

Withdrawal/Redaction Sheet

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. fax	Sarah to Sandra Thurman re personal (5 pages)	05/08/2000	Personal Misfile

COLLECTION:

Clinton Presidential Records
National AIDS Policy Office

OA/Box Number: 21065

FOLDER TITLE:

Africa, 05/07-20/00 [2]

2007-1550-F
kc1269

RESTRICTION CODES

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

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

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

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

RR. Document will be reviewed upon request.

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

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

FOIA MARKER

**This is not a textual record. This is used as an
administrative marker by the William J. Clinton
Presidential Library Staff.**

Collection/Record Group: Clinton Presidential Records

Subgroup/Office of Origin: National AIDS Policy Office

Series/Staff Member:

Subseries:

OA/ID Number: 21065

FolderID:

Folder Title:

Africa, 05/07-20/00 [2]

Stack:

S

Row:

67

Section:

1

Shelf:

3

Position:

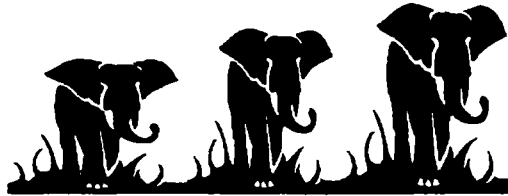
1

United States Department of State

Washington, D.C. 20520



OFFICE OF SOUTHERN AFRICAN AFFAIRS (AF/S)
TELECOPIER TRANSMITTAL

DATE: MAY 30, 2000 NO. OF PAGES (INCLUDING COVER): 6TO: AID/AFR - Bill JEFFERS 216 - 3233

<u>USTR - Joe RIPLEY</u>	<u>395 - 4505</u>
<u>USDA - FRANKIE KING</u>	<u>720 - 5779</u>
<u>ONAP - SANDRA THURMAN</u>	<u>456 - 2439</u>
<u>USOOC - GERALD FELDMAN</u>	<u>482 - 5198</u>
<u>DDO/ISA - ADAM GRISOM</u>	<u>703 - 695 - 4620</u>

FAX NUMBER: _____

FROM: Don BOOTH PHONE: 647 - 2849COMMENTS: You clearance on the attached
is requested by COB Thursday June 1.
Thank you

THE FAX NUMBER FOR THE OFFICE OF SOUTHERN AFRICAN AFFAIRS IS
(202) 647-5007.

APPR:	WSC	...
DRAFT:	DBO	...
CLR 1:	ARE	...
CLR 2:	KFI	...
CLR 3:	MAD	...
CLR 4:	WJE	...
CLR 5:	JCA	...
CLR 6:	JRI	...
CLR 7:	FKI	...
CLR 8:	MLA	...
CLR 9:	ANE	...
CLR10:	STH	...

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AF/S:DBOOTH:DB
05/30/00 7-9849
AF:WSCHNEIDMAN

AF/S:ARENDR PM/RSAT:KFITZPATRICK PM/HDP:MADAMS
AID/AFR:WJEFFERS INL:JCALLAHAN USTR:JRIPLEY
USDA:FKING PRM:MLANGE AF/RA:ANEWTON ONAP:STHURMAN
USDOC:GEELDMAN DOD/ISA:AGRISSOM OES:KSHIPPE

ROUTINE GABORONE

ROUTINE DAR ES SALAAM, HARARE, KINSHASA, LILONGWE,
LUANDA, LUSAKA, MAPUTO, MASERU, MBABANE, PORT LOUIS+

E.O. 12958: N/A

TAGS: PREL, ECIN, ETRD, EAGR, SADC

SUBJECT: U.S.-SADC FORUM 2: WASHINGTON INPUT FOR FOLLOW-UP
WORK PLAN

1. WASHINGTON AGENCIES HAVE REVIEWED THE COMMUNIQUE AND PROPOSE THAT THE FOLLOWING ELEMENTS BE INCORPORATED IN THE FOLLOW-ON WORK PROGRAM TO BE NEGOTIATED WITH THE SADC SECRETARIAT AND TROIKA DURING THE UPCOMING MEETING OF THE U.S.-SADC FORUM STEERING GROUP.
2. ACTIVITIES TO BE PURSUED PRIMARILY THROUGH/BY THE SADC SECRETARIAT:
 - A. TRADE ADVISER FOR SADC SECRETARIAT: FUND THE TRADE ADVISER POSITION FOR AN ADDITIONAL TWO YEARS (THREE YEARS TOTAL). RCSA TO IMPLEMENT WITH DA. TARGET: HAVE ADVISER HIRED AND IN PLACE BY AUGUST 1, 2000.
 - B. TRADE TECHNICAL ASSISTANCE: PROVIDE TECHNICAL ASSISTANCE TO SADC MEMBER STATE TRADE OFFICIALS UNDER SADC SECRETARIAT AUSPICES IN AREAS SUCH AS PRODUCT STANDARDS, RULES OF ORIGIN, CUSTOMS HARMONIZATION, DISPUTE SETTLEMENT. RCSA TO IMPLEMENT WITH DA. TARGET: TECHNICAL ASSISTANCE PLAN AGREED WITH SADC SECRETARIAT BY AUGUST 1, 2000.

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- C. TRADE TECHNICAL ASSISTANCE: PROVIDE TECHNICAL ASSISTANCE TO SADC MEMBER STATE TRADE OFFICIALS IN THE AREA OF INTELLECTUAL PROPERTY RIGHTS PROTECTION OR OTHER MUTUALLY AGREED AREA(S) NOT COVERED BY RCSA'S ONGOING OR PLANNED PROGRAMS. USDOC/CLDP TO IMPLEMENT WITH ESF (\$250,000). TARGET: FIRST TECHNICAL ASSISTANCE TEAM LAUNCHED BY NOVEMBER 1, 2000.
- D. SEMINARS ON WTO ISSUES RELATED TO SADC TRADE PROTOCOL IMPLEMENTATION: RCSA TO IMPLEMENT WITH DA. TARGET: FIRST SEMINAR HELD IN NOVEMBER 2000; FOLLOW-UP SEMINAR WITHIN SIX MONTHS THEREAFTER.
- E. CONCLUDE U.S.-SADC TIFA. AF/S TO PRESS MEMBER STATES TO AUTHORIZE SADC SECRETARIAT AND TROIKA (AT OR BEFORE THE NEXT SADC SUMMIT) TO NEGOTIATE PROPOSED TIFA WITH USTR. TARGET: TIFA SIGNING BY NOVEMBER 1, 2000.
- F. SADC/PRIVATE SECTOR PROGRAM ON SADC FTA IMPLEMENTATION: RCSA TO ARRANGE IN CONJUNCTION WITH SADC SECRETARIAT. FUND WITH DA. TARGET: HOLD FORUM BEFORE FEBRUARY 1, 2000.
- G. PROVIDE SADC MEMBER STATES MORE INFORMATION ABOUT AGOA: EMBASSY GABORONE TO PROVIDE INFORMATION TO THE SADC SECRETARIAT WHICH CAN BE PASSED ON TO MEMBER STATE TRADE OFFICIALS. TARGET: PROVIDE INFORMATION BY JUNE 1, 2000.
- H. U.S. SUPPORT OF WAIVER FOR EU-ACP PARTNERSHIP AGREEMENT. TARGET: USTR TO MAKE DECISION ON WAIVER BY ??? AND COMMUNICATE IT TO SADC VIA THE SADC SECRETARIAT.
- I. DISASTER PREPAREDNESS AND MANAGEMENT: PHASE 1 - DEFINE SADC'S NEEDS AND DESIRES, POSSIBLY THROUGH HOLDING OF AN ORGANIZATIONAL/INFORMATIONAL SEMINAR. DOD/EUCOM, STATE/PRM, AID/W AND RCSA TO COORDINATE WITH SADC SECRETARIAT IN ARRANGING THIS. FUNDING FROM 99ESF. TARGET: HOLD SEMINAR BY SEPTEMBER 15, 2000. PHASE 2 - FUND START-UP OF A DISASTER MANAGEMENT UNIT IN SECRETARIAT OR OTHER UNIT AGREED BY SADC MEMBER STATES. FUNDING FROM 99ESF. TARGET: HAVE A DISASTER MANAGEMENT UNIT ESTABLISHED BY JANUARY 1, 2001.
- 3. ACTIVITIES TO BE PURSUED PRIMARILY WITH THE SADC MEMBER STATES DIRECTLY:
 - A. SUPPORT TECHNICAL WORKING GROUPS RESPONSIBLE FOR ENSURING IMPLEMENTATION OF SADC TRADE PROTOCOL AT THE NATIONAL LEVEL. RCSA TO MANAGE USING DA. TARGET: INITIATE PROGRAM BY DECEMBER 1, 2000.
 - B. SEMINAR(S) ON SANITARY-PHYTOSANITARY STANDARDS: PURPOSE IS TO ENABLE SADC EXPORTERS TO BETTER UNDERSTAND U.S. SPS REGULATIONS. USDA, WORKING THROUGH THE REGIONAL AGRICULTURE ATTACHE'S OFFICE IN PRETORIA, TO ORGANIZE

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- SEMINAR(S) FOR ALL SADC MEMBER STATES USING ATRIP FUNDS. TARGET: HOLD SEMINAR BY NOVEMBER 15, 2000.
- C. STRENGTHEN POLICING OF TRAFFICKING IN ILLICIT DIAMONDS: AF TO PURSUE THROUGH DIPLOMATIC APPROACHES TO SADC MEMBER STATES. ONGOING ACTIVITY.
- D. SEMINAR ON CONFLICT PREVENTION AT CAPETOWN CENTRE FOR CONFLICT RESOLUTION: FOCUS IS CAPACITY BUILDING, INCREASING SOUTHERN AFRICAN EXPERTISE IN CONFLICT PREVENTION AND RESOLUTION. PM/RSAT TO ORGANIZE WITH THE CENTRE. SEMINAR TO BE FUNDED WITH ESF (\$125,000). ISSUE: TO WHOM IS ESF ALLOCATED? PM? TARGET: COORDINATE WITH ISDSC TO CONDUCT SEMINAR BEFORE DECEMBER 15, 2000.
- E. TRAINING IN CONFLICT PREVENTION BY FUND FOR PEACE: THIS WOULD FOLLOW AFTER AND EXPAND UPON ISSUES ADDRESSED AT THE CONFLICT PREVENTION SEMINAR. AF/RA TO ORGANIZE. FUNDING SOURCE IS ESF (\$250,000). ISSUE: TO WHOM IS ESF ALLOCATED? AF/? TARGET: COORDINATE WITH ISDSC TO INITIATE TRAINING WITHIN THREE MONTHS OF ABOVE MENTIONED CAPETOWN SEMINAR.
- F. REFUGEE SUPPORT: PRM TO MAKE ITS MIGRATION PROGRAM RESOURCES MORE ACCESSIBLE AND RELEVANT TO SADC MEMBER STATES. PRM TO IMPLEMENT (NOTE: PRM - PLEASE EXPLAIN WHAT THIS MIGHT ENTAIL AND INDICATE SOURCE OF FUNDS IF ANY ARE NEEDED TO FOLLOW THROUGH. END NOTE) TARGET: IMPLEMENT BY ???
- G. ANNUAL WORKING-LEVEL CONSULTATIONS ON SMALL ARMS AND LIGHT WEAPONS: OBJECTIVE IS TO ENHANCE U.S.-SADC COOPERATION IN CONTROLLING THE FLOW OF WEAPONS TO AREAS OF CONFLICT. PM/RSAT AND INL TO IMPLEMENT. ISSUE: WHICH BUREAU/OFFICE HAS THE LEAD?? TARGET: PROPOSAL TO SADC CAPITALS BY JUNE 30, 2000. CONSULTATIONS HELD BY OCTOBER 15, 2000.
- H. ASSESSMENT OF SURPLUS WEAPONS AND EXCESS ARMS STOCKPILES: DOD (PLEASE SPECIFY WHICH OFFICE IN DOD HAS THE LEAD) WILL SEND TEAMS TO INTERESTED SADC MEMBER STATES TO ADVISE ON HOW TO DETERMINE WHETHER THERE ARE SURPLUS ARMS/EXCESS STOCKPILES AND SUGGEST MEANS OF ELIMINATING SUCH. DOD-FUNDED PROGRAM. TARGET: INITIAL CONTACT TO SADC MEMBER STATES AND ISDSC BY SEPTEMBER 1, 2000. FIRST ASSESSMENT TEAM TO SOUTHERN AFRICA BY NOVEMBER 1, 2000.
- I. JOINT U.S.-SADC COMMUNIQUE AT UNGA ON NEED FOR RESTRAINT IN SALE OF CONVENTIONAL ARMS: OBJECTIVE IS TO INCREASE PRESSURE ON ARMS SUPPLIER STATES TO RESTRICT/BETTER CONTROL SALES OF WEAPONS TO AREAS OF CONFLICT IN AFRICA. PM/RSAT TO PREPARE DIPLOMATIC APPROACHES TO SADC MEMBER STATES. TARGET: JOINT

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COMMUNIQUE ISSUES DURING SEPTEMBER-OCTOBER 2000 UNGA SESSION. (NOTE: SADC NOTED BUT DID NOT/NOT AGREE TO THIS PROPOSAL AT THE FORUM. END NOTE)

- J. EXPANDED DEMINING ACTIVITIES IN SOUTHERN AFRICA: PM/HDP TO EXPAND/INITIATE DEMINING PROGRAMS IN MOZAMBIQUE AND ZAMBIA USING NADR FUNDS. TARGET: ASSESSMENT TEAM TO ZAMBIA BY SEPTEMBER 1, 2000. PROVISION OF DEMINING TECHNOLOGY AND SOME EQUIPMENT BEGINNING JULY 2000.
- K. ANTI-CRIME TRAINING: INL TO USE INC FUNDS TO TRAIN SADC MEMBER STATE OFFICIALS AT THE ILEA BEING ESTABLISHED IN BOTSWANA. TARGET: FIRST COURSES OFFERED AT ILEA BY APRIL 1, 2001.
- L. BORDER CONTROL ENHANCEMENT: THE OBJECTIVE HERE IS TO TACKLE SOUTHERN AFRICAN BORDER CONTROL WEAKNESSES IN A SYSTEMIC MANNER, LOOKING AT LAWS, REGULATIONS, PROCEDURES, STAFFING, TRAINING AND EQUIPMENT. PHASE 1 INVOLVES DISPATCH OF ASSESSMENT TEAMS TO INTERESTED MEMBER STATES. STATE/INL TO MANAGE THE PROGRAM USING INC FUNDS. STATE/INL TO COORDINATE WITH RCSA TO ENSURE THAT BORDER CONTROL ACTIVITIES COMPLEMENT RCSA'S ONGOING EFFORTS TO STREAMLINE CUSTOMS PROCEDURES FOR GOODS TRADED ACROSS SADC NATIONAL BORDERS. TARGET: FIRST ASSESSMENT TEAM TO THE REGION BY JULY 15, 2000. AN IMPORTANT ELEMENT OF PHASE 2 WILL BE TO DEVELOP THREE MODEL BORDER FACILITIES TO SERVE AS DEMONSTRATION PROJECTS. TARGETS: 1) U.S. (STATE/INL) TO PROPOSE THREE BORDER POSTS AND WORK BILATERALLY WITH THE SADC MEMBER STATES CONCERNED TO SECURE AGREEMENT ON THE THREE PILOT PROJECT LOCATIONS BY SEPTEMBER 15, 2000. 2) U.S. (STATE/INL) INITIATES PROJECTS WITH RELEVANT MEMBER STATES USING ESF (UP TO \$375,000) BY NOVEMBER 1, 2000.
- M. COMPLETE THE "CONVENTION AGAINST TRANSNATIONAL CRIME" AND ITS PROTOCOL ON TRAFFICKING IN WOMEN AND CHILDREN AND THE "PROTOCOL AGAINST ILLICIT MANUFACTURING OF AND TRAFFICKING IN FIREARMS. INL TO ORGANIZE DIPLOMATIC APPROACHES TO SADC MEMBER STATES. TARGET: BOTH COMPLETED BY DECEMBER 31, 2000.
- N. COMBAT SPREAD OF HIV/AIDS: IMPLEMENT "OPERATION STORM WARNING" WHICH FOCUSES ON TRANSMISSION ALONG MAJOR TRANSPORT CORRIDORS. AID, THROUGH ITS BILATERAL MISSIONS IN MANY SADC MEMBER STATES AND ITS REGIONAL HIV/AIDS PROGRAM RUN BY USAID PRETORIA, TO IMPLEMENT USING DA FUNDS. TARGET: PROJECT DESIGNED AND IN IMPLEMENTATION PHASE BY ???
- O. REGIONAL WATER MANAGEMENT: OES TO WORK WITH RELEVANT MEMBER STATES AND THE SADC ENVIRONMENT SECTOR COORDINATING UNIT. PROPOSED PROJRCT IS SUPPORT TO THE OKAVANGO RIVER BASIN INITIATIVE. IMPLEMENTATION TO BE

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DONE BY (OES PLEASE PROVIDE NAME OF IMPLEMENTER(S) AND
A BRIEF DESCRIPTION OF WHAT THE PROJECT HOPES TO
ACHIEVE). FUNDING TO COME FROM THE ENVIRONMENTAL
DIPLOMACY FUND. TARGET: INITIAL SUPPORT TO THE
COMMISSION BY ???

YY

PRETORIA
WINDHOEK Y

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United States Department of State

Assistant Secretary of State
for African Affairs

Washington, D.C. 20520-3430

JUN 9 2000

Ms. Sandra Thurman
Director National AIDS Policy

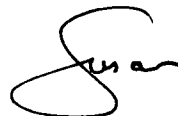
Dear Sandy,

I want to thank you very much for taking time from your busy schedule to participate in the second U.S.-SADC Forum in Maputo last month. Your participation was essential to the success of the HIV/AIDS plenary, a keystone of the Forum meetings.

The SADC delegations greatly appreciated your thorough explanation of the HIV/AIDS pandemic and the discussion of U.S. efforts to combat the disease. Your eloquent interventions ensured that the discussions were not only lively but also focused and conducive to achieving real results. I hope you felt the Forum left us better armed to direct our efforts in the region against HIV/AIDS.

Deputy Secretary Talbott and I appreciate the time and effort you invested in making this Forum so successful.

Sincerely,



Susan E. Rice

Thanks for everything, girl!

The following information was obtained from the U.S. Department of State, Office of African Affairs, and is being provided to you for your information. It is not to be used for any other purpose without the express written permission of the U.S. Department of State.

Very truly yours,

Deputy Secretary of State
Richard L. Armitage

***** Travel Voucher *****

Name : SANDRA L THURMAN
 Address : 514 D STREET, NE
 WASHINGTON DC 20002
 Duty Station: WASHINGTON DC
 Office Phone: 202-456-2959 (TDY Travel)
 Department : REG99A/OS/HQ

Period of Travel
 From: 05/07/00 To: 05/20/00

Travel Number : 0225THU002
 Approve Date : _____

Travel Advance Information

Voucher Submitted On: _____

Outstanding :	Date received :
Amount Applied :	Amount Received: 2554.64
Amount due Government:	Check Attached : _____
Balance Outstanding :	Payee signature: _____

I hereby assign to the United States any right I may have against any parties in connection with reimbursable transportation charges described below, purchased under cash payment procedures (41 CFR Chpts. 301-304)

***** GTRs and Tickets *****

Traveler's Initials ST

Ticket No. & Date	Value	Carrier	Mode	Departure/Arrival
7788173750			AIR	WASHINGTON DC
XXXXX			AIR	JOHANNESBURG NS
XXXXX			AIR	JOHANNESBURG NS
XXXXX			AIR	MAPUTO NS
XXXXX			AIR	MAPUTO NS
XXXXX			AIR	JOHANNESBURG NS
XXXXX			AIR	JOHANNESBURG NS
XXXXX			AIR	DAR ES SALAAM NS
XXXXX			AIR	DAR ES SALAAM NS
TOTAL TICKET COST	6945.70			WASHINGTON DC

I certify that this voucher is true and correct to the best of my knowledge and belief, and that payment or credit has not been received by me. When applicable, per diem claimed is based on the average cost of lodging incurred during the period covered by this voucher.

Amount Claimed : 2554.64

Amount Applied : _____

Net To Traveler: 2554.64

Signature: *Sandra L Thurman*
 SANDRA L THURMAN

Date: June 2, 2000
 SSN: 259 98 5363

This voucher is approved. Long distance telephone calls, if any, are certified as necessary in the interest of the Government. (NOTE: If long distance telephone calls are included, the approving official must have been authorized in writing by the head of the department or agency to so certify (31 U.S.C. 680a).)

Approving official
 Signature: _____

Date: _____

(PENDING AUTHORIZATION)

This voucher is certified correct and proper for payment

Authorized certifying official

Signature: _____ Date: _____

Date	Description	M&IE Cost	Lodge Cost	Other Cost
050700	DEPARTED WASHINGTON DC			
	JOHANNESBURG, NS			
050700	TAXI CAB COST			20.00
050700	PER DIEM FOR DAY OF DEPARTURE			35.25
050700	VISA FOR MOZAMBIQUE			40.00
050700	VISA FOR TANZANIA			50.00
050800	LODGING COST (ALLOWED)		61.40	
050800	BUSINESS PHONE CALLS			124.05
050800	TAX ON HOTEL ROOM			0.62
050900	MAPUTO, NS			
050900	BREAKFAST, LUNCH AND DINNER	68.00		
050900	LODGING COST (ALLOWED)		136.00	
050900	BUSINESS PHONE CALLS			130.90
051000	BREAKFAST, LUNCH AND DINNER	68.00		
051000	LODGING COST (ALLOWED)		136.00	
051000	BUSINESS PHONE CALLS			48.30
051000	CHARGE FOR SENDING A FAX			11.00
051100	BREAKFAST, LUNCH AND DINNER	51.00		
051100	LODGING COST (ALLOWED)		136.00	
051100	BUSINESS PHONE CALLS			208.95
051100	PER DIEM BALANCE DUE			17.00
051200	JOHANNESBURG, NS			
051200	LODGING COST (ALLOWED)		70.00	
051200	PER DIEM FOR THAT DAY			47.00
051200	BALANCE ON PER DIEM NOT SHOWING			24.17
051200	BALANCE ON HOTEL ROOM			47.42
051300	DAR ES SALAAM, NS			
051300	BREAKFAST, LUNCH AND DINNER	65.00		
051300	LODGING COST (ALLOWED)		180.00	
051300	BUSINESS PHONE CALLS			39.88
051300	BLANCE ON HOTEL CHARGE			9.41
051400	BREAKFAST, LUNCH AND DINNER	65.00		
051400	LODGING COST (ALLOWED)		180.00	
051400	BUSINESS PHONE CALLS			39.88
051400	BLANCE ON HOTEL CHARGE			9.41
051400	CHARGE FOR SENDING FAX			6.25
051500	BREAKFAST, LUNCH AND DINNER	65.00		
051600	BREAKFAST, LUNCH AND DINNER	65.00		
051700	BREAKFAST, LUNCH AND DINNER	65.00		
051800	BREAKFAST, LUNCH AND DINNER	65.00		
051900	BREAKFAST, LUNCH AND DINNER	65.00		
052000	BREAKFAST, LUNCH AND DINNER	48.75		
052000	TAXI CAB COST			55.00
052000	ARRIVED WASHINGTON DC			

TOTAL M&IE LODGING AND OTHER

690.75

899.40

964.49

Name: SANDRA THURMAN

** Voucher Order No:

0225THU002

*** VOUCHER REMARKS TEXT
TRAVEL EXPENSES.

CAN	OBJ CLASS	EXPENSED AMT.	PROJECT CODE
001990225	21.52	9471.84	
001990225	21.9M	28.50	



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

FACSIMILE TRANSMITTAL SHEET

TO: Elaine Poski FROM: Sarah (395-1441)

COMPANY:

DATE:

FAX NUMBER:

201 480-8382

TOTAL NO. OF PAGES INCLUDING COVER:

4

PHONE NUMBER:

RE:

Voucher - Signed (Originals mailed)

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

NOTES/COMMENTS:

Thanks so much Elaine!!
I hope you feel better
soon - have a great
weekend!
St

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

SALES PERSON: 07
CUSTOMER NBR: 553100ITINERARY
TUNNAMDATE: 09 MAY 00
PAGE: 01TO: SANDRA L THURMAN
THE WHITE HOUSE OFFICE OF NATL AIDS POLICY
736 JACKSON PLACE, NW
WASHINGTON DC 20002
FEDEX 202-544-2778

FOR: THURMAN/SANDRA

REF: 0.217,7500W

09 MAY 00 - TUESDAY
AIR SOUTH AFRICAN FLT:144 ECONOMY LUNCH
LV JOHANNESBURG 125P EQP: BOEING 737-200
AR MAPUTO 220P 55MIN
NON-STOP
REF: RCTSYA

12 MAY 00 - FRIDAY
AIR SOUTH AFRICAN FLT:147 ECONOMY DINNER
LV MAPUTO 610P EQP: AIRBUS A320
AR JOHANNESBURG 705P 55MIN
NON-STOP
REF: RCTSYA

13 MAY 00 - SATURDAY
AIR SOUTH AFRICAN FLT:186 BUSINESS DINNER
LV JOHANNESBURG 350P EQP: BOEING 767
AR DAR ES SALAAM 800P 03HR 10MIN
NON-STOP
REF: RCTSYA

HOTEL DAR ES SALAAM
SHERATON HOTELS
SHERATON DAR ES SALAAM
OHIO STREET 25
DAR ES SALAAM TANZANIA
PHONE 255-51-112416
FAX 255-51-113981
GUARANTEED LATE ARRIVAL
CONFIRMATION C705912770

OUT-14MAY
1 NIGHT
1 ROOM 1X CORPORATE RATE
RATE 190.00USD PER NIGHT
CANCEL BY 05P DAY OF ARRIVAL

19 MAY 00 - FRIDAY
AIR AIR TANZANIA CORP FLT:754 BUSINESS SNACK
LV KILIMANJARO 525P EQP: BOEING 737-200
AR ENTEBBE 635P 01HR 10MIN
NON-STOP

CONTINUED ON PAGE 2

SALES PERSON: 21
CUSTOMER NBR: 553400

ITINERARY

ULIUWF

DATE: 09 MAY 00
PAGE: 01

TO: SANDRA L THURMAN
THE WHITE HOUSE OFFICE OF NATL AIDS POLICY
736 JACKSON PLACE, NW
WASHINGTON DC 20002

FOR: THURMAN/SANDRA

REF: U,217,7500W

14 MAY 00 - SUNDAY

AIR AIR TANZANIA CORP
LU DAR ES SALAAM

FLT:574

ECONOMY
1055A

SNACK

EQP: BOEING 737-200
50MIN

AR KILIMANJARO

1145A

NON-STOP

THANK YOU FOR USING SATOTRAVEL.
LOCAL PHONE NUMBER 301-984-8894 MON-FRI 730AM-530P
ON TRAVEL STATUS CALL 800-496-3628 MON-FRI 730AM-530P
YOUR REFERENCE CODE IS SABRE V075

FARE IS 127.00 USD ONE-WAY

REFUND RESTRICTIONS APPLY/FARE SUBJECT TO CHANGE UNTIL TKTD

Fedex to Tarz costs at least

\$150.00 + won't be delivered
until the 12th - if no customs
problems.....

Shall I hold off?

Claudine Mshali

Torge Andersen
Ron Dellums
Cornelius Baker

~~Walter~~
Mary Fisher
~~Walter~~

Atlanta
Civran
Gayle

Tony Fauci

David Ho

June Osborne

Art ~~Armann~~ Armann PAD

Mark Smith

West Coast

Faige, Bill

Tony Fauci

David Ho

June Osborne

Art Armann

Torge Andersen

Ron Dellums

Cornelius Baker

Pat Christen

Phil Wilson

~~Walter~~

Elysebeth Birch

~~Walter~~



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

FACSIMILE TRANSMITTAL SHEET

TO:

Sandy Thurman

FROM:

Cheryl Baucle

COMPANY:

DATE:

May 10, 2000

FAX NUMBER:

258-1-30-5305

TOTAL NO. OF PAGES INCLUDING COVER:

22

PHONE NUMBER:

RE:

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

NOTES/COMMENTS:

Please deliver to Sandra Thurman – room 1021

Hi Sandy – I think the attached is what you asked for. Let me know if I can send anything else.

Talk to you soon!

Cheryl

736 Jackson Place
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Remarks by Sandra Thurman
Director, Office of National AIDS Policy
Sixth Annual African American Summit

A little over one year ago, President Clinton came to Ghana to help Americans and Africans begin to see each other through new eyes. He was in fact the first American President ever to visit Ghana, and he came then, as we do now, to reach out to our brothers and sisters in Africa, and to create together a bold new partnership for the new millennium.

Beyond the old stereotypes and policies of paternalism, our shared vision is one of hope and empowerment, of democracy and freedom. It is a vision born of more than just compassion. It is a vision born of the realization that we are a global community with a shared destiny. And in this global community, both crisis and opportunity have no borders.

When President Clinton spoke here in Ghana he said:

"We need partners to deepen the meaning of democracy in America, in Africa, and throughout the world. We need partners to build prosperity. And we need partners to live in peace.

Well today, I would like to add that we need partners to confront our global battle against AIDS. To win, we will need to wage this war together.

As Africa stands on a brink of a new day, a silent killer stalks.

As the United States and Africa build a new partnership for growth and opportunity, a silent killer stalks.

And as we work together to build a better future for our children and grandchildren, a silent killer stalks.

And that killer is AIDS.

My friends, the American family has AIDS. The African family has AIDS. Our global family has AIDS. And so, in a very real way, we are all living with AIDS -- with no cure or vaccine in sight -- and will be for generations to come.

If we are determined to hold fast to our new vision for the 21st century -- we must commit today to join forces in an all-out war on a common enemy.

And that enemy is AIDS.

AIDS is a plague of biblical proportion, and it is claiming more lives than all armed conflicts waging around the world today . . . combined. While many of us have witnessed its devastation,

it is almost impossible to grasp the grip that AIDS has on villages across this continent and on communities around the world.

Today and every day, here in Africa, AIDS buries more than 5,500 women, men, and children. And that number will more than double in the next few years. AIDS is now the leading cause of death among all people of all ages in Africa -- and among young adult African-American men here in the United States.

And yet, the epidemic rages on. Each day, 11,000 people in Africa become HIV infected -- one every 8 seconds. Most of these new infections are among young people, under the age of 25. And by 2005, more than 100 million people worldwide will be HIV+.

In a host of different ways and from a variety of different vantagepoints, it is our children who are caught in the crossfire of this relentless epidemic, and who are crying out for our help. Our next generation is indeed in jeopardy.

In many communities throughout sub-Saharan Africa, AIDS has virtually wiped out parents and providers, leaving behind children and grandparents to care for each other.

In some countries, between one-fifth and one-third of all children have already been orphaned by AIDS. And the worst is yet to come. Within the next decade more than 40 million children will be orphaned by AIDS -- 95% of who will live in sub-Saharan Africa -- and this tragedy will continue to grow for at least another 30 years.

In just a few short years, AIDS has wiped out decades of hard work and steady progress in development -- and will soon double infant mortality, triple child mortality, and slash life expectancy by 20 years or more. In South Africa, from 60 to 40. In Zimbabwe, from 65 to 39. And in Zambia, from 56 to 37. And AIDS has had a devastating impact on economic growth -- striking down skilled workers in their prime and forcing many companies to hire two employees for every one job -- assuming that one will die of AIDS.

Yet amidst this tragedy is hope. Amidst this crisis is opportunity; the opportunity to empower women and men, to protect children, and to support families and communities in our battle against AIDS. In cities and villages across Africa, efforts are being made to stem the rising tide of HIV infection, to prolong the lives of those who are sick, and to stitch together a tapestry of family support systems for the growing millions of children orphaned by AIDS.

Twice this year, I have visited South Africa, Uganda, and Zambia at the request of President Clinton. Together with leaders from Congress and the private sector, we came to bear witness to the AIDS emergency and to search for ways to enhance our understanding and support for sustainable solutions springing up across this vast continent.

During these trips, we were blessed to visit with some of the real heroes in the battle against AIDS. From Cape Town to Kampala, we were inspired by women, men, families, and communities who refused to give up or give in, despite the seemingly insurmountable odds.

Take Bernadette, a woman from a small village outside Masaka, Uganda.

Bernadette has lost 10 of her 11 adult children to AIDS. Today, at age 70, she is caring for her 35 grandchildren. With loans from a village banking system, she has begun growing sweet potatoes, beans, and maize, raising goats and pigs, and trading in sugar and cooking oil.

With the money she earns, she is now able to send 15 of her grandchildren to school, provide modest treatment for the 5 who are HIV+, and begin construction on a house big enough to sleep them all. In her spare time, she participates in an organization called "United Women's Effort to Save Orphans" -- founded by the first lady of Uganda, Mrs. Museveni -- linking in solidarity thousands of women allied in the same great struggle.

And these women are not alone. From the young people doing street theater in Lusaka to educate their peers about HIV to the support groups in Soweto providing home and community based care for people living with AIDS -- communities are mobilizing and creating ripples of hope.

These are the faces of children and families living in a world with AIDS. And their spirit, their determination, and their resilience lead us on.

But we must remember, the tragedy of AIDS is not slowly nearing its end, it is just beginning to unfold. So as we struggle to move forward together -- the futures of these children and families compel us all to find ways to do better, to be smarter, to move faster, and to develop whatever capacity we lack, so we can gear up for the long haul.

Luckily, painful experience has taught us some valuable lessons, and we should take them to heart.

First, in reality, we are much more alike than we are different. And while we must celebrate our diversity -- there is much we can learn from each other.

Second, leadership matters.

While this war will depend on the valiant efforts of dedicated soldiers in communities worldwide, it can not be won without leadership from the top. We learned this the hard way in the United States. Throughout the 1980s, a legion of volunteers fashioned a caring response to AIDS, while the government said nothing. With the leadership of President Clinton, we have made great strides -- but much more remains to be done.

Here in Africa, President Museveni has been a strong and effective AIDS leader. In partnership with communities and donor nations, Uganda has cut the rate of HIV by more than half -- and has organized model programs for HIV counseling and testing, and AIDS care and support. In Senegal too, early leadership and mobilization has kept their AIDS prevalence low. In the final analysis -- there is simply no substitute for real and committed leadership.

Third, this fight requires an investment -- of time, energy and resources.

our new partnership, and more energized by our determination to doing everything that we can do to win the battle against AIDS.

Let me close with the words of Frederick Douglas, another great African-American civil rights leader:

"It is not light that is needed, but fire; it is not the gentle shoulder, but thunder. We need the storm, the whirlwind, and the earthquake. The feeling of the nation must be quickened and the conscience must be roused."

Let us commit together to not squander the loss of the nearly 14 million people around the world we have lost to AIDS, but instead build from this tragedy a foundation for hope, a legacy of compassion, and a partnership forged by our shared struggle.

Let us wage this holy war together and let's win.

Thank you and god bless you.

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release

May 10, 2000

TEXT OF A LETTER FROM THE PRESIDENT
TO SENATOR DIANE FEINSTEIN

May 10, 2000

Dear Senator Feinstein:

I am pleased to inform you that today I will sign an Executive Order that is intended to help make HIV/AIDS-related drugs and medical technologies more accessible and affordable in beneficiary sub-Saharan African countries. The Executive Order, which is based in large part on your work in connection with the proposed Trade and Development Act of 2000, formalizes U.S. government policy in this area. It also directs other steps to be taken to address the spread of HIV and AIDS in Africa, one of the worst health crises the world faces.

As you know, the worldwide HIV/AIDS epidemic has taken a terrible toll in terms of human suffering. Nowhere has the suffering been as great as in Africa, where over 5,500 people per day are dying from AIDS. Approximately 34 million people in sub-Saharan Africa have been infected and, of those infected, approximately 11.5 million have died. These deaths represent more than 80 percent of the total HIV/AIDS-related deaths worldwide.

To help those countries most affected by HIV/AIDS fight this terrible disease, the Executive Order directs the U.S. Government to refrain from seeking, through negotiation or otherwise, the revocation or revision of any law or policy imposed by a beneficiary sub-Saharan government that promotes access to HIV/AIDS pharmaceuticals and medical technologies. This order will give sub-Saharan governments the flexibility to bring life saving drugs and medical technologies to affected populations. At the same time, the order ensures that fundamental intellectual property rights of U.S. businesses and inventors are protected by requiring sub-Saharan governments to provide adequate and effective intellectual property protection consistent with World Trade Organization rules. In this way, the order strikes a proper balance between the need to enable sub-Saharan governments to increase access to HIV/AIDS pharmaceuticals and medical technologies and the need to ensure that intellectual property is protected.

I know that you preferred that this policy be included in the Conference Report on the Trade and Development Act of 2000, as did I. However, through this Executive Order, the policy this Administration has pursued with your support will be implemented by the U.S. Government. The Executive Order will encourage beneficiary sub-Saharan African countries to build a better infrastructure to fight diseases like HIV/AIDS as they build better lives for their people. At the same time, the Trade and Development Act of 2000 will strengthen African economies, enhance African democracy, and expand U.S.-African trade. Together, these steps will enable the United States to forge closer ties with our African allies, broaden export opportunities for our workers and businesses, and promote our values around the world.

Thank you for your leadership on this critically important issue.

Sincerely,

WILLIAM J. CLINTON

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

FACSIMILE TRANSMITTAL SHEET

TO:

Guest: Sandra Thurman

FROM:

Sarah

COMPANY:

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May 8, 2000

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USAID/SA TODAY

United States Agency for International Development in South Africa

HEALTH DEVELOPMENT

SEPTEMBER 1999

USAID manages the U.S. government's development assistance throughout the world. USAID South Africa's activities are designed to benefit people who were disadvantaged by apartheid, working through government and civil society partnerships in six key areas:

- 1) Democracy and governance
- 2) Education
- 3) Health and HIV/AIDS
- 4) Economic analysis capacity
- 5) Sustainable employment
- 6) Housing, urban and environmental services

SUPPORTING A UNIFIED HEALTH SYSTEM

The major health care challenge for South Africa is to provide equity in basic health care for all South Africans. A highly fragmented public health system served different population groups in the past. Compounded by a focus on curative treatment and lack of community participation, the majority population was deprived of even basic primary health care (PHC). Emphasis is now on developing an integrated PHC program as the cornerstone of South Africa's new health system.

Deaths from HIV/AIDS in Southern Africa are reported to be the highest in the world. Recent estimates suggest that over 22 percent of pregnant women in public health facilities in South Africa are HIV positive, with rates ranging as high as 32 percent in KwaZulu-Natal Province. The government has responded to the crisis with a comprehensive national action plan, embodied in the "Partnership Against AIDS" campaign, in which every

South African is urged to unite to conquer HIV/AIDS.



Community Outreach:
Monitoring children's growth

USAID works with South Africans to address two key health issues: combating HIV/AIDS and improving PHC. An important goal is to enable South Africa's health care officials to provide professional services that are patient-focused in a caring environment. The following objectives are emphasized:

- Increased use of essential PHC services and practices;
- Increased use of HIV/AIDS prevention and mitigation services and practices.

Equity in Integrated Primary Health Care Project

The EQUITY grant agreement was signed in September 1995. The EQUITY Project assists the South African government to change and strengthen its health delivery system so that high quality essential services can be made available to all South Africans, especially those currently under-served.

Equity is a seven-year, \$50 million project. The South African government demonstrates strong support for this project by providing counterpart funds of 34 percent of the total project budget.

The ultimate beneficiaries of improved health systems are those individuals previously denied adequate health care, particularly mothers and children in the rural areas, who will soon have access to adequate, integrated PHC services. The intermediate beneficiaries are the provincial and local government health departments and health training institutions.

Two years into the full implementation of this project, the National Department of Health (NDOH) and the East-



Treating tuberculosis

ern Cape Department of Health (ECDOH), supported by Management Sciences for Health (MSH), have made significant progress towards the goal of improving the access and quality of PHC services to historically disadvantaged population groups, accomplishments include:

- A unified drug logistics system has been fully implemented in the Eastern Cape and is being adapted nationally.
- The Directly Observed Treatment System (DOTS) methodology for diagnosis and treatment of tuberculosis is being implemented for the first time in multiple sites in the Eastern Cape.



- Condoms are widely and freely available in public sector institutions of the Eastern Cape for the first time without need for prior consultation with a medical official.
- Public/private partnerships involving the administration and management of small hospitals have been successfully initiated in the Eastern Cape.
- Prevention workshops provided for youth in urban, rural and informal settlement areas;
- Capacity building and technical assistance to NGOs in program design, implementation and development of education materials;



Helping improve community health clinics

Mitigating the Impact of HIV/AIDS

Since 1992, USAID/SA's HIV/AIDS strategy has been to support educational and prevention efforts. Accomplishments include:

- Community outreach and AIDS awareness activities for those "at risk", especially youth and women;
- Mining communities in Lesedi and Carltonville have been helped to reduce STDs among mine workers, their families and surrounding communities through the training of educators and motivators. A staffed mobile health clinic also takes service directly to the people who most need assistance.

A new five-year, \$10 million, HIV/AIDS grant has been developed recently with the DOH to support the government's campaign, "Partnerships Against AIDS". Focus is on prevention efforts, such as raising awareness, building capacity, linking research and service on sexually transmitted infections (STIs) and activities that support national initiatives for vaccine development. The USAID program will support prevention efforts in several sectors, including labor, business, media and local government. Discussions are underway with the DoH to support community-based efforts for programs to assist children, made vulnerable as a result of HIV/AIDS.

The South Africa Demographic and Health Survey (SADHS)

USAID/South Africa is pleased to have contributed to the SADHS, which was recently launched. This survey is the first of its kind in South Africa after 1994, and marks an extensive collaborative effort between the DOH, the Medical Research Council (MRC) and USAID. The information provides data on key maternal and child health indicators, including medical care for mothers during pregnancy, immunization coverage, family planning, women's status, and reproductive health. The data will provide a wealth of information on women and children, and will be of enormous utility to policy makers, program managers, and researchers.

Reducing Violence

As a special emphasis area for mitigating the impact of HIV/AIDS, USAID is supporting a community



White House AIDS Advisor visits South African children

based program to reduce violence, especially towards young women:

Amy Biehl Foundation Trust – "Weaving a Barrier Against Violence" is a program of the Amy Biehl Foundation Trust (ABFT) in the Western Cape that honors the memory of the Fullbright scholar whose life was lost in Gugulethu in 1993. The project helps disadvantaged youth between the ages of 10 and 15 and their families in health care, first aid training, education, skills development, after school programs, income generation, recreational therapy, and counselling. A unique feature of this program is the community based integrated development approach of ABFT. An income generation scheme featuring bread production will ensure the long term sustainability of ABFT, as well as providing much needed jobs for youth in the community. This program receives funding from several SO's of the Mission.

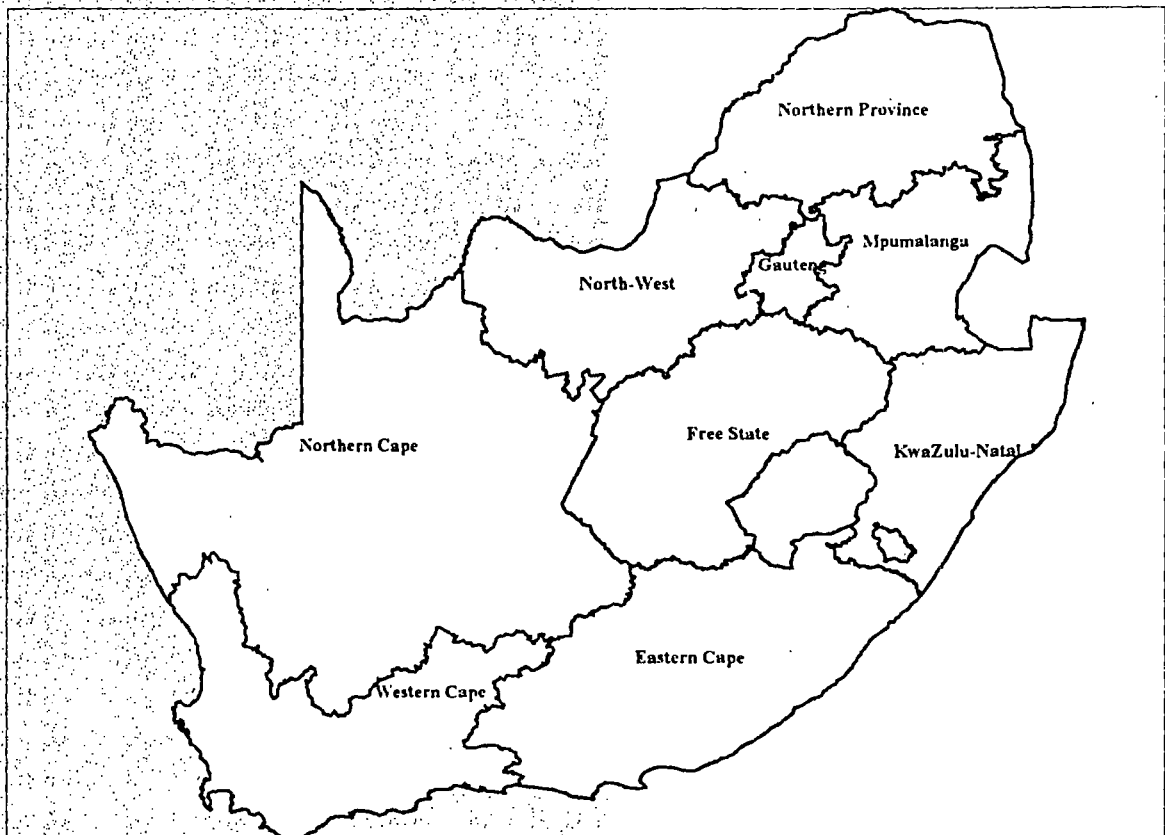
Further information is available from USAID/SA's Health Development Team Leader,

Dr. Ken Yamashita: (Tel) 012-323-8869 ext 231 or (Fax) 012-323-6443

P.O. Box 55380, Arcadia, Pretoria, 0007, South Africa. * Website: <http://www.sn.apc.org/usaidsa>

SUMMARY REPORT

NATIONAL HIV SERO-PREVALENCE SURVEY OF WOMEN ATTENDING PUBLIC ANTENATAL CLINICS IN SOUTH AFRICA 1999



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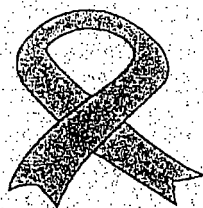
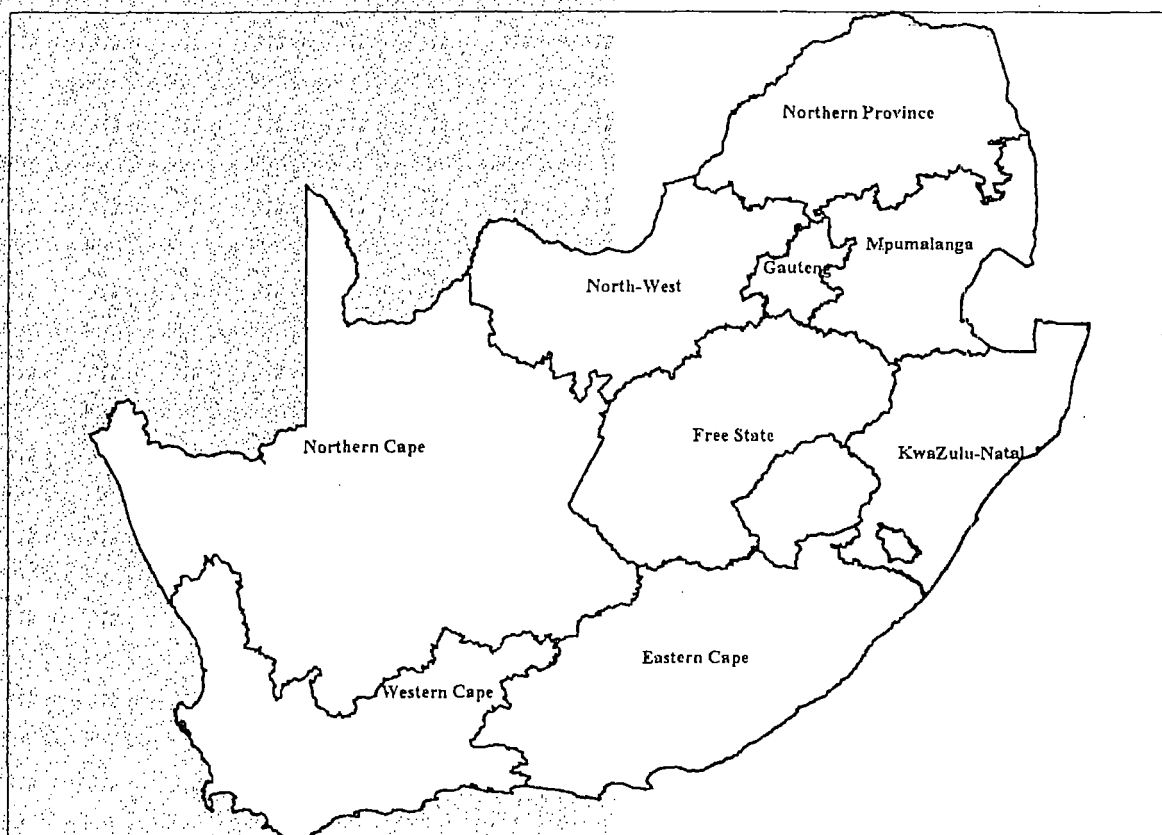
DEPARTMENT OF HEALTH

Directorate: Health Systems Research &
Epidemiology
April 2000

SUMMARY REPORT

NATIONAL HIV SERO-PREVALENCE SURVEY OF WOMEN ATTENDING PUBLIC ANTENATAL CLINICS IN SOUTH AFRICA

1999



AIDS HELPLINE
T 0800-012-322



DEPARTMENT OF HEALTH

Directorate: Health Systems Research &
Epidemiology
April 2000

ACKNOWLEDGMENTS

I would like to thank the Provincial Heads of Department for the support given throughout the execution of this annual survey and acknowledge the keen participation of provincial health departments, in particular co-ordinators P Moetlo (NP), R Rabie, (NC), M Kutu (EC), L Smit (WC), L van der Bank (FS), B Harris (MP), S Jikwana (GP), B Singh (KZN) & F Monama and C Vundule (NW) and staff in participating clinics.

Many thanks to the South African Blood Transfusion Services, SAIMR laboratories, Virology Departments of Cape Town and Natal Universities, the NIV, and the Medical University of Southern Africa (MEDUNSA) who have worked hard to ensure good quality data.

Sincere thanks to the Medical Research Council, our principal partners in refining the survey methodology and in particular, Dr Jonathan Levin, MRC statistician for assisting with analysis and verification of the findings.

Special thanks go to women attending antenatal clinics who participated and without whom the survey would not have been possible.

Finally I would like to acknowledge the unit that is responsible for co-ordination of the survey. Mrs Nthari Matsau, Chief Director: Health Information, Evaluation and Research and in particular Dr Lindiwe Makubalo, Director: Health Systems Research, Research Co-ordination & Epidemiology, Dr Rose Mulumba Deputy Director, Health Systems Research, Research Co-ordination & Epidemiology, Mr Mani Naicker, Ms Ntomboxolo Bikitsha, Ms Lusanda Mahlasela, and everyone who played a role in the coordination of this study and compilation of this report.

Dr A NTSALUBA

Director General: Department of Health

March 2000

1. INTRODUCTION

HIV/AIDS is the most serious and devastating disease that faces the world today. Available information is showing that developing countries are most affected. The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that 95% of people currently infected with HIV/AIDS and 95% of the lives claimed by AIDS since the beginning of the epidemic, live in developing countries (UNAIDS, 1999)

Over the last few years the national and international response to the HIV/AIDS epidemic has increased dramatically. This, in addition to observations that the epidemic can be slowed down with appropriate interventions, is giving hope to the challenge of the epidemic.

In 1990 the Department of Health (DOH) instituted a mechanism to monitor the HIV epidemic in South Africa. Since then, a series of anonymous unlinked surveys of HIV have been conducted yearly amongst women attending antenatal clinics in public health facilities.

The tenth annual national HIV survey of women attending antenatal clinics of the public health services took place during October 1999. These surveys form the cornerstone of HIV surveillance in South Africa, and are extremely important for South Africa to monitor the stage the epidemic has reached and assess whether intervention strategies may be impacting on the epidemiological profile of HIV/AIDS.

The following report outlines the main findings, extrapolates HIV infection rates beyond women from antenatal clinics and in presenting the statistics would like to emphasize that the main value of these estimates lies in what can be done to prevent the spread of the epidemic, in joint partnership programmes.

2. OBJECTIVES OF THE HIV SURVEY

The specific objectives of the 1999 survey were to determine, in women attending antenatal clinics of the public health services, at the end of 1999 estimates of;

- The point prevalence of HIV infections throughout South Africa
- The prevalence of HIV in each province
- The prevalence of HIV in each region
- Prevalence trends from 1990 to 1999

The study also aimed to;

- Describe the above prevalence in terms of temporal trends, geographical location, age and race,
- Study determinants such as education and race (as proxy indicators for socio-economical status) with relation to women's risk of contracting HIV and syphilis and
- Use the data for projections of HIV infection in the general population.

3. SURVEY METHODOLOGY

3.1 Study design

An anonymous, unlinked cross-sectional survey was conducted among pregnant women attending antenatal clinics of the public health sector in South Africa. First time antenatal clinic attenders (during the current pregnancy) were eligible for inclusion in the study. The survey ran concurrently across the nine provinces, during the month of October 1999.

A standard national protocol was developed in collaboration with the MRC and other partners and has been phased-in over a three year period. It has strengthened the study methodology, in particular sampling and quality control. The protocol is followed closely by eight provinces with the exception of Mpumalanga province which is expected to phase-in the national protocol in the 2000 survey. Implementation of this protocol has been monitored closely and gradual phasing-in was adopted so as to ensure that expected prevalence trends are not disrupted.

3.2 Study administration

The national department of health (co-ordinating office) hosted a planning workshop before commencing the study. At this workshop sample sizes were determined and the roles and responsibility of provincial co-ordinators and others involved in the study were agreed and clarified.

Provincial co-ordinators were responsible for overseeing the smooth running of the survey in each province, ensuring that the proper sampling method was applied and that the sites were prepared. Their co-ordinating role also entailed making arrangements for the fieldwork material (5 ml vacutainers with SST gel and clot activator, paired bar-code labels and data capture sheets) to be delivered on time. Finally each provincial coordinator was responsible for overseeing the data entry process, as participating laboratories generated testing results.

Each participating laboratory had a co-ordinator who was responsible for the overall running of the testing procedures for a specific province (s). The laboratory co-ordinator ensured the effective running of the ELISA and RPR tests. Using the bar-code label on each data-capture sheet, the results for each test were filled-in and the data capture sheet sent back to the provincial co-ordinator for data entry. The laboratory co-ordinator was also responsible for the quality assurance test for HIV and storage and shipment of all HIV positive sera to the University of Natal-Durban (UND) Virology laboratory for possible future HIV incidence testing.

The national co-ordinating office was responsible for the overall co-ordination of the survey and preparation of this report.

3.3 Field Logistics

Field logistics for the study were elaborate as large distances were covered between the 487 participating clinics. Not all clinics were easily accessible but their inclusion was however critical for achieving a representative sample of women. Other logistical arrangements included transporting blood specimens from clinics where they were collected to laboratories for testing. The SAIMR network of courier services was employed for this purpose, except in deep rural areas where private contractors were brought on.

3.4 Sentinel population

The sentinel population for the study comprised pregnant women. The choice of pregnant women is based on international scientific practice. Pregnant women are normally preferred as they are sexually active, constitute an easily identifiable, accessible and stable population, and are more likely than other groups to be representative of the general population. In addition, this group obtains health care at facilities where blood is drawn as part of routine medical services offered for women's health

In South Africa 89,4% of all pregnant women and 90,2% of African women attend public antenatal clinics (DHS, 1999). As only public sector health facilities are sampled, there is an inherent under-representation of race groups other than African women.

3.5 Sampling methodology

The sampling method used was a systematic cluster random sample in which weighting is conducted using the probability proportional to size (PPS) technique. Each selected clinic/site is the primary sampling unit (PSU). This means that at each clinic, all first time antenatal clinic attenders have the same chance of being selected for the study.

The PPS method was used in all provinces except Mpumalanga, where a blanket survey (including all antenatal clinics of the public sector) was conducted every year since 1995 and participating clinics are selected from the total number of antenatal clinic points.

3.6 Inclusion criteria/procedures

In the public health sector, when women present at the antenatal clinic, routine blood specimens are taken to test and, if necessary to treat the women for syphilis. 5ml of blood are drawn into a tube which is labeled with the woman's name, age and the facility.

For this survey women attending each of the participating clinics for the first time in the current pregnancy were eligible for inclusion in the study. In accordance with

ethical principles and guidelines followed by the survey the women are given a full briefing and they are informed that the survey is unlinked, anonymous and confidential ie. it is not possible to link any result to an individual by name or any other identifier. They are then given the option to agree or decline participation in the survey. They are offered three choices;

Consent to participate in the study and not know their HIV status; consent to participate in the study and know their HIV status; refuse to participate in the study altogether.

The woman's preference is complied with using the following process:

If a woman chooses to participate and know her HIV status she is encouraged to visit the voluntary, testing and counseling facilities offered as a separate service by clinics as it is not possible through the antenatal survey procedure to trace a woman's HIV status on account of the built in confidentiality.

If a woman chooses not to participate in the antenatal survey, a blood specimen is only taken for syphilis testing as per routine care service. Blood for the antenatal survey HIV test is not taken and the woman is not included in the study.

3.7 Sampling sites

The 1997 standardized national survey protocol proposes that specific sites are chosen from each region and that the same sites are used in future studies. This approach is more compatible with the principles of sentinel surveillance and has been used successfully in KwaZulu-Natal for the past 8 years.

In 1999, a total of 487 sites (clinics) participated in the survey. All sites were asked to consider for inclusion in the sample the first forty antenatal attenders (during the current pregnancy) in the period 1st to 31st October 1999. The sampling sites have been plotted on provincial maps using Geographical Information System (GIS) technology. Antenatal clinics for which co-ordinators could not be obtained are also listed. These will have to be located using the Global Positioning System (GPS), prior to the mapping. A total of 16,841 women (blood specimens) were included from the 487 sites in 1999.

3.8 Laboratory testing

In accordance with the recommendations of the World Health Organization (WHO) on HIV screening for surveillance purposes, blood specimens were tested with one ELISA (Abbot Axysm System for HIV -1/HIV-2) assay in all provinces except the Western Cape. Serum that was reactive on this test was considered HIV antibody positive. Due to the low HIV prevalence rate in the Western Cape province (less than 10%), two ELISA tests were used. Any serum found reactive on the first assay was retested with the second ELISA test which was based on a different antigen preparation or a different test principle. Serum that was non-reactive on the first test was considered HIV antibody negative and was not retested. The specimens were also screened for active syphilis using the RPR test.

3.9 Quality assurance

The National Institute of Virology (NIV) was responsible for the quality control of the HIV prevalence testing. A panel of twenty specimens was sent by the NIV to each of the seven laboratories participating in the sero-prevalence survey, namely the South African Institute for Medical Research (SAIMR) central laboratory in Johannesburg, the SAIMR provincial labs in Bloemfontein, Kimberly, Port Elizabeth Cape-Town and the virology laboratories of the University of Natal-Durban (UND) and Medical University of Southern Africa (MEDUNSA). All participating laboratories were asked to test each of the twenty specimens in the NIV panel for HIV antibodies.

3.10 Data processing and analysis

Data analysis was done using the EPI INFO 6 and STATA software packages. These packages are preferred because they have the option of assuming a clustered sampling design in their analysis instead of simple random sampling. Developed jointly by the World Health Organization (WHO) and the Centres for Disease Control and Prevention (CDC), EPI INFO 6, it is also freely available and already used extensively in most provinces by surveillance officers. Copies of an EPI INFO 6 programme designed for the purpose of the survey were made available to each of the provincial survey co-ordinators for data entry.

4. SURVEY RESULTS

4.1 National HIV prevalence

On the basis of the 1999 survey, the HIV prevalence rate is estimated at 22.4% of women attending antenatal clinics being HIV positive by the end of 1999.

The estimates for the years 1990 to 1998 showed a steady increase from 0.73 % in 1990 to 22.8% in 1998. The 1999 prevalence rate (which lies within the same confidence interval as the 1998 estimates) suggests that HIV prevalence rates have not increased and that we may be seeing a slight change in the epidemiological trends of the HIV epidemic in South Africa. Table 1 shows HIV prevalence rates in relation to rates in 1998.

4.2 HIV prevalence by age

HIV prevalence continues to present differently in different age groups. Women in their 20's continue to have the highest HIV prevalence rates. The 20-24 years old group was found to have an HIV prevalence rate of 25.6% while the 25-29 years old women rate was 26.4%. These rates are similar to HIV in the same age groups in 1998.

There are suggestions of an upward shift in HIV prevalence in relation to age. In 1999 the age group 35 to 44 were found to have slightly higher HIV prevalence rates than the same group in the previous years.

It is noted that HIV prevalence amongst teenagers was lower in 1999 than in 1998.

4.3 Provincial HIV rates

Provincial HIV prevalence rates are shown in table 1 and graph 2.

In 1999 provincial HIV rates were as follows; KwaZulu-Natal 32.5%, Mpumalanga 27.3%, Free State 27.9%, Gauteng 23.8%, North West 23.1%, Eastern Cape 18.0%, Northern Cape 10.1%, Northern Province 11.4%, Western Cape 7.1%.

The provincial rates are clearly suggesting a changing epidemiological pattern for HIV prevalence in South Africa. As in previous years, a continuous increase in HIV prevalence is observed in five of the nine provinces, namely Free State, Gauteng, North West, Eastern Cape, and Western Cape.

Interestingly, we observe no significant increase in HIV prevalence rates from those rates observed in the previous year in three provinces, viz KwaZulu-Natal, (32.5%: 32.5%) Northern Cape (10%: 9.9%) and the Northern province (11.3%: 11.5%) in 1999 and 1998 respectively. Mpumalanga reports a lower prevalence rate between the two years. This sudden decrease may be attributed partly to the sampling method used in that province. The provincial prevalence rates are shown in table 4 and graph 4

4.4 Rates of increase

Rates of increase for HIV prevalence give a useful indicator of the rate at which the epidemic may be escalating. The national HIV prevalence and rate of increase did not change from 1988 to 1999. An increase was observed in six of the provinces. The rate of increases by province in 1998 to 1999 is as follows:

Western Cape	(36.5%)
Free State	(22.4%)
Eastern Cape	(13.3%)
North West	(08.0%)
Gauteng	(05.8%)
Northern Cape	(02.0%)

Rates of increase were observed in four of the age groups as follows:

<20	(21.4%)
35-39	(20.9%)
40-44	(15.2%)
30-34	(13.6%)

4.5 Extrapolation to the general population

As the antenatal survey results are only able to give direct estimates of HIV among (pregnant) women, no information is available on women who are not pregnant as well as men and children. In order to obtain an estimate on the approximate numbers of men, infants and children who might have been infected with HIV at the end of 1999, projections are, therefore, made to extrapolate the numbers of persons who would have been infected in 1999. The numbers infected need to be viewed with the some caution because of the limitations in the methodology applied.

Our projections of the estimated number of individuals infected with HIV in South Africa by the end of 1999 are as follows; Women (15-49yrs.) 2.2 million; men (15 - 49yrs.) 1.9 million and babies 94,608 - 102, 000. In total this is an estimated number of approximately 4.2 million South Africans.¹ UNAIDS estimates of the number of people infected with HIV in South Africa concur with the estimates in this study.

These estimates suggest that approximately one in every 10 South Africans are infected with HIV

6. DISCUSSION / CONCLUSION

National prevalence trends

The findings of the antenatal prevalence study show that the national prevalence rate has not increased from the previous year. The decimal point difference in the national prevalence rate between 1998 and 1999 should not be read as a decrease as the true value for each estimate could lie anywhere within the range of confidence limits, which are similar for the two years.

The data from the 1999 antenatal survey seems to suggest that we may be seeing a slight change in the epidemiological pattern of the HIV epidemic in South Africa.

¹ The numbers of those infected in the age groups not represented here are very small and would not influence the estimated numbers significantly.

While there is an increase in HIV prevalence from 1998 to 1999 in seven provinces, for the very first time the increase in HIV prevalence has ceased to occur in an exponential manner as it did between 1990 to 1998 when it increased steadily from 0.73 % in 1990 to 22.8% in 1998. The pattern observed in 1999 is consistent with an HIV/AIDS epidemic that has reached its plateau level and is entering its 'stabilization' phase after a decade of rapid spread (UNAIDS, 1999)

Ten year trends

Graph 1 shows HIV prevalence trends in South Africa for the past 10 years. Between 1990 and 1992 HIV was largely characterised by infections in the homosexual male population. From 1993 onwards the HIV infection pattern changed to become mainly heterosexual as in the rest of sub-Saharan Africa. This shift resulted in a much greater number of people being infected and a much more rapidly increasing HIV prevalence.

Between 1992 and 1994 there was an exponential increase from approximately 2% to 8 %. Variations from 1995 to 1998 have consisted in sharp increases in the HIV prevalence rate each year. In total the HIV prevalence rate has increased more than 30 times from the beginning of the epidemic in 1990.

With the observations made in 1999, it may be premature for South Africa to conclude that the HIV epidemic has stabilized based on the available data. It is however worth noting that Uganda and Thailand both reported similar shifts in their epidemiological profiles. Uganda in fact had reported a 29% decline in 1995 from the reported rate in 1994.

Provincial prevalence trends

As illustrated in past surveys, the progression and magnitude of the HIV epidemic varies across different geographic regions South Africa. These differences are shown in map 1. They illustrate the important fact that the epidemic is at different stages in different parts of the country.

Over the years, KwaZulu-Natal and the Western Cape have consistently remained at the extreme ends of HIV prevalence levels. While findings from the 1999 antenatal HIV survey confirm these trends, they also begin to point our attention to the different stages of the epidemic in different provinces and in different age groups.

Whilst KwaZulu-Natal remains the province with the highest prevalence rate, no increased rate is shown in this province between 1998 and 1999. In contrast, the Western Cape, whilst remaining the province with the lowest level of infection, shows a 36.5% rate of increase from 5.2% in 1998 to 7.1% in 1999.

The variation in HIV infection levels across the provinces of South Africa has been partially explained by urban-rural differences as well as differences in the level of migration and other social circumstances.

Age associated Prevalence trends

With respect to age related prevalence rates, the 1999 survey shows that the HIV prevalence pattern has remained more or less similar to the pattern seen over the years. Women in their 20s continue to represent the group with the highest number of individuals who have HIV infection. HIV prevalence has increased in all age groups except the teenage groups where the rate of increase was lower.

In other epidemics (countries) such as Uganda this decline in HIV prevalence amongst teenagers has signaled a positive trend suggesting that new infections (incidence) may be on the decline. Clearly, HIV incidence studies are required to confirm these observations. A true decline in HIV incidence amongst teenage girls in the antenatal clinics in Uganda and a reduction in HIV prevalence amongst young male military recruits in Thailand correlated with maturing of the epidemic and an overall reduction in HIV prevalence in the country. These reductions in HIV prevalence were confirmed by a reduction in new infections (incidence studies) and suggested success of intervention programmes which has included amongst other things effective HIV messaging, condom use and treatment of STDs.

General

The most important finding of this survey is that the prevalence of HIV/AIDS remains alarmingly high in all provinces and in most age-groups. Projections of the actual number of individuals who have HIV infection out of the total population of South Africa have their limitations. What is important however is the clear indication that several million individuals (4.2 million) are infected with HIV in South Africa. These findings have important implications on the ongoing and future efforts of HIV/AIDS partnerships.

In the provinces and age groups where HIV did not increase from the previous year it is important that there is caution in concluding that the epidemic is indeed slowing down as other data are required to support such a conclusion. UNAIDS has documented that the HIV epidemic can display a progression in waves interrupted by periods of *relative* stability. Close and proper monitoring of programmes is required to prevent these waves and ensure an *absolute* stabilization of HIV infection rates. In this respect, apart from ongoing disease prevention and control programme activities, a second generation surveillance programme is being put in place which will include incidence testing to assess new cases of infection as well as behavioral surveillance and risk surveillance to assess the impact of intervention strategies.

While commitment is seen at all levels of society, the HIV/AIDS epidemic requires an ever increasing concerted effort to meet the challenges it presents to infected and affected individuals, to employment and industry, social welfare, health services, families and the entire social fabric of South African society.

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Figure 1: HIV Prevalence trends in South Africa 1990 - 1999

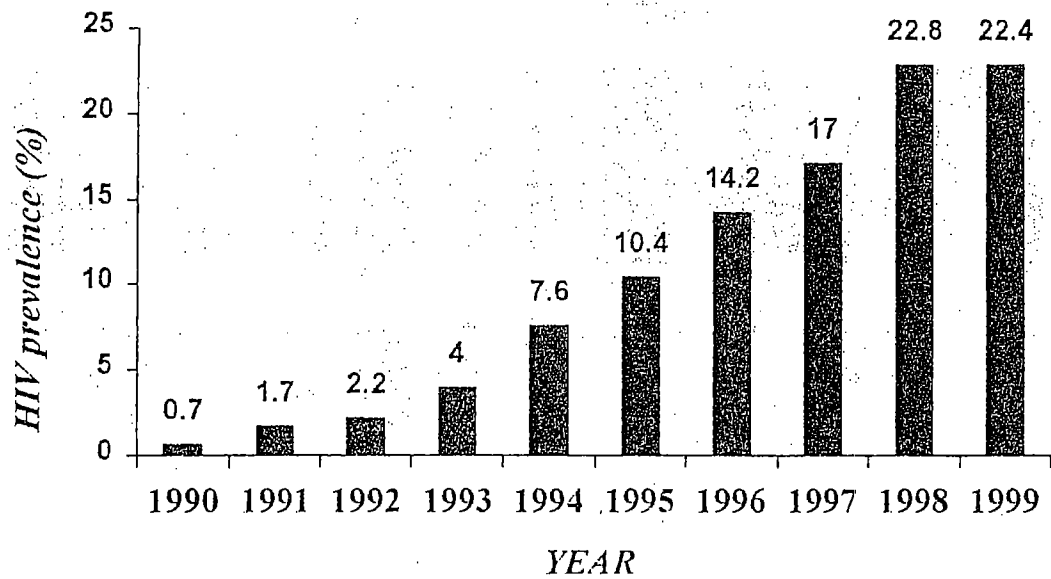


Figure 2: HIV Prevalence by Province in South Africa, 1999

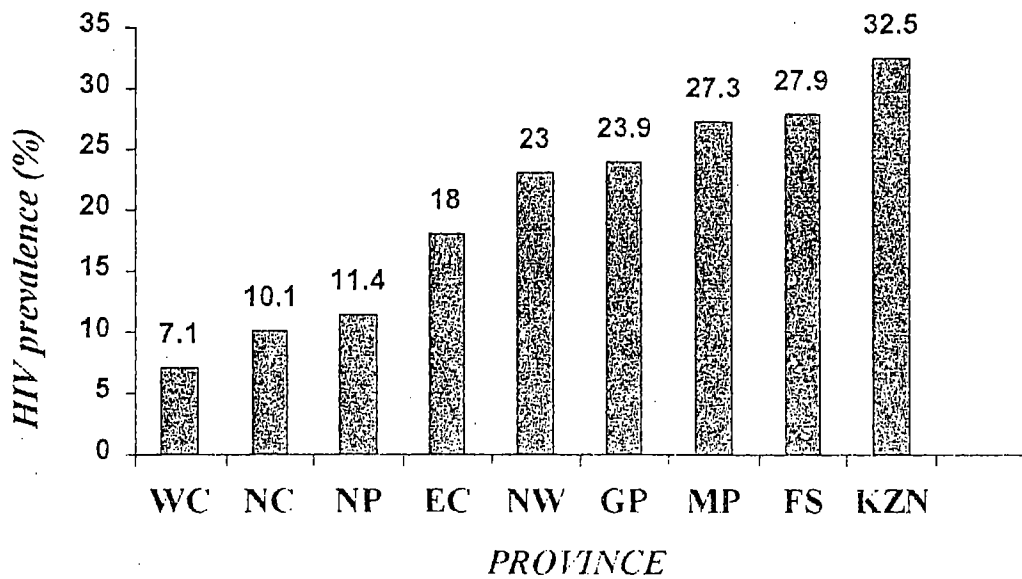


Figure 3: HIV Antenatal Survey, 1999

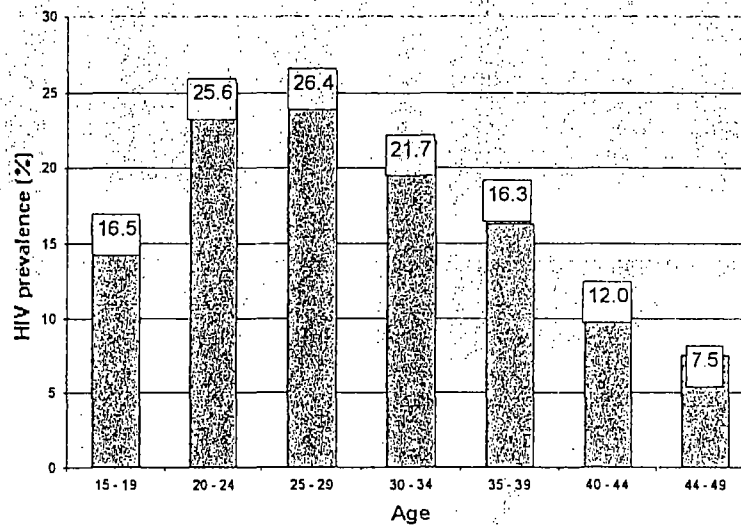


Table 1: HIV prevalence amongst women attending antenatal clinics in 1999

PROVINCE	Est (HIV+) 95% CI 1999
KwaZulu/Natal	32.5 (30.1 - 35.0)
Free State	27.9 (25.2 - 30.7)
Mpumalanga	27.3 (24.7 - 29.8)
Gauteng	23.9 (21.7 - 26.0)
North West	23.0 (19.7 - 26.3)
Eastern Cape	18.0 (14.9 - 21.1)
Northern Province	11.4 (9.2 - 13.6)
Northern Cape	10.1 (6.6 - 13.5)
Western Cape	7.1 (4.4 - 9.9)
National	22.4 (21.3 - 23.6)

NB: The true value is estimated to fall within the two confidence limits, thus the confidence interval is important to refer to when interpreting data.

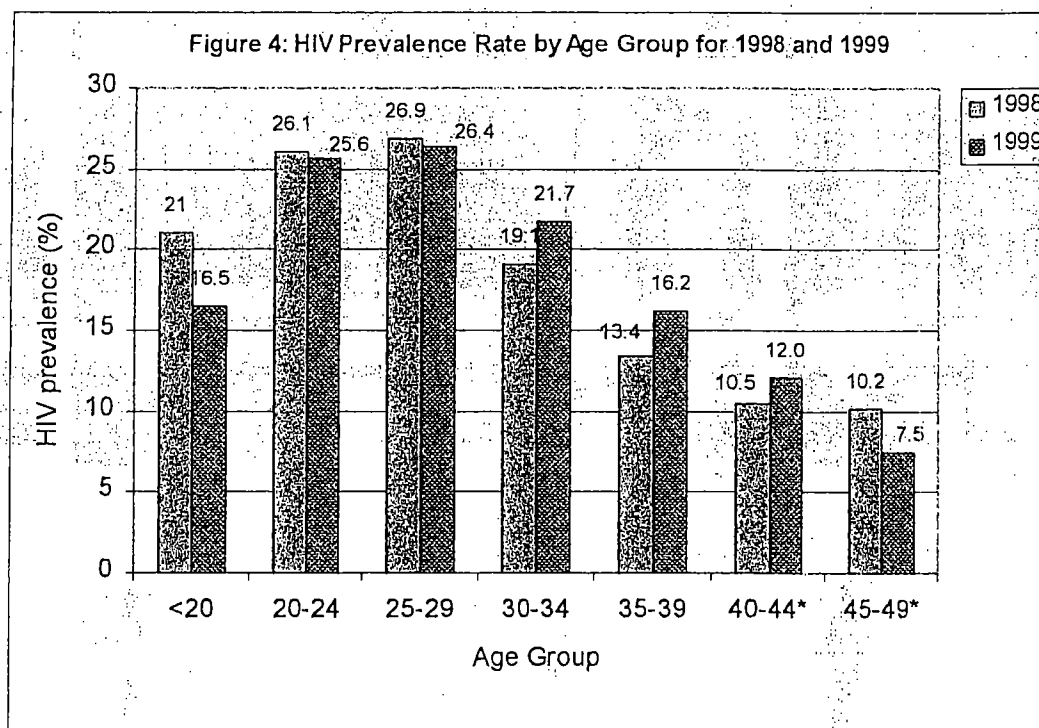


Table 2: HIV prevalence by age, comparing 1998 and 1999 antenatal survey findings

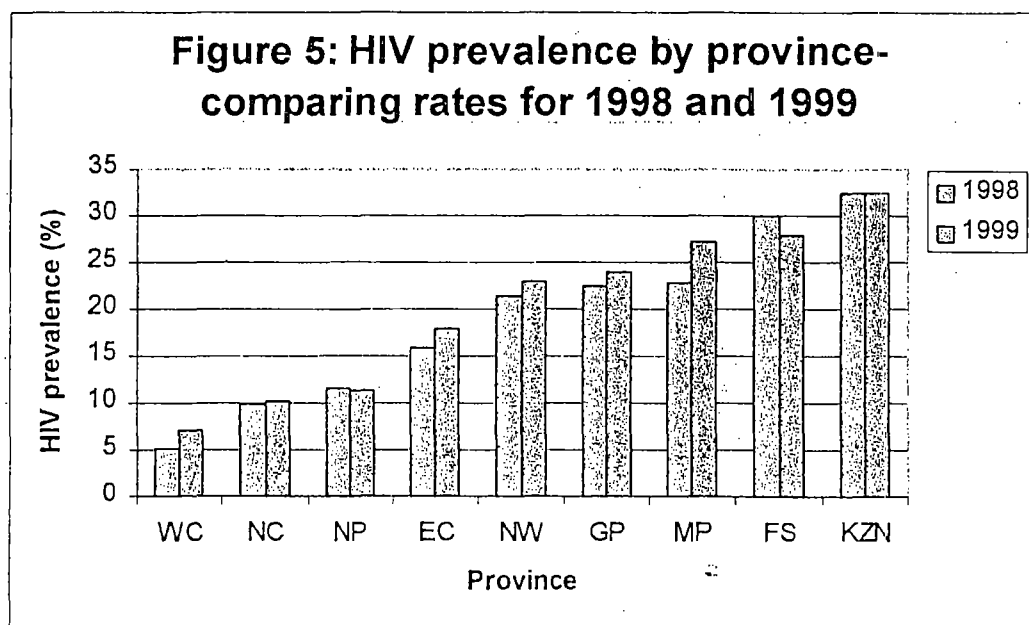
AGE GROUP	Est (HIV+) 95% CI 1998	Est (HIV+) 95% CI 1999
<20	21.0 (18.4 - 23.8)	16.5 (14.9 - 18.1)
20-24	26.1 (24.1 - 28.1)	25.6 (24.0 - 27.3)
25-29	26.9 (24.7 - 29.0)	26.4 (24.6 - 28.3)
30-34	19.1 (17.1 - 21.1)	21.7 (19.1 - 23.8)
35-39	13.4 (11.2 - 15.6)	16.2 (14.1 - 18.3)
40-44*	10.5 (6.8 - 14.1)	12.0 (8.5 - 15.6)
45-49*	10.2 (0.4 - 20.0)	7.5 (-.77 - 15.9)

* Note that the wide confidence intervals (CI) are a result of the smaller numbers of women who participated in the study.

Table 3: HIV prevalence by province, comparing 1998 and 1999 antenatal survey findings

PROVINCE	Est (HIV+) 95% CI 1998	Est (HIV+) 95% CI 1999
KwaZulu/Natal (KZN)	32.5 (29.3 - 35.7)	32.5 (30.1 - 35.0)
Mpumalanga (FS)	30.0 (24.3 - 35.8)	27.3 (25.2 - 30.7)
Free State (FS)	22.8 (20.2 - 25.3)	27.9 (24.7 - 29.8)
Gauteng (GA)	22.5 (19.2 - 25.7)	23.9 (21.7 - 26.0)
North West (NW)	21.3 (19.1 - 23.4)	23.0 (19.7 - 26.3)
Eastern Cape (EC)	15.9 (11.8 - 20.0)	18.0 (14.9 - 21.1)
Northern Province (NP)	11.5 (9.2 - 13.7)	11.4 (9.1 - 13.5)
Northern Cape (NC)	9.9 (6.4 - 13.4)	10.1 (6.6 - 13.5)
Western Cape (WC)	5.2 (3.2 - 7.2)	7.1 (4.4 - 9.9)
National	22.8	22.4

NB: The true value is estimated to fall within the two confidence limits, thus the confidence interval is important to refer to when interpreting data.



Sharing the nightmare

Telling people at work you're HIV-positive is critical to managing the Aids crisis at a national level, says **Kevin Osborne**, reporting on a soon-to-be launched national public disclosure initiative. He spoke to Ricki Treurnicht about how she shared the most frightening news of her life

An estimated 3.6 million people are currently living with HIV and more than 1 500 new infections occur every day. Translated into human terms, this means that we all know someone who's HIV-positive. But the question is: has that person shared the information with you? Because the time will come when he or she does. And how will you react when you're told that someone close to you is HIV-positive?

For Johannesburg personnel consultant Alta Beekhuizen, that day came in November 1996. She recalls it clearly. She'd just arrived home from work when her daughter told her that Ricki, her closest friend for 12 years, was on the phone. Alta looked forward

to the time when Ricki could meet her, but when Ricki's secretary, behind her desk, couldn't meet her eyes and then abruptly told her that the results of my routine test indicated I was HIV-positive.

Without offering much in the way of support, the doctor ushered Ricki out of the room. With her head full of fearful images and thoughts of suicide, Ricki drove home, knowing the life-path she'd planned had just taken a major detour. She needed to share her news. Alta was the person she chose to tell.

At the time, I suppose I wasn't thinking clearly, so I didn't wonder how I would tell her, or what it would mean to her.

When she got home she phoned Alta, who lives 1 000 kilometres away.

I knew about HIV, but hadn't paid it much attention. Yet in an instant it was real. So close. Looking back, I reacted with total shock and disbelief, says Alta.

They made immediate plans for Alta to visit Ricki in Cape Town, but neither slept well that night. I wept for the loss of my friend. I wept for the loss of her quality of life and for what she'd have to go through, says Alta. And I wept for me.

For Ricki, a devout Buddhist, the painfully slow passage to self-discovery in the shadow of HIV began that night. Knowing that I wasn't alone, that at least someone else in my world shared my pain, gave me greater comfort than I initially realised.

Her diagnosis turned out to be the catalyst for rediscovering her spirituality and coming to an understanding that the physical is just one colour in life's spectrum. Since Ricki's voluntary disclosure she's experienced the sharp edge of society's prejudice, even in a sophisticated business environment. Disclosing at your

'Knowing I wasn't alone, that someone else shared my

place of employment is difficult but very necessary, she says. It's part of a process of self-acceptance and normalisation.

Prejudice in the workplace makes HIV disclosure a seemingly insurmountable obstacle. But until it becomes an acceptable part of the work landscape, HIV/Aids will continue to carry a stigma, causing untold human misery. And this must affect the productivity and economic viability of a country where an estimated

22.8 percent of the population are currently living with HIV. All workplaces should actively promote voluntary disclosure within a protective and supportive environment, says Nikki Schaaf of the National Aids Convention of South Africa (Nacosa).

to catching up on all the latest news. When I heard Ricki's voice, I knew something was wrong, she recalls. But she had no idea just how devastating the news would be.

For the recently divorced Ricki Treurnicht, that Tuesday in November began in a routine way. A successful businesswoman, she'd had a typically taxing morning by the time she picked up her mother to take her to the doctor.

Earlier in the day my doctor, with whom I've been for two years, had said she wanted to chat to me. I was curious but presumed she wanted to talk to me about my mom's treatment. After she'd seen my mother, I stayed on at her request. She moved be-



THE
HIT
WAS
A
QUESTION
RIGHT
FROM
THE
START
BY
JANIS
PARK

pain, gave me greater comfort than I initially realised

How to respond

- Show empathy and reach out. It can be important to be together when a crisis is made, even if it's just a phone call. It's an immediate physical contact shows your emotional relationship won't change.
- If it's over the phone, make plans to see each other immediately. Move mountains to be together at this time.
- Let your friend know she's loved, for most

people living with HIV, the fear of rejection is greater than the fear of illness and death.

- Listen attentively. Don't interrupt or make her shocked and upset in this unexpected news. Allow your friend the space to talk.
- Don't ask how, where, when or why. At this moment these are unimportant. Allow your friend the space to absorb the fact that she's shared this information with you.

On a note, I will be moving to another

- It's a great comfort to know a friend is in a positive frame of mind. It's a chance to share the news. Explore various options in which confidentiality can be maintained.
- Thank your friend a positive friend for sharing this news with you, for trusting you. This will show that you understand the stigma that's often associated with the disease.

love lines

Free to choose

Imagine this: the perfect date, the perfect chardonnay, and now for the big choice – do you go for the crispy duck à l'orange or the butter-nut gnocchi? The wrong choice could spoil the taste of the expensive wine and ruin a wonderful evening. Your insecurity about your meal lies in your inability to choose. To make the right decision you need to know the difference in taste and texture between the two dishes.

This may sound a little pretentious for what is essentially an elaborate chow-down, but when translated into the macrocosm of life, the ability to make the correct choices could mean the difference between being someone who determines her own destiny and being a victim of circumstance. This also applies to your sexual life. The notion of informed or educated choice in the world of sexuality implies knowing your rights, knowing what you want on your personal sexual menu.

We need to make buzz words such as 'freedom of choice' and 'the right to choose' real – part of day-to-day negotiations.

Legally, South African women have more choices than ever before. Just as our country has been liberated from racial oppression, so women in this country are now, supposedly, backed by law and liberated from sexual oppression. This means you're technically free to choose your sexual partner, contraception and even termination of pregnancy. And yet the reality is vastly different. When you consider rape and domestic violence statistics, the term 'freedom of choice' has a hollow ring.

According to an Institute for Security Studies survey conducted last year, 90 percent of women in this country have experienced physical abuse, while 71 percent have experienced sexual abuse. Certainly not something any woman would choose for herself.

So, how can you make informed and educated choices about your sexual destiny? Organisations such as People Opposing Women Abuse (Powa), the Planned Parenthood Association, the Reproductive Rights Alliance, as well as other women's groups opposed to violence against women, provide information and support. But first you have to choose to be a survivor – not a victim – and ask for help.

The courage and conviction of the women who choose to stand up for their rights amidst personal turmoil and often tragedy, deserve praise and support on every front – from the media to the workplace and, finally, in the home.

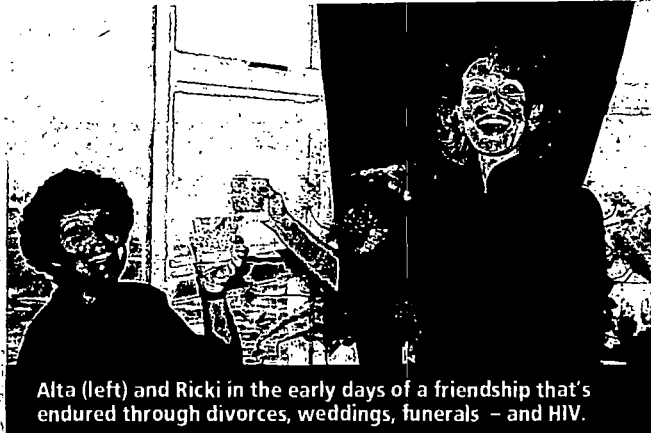
Contact Powa at ☎ (011) 642 4345, the Planned Parenthood Association at ☎ (011) 482 4601 or ☎ (021) 448 7312, and the Reproductive Rights Alliance at ☎ (011) 403 2101.

For more information, contact loveLife at Box 45, Parklands 2121 ☎ (011) 327 7379 or e-mail talk@loveLife.org.za.

Sweet: National Education Minister Kader Asmal for prioritising life skills and sex education in South African schools.

Sour: The South African National Aids Council for its lack of a clear vision and leadership, and for failing to communicate to the country's citizens what it's doing, when it's doing it and when we can expect results in the fight against the epidemic.

**love
Life**
TALK ABOUT IT



Alta (left) and Ricki in the early days of a friendship that's endured through divorces, weddings, funerals – and HIV.

This can happen only where there are secure policies that guard against all forms of even the most subtle workplace discrimination and stigmatisation. As an example, she suggests a scenario in which promotion is blocked or staff are passed over for training on the never-to-be-admitted grounds that they will die sooner than an HIV-negative colleague and consequently offer a less desirable investment for the company. Secure policies complement wellness and care programmes, she says.

One of the most successful wellness management centres has been implemented at Eskom, where HIV-positive workers are helped to manage stress and understand and practise good nutrition. The centre also runs Aids education projects, encouraging HIV-negative staff to be tested and to develop personal strategies to remain negative. It also provides support for the friends and family of those living with the disease.

Eskom is using the support of the South African chapter of the United Nations Gipa (Greater Involvement of People Living with HIV/Aids) initiative. One of its strategies is to place publicly acknowledged HIV-positive people within the workplace, says Kgobati Magome, manager of this two-year pilot project. Musa Njoko, the Gipa placement at Eskom in KwaZulu-Natal, believes her presence in the company has resulted in a shift in attitude. Fellow employees who're HIV-positive are increasingly finding the strength to disclose, she says.

The national Department of Health's Beyond Awareness Campaign is completing a booklet and video on public disclosure. Its launch is aimed to coincide with the World Aids Conference in Durban from July 9 to 14.

There was much to be gained for the people to whom disclosure is made as there is for those who share their initially frightening secret – as Ricki's friend Alta will attest.

Alta says, 'In some strange way this knowledge has made it easier for my family to talk about HIV and relationships. As the mother of two daughters – Lizelle, a 21-year-old university student and Michelle (14) – she finds this invaluable.

'It's forced us to work with HIV at an individual and personal level, to own it as a family', she says.

And that's really where we'll heal the stigma.

Who to contact for help

Aids Helpline ☎ 08000 1-2322

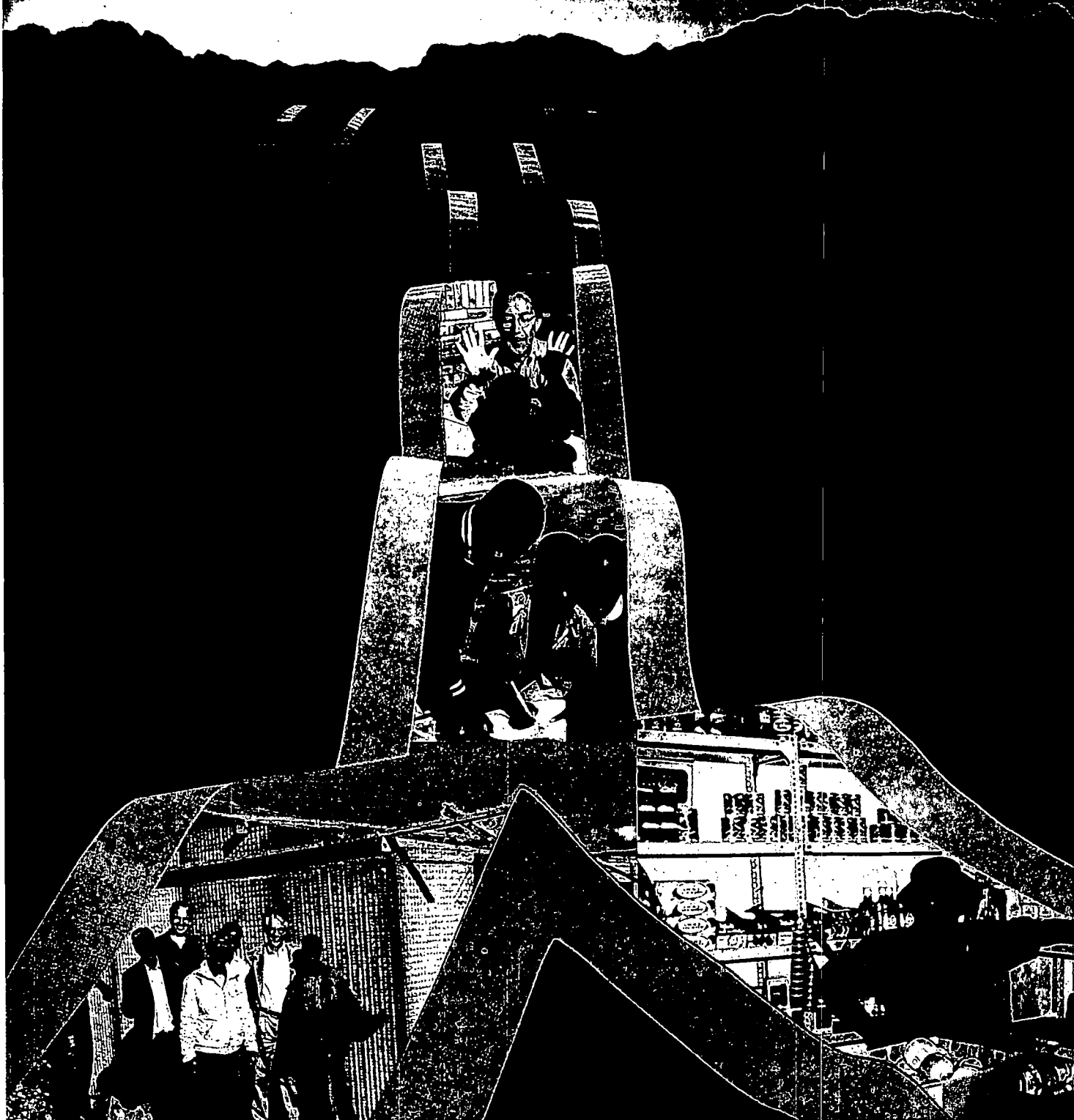
Nacosa ☎ (021) 423-1041

Aids Write-in Service, Box 13307, Jacobs 4026

Beyond Awareness Campaign – call the Aids Action office ☎ (011) 482-6737 or visit www.lifanet.co.za

Aids Law Project ☎ (011) 403-6918

Making a difference



USAID / SOUTH AFRICA

U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT

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I. INTRODUCTION

Less than ten years ago, South Africa was in the throes of political struggle and domestic unrest which prompted most countries of the world to impose economic sanctions to encourage the end of apartheid. U.S. sanctions were accompanied by expansion of U.S. foreign assistance to South Africa, which grew from \$7 million in FY 85 to \$80 million in FY 93. This assistance was focused on strengthening the majority population to assume leadership roles in a democratic South Africa.

TABLE 1: USAID/SOUTH AFRICA FUNDING LEVELS
(1985 - 1999)

FISCAL YEAR*	GRANT	GUARANTEE	TOTAL OBLIGATIONS**
1999	\$53.35 million	-	\$53.35 million
1998	\$ 70.6 million		\$ 70.6 million
1997	\$ 86.5 million	\$ 24.0 million	\$110.5 million
1996	\$ 120.6 million	\$ 42.9 million	\$ 163.5 million (actual)
1995	\$ 122.9 million (Includes \$ 2.9 million from Global Bureau)	\$ 64.0 million	\$ 186.9 million (actual)
1994	\$ 131.0 million	\$ 81.0 million	\$ 212.0 million
1993	\$ 80.0 million		\$ 80.0 million
1992	\$ 80.0 million		\$ 80.0 million
1991	\$ 50.0 million		\$ 50.0 million
1990	\$ 32.9 million		\$ 32.9 million
1989	\$ 32.8 million		\$ 32.8 million
1988	\$ 25.4 million		\$ 25.4 million
1987	\$ 15.5 million		\$ 15.5 million
1986	\$ 14.1 million		\$ 14.1 million
1985	\$ 7.0 million		\$ 7.0 million
Total	\$925.6 million	\$211.9 million	\$1137.5 million

* U.S. fiscal year: October 1 - September 30.

** Funds obligated in one year are used to implement activities in that year in and in subsequent years

In April 1994, South Africa entered a new stage of nonracial democracy with the election of Nelson Mandela as President. To support that change and to help redress the social and economic legacies of apartheid, President Clinton committed the U.S. to an approximate doubling of U.S. assistance over the period FY 94 - FY 96. All funds for this pledge period have been obligated and implementation of program activities is continuing. This program, carried out in close consultation with other members of the U.S. Mission such as United States Information Service (USIS) and the Department of State, is now fully funded. The Mission is now working under a ten-year strategy for sustainable transformation in South Africa (See Section V).

II. SOUTH AFRICAN CONTEXT

South Africa's new political leaders are working hard to establish a culture of participation and to build political consensus within South Africa on policy and development goals. They have achieved remarkable success in allaying the fears of the minority population and building cooperation across political party lines at the national, provincial, and local levels. This progress has not been without problems, however, especially over issues of provincial powers. In addition to maintaining a broad political coalition, the Republic of South Africa (RSA) has been widely applauded for instituting market-oriented and fiscally-conservative economic policies and looking to long-term growth as the main vehicle for majority upliftment.

Goals of the South African government include:

- * Consolidating democracy and reforming civil society
- * Spurring economic growth and job creation through policies which are conducive to growth and the private sector while maintaining fiscal discipline
- * Meeting the tremendous needs of the majority population in education, housing, health and other areas within the constraints of a responsible economic policy

This represents the RSA's national vision for catalyzing popular participation in South Africa's transformation to sustainable development. It aims to help the poor and to involve them in their own development. The government puts a premium on community involvement and grassroots participation. It also calls for cooperative efforts by the various branches of government, civil society, business, and labor.

III. CURRENT USAID PROGRAM

Since the democratically held elections, USAID/South Africa has worked to ensure that its assistance is supportive of the South African government's developmental priorities. Based on (a) dialogue with the RSA at various levels, (b) coordination with other international donors in various sectors, and (c) joint review and assessment of our past assistance activities with non-governmental organizations and the private sector, the overall goal of the USAID program through 2005 is sustainable transformation. Sustainable transformation means:

Assisting South Africa through the point where democracy is sufficiently consolidated; basic systems and policies for social service delivery are in place; processes of institutional change and the development of management and technical capacity are far enough along so that there is reasonable confidence that South Africa's majority population is on a course to sustainable political, economic, and social development.

A vital element of transformation is increasing participation and empowerment of the majority population -- the sub-goal of USAID assistance. Apartheid was a top-down system in which most aspects of life of the majority population were decided by the minority government. The present government does not want to merely change the faces of government leaders who are making decisions for the people, but to include the people in decision-making so that they can ensure government programs are responsive to their needs and hold the government accountable for its performance.

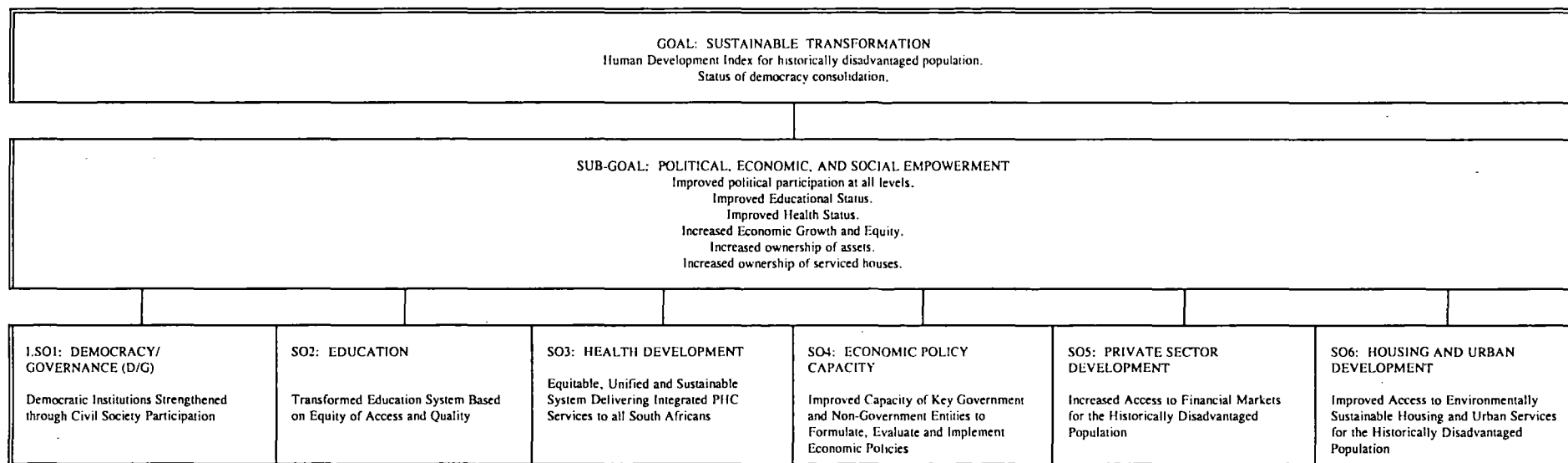
The role of foreign assistance is not to become a principal driver of development, but to provide supplementary help that supports internal processes, particularly in developing new policies and systems. In those limited cases in which such assistance supports services delivery, it is as a means to the end of policy or system change.

Program priorities that guide development and implementation of USAID assistance include: (a) participation, (b) sustainability, (c) appropriate linkages with USAID regional and global initiatives, and (d) results orientation. We

have applied and will continue to apply various mechanisms to ensure that participation is broad and effective which will help ensure that our program contributes to the development of South Africa.

IV. RESULTS FRAMEWORK

**USAID/South Africa COUNTRY STRATEGY PLAN
STRATEGIC OBJECTIVES AND RESULTS FRAMEWORK**



IV. SIX STRATEGIC OBJECTIVES

In developing proposals for a future program, we considered the government's developmental priorities, areas important for sustainable transformation, the Mission's experience and comparative advantage, and what we thought we could realistically aim to accomplish within reasonable bounds of program duration and funding levels. This led us to focus on six strategic objectives (SOs) in the following areas:

- SO1 -- DEMOCRACY AND GOVERNANCE
- SO2 -- EDUCATION
- SO3 -- PRIMARY HEALTH/HIV/AIDS
- SO4 -- ECONOMIC POLICY CAPACITY
- SO5 -- PRIVATE SECTOR DEVELOPMENT
- SO6 -- SHELTER, URBAN AND ENVIRONMENT SERVICES

SO-1. DEMOCRACY AND GOVERNANCE

The Mission has a long history of promoting civil society and human rights development in South Africa through local NGOs. We plan to build on this experience to support democratic consolidation, a human rights culture, a more equitable justice system, NGO integration into RSA service delivery, and a strong civil society. The Mission's Administration of Justice program relies heavily on NGOs as implementers in direct support of RSA activities.

While many of these areas involve assistance to the RSA, some are directed at supporting civil society as a balance to the government. Examples of the latter are support to NGOs for monitoring government performance, providing information to the public, and protecting human rights. USAID also is supporting civil society participation in the development of new public policies and laws; strengthening of legislatures; improving new government structures at provincial and local levels; creating new partnerships for development that link government, civil society and business, and helping NGO sustainability efforts.

SO 2. EDUCATION

Education is one of the RSA's top priorities and a key to sustainable economic growth and development. One of the lessons of international development experience is the strong linkage between education (especially basic education) and long-term growth. This linkage is particularly strong in South Africa, where shortage of skilled labor and poor basic education standards among the majority population are obstacles to economic growth.

The Mission has experience in this sector--a substantial proportion of past USAID assistance has been in direct support of education, training and human resource development. Key among USAID's objectives in this sector has been the development of models for possible wider application. Much of this past work with NGOs in basic and tertiary education is expected to feed into existing and planned programs with the RSA in two main component areas.

The first component is a program to support policy and systems change, capacity building, and participation/empowerment in basic education, with a focus on four provinces. The second component is a program to strengthen historically disadvantaged institutions (HDIs) in the tertiary education sector (universities and technikons) through the Tertiary Education Linkages Project (TELP). TELP is a ten-year project that began in 1995. It focuses on strengthening HDIs through a combination of training technical assistance in five focus areas and linkages with U.S. universities and U.S. universities. Workforce development is another aspect of training education being supported.

SO 3. HEALTH

The Equity in Integrated Primary Health Care Project (EQUITY) was the first major USAID/South Africa bilateral project with the RSA. The EQUITY Project takes a capacity-building and systems development approach in assisting the RSA to change and strengthen its national health system so that quality, essential services are accessible to all South Africans -- especially those who are under-served. To accomplish this, the EQUITY Project concentrates support initially in a single province (Eastern Cape) in order to have sufficient resources both to develop the system

and to make it fully operational. The national scope of the project will be achieved by intensive coordination among all nine provinces and the national DOH to ensure that replicating effective systems will proceed rapidly throughout the country.

The RSA has begun the process of consolidating the fragmented health system, redistributing services in an equitable manner, and drastically changing health care priorities to ensure that integrated PHC, with its community orientation and focus on priority health interventions, can be achieved. The EQUITY Project supports the government's efforts and clearly contributes to the shared goal of equitable access to essential health care by all South Africans.

USAID'S FUTURE SUPPORT: USAID/South Africa, in collaboration with the Government of South Africa and civil society organizations (CSOs), is currently developing a new activity to address HIV/AIDS for the public and private sectors. For the coming years (1999-2003), USAID/SA will support South Africa's efforts at reducing the spread and impact of the HIV/AIDS epidemic, including related STD, TB, and Health Reproduction (HR) issues. The \$21 million design is in progress to address awareness, prevention, cure/treatment, care/support and mitigation services and practices.

USAID has five priorities in health: (1) increased access to an integrated package of PHC services; (2) an effective health care referral system in operation; (3) improved management of integrated PHC delivery systems at the provincial level; (4) PHC training programs strengthened and institutionalised at the provincial level; and (5) increased capacity for the PHC system to deliver appropriate HIV/STD prevention and treatment. USAID also is planning a new focus on HIV/AIDS/STDs.

SO 4. ECONOMIC POLICY CAPACITY

Structural economic change is required to increase economic growth and job creation, both of which are vitally important for sustainable development. To support the government's efforts in addressing this area, USAID initiated the "Support for Economic Growth and Analysis" (SEGA) activity in FY 1996. SEGA aims to achieve the following results:

1. Strengthened government departments that deal with economic policy matters;
2. Strengthened think tanks to formulate and evaluate economic policy options for all economic policy makers;
3. Individuals trained in economics and policy analysis; and
4. Strengthened centers of economics training (Centers of Excellence in Economics), especially within the historically disadvantaged institutions.

The third activity above represents the "Mandela Scholars Program" under the United States-South Africa Binational Commission. This program will send approximately 50 South Africans from the disadvantaged community to the U.S. for masters and doctoral training in economics. The purpose of this activity is to equip a core group of highly-trained individuals with an education that will help them to formulate growth-promoting policies for the South African economy.

SO 5. PRIVATE SECTOR DEVELOPMENT

Supporting black participation in the private sector is vital for producing sustainable economic gains for the majority population and for reinforcing the political will to rely on private sector-led growth. In the past, USAID's private sector program focused on provision of microenterprise credit through NGOs. Present and future programs will stress broader business development among the previously disadvantaged majority, specific needs of the agricultural sector, the enabling environment for small and medium enterprises (SMEs), and business input to national economic policy-making. The USAID-funded Southern African Enterprise Development Fund is one of capital for South African SMEs. A cross-cutting theme is empowerment of the majority population through expanded ownership and participation in the formal economy. Job creation is an important outcome of such entrepreneurial development.

SO 6. SHELTER, URBAN AND ENVIRONMENT SERVICES

There is an enormous need for housing and related urban services among South Africa's majority population. Extreme poverty and the unavailability of credit make it difficult for this historically disadvantaged group to obtain adequate shelter.

USAID's goal is to improve access to environmentally sustainable urban services for disadvantaged South Africans by working collaboratively with all major stakeholders in the shelter sector. USAID supports the efforts of all tiers of government to improve the shelter and urban infrastructure policy environment. It works with private financial institutions to increase access to credit for low-income households and to develop effective lending models. It also assists NGOs and community-based groups to develop viable projects and to constructively interact with the public and private sector in order to improve their shelter conditions. Finally, USAID is supporting initiatives to increase the environmental management capacity of local authorities and to enhance the participation of communities in urban development.

TABLE 2: PLANNED OBLIGATION LEVELS BY STRATEGIC OBJECTIVE, 1999

STRATEGIC OBJECTIVE	PROJECT	FUNDING LEVEL	% OF TOTAL
SO 1: DEMOCRACY AND GOVERNANCE		\$ 14.55 million	27%
	Democratic Institution Strengthening	\$ 14.20 million	
	Self-Help	\$ 0.35 million	
SO 2: EDUCATION TRANSFORMATION		\$11.77 million	22%
	Support for Tertiary Education	\$ 0.74 million	
	Transformed Education System	\$ 4.80 million	
	Tertiary Education Linkages Project	\$ 5.46 million	
	Transition Support Fund	\$ 0.77 million	
SO 3: UNIFIED HEALTH SYSTEM		\$ 11.15 million	21%
	Equity in Health	\$ 11.15 million	
SO 4: ECONOMIC POLICY CAPACITY		\$0.50 million	10%
	Support for Economic Growth and Analysis	\$0.50 million	--
SO 5: PRIVATE SECTOR DEVELOPMENT		\$ 3.71 million	7%
	Black Private Enterprise Support	\$ 0.90 million	
	SAEDF	\$ 2.5 million	
	Transition Support Fund	\$ 0.31 million	
SO 6: HOUSING AND URBAN DEVELOPMENT		\$ 11.675 million	22%
	Environmental Sustainable Housing and Urban Development	\$ 11.575 million	
	Transition Support Fund	\$ 0.10 million	
TOTAL		\$ 53.350 million	100%

VI. PROGRAM IMPLEMENTATION

USAID/South Africa is implementing a comprehensive program to assist the goal of sustainable transformation (See Table 4).

Program areas represent USAID's technical strength and complement other donors' programs in South Africa. The activities are implemented in a participative manner that has proven effective, blends with South African consultative traditions and maximizes opportunity for success. Activities are selected from advertised and solicited proposals from South African and U.S. PVOs, NGOs, CBOs, and private contractors. Activities implemented under agreements with the South African government are selected cooperatively.

Our strategic principles are consistent with USAID's New Partnerships Initiative (NPI), announced by Vice-President Gore. This initiative stresses cooperation, empowerment, and non-dependence through partnerships among donors, NGOs and host country governments. Key principles embodied in the USAID/South Africa program fit directly with NPI:

- * focus on empowerment through citizen participation and ownership;
- * emphasize the role of local NGOs, universities, foundations, small businesses, and decentralized government in sustainable development;
- * mobilize U.S. nongovernmental resources to support local capacity building;
- * improve the enabling environment for NGOs and small business; and
- * a goal of graduating from U.S. assistance.

NGO PARTNERSHIPS: Program expansion since FY94 has effectively enabled USAID/South Africa to continue its broad support to the important NGO community while concurrently providing considerable government-to-government assistance. An integral part of the Mission's strategy is to help build bridges where appropriate between the government at national, provincial and municipal levels, and the NGO community. The objective is to build on key, successful NGO programs, many of which were funded by USAID in the past.

THE U.S. SOUTH AFRICA BINATIONAL COMMISSION (BNC): BNC meetings have taken place annually since 1995. BNC, core-chaired by Vice President Gore and Deputy President Mbeki, was formed to facilitate bilateral cooperation on key issues of mutual concern. USAID/South Africa supports the objectives of the BNC in many substantive areas. Particular emphasis is placed on support to the Human Resource Development and Education Committee. Other assistance supports the objectives of the Agriculture Committee; Conservation, Environment and Water Committee; Energy Committee; Housing Working Group and Health Working Group. Finally, USAID/South Africa, in cooperation with the U.S. Information Service/South Africa, provides broad assistance to facilitate exchanges and internships recommended by the various BNC Committees.

COORDINATION WITH THE SOUTH AFRICAN GOVERNMENT: USAID/South Africa annually proposes, in partnership with government ministries, new projects and activities (See Table 3) to be developed and implemented under the government's bilateral project agreements. These proposals are jointly reviewed and negotiated with relevant South African partners prior to funding commitments. USAID also cooperates with the Department of Finance on annual progress reviews of the overall program.

TABLE 3: BILATERAL AGREEMENTS FY 1994 - 1999 (\$ millions)

MINISTRY	PROJECT	TOTAL LOA	FY 1994	FY 1995	FY 1996	FY 1997	FY 1998	FY 1999
MINISTRY OF JUSTICE	ADMINISTRATION OF JUSTICE	16.5	1.5	3.0	4.0	1.8	4.2	1.0
	CONSTITUTIONAL DEVELOPMENT & PROVINCIAL AFFAIRS	18.1	-	-	-	-	2.8	2.4
MINISTRY OF EDUCATION	SOUTH AFRICAN BASIC EDUCATION RECONSTRUCTION	36.8	--	3.9	10.9	17.0		-
	TRANSFORMED EDUCATION SYSTEM	8.6	--	--	--	--	5.0	2.2
	SOUTH AFRICA EDUCATION SUPPORT AND TRAINING	8.0	--	1.5	6.5	--	--	--
	SUPPORT TO TERTIARY EDUCATION PROJECT	9.7	--	--	6.3	--	--	0.4
	TERTIARY EDUCATION LINKAGES PROJECT	29.8	--	7.8	7.8	3.0	5.7	5.5
OFFICE OF THE DEPUTY PRESIDENT (SIGNED BY MINISTRY OF EDUCATION)	YOUTH DEVELOPMENT SUPPORT FOR TERTIARY EDUCATION	3.0	--	3.0	--	--	--	--
MINISTRY OF HEALTH	INTEGRATED PRIMARY HEALTH CARE/HIV/AIDS	50.0	--	8.0	10.9	14.7	9.1	11.15
MINISTRY OF FINANCE	SUPPORT FOR ECONOMIC GROWTH AND ANALYSIS/ MANDELA ECONOMICS SCHOLARS PROGRAM	29.1	--	--	3.9	4.0	8.5	--
MINISTRY OF TRADE AND INDUSTRY	BLACK PRIVATE ENTERPRISE DEV.	2.5	--	2.5	--	--	--	--
DEPARTMENT OF PUBLIC ENTERPRISES	BLACK PRIVATE ENTERPRISE DEV.	2.1	--	--	1.5	--	0.6	--
DEPARTMENT OF WATER AFFAIRS & FORESTRY	INSTITUTIONAL DEV. PROJECT	2.7	--	--	0.5	0.5	0.2	1.0
MINISTRY OF CONSTITUTIONAL DEVELOPMENT & PROVINCIAL AFFAIRS	MUNICIPAL INFRASTRUCTURE INVESTMENT FRAMEWORK	10.3	--	--	1.8	5.3	3.2	--
	MUNICIPAL INFRASTRUCTURE PROVISION SUPPORT (PREVIOUSLY IN RDP)	0.3	--	0.3	--	--	--	--
MINISTRY OF HOUSING	SHELTER ACCESS FACILITATION PROGRAM	5.5	--	--	3.0	1.0	1.0	1.2
	BASIC SHELTER SUPPORT	1.6	0.5	1.1	--	--	--	-
DEPT. OF ENVIRONMENT AND TOURISM	GLOBAL CLIMATE CHANGE	5.0	--	--	--	--	2.0	3.0
TOTAL		239.6	2.0	31.1	57.1	47.3	42.3	28.35

**TABLE 4: USAID/SOUTH AFRICA
LIFE OF PROJECT DATA SHEET**

STRATEGIC OBJECTIVE	PROJECT NAME	START DATE	END DATE	Authorized Funding (Million)
SO1: DEMOCRACY AND GOVERNANCE	Democracy Institutional Strengthening	1997	2005	\$ 98.7
	Labor Union Training	1983	1997	\$ 25.0
	Community Outreach and Leadership Development	1986	2001	\$ 149.3
SO2: EDUCATION TRANSFORMATION	Education Support and Training	1986	1999	\$ 50.0
	Support for Tertiary Education	1990	2003	\$ 137.0
	South African Basic Education Reconstruction	1992	2000	\$ 55.3
	Tertiary Education Linkages Project	1995	2004	\$ 50.0
	Transformation Education System	1997	2005	\$ 95.0
SO3: UNIFIED HEALTH SYSTEM	Equity in Health	1995	2005	\$ 71.0
SO4: ECONOMIC POLICY CAPACITY	Support for Economic Growth Analysis / Mandela Economic Scholars Program	1996	2005	\$ 30.0
SO5: PRIVATE SECTOR DEVELOPMENT	Southern African Enterprise Development Fund	1997	2005	\$ 50.0
	Black Private Enterprise Development	1987	2001	\$ 83.0
SO6: HOUSING & URBAN DEVELOPMENT	Shelter and Urban Development Support	1993	2003	\$ 70.0
	Environmentally Sustainable Shelter and Urban Development	1998	2005	\$ 27.0
	Basic Shelter and Housing Guarantee*	1995	1999	(\$ 94.9)
	Private Sector Housing Guarantee*	1994	2001	(\$ 75.0)
OTHER SUPPORT	Self-Help	1980	1998	\$ 9.0
	Transitional Support Fund	1995	2005	\$ 50.0
TOTAL				\$ 1050.3

*Guarantees not included in total

ACRONYMS

AOJ	Administration of Justice
BNC	Binational Commission
CBO	Community Based Organization
DOH	Department of Health
HBCU	Historically Black Colleges and Universities
HDI	Housing Guarantee
MOJ	Ministry of Justice
NGO	Non-Governmental Organization
NPI	New Partnership Initiative
ODA	Overseas Development Assistance
PHC	Primary Health Care
PVO	Private Voluntary Organization
RSA	Republic of South Africa
SAEDF	Southern African Enterprise Development Fund
SBLG	Small Business Loan Guarantee
SME	Small and Medium Enterprises
SO	Strategic Objective
USAID	United States Agency for International Development
USIS	United States Information Service

PROJECTS

BPED	Black Private Enterprise Development
COLD	Community Outreach/Leadership Development
EQUITY	Equity in Integrated Primary Health Care Project
LUT	Labor Union Training
SABP	South African Bursaries Program
SABER	South African Basic Education Reconstruction
SEGA	Support for Economic Growth and Analysis
SELF HELP	Self Help Support Community Dev. Fund
STEP	Support for Tertiary Education
SUDS	Shelter and Urban Development Support
TELP	Tertiary Education Linkages Project
TSF	Transition Support Fund

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SCHEDULE OF Ms. Sandra Thurman - White House Advisor on HIV/AIDS

DATE & TIME	EVENT	CONTACT PERSON	COMMENTS
Monday, May 8 1430	Arrival on Delta 7004	Caroline Connolly Cell Phone - 083 417 6860 Office - 012 323 8869 x257	Ms. Connolly will met Ms. Thurman at airport
Monday, May 8 1930	Dinner with Ambassador Lewis, Stacy Rhodes - Mission Director USAID/South Africa & Caroline Connolly - PHN Officer	Caroline Connolly Cell Phone - 083 417 6860 Office - 012 323 8869 x257	Dinner will be at the Park Hyatt restaurant - 191 on the Park - the reservation is under the name of Ambassador Lewis
Tuesday, May 9 1300	Depart Hotel for charter flight	Control Room at Park Hyatt	
Friday, May 12 1225	Arrival on SAA Flight 143	Caroline Connolly Cell Phone - 083 417 6860 Office - 012 323 8869 x257	Ms. Connolly will met Ms. Thurman and take her to the hotel: Villa Sterne - 212 Johann Rissik Drive, Waterkloof Ridge, Pretoria Phone: 012 346 2255 Fax: 012 460 3161
Friday, May 12 1430	Meeting with Mary Crewe Director of the Center for the Study of Aids - University of Pretoria	Caroline Connolly Cell Phone - 083 417 6860 Office - 012 323 8869 x257	Ms. Crewe will come to the hotel.
Friday, May 12 1600	Meeting with Ms. Rose Smart - HIV/AIDS Consultant	Caroline Connolly Cell Phone - 083 417 6860 Office - 012 323 8869 x257	Ms. Smart will come to the hotel.
Friday, May 12 1900	Dinner with Dr. James McIntyre Cell - 083 378 2468	Caroline Connolly Cell Phone - 083 417 6860 Office - 012 323 8869 x257	Dr. McIntyre will come to Ms. Connolly's home and Ms. Thurman will be picked up and taken to Ms. Connolly's home
Saturday, May 13 1100 am	Shopping	Caroline Connolly Cell Phone - 083 417 6860 Office - 012 323 8869 x257	Ms. Connolly will pick Ms. Thurman up at her hotel.
Saturday, May 13 1400	Arrival at airport for departure	Caroline Connolly Cell Phone - 083 417 6860 Office - 012 323 8869 x257	Ms. Connolly will take Ms. Thurman to the airport.