

The Global  
Herald

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AIDS Pandemic  
Destabilizes Africa

AIDS Deaths Cut  
Dramatically in Africa

Failure To Fund Response  
Leads to More Deaths

Global Response Now  
Fulfills Promise

# Pay Now or Pay More Later

By PREDIC T. FUTURE

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**An Independent Report on the  
Response to the Global HIV/AIDS Pandemic**

NEW YORK, DEC. 1, 2005 – Experts point to the political instability in Africa, Asia, and the Caribbean to the dramatic increase in the number of AIDS orphans. Last week's declaration of martial law in three southern African nations, following weeks of riots, are new evidence, experts say, of the growing threat of street gangs, composed mainly of teenagers orphaned by AIDS. Local police forces, their numbers depleted dramatically by AIDS, have been unable to control the situation and armed soldiers are now patrolling the streets in several capitals.

The insurgency which last month occupied Nigeria's oil fields, severely disrupting the country's oil exports, relied heavily on teenage soldiers, many of them AIDS orphans. The epidemic is also having a severe impact on peacekeeping, with many African militaries now refusing to provide troops for the peacekeeping missions. Generals have said AIDS has decimated their officer corps and that they will not overextend their forces.

NEW YORK, DEC. 1, 2005 – On the other hand, substantial progress has been made in reducing the impact of the disease in Africa. While AIDS had been expected to reduce economic growth by two-thirds and plunge the continent into instability, the rate of infection as well as overall AIDS deaths have been cut dramatically.

Experts point to the efforts by African leaders at all levels of society to end stigma, respect human rights and end corruption. Youth have become the focal point of anti-AIDS campaigns and their voice as well as that of people living with AIDS has been taken seriously. Just as critical, experts say, was the success since 2001 of the Stop Global AIDS Campaign in pressuring wealthy governments to mobilize \$10 billion annually to combat AIDS in Africa, with comprehensive prevention, care and treatment. The US and other countries decided lift the threat of trade sanctions from countries producing

**Global AIDS Alliance**

the G7 nations in July 2002 managed creditor countries.



WHAT'S GOING ON:  
***Pay Now or Pay More Later***

**An Independent Report on the  
Response to the Global HIV/AIDS Pandemic**

***"Injustice anywhere represents a threat to justice everywhere."***  
-- Martin Luther King Jr.

**A Report of the Global AIDS Alliance**  
Written by Dr. Paul S. Zeitz  
December, 2001

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## Partners of the Global AIDS Alliance

Africa AIDS Initiative  
Africa Alive! YouthAIDS Initiative [Johns Hopkins University Center for Communication Programs, Population Services International, Global Justice, and AAWW]  
Africa Directions-Zambia  
African Services Committee  
AFRICARE  
American Jewish Congress  
American Jewish World Service  
American Public Health Association  
Artists Against AIDS Worldwide (AAAW)  
Black Church Communal Network  
Cameroon Baptist Convention Health Board  
Civil Society Consultative Group on HIV/AIDS in Nigeria  
Church World Service  
Constituency for Africa  
Development Indian Ocean Network (DION)  
Drop-the-Debt Campaign  
Episcopal Church, USA  
Essential Action  
Ghana HIV/AIDS Network  
Global AIDS Action Network  
Global Immunity  
Global Justice  
Global Lawyers and Physicians for Human Rights  
Hope Africa

Hope for African Children Initiative (HACI) [Plan International, Save the Children, CARE, Society for Women and AIDS in Africa, and the World Conference on Religion and Peace]  
Institute for Policy Studies  
INTERACTION  
Jewish Coalition Responding to AIDS in Africa  
Jubilee USA Network  
Jubilee Plus at New Economics Foundation  
King Cole Inc  
Malawi Network of People Living with HIV/AIDS  
Malawi Network of AIDS Organizations  
Malawi-Washington Association  
MIT United Trauma Relief  
NAACP  
National Association of People with AIDS of Malawi  
Pan African Charismatic Evangelical Congress (PACEC)  
Peace Corps Friends of Malawi  
Physicians for Human Rights  
Red Hot Inc.  
Religious Action Center of Reform Judaism  
RESULTS  
Student Global AIDS Campaign  
United Methodist Church, General Board of Church and Society  
Washington Office on Africa

## Executive Summary

This report argues that the persistent underfunding of the global AIDS response is inexcusable. As each minute ticks by, another African child dies from AIDS. Yet right now, across Africa and other heavily impacted regions, there are prevention, care and treatment interventions ready to be implemented which would help prevent these deaths and address the HIV/AIDS crisis. Our knowledge of what works to fight HIV/AIDS is now high – but the available resources to implement programs remain obstructively low.

The price tag may look big. Experts estimate that at least \$10 billion is needed, per year, to fuel a serious attempt by the international community to reduce the spread of HIV and deal with its consequences. But if checks are not written, the price tag will only increase. And the consequences, in financial and non-financial terms may show that \$10 billion a year was a price well worth paying. Independent reports by the National Intelligence Council and the International Crisis Group show that the rampant spread of HIV/AIDS is directly contributing to societal instability and political unrest in countries around the world. In the wake of the September 11<sup>th</sup> terrorist attack and the subsequent global war on terrorism, combating global infectious diseases are an integral part of the long-term strategy to ensure peace and stability in parts of the world that could expand the breeding grounds for potential terrorists.

But, despite the staggering statistics and devastating economic and social impact of global AIDS, just \$1.5 billion was spent on this issue last year. In April 2001, United Nations Secretary General Kofi Annan urged countries around the world to come up with \$7-10 billion per year to the Global AIDS, TB, and Malaria Fund. So far, only \$1.5 billion has been pledged, and over several years. Many of these pledges do not represent supplementary funding to

existing overseas development assistance (ODA). In fact, since the tragic September 11, 2001 terrorist attack on the United States, there are indications that funding for the global AIDS response may be reduced.

Governments cannot any longer offer up the argument that the problem is not money, but knowing what to do with it. After two decades of experience of attempting to cope with HIV in developing countries, it is clear ‘what works’ and new mechanisms have been established at the levels of civil society, government and international institutions. Investments in proven programs have demonstrated our ability to overcome key challenges by enhancing absorptive capacity, building infrastructure, increasing technical and operational capacity, and designing accountability systems to ensure that resources are used effectively.

African governments are demonstrating more effective commitment to fighting AIDS, and this year committed to spend 15 per cent of GNP on health. However, this requires a health budget increase of at least 50 per cent for most African countries, which most simply cannot afford. Uganda, Senegal, and Thailand have implemented national AIDS control programs that have decreased HIV transmission or kept HIV prevalence down. Botswana, Malawi, Ghana, Uganda, Nigeria and other countries are implementing national plans to expand access to lifesaving antiretroviral agents. Civil society initiatives, such as the Hope for African Children Initiative, and Africa Alive! Youth AIDS Initiative are working at community level to educate young people and provide care for orphans. The recent Global Fund to Fight AIDS, Malaria, and TB, and the HIPC debt relief Initiative are multilateral mechanisms that can be used to disburse and integrate resources. However, such efforts cannot develop and expand without dramatically increased funding.

Since the first HIV case 20 years ago, over 60 million persons have been infected, and over 20 million have already died from AIDS. The spread continues, particularly in poorer countries. In Africa, there are an estimated 11,000 new infections per day, and during 2001 approximately 2.3 million Africans will die from HIV/AIDS. Currently, there are approximately 14 million children orphaned by HIV/AIDS, with a projection of 40 million children by 2010 if no action is taken. With each minute that passes, another African child dies of AIDS. The persistent lack of financial investment

necessary to stop global AIDS forces all of us to ask the question of “What’s Going On?” This report shows that we are now at a crossroads. The path we choose to take will have decisive implications: not just for people who live with HIV and die from AIDS and their families and communities; or the countries with the highest prevalence rates where stripped of human capital and the rate of economic growth could be severely reduced leading to social and political unrest; but for future generations around the world.

## Glossary of Acronyms

AAIYA	Africa Alive! YouthAIDS Initiative
ADF	Africa Development Forum
AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral Drugs
COPE	Community-based Options for Protection and Empowerment
ECR	Expanded and Comprehensive Response
HAART	Highly Active Antiretroviral Therapy
HACI	Hope for African Children Initiative
HIPC	Heavily Indebted Poor Country Initiative
HIV	Human Immunodeficiency Virus
IDA	International Development Association
IMF	International Monetary Fund
JHU/CCP	Johns Hopkins University/Center for Communication Programs
NGO	Nongovernmental Organization
ODA	Overseas Development Assistance
OVC	Orphans and Other Vulnerable Children
PLWHA	People Living With HIV/AIDS
PSI	Population Services International
SGAC	Stop Global AIDS Campaign
TB	Tuberculosis
UN	United Nations
UNAIDS	UN Joint Special Program Against HIV/AIDS
USAID	United States Agency for International Development
USD	United States Dollar
WB	World Bank
WHO	World Health Organization
WTO	World Trade Organization

### ***Stop Global AIDS Campaign***

The Stop Global AIDS Campaign has three inter-related parts:

**DONATE THE DOLLARS**—resource mobilization for action that saves lives;

**TREAT THE PEOPLE**—access to lifesaving medications at best world prices;

**DROP THE DEBT**—debt cancellation for countries heavily impacted by the HIV/AIDS pandemic.

## I. Introduction

The global HIV/AIDS pandemic is the worst infectious disease crisis to confront the world since the bubonic plague halved the population of Europe in the five years after its arrival in 1347. To date, over 20 million

HIV/AIDS is increasing dramatically in the Asia and Pacific Region. India leads Asia in absolute numbers of individuals living with HIV/AIDS, estimated between three and five million. China, while not as affected by

**Table 1: AIDS Epidemic Update, Global and Sub Saharan Africa - December 2001**

	Global	Sub-Saharan Africa
Total Number of AIDS Cases Since Onset of Pandemic	60 million	47.4 million
People Living with HIV/AIDS	40 million	28.1 million
New Infections in 2001	5 million	3.4 million
Deaths due to HIV/AIDS in 2001	3 million	2.3 million
Cumulative Deaths due to HIV/AIDS as of 2000	21.8 million	17 million

[http://www.unaids.org/epidemic\\_update/report\\_dec01/index.html](http://www.unaids.org/epidemic_update/report_dec01/index.html)

[http://www.unaids.org/wac/2000/wad00/files/WAD\\_epidemic\\_report.PDF](http://www.unaids.org/wac/2000/wad00/files/WAD_epidemic_report.PDF)

people have died of AIDS worldwide. Another 40 million live with HIV/AIDS today. The situation in Africa is particularly alarming. In 1998, an estimated 200,000 Africans died from war, while 2.2 million Africans died from AIDS. Approximately 5 million adults and children in the year 2000 were newly infected with HIV. Each day in Africa there are an estimated 5,500 AIDS deaths and 11,000 new HIV infections.

The massive loss of human life resulting from AIDS will continue to change social, economic and political structures in African countries in ways that have not yet been imagined. This loss will forever change relationships at family, community and political levels. One measure of the massive social change still to come is the growing number of orphans, children affected by HIV/AIDS and other children made vulnerable by the pandemic. In 2010, 20 percent to 30 percent of all children under 15 will be orphaned in 11 Sub-Saharan African countries, even if all new infections are prevented and some form of treatment is provided to slow the onset of AIDS in those living with HIV.

HIV/AIDS as countries further south, has a growing problem, with seroprevalence rates (now estimated at 0.1-0.4 million) increasing rapidly. The number of people with HIV/AIDS in this region may grow larger than those in Sub-Saharan Africa in absolute numbers before 2010.

HIV also is spreading rapidly in Latin America. Prevalence is high in Brazil and in the Caribbean countries, with the exception of Cuba. Deteriorating health care infrastructures are causing a dramatic rise in HIV in Russia, the Newly Independent States (NIS) and, to a lesser extent, in Eastern Europe (as a result of economic difficulties). After a slow and late start, HIV is spreading rapidly throughout the European part of the NIS beyond the original cohort of intravenous drug users. An estimated 270,000 people were HIV-positive in 1998, representing a more than five-fold increase from 1997. Although Ukraine has been hardest hit, Russia, Belarus and Moldova have registered major increases. Russian Health Ministry officials predict that the HIV-positive population in Russia alone could reach two million by 2002.

Recognizing the magnitude of this global crisis, leaders from civil society, governments and multinational agencies declare HIV/AIDS the single most critical security and development issue facing the world today. Developing, financing and implementing programs to slow the spread of the HIV and reduce the impact of HIV/AIDS are now among the highest priorities of many key stakeholders.

There is a global consensus that the major impediment for action is the huge financial gap in resources being made available compared to the resources required to stop global AIDS. Experts estimate that approximately \$10 billion per year is required to provide a minimal package of prevention, care, treatment, and orphans response interventions to stop global AIDS. During 2001, only \$ 1.5 billion dollars of grants or local resources in poor countries was spent from all sources to combat global AIDS. Of these resources, an estimated \$400 million was spent in sub-Saharan Africa.

Despite nearly 3 years of advocacy, international meetings, declarations, and Initiatives (Table 1) there are still no major new commitments of resources to mount and sustain a serious effort to stop global AIDS.

In June 2001, at the UN General Assembly Special Session on HIV/AIDS, governments from around the world committed themselves to specific objectives and timeframes in the Declaration for Action. Unfortunately, there was no international commitment to provide the resources necessary to fight global AIDS.

Governments in the developing world are unable to fund this fight from their own limited budgets. In sub-Saharan Africa, despite the IMF and World Bank's Enhanced Heavily Indebted Poor Country Initiative (HIPC), African governments are still paying over \$13 billion per year in hard currency debt servicing payments to the IMF, the World Bank, and other rich governments. The majority of countries to benefit from HIPC debt relief are still paying more in debt servicing payments than they pay for health care, education, and/or HIV/AIDS response combined.

The repercussions of the September 11, 2001 terrorist attacks in the United States of America include a global economic downturn, which is reducing economic growth in African countries, thus undermining their ability to implement their National HIV/AIDS Strategic Plans. In the wake of the September 11, 2001 terrorist attacks in the United States of America, overseas development assistance (ODA) from rich governments that may have gone to Africa for HIV/AIDS is at serious risk of being diverted to support the global war on terrorism and the humanitarian assistance to Afghanistan and Pakistan. In the wake of the September 11, 2001 terrorist attacks in the United States of America, the United States of America and the Government of Canada took action to protect their citizens from bioterrorism by invoking a threat to buy generic drugs. These threats dramatically reduced the price of the branded products. African governments are attempting to ensure this same right to protect the millions of lives of our citizens that are being decimated by the HIV/AIDS pandemic.

**Table 2: Chronology of International Dialogue and Initiatives to Stop Global AIDS**

<b>Date</b>	<b>Event</b>
July 1999	G8 Endorses Expansion of Debt Relief for Poor Countries
Sept 1999	Enhanced Heavily Indebted Poor Country Initiative announced
Jan 2000	UN Security Council declares HIV/AIDS as a threat to global security
July 2000	G8 Announces Infectious Disease Initiative
Dec 2000	African Leaders call for action at African Development Forum (ADF)
April 2001	UN Secretary General Annan Calls for \$7-10 billion per year to Stop Global AIDS; African Leaders commit 15% of GNP for health care and call for global action at Abuja Summit
May 2001	President George W. Bush announces \$ 200 Million for the Global AIDS, TB, and Malaria Fund
June 2001	Global Leaders sign Declaration of Action at UN General Assembly Special Session on HIV/AIDS
July 2001	G8 Endorses New Africa Initiative/ New Partnership for Africa Development

## II. Action Equals Life

***What's Going On  
Tell me  
People Crying; people crying  
Mother, mother  
There's too many of you crying  
Oh, brother, brother, brother  
There's far too many of you dying  
That's right  
You know we've got to find a way  
To bring some loving here today***  
Marvin Gaye, 1971

[www.aaaw.org](http://www.aaaw.org)

The need to implement an expanded and comprehensive response (ECR) to the HIV/AIDS pandemic is urgent. Leaders of nations and other stakeholders now recognize this pressing need and are calling for expanded programs for both communities and individuals. A special focus is on the profound numbers of HIV/AIDS orphans and vulnerable children (OVC). Many countries have begun scaling-up to expand delivery of interventions and programs to more individuals. It is critical to ensure high quality, improve accountability systems and increase the range of interventions and programs that are delivered to populations not currently served.

Partners are joining together to launch the Stop Global AIDS Campaign, which is based on the premise that money raised now to fight AIDS can be effectively used right now to save millions of lives. During the 1980s and 1990s, we identified some appropriate responses, but neither the rate of transmission nor the impact of the pandemic has sufficiently been reduced. Experience has provided lessons and tools that can be expanded to increase the geographic coverage and number of individuals served by a program and on increasing coverage to different population types, improving the quality and scope of

the services offered, and improving accountability systems. The five expected results of the Stop Global AIDS Campaign:

- Reduction in HIV transmission
- Reduction in AIDS morbidity and mortality
- Improved quality of life for people living with HIV/AIDS
- Lessening of the impact of the epidemic in affected locations and populations
- Increased responsiveness of the health and education sectors to deliver programs to vulnerable populations, including children orphaned by AIDS

Investments in proven programs have demonstrated our ability to overcome key challenges by enhancing absorptive capacity, building infrastructure, increasing technical and operational capacity, and designing accountability systems to ensure that resources are used effectively. It is only through the expanded and comprehensive delivery of proven interventions that the global battle against HIV/AIDS can be won. This battle requires the full support and investment of nations and the international community in building and refining the necessary systems and infrastructure.

## A. Civil Society Initiatives

Innovative civil society mechanisms that will channel resources to civil society partners and governments to rapidly deliver

resources for the implementation of HIV/AIDS programs are operational and require urgent funding:

- **The Hope for African Children Initiative (HACI)**



### **What is it really like to be a child orphaned by AIDS in Africa?**

Christopher is a 13-year-old boy who lives a few miles from the village of Kassana, one hour from Kampala, the capital of Uganda. After losing his mother to AIDS this past December, Christopher is one of the estimated 1.7 million children orphaned by the epidemic in this country. His father was the first adult in his family to succumb to AIDS. Unlike most other orphans, who often end up in the care of a relative within their extended families, Christopher runs his own household. His name has been added to the statistics that quantify what are now known as "child-headed households". These homes are managed by children who are basically left to themselves, despite the occasional help from village members or from an international development organization. Emotionally scarred and frightened, these children cope with grief while facing a very uncertain future with a number of dependents.

Christopher's brother, Kinthu Habatt, is nine years old. Their three sisters are currently in the care of other relatives. "In our culture it is common practice for the extended family to take care of the children who have lost their parents", explains Dorothy, a program officer with the National Community of Women living with HIV/AIDS (NACWOLA). "Siblings are often separated because no single family can take on the whole lot of orphans. We, however, try to encourage the family unit to stay together, but resources are scarce". Things worsen when orphans themselves develop HIV symptoms. Without drugs that prevent mother to child transmission of the virus, the chances of contracting it at birth are about 30%. Although Christopher himself appears to be healthy, his younger sister has been getting sick more and more frequently. None of the children has yet gone for voluntary HIV testing. Program staff says they are too young to face a potentially devastating result. Moreover, if the HIV status is confirmed, the foster family may be even less inclined to look after a sick child whose days are numbered.

<http://www.hopeforafricanchildren.org/christopher.htm>

The Hope for African Children Initiative (HACI) is a community-based, pan-African effort established by five leading global humanitarian organizations to specifically address the challenges faced by children orphaned by the AIDS pandemic in Africa, and the millions more whose parents are sick or dying from opportunistic infections caused by the HIV virus. CARE International, PLAN International, Religions for Peace, Save the Children Alliance, and the Society for Women and AIDS in Africa are working together to increase the capacity of local communities to provide care, services and assistance to African children affected by HIV/AIDS and their families. Partners in the initiative represent a diverse group of members, composed of secular and faith-based organizations.

The Hope for African Children Initiative is based on three fundamental principles: it is child-focused, community-focused and committed to ensure program integration. Since HIV/AIDS related problems cannot be adequately addressed by any single intervention, multiple interventions are needed to respond to the broad range of needs of children, their families and communities. The initiative focuses on a holistic approach by addressing the entire child-focused prevention-care-mitigation cycle with mutually reinforcing program strategies.

Through the initiative these five organizations have extended the scope of their combined efforts on AIDS far beyond what anyone of them could achieve individually. Collectively, these are among the world's largest service delivery organizations implementing programs in every African country for the past sixty years. These organizations have the capacity to receive and manage funds from bi-lateral and multi-lateral donors, as well as private and public funders. Collectively, the Hope for African Children partners already manage a \$1.5 billion budget and implement programs in five different continents. As other partners join the

initiative, the capacity to use resources to implement programs will increase exponentially.

These organizations already have established financial mechanisms and field structures in place to enable them to receive funds and to rapidly disburse them to international NGOs, local NGOs, religious groups and community based organizations running successful programs on the ground. Financial monitoring mechanisms are rigorous, as partner organizations are used to being accountable to public and private donors in their respective countries. Moreover, the Hope for African Children Initiative has adopted an operational target whereby 80% of all funding will be spent to support community programs, 10% will be used for regional advocacy and only 10% will go to cover administrative and overhead costs. The design of this program was made possible by a \$ 1 million planning grant from the Bill and Melinda Gates Foundation.

The management structure of partner organizations is designed to offer maximum donor flexibility, while ensuring a programmatic approach. Partner organizations have agreed to set up a joint international secretariat in Africa to promote a common development framework, while country offices are responsible for tailoring programs to their own needs and managing them accordingly. HACI organizations have advocacy and fundraising offices in over 20 donor countries—a feature that allows public and private funders to choose where and how to allocate resources—as well as offices in countries where programs are implemented. At the country level offices are in the capital city, as well as in regions and districts. Together, partner organizations have the operational infrastructure and the network necessary to effectively reach even the remotest rural areas.

As a member of the Orphans and Vulnerable Children Donor Group with UNICEF, USAID and the World Bank, The

Hope for African Children Initiative has a built-in consultative process with governments and public and private donors. The initiative aims to bridge the gap between donors and communities by

ensuring that program strategies respond to the development objectives of African governments as well as to the guidelines set by the international community.

### **Hope For African Children Initiative in Malawi: Community-based Options for Protection and Empowerment (COPE)**

Malawi is an extremely poor, densely populated country in southeastern Africa. It has a population of approximately 10 million. HIV/AIDS is a significant impediment to Malawi's economic and social development. The country is in an advanced stage of an HIV/AIDS epidemic, the effects of which is already severe and can be expected to become worse. An estimated 14 percent of the adult (15–49 years of age) population is HIV positive. The problems emerging in Malawi among children and families affected by HIV/AIDS are similar to those seen elsewhere in sub-Saharan Africa.

COPE was launched in July 1995 in Malawi's Mangochi District, initially, in nine villages around the Mangochi town area; COPE implemented a broad range of interventions aimed at mitigating the impacts of HIV/AIDS on children and families. These interventions included structured recreation activities, a microfinance program, support for wetlands gardens, outreach visits to identify children in need of health services, home-based care training, HIV prevention activities through drama groups, apprenticeships for adolescents, and anti-AIDS clubs for youth.

When COPE began its process of systematically working to mobilize and strengthen community responses to orphans and vulnerable children and to HIV/AIDS generally, it began to breathe life into the nationally mandated AIDS committee structure. The community mobilization process has produced AIDS committees that have taken responsibility for identifying their needs, that are committed to finding solutions, and that are taking the initiative to mobilize resources—starting with their own and gradually widening the circle of resources to include those external to their community. A key factor in the process is that communities “own” these activities. The communities recognize that they are taking action that is in their own interests, and they can make a direct correlation between, first, taking action in their own interests; then allocating their resources in their community; and, finally, making small steps of progress. Seeing that small progress gives people the courage and confidence in their abilities to try bigger and better things.

With increased funding COPE could expand and strengthen community action. COPE should intensify efforts to improve and integrate activities in home-based care, prevention, and economic strengthening with a view toward anticipating impacts of HIV/AIDS. Resources should be provided only where communities have taken responsibility for problem solving and have invested their own resources.

<http://www.hopeforafricanchildren.org>

Source: USAID Review of the COPE Program, 2001.

- **Africa Alive! YouthAIDS Initiative (AA!YA)**

**We Speak About It**

by Philip Ochieng Odhiambo, age: 22 years : Kenya

We speak about it,  
We hear about,  
It kills our loved ones,  
Africa let's rise against AIDS.

It came like a tornado,  
Sweeping across its path of destruction,  
With its mighty lethal power,  
Africa let's rise against AIDS.

It has no choice,  
For the young and the old,  
The rich and the poor alike,  
Africa let's rise against AIDS.

Brother! Sister!  
AIDS is real,  
AIDS is not any myth,  
It's here with us,  
Africa let's rise against AIDS.

Abstinence, faithfulness and use of  
Condoms are the key to  
Curb the spread of AIDS;  
Africa let's rise against AIDS.

<http://www.africaalive.org/poems/poems01.htm>

**Africa Alive! YouthAIDS Initiative** is a cooperative effort between The Johns Hopkins University Center for Communication Programs (JHU/CCP), Population Services International (PSI), Artists Against AIDS Worldwide and Global Justice. **Africa Alive! YouthAIDS Initiative** brings together the resources of key partners:

**Africa Alive!** is supported by JHU/CCP, a pioneer in the field of health communication with more than 20 years experience in developing and managing over 300 country-based projects and contracts;

Population Service International's programs in over 50 countries, **YouthAIDS** is an

initiative dedicated to protecting the world's youth from HIV/AIDS by providing at-risk youth with the information, skills, and HIV/AIDS prevention products and services they need to practice healthier behaviors.

The Student Global AIDS Campaign seeks to mobilize a student and youth movement in the US, in partnership with youth in Africa, to advocate for increased government, private sector, and civil society leadership in the fight against AIDS. The campaign advocates for vastly increased spending toward fighting AIDS with a comprehensive program (with at least \$10 billion in contributions to the Global Health Fund; total bilateral and multilateral debt cancellation in order to free up desperately

needed resources for AIDS and the social sector; and guaranteed access to treatment and care, including ARV's;

Artists Against AIDS Worldwide ([www.aaaw.org](http://www.aaaw.org)) is an entertainment and artist-led non-profit organization dedicated to raising the awareness and money needed to bring direct care to those affected by AIDS, especially in Africa. AAW is dedicated to raising money from the general

public, governments, and corporations and through debt relief to stop the humanitarian crisis of AIDS. AAW aims to campaign against the causes of AIDS especially extreme poverty.

***Africa Alive! YouthAIDS Initiative*** hopes that by combining efforts and resources, they will extend the reach of both initiatives and help stop the spread of HIV/AIDS among the world's youth.



## **Illustrative Country Program: Nigeria**

This section gives a brief outline of how the Africa Alive! YouthAIDS Initiative will expand programs in Nigeria with increased funding. JHU and PSI both work in Nigeria where many innovative and dedicated youth organizations and initiatives are making a difference. Africa Alive! YouthAIDS would focus on supporting and strengthening existing successful interventions rather than starting new initiatives from scratch.

### **Mass Media/Entertainment Education**

Current mass media youth campaigns center on the theme of "Knowledge is Power." JHU/PSI would expand the reach of radio and TV ads, and as they do in South Africa, would make mention of the newly established youth hotline in all mass media communications. AA!YA would expand the current Gold Circle traveling youth rallies already reaching youth in both rural and urban areas. The initiative would link its messages into the many youth radio shows, like the "Listen Up!" program in northern Nigeria and the many shows on commercial FM in major urban centers.

### **Peer Education**

The project will work to expand the extensive peer educator networks in Nigeria. PSI, for example, is affiliated with Planned Parenthood of Nigeria (PPFN), using mobile peer educators to visit nightclubs. Youth organizations like Community Life Project in Lagos and Action Health International have a strong presence in inner city communities, reaching typically disenfranchised out-of-school youth.

### **Youth newspapers**

Building on the *Trendsetters* model, JHU/PSI will work with young journalists to start local youth-oriented lifestyle newspapers. These will incorporate relevant, accurate information about sexual health, HIV/AIDS and relationships, combined with upbeat lifestyle reporting on local and international music, arts, movies, advice columns, etc. They will also work with the private sector to identify potential sponsors and advertisers and to establish effective distribution systems. Franchised food outlets, for example, could have distribution boxes for the papers at the entrances.

### **Youth advocacy and organizational development (GJ/YAA) re: Nigeria**

With a prevalence rate estimated at 5.4% in 1999, Nigeria faces an explosive spread of the HIV epidemic with devastating repercussions on youth. Global Justice will strengthen its partnerships with Nigerian youth organizations in order to facilitate youth-to-youth dialogue and support youth mobilization efforts in Nigeria. Youth in Nigeria can build upon the leadership President Obasanjo and the Nigerian Government. During the Abuja Summit, African leaders agreed to increase health budget spending to 15% of overall expenditures. The youth of Nigeria can lobby that the Nigerian government meets these promised targets. Nigerian youth can also support global campaigns for complete bilateral and multilateral debt cancellation as well as vastly increased foreign assistance.

Source: Africa Alive! YouthAIDS Initiative Concept Paper, October 2001  
<http://www.africaalive.org/youthaids.htm>

## B. Treat the People

### **Medecins Sans Frontiers's Khayelitsha Township Project in South Africa**

MSF's project in South Africa is bringing hope to a dire situation. MSF works in just one of Cape Town's townships, Khayelitsha (pop. 500,000), where they support a government-run mother-to-child transmission prevention program and have set up clinics that provide care to people with HIV/AIDS. MSF recently introduced antiretroviral therapy that, in wealthy nations, has turned AIDS from a death sentence to a chronic disease. The vision of this project is improving and extending the lives of our patients, we seek to demonstrate that it is possible to provide treatment in a resource-poor setting, and in the process, develop a model that is replicable in similar settings around the world.

MSF developed a comprehensive program to address all aspects of the use of antiretroviral therapy. Most importantly, they ensure that they have the support of all local stakeholders: provincial health authorities, medical staff at our clinics, the NGOs with whom we work, and most importantly, our patients, most of whom knew little about antiretrovirals before the project began.

Antiretroviral therapy alone will not turn around the HIV/AIDS epidemic in Khayelitsha. Community involvement will. In a culture in which HIV infection is still stigmatized, demonstrating that HIV can be a chronic condition, not a rapid death sentence, can lead to a change in attitude, perception, and behavior, as antiretroviral therapy has already done in countries with widespread access to medicine.

In a country where there has been little incentive to get tested for HIV, we believe the availability of treatment will encourage people to learn their status. As an HIV-positive Khayelitsha woman said when the program was launched, "I believe that the availability of treatment will help people come out and seek help at the clinics. I think that it will encourage people to go for HIV testing simply because now there is help available."

Excerpted from an article written by an MSF field volunteer in South Africa  
<http://www.doctorswithoutborders.org/publications/alert/2001/summer/letter2.html>

The World Health Organization global standard for the use of antiretroviral medications, known as the "triple drug cocktail," indicates that approximately 5 million of the 27 million Africans with HIV infection are eligible for treatment. Despite the known and scientifically proven benefits of antiretroviral agents, only an estimated 5,000 Africans, or 1% of the total number of treatable Africans, currently have access to life-extending antiretroviral medications.

Antiretroviral medications reduce the amount of HIV that an infected person has in their body. This benefit dramatically reduces HIV transmission through sexual transmission and from mother-to-child, while simultaneously extending the life of economically productive parents. By offering antiretroviral agents to HIV-infected people in resource poor settings, prevention interventions are more likely to succeed. People will have a strong incentive to seeking voluntary counselling and testing

(VCT). Access to treatment will greatly accelerate the destigmatization of AIDS as a death sentence, as HIV-infection will be rapidly be transformed into a manageable chronic disease.

Another compelling rationale for rapidly expanding access to antiretroviral agents is to implement orphans prevention. By treating parents with these drugs, we can effectively keep mothers and fathers alive.

International experts from around the World have testified and believe that existing infrastructure through private sector clinics, employer-based programs, faith-based organizations, DOTS programs, community-based programs, and other settings can be used to effectively and safely deliver antiretroviral agents now. We also know that the production of high quality and effective generically-manufactured drugs puts a downward pressure on costs and

allows for the coformulation of multiple drugs in ways that optimize their use in resource poor settings. Both patented and generically manufactured drugs must be utilized to increase access at the lowest possible cost, in ways that are consistent with international trade agreements.

While the Harvard Consensus Statement on the following page describes one tool for providing antiretroviral treatment to HIV infected persons in poorer countries, Directly Observed Therapy (DOT) model is not the only method to provide medication for people with HIV infection, in resource rich or resource poor settings. Research indicates that income is not a predictor of adherence to medication. Efforts to provide treatment for people with HIV infection in resource poor settings should not be predicated on participation in DOT programs.

## **HIV Treatment Feasible in Low-Income Countries (Excerpt from the Harvard Consensus Statement on AIDS, April 2001)**

In the low income countries, the overwhelming proportion of HIV-infected persons have no access to HAART. In sub-Saharan Africa, for example, this lack of treatment access has translated into rapidly escalating death rates. The lack of feasibility studies in poorer countries has impeded the widespread dissemination of HAART to many of the places where it is needed most. One of the key arguments against AIDS treatment in low-income countries is the belief that patients will fail to take antiretroviral drugs consistently and therefore, not only will become resistant to these drugs but also transmit resistant virus.

One of the key arguments against AIDS treatment in low-income countries is the belief that patients will fail to take antiretroviral drugs consistently and therefore, not only will become resistant to these drugs but also transmit resistant virus. To ensure that patients take antiretroviral drugs regularly, the Harvard-Haiti protocol dispenses drugs using the principles of directly observed therapy (DOT), which have been demonstrated to be effective in treating tuberculosis and reducing the emergence of drug resistant strains. Each HIV-infected patient is assigned an *accompagnateur*, (a “companion”, most often a community health worker) who observes ingestion of the HAART medications daily and offers support to the patient and family. Directly observed therapy of HAART (or DOT-HAART) ensures that the HIV-infected patient is taking medications regularly, and this promotes the best clinical outcome for the patient and minimizes the opportunities for drug resistance to develop. Dozens of patients have been enrolled in the Harvard-Haiti project, and all have had a positive clinical response, characterized by weight gain and the abatement of AIDS-related symptoms, and the medications have been well tolerated.

The DOT model for delivery of HAART is particularly compelling for several reasons. First, a widespread, successful global infrastructure has already been established for DOT-based tuberculosis treatment programs, through which HAART might be effectively delivered. Second, substantial overlap exists between those infected with tuberculosis and AIDS, since tuberculosis is the major opportunistic infection of HIV disease in poor country settings. Third, DOT is cost-effective (i.e., an efficient use of limited resources) in poor, low-wage settings, as it is labor- rather than resource-intensive and requires only community workers with little training. Fourth, the tight control of drug dispensing in DOT blocks the development of a black market in antiretroviral drugs. This matter, in particular, is of considerable importance to those seeking efficacious AIDS treatment as well as to pharmaceutical companies, who need protection from a black market when providing drugs at deeply discounted prices.

HAART delivery in poor settings has not been limited to Haiti. Both Senegal and Côte d'Ivoire have seen successful distribution of HAART. In Senegal, 86 patients have been treated in a pilot program for over two years. These studies show that persons in poor countries are able to adhere to medications and that AIDS treatment can be successfully delivered. Based on clinical trial data from developed countries, there is ample reason to expect that AIDS treatment in these settings will result in similarly significant gains in extending life and health.

[http://www.hsph.harvard.edu/organizations/hai/overview/news\\_events/events/consensus\\_aids\\_therapy.pdf](http://www.hsph.harvard.edu/organizations/hai/overview/news_events/events/consensus_aids_therapy.pdf)

## B. Multilateral Initiatives

In addition to these civil society mechanisms, there are global multipartner efforts underway that can rapidly channel

resources to programs that can immediately achieve results:

- **Global AIDS, TB, and Malaria Fund**

The purpose of the Fund is to attract, manage and disburse additional resources through a new public-private partnership that will make a sustainable and significant contribution to the reduction of infections, illness and death, thereby mitigating the impact caused by HIV/AIDS, tuberculosis and malaria in countries in need, and contributing to poverty reduction as part of the Millennium Development goals.

The Fund will balance its resources by giving due priority to areas with the

public-private formulation and implementation processes, in support of technically sound and cost-effective interventions, for the prevention, treatment, care and support of the infected and directly affected. Initiatives such as the Hope for African Children Initiative, the Africa Alive! YouthAIDS Initiative, and the Treat-the-People programs should be top priorities for funding by the Global Fund.

The Fund will provide resources for the purchase of appropriate commodities to prevent and treat the three diseases,

### **Criteria for Global AIDS, TB, and Malaria Fund Investments**

In making its funding decisions, the Fund will support proposals which:

**Focus on best practices** by funding interventions that work and can be scaled up to reach people affected by HIV/AIDS, tuberculosis, and malaria.

**Strengthen and reflect high-level, sustained political involvement** and commitment in making allocations of its resources.

**Support the substantial scaling up and increased coverage of proven and effective interventions**, which strengthen systems for working: within the health sector; across government departments; and with communities.

Source: Global Fund website: [www.globalfundatm.org](http://www.globalfundatm.org)

greatest burden of disease, while strengthening efforts in areas with growing epidemics. The Fund will support strategies that focus on clear and measurable results. The Fund will focus its resources on increasing coverage of critical and cost-effective interventions against the three diseases.

The Fund will provide grants to public, private, and nongovernmental programs, respecting country-level

and provide associated support for strengthening comprehensive commodity management systems at country level, as a component of technically sound and reviewed programs.

The Fund will seek to **establish a simplified, rapid, innovative process** with efficient and effective disbursement mechanisms, minimizing transaction costs and operating in a transparent and

accountable manner based on clearly defined responsibilities. The Fund should make use of existing international mechanisms and health plans.

A well-managed fund of significant size can have a multiplier effect in many ways: by helping to create the conditions at country level that will enable other donors to

increase their level of spending on health and development; by giving political prominence to the importance of achieving better outcomes in HIV/AIDS, malaria and tuberculosis; and by demonstrating to donors and national governments the benefits to be achieved by linking funding to better results.

- **Debt Cancellation for HIV/AIDS Programs**

***External debt continues to constrain human development and realisation of human rights. African leaders should work together to advocate for debt cancellation in order to expand resources to invest in social services and HIV prevention and care. The debt burden of African nations is unsustainable. Debt service obligations displace spending on poverty reduction including HIV/AIDS and the response to orphans.***

-- Right Honourable Justin Malewezi, Vice President of the Republic of Malawi  
Delivered at the African Development Forum,  
Addis Ababa, Monday 4th December, 2000

A key factor that makes it more difficult for impoverished governments to invest in HIV/AIDS programs is the external debt burden. African countries currently carry a combined external debt of \$227 billion. Annual debt service obligations on the principal and interest due amounts to \$14.5 billion per year, equal to 5% of region's GDP and 15 percent of export earnings. Sub-Saharan African countries are thus required to allocate scarce foreign exchange to debt servicing, limiting their ability to implement effective national responses to the HIV/AIDS crisis and to other social sector priorities.

The Heavily Indebted Poor Country Initiative (HIPC) was first launched in 1996. It was the first multilateral approach to reduce the external debt of the world's poorest, most heavily indebted countries. The principal objective of the Debt Initiative for the heavily indebted poor countries (HIPC) is to bring a country's debt burden to what lending agencies consider sustainable levels. Participation in the program is dependent

upon lenders' satisfaction with participating countries' policy performance.

Among the many legitimate claimants on the new funds potentially freed up by HIPC debt relief, HIV/AIDS and OVC response programs should be prioritized because scaling-up the delivery of available HIV/AIDS interventions can yield tangible and measurable results within a limited timeframe. Unfortunately, many countries which have large debt burdens (multilateral and bilateral), as well as a significant HIV burden or risk, are not currently eligible or participating for debt relief under the Enhanced HIPC Initiative.

Creditor countries have finally accepted that a debt crisis exists in the poorest countries, and have taken beginning steps to reduce the debts in 18 countries in Africa. However, the benefits of the current creditor's plan are limited – these countries get just a one third cut in their annual debt service payments. Of the 24 countries that have received debt relief so far, in 15 the annual debt servicing payments will still be

higher than what the country is currently able to spend on basic health care. In total, debt service costs for the poorest nations will reach \$2 billion a year through 2005, in spite of the Heavily Indebted Poor Country Initiative (HIPC) debt relief program, if no further action is taken.

As shown in a recent report by Jubilee Plus (<http://www.jubileeplus.org>), the debt reduction targets used in the HIPC Initiative rely on overly optimistic projections of economic growth and fail to take into account the impact of falling export commodity prices. Also, because of fears of the cost to creditors of deeper debt reduction, the definition of what levels of debt are "sustainable" is kept high. Jubilee Plus shows that only 3 countries, Uganda, Mozambique, and Benin will have sustainable debts in the near future, using a definition of "sustainable debt" that reflects the budgetary impact of debt payments.

Even according to the criteria of debt sustainability used in the HIPC Initiative, at least 7 HIPC countries whose payment levels have been reduced will still have unsustainable debt levels. Malawi, for instance, where 15.9% of adults are infected with HIV, will not have sustainable debt levels according to HIPC criteria until 2014.

Nigeria is another country where the case for debt cancellation should be strong. At the end of 1999, over 2 million Nigerians were infected with HIV (end of 1999 figures), 5% of the adult population. As shown by Jubilee Plus, Nigeria pays US\$1.7 billion in debt service every year to rich western creditors, eleven times the annual health budget. Yet, despite the country's strategic importance, creditor intransigence has left it outside the HIPC program, and prospects for serious debt reduction are slim.

In the context of the HIV/AIDS emergency throughout Sub-Saharan Africa, the poorest

region of the world, the case for more debt cancellation to help fund an expanded and comprehensive response to the HIV/AIDS crisis is clear. Immediate multilateral debt cancellation to countries enrolled in the HIPC program could provide over half a billion per year for the HIV/AIDS fight, without costing the American taxpayer anything, and without negatively affecting the credit rating of these institutions. Already, some of the funds released by debt cancellation are being used to fight HIV/AIDS – for example in proven programs in Uganda, Tanzania and Cameroon. We need to build upon these successes.

A process that could free up more resources to fight AIDS and poverty, and benefit a broader range of countries, is an international bankruptcy procedure modeled on the US bankruptcy code. In such a process, creditors and debtors would make their cases before a panel of experts of their choosing, with the debtor countries benefiting from a standstill in debt payments. A recent report by the United Nations Conference on Trade and Development (UNCTAD) called for such an independent debt sustainability assessment for African countries, followed by cancellation of debts deemed unpayable. (see <http://www.unctad.org/en/pub/pogdsafricad1.en.htm>)

Debt cancellation should not be made contingent on externally imposed policies such as the imposition of user fees for primary health care and primary school – policies which disproportionately harm people who are poor and vulnerable such as orphaned and vulnerable children. Congress has already taken important action to oppose the imposition of user fee policies by the IMF and the World Bank as a part of debt agreements or new loans. The US Treasury must ensure that this policy is enforced.

## **Burkina Faso uses Debt Relief to augment funding of National AIDS Plan**

In June 2000, the Government of Burkina Faso and its international partners held a Roundtable meeting on HIV/AIDS. At the end of the meeting, the donors endorsed the National Strategic Framework Against HIV/AIDS 2001-2005 and a total of US\$ 93.9 million was pledged, covering over 90 percent of the estimated US\$101.5 million cost of the framework.

The largest pledges came from the World Bank, in the form of a US\$22 million credit, and from the Dutch, as a US\$12 million grant. Significantly, however, the Government of Burkina Faso committed more funds than any other external donor, promising to spend US\$10 million of its own money over the next five years for HIV/AIDS. Of this US\$10 million, US\$6 million is from HIPC savings.

In July 2001, Burkina Faso reached its HIPC completion point, and qualified for relief on about US\$700 million of its total debt stock. This translates into about US\$37 million a year in budgetary savings on debt servicing. The Burkina Faso Government's commitment demonstrates that debt relief can be an important resource of domestic funding for HIV/AIDS activities. Burkina Faso is one of the poorest countries in the world, ranking 172<sup>nd</sup> out of 174 countries in the United Nations Human Development Index for 1998. The country has a GNP per capita of just US\$240.

Source: UNAIDS AIDS, Poverty, and Debt Relief Newsletter, August 2001  
<http://www.unaids.org/debt/index.html>

### III. Pay Now

***We must press on with our agenda for peace and prosperity in every land. My country is pledged to encouraging development and expanding trade. My country is pledged to investing in education and combating AIDS and other infectious diseases around the world. Following September 11th, these pledges are even more important. In our struggle against hateful groups that exploit poverty and despair, we must offer an alternative of opportunity and hope.***

-- President George W. Bush, November 10, 2001, to UN General Assembly

#### A. The Resource Gap

To implement an expanded and comprehensive HIV/AIDS response in sub-Saharan Africa, a recent report by the Global AIDS Alliance estimates that up to \$15 billion in external grant resources are needed on annual basis from 2002-2007. The UN, the World Bank, experts at Harvard University have also estimated that an appropriate and adequate response to the global AIDS crisis will cost at least \$10 billion per year, not millions. The GAA estimate builds on data provided by earlier UN and World Bank reports, but projects achievable levels of population coverage and it includes cost estimates for infrastructure development, capacity building, and impact mitigation--which have not been previously addressed. Additional resources can be immediately used to finance the delivery of known interventions through the existing infrastructure, while at the same time strengthening and expanding new infrastructure over time.

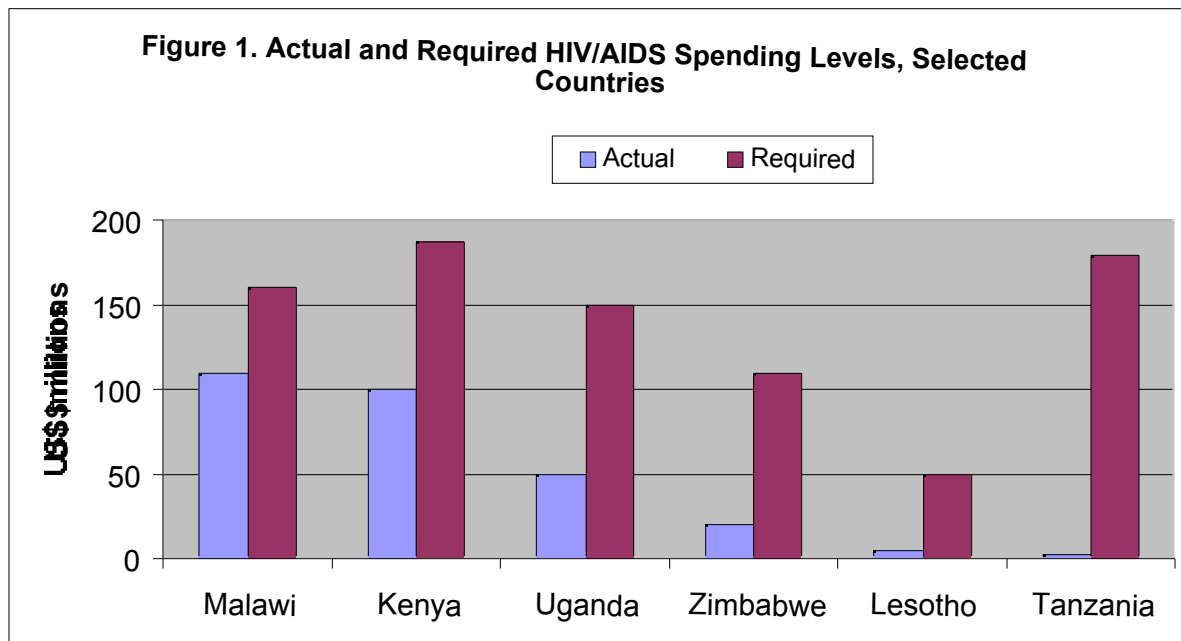
Although the HIV/AIDS crisis has led some donor countries to increase their foreign assistance allocations over the past several months, there is little sign that the level of funding needed to mount an effective response to the epidemic will materialize. After two years of intensive efforts by the UN and many others, it is estimated that \$1.5 billion US dollars of external grant resources will be spent over the next year to combat the HIV/AIDS crisis in sub-Saharan Africa. That is far below what most experts

believe necessary. The New Partnership for Africa Development represents the type of broad-based reconstruction plan that is urgently needed to break the cycles of poverty and AIDS in sub-Saharan Africa. An incremental, underfunded approach will only exacerbate the crises on the continent.

There is an international commitment that developed countries contribute 0.7 percent of their GNP to aid for poorer countries. The United States of America provides less than one-tenth of one percent of its GNP to overseas development assistance. This translates into US per capita support for overseas development assistance to be the smallest of all of the rich countries. America--the richest country in the history of the world, simply cannot be called the most generous nation one. The paucity of US foreign assistance persists in spite of widespread support among the American people for greatly increased assistance to impoverished countries, as documented by several recent surveys.

While the US ranks low in the table for aid for poor countries, most other rich countries also give below 0.7 per cent. In fact, development assistance from all sources to sub-Saharan Africa declined by 40% during the 1990s, despite the increase of poverty, decline in many key health and education indicators, and of course the exponential spread of HIV/AIDS.

## B. The Africa Gap



Source: USAID Background Paper for AGOA Conference, 2001.

As a result of their poor economies, an overwhelming debt burden, inappropriate and externally imposed loan conditionalities, and minimal international investment, few impoverished countries in Africa or in other parts of the World can mount an effective national response to HIV/AIDS, nor can their citizens pay for treatment once infected. As of 1998, annual spending on HIV/AIDS in selected countries in Africa, from all sources, averaged less than \$1/capita. This level of investment does not cover even the relatively modest amounts needed for basic HIV/AIDS prevention education and outreach, let alone cover the more significant investments needed for care and treatment of those already infected.

While the numbers on actual AIDS funding are imprecise, it appears that as of 2000 African countries are today spending \$300 to \$400 million a year for AIDS. These numbers are discouraging. In 1996-97, a total of \$165 million was spent on AIDS

programs in Africa. Of this, \$150 million came from external sources (donor agencies, multilateral banks, and United Nations organizations), and \$15 million was from African governments.

Estimates from a survey of donor countries last year suggest that external funding for AIDS in Africa may have risen to around \$210 million in 1998. Further increases over the past two years have brought total expenditures on AIDS to \$300-400 million a year in 2000, and recent new financial commitments suggest that actual disbursements will also rise in the coming years. But a much larger “quantum leap” in funding will be needed to close the gap, which was allowed to widen in the 1990s.

More recently, The Futures Group interviewed AIDS program managers in six countries and they compared their countries’ actual spending against the managers’ estimate of need (see Figure 1).

All managers indicated a large unfilled resource gap.

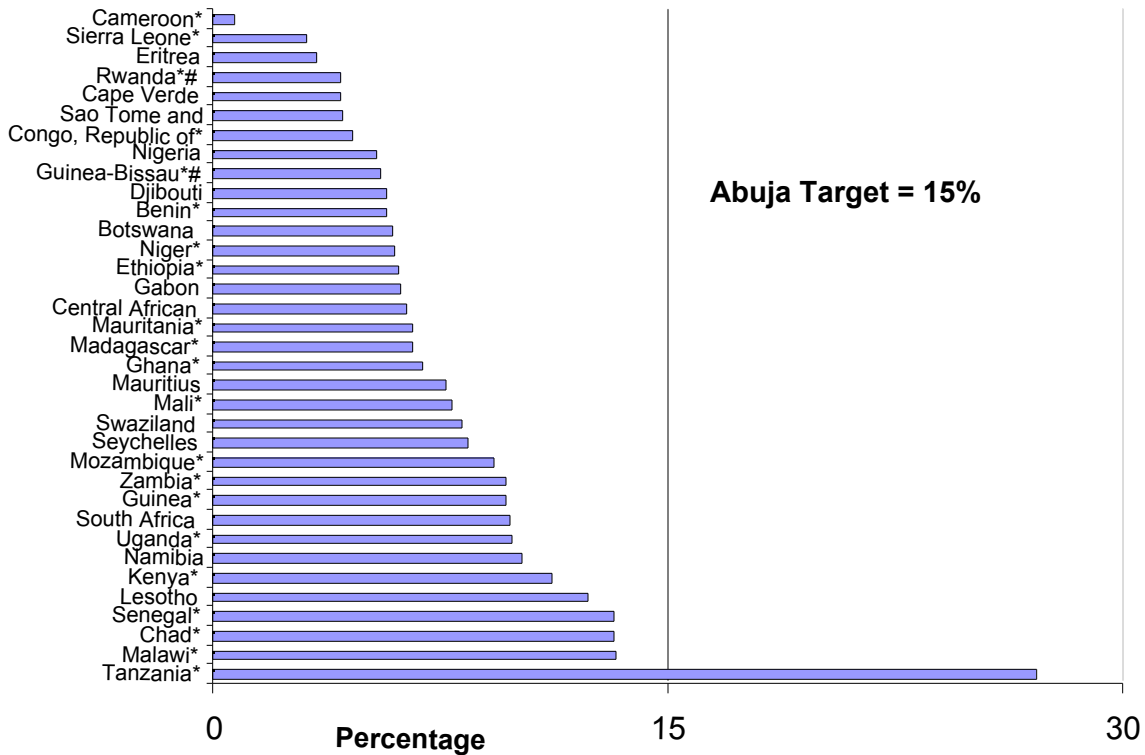
Finance and planning authorities in Africa must balance the requirements of HIV/AIDS funding against other pressing needs. The most affected countries and governments will have to devote considerable resources to HIV/AIDS interventions.

In that spirit, government leaders at the April 2001 meeting of the Organization of African Unity (OAU) in Abuja committed to spend a substantial share of available resources on health. Much of the increment would be allocated to malaria, tuberculosis, and

HIV/AIDS control programs. Virtually all African countries will have to increase health spending by 50 percent or more to reach the 15 percent allocation target (see Figure 2).

Such an increase may pose fiscal problems. For the heavily indebted poor countries, identified with an asterisk (\*) in Figure 2, the HIPC Initiative may help overcome that constraint. Donors can be expected to work closely with governments assigning high priority to HIV/AIDS programs and sharing the burden of the projected high costs of providing adequate services.

**Figure 2. Public Expenditure on Health as Percentage of Total Public Expenditure**



\*

Heavily indebted, poor countries  
#Data from interim PRSP documents

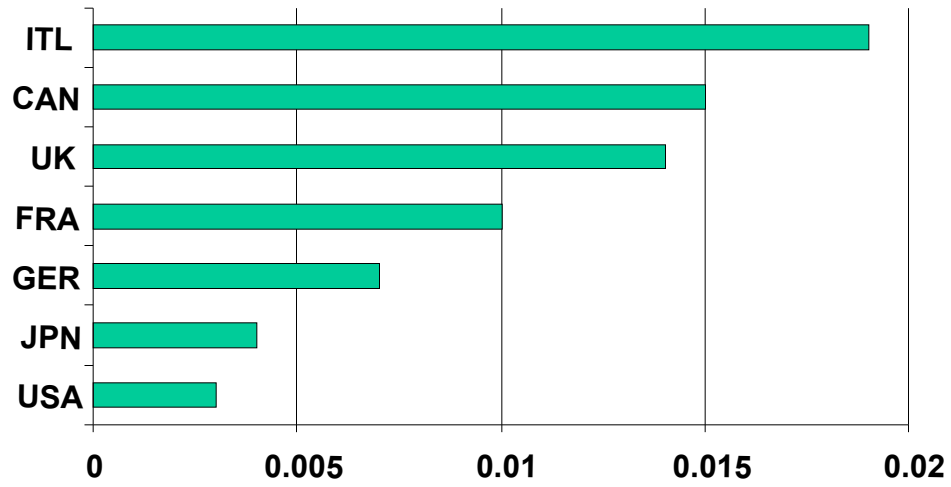
Source: Data in Figure 2 come from WHO, *World Health Report 2000*, Annex Table 8, with the exception of Guinea-Bissau and Rwanda, which, because of the appearance of overstatement in the WHR data, were taken from the interim PRSP documents prepared by the governments of those countries.

### C. The G7 Gap

On May 11, President George W. Bush announced that the US Government would contribute 200 million in FY2001 resources. In the weeks that followed this announcement, the other G7 partners and the EU announced commitments to the Fund in the \$ 100 - 200 million range. Some partners made their pledges over

several years and many of these pledges reallocations rather new increases in funding for the global AIDS response. These commitments to the Global Fund from the G7 represent tiny fractions of GDP (Figure 3). The US is contributing the smallest percentage of GDP of the G7 countries.

**Figure 3: G7 Countries % GDP Contribution to Global Fund to Fight AIDS, TB, Malaria**



**Table 3: Pledges to Global AIDS, TB and Malaria Fund**

<b>DATE</b>	<b>CONTRIBUTOR</b>	<b>PLEDGES US\$</b>	<b>TOTAL US\$</b>
	<b>Donations by private individuals</b>	<b>183,076</b>	<b>1,523,310,521</b>
	<b>Donations by corporations</b>	<b>1,095</b>	<b>1,523,127,445</b>
	<b>Donations by non-profit organizations and Foundations</b>	<b>1,350</b>	<b>1,523,126,350</b>
<b>7 August 2001</b>	<b>Kuwait</b>	<b>1,000,000</b>	<b>1,523,125,000</b>
<b>30 July 2001</b>	<b>Stupski Family Foundation</b>	<b>40,000</b>	<b>1,512,125,000</b>
<b>24 July</b>	<b>United States</b>	<b>100,000,000</b>	<b>1,512,085,000</b>
<b>21 July 2001</b>	<b>Italy</b>	<b>200,000,000</b>	<b>1,402,805,000</b>
<b>20 July 2001</b>	<b>Russia</b>	<b>20,000,000</b>	<b>1,222,805,000</b>
<b>18 July 2001</b>	<b>Canada</b>	<b>100,000,000</b>	<b>1,202,085,000</b>
<b>18 July 2001</b>	<b>European Commission</b>	<b>109,000,000</b>	<b>1,202,085,000</b>
<b>13 July 2001</b>	<b>Germany</b>	<b>139,000,000</b>	<b>993,085,000</b>
<b>11 July 2001</b>	<b>Byers Choice, Ltd.</b>	<b>10,000</b>	<b>854,085,000</b>
<b>5 July 2001</b>	<b>Niger</b>	<b>50,000</b>	<b>854,075,000</b>
<b>3 July 2001</b>	<b>Japan</b>	<b>200,000,000</b>	<b>854,025,000</b>
<b>27 June 2001</b>	<b>Andorra</b>	<b>100,000</b>	<b>654,025,000</b>
<b>27 June 2001</b>	<b>Luxembourg</b>	<b>2,700,000</b>	<b>653,925,000</b>
<b>26 June 2001</b>	<b>Austria</b>	<b>1,000,000</b>	<b>651,225,000</b>
<b>26 June 2001</b>	<b>Liberia</b>	<b>25,000</b>	<b>650,225,000</b>
<b>25 June 2001</b>	<b>Zimbabwe</b>	<b>1,000,000</b>	<b>650,200,000</b>
<b>25 June 2001</b>	<b>Uganda</b>	<b>2,000,000</b>	<b>649,200,000</b>
<b>25 June 2001</b>	<b>Nigeria</b>	<b>10,000,000</b>	<b>647,200,000</b>
<b>19 June 2001</b>	<b>Bill and Melinda Gates Foundation</b>	<b>100,000,000</b>	<b>637,200,000</b>
<b>8 June 2001</b>	<b>Winterthur Insurance (Credit Suisse)</b>	<b>1,000,000</b>	<b>537,200,000</b>
<b>31 May 2001</b>	<b>France</b>	<b>136,000,000</b>	<b>536,200,000</b>
<b>31 May 2001</b>	<b>United Kingdom</b>	<b>200,000,000</b>	<b>400,200,000</b>
<b>11 May 2001</b>	<b>United States</b>	<b>200,000,000</b>	<b>200,200,000</b>
<b>8 May 2001</b>	<b>International Olympic Committee</b>	<b>100,000</b>	<b>200,000</b>
<b>3 May 2001</b>	<b>Secretary-General Kofi Annan*</b>	<b>100,000</b>	<b>100,000</b>

Figures provided by the [United Nations Fund for International Partnerships](http://www.un.org/News/ossg/aids.htm).  
<http://www.un.org/News/ossg/aids.htm>

#### IV. Or Pay More Later

*Suppose we woke up tomorrow morning and learned that every single man, woman and child, every single person, in Miami, Minneapolis, Atlanta, Denver, Boston, Seattle, Washington DC, New York City, Los Angeles, Chicago, Houston, Philadelphia, San Diego, Detroit and Dallas, combined, were infected with a virus for which there was no cure. Don't you think that we would respond, as rapidly and with the kind of finances as we did after September 11th? But, that is the reality in Africa today. If you want to look at a ticking time bomb, look at Asia, where it's also a living reality.*

-- Senator Patrick Leahy, November 7, 2001

Over the past two years political and civic leaders have mobilized an unprecedented shift in political will to battle the global AIDS pandemic. African countries have developed National Strategic Plans that are being rolled out to the district and community levels, HIV/AIDS business coalitions are forming, churches and other faith-based groups are scaling-up their response.

As the fragile democracies in Africa and other low-income areas grapple with the vast challenge of combating AIDS, it is a tremendous opportunity for stronger democracies to lend a supportive hand.

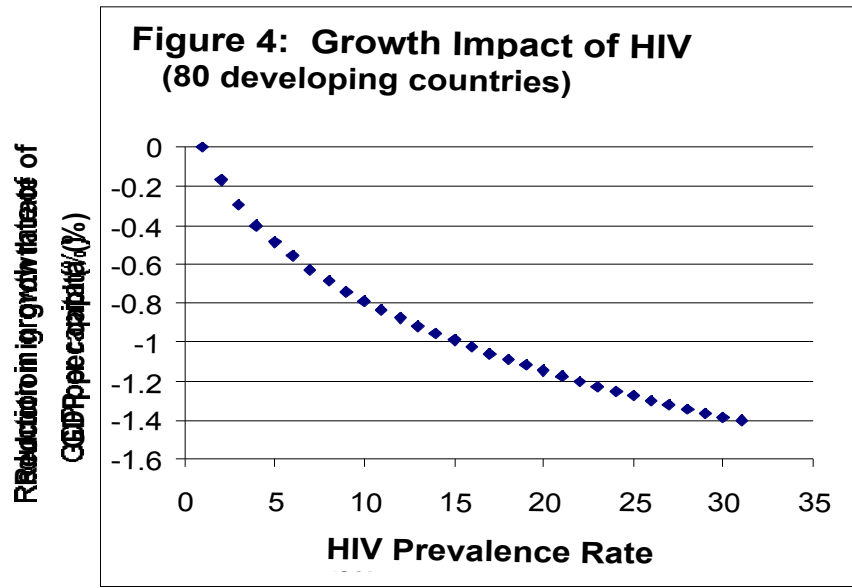
##### A. Severe Drag on Economic Growth

The estimated growth impact of HIV/AIDS will be the reduction in the growth rate of GDP per capita. For low prevalence rate countries the estimated growth impact is small. For Africa with an average HIV prevalence rate of 8 percent, the rate of growth of GDP per capita was reduced by about 0.7 percentage points per year in the 1990s. The impact on GDP is even more

African families--and especially the youth--are willing and able to take on the responsibility to care for themselves, if they are given the information and tools to lead a safer, healthier life.

Left unchecked, the persistent infectious disease burden is likely to aggravate and, in extreme cases, may even provoke social fragmentation, economic decay, and political polarization in the hardest hit low-income countries. This, in turn, will hamper progress against infectious diseases. New and re-emergent infectious diseases are likely to have a disruptive impact on global economic, social, and political dynamics.

substantial, and especially for high prevalence rate countries. In the case of a typical sub-Saharan country with a prevalence rate of 20 percent, the rate of growth of GDP would be some 2.6 percentage points less each year. At the end of a 20-year period GDP would be 67 percent less than what it could have been.

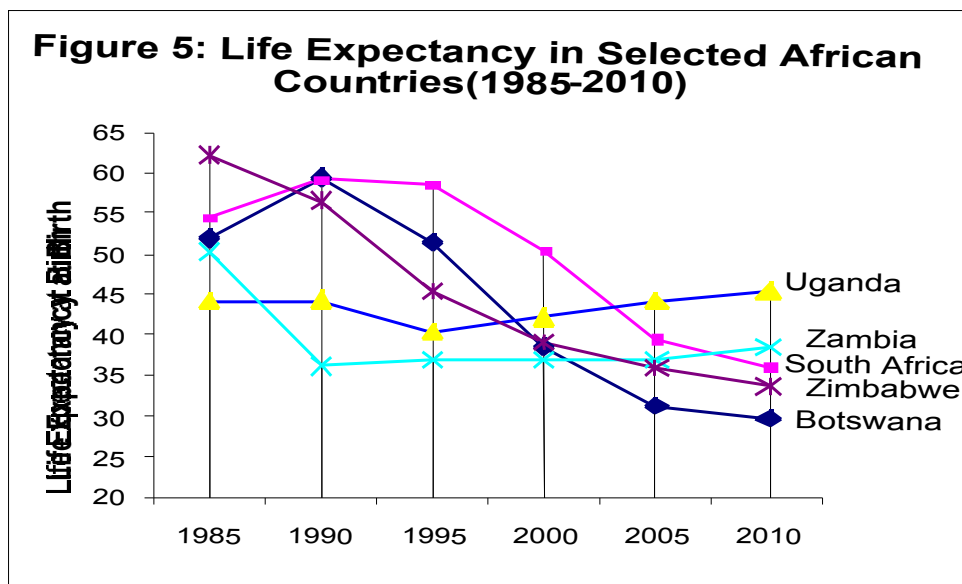


Source: Bonnel, R. Economic Analysis of HIV/AIDS. September 2000.  
[http://www.iaen.org/files.cgi/435\\_HIVEconAnalysisADF.pdf](http://www.iaen.org/files.cgi/435_HIVEconAnalysisADF.pdf)

## B. Unprecedented Demographic Catastrophe

In the most heavily affected countries, the demographic impact is staggering. Projections from the US Census Bureau indicate that by 2003 Botswana, South Africa and Zimbabwe will be experiencing negative population growth—an outcome that was judged highly unlikely just a few years ago. Several other countries, including Malawi, Swaziland, Namibia and Zambia, will see their population remain constant. In the absence of AIDS, their population would have grown by 1.0-2.3 percent per year.

Hard-won gains in life expectancies are being wiped out in countries affected by the HIV epidemic. In the countries with the highest HIV prevalence rate such as Botswana and Zimbabwe life expectancy has fallen from 70 to about 39 years. In four other countries (Malawi, Mozambique, Rwanda and Zambia) the HIV/AIDS epidemic has cut life expectancies by a decade or more. If these trends continue unabated, the future looks even bleaker. By 2010, life expectancy in Botswana, Zimbabwe and South Africa would fall to about 30 years, nearly half its level of twenty years ago.



Source: US Census Bureau, May 2000

## C. Destabilizing Political and Security Impact

### • HIV/AIDS as a Security Issue, June 2001

"For a growing number of states, AIDS can no longer be understood or responded to as primarily a public health crisis. It is becoming a threat to security. But where it reaches epidemic proportions, HIV/AIDS can be so pervasive that it destroys the very fibre of what constitutes a nation: individuals, families and communities; economic and political institutions; military and police forces. It is likely then to have broader security consequences, both for the nations under assault and for their neighbours, trading partners, and allies."

International Crisis Group Report: <http://www.crisisweb.org/projects/showreport.cfm?reportid=321>

### • The Global Infectious Disease Threat and Its Implications for the US, January 2000

"At least some of the hardest-hit countries, initially in Sub-Saharan Africa and later in other regions, will face a demographic catastrophe as HIV/AIDS and associated diseases reduce human life expectancy dramatically and kill up to a quarter of their populations over the period of this Estimate. This will further impoverish the poor and often the middle class and produce a huge and impoverished orphan cohort unable to cope and vulnerable to exploitation and radicalization. "

National Intelligence Council Report at: <http://www.odci.gov/cia/publications/nie/report/nie99-17d.html>

According to recent research by the National Intelligence Council and the International Crisis Group, the infectious disease burden will add to political instability and slow democratic development in Sub-Saharan Africa, parts of Asia, and the former Soviet Union, while also increasing political tensions in and among some developed countries. The severe social and economic impact of infectious diseases, particularly HIV/AIDS, and the infiltration of these diseases into the ruling political and military elites and middle classes of developing countries are likely to intensify

the struggle for political power to control scarce state resources.

This impact will hamper the development of a civil society and other underpinnings of democracy and will increase pressure on democratic transitions in Sub-Saharan Africa where the infectious disease burden will add to economic misery and political polarization. Heavily affected AIDS countries will be more susceptible to revolutionary wars, ethnic wars, genocides, and disruptive regime transitions. High infant mortality has a particularly strong correlation with the likelihood of state failure in partial democracies.

## D. Exorbitant Costs of Inaction

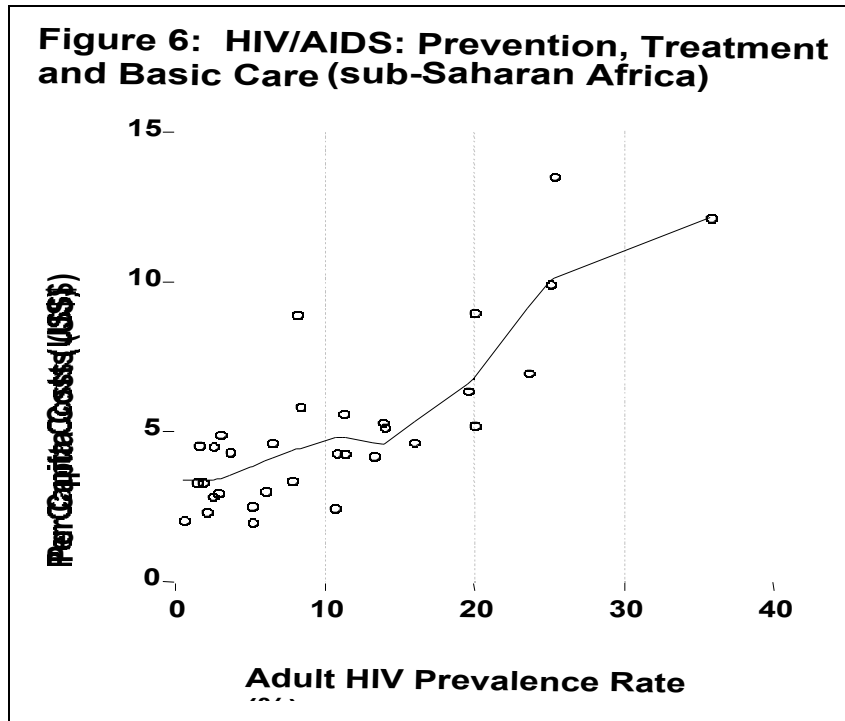
A delay in implementing HIV/AIDS interventions while the prevalence rate remains low has a serious economic impact on those countries. The cost of delaying action is illustrated by Figure 5. When the HIV prevalence rate in the general population is below 5 percent, HIV/AIDS program costs about US\$3 per capita. But once the HIV prevalence rate exceeds 15%,

the cost of HIV/AIDS program rises rapidly to about US\$10-12 per capita.

Few countries can afford the financial cost of inaction. In the case of a low-income country with a per capita income of US\$300, the budgetary cost of implementing a national scale HIV/AIDS program amounts to 1.0 percent of GDP when the HIV prevalence rate is less than 5 percent. If

implementation is delayed so that the HIV prevalence rate reaches 20 percent of the population, the budgetary cost amounts to

3.3 percent of GDP. This cost excludes the provision of antiretroviral drugs.



Source: Bonnel, R. Economic Analysis of HIV/AIDS. September 2000.  
[http://www.iaen.org/files.cgi/435\\_HIVEconAnalysisADF.pdf](http://www.iaen.org/files.cgi/435_HIVEconAnalysisADF.pdf)

## V. Future Scenarios

*"The vision which fueled our struggle for freedom; the development of energies and resources; the unity and commitment of common goals – all these will be needed if we are to bring AIDS under control."*

-- Nelson Mandela

The question that we should all be asking is, What's Going On? What kind of future are we creating? Here are two possible future scenarios:

### OPTION #1:

- Dec 1, 2001: UNAIDS Reports 2.3 million Africans die from HIV/AIDS in 2001  
African Governments take no bold action to Stop AIDS in Africa  
The USG, G8, IMF, WB, UN take no bold action to Stop AIDS in Africa
- Dec 1, 2002: UNAIDS Reports 3 million Africans die from HIV/AIDS in 2002  
Wars in Africa expand;
- Dec 1, 2003: UNAIDS Reports 3.5 million Africans die from HIV/AIDS in 2003
- Dec 1, 2004: UNAIDS Reports 4 million Africans die from HIV/AIDS in 2004 leading to anarchy and conflict throughout sub-Saharan Africa.

### OPTION #2:

- Dec 1, 2001: UNAIDS Reports 2.3 million Africans die from HIV/AIDS in 2001  
African Governments Convene to Sign Emergency Declaration of Action and assert bold leadership to Stop AIDS in Africa  
The USG, G8, IMF, WB, UN support the efforts by African Governments to mobilize billions to Stop AIDS in Africa
- Dec 1, 2002: An expanded and comprehensive response to the HIV/AIDS pandemic in sub-Saharan Africa is being implemented. Early indications are that youth programs are reducing transmission; VCT is expanding; access to treatment goes up from 0%;  
UNAIDS Reports 2.5 million Africans die from HIV/AIDS in 2002
- Dec 1, 2003: Dramatic efforts to Stop AIDS in Africa are working. Death rates are declining; Transmission is slowing; Fewer Orphans being generated;  
UNAIDS Reports 1.5 million Africans die from HIV/AIDS in 2003

***Which future do we want?***

# The Global Herald

## *AIDS Pandemic Destabilizing Africa*

### *Failure To Fund Response Leaves Millions to Perish*

By PREDIC T. FUTURE

**NEW YORK, DEC. 1, 2005** – Experts are linking the recent upswing in political instability in Africa, Asia, and the Caribbean to the dramatic increase in the number of AIDS orphans. Last week's declaration of martial law in three southern African nations, following weeks of riots, are new evidence, experts say, of the growing threat of street gangs, composed mainly of teenagers orphaned by AIDS. Local police forces, their numbers depleted dramatically by AIDS, have been unable to control the situation and armed soldiers are now patrolling the streets in several capitals

The insurgency which last month occupied Nigeria's oil fields, severely disrupting the country's oil exports, relied heavily on teenage soldiers, many of them AIDS orphans. The epidemic is also having a severe impact on peacekeeping, with many African militaries now refusing to provide troops for the peacekeeping missions. Generals have said AIDS has decimated their officer corps and they dare not overextend their forces.

# The Global Herald

## *AIDS Deaths Cut Dramatically in Africa*

### *Global Response Now Fully Funded*

By PREDIC T. FUTURE

**NEW YORK, DEC. 1, 2005** – On World AIDS Day experts are saying substantial progress has been made in reducing the impact of the disease in Africa. While AIDS had been expected to reduce economic growth by two-thirds and plunge the continent into instability, the rate of infection as well as overall AIDS deaths have been cut dramatically.

Experts point to the efforts by African leaders at all levels of society to end stigma, respect human rights and end corruption. Youth have become the focal point of anti-AIDS campaigns and their voice as well as that of people living with AIDS has been taken seriously. Just as critical, experts say, was the success since 2001 of the Stop Global AIDS Campaign in pressuring wealthy governments to mobilize \$10 billion annually to combat AIDS in Africa, with comprehensive prevention, care and treatment. The US and other countries decided lift the threat of trade sanctions from countries producing generic AIDS drugs. And, the G7 nations in July 2002 mandated creditor agencies to cancel the debts of affected countries.