequate resources:**
 - In FY 2000, USG is providing \$235 m worldwide (\$169 for Africa). Worldwide Africa (donor and countries) contribution is approximately \$350 m, yet need is \$3 billion.
 - USG contribution should provide \$335 m in 2001, \$500 m in 2002, \$750 m in 2003, and maintain that rate for five subsequent years for implementation of

DRAFT

programs. An additional \$300 is required annually for research and development on AIDS vaccines, protective topical microbicides and improved treatment regimes.

- Limited Capacity:
 - In affected countries, governments, NGOs, communities, institutions, all need major capacity building efforts
 - USAID requires dedicated HIV/AIDS staff in each LIFE emphasis country to manage its programs and coordinate USG efforts.
- Lack of critical tools: (such as AIDS prevention vaccines and microbicides.) Requires a Manhattan Project type of intensive focused effort (NIH, IAVI, GAVI) involving a coordinated, multi-pronged approach to simultaneously testing promising vaccine and drug candidates. Currently \$1.9 billion is expended by the USG on AIDS research.

IX. How do we know if it is working?

The USG will use indicators firmly established under the LIFE initiative and the International Partnership Against AIDS in Africa to monitor progress. A country profile database will be established providing country-based information on the epidemiology of the epidemic, scope of the country response, and indicators of progress. These profiles will be created through a collaborative effort led by the USG (USAID, CDC, Bureau of Census, NIA, DOD, etc) working with UNAIDS, WHO and selected other governments (e.g. U.K. and Sweden), and will use established indicators, and data aggregation and analysis systems. Profiles will be updated semi-annually and will facilitate regrouping/ strategy revisions, etc. A semi annual supplemental report will address data that relates to security issues.

X. Next Steps: (12 month plan)

- Discussion of HIV/AIDS at international fora: G-8, SADC, EU-US, UNAIDS PCB
- Discussion of HIV/AIDS efforts and required assistance in upcoming President Mbeki visit and with other high level visits.
- UN special meeting of General Assembly; Millennium conference
- Personal calls by POTUS/VP with specific leaders to galvanize worldwide attention and resource mobilization.
- Specific work with DOD, DOL, Treasury—US HIV/AIDS “strikeforce”. Coordination with USAID to provide background HIV/AIDS technical assistance on the issues.
- Increased communication and collaboration with USG advocacy and expert groups (e.g. NGOs, universities, etc)
- Identification of necessary studies (e.g. economic, intelligence, military, HIV surveillance) to be undertaken.
- Increased USG participation in country level IPAA actions.

education budget (above current levels) just to maintain teacher levels of two years ago.

Fax

To: Sandy Thurman
Ken Bernard
Bernhard Schwartlander
David Stanton

From: Paul Delay
Alex Ross

Fax: Sandy 202-456-2439
Ken 202-456-9390
Bernhard 41227914165
David 202-216-3046

Pages: 3

Phone: **Date:** 06/06/00

Re: Justification for targets **CC:**

☐ **Urgent** ☐ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

● **Comments:**

Attached is the justification for the targets for the battle plan. Bernhard should be sending a refined analysis of the estimated need and current expenditure.

We are leaving for the Nanyuki thi afternoon (Sunday). Try reaching us by phone at 254-17-630-0000 or by fax at 254-17-631-316. The hotel has a general email at mksc@formnet@com.

Thanks

Paul and Alex

JUSTIFICATION FOR THE TARGETS FOR THE USG RESPONSE TO THE AIDS PANDEMIC:

1. Reduce expected new HIV infections over the next five years in Africa from 20 million to 10 million, and in all other regions from 10 million to 7 million.
2. At least 50% of HIV infected pregnant women will have access to interventions that will reduce mother-to-infant HIV infection.
3. At least 30% of HIV infected persons have access to basic care and support services.
4. At least 30% of AIDS orphans will have access to basic community support services.

These targets represent the four major areas for combatting the AIDS pandemic: reducing sexual transmission of HIV (accounting for over 80% of all infections), reducing mother-to-infant HIV transmission, increasing access to care and support services for HIV infected persons and their survivors (orphans) These targets are ambitious for the five year time frame that is envisioned, however, they are realistic and achievable if appropriate resources are identified and donor and affected country governments are committed to building capacity and health care infrastructure to implement the appropriate scope and scale of these interventions.

1. In 1999, in sub-Saharan Africa, approximately 4 million persons became infected with HIV, of which 55% were women. This is a doubling of annual incidence (number of new infections in any given year) from 1993. Extensive experience from prevention programs in Uganda, Thailand, Dominican Republic and Senegal support the target of a 50% reduction in new annual HIV infections within the next five years, based on realistic resource requirements of approximately \$2.00 per capita per year for prevention. Success will also be dependent on the effectiveness of national country political mobilization in support of prevention programs.
2. Currently, in sub-Saharan Africa, less than 5% of the 22 million persons infected with HIV have access to HIV testing. Approximately 2 million HIV positive women become pregnant each year in sub-Saharan Africa, of which over 60% utilize health services at some point in their pregnancy (1.2 million). However, currently less than 1% of all pregnant women are screened for HIV status and offered an antiviral drug regimen to reduce HIV transmission to their newborn. Voluntary counseling and testing services along with mother-to-infant prevention interventions can be provided in these health settings that women are now using for pre-natal care.
3. As of the end of 1999, there were over 22 million currently HIV infected persons living in sub-Saharan Africa. Persons with end stage HIV related disease are often hospitalized for short periods of time. In fact, in the most severely affected countries in east and southern Africa up to 60% of hospital beds can be devoted to HIV infected patients. However, the level of care available and access to even the most basic symptomatic treatments, let alone effective prevention and treatments of opportunistic infections, is essentially non-existent. This is due to lack of critical health commodities and training on the care of HIV related disease. Over the next five years, with significant investments in infrastructure, a basic package of care can be made

available. This would include prophylaxis for tuberculosis and other lung diseases and treatment of the array of other opportunistic infections symptoms, such as diarrhea and fever. It is important to note that in the U.S., only about 30% of persons living with HIV actually have access to antiviral drugs. Considering the massive need to provide better access to HIV testing and the building up of healthcare systems, a goal of 30% within five years represents a dramatic increase. The package of care and support that would be provided could enhance survival and quality of life in Africa as significantly as that achieved in the U.S. through the use of combination antiviral therapies.

4. There are now nearly 24 million children who have lost one or both parents in the 19 most severely affected countries in Africa. Interventions must be directed at maintaining these children within their community, either in extended kinship families or in child headed households. These services must initially be targeted at those families most at risk for orphanhood, such as children serving as caregivers to sick and dying parents. Community support services include health and non-health services: paying for school fees, providing food assistance, provision of health services, provision of vocational training, microenterprise assistance, and stigma reduction. Current assistance programs reach a very small proportion of orphans and affected children (several hundred thousand). Significantly increased resources would support community and family based assistance programs to reach at least a third of the children at risk. Faith based organizations are particularly important in this effort given their coverage of communities and tradition of providing health and social services to communities. In addition, achieving target 3 above will allow parents to survive longer, thus delaying orphanhood.

Keenan, Josefine (Chris) (HEALTH)

From: WHSR
Sent: Thursday, April 13, 2000 12:04 PM
To: Babbitt, James F. (VP); Byrne, Catherine E. (AF); Cables; Dempsey, Nora B. (AF); Feldman, Daniel F. (MULTI); Mclean, Matthew K. (MULTI); Naplan, Steven J. (MULTI); Patten, Wendy L. (MULTI); Schwartz, Eric P. (MULTI); Smith, Gayle E. (AF); Vaccaro, Jonathan M. (Matt) (MULTI); Wilcox, Richard M. (MULTI)
Subject: NEW REPORT ON THE MACROECONOMIC IMPACT OF HIV/AIDS

ActionAddres: RUEHC/SECSTATE WASHDC IMMEDIATE 1288
Classification: UNCLASSIFIED
DateTime: 131451Z APR 00
Distribution: SIT: BABBITT BYRNE NSC DEMPSEY FELDMAN MCLEAN NAPLAN PATTEN
SCHWARTZ
SMITH VACCARO WILCOX

Identifier: M4394491
InfoAddres: RUCPDO/DEPT OF COMMERCE WASHDC IMMEDIATE
Line1: OAAUZYUW RUEHSA2860 1041451-UUUU--RHEHAAX.
Line2: ZNR UUUUU ZZH
Line3: O 131451Z APR 00
Line4: FM AMEMBASSY PRETORIA
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Precedence: IMMEDIATE
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DEPT FOR AF/S (MKOPLOVSKY)
DEPT PASS USTR RWHITAKER, BSCHWARTZ
USDOC FOR 4510/ITA/IEP/ANESA/OA/SMILLER

E.O. 12958: N/A
TAGS: ECON, SOCI, TBIO, SF
SUBJECT: NEW REPORT ON THE MACROECONOMIC IMPACT OF HIV/AIDS

REF: 99 PRETORIA 12722

SUMMARY

1. IN A RECENT REPORT, ING BARINGS ATTEMPTED TO FORECAST THE MACROECONOMIC EFFECTS OF HIV/AIDS IN SOUTH AFRICA. ITS REPORT CONCLUDES THAT THE EPIDEMIC WILL HAVE A PROFOUND IMPACT ON THE COUNTRY'S ECONOMY. THE INFECTION RATES FOR THE ECONOMICALLY ACTIVE POPULATION WILL REACH 26 PERCENT, CONCENTRATED MOSTLY IN THE UNSKILLED OR SEMI-SKILLED WORKFORCE, BUT ALSO SIGNIFICANTLY AFFECTING THE SKILLED WORKFORCE. AS A RESULT, THE STUDY CALCULATES THAT GDP WILL BE ON AVERAGE 0.3 TO 0.4 PERCENT LESS PER YEAR THAN IT WOULD BE WITHOUT AIDS. ACCORDING TO THE REPORT, THE COSTS OF AIDS ARE LIKELY TO INCREASE INFLATION AND DEPRESS DOMESTIC SAVINGS AS WELL AS EXACERBATING THE SKILLS SHORTAGE. END SUMMARY.

INTRODUCTION

2. ING BARINGS RECENTLY RELEASED ITS FORECAST OF THE MACROECONOMIC EFFECTS OF HIV/AIDS IN SOUTH AFRICA. THEY BEGAN BY MODELING THE DEMOGRAPHIC CHANGES LIKELY TO OCCUR AND THEN CONDUCTED LONG-TERM ECONOMIC FORECASTS TAKING THESE CHANGES INTO ACCOUNT. THE REPORT CAUTIONED THAT LITTLE PREVIOUS WORK HAS BEEN DONE ON ECONOMIC MODELING OF THE EPIDEMIC AND SERIOUS GAPS IN THE DATA EXIST.

THE DEMOGRAPHIC IMPACT

3. USING THE ACTUARIAL SOCIETY OF SOUTH AFRICA NATIONAL AIDS MODEL, ING BARINGS FORECAST THAT THE TOTAL POPULATION WILL BE 23 PERCENT LOWER BY 2015 THAN IT WOULD BE WITHOUT AIDS. IN MAKING THIS FORECAST, THE REPORT ASSUMES THAT SEXUAL BEHAVIOR DOES NOT SIGNIFICANTLY CHANGE AND THAT NO MEDICAL ADVANCES OCCUR.

4. OTHER FINDINGS INCLUDED:

- HIV INFECTION RATES WILL PEAK AT 16.7 PERCENT IN 2006 AND THEN START TO DECLINE.
- AIDS DEATHS WILL PEAK IN 2010 AT 1.8 AIDS DEATHS PER 100 PEOPLE AND 256 AIDS DEATHS PER 100 NORMAL DEATHS ANNUALLY.
- APART FROM THE 0-9 AGE GROUP, AIDS DEATHS ARE MAINLY CONCENTRATED IN THE 25-50 AGE GROUP.

5. WITH REGARD TO LABOR FORCE, THE STUDY FOUND:

- THE HIV INFECTION RATE AMONG ECONOMICALLY ACTIVE PERSONS WILL PEAK AT ABOUT 25.5 PERCENT BY 2006.
- THE HIV INFECTION RATE OF UNSKILLED OR SEMI-SKILLED LABOR WILL PEAK AT 32.8 PERCENT AFTER 2015.
- THE HIV INFECTION RATE OF SKILLED LABOR WILL PEAK AT 22.8 PERCENT IN 2006.
- THE HIV INFECTION RATE AMONG HIGHLY SKILLED LABOR WILL PEAK AT 13.1 PERCENT IN 2005.
- AIDS DEATHS OF HIGHLY SKILLED PEOPLE WILL PEAK AT 1.2 PER 100 WORKERS ANNUALLY.
- AIDS DEATHS OF SEMI AND UNSKILLED PEOPLE WILL PEAK 3.4 PER 100 WORKERS ANNUALLY.

MACROECONOMIC ASSUMPTIONS

6. THE REPORT IDENTIFIED KEY ECONOMIC COSTS OF THE HIV/AIDS CRISIS IN SOUTH AFRICA AND SETS FORTH BASIC ASSUMPTIONS ABOUT THEM. THE COSTS INCLUDE:

A) LOWER LABOR FORCE AND PRODUCTIVITY: THE REPORT DETERMINED THAT THE LABOR SUPPLY WILL BE ADVERSELY AFFECTED BY AIDS, WITH SKILLED LABOR COSTING THE ECONOMY MORE. THERE WILL ALSO BE LOWER LABOR PRODUCTIVITY BECAUSE OF ABSENTEEISM FROM ILLNESS OR COPING WITH FAMILY MEMBER'S ILLNESS.

B) COST PRESSURES: COMPANIES WILL BE AFFECTED BY BOTH DIRECT COSTS SUCH AS INCREASED CONTRIBUTIONS TO PENSION, LIFE AND MEDICAL BENEFITS, AND INDIRECT COSTS SUCH AS INCREASED SPENDING ON RECRUITMENT, LEAVE, AND THE NEGATIVE IMPACTS ON CLIENTS. THESE COSTS WILL FILTER THROUGH THE ECONOMY.

IMPACT ON WAGE COSTS

YEAR	INCREASE IN WAGE BILL	PASSED TO CONSUMER	IMPACT ON PPI
------	-----------------------	--------------------	---------------

2015	45 PERCENT	15.0 PERCENT	4.5 PERCENT
------	------------	--------------	-------------

(THE REPORT ASSUMES ONLY THE SKILLED AND HIGHLY SKILLED HAVE BENEFITS THAT WILL BE INCREASED)

C) DEMAND CHANGES: THE REPORT ASSUMES THAT THE HIGHER WAGE BILL WILL BE LARGELY ABSORBED BY THE EMPLOYER WHO WILL PASS IT ON THROUGH HIGHER PRICES OR ABSORB IT IN OPERATING COSTS.

THE REMAINING PORTION WILL BE ABSORBED BY THE LABOR FORCE
(AGAIN, THE REPORT ONLY CONSIDERS THE SKILLED AND HIGHLY
SKILLED SECTIONS OF THE FORCE FOR THIS PURPOSE). THIS IN
TURN WILL TRANSLATE INTO A WAGE INCOME THAT IS ALMOST 6
UNCLAS SECTION 02 OF 03 PRETORIA 002860

DEPT FOR AF/S (MKOPLOVSKY)
DEPT PASS USTR RWHITAKER, BSCHWARTZ
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E.O. 12958: N/A
TAGS: ECON, SOCI, TBIO, SF
SUBJECT: NEW REPORT ON THE MACROECONOMIC IMPACT OF HIV/AIDS

PERCENT LESS THAN WOULD HAVE BEEN EXPECTED WITHOUT AIDS BY
2010. INITIALLY, HOWEVER, THE REPORT NOTED THAT LOWER
POPULATION FIGURES MIGHT ACTUALLY RAISE HOUSEHOLD INCOMES.
COMBINING THE TWO, AND ADDING HIGHER DEMAND FOR HEALTH
SERVICES, THE REPORT CONCLUDES THAT THE DECLINE IN HOUSEHOLD
DEMAND WILL BE GREATEST FOR SEMI AND NON-DURABLE PRODUCTS.

NET CHANGE IN HOUSEHOLD DEMAND IN 2015
PERCENT CHANGE IN DEMAND FOR
RESIDENCES DURABLES SEMI NON- SERVICES SAVINGS
DURABLES DURABLES
-9.1 -7.8 -9.3 -9.3 5.5 -6.5

D) HIGHER GOVERNMENT EXPENDITURE ON HEALTH SERVICES: THE
REPORT ASSUMES THAT THOSE PEOPLE WHO ARE NOT SKILLED OR
HIGHLY SKILLED WILL HAVE THEIR MEDICAL CARE COVERED BY THE
STATE. USING AN ESTIMATED CURRENT AVERAGE AMOUNT EXPENDED BY
THE GOVERNMENT ON AIDS PATIENTS (R3,750), THE REPORT
ESTIMATES THE GOVERNMENT WILL HAVE TO SPEND R3,656 MILLION ON
AIDS PATIENTS IN 2015. THE REPORT ASSUMES NO CHANGE IN THE
COST OR TYPE OF CARE THE GOVERNMENT CURRENTLY PROVIDES. THE
REPORT THEN ASSUMES THE INCREASE EXPENDITURE WILL BE FINANCED
BY THE BUDGET.

THE FORECAST

7. USING THE FIGURES AND ASSUMPTIONS ABOVE, THE REPORT
CONCLUDES THAT:
--GDP AND GROWTH WILL BE LOWER DUE TO LOWER CONSUMPTION, BUT
INVESTMENT WILL BE STABLE. GDP WILL DECLINE 0.3 TO 0.4
PERCENT A YEAR AS A RESULT OF AIDS, RESULTING IN A GDP THAT
IS 4.7 PERCENT LESS AND GROWTH 0.8 PERCENT LESS THAN THEY
WOULD BE WITHOUT AIDS IN 2011.
--THE UNEMPLOYMENT RATE WILL DECLINE marginally.
--THE FISCAL DEFICIT DETERIORATES DUE TO HIGHER EXPENDITURE
AND LOWER REVENUE. THE REPORT ASSUMES THE BUDGET DEFICIT IS
FLEXIBLE AND THUS THE SAG WILL AVOID FURTHER GOVERNMENT
EXPENDITURE DECLINES CAUSING REVENUE TO DECLINE FURTHER AND
DRAGGING GDP DOWN FURTHER. INSTEAD, THE REPORT ASSUMES THERE
WILL BE MORE PUBLIC BORROWING AND LOWER GOVERNMENT SAVINGS.
--DOMESTIC SAVINGS WILL SUFFER AND WILL NEED TO BE MADE UP BY
FOREIGN SAVINGS, WHICH WILL LEAD TO A HIGHER CURRENT ACCOUNT
DEFICIT. THE STUDY CALCULATES TOTAL DOMESTIC SAVINGS WILL BE
15 PERCENT LESS IN 2011 THAN IT WOULD BE WITHOUT THE AIDS
EPIDEMIC.
--THE CURRENT ACCOUNT DEFICIT WILL BE PUSHED CLOSE TO 3
PERCENT OF GDP.
--HIGHER CPI WILL PUT PRESSURE ON INTEREST RATES AND EXCHANGE
RATES.

SECTOR RISK EXPOSURE

8. THE REPORT ALSO LOOKED BY SECTOR AT INFECTION RISK AS
WELL AS POTENTIAL WAGE COSTS. MINING, GENERAL GOVERNMENT AND
AGRICULTURE WERE FOUND TO HAVE THE HIGHEST INFECTION RISK,
WITH THE INFECTION IN THESE POPULATIONS PEAKING AT 26 TO OVER

29 PERCENT. FINANCE AND INSURANCE AND BUSINESS SERVICES FACED THE GREATEST POTENTIAL WAGE COSTS. COMBINING THE TWO RISKS, THE STUDY FOUND THAT THE TRANSPORT AND STORAGE INDUSTRY AS WELL AS THE CATERING AND ACCOMMODATION SECTOR ARE THE MOST EXPOSED TO THE AIDS RISK.

CONCLUSION

9. THE STUDY CONCLUDES THAT THE NET EFFECT OF THE EPIDEMIC WILL BE NEGATIVE FOR GROWTH. IT CAUTIONS THAT THERE IS A POSSIBILITY OF A VICIOUS CYCLE IN WHICH COSTS OF DISEASE WILL DRAIN SAVINGS AND EXACERBATE THE ALREADY LOW SAVINGS RATE. THE ECONOMY WILL THEN REQUIRE MORE FOREIGN SAVINGS, BUT THE GROWING RISK PERCEPTION BECAUSE OF AIDS IS UNLIKELY TO LEAD TO FOREIGN CAPITAL INFLOWS. THUS, THE GOVERNMENT WILL HAVE TO TAKE OUT FOREIGN LOANS THAT WILL IN TURN LEAD TO HIGHER CURRENT ACCOUNT DEFICITS. THE DEFICITS WILL PUSH INTEREST RATES HIGHER THEREBY DEPRESSING ECONOMIC GROWTH FURTHER.

10. ALTHOUGH THE SOUTH AFRICAN UNEMPLOYMENT RATE IS OVER 25 PERCENT AND THUS PRACTICALLY MATCHES THE INFECTION RATES FOR THE ECONOMICALLY ACTIVE POPULATION, THE REPORT CAUTIONS THAT EVERY PERSON DYING OF AIDS CANNOT BE REPLACED BY THE UNEMPLOYED. MOST OF THE UNEMPLOYED ARE UNSKILLED OR SEMI-SKILLED LABORERS. EVEN THOUGH MOST OF THE AIDS DEATHS WILL OCCUR AMONG THIS SAME GROUP, SKILLED AND HIGHLY SKILLED PEOPLE WILL ALSO BE SIGNIFICANTLY AFFECTED. THE REPORT THEREFORE CONCLUDES THAT AIDS WILL "EXACERBATE THE EXISTING SKILLS SHORTAGE WITHIN THE ECONOMY."

11. THE REPORT CALLS ON THE GOVERNMENT TO:

- FORMULATE A CLEAR AIDS STRATEGY,
 - MOVE FASTER TO DISMANTLE STRUCTURAL OBSTACLES TO FOREIGN INVESTMENT,
 - CONSIDER CHOICES ON ANTI-AIDS DRUGS, ESPECIALLY REGARDING
- UNCLAS SECTION 03 OF 03 PRETORIA 002860

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DEPT PASS USTR RWHITAKER, BSCHWARTZ
USDOC FOR 4510/ITA/IEP/ANESA/OA/SMILLER

E.O. 12958: N/A

TAGS: ECON, SOCI, TBIO, SF

SUBJECT: NEW REPORT ON THE MACROECONOMIC IMPACT OF HIV/AIDS

TRANSMISSION, AND

- FOCUS ON EDUCATION, ACCESS TO CONDOMS AND TREATMENT OF STDs.

COMMENT

12. IN THE FIRST MAJOR STUDY TO LOOK AT THE ECONOMIC EFFECTS OF HIV/AIDS, ING BARINGS PAINTS A DEPRESSING PICTURE. THE AREAS WHERE THE SOUTH AFRICAN ECONOMY IS ARGUABLY THE WEAKEST--SKILLS AND SAVINGS--ARE LIKELY TO BE THE WORST HIT BY THE AIDS EPIDEMIC. IT MAKES APPROPRIATE SAG ACTION ALL THE MORE URGENT.

13. THE REPORT ALSO HIGHLIGHTS THE NEED FOR MORE AND BETTER STUDIES OF THE IMPACT OF HIV/AIDS. USAID IS FUNDING ONE SUCH STUDY WHICH SHOULD FURTHER HELP SAG POLICYMAKERS UNDERSTAND THE IMPLICATIONS OF THE DISEASE.

LEWIS



Jonathan M. Vaccaro
04/05/2000 08:49:23 AM

Record Type: Record

To: Kenneth W. Bernard/NSC/EOP@EOP, Matthew K. Mclean/NSC/EOP@EOP, Richard M. Wilcox/NSC/EOP@EOP, Eric P. Schwartz/NSC/EOP@EOP

cc: Jonathan M. Vaccaro/NSC/EOP@EOP

Subject: AIDS in Africa grant: FYI

Gates Foundation gives \$57 million for UN efforts to prevent HIV/AIDS in Africa

4 April -- Secretary-General Kofi Annan today welcomed a \$57 million grant from the Bill and Melinda Gates Foundation to protect African youth from HIV/AIDS in four African countries. The United Nations Population Fund (UNFPA) announced the grant at a press conference today. The money will be used for national campaigns to educate and protect youth in Botswana, Ghana, Tanzania and Uganda. The five-year initiative is to be implemented by UNFPA, governments, local groups and two international non-governmental organizations.

Describing HIV/AIDS as "a tragedy on a biblical scale," Mr. Annan said in a statement issued today that he hoped other partners would emulate the Gates Foundation. Africa was leading the counter-attack against the disease, and the grant would contribute immeasurably to efforts to control its spread. The first battle was to "smash the wall of silence and stigma" surrounding the disease, the Secretary-General said. In 1999, the General Assembly set a target of reducing HIV infection in young people by 25 per cent by the year 2004. Currently, half of all new cases of HIV infection are among young people aged 15-24, according to UNFPA. "This grant puts resources where the need is most urgent: protecting the most vulnerable and safeguarding each country's future," UNFPA Executive Director Dr. Nafis Sadik said at today's press conference.

According to estimates by the Joint United Nations Programme on HIV/AIDS (UNAIDS), some 5.6 million people were infected last year, of whom 3.8 million live in sub-Saharan Africa. Of the 33.6 million persons believed to be living with HIV/AIDS now, 23.3 million live in that region.



Alex Ross <aross@afr-sd.org>

05/17/2000 11:16:39 AM

Record Type: Record

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

cc:

Subject: [Fwd: Re: Revised USG Battle Plan]

Ken and Laura,

Here is the revised version that incorporates some edits from Mike Iskowitz and for which we are comfortable with.

Regarding your question, Ken, on coverage. This is tough. When you look at the sheet that Paul had sent over with the breakout of the \$3 billion, you will see what it would purchase (for Africa) and some sense of coverage. It does not appear that we have one number to reflect what % of the African population the entire \$3 billion would cover.

Indeed, there is a great deal of difference between covering people with mass media messages vs. intense treatment. So here is a rough guide referring to the table you have:

Prevention (\$1.03 b)

Mass media would cover 100% of the African population (on the order of 620 million people in sub-Saharan Africa)

More intense behavior change targeted at 30% of those in need (e.g., truck drivers, CSW, etc). I cannot give you a denominator figure here.

CARE AND TREATMENT (\$1.3 billion)

If you divide \$1.3 b by \$194/yr/person, you end up with 6.7 million people (but that probably includes the various types of interventions).

[There are 22+ million people living with HIV/AIDS in Africa, presumably not all need care right away)

For an additional \$14 million, coverage for 1.1 million with cotrimoxazole.

TESTING AND COUNSELING (\$470 million)

15% of adults 15-49 in sub-Saharan Africa (or 261 million people) = 39.15 million people

CARE FOR VULNERABLE CHILDREN (\$390 million)

Coverage of 7.8 million children

MTCT (\$120 million)

We expect this would cover (VCT, drug, administration, breast feeding, and cost of case finding). Uses an overall prevalence rate for Africa

as a whole of 8%. There are 25.4 million pregnancies in Africa (assume 8% of women infected).

Rough coverage is 1.7-2 million people.

A sidenote, these budget numbers above total more than \$3 billion, yet what we are saying is that AT LEAST \$3 billion is needed.

Hope this helps

Alex

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

Subject: Re: Revised USG Battle Plan

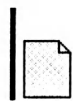
Date: Wed, 17 May 2000 09:14:24 -0400

From: Cheryl_S._Bauerle@opd.eop.gov

To: Alex Ross <aross@afr-sd.org>

here it is - thanks!

(See attached file: USG BATTLE PLAN.doc)



- USG BATTLE PLAN.doc

Message Sent To:

Kenneth W. Bernard/NSC/EOP

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Cost Estimates for Prevention, Care, and Treatment of HIV/AIDS for Sub-Saharan Africa

UNAIDS and USAID have estimated the costs, as outlined below, of prevention, treatment, and orphan care in Sub-Saharan Africa. There are substantial needs in Asia and Eastern Europe as well. It must be noted that most of these activities are inter-related and funding one category requires concomitant funding of others. The rough estimates are the annual bare minimum costs in year 2000 dollars:

- **Treatment and Care** **\$1.3 billion**
Assumes reaching 30 percent of those in need at \$194/yr/person. Includes treatment of HIV-related illness such as TB, but excludes treatment with anti-retrovirals. Providing Cotrimoxazole (Bactrim/Septra) would add only \$14 million, assuming treating 1.1 million per year - only those with moderately advanced disease.
 - **Prevention Activities** **\$1.03 billion**
Including behavior change communications, condom social marketing, STD services, and safe blood programs.
 - **HIV Testing and Counseling** **\$470 million**
Assumes reaching 15 percent of all adults (15-49) at \$12/person.
 - **Care for Orphans and Vulnerable Children** **\$390 million**
Assumes reaching 30 percent of affected children at \$50/yr/child. Excludes orphanage care.
 - **Prevention of Mother-Child Transmission** **\$120 million**
Based on \$4 Nevirapine, not \$80 (other) drugs. Includes administration of drugs and breast milk substitutes for 400,000 infected women/yr at \$55/person (about \$70/each if you include HIV testing). Could cost 20 times that amount.
- Total needed for sub-Saharan Africa: at least \$3.0 billion/year**
- Total currently available from all sources: \$0.5 billion/year**

**WHITE HOUSE BRIEFING
HIV/AIDS and TB/MALARIA EXPANDED RESPONSE**

November 29, 2000, 11:00 am

Agenda

- I. Introductions**
- II. Evolution of Rapid Response**
 - Description of USAID's approach to LIFE
 - The expanded response concept
 - Scaling up – process for decision making
 - Expected results and targets
 - HIV/AIDS strategy
 - 1. Rapid scale up
 - 2. Intensive focus
 - 3. Basic countries
- III. HIV/AIDS Country/Budget Plans**
- IV. TB/Malaria Strategy and Country Budget Plans**
- V. Key Issues**
 - Special authorities and expedited procurement HIV/AIDS
 - Inter-agency coordination
 - Directives:
 - World Bank HIV/AIDS Trust Fund
 - IAVI
 - Microbicides
 - UCSF
 - Monitoring and evaluation
 - Hill Consultations
- VI. Questions and Answers**



HIV/AIDS and Infectious Diseases Rapid Response

November 29, 2000



End-2000 Global HIV/AIDS Estimates Children and Adults

- People living with HIV/AIDS 36.1 million
- New HIV infections in 1999 5.3 million
- Deaths due to HIV/AIDS in 1999 3 million
- Cumulative number of deaths due
to HIV/AIDS 21.8 million

Resource Needs and Gaps

Annual Estimated Needs and Available Funding for sub-Saharan Africa for HIV/AIDS Prevention and Care in FY 2000

	Estimated Amount needed	USAID funding in FY2000 ¹	Other USG (CDC)	Estimated World Spending on sub-Saharan Africa ²	Shortfall
Prevention	\$1.2- \$ 2 billion	\$ 99 million	\$34 million	\$425 million	\$.8-1.2 billion
Care	\$1.8- \$2.9 billion	\$ 35 million	\$-- 0	\$ 75 million	\$1.75-2.8 billion
Total	\$3.0 - \$4.9 billion	\$134 million	\$34 million	\$500 million³	\$2.5 -\$4.4 billion

¹ USAID worldwide HIV spending is \$200 million in FY 2000.

² Includes all donors, lending agencies and host country public sector. Does not include foundations or personal out-of-pocket expenditures.

³ Of this amount, approximately \$415 million is funded through developed country grants and loans and \$85 million derives from host country governments, primarily for inpatient care costs.



Evolution of the Rapid Response

- **FY 2000 Life Initiative:** An additional \$100 million for an Interagency USG program with USAID, CDC, and DoD
- **15 Countries:** Kenya, Uganda, Zambia, Ethiopia
Malawi, Mozambique, Nigeria, Rwanda,
Senegal, South Africa, Tanzania,
West Africa, Zimbabwe, and India
- **Four Program Elements:**
 - Primary prevention
 - Caring for children affected by AIDS
 - Home and community based care and treatment
 - Capacity and infrastructure development



LIFE Countries

- Botswana
- Cote d'Ivoire
- Ethiopia
- India
- Kenya
- Malawi
- Mozambique
- Nigeria
- Regional programs
- Rwanda
- Senegal
- South Africa
- Tanzania
- Uganda
- Zambia
- Zimbabwe



Evolution of the Rapid Response Funding for FY 2001

USAID HIV-AIDS Funding	Account
\$330 million	All accounts
\$300	CSD
\$15	Non-CSD (ESF, FSA, SEED)
\$15	CSD-Vulnerable Children



Evolution of the Rapid Response

Expanded Response Elements target for 2007:

- Reduce HIV Prevalence rates among those 15-24 years of age by 50% in high prevalence countries**
- Maintain prevalence below 1% among 15-49 year olds in low prevalence countries**



Evolution of the Rapid Response

Targets continued:

- Ensure that at least 25% of HIV/AIDS infected mothers in high prevalence countries have access to interventions to reduce HIV transmission to their infants**
- Help local institutions provide basic care and support services to at least 25% of HIV infected persons and to provide community support services to at least 25% of children affected by AIDS in high prevalence countries**



USAID is Scaling Up HIV/AIDS Activities

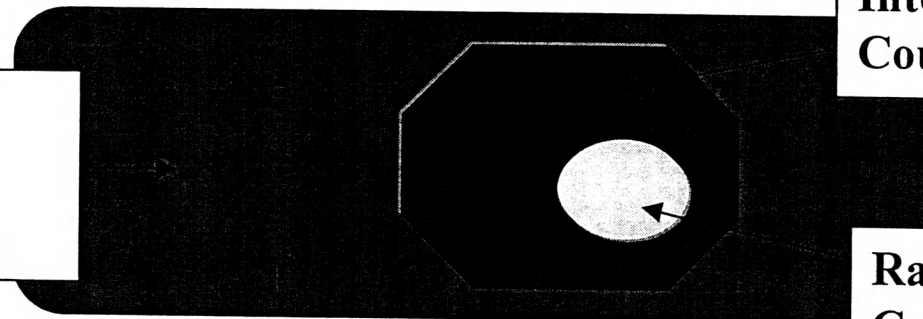
➔ Three Country Designations:

- Rapid Scale Up
- Intensive Focus
- Basic Programs

**HIV/AIDS Basic
Programs Countries
(25+ TBD)**

**Intensive Focus
Countries (20-TBD)**

**Rapid Scale Up
Countries (4)**





Criteria for Rapid Scale-Up & Intensive Focus Countries

- **The relative severity of the epidemic**
- **The magnitude of epidemic**
- **The impact on economic and social sectors**
- **Enabling environment**
- **The risk of a rapid increase in prevalence**
- **Availability of other sources of funding**
- **Return on investment**
- **Security and safety issues**
- **National Interest**



Criteria for Country Programs

	% pop. with HIV/AIDS	# persons infected with HIV/AIDS	Pop. (000s)	Prev. trend	Extent of Migration	Use of condom with sex worker	Tradition frequent visit to sw	Governmental commitment
ANE								
Cambodia	4.04	220,000	10,931	rapid incr	high	increasing	yes	very promising
India (overall)	0.70	3,700,000	997,663	variable	moderate	increasing	varies	improving
1) Tamil Nadu	1.5+	307,994	55,859	slow incr.	moderate	increasing	unk	high
2) Maharastra	>2.00+	747,049	78,700	rapid incr	high	slowly incr.	no	improving
Nepal	0.29	34,000	23,398	slowly incr	high	increasing	no	moderate
Total		4,910,950	1,710,782					



Rapid Scale-Up Countries

- 4 countries
- increased budget and support to achieve measurable impact within 1-2 years
- in high prevalence countries, work to ensure that at least 80% of population receives a comprehensive package of prevention & care services within 3-5 years



Rapid Scale-Up

- Cambodia
- Kenya (LIFE)
- Uganda (LIFE)
- Zambia (LIFE)



Intensive Focus Countries

- **13 countries and 3 targeted sub-regions**
- **Timeframe: within 3-5 years**
- **Strategy: resources increased & targeted to:**
 - **reduce prevalence rates (or keep rates low),**
 - **reduce HIV transmission from mother to infant**
 - **increase support services for those living with &/or affected by AIDS**



Intensive Focus Countries

AFRICA

- Ethiopia (LIFE)
- Ghana
- Malawi (LIFE)
- Mozambique (LIFE)
- Namibia
- Nigeria (LIFE)
- Rwanda (LIFE)
- Senegal (LIFE)
- South Africa (LIFE)
- Tanzania (LIFE)
- West Africa Region (LIFE)

ANE

- India (LIFE)
- ANE Region

LAC

- Brazil
- Caribbean Sub-Region

E&E

Russia



Basic Countries

- **25 countries and several targeted sub-regions, *maintain*:**
 - technical assistance
 - training
 - commodity support, and
 - help identify other sources of funding and support



Basic Countries

AFRICA

- Angola
- Benin
- DR of Congo
- Eritrea
- Guinea
- Madagascar
- Mali
- Zimbabwe (LIFE)
- REDSO/E
- Sahel
- Southern Africa Region (LIFE)

ANE

- Bangladesh
- East Timor
- Indonesia
- Nepal
- Philippines

E&E

- Central Asian Republics
- Ukraine
- CEE Regional
- NIS Regional

LAC

- Bolivia
- Dom. Republic
- El Salvador
- Guatemala
- Guyana
- Haiti
- Honduras
- Jamaica
- Mexico
- Nicaragua
- Peru
- G-CAP



TB Country Programs

Expanded Country Programs

DR Congo	Cambodia	Russia*
Ethiopia	India*	Baltics
Kenya	Indonesia	Brazil
Malawi	Philippines*	Dominican Republic
Senegal		Haiti
Uganda		

On-Going Programs

South Africa, Bolivia, El Salvador, Honduras, Mexico, Peru, Central Asian Republics, Ukraine, Romania, SE Europe Regional

* Existing program



Criteria for expanded TB programs in key countries

- Countries of greatest need, defined by:
 - Greatest burden of TB – high incidence of TB (case detection estimated rates of over 100/100,000) and/or those that significantly contribute to the global burden of TB
 - Countries with high HIV/AIDS prevalence, and
 - Countries at risk of escalating epidemics of multi-drug resistance.
- Political commitment; technical & managerial feasibility



Malaria Rapid Response Objective

FY 2001: USAID receives \$50 million for malaria

- Doubles USAID malaria investments
- By 2005, (depending on the availability of funding), USAID will contribute to:
 - At least 60 % of those suffering from malaria have prompt access to and use of affordable and appropriate antimalarials within 24 hours
 - At least 60% of those at risk benefit from protective measures, such as insecticide treated mosquito nets; and,
 - At least 60 % of all pregnant women who are at risk of malaria have access to presumptive, intermittent treatment.



Challenges

- **Special Authorities and Expedited Procedures**
- **Interagency Coordination**
- **Directives**
- **Meeting Expectations: Interim Indicators**



FY 2001 Legislative Directives

\$.5 million	UCSF epidemiologic profiles
\$10 million	International AIDS Vaccine Initiative
\$15 million	Microbicides
\$20 million	World Bank Trust Fund
Total \$45.5 million	

Monitoring and Evaluating Programs

- **HIV seroprevalence in 15-24 y.o.**
- **Condom use with last non-regular partner/Number of casual sex partners**
- **Total number of condoms sold**
- **% pop utilizing VCT services**
- **% of target orphans with access to community services**
- **% of target population with access to treatments to reduce MTCT**
- **% STI cases treated according to national standards**
- **% HIV infected persons with access to basic care and psychosocial support**

Curtailing the Global AIDS Pandemic- The U.S. Government Responds

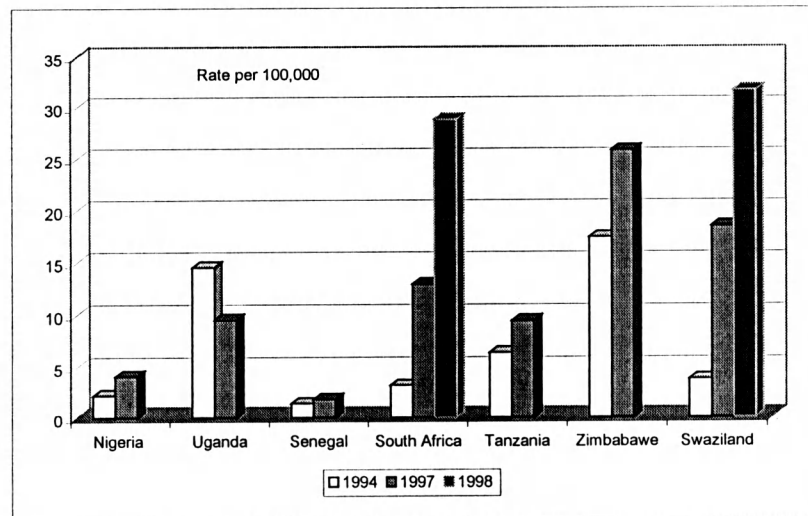
Setting the Stage – Humankind’s Deadliest Health Crisis

The HIV/AIDS pandemic is the defining public health crisis of our time. Not only is the spread of HIV creating a humanitarian tragedy of epic proportion, it is also threatening to undo four decades of progress in international development, and endangering the economic and political stability of entire regions of the world. At the start of the 1990's, health experts estimated that between 15 and 20 million people would be living with HIV by the beginning of the 21st century. Ten years later, the true magnitude of the epidemic is far more alarming: over 36 million people are living with HIV.

Since its first recognition in 1981, 57 million men, women and children have become infected with HIV worldwide. Nearly 22 million people have died of AIDS, with 3 million deaths in the last year alone. Over 13 million children under 15 have lost one or both parents to AIDS, and the total number of AIDS orphans is expected to exceed 40 million by 2010. HIV/AIDS is now the fourth leading cause of death worldwide and the single leading cause of death in sub-Saharan Africa.

No part of the globe is untouched. Every country of the world has reported cases of HIV/AIDS. At the dawn of this 21st century, HIV/AIDS prevalence among adults exceeded 20% in 7 countries in the developing world (all in Africa) and was above 10% in 9 additional countries. In another 41 countries, prevalence equals or exceeds 1%. 22 of these are in Africa, 11 are in Latin America, 4 in Asia and 1 in Eurasia. In contrast, HIV/AIDS prevalence in the United States was 0.6% at the end of 1999.

HIV Prevalence Trends in Selected African Countries



Source: UNAIDS

Sub-Saharan Africa, where 70% of all persons living with HIV/AIDS reside, has borne the brunt of the pandemic. In the hardest hit African countries, infant mortality is twice as high as it would have been without AIDS. With increases in premature death due to AIDS, life expectancy has plummeted. Nearly half of all persons who acquire HIV are less than 25 years of age; most will die before their 35th birthday. AIDS mortality has brought population growth to a near stand still in Botswana, South Africa, and Zimbabwe. Within three years time these countries will be experiencing *declines* in size of their populations due to AIDS deaths.

The economic toll on Africa is equally striking. Families caring for sick members are seeing a dramatic drop in income and productivity. As a result, children are being removed from school, farm assets are being sold and communities are seeing food production decline by as much as 50%. In the hardest hit countries, GDP has declined by 5 to 10 percent as all economic sectors are being affected. For example, trucking firms in South Africa have lost up to 30% of their drivers reducing their ability to move goods to markets. Schoolteachers in Zambia are dying faster than new ones can be trained. The health sector is bearing a double burden from HIV-AIDS. Health systems are shouldering the demands to provide care to millions of people sick and dying from AIDS while the health care workforce is declining due to AIDS deaths among doctors, nurses, and midwives.

Other parts of the world have not been spared the ravages of the pandemic. The second largest regional epidemic is in the Asia Pacific region, where nearly 60% of the world's population lives. With its dense populations, this part of the world could eclipse the African epidemics in size and scope. We have seen the epidemic explode in Cambodia, Burma, Thailand and some states of India. Even with a prevalence of less than one percent, India is the second most affected country in the world with over 3 million people infected. Other countries in the

region, most notably Indonesia and Philippines, have maintained low prevalence epidemics over the last decade, giving rise to hope that with successful behavioral interventions, this region's epidemics can be contained.

Other epidemics are spreading rapidly as well. In the Western Hemisphere, the epidemics in the Caribbean region are the fastest growing outside of Africa, fueled largely by heterosexual contact. Over the last five years, Eastern Europe and the former Soviet states have seen an explosive epidemic of HIV among injection drug users. These epidemics are now showing signs of entering the general population.

The global HIV/AIDS pandemic poses a dual challenge to the nations of the world. The first challenge is address the urgent need to implement and scale up prevention programs known to slow the spread of HIV. The second is to address the healthcare needs of the millions of persons infected, and provide assistance to the families and communities ravaged by this extraordinary emergency.

A Record of Achievement

The U.S. Government has been the world leader in responding to the global pandemic of AIDS. Since 1993, the U.S., through the United States Agency for International Development (USAID), has dedicated over \$1.5 billion dollars for the prevention and mitigation of this epidemic in the developing world. In addition to this financial support, USAID has been recognized as the global leader in developing key interventions for preventing HIV transmission; demonstrating their effectiveness and provided direct assistance to affected countries to build their capacity to respond.

USAID works in more than 50 of the hardest hit developing countries around the world. Preventing sexual transmission, which is responsible for about 80% of HIV infections, is central to our widespread efforts in service delivery, capacity building, biomedical and behavioral research, and policy formulation. Over the past decade, we have worked with local governments and community groups to provide intensive, AIDS education to over 40 million of the most vulnerable men, women and young persons, helping them to reduce their risk of HIV infection. To accomplish this task, USAID has trained over 200,000 new, dedicated counselors and educators. In 1998, with the release of clinical field trial data on new ways to reduce mother-to-infant HIV transmission, which accounts for over 10% of new infections, USAID launched a series of country sites to provide this important new prevention service. But while prevention is the guiding principle of our programs, we have learned that we cannot have a truly effective prevention program without providing basic care and support services to those infected and to their families. We now provide assistance to increase access to HIV testing, improving symptomatic care and treatment of opportunistic infections, such as tuberculosis, and initiating field trials to explore ways to deliver simpler and less expensive antiviral treatment regimens.

Direct support to countries to build capacity in order to prevent new infections and to provide care and support for those infected and their families: Over 70% of USAID's support in HIV/AIDS has been through the work of nearly 1000 local and international non-governmental organizations (NGOs) and community based organizations (CBOs). NGOs are often relied upon to reach those most vulnerable to infection and in need of care and support services. USAID places a high priority on building the capacity of local NGOs through partnerships with other developing country NGOs, international technical assistance providers, and US-based AIDS Service Organizations. Recognizing the need to keep pace with the pandemic, USAID is increasing the coverage of our programs to reach those most in need of services through local institutions.

Key Accomplishments in country programs:

- HIV prevalence in young adults reduced. In **Uganda**, USAID's support was instrumental in reducing the prevalence of HIV in 15-24 year olds in urban areas by 50 percent, and nationally by a third. Similarly, with USAID support, over the past few years **Zambia** has achieved a 42% reduction in the rate of HIV among 15-19 year-olds.
- Low HIV prevalence and stabilizing HIV prevalence rates maintained. In **Senegal, Philippines and Indonesia**, early, comprehensive HIV intervention programs supported by USAID and other donors have helped prevent a major epidemic, keeping the prevalence rate to less than 2 percent. USAID has been instrumental in stabilizing the HIV prevalence rate in **Kenya**, and reducing national rates of sexually transmitted diseases (STDs).
- Voluntary testing and counseling pioneered. In 1990, USAID provided funding for the AIDS Information Center in **Uganda**, the first program in Africa offering voluntary and anonymous HIV counseling and testing. In eight years, over 400,000 clients were served. Building on this success, USAID now supports voluntary counseling and testing in more than 15 countries.
- Distribution of condoms increased. USAID has provided over one billion condoms and developed new technologies so that people can protect themselves and their partners. In **Thailand**, through a 100% "condom only" brothel policy and intensive general and targeted interventions focused on behavior change, HIV prevalence has been kept at 2 percent over the past four years, and STI rates in men have dropped by 300 percent. USAID support for social marketing of condoms has increased sales by over 100 percent between 1996 and 1998 in four African countries (**Kenya, Madagascar, Mozambique, and Zimbabwe**). In 1999, USAID launched new social marketing programs in **Eritrea, South Africa, and Haiti**.

Bureau of Census: Early in the epidemic, USAID recognized the importance of collecting essential surveillance data-to track the expanding epidemic and to

measure the impact of prevention efforts. In 1987, USAID initiated funding for the International Programs Center at the U.S. Bureau of Census to collect HIV surveillance data, provide technical assistance to country programs, analyze the significance of the data, and to provide conclusions and recommendations. The Bureau of Census is now recognized as the world-wide leader in tracking patterns and trends in HIV infection, for example, in projecting the numbers of AIDS orphans and in providing critical data for the annual UNAIDS global reports.

International HIV/AIDS Alliance Launched in 1993. In 1993, USAID consulted with HIV/AIDS experts and NGO support specialists and joined a small group of bilateral, multilateral and private donors to establish The International HIV/AIDS Alliance (IHAA) --an innovative mechanism to directly address the urgent problem of building the capacity of country level NGOs and community based groups to provide effective responses to the epidemic. The IHAA model is to identify a qualified indigenous NGO in a target country, provide funding and training in both administrative and technical aspects of HIV/AIDS service delivery, and then to assist that NGO to support smaller, community based organizations in the delivery of culturally appropriate, technically sound services at the micro scale of households and villages, where the realities of the HIV/AIDS epidemic unfold. The International HIV/AIDS Alliance has experienced steady growth from an annual budget of \$3.5 million in 1997 to over \$5 million in 1999. Donor support to the Alliance has grown to include the European Union and its member states, the UN organizations and other multilaterals, and private foundations and companies. In 1999 alone, the Alliance reached 1.5 million beneficiaries, nearly 400 NGOs in 13 countries - almost an 80% increase from their work in 1998.

Greater Involvement of Persons Living with AIDS (GIPA): In 1994, USAID played a major role in supporting the development of GIPA Initiative at the Paris AIDS Summit. This initiative recognizes the critical contributions that persons infected with AIDS can provide to the design, implementation and evaluation of culturally sensitive and effective prevention and care efforts. USAID strives to ensure that the GIPA principle is reflected in all of its assistance projects.

Women and AIDS: USAID leadership has built new knowledge and capacity to address the overwhelmingly heterosexual epidemic in developing countries, by providing over 5 million to the International Center for Research on Women (ICRW). This program of 17 studies in 13 countries was the first concerted effort to document the impact of the epidemic in regions where over half of HIV infections are in women and girls, and where they are the principal providers of AIDS care. It supported policy dialog and promoted innovative interventions designed to deal with the diverse economic, social, and political disadvantages that increases women's vulnerability to HIV infection, and it moved issues of gender squarely to center stage in international HIV/AIDS work.

USG Instrumental in Creating UNAIDS: Concerned with the need for a broader, more effective response to the AIDS pandemic, the USG worked with other donor and UN partners to create UNAIDS, which was launched in 1996. UNAIDS is an innovative program which brings the UN family together in a “joint venture” to fight AIDS. The USG, through USAID, has been UNAIDS largest funder, having given over \$80 million in grant assistance since 1996.

UNAIDS documented and publicized the full dimensions of the global AIDS crisis, and helped focus world leaders’ attention on the crisis – and how to respond to it – at global fora such as the United Nations Millennium Summit, UN Security Council meetings, and the Africa Development Forum. In June 2001, a Special Session of the UN General Assembly will be devoted to HIV/AIDS. UNAIDS “Theme Groups on HIV/AIDS” were established in 86 out of 88 priority countries, and technical teams in priority areas such as access to drugs, education, mother to child transmission and voluntary counseling and testing are functioning.

In large part due to the leadership of UNAIDS, global HIV/AIDS reduction targets have been set and global, UN, and national strategies developed to achieve them. An “International Partnership Against AIDS in Africa (IPAA)” was formed which has begun to mobilize political commitment. More national leaders have assumed responsibility for combating AIDS. International commitments from pharmaceutical companies and the business sector, private foundations, the UN (e.g. UNICEF in East and Southern Africa has committed to spending 50% of its resources on AIDS), the World Bank, and the bilateral donor community increased an estimated 2.5 times from 1997 to 2000. Additional funding sources are being tapped, such as the innovative use of debt relief, and the stage is set for further increases in resources for HIV/AIDS in 2001.

Achievements in Research: USAID has been a leader in innovative research and development needed to prevent and mitigate the effects of the AIDS pandemic. Without USAID support, many innovative products and methods would have never been developed. The results of this research have proven useful in the U.S. as well as in developing countries.

- **Female Condom:** USAID funded research was pivotal in securing FDA approval of the Reddy Female Condom, making this woman-controlled barrier method available in the U.S. and around the world.
- **Syphilis Diagnostic Test:** USAID funded the research and development of a syphilis test that is simple and inexpensive and can be used in low resource settings to diagnose and effectively treat this common sexually transmitted infection, whose presence increases the efficiency of HIV transmission.
- **Voluntary HIV Counseling and Testing:** USAID funded research in a three country study that demonstrated that providing high quality HIV testing and

counseling services results in sustained behavior change and is a cost-effective HIV prevention intervention.

- **Treating Sexually Transmitted Infections:** USAID funded research demonstrated that levels of sexually transmitted infections in whole communities could be reduced with periodic treatment of persons at highest risk.

USAID continues to support the development of innovative technologies and methods needed to reduce the spread of HIV and mitigate its effects. This includes research and development of HIV vaccines, microbicides, diagnostic tests for sexually transmitted infections; improving the effectiveness of AIDS education in the classroom and the workplace; assisting mothers and families in preventing mother-to-child transmission of HIV; and expanding care and support for people and families infected with and affected by HIV.

USAID Identifies the Tragic Aftermath of HIV Infection on Children:

HIV/AIDS is undermining the safety and well being of children in unprecedented ways and on a staggering scale. Leading the call to action to recognize the severity of the situation of children affected by HIV/AIDS, USAID released a seminal report on World AIDS Day, in 1997. ***Children on the Brink: Strategies to Support Children Isolated by HIV/AIDS*** helped to define the nature and magnitude of the problem and identified strategies to address it that have guided the development of activities worldwide. Updated in July 2000, the document is the source of estimates and projections of children who will have lost one or both parents from all causes, including AIDS, in a sample of 34 severely affected countries.

USAID began its direct support of programs to address the needs of children affected by HIV/AIDS in 1998 and is currently funding activities that focus on orphans and other vulnerable children in eighteen countries. The foundation of the USAID response is to strengthen family and community capacity to continue to care for these children within their communities. Funding provides necessary support to ongoing community efforts and fosters initiation of similar efforts where they do not yet exist. Community-based interventions include: volunteer visiting programs; material support, such as food and shelter; economic strengthening activities, including credit and savings; counseling and ongoing emotional support; support to parents in planning for the future care of their children; and interventions by which communities address the stigma that is often directed at people living with HIV/AIDS and their families. Training activities build local capacity of organizations that provide care and support to communities and families coping with HIV/AIDS. Operations research has been initiated to determine optimal community based approaches that provide support to children and their families. Planning efforts identify and develop strategies to address the impacts of HIV/AIDS on the accessibility and quality of education - both in and out of school - in AIDS affected areas.

The Legacy of Leadership: Expanding our Efforts

From years of painful experience with this pandemic, it has become increasingly evident that a cornerstone for success in battle against the AIDS anywhere is clear and consistent leadership. The challenges presented by this growing plague are great, and in the absence of a steadfast commitment from political leaders in all levels of government and from civic leaders from all sectors of society, our ability to prevail is seriously jeopardized. We saw this kind of leadership in Uganda, Senegal, and Thailand in the early days of this pandemic – and we bore witness to the real results achieved through this bold and decisive action that started with the head of state. Despite seemingly insurmountable odds, we saw communities and entire countries stem the rising tide of new infections and begin to care for the growing number of people infected and affected by HIV. But as a global community, our collective action was being far outpaced by a pandemic raging out of control – and strengthened leadership was desperately needed.

In April 1998, President and Mrs. Clinton traveled to Africa and spent two weeks visiting five countries. During that time, they witnessed first-hand the grave implications of the AIDS pandemic at its epicenter -- sub-Saharan Africa. This experience reconfirmed what this Administration had already begun to understand -- that the global AIDS crisis was much more than a health crisis; it was a fundamental development crisis, an economic and trade crisis, and a stability and security crisis. Such a crisis clearly demanded a more broad-based response, not just from the United States Government, but from the global community. To that end, on December 1, 1998, President Clinton charged the White House Office of National AIDS Policy Director with leading a fact finding mission on AIDS to sub-Saharan Africa and reporting back with a battle plan for an enhanced USG response.

■ The LIFE Initiative represents an unprecedented United States Government mobilization.

In July 1999, the Administration launched the Leadership and Investment in Fighting an Epidemic (**LIFE**) Initiative. LIFE represented a major breakthrough – a turning point in the role of the USG in the global battle against AIDS. This effort sought not only to increase US investment but also to dramatically enhance US leadership in a global mobilization toward our shared goals in the fight against AIDS. These goals, put forward by the Joint United Nations Program on AIDS (UNAIDS) in cooperation with its bilateral or multilateral partners, are as follows.

- The incidence of HIV infection will be reduced by 25% among 15-24 year olds by 2005. (Currently 2 million young adults are infected each year in sub-Saharan Africa.)

- At least 75% of HIV infected persons will have access to basic care and support services at the home and community levels, including drugs for common opportunistic infections (TB, pneumonia, and diarrhea). (Currently, less than 1% of HIV infected persons have such access.)
- Orphans will have access to education and food on an equal basis with their non-orphaned peers.
- By 2001, domestic and external resources available for HIV/AIDS efforts in Africa will have doubled to \$300 million per year. (Currently approximately \$150 million per year is spent on HIV/AIDS prevention in sub-Saharan Africa.)
- By 2005, 50% of HIV infected pregnant women will have access to interventions to reduce mother-to-child HIV transmission. (Currently, less than 1% of HIV infected pregnant women have access to such services in sub-Saharan Africa.)

<u>Joining Forces for LIFE:</u> Leadership and Investment in Fighting an Epidemic <i>A Global AIDS Initiative</i>
--

■ **The LIFE initiative has enabled the US government to pursue four critically important and interconnected program areas.**

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

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

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

(4). Strengthening Prevention and Treatment by Augmenting Planning, Infrastructure, and Capacity Development. Strengthening host country ability

to plan and implement effective interventions. Strengthening the capacity for effective partnerships and the ability of community based organizations to deliver essential services. Strengthening surveillance systems to track the epidemic and target HIV/AIDS programs.

- The LIFE Initiative has enabled the United States Government to more than triple its AIDS specific investment in the global battle against AIDS over the last two fiscal years, and to further expand these increased resources through debt relief, concessional loans at the World Bank, and other important efforts.

Global AIDS Funding Chart

	FY99	FY01
AIDS Specific Funding		
USAID	\$135m	\$330m
CDC	\$7m	\$116m
DOD	0	\$10m
DOL	0	\$10m
TOTAL	\$142m	\$466m
Non-AIDS Specific Funding		
Debt Relief	0	\$435m
GAVI	0	\$50m
World Bank Concessional Loans targeted to AIDS	0	\$500m
Basic Education	\$123m (check with OMB)	\$138 (check with OMB)

- **The LIFE initiative has enabled the United States Government to engage a host of federal agencies in the first ever government-wide mobilization against AIDS.**
- **USAID.** From years of extensive experience in the fifty countries around the world in which USAID provides AIDS funding, the agency has developed and evaluated model programs that the agency can now begin to bring to scale. As a result of new funding provided through the LIFE initiative in FY 2000, USAID was able to provide a more "intensive focus" in 15 countries including those hardest hit in sub-Saharan Africa and India. With the additional resources secured in FY 2001, USAID will be able to expand this intensive focus to 20 countries, providing additional resources and support to Russia, the Caribbean, and Brazil. In addition, in fiscal year 2001, USAID will identify four countries that are position for "rapid scale-up" of essential activities. These countries will be selected from a variety of criteria including the

severity of the epidemic, its impact on economic and social sectors, strength of support from the host government, and ability to demonstrate quantifiable results. As additional agencies have become part of the overall USG effort, USAID has remained the lead agency on the ground throughout the world, providing in-country presence and coordination.

The LIFE initiative has also enabled USAID to pioneer and push for a broad-based multisectoral approach. Recognizing the enormous impact of HIV/AIDS on multiple sectors, particularly in Africa, USAID has documented the impact of the epidemic as well as developed appropriate interventions. Efforts have focused on the education sector, certain economic sectors (such as mining), microfinance, democracy and governance, and agriculture. In the education sector in particular, USAID has worked very closely with other donors to identify solutions to the loss of teachers to HIV/AIDS as well as to design curriculum addressing HIV/AIDS prevention. Moreover, USAID has been working to address the key underlying factors that encourage HIV/AIDS transmission, such as the lack of inheritance rights for women, economic migration patterns, and conflict that results in refugee movements.

- **Centers for Disease Control and Prevention.** In collaboration with USAID and the other agencies of the Department of Health and Human Services (DHHS), the CDC is providing vital public health assistance to 14 countries in Africa and India to combat the HIV/AIDS epidemic. Ongoing activities are focused in three areas: (1) provision of technical assistance for primary HIV prevention (voluntary HIV counseling and testing, blood safety, behavior change and mother-to-child transmission); assistance in developing surveillance programs to target prevention resources and assess the effects of HIV prevention interventions; and provision of technical assistance for the care and treatment of opportunistic infections and STDs and for the provision of palliative care and psychosocial support to persons living with HIV/AIDS and their families.

The DHHS and CDC propose to expand these efforts to an estimated 24 country programs in Africa, Asia, and the Caribbean/Latin America with increased resources proposed for FY 2001. Enhanced activities would include increased technical assistance and support to improve national surveillance programs for HIV, STDs, and TB; infrastructure support through expanded in-country and U.S.-based training efforts for host country epidemiologists, HIV prevention and care program managers, and service delivery providers; expansion of home-based care service delivery capacity and assistance in developing locally appropriate care and treatment interventions for HIV-infected persons; and expanded HIV prevention initiatives in mother-to-child transmission

- **Department of Defense.** Under the LIFE initiative, the Department of Defense allocated \$10 million in FY 2001 to assist African militaries in

designing and executing HIV/AIDS education and prevention programs for military troops, and to integrate train the trainer programs into U.S. forces engagement with African militaries. Specifically the DOD program will seek to assess HIV prevalence and risk behaviors, develop and augment regional and local prevention plans through training and infrastructure, evaluate the effect of prevention efforts and ensure incorporation of HIV/AIDS programs into the military culture of host governments to ensure a lasting impact. The program is intended to continue beyond FY 2002 as long as funds are available. The U.S. Navy and its Naval Health Research Center are the primary implementing agency for this program.

The U.S. Army and the Civil Military Alliance to Combat HIV and AIDS have also developed prevention and education modules for training UN peacekeepers pre-deployment, and continue to work with UNDPKO on activities related to HIV/AIDS and STD prevention. Through the expanded IMET program the Internal Health Resources Management School in Monterey, California, is developing executive level training courses for senior civilian and military leaders responsible for HIV/AIDS in other countries. These courses will be taught as part of the E-IMET program starting in early 2001.

- **Department of Labor.** Utilizing reprogrammed FY 2000 funding, the Department has begun a pilot project on workplace based HIV/AIDS education in the Republic of Malawi in south central Africa. Working with the Ministry of Labor, employers, trade unions, a vocational school, and US based Project Hope, the pilot seeks to implement and evaluate a comprehensive workplace-based HIV prevention program. The Department plans to expand this program in fiscal year 2001 with the \$10 million currently pending in Congress. This expansion will draw on lessons learned from the Malawi pilot and will include Nigeria, Tanzania, Zambia, and Botswana in sub-Saharan Africa, India, Vietnam, and Cambodia in Asia, a regional program in the Caribbean, and Russia. The overall objective of this effort is to reduce HIV infections through workplace prevention programs and to improve the workplace environment for people living with AIDS through the development of non-discrimination and other HIV-AIDS policies.
- **Department of State.** The Department has launched a diplomatic initiative on international HIV-AIDS to raise the profile of this issue around the world and to foster a deeper commitment overseas to this fight. The Secretary's initiative instructed US ambassadors to work with foreign leaders and their governments on the need to increase the priority given to HIV-AIDS and resources available for essential HIV prevention and AIDS care programs. The State Department also works closely with international organizations, other governments, and the private sector to draw greater attention to HIV-AIDS and the need for global cooperation and concerted action. Secretary Albright hosted a meeting of female foreign ministers during the UN General

Assembly session in September 2000 to discuss the global HIV/AIDS situation and the special needs of women and girls in fighting this disease. A letter signed by the foreign ministers was sent to UN Secretary General Annan urging more global action to address the AIDS pandemic.

- **Department of the Treasury.** The Department has been out front in providing information on the economic impact of AIDS throughout the US government, to the Congress, and to both donor and developing nations. In addition, the Department has actively pursued four HIV-AIDS related initiatives. First, the Secretary and the President have worked vigorously to secure debt relief for Heavily Indebted Poor Countries (HIPC). The Administration was successful in pushing this initiative at the Cologne G-7/G-8 Summit and in securing \$435 million in fiscal year 2001 for this purpose. These funds will enable poor countries, many in sub-Saharan Africa, to redirect scarce resources from debt service into poverty reduction as well as AIDS prevention and care programs. Second, the Administration called on the World Bank and other multilateral development banks to dedicate an additional \$400 to \$900 million annually of low-interest loans to prevent infectious diseases such as AIDS and to build effective health care delivery systems. As a result, working with the World Bank, the Administration helped to secure a new \$500 million program of concessional loans for AIDS care and prevention programs in sub-Saharan Africa. Third, as part of the President's Millennium Vaccine Initiative, the Department continues to work with the Congress to pass a new \$1 billion tax credit for sales of vaccines for HIV/AIDS, malaria, and tuberculosis to accelerate their development, production, and distribution. And fourth, the Department is working with the Congress and the World Bank on implementation of the newly authorized World Bank AIDS Trust Fund.
- **Peace Corps.** The Peace Corps launched an initiative designed to train all 2,400 Peace Corps volunteers serving in 25 countries in Africa as AIDS educators and basic care providers.
- **USUN.** USUN played a critical role in bringing international attention to the threat posed by HIV/AIDS and in formulating the foundation for future international efforts to fight the epidemic. Specifically, under the leadership of the U.S. ambassador to the UN, the first meeting of the UN Security Council in 2000, chaired by Vice President Gore, focused on HIV/AIDS. In part, as a result of that session, the UN Security Council in July passed a resolution determining that HIV/AIDS posed a threat to international peace and security. The UN Security Council also agreed to incorporate explicit language to protect peacekeepers and the communities in which they serve from HIV/AIDS in all future resolutions on peacekeeping.

Further, USUN succeeded in convincing a number of nations of the importance of high-level leadership, international coordination and shared

goals and commitments to winning the battle against HIV/AIDS. To that end USUN has offered the idea of forming a global coordinating body of Presidential Envoys on AIDS Cooperation (PEACs) from the highest levels of the world's governments. The U.S. appointed its PEAC, Sandra Thurman, in August 2000. The UN General Assembly has also decided to hold a Special Session on HIV/AIDS in New York, July 25-27, 2001 to create a Declaration of Political Commitment to help turn the corner on global resources and political leadership dedicated to fighting the epidemic.

- **Office of National AIDS Policy.** Central to this broad-based US government response has been the coordination needed to maximize both effectiveness and impact. This coordination function has been supplied by the White House through its Office of National AIDS Policy, and in consultation with the National Security Council, the National Economic Council, and the Office of Management and Budget. In addition, the President established an Intergovernmental Working Group (IWG) on Global AIDS co-chaired by the Office of National AIDS Policy and the National Security Council.
- **The LIFE initiative has enabled the United States Government to leverage enhanced leadership and increased resources from other donor nations as well as other sectors in this global mobilization against AIDS.**

As President Clinton said in signing the Global AIDS and Tuberculosis Relief Act of 2000: "The United States cannot and should not battle AIDS alone. This crisis will require the active engagement of all sectors or all societies working together. Every bilateral donor, every multilateral lending agency, the corporate community, the foundation community, the religious community, and every host government of a developing nation must do its part to provide the leadership and resources necessary to turn this tide. It can and it must be done."

With this in mind, the President has challenge our G-8 partners and other donor nations to match the significant new investments in global AIDS secured by the U.S. He has also directed all US government representatives to use every opportunity to raised HIV/AIDS in every diplomatic forum and to push for enhanced coordination and cooperation in this global crisis. In May 2000, President Clinton and EU President Guterres released a bold statement outlining future collaboration between the two in HIV/AIDS, tuberculosis, and malaria in Africa. In July 2000, the President secured agreement from our G-8 partners to increase resources to fight HIV/AIDS and other leading infectious killers. The President also obtained a commitment from our APEC (Asia Pacific Economic Cooperation) partners.

And the Administration's efforts at enlisting new allies were not limited to other donor nations, but also included a number of other private sector partners . In this spirit, the White House hosted a number of individual summits for labor,

foundation, and religious leaders. A complete calendar of activities related to the LIFE initiative follows.

Key Administration Events, 1998-2000

April 1998	President Clinton and the First Lady visit Africa.
December 1998	President Clinton charges the Director of the Office of National AIDS Policy (ONAP) to conduct a fact-finding mission in Africa.
February 1999	ONAP Director, Sandy Thurman, leads Presidential delegation to Africa, visiting Uganda, Zimbabwe, Zambia, and South Africa.
March 1999	The U.S. hosts the first U.S.-Africa Ministerial meeting (Ministers of Trade, Finance and Foreign Affairs). HIV/AIDS is a prominent issue. Secretary of State, Madeline K. Albright, launches a diplomatic initiative, the "U.S. International Response to HIV/AIDS," instructing U.S. ambassadors to raise the profile of global HIV/AIDS and encourage political commitment overseas to combat the disease.
April 1999	ONAP Director Thurman leads Presidential Mission to Uganda, Zambia and South Africa. USAID is instrumental in helping to establish the International Partnership against AIDS in Africa. U.S.-Southern Africa Development Council (SADC) Forum highlighted HIV/AIDS as part of the high-level agenda in this initial multilateral discussion. Under Secretary for Global Affairs, Frank E. Loy, and UNAIDS Director, Dr. Peter Piot, co-hosted a briefing for the foreign diplomatic community on the foreign policy implications of the HIV/AIDS pandemic. U.S. negotiated an HIV/AIDS resolution in the UN Human Rights Commission meetings strengthening international commitments to HIV/AIDS cooperation and to securing

greater respect for human rights for persons living with HIV/AIDS.

- June 1999 President Clinton proposes an initiative to link debt relief with health, education and social needs, with special attention on HIV/AIDS at the Cologne G-8 meeting.
- July 1999 Vice President Gore launches the LIFE Initiative.
- September 1999 First Lady Hillary Rodham Clinton hosts a meeting with key foundations to encourage involvement in support of HIV/AIDS programs.
- October 1999 Secretary of State, Madeline K. Albright, raised HIV/AIDS issues with all heads of state in her meetings during the UN General Assembly.
- Secretary Albright raised HIV/AIDS issues with heads of State during trip to Africa, encouraging a higher priority to HIV/AIDS by national governments.
- Congress approves an additional \$100 million for the fight against HIV/AIDS globally, with an emphasis on Africa.
- November 1999 Secretary of State Albright opened the UN Program to commemorate World AIDS Day at UN Headquarters in New York.
- USUN Ambassador Holbrooke traveled to Africa and discussed HIV/AIDS foreign policy concerns with African leaders in preparation for U.S. chairing the UN Security Council.
- December 1999 Secretary Albright raises HIV/AIDS with all Heads of State during trip to Africa.
- Mrs. Clinton holds a UN Conference on the status of AIDS orphans around the world.
- January 2000 UN Security Council meeting on HIV/AIDS in Africa chaired by Vice President Gore, initiated greater U.S. commitment to international assistance for HIV/AIDS.
- Secretary of Labor Alexis Herman co-hosts with AFL-CIO President John Sweeney the first U.S.-Africa Trade Union Summit on HIV/AIDS Workplace Education and Prevention.

February 2000	The National Security Council forms an interagency working group on HIV/AIDS Ambassador Holbrooke joined interagency briefing of Congressional leaders on HIV/AIDS as a foreign policy issue, focusing on its impact on international peacekeeping efforts.
March 2000	President Clinton visits India and signs Joint Statement on HIV/AIDS with Prime Minister Vajpayee. The Secretary of State raised the issue of enhanced U.S.-EU cooperation on AIDS and other infectious diseases at the U.S.-EU ministerial meeting.
May 2000	President Clinton highlights HIV/AIDS in Africa in major address at the National Summit on Africa. President Clinton and EU President Guterres released a joint statement on collaborating on HIV/AIDS, TB and Malaria at the EU-U.S. Summit.
June 2000	Secretary of the Treasury Summers and ONAP Director Thurman visit Africa. HIV/AIDS as an economic issue is high on the U.S. agenda.
July 2000	U.S. scientists and ONAP Director Thurman attend the International AIDS Conference in Durban. The U.S. helped pass a resolution on HIV/AIDS and its implications for peacekeeping operations, the first UN Security Council resolution on a health issue. G-8 Summit focuses on HIV/AIDS issues as a top priority and mobilizes resources from G-8 partners.
August 2000	President Clinton visits Nigeria and makes HIV/AIDS is a key issue. President Clinton appoints ONAP Director Thurman as the first Presidential Envoy for AIDS Control. Congress passes and President Clinton signs the Global HIV/AIDS and TB Relief Act of 2000.

September 2000	President Clinton addresses HIV/AIDS as a key issue for the millennium at the UN Millennium Summit. At the 55th UN General Assembly in New York, the Secretary of State joined twelve other female foreign ministers in sending a letter to Secretary General Kofi Annan proclaiming their joint resolve to combat the global scourge of HIV/AIDS,.
October 2000	Congress approves large increases in HIV/AIDS funding for USAID and debt relief pursuant to the President's budget request.
November 2000	Mrs. Clinton visits AIDS programs in Vietnam.
December 2000	The White House hosts a Religious Leaders Summit on the occasion of World AIDS Day 2000. President Clinton delivers AIDS address at Howard University. Administration works with Congress advocating strategy for HIV/AIDS funding currently pending in the Labor-HHS appropriations bill.

IV. Challenges for the Future

- Resources.** At this juncture, the good news is that we know what works. What we need now are the resources required to bring these proven programs and strategies to a scale that matches the magnitude of this ever-expanding pandemic. Over the past few years the US government, as the largest global AIDS donor, has secured significant funding increases and has leveraged others to do the same. However, much more remains to be done. The Joint United Nation Program on AIDS (UNAIDS) has said that it will take an investment of at least \$3 billion to put an effective HIV prevention and basic AIDS care program in place in Africa alone. Last year, collective spending was only one tenth that amount, approximately half of which came from the U.S. In addition, \$3 billion is also required to put a similar program in place for the rest of the world, only half of which is currently available. As President Clinton said before the United Nations Security Council at the Millennium Summit in September, "we must join together to help close this gap." In the years ahead we must work with the Congress, the private sector, and the global community to close the gap between rhetoric and real action, and between the resources needed and those currently being invested.
- Leadership.** The U.S. government-wide effort mobilized through the LIFE initiative has played a major role in elevating the global AIDS pandemic high on

the diplomatic radar screen. But it is vital to remember that we are at the beginning and not the end of this pandemic. Together, we must join forces in the battle against AIDS as we would in the face of any other disaster where hundreds of millions of lives hang in the balance. Now, more than ever, continued moral authority and steadfast leadership are desperately needed. There are no simple solutions or quick fixes. Winning the war on AIDS means keeping the U.S. government as an outspoken, out-front, leader in this fight. Not just this year or next, but for the long haul until our work is done.

The pages of history reveal moments in time when the global community came together in the face of seemingly insurmountable odds and changed the world. Time and again we have borne witness to what can be accomplished by those who refuse to give up or give in. Together we must reach for one of those moments again now, or we will surely pay the price later.

BARBARA LEE
9TH DISTRICT, CALIFORNIA



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Congress of the United States
House of Representatives
Washington, D.C. 20515-0509

September 27, 2000

The Honorable Nancy Pelosi
Ranking Member
Appropriations Subcommittee on Foreign Operations
1016 Longworth House Office Building
Washington D.C. 20515

Dear Ranking Member Pelosi:

As you and your colleagues resolve the differences between the House and Senate FY01 Foreign Operations Appropriations Bill, we write to seek your support for \$150 million to fully fund the World Bank AIDS Trust Fund authorized under H.R. 3519. As you are aware, the House and Senate fully supported H.R. 3519, the Global AIDS and Tuberculosis Relief Act and it was signed into law on August 19, 2000 (P.L. 106-264).

The Congress has demonstrated strong leadership to combat this global health crisis by passing this critical legislation; however, funding is needed to demonstrate our full commitment.

The World Bank AIDS Trust Fund would be a landmark public/private partnership that could leverage contributions from the international donor community and the private sector, thereby increasing the initial U.S. contribution to potentially, over \$1 billion a year. These funds would be made available through grants to support HIV/AIDS best practices in the countries hardest hit by HIV/AIDS, particularly in sub-Saharan Africa. Thus, establishment of the trust fund must be a priority.

As you know, the global epidemics of HIV/AIDS and tuberculosis are claiming millions of lives each year. As the death toll increases, these diseases are devastating whole countries, undermining education and health care infrastructures, and wiping out decades of progress on economic development.

We know that infectious diseases like AIDS and tuberculosis do not respect national borders. In order to protect the public health in our own country, we must do more to combat the major diseases confronting developing countries in Africa, Asia, and around the world.

In addition to our request for funding for the World Bank AIDS Trust Fund, we would also like to express our support for the following key areas which are authorized by the legislation:

- \$300 million for the President's international HIV/AIDS initiatives under the LIFE Initiative to support ongoing HIV/AIDS programs in developing countries, including primary HIV prevention and education, HIV care and treatment services, voluntary testing and counseling, and medications to help prevent perinatal transmissions;
- \$60 million for tuberculosis prevention and treatment programs;
- \$50 million for the Global Alliance for Vaccines and Immunizations (GAVI) to coordinate a worldwide effort to protect the three million children who die every year from vaccine-preventable diseases; and

- \$10 million for the International AIDS Vaccine Initiative (IAVI), which encourages public-private partnerships to ensure the development of safe, effective and accessible preventive HIV vaccines for use throughout the world.

In a time of growing federal budget surpluses there is every reason to act decisively to protect global and domestic health by fully funding the Global AIDS and Tuberculosis Relief Act. Additionally, these new investments must be made without eliminating or scaling back funds for ongoing health or development programs. Funds to existing and effective programs that are already helping millions of individuals should not be reduced; we must therefore increase appropriations levels to fund these new initiatives.

Time is running out, of course, and we recognize the difficult challenge the conferees face in completing the work on the FY 2001 Foreign Operations Appropriations bill. It is our hope that with your leadership the World Bank AIDS Trust Fund, along with other important programs are funded.

Sincerely,

Barbara Lee

Joe J. Lieberman

James E. Clyburn

John D. Dingell

Donald Payne

Mark Foley

Jonnie Morella

Ken McConnamara

~~Gregory W. Meeks~~

Nick Lampson

Lynn W. Woolsey

Patrick J. Kennedy

Shered Brown

John D. Dingell

Sam M. Houston

Elijah Cummings

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REP. BARBARA LEE

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Congress of the United States
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WASHINGTON OFFICE
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