FOIA Number: 2007-1550-F

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: 21066

FolderID:

Folder Title:
[International AIDS Conference, XIII, Briefing Book, Sandra Thurmon] [1]

Stack:	Row:	Section:	Shelf:	Position:
S	67	1	4	1

Table of Contents - Michael

*Back folder contains: NIC Report, UNAIDS 99 Update, Africa Report

Clinton Presidential Records
Digital Records Marker

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

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

1

Divider Title: _____

THURMAN ITINERARY OVERVIEW
XIII International Conference on AIDS – Durban, South Africa

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
July 2	*July 3*	*July 4*	*July 5*	*July 6*	*July 7*	*July 8*
		3:15 PM Depart Reagan National Airport Delta #746 4:25 PM Arrive JFK 5:55 PM Depart JFK Delta #7004	4:00 PM Arrive Jo'burg 6:00 PM Depart Jo'burg South African Air #525 7:10 PM Arrive Durban	4 - 6:00 PM Independence Day Celebration, Consul General's residence	3:40 – 5:00 PM Tentative - 'Taking Home the Message: How to Use Information Gained in Local Communities' (Wilson Workshop) Larry Altman	8:30 – 10:30 AM Remarks, Opening Plenary HIV Prevention Works Symposium 2:00 PM Dr. Mtshali (Royal) 5:30 – 8:30 PM FXB Reception
Sunday	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
July 9	*July 10*	*July 11*	*July 12*	*July 13*	*July 14*	*July 15*
Countess Albina (coffee) 1 – 2:00 PM Federal Press Conference (Fauci, O'Neill, Gayle, Goosby, Thurman) 1:10 PM Today Show 3:00 PM CNN 7 - 9:30 PM Opening Ceremony	9:00 AM - 4:00 PM Edendale and Grey Hospital – Pietermaritzburg (National Geographic only press) 5:30 – 5:40 PM WebMD Daily Update 'Access to Care' (Goosby, Wilson, Thurman) Dinner (hosted by Dr. Salim Abdul Karim)	9:15 – 10:15 AM USAID/LIFE Press Conference 'One Year Later' 12 – 2:00 PM NGO Twinning Luncheon 3 – 4:00 PM PLWA Roundtable Discussion 5:30 – 5:40 PM WebMD Daily Update 'Living with HIV/AIDS' (Goosby, Wilson, Thurman) 6:30 – 8:30 PM FHI Reception 8:00 PM NPR Interview *GORE – MBEKI Dinner*	9 –11:00 AM Chair Plenary Session 'Preventing HIV' 1 - 4:30 PM Microfinance project site visit (Durban) 5:30 – 7:30 PM US Delegation Reception 7:00 PM Harvard AIDS Institute Reception	1:40 PM Ambassador Lewis presentation 5:30 – 5:40 PM WebMD Daily Update 'Vaccines' (Thurman, Goosby)	7:30 AM Site visit to children's home (Durban) 9:00 AM Arrive at Royal for Mandela ceremony 10:55 AM Press conference 12:30 - 1:30 PM Closing Ceremonies	7:00 AM Depart Durban South African Air#9576 8:10 AM Arrive Jo'burg 1:05 PM Depart Jo'burg Air Tanzania #766 5:50 PM Arrive Kilimanjaro
Sunday	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
July 16	*July 17*	*July 18*	*July 19*	*July 20*	*July 21*	*July 22*
9:30 AM Depart Kilimanjaro Air Tanzania #772 9:50 AM Arrive Kigali (lose hour)				8:50 AM Depart Kigali Kenya Airways #473 11:10 AM Arrive Nairobi 10:15 PM Depart Nairobi Northwest Air #8566	6:10 AM Arrive Amsterdam 11:35 AM Depart Amsterdam Northwest #37 2:05 PM Arrive Washington Dulles	

Basics

Airport You will be cleared through customs in Jo'burg. The Durban airport is currently under construction. You will be met by a SSS staff member and you driver (a close protection officer), escorted to baggage and then the car. 15 - 20 minutes to hotel.

Hotels

The Royal Hotel
267 Smith Street
P.O. Box 1041
Durban 4000, South Africa
Tel: 27 31 304 0331
Fax: 27 31 305-3504

Check-in on Friday, July 5th.
Check out on Saturday, July 15th.

The OAR staff will meet you in the lobby and assist with check-in. Room and tax have been prepaid.

Hotel des Mille Collines
B.P. 1322
Kigali - Rwanda
Tel: 250-76530
Fax: 250-76541

Transport The car and driver will be available to you for the duration of the conference.

Registration You are registered and prepaid. Conference registration materials will be delivered to your hotel room upon your arrive.

Conference The International Conference Center (ICC) will house most official events. 5 - 10 minute walk from the Royal Hotel.

Staff Michael is staying in the Royal with you (checks in on the 7th after two nights at the Hilton). Jeff is staying at the Hilton. Cheryl is staying at the Holiday Inn Garden Court. Paul Gaist is staying at the Royal.

Cell phones You, Michael, Jeff and Cheryl will all be provided with cell phones. They will be available at.... All numbers are listed on the following pages.

Your Office

Regus Business Centre
Old Mutual Centre Building
303 West Street, 26th Floor
Tel: 27 31 336 2534
Fax: 27 31 336 2620

5 - 10 minute from the Royal Hotel and the ICC.

Available to you from the 9th - the 14th.

Contacts

Contacts

The Royal Hotel	Tel: 27 31 304-0331 Fax: 27 31 305-3504
Thurman Office	Regus Business Centre Old Mutual Centre Building, 303 West St, 26th Flr Tel: 27 31 336 2534 Fax: 27 31 336 2620
Hilton Hotel	Tel: 27 31 336-8100
Holiday Inn (Cheryl)	167 Marine Parade Tel: 27 31 337-3341 Fax: 27 31 332-9885
Thurman Cell	
Iskowitz Cell	
Bauerle Cell	
Kamen Cell	
Miguel Gomez	?
Caroline Connelly	Cell: 27 83 417 6860
Ron MacInnis	Cell: 27 82 858 6421
Nils Dulaire	Cell: 27 82 858 3464
Mary Partlow	Cell: 082 858 6422
Linda Jackson	Cell: 27 82 858 1162 Off: 27 31 336 2534
Sarah Holewinski	Office: (202) 456-2959 Cell: (202) 904-3682

Country Contacts

COUNTRY CONTACTS

SOUTH AFRICA

U.S. Embassy
877 Pretorius St
Pretoria
Tel: (27-12) 342-1048

American Consulate General
Durban House, 29th Floor
333 Smith Street, Durban 4001
Tel: 27 31 304-4737

USAID
Sancardia Building
9th Floor
524 Church St
Pretoria
Tel: (27-12) 323-8869
Fax: (27-12) 323-6443

Principal U.S. Officials
Ambassador -- Delano E. Lewis
DeputyChief Mission/Minister-Counselor -- John Blaney
Commercial Minister-Counselor -- Roger Ervin
Economic Counselor -- Robert Godec
Political Counselor -- Marguerita Ragsdale
Administrative Counselor -- Steven Buckler
Public Affairs Officer -- Thomas Hull
Defense and Air Attache -- Col. Dennis Rider, USAF
USAID Director -- Stacey Rhodes
Agricultural Attache -- Richard Helm
Consul General Cape Town -- April Glaspie
Consul General Durban -- Craig Kuehl
Consul General Johanneeburg -- Sue Ford-Patrick

Principal Government Officials
Foreign Affairs -- Dr. NC Dlamini-Zuma
Justice -- Mr. PM Maduna
Defense -- Mr. MGP Lekota
Finance -- Mr. TA Manuel
Home Affairs -- Mr. M Buthelezi
Safety and Security -- Mr. SV Tshwete
Trade and Industry -- Mr. A Erwin
Agriculture and Land Affairs -- Ms. AT Didiza
Health -- Dr. ME Tshabalala-Msimang
Welfare and Population Development --Dr. ZST Skweyiya
Education -- Prof. AK Asmal
Labor -- MMS Mdladlana
Housing -- Sankie Mthembi-Mahanyele
Communications -- Dr. I Matsepe-Casaburri
Intelligence -- Mr. JM Nhlanhla
Minister in the Office of the Presidency -- Mr. EG Pahad

TANZANIA

U.S. Embassy
140 Msese Road
Kinondoni District, Dar es Salaam
P.O. Box 9123, Dar es Salaam, Tanzania
Phone: 255-51 666-010 through 5
Fax: 255-51 667-285
Office hours are 7:30 a.m. to 4:00 p.m

Ambassador: Charles R. Stith

USAID
Robert F. Cunnane
Health and Population Officer
Work: 255-51-117540
Fax: 255-51-116559

RWANDA

USAID/Kigali
Blvd. de la Revolution - B.P. 28
Kigali
Tel: 250-73251
Fax: 250-73950
Director: George Lewis

President -- Paul Kagame
Vice President -- NA
Prime Minister Bernard Makuza
Min. of Agriculture Dr. Ephrem, Kabayija
Min. of Commerce -- Alexandre Lyambabaje
Min. of Defense Emmanuel, Col. Habyarimana
Min. of Education Emmanuel Mudidi
Min. of Energy, Water, & Natural Res Marcel Bahude
Min. of Finance & Planning Donat Kaberuka
Min. of Health Ezechias, Rwabuhihi, M.D.
Min. to the President's Office Joseph Mutaboba
Governor, Central Bank Francois Mutemberezi

Ambassador to the US -- Richard Sezibera

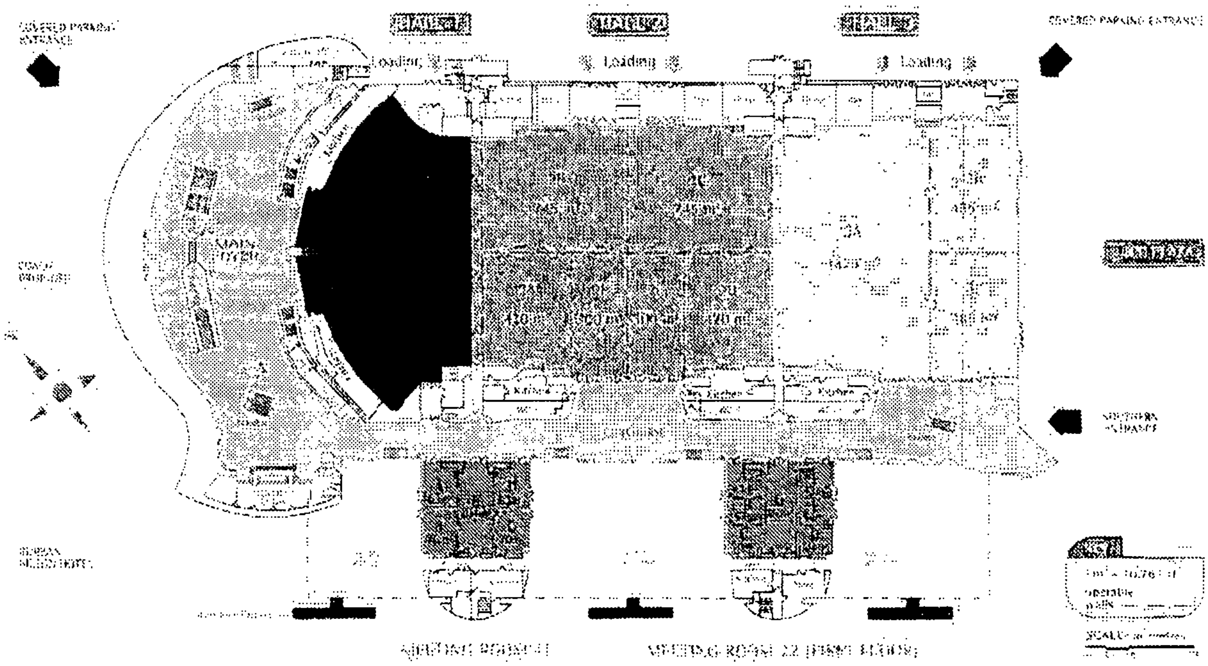
Maps

ICC DURBAN

INTERNATIONAL CONVENTION CENTRE DURBAN

WHERE AFRICA AND THE WORLD MEET

GROUND FLOOR



VENUE CAPACITIES

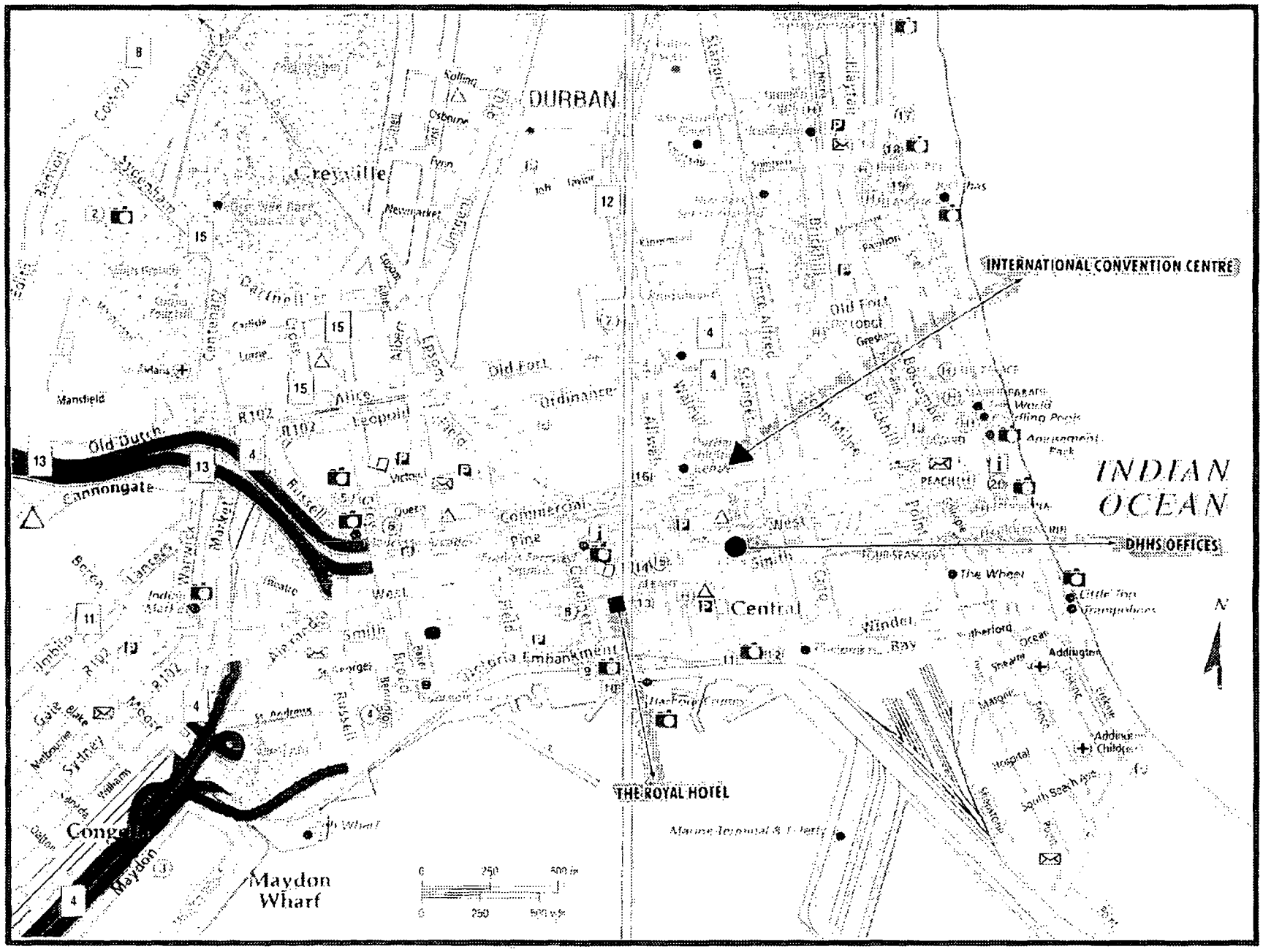
Venue	Hall 1	Hall 1A	Hall 1B	Hall 2	Hall 2A/D	Hall 2B/C	Hall 2E/F	Hall 3	Hall 3A	Hall 3B	Hall 3C
Theatre	1800	840	840	2600	450	650	100	2050	1250	400	400
Classroom	790	375	325	1040	160	260	100	1150	550	250	250
Cocktail	1050	525	525	2500	400	600	200	2100	1400	350	350
Banquet	690	300	300	1400	250	350	100	1900	300	250	350

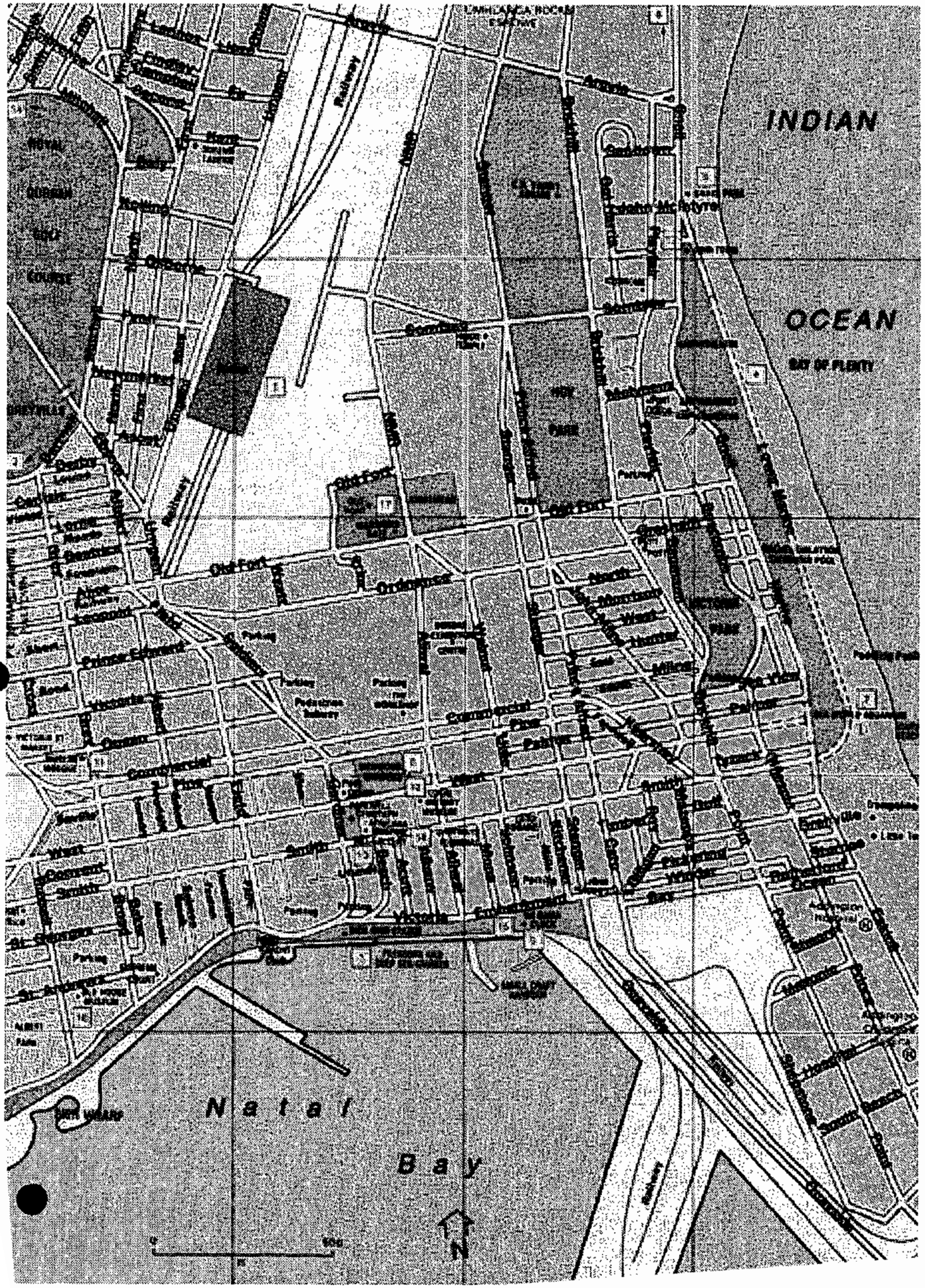
Maximum room capacities are listed based on number of delegates - additional set up requirements including podiums, dance floors etc. will reduce capacities. Banquet capacities are based on round tables for 10 guests each.

- Raked auditorium - 1 800 delegates.
- Raked auditorium capable of subdivision: 2 x 840 seats.
- Plenary sessions for up to 3 000 delegates.
- Banqueting for up to 3000 guests.
- 7 000 m (75 400 ft) of flat floor, column free space - subdivisible into a wide variety of room sizes.
- Additional venues include up to 33 meeting rooms ranging from 43 m to 196 m.
- 3 Outdoor courtyard venues, of over 1 000 m (10 764 ft) each.
- Convenient registration facilities.
- Floor loading of up to 15 kns (1.5 tons).
- 6m x 6m service grid in main halls.
- Central kitchen with 12 satellite kitchens capable of serving food and beverages to all function rooms.
- Business complex, including banking and foreign exchange facilities, medical service and gift shop.
- Hospitality suites.
- State-of-the-art audio-visual facilities.
- Interpretation facilities for 5 languages and a base language.
- Undercover parking for 640 cars and open parking for 400 cars.
- Fully air-conditioned.
- Large exhibition loading yards.

ICC Durban, P O Box 155, Durban, 4000, South Africa.
Tel: +27 (31) 360 1000 Fax: +27 (31) 360 1005
E-mail: mktg@icc.co.za Internet: www.icc.co.za

Durban, South Africa




INDIAN
OCEAN
Natal
Bay
N


ZIMBABWE
BOTSWANA
Messina
MOZ.
NAMIBIA
Pietersburg
PRETORIA
Johannesburg
SWAZ.
Upington
Kimberley
Ladysmith
Richards Bay
Bloemfontein
LES.
Durban
De Aar
South Atlantic Ocean
East London
Indian Ocean
Saldanha
Cape Town
Mosselbaai
Port Elizabeth
0 100 200 km
0 100 200 mi

Clinton Presidential Records
Digital Records Marker

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

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

2

Divider Title: _____

Thurman			Tuesday July 4, 2000
7:00 AM		7:30 AM	
8:00 AM	Senior Staff	8:30 AM	
9:00 AM		9:30 AM	
10:00 AM		10:30 AM	
11:00 AM		11:30 AM	
12:00 PM		12:30 PM	
1:00 PM		1:30 PM	
2:00 PM		2:30 PM	
3:15 PM	Depart Reagan National Airport, Delta Flight #746	3:30 PM	
4:00 PM		4:25 PM	Arrive JFK New York
5:00 PM		5:55 PM	Depart JFK Delta/South African Airways Flight #7004
6:00 PM		6:30 PM	
7:00 PM		7:30 PM	
8:00 PM		8:30 PM	
9:00 PM		9:30 PM	
10:00 PM		10:30 PM	

Thurman			Wednesday July 5, 2000
7:00 AM		7:30 AM	
8:00 AM		8:30 AM	
9:00 AM		9:30 AM	
10:00 AM		10:30 AM	
11:00 AM	(Michael arrives in Jo'burg)	11:30 AM	
12:00 PM		12:30 PM	
1:00 PM		1:30 PM	
2:00 PM		2:30 PM	
3:00 PM		3:30 PM	
4:00 PM	Arrive Jo'burg. Michael will greet you.	4:30 PM	
5:00 PM		5:30 PM	
6:00 PM	Depart Jo'burg. South Africa Airwaye Flight #525 (with Michael)	6:30 PM	
7:10 PM	Arrive Durban.	7:30 PM	
8:00 PM		8:30 PM	
9:00 PM		9:30 PM	
10:00 PM		10:30 PM	

Thurman			Friday July 7, 2000
7:00 AM		7:30 AM	
8:00 AM		8:30 AM	
9:00 AM	(9:10 AM Cheryl arrives - Durban)	9:30 AM	
10:00 AM		10:30 AM	
11:00 AM		11:30 AM	
12:00 PM		12:30 PM	
1:00 PM		1:30 PM	
2:00 PM		2:30 PM	
3:00 PM		3:40 PM	Wilson Workshop NO SPEAKING ROLE
	"Taking Home the Message: How to use information gained in local communities"		
5:00 PM		5:30 PM	
6:00 PM		6:30 PM	
7:00 PM		7:30 PM	
8:00 PM		8:30 PM	
9:00 PM		9:30 PM	
10:00 PM		10:30 PM	

Thurman			Thursday July 6, 2000
7:00 AM		7:30 AM	
8:00 AM		8:30 AM	
9:00 AM		9:30 AM	
10:00 AM		10:30 AM	
11:00 AM	(Satcher arrives in Durban)	11:30 AM	
12:00 PM		12:30 PM	
1:00 PM		1:30 PM	
2:00 PM		2:30 PM	
3:00 PM		3:30 PM	
4:00 PM	Independence Day Celebration (Consul General's Residence)		
6:00 PM		6:30 PM	
7:00 PM		7:30 PM	
8:00 PM		8:30 PM	
9:00 PM		9:30 PM	
10:00 PM		10:30 PM	

Thurman		Saturday July 8, 2000	
7:00 AM		7:30 AM	
8:00 AM		8:30 AM	
Opening Plenary of HIV Prevention Works Symposium, (Playhouse)			
		10:30 AM	
11:00 AM		11:30 AM	
12:00 PM		12:30 PM	
1:00 PM		1:30 PM	
2:00 PM	**Meet with Dr. Mtshali at the Royal** (Kamen arrives in Durban)	2:30 PM	
3:00 PM		3:30 PM	
4:00 PM		4:30 PM	
5:00 PM		5:30 PM	
Francois-Xavier Bagnoud Reception **(Countess Albina)** **Durban Jewish Club**			
		8:30 PM	
9:00 PM		9:30 PM	
10:00 PM		10:30 PM	

Thurman			Sunday July 9, 2000
7:00 AM		7:30 AM	
8:00 AM	(Dr. Satcher welcomes the Palliative Care Satellite Conference)	8:30 AM	
9:~~30~~ AM	Meet Countess Albina for coffee ~~(time/place not confirmed as of Monday the 3rd)~~ ~~Hilton~~ Hotel	9:30 AM	
10:00 AM		10:30 AM	
11:00 AM		11:30 AM	
12:00 PM		12:30 PM	
1:00 PM	Federal Press Conference: "The International AIDS Conference's Impact on U.S. HIV/AIDS Programs for Communities of Color". Live Webcast. Fauci, O'Neill, Gayle, Goosby, Thurman. (Hilton - Inzinga Room)		
2:00 PM			
3:00 PM	CNN Interview	3:30 PM	
4:00 PM		4:30 PM	
5:00 PM		5:30 PM	
6:00 PM		6:30 PM	
7:00 PM	Opening Ceremony (Kingsmead Stadium) Transportation will be provided, public event, 10 - 20,000 people. Taking security is therefore highly recommended or watch it via CCTV from the office.		
		9:30 PM	
10:00 PM		10:30 PM	

NOTE: Looking into morning site visit (Salvation Army?)

Thurman			Monday July 10, 2000
7:00 AM		7:30 AM	
8:00 AM		8:30 AM	
9:00 AM	Depart Royal Hotel for Edendale (Thurman, Iskowitz, Derryck, NG crew) (VonZinkernagel/Galst to attend plenary. Will debrief you later, pre-WebMD Daily Update)	9:30 AM	
9:45 AM	USAID Press Conference, release of new stats. 'The AIDS Pandemic in the 21st Century: The Demographic Impact in Developing Countries' (Ground level, ICC)		
10:00 AM		10:30 AM	Arrive Edendale
11:00 AM		11:30 AM	
12:00 PM	Lunch - Lily of the Valley	12:30 PM	
1:00 PM		1:30 PM	
2:00 PM		2:30 PM	Depart Edendale
3:00 PM		3:30 PM	
4:00 PM	Arrive back at the Royal Hotel	4:30 PM	
5:00 PM	Debrief with VonZinkernagel and Galst	5:30 PM	WebMD Daily Update: 'Access to Care', Live Webcast. Goosby, Wilson, Thurman. (Hilton - Inzinga Room)
6:15 PM	Dinner hosted by Dr. Salim S. Abdool Karim for distinguished guests (Dr. Satcher - Live Event AIDS 2000: Taking the Lead. Regus Business Center)	6:30 PM	
7:00 PM		7:30 PM	
8:00 PM		8:30 PM	
9:00 PM		9:30 PM	
10:00 PM		10:30 PM	

Thurman			Tuesday July 11, 2000
7:00 AM		7:30 AM	
8:00 AM	(Dr. Satcher - TENTATIVE - visit to local clinic)	8:30 AM	
9:15 AM	USAID/LIFE Press Conference "One Year Later". Thurman, Derryck, Gayle. (Ground Floor, ICC)		
10:15 AM		10:30 AM	Tentative - Site visit for media to Ndwedwe District (one hour outside Durban). USAID funded project.
11:00 AM		11:30 AM	
12:00 PM	African and American NGO Twinning Luncheon (The Edward Hotel) *Michael, Cheryl and Jeff have been placed on the attendee list		
2:00 PM		2:30 PM	
3:00 PM	PLWA Roundtable Discussion - Satcher, Thurman, Goosby. (Hilton - Inzinga Room)		
5:00 PM		5:30 PM	WebMD Daily Update: Living w/ HIV/AIDS, Live Web - Goosby, Wilson, Thurman. (Hilton - Inzinga Room)
6:00 PM		6:30 PM	FHI Reception 'The Top of the Royal'
8:00 PM	NPR Studio Interview (Jeff Kamen) "Talk of the Nation",	8:30 PM	
9:00 PM		9:30 PM	
10:00 PM		10:30 PM	

NOTE: GORE-MBEKI Dinner...

Thurman			Wednesday July 12, 2000
7:00 AM		7:30 AM	
8:00 AM		8:30 AM	
9:00 AM	Chair, Plenary Session "Prevention of HIV". (ICC, Hall I)		
(10:15 AM USAID Press Conference: Confronting Stigma and Denial - The Demand for Voluntary Counseling and Testing)			
11:00 AM		11:30 AM	
12:00 PM		12:30 PM	
1:00 PM	Depart Ulundi Street entrance (of the Royal) (Dr. Satcher's Symposium Keynote Address: Accessing Vulnerable Groups: Youth (ICC, Hall 4))	1:30 PM	Ntinga Microenterprise Support Project. USAID Program - see attached briefing material.
		2:30 PM	Depart Ntinga for Cato Manor
3:00 PM	Cato Manor		
4:00 PM	Depart Cato Manor for the Royal Hotel	4:30 PM	
5:00 PM		5:30 PM	
	U.S. Delegation Reception (Holiday Inn - Elangeli)		(FYI - 6 PM. Marsha Martin, D. VonZin. & Fran Page, Live Webcast/Roundtable on Women and AIDS, Regus Business Centre)
7:00 PM	Harvard AIDS Institute Reception (Royal Hotel)		
9:00 PM		9:30 PM	
10:00 PM		10:30 PM	

Thurman		Thursday July 13, 2000	
7:00 AM		7:30 AM	
8:00 AM		8:30 AM	
9:00 AM	(USAID Press Conference: Children on the Brink. Release of report. Ground Level, ICC)	9:30 AM	
10:00 AM		10:30 AM	
11:00 AM		11:30 AM	
12:00 PM		12:30 PM	
1:00 PM		1:40 PM	(Ambassador Lewis Presentation)
2:00 PM		2:30 PM	
3:00 PM		3:30 PM	
4:00 PM	(Satcher departs Durban)	4:30 PM	
5:00 PM		5:30 PM	WebMD Daily Update: 'Vaccines'. Live Webcast. Goosby, Thurman. (Hilton - Inzinga Room)
6:00 PM	(Roundtable w/ Palenicek,/VonZinkernagel 'The RWCA' - Live Webcast, Regus Business Centre_)	6:30 PM	(Helene Gayle, Live Webcast on 'Prevention' - Regus Business Centre)
7:00 PM		7:30 PM	
8:00 PM		8:30 PM	
9:00 PM		9:30 PM	
10:00 PM		10:30 PM	

Thurman			Friday July 14, 2000
7:00 AM		7:30 AM	Children's Home (Durban) site visit with media.
Lewis, Thurman, Dangor, Derryck.			
10:00 AM	Arrive at Royal Hotel for Mandela Signing (see attached attendee list)		
10:55 - 11:00 AM	Brief remarks to press	11:30 AM	
12:00 PM		12:30 PM	Closing Ceremonies
Closing Ceremonies		1:30 PM	
2:00 PM		2:30 PM	
3:00 PM		3:30 PM	
4:00 PM		4:30 PM	
5:00 PM		5:30 PM	
6:00 PM		6:30 PM	
7:00 PM		7:30 PM	
8:00 PM		8:30 PM	
9:00 PM		9:30 PM	
10:00 PM		10:30 PM	

Thurman			Saturday July 15, 2000
7:00 AM	Depart Durban, South African Air Flight # 9576	7:30 AM	
8:10 AM	Arrive Johannesburg	8:30 AM	
9:00 AM		9:30 AM	
10:00 AM		10:30 AM	
11:00 AM		11:30 AM	
12:00 PM		12:30 PM	
1:05 PM	Depart Jo'burg, Air Tanzania Flight # 766	1:30 PM	
2:00 PM		2:30 PM	
3:00 PM	(Cheryl departs Durban)	3:30 PM	
4:00 PM		4:30 PM	
5:00 PM		5:55 PM	Arrive Kilimanjaro
6:00 PM		6:30 PM	
7:00 PM		7:30 PM	
8:00 PM		8:30 PM	
9:00 PM		9:30 PM	
10:00 PM		10:30 PM	

Thurman			Sunday July 16, 2000
7:00 AM		7:30 AM	
8:00 AM		8:30 AM	
9:00 AM		9:30 AM	Depart Kilimanjaro, Air Tanzania Flight # 772
		9:50 AM	Arrive Kigali (lose an hour!)
10:00 AM		10:30 AM	
11:00 AM		11:30 AM	
12:00 PM		12:30 PM	
1:00 PM		1:30 PM	
2:00 PM		2:30 PM	
3:00 PM	(Michael departs Durban)	3:30 PM	
4:00 PM		4:30 PM	
5:00 PM		5:30 PM	
6:00 PM		6:30 PM	
7:00 PM		7:30 PM	
8:00 PM		8:30 PM	
9:00 PM		9:30 PM	
10:00 PM		10:30 PM	

Thurman			Monday July 17, 2000
7:00 AM		7:30 AM	
8:00 AM		8:30 AM	
9:00 AM		9:30 AM	
10:00 AM		10:30 AM	
11:00 AM	(Michael arrives Washington DC)	11:30 AM	
12:00 PM		12:30 PM	
1:00 PM		1:30 PM	
2:00 PM		2:30 PM	
3:00 PM		3:30 PM	
4:00 PM		4:30 PM	
5:00 PM		5:30 PM	
6:00 PM		6:30 PM	
7:00 PM		7:30 PM	
8:00 PM		8:30 PM	
9:00 PM		9:30 PM	
10:00 PM		10:30 PM	

Thurman			Tuesday July 18, 2000
7:00 AM		7:30 AM	
8:00 AM		8:30 AM	
9:00 AM		9:30 AM	
10:00 AM		10:30 AM	
11:00 AM		11:30 AM	
12:00 PM		12:30 PM	
1:00 PM		1:30 PM	
2:00 PM		2:30 PM	
3:00 PM		3:30 PM	
4:00 PM		4:30 PM	
5:00 PM		5:30 PM	
6:00 PM		6:30 PM	
7:00 PM		7:30 PM	
8:00 PM		8:30 PM	
9:00 PM		9:30 PM	
10:00 PM		10:30 PM	

Thurman			Wednesday July 19, 2000
7:00 AM		7:30 AM	
8:00 AM		8:30 AM	
9:00 AM		9:30 AM	
10:00 AM		10:30 AM	
11:00 AM		11:30 AM	
12:00 PM		12:30 PM	
1:00 PM		1:30 PM	
2:00 PM		2:30 PM	
3:00 PM		3:30 PM	
4:00 PM		4:30 PM	
5:00 PM		5:30 PM	
6:00 PM		6:30 PM	
7:00 PM		7:30 PM	
8:00 PM		8:30 PM	
9:00 PM		9:30 PM	
10:00 PM		10:30 PM	

Thurman			Thursday July 20, 2000
7:00 AM		7:30 AM	
8:00 AM		8:50 AM	Depart Kigali, Kenya Airways Flight #473
9:00 AM		9:30 AM	
10:00 AM		10:30 AM	
11:10 AM	Arrive Nairobi	11:30 AM	
12:00 PM		12:30 PM	
1:00 PM		1:30 PM	
2:00 PM		2:30 PM	
3:00 PM		3:30 PM	
4:00 PM		4:30 PM	
5:00 PM		5:30 PM	
6:00 PM		6:30 PM	
7:00 PM		7:30 PM	
8:00 PM		8:30 PM	
9:00 PM		9:30 PM	
10:15 PM	Depart Nairobi, Northwest Flight # 8566	10:30 PM	

Thurman			Friday July 21, 2000
6:10 AM	**Arrive Amsterdam**	7:30 AM	
8:00 AM		8:30 AM	
9:00 AM		9:30 AM	
10:00 AM		10:30 AM	
11:00 AM		**11:35 AM**	**Depart Amsterdam, Northwest Flight # 37**
12:00 PM		12:30 PM	
1:00 PM		1:30 PM	
2:05 PM	**Arrive Washington Dullee (& Pick Up)**	2:30 PM	
3:00 PM		3:30 PM	
4:00 PM		4:30 PM	
5:00 PM		5:30 PM	
6:00 PM		6:30 PM	
7:00 PM		7:30 PM	
8:00 PM		8:30 PM	
9:00 PM		9:30 PM	
10:00 PM		10:30 PM	

Clinton Presidential Records
Digital Records Marker

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

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

3

Divider Title: _____

Plenary **Debate** **Roundtable** **Symposium** **Satellite**

FRIDAY, 7 JULY 2000				
Time	I.C.C. 3	I.C.C. 4	HILTON 10	CITY HALL 3
07:30	NGO SAT:			
08:00	Women, Men, Sex & HIV : Roles, Risks and Responsibilities: A global dialogue	NGO SAT: Faith-based organisations response to the AIDS crisis in Africa	NGO SAT: Breastfeeding & HIV-1 Transmission: Future Research Directions	NGO SAT: Putting third first-critical legal issues and HIV/AIDS
17:30				
18:00				

SATURDAY, 8 JULY 2000					
Time	I.C.C. 5	UNISA 1,2,3,4,5	UNISA 6	PLAYHOUSE 11 & 12	TBD
08:00		NGO SAT:	NGO SAT:		
09:00		Breaking the Silence at all fronts	Nursing partnerships to break	NGO SAT.	
09:30	NGO SAT:	in fighting the HIV epidemic	the HIV/AIDS silence	Third international	
10:00	Indaba symposium of global Christian perspectives to HIV/AIDS	in India		prevention works symposium	NGO SAT: HIV/AIDS media bnefing with new research from JAMA being presented
13:00					
15:00					
17.00					
19.00					

SUNDAY, 9 JULY 2000				
Time	I.C.C. 4	I.C.C. 5	UNISA 1	UNISA 3
08:00		NGO SAT:		
09:00		Gender, Human Rights, Sexuality	NGO SAT	
10.00	NGO SAT:	& HIV:	Better practices in AIDS	NGO SAT
	S.A.D.C. Regional Meeting	New challenges for women in	prevention social marketing	Local responses to HIV/AIDS
12:00		prevention, care, treatment		
13:00		and support		NGO SAT: Care for HIV & TB: Considerations for prevention, prophylaxis and integration
16:00				
16:15				
16:30				
18:00				

SUNDAY, 9 JULY 2000				
Time	UNISA 4	UNISA 6	CITY HALL 3	HILTON 10
08:00		NGO SAT:		
09:00		Supportive care and care		NGO SAT:
09:30		for the caregiver	NGO SAT:	The UNAIDS drug access
10:00	NGO SAT:		Improving access to	initiative : Status and
	Intestinal worms - a major		AIDS drugs in	preliminary results of
	impact on AIDS and TB		developing countries:	early evaluation
13:00			tested strategies	
13:30				
14:00				
15:00				NGO SAT:
16:00		NGO SAT:		Adherence issues for
		AIDS in India		children, youth & families:
17.30				A family focused model
18:00				

Plenary **Debate** **Roundtable** **Symposium** **Satellite**

MONDAY, 10 JULY 2000

Time	I.C.C. 1	I.C.C. 2	I.C.C. 3	I.C.C. 4	I.C.C. 5	I.C.C. 6	ROYAL 14
09:00 - 11:00	P.01 : The Brazilian Case Revisited Update Chairs: Hoosen Coovadia; Salim Abdool Karim **The deafening silence of Aids** **Cameron, Edwin* P.02 : The Assault on Care: Home Based Care Chairs: Manto Tshabalala-Msimang; Peter Piot **Development, Economics, Inequity and AIDS** *TBD* **Successes in HIV control, Fact or Fiction?** **Anderson, Roy* **Inequity in treatment access** **Kalumba, Katele*						
13:00 - 14:30	Sy01 : Symposium: Science of HIV/AIDS : Evolution & Impact	Db01 : Debate Donor Agencies are too focused on prevention & pay insufficient attention to the social and economic impacts of the epidemic *Paul Farmer/Medal O.C.I*	Rt01 : Roundtable Exposing the Silence	E01 : Oral Abstract Testing & Informed Consent	E02 : Oral Abstract Empowerment, Advocacy and Activism	E03 : Oral Abstract HIV/AIDS in children *R. Bajgar NCI*	C01 : Oral Abstract Female condoms - Where are we now?
14:45 - 16:15	Db02 : Debate Social Theory offers solutions and understanding of the HIV epidemic *Paula Treichler* *Quarraisha Abdool Karim*	Sy02 : Symposium: Prevention & Treatment Rights	Sy03 : Symposium: Mother-to-child transmission of HIV	E04 : Oral Abstract Innovative approaches to reach migrants & mobile populations	Rt02 : Roundtable Vaccines for developing countries: Development, access and delivery	E06 : Oral Abstract Paediatric anti-retroviral therapy	C02 : Oral Abstract Male circumcision - An ignored intervention
16:30 - 18:00	Db03 : Debate Vaccines for testing in developing countries should be matched to the dominant local HIV strain/subtype *Carolyn Williamson/Bellarmy Mbidde*	Db04 : Debate Innate immunity is as important as adaptive immunity in preventing HIV infection and progression to disease *Jay Levy/Giuseppe Pantaleo*	Sy04 : Symposium Policy Dialogue : Engaging Youth in the fight against AIDS	E05 : Oral Abstract Role of religion & religious institutions "Access or Avoidance"	E05 : Oral Abstract Notification, reporting and disclosure	Sy05 : Symposium Management of drug resistance	C03 : Oral Abstract Male condoms
18:30 20:00 20.30 21:00			NGO SAT: Global update on HIV in women	NGO SAT: The joint commitment of ANRS and developing countries to fight HIV/AIDS	NGO SAT: Access to Microbicides. Overcoming policy barriers		

MONDAY, 10 JULY 2000

Time	D.E.C. 7	D.E.C. 8	D.E.C. 9	HILTON 10	PLAYHOUSE 11	PLAYHOUSE 12	CITY HALL 13
11:30 - 13:00	Poster Session : C/D01 Criminalisation of HIV Transmission is a preventative measure (positive publication)			Plenary: CP01 Chair: Jurek Domaradzki Facts of life living with HIV/AIDS : Publication Criminalisation Based restrictive	Plenary Sess : CP01 Chair: Robin Gorna Female controlled prevention **Mitchell Warren* **Megan Gottemoeller* **Rosemarie Mantor*	Plenary: CP01 The role of the Church in addressing HIV/AIDS in African and African American communities	Plenary: CP02 Chair: Joseph Scheich Keeping it safe maintaining gay safe sex practices in the light of treatment for HIV **Andy Quan* **Rainer Schilling* **Brenton Wong* **Jorge Huerdo*
13:00 - 14.30	E07 : Oral Abstract HIV prevention in Educational institutions	D07 : Oral Abstract Communities: Catalyst for change	D08 : Oral Abstract Reducing risky sexual behaviour : Insights & interventions	E08 : Oral Abstract Access to care across the Continuum	E09 : Oral Abstract Animal Models - interventions	E10 : Oral Abstract HIV Diagnostics	C04 : Oral Abstract Vaccine preparedness
14:45 - 16:15	E11 : Oral Abstract Methods in behavioural research on HIV risks	D09 : Oral Abstract Mother-to-child transmission: Issues in breastfeeding transmission	D10 : Oral Abstract Male condoms - challenges, opportunities and distribution	E12 : Oral Abstract Quality nursing care makes a difference	E13 : Oral Abstract HIV molecular evolution	E14 : Oral Abstract HIV replication and pathogenesis *Suresh Arya, NCI*	C05 : Oral Abstract Tuberculosis and HIV/AIDS interventions
16:30 - 18:00	E15 : Oral Abstract Speaking & listening: Parents & Children	D06 : Oral Abstract Reaching out : Male & Female sex workers	D05 : Oral Abstract Breaking the Silence Reversing denial and facing our fears	E16 : Oral Abstract Gynaecological complicatuons in HIV-positive women	E17 : Oral Abstract Methodology and epitope identity	E18 : Oral Abstract Biological correlates of HIV transmission	C06 : Oral Abstract Reducing mother-to-child transmission

Plenary Debate **Roundtable** **Symposium** **Satellite**

MONDAY, 10 JULY 2000				
TIME	UNISA 3	UNISA 6	CITY HALL 3	CHAMBER OF COMMERCE
06:30		NGO SAT: International Multicentre controlled clinical trials in TB and HIV Infection		
09:00				
18:00			NGO SAT: Breaking the silence with community-based research: A network building satellite	
18:30	NGO SAT: Developing a program managers' guide to effective HIV/AIDS programming - A framework and methodology	NGO SAT: Cultural & Social impact on HIV/AIDs intervention in Chinese communities		NGO SAT: Closed editorial meeting of the Cochrane Review Group on HIV infection and AIDS
20:30				
21:00				

Plenary **Debate** **Roundtable** **Symposium** **Satellite**

TUESDAY, 11 JULY 2000							
Time	I.C.C. 1	I.C.C. 2	I.C.C. 3	I.C.C. 4	I.C.C. 5	I.C.C. 6	ROYAL 14
09.00 - 11.00	[illegible] **Viral Factors in HIV disease** *David Ho* **Host Factors in HIV disease** ***Anthony Fauci*** **Advances in Treatment of HIV/AIDS** *Maurp Schechter* **Human Rights / Global Inequity and HIV/AIDS** *TBD*						
13:00 - 14:30	D005 : Debate HIV positive women should be encouraged to exclusively breastfeed *Ann Coovadia-Mary Glenn Fowler*	Rt03 : Roundtable Living with HIV	[illegible] Oral Abstract Anti-retroviral therapy in resource poor settings - Real world data	Sy07 : Symposium Public policy - Implementation and Impact	[illegible] Evaluation of responses	Sy06 : Symposium: Tuberculosis in HIV patients	C05 : Oral Abstract Post-exposure prophylaxis
14:45 - 16:15	D006 : Debate Research participants in developed and developing countries should receive the same standard of care *Jorge Bermal-Solomon Benatar*	14:45 - 18:00 Sy08 : Symposium Outstanding issues in the international response to HIV/AIDS	B05 : Oral Abstract Mother-to-child transmission	[illegible] Innovative approaches to reach disadvantaged women	[illegible] Media responses and responsibility	B06 : Oral Abstract Opportunistic infections	C06 : Oral Abstract Determinants of disease progression
16:30 - 18:00	D007 : Debate Until there are more affordable drugs, and retroviral therapy less than HAART is acceptable in developing countries *Raphael Pandaya- Idris Abdallah*	Rt05 : Roundtable Mother-to child transmission obstacles in implementation	[illegible] Global action to expand national response in Africa	[illegible] Intellectual property and Human Rights : Access to drugs	[illegible] Adherence to anti-retroviral therapy - why so low?	C11 : Oral Abstract Natural history of HIV/AIDS in developing countries	
18:30 - 20:30				NGO SAT: Understanding HIV vaccine development & what NGO's can do to move things forward	NGO SAT: Building political commitment for effective HIV/AIDS policies and programs		
21:00 - 21:30							

TUESDAY, 11 JULY 2000							
Time	D.E.C. 7	D.E.C. 8	D.E.C. 9	HILTON 10	PLAYHOUSE 11	PLAYHOUSE 12	CITY HALL 13
06:30 - 08.30				NGO SAT: HIV Care and prevention - North & South : An international case conference I			
11:30 - 13:00	[illegible] CHW Mothers should advocate against treatment to prevent mother to child transmission without treatment for the mother			Pamelela:: CHWs International and national models [illegible]	Pamelela : CHW Successes and obstacle [illegible]	Pamelela : CHWs The role of HIV transmission within the family and community	Pamelela: CHW Sexual and reproductive rights of positive women
13:00 - 14:30	[illegible] Oral Abstract Behind walls - HIV in prison	L01 : Oral Abstract Intensifying the response	[illegible] Oral Abstract Behavioural predictors and outcomes of HAART	[illegible] HIV related malignancies	[illegible] Immune response in the context of treatment	[illegible] Oral Abstract New vaccine designs I *M. Robert-Guroff, NCI*	C12 : Oral Abstract Voluntary counselling and testing
14:45 - 16:15	[illegible] Oral Abstract Peer interventions strategies	L04 : Oral Abstract Economic impact of AIDS on households & organisations	C13 : Oral Abstract Strategies for adherence to therapy	[illegible] Home care models	[illegible] Cytokine / Chemokine and Receptors	[illegible] Oral Abstract Molecular biology of viral resistance	Rt04 : Roundtable AIDS vaccine development for Africa
16:30 - 18:00	[illegible] Oral Abstract Sexual behaviour of students: From primary school to university	[illegible] Oral Abstract Sex work and HIV, lessons and challenges	C15 : Oral Abstract Stigma	Sy09 : Symposium Gender issues in disease progression	[illegible] New antivirals/Targets II	[illegible] Oral Abstract HIV diversity	C10 : Oral Abstract Biological determinants of transmission
18:30 - 21:00				NGO SAT: Getting the most out of PLHA involvement			

Plenary Debate Roundtable Symposium **Satellite**

TUESDAY, 11 JULY 2000				
Time	UNISA 1	UNISA 3	UNISA 6	
18:00	NGO SAT:			
18:30	General meeting of The	NGO SAT:	NGO SAT:	
	Cochrane Review Group	Taking it to the streets.	The female condom:	
	on HIV infection and	An international forum	Where we've been and	
20:30	AIDS	for community health	where we're going	
21:00		outreach workers		
21:30				

Plenary **Debate** **Roundtable** **Symposium** **Satellite**

WEDNESDAY, 12 JULY 2000							
Time	I.C.C. 1	I.C.C. 2	I.C.C. 3	I.C.C. 4	I.C.C. 5	I.C.C. 6	ROYAL 14
09:00 - 11:00	Prevention does work! *Peter Lamptey* Gender, Sexuality and HIV *Geeta Rao Gupta* Strategies to reduce mother-to-child transmission *Chewe Luo* Advances in topical microbicides *Lut van Damme*						
13:00 - 14:30	Db08 : Debate Population based STD treatment programmes should be implemented to reduce HIV transmission *TBD*	Rt06 : Roundtable Prevention of HIV	Sy10 : Symposium The AIDS epidemic: Can the Health Sector respond?	Sy11 : Symposium Accessing vulnerable groups : Youth *D. Satcher, DHHS*	Public health and Human Rights	Oral Abstract Switching anti-retroviral regimens	Oral Abstract Injecting drug use and HIV
14:45 - 16:15	Db09 : Debate Sufficient immune reconstitution is possible in context of HAART *TBD*	Db15 : Debate Compulsary licencing & parallel imports. Will they improve access to AIDS drugs? *TBD*	Sy12 : Symposium Caring for the child with HIV infection	Oral Abstract Ethics of care : Strategies for improving care	Oral Abstract Innovative approaches to reach sex workers	Oral Abstract Immune based therapies	Oral Abstract HIV vaccine trials *J. McNamara, NIAID*
16:30 - 18:00	Db10 : Debate Hydroxyurea has an important role as a component of anti-retroviral therapy *Francis Barany and Jerschel*	Db11 : Debate Structural adjustment fuels the AIDS epidemic *Edith Gabriel Mukasa*	Sy13 : Symposium Effects of HIV interventions	Oral Abstract Regulating HIV prevention and therapeutic goods and services	Oral Abstract Innovative approaches to reach injecting drug users	Oral Abstract Clinical trials of anti-retroviral therapy	Rt07 : Roundtable Blood safety
18:00 18:30 20:30 21:00			NGO SAT: Prevention of mother-to-child transmission of HIV: Pilot project implementation issues	NGO SAT: Developing an African AIDS vaccine strategy	NGO SAT: What can simulation modeling tell us about the impacts of prevention interventions in different contexts?		

WEDNESDAY, 12 JULY 2000							
Time	D.E.C. 7	D.E.C. 8	D.E.C. 9	HILTON 10	PLAYHOUSE 11	PLAYHOUSE 12	CITY HALL 13
11:30 - 13:00	Special Session : Db05 People should go for HIV testing if treatment is available	Plenary : Pl05 Mobility and migration	Plenary Session : Pl01 Decriminalization of sex workers) leads to decreased transmission		Plenary : Pl02 Making a difference - Men and AIDS	Plenary : Pl03 Shooting up - IDU's and needle exchange Keeping it safe?	Plenary : Pl04 Dying conditions
13:00 - 14:30	Oral Abstract Gender & sexuality : Still on the agenda	D20 : Oral Abstract Community-based interventions: How effective are they?	Oral Abstract How mobile is the virus? Migrants and their partners	Oral Abstract Immune reconstruction *C. Lane and A. Saville, NIAID*	Oral Abstract Human Herpes Virus-8 (HHV-8)	Oral Abstract New vaccine designs	Oral Abstract New developments in breastfeeding transmission of HIV
14:45 - 16:15	Oral Abstract Violence against women : Cries & whispers	D22 : Oral Abstract Dollars and Sense - cost of medical care	Oral Abstract Injecting - an international epidemic	Oral Abstract Pharmacology and pharmacokinetics	Oral Abstract Co-infection of HIV and Hepatitis viruses	Oral Abstract New anti-virals-I	Oral Abstract Implementing Mother-to-child intervention programmes: Successes and challenges
16:30 - 18:00	Oral Abstract "Hope or Hindrance" custom, religion and sexuality	D23 : Oral Abstract Making voluntary testing work	Oral Abstract Pushing the agenda: advocacy and involvement	Oral Abstract Management of HIV disease in real life	Oral Abstract CD8/CD4 cells: Implicaton for vaccine development	Oral Abstract Ethics of research	Oral Abstract Cost-effectiveness of mother-to-child transmission
19:00 21:00				NGO SAT: Social marketing: An effective strategy in prevention of HIV/AIDS & STD			

Plenary **Debate** **Roundtable** **Symposium** **Satellite**

THURSDAY, 13 JULY 2000							
Time	I.C.C. 1	I.C.C. 2	I.C.C. 3	I.C.C. 4	I.C.C. 5	I.C.C. 6	ROYAL 14
09:00 - 11:00	[illegible] Plenary : Challenges of HIV Vaccine **Genetics and transmission of HIV** *Francine McCutchan* **An AIDS vaccine by 2007, myth or reality?** *Margaret Liu* **AIDS vaccine challenges to the pharmaceutical industry** *Peter Young* **Ethics of AIDS research in developing countries** *Malegapuru Makgoba*						
13:00 - 14:30	Db12 : Debate Prevention policy should be directed to changing the behaviour of those who display the highest risk behaviour *Tom Coates, Tim Rhodes*	Rt08 : Roundtable Challenges of HIV Vaccine	Sy15 : Symposium Intersectoral response to HIV/AIDS	Sy16 : Symposium HIV vaccine trials : Ethics	[illegible] Oral Abstract Protecting the children: Orphan care and support	Sy14 : Symposium Issues in antiretroviral therapy	[illegible] Oral Abstract HIV prevalence and risk factors
14:45 - 16:15	Db13 : Debate TB Prophylaxis should be given to all HIV infected persons *Kevin Mwinga, Gary Maartens*	[illegible] See supplement for details	[illegible] New Developments in Affordable Antiretroviral Therapy ***M. Dybul, NIAID*** (16:00)	Rt09 : Roundtable International support for the prevention of mother-to-child transmission	Sy18 : Symposium Personal accounts in dealing with AIDS ***Neal Nathanson, OAR***	Sy20 : Symposium Report back on the 3rd International HIV Prevention Works meeting	[illegible] Oral Abstract Association of STI and HIV
16:30 - 18:00	Db14 : Debate Future microbicides research should focus on specific anti-HIV approaches *Kenneth Mayer, Anita Hoosen*	[illegible] See supplement for details	See supplement for details	Vaccines Immunotherapy & Immunopathogenesis ***C. Womack, NIAID***	[illegible] Oral Abstract The Multisectoral Response: Making programmes work	[illegible] Oral Abstract Structured treatment interruptions	[illegible] Oral Abstract Sexually transmitted disease control interventions
18.30 21:00				NGO SAT. Networking for effective responses to HIV/AIDS: Evidence from regional harm reduction networks			

THURSDAY, 13 JULY 2000							
Time	D.E.C. 7	D.E.C. 8	D.E.C. 9	HILTON 10	PLAYHOUSE 11	PLAYHOUSE 12	CITY HALL 13
06:30 08.50				NGO SAT: HIV care & prevention - North & South: An international case conference II			
11:30 - 13:00	Update Session : [illegible] How can ARV referrals be made available with/without the required infrastructure?	Mainstream : CM13 Nutrition in resource poor settings : the importance of education and counselling	Workshop : CW06 And the media plays on [illegible]		Mainstream : CM14 Are the counsellors counselling? - Quality and effectiveness of counselling	Mainstream : CM15 Home and community care - challenging stigma	Mainstream : CM16 HIV/AIDS vaccines and the work for communities in Africa
13:00 - 14:30	[illegible] Oral Abstract Recruitment for HIV vaccine trials	D09 : Oral Abstract Prevention and action: Men who have sex with Men	[illegible] Oral Abstract Caring for caregivers	[illegible] Oral Abstract Hepatitis C and HIV Co-infection - Clinical aspects	[illegible] Oral Abstract Microbicides	Sy17 : Symposium Immune recognition and [illegible] immune escape I	[illegible] Oral Abstract Measuring the epidemic
14:45 - 16:15	Sy19 : Symposium HIV/AIDS families and communities	D11 : Oral Abstract "Where are we now?" Gays, Lesbians, Bisexual and Transgendered voices	[illegible] Oral Abstract Positive people : Leading initiatives	[illegible] Oral Abstract Palliative and Terminal care	[illegible] Oral Abstract HIV in Men who have sex with Men	[illegible] Oral Abstract Risk factors for lipodystrophy syndrome	[illegible] Oral Abstract Trends in the epidemic
16:30 - 18:00	[illegible] Oral Abstract Protecting the children: Orphan care & support	D12 : Oral Abstract HIV discordant couples: Living with HIV	[illegible] Oral Abstract Breaking the silence around traditional medicine for HIV/AIDS prevention and care	[illegible] Oral Abstract Training community and health care workers	[illegible] Oral Abstract Responding to stigma and discrimination	[illegible] Oral Abstract Lipid metabolism and cardiovascular risk	Sy21 : Symposium Effect of HAART on HIV trends
18:30 21:00				NGO SAT: Children on the brink: Principles and issues in program implementation			

Plenary Debate **Roundtable** **Symposium** **Satellite**

THURSDAY, 13 JULY 2000	
Time	UNISA 6
18:30	NGO SAT:
	Community
21:00	mobilisation

FRIDAY, 14 JULY 2000		Fri, 14-Jul - Sun, 16-Jul	Sun, 16-Jul - Fri, 21-Jul
Time	UNISA 1,2,3,4,5	University	
13:30	NGO SAT:	NGO SAT:	NGO SAT:
	Gender, Human Rights, Sexuality & HIV:	Building epidemiological capacity to	Ethical issues in international
	New challenges for women in	respond to the challenge of infectious	health research
17:00	prevention, care, treatment and support	and communicable diseases	

Clinton Presidential Records
Digital Records Marker

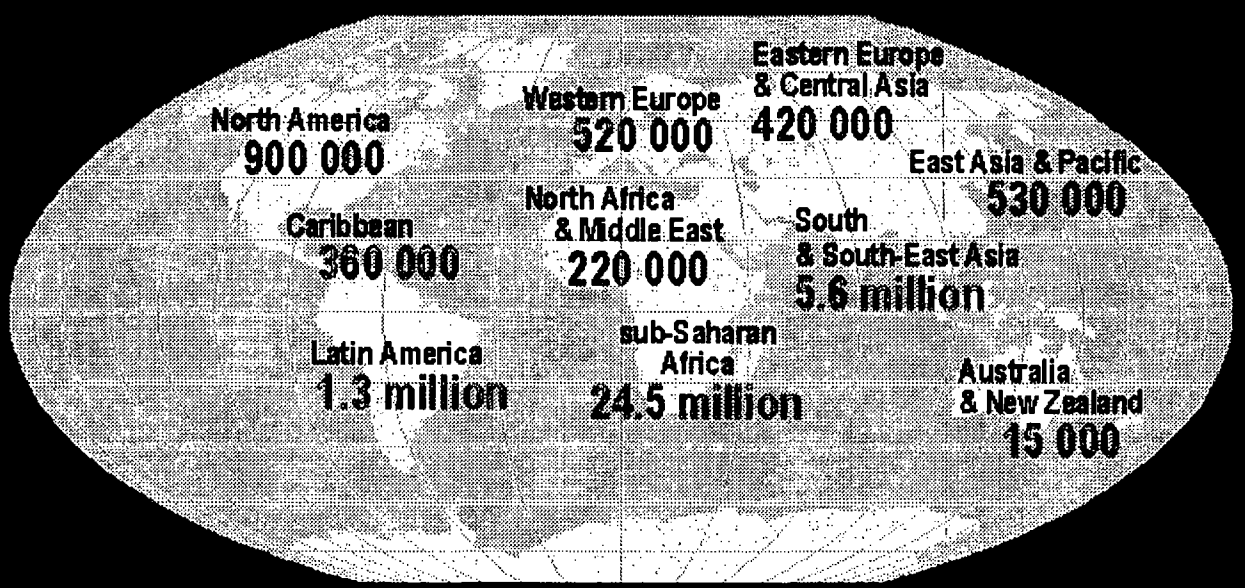
This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

4

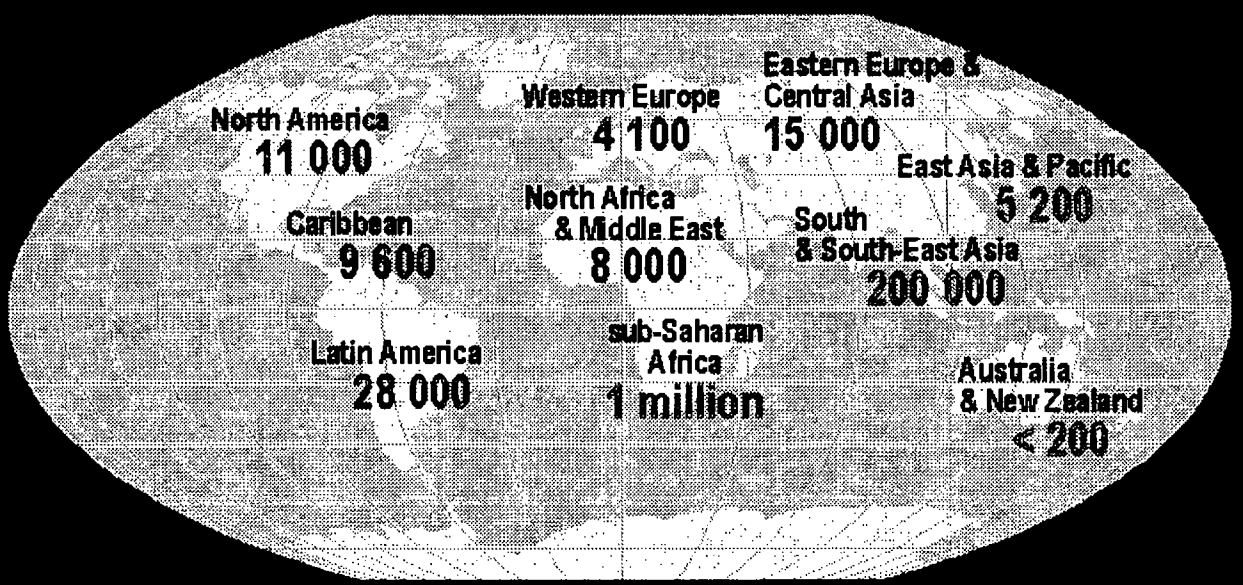
Divider Title: _____

Adults and children estimated to be living with HIV/AIDS as of end 1999



Total: 34.3 million

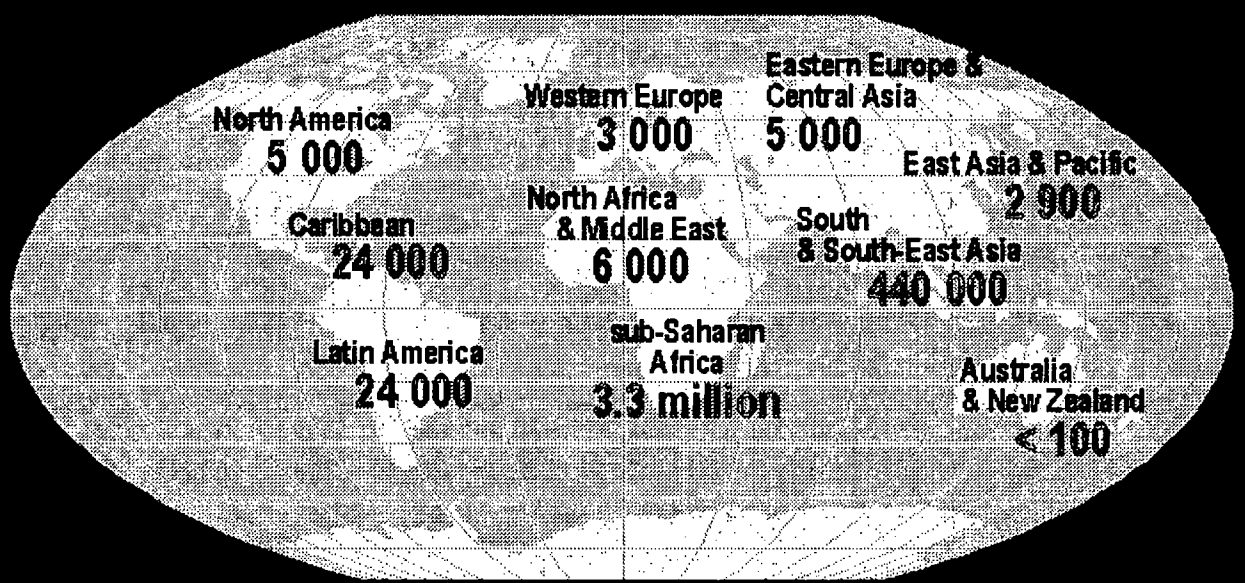
Children (<15 years) estimated to be living with HIV/AIDS as of end 1999



Total: 1.3 million

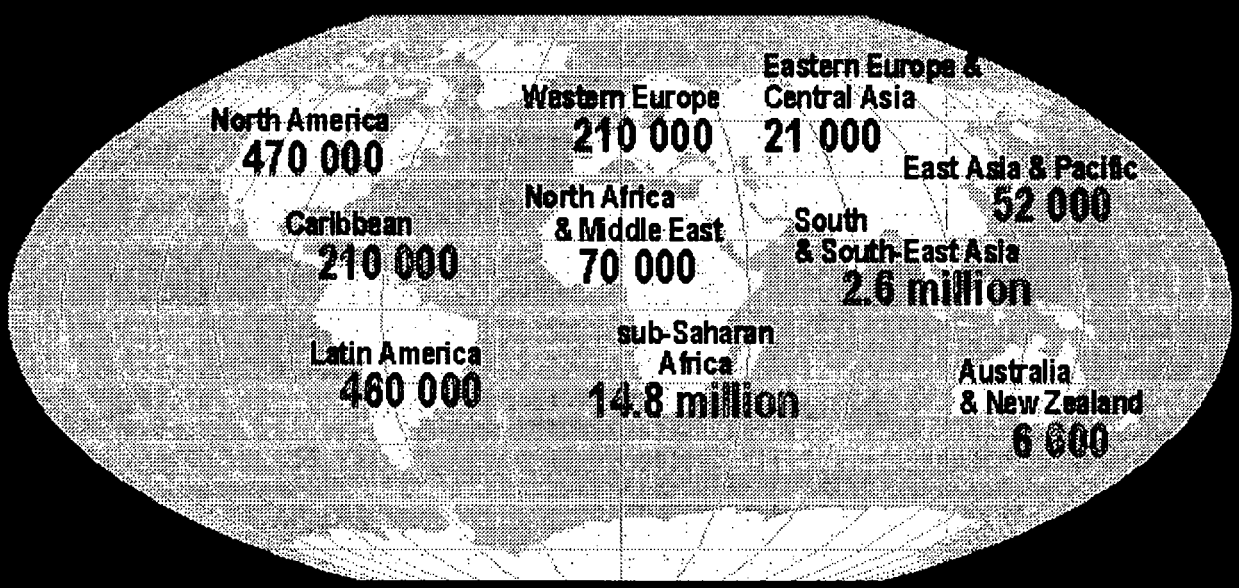
UNAIDS

Estimated deaths in children (<15 years) due to HIV/AIDS from the beginning of the epidemic to end 1999



Total: 3.8 million

Estimated adult and child deaths due to HIV/AIDS from the beginning of the epidemic to end 1999

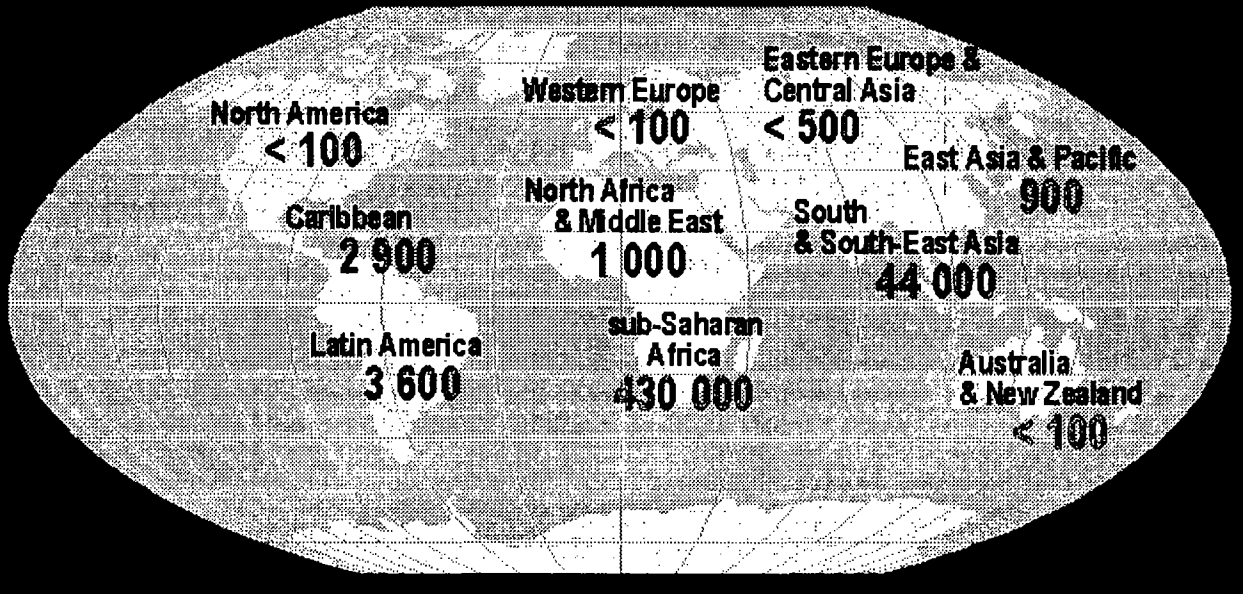


Total: 18.8 million

Estimated adult and child deaths from HIV/AIDS during 1999

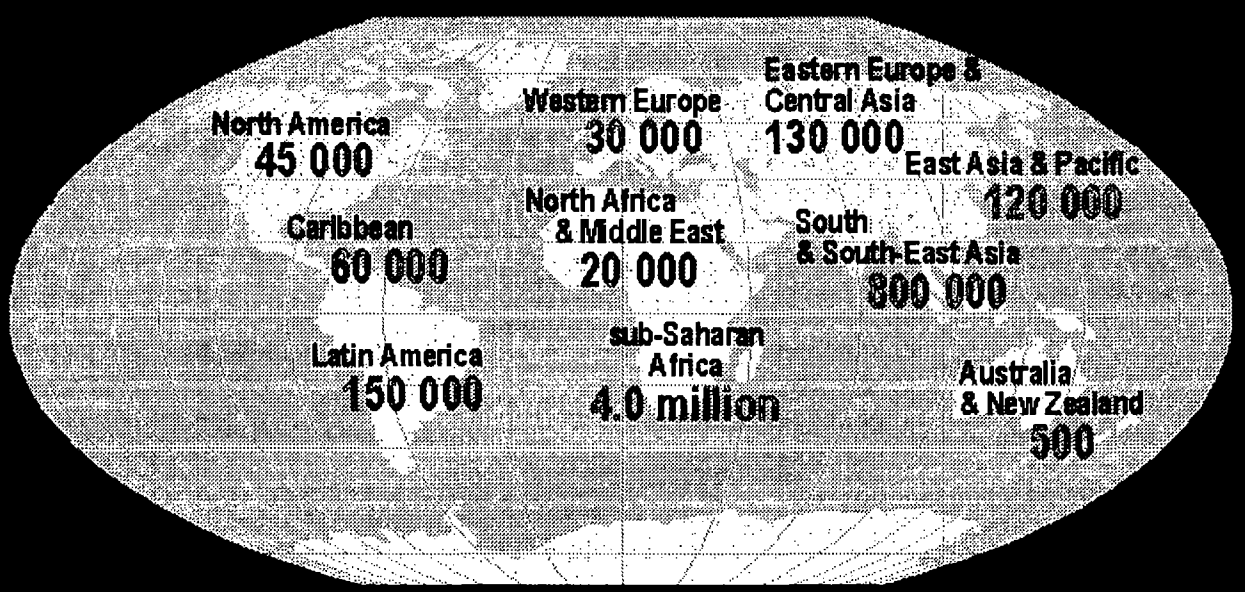
Total: 2.8 million

Estimated deaths in children (<15 years) from HIV/AIDS during 1999



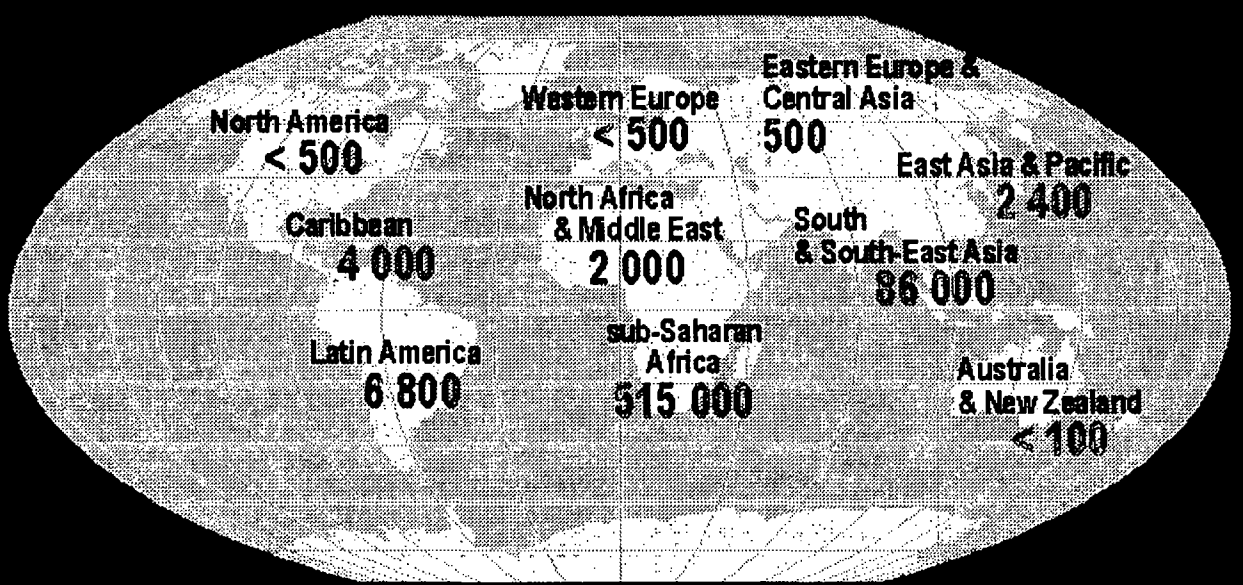
Total: 480 000

Estimated number of adults and children newly infected with HIV during 1999



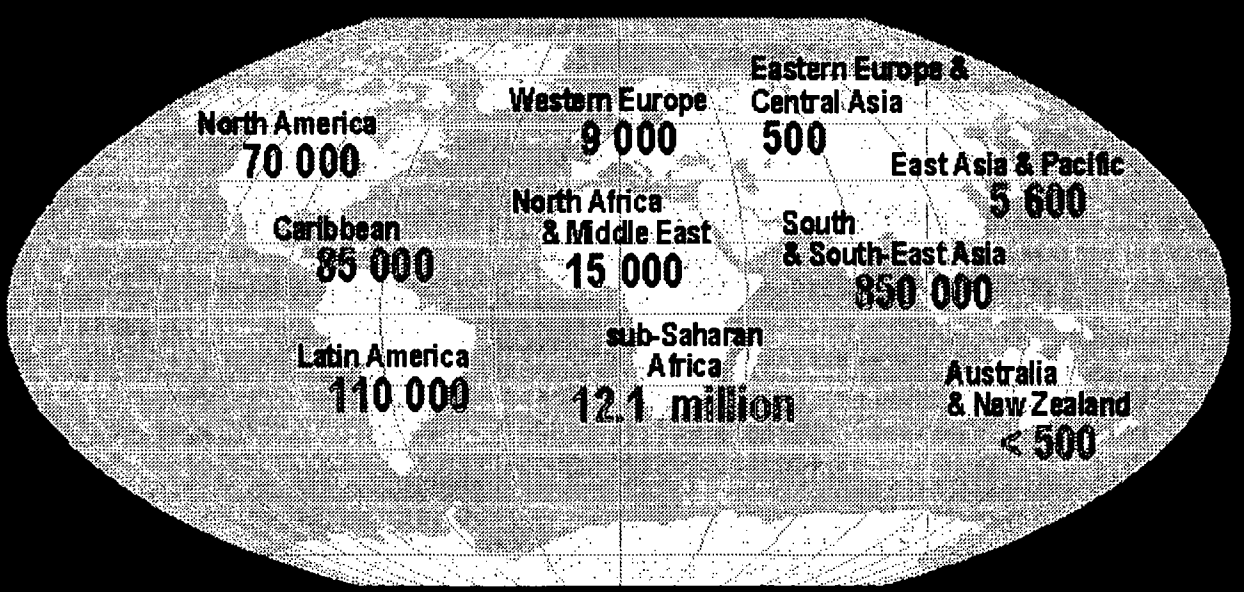
Total: 5.4 million

Estimated number of children (<15 years) newly infected with HIV during 1999

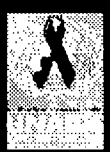


Total: 620 000

Cumulative number of children estimated to have been orphaned by AIDS at age 14 or younger at the end of 1999



Total: 13.2 million



[illegible] orphaned [illegible] before their fifteenth birthday [illegible]

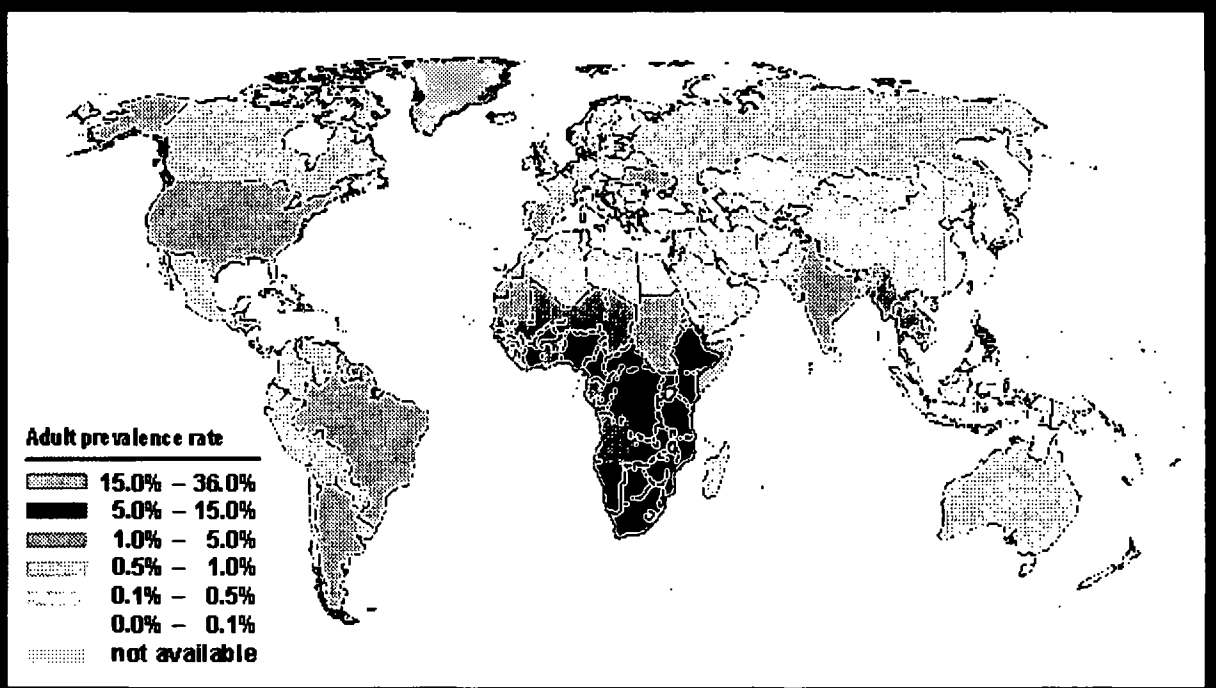
[illegible]

Regional HIV/AIDS statistics and features, end of 1999

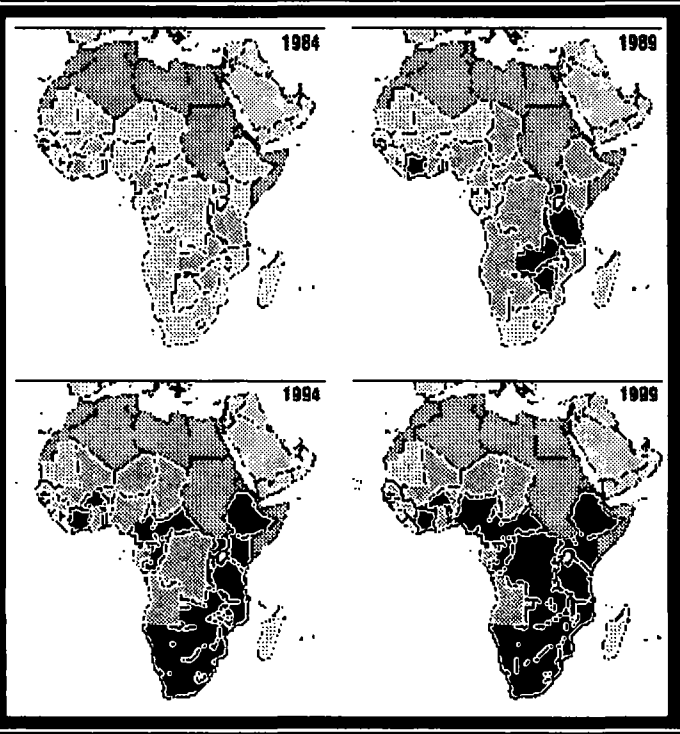
	Epidemic started	Adults & children living with HIV/AIDS	Adults & children newly infected with HIV	Adult prevalence rate	% HIV-positive women	Main mode(s) of transmission for those living with HIV/AIDS
Sub-Saharan Africa	late '70s–early '80s	24.5 million	4 million	8.57%	55%	Hetero
North Africa & Middle East	late '80s	220 000	20 000		20%	IDU, Hetero
South and South-East Asia	late '80s	5.6 million	800 000	0.12%	35%	Hetero, IDU
East Asia & Pacific	late '80s	530 000	120 000	0.64%	13%	IDU, Hetero, MSM
Latin America	late '70s–early '80s	1.3 million	160 000	0.06%	25%	MSM, IDU, Hetero
Caribbean	late '70s–early '80s	360 000	60 000	0.49%	35%	Hetero, MSM
Eastern Europe & Central Asia	early '90s	420 000	130 000	2.11%	25%	IDU
Western Europe	late '70s–early '80s	520 000	30 000	0.21%	25%	MSM, IDU
North America	late '70s–early '80s	900 000	45 000	0.23%	20%	MSM, IDU, Hetero
Australia & New Zealand	late '70s–early '80s	15 000	500	0.58%	10%	MSM, IDU
TOTAL		34.3 million	5.4 million	0.13%	47%	

A global view of HIV infection

33 million adults living with HIV/AIDS as of end 1999



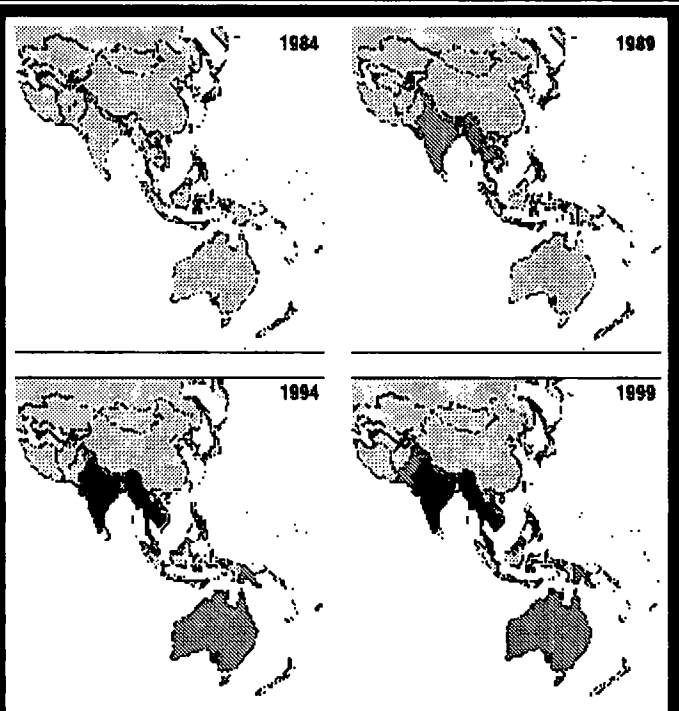
Spread of HIV over time in sub-Saharan Africa, 1984 to 1999



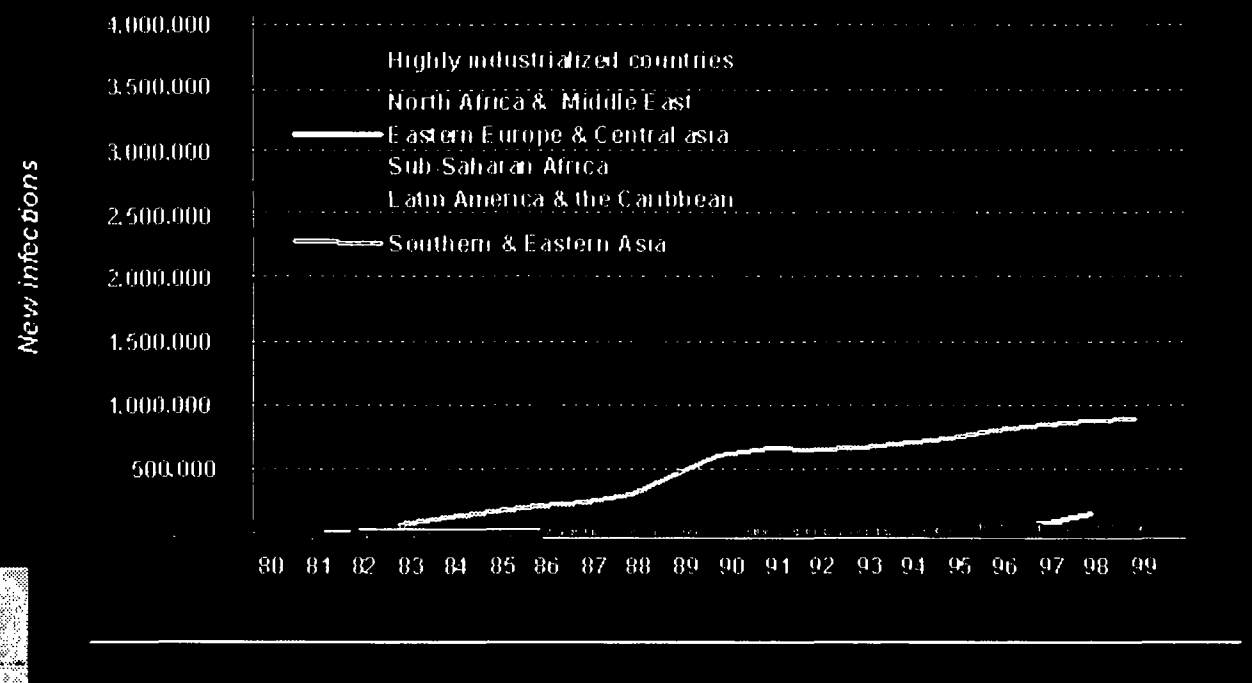
Estimated percentage of adults (15–49) infected with HIV

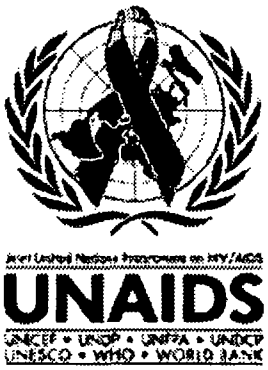
- 20.0% – 36.0%
- 10.0% – 20.0%
- 5.0% – 10.0%
- 1.0% – 5.0%
- 0.0% – 1.0%
- trend data unavailable
- outside region

Spread of HIV over time in Asia, 1984 to 1999



Estimated number of new infections by region, 1980 to 1999





Fact Sheets - HIV/AIDS IN AFRICA

HIV/AIDS IN AFRICA

While some gains were made in prevention and care in a number of countries, there were 4 million new HIV infections in sub-Saharan Africa during 1999. In Africa, AIDS now kills ten times more people a year than war.

- There are now **16 countries** in Africa in which more than one-tenth of the adult population (aged 15-49) is infected with HIV.
- In the six countries of **southern Africa**, AIDS is expected to claim the lives of between 8% and 25% of today's practising doctors by the year 2005.
- In seven countries, all in the southern cone of the continent, at least one **adult** in five is living with HIV. In countries where 10% of the adult population has HIV infection, almost 80% of all deaths in young adults aged 25-45 will be associated with HIV.
- Infection rates in young African **women** are far higher than in young men. According to studies presented in the report, the average rates in teenage girls were over five times higher than in teenage boys. Among young people in their early 20s, the rates were three times higher in women. In Africa, women's peak infection rates occur at earlier ages than men's. This helps explain why there are an estimated 12 women living with HIV for every 10 men in this region.
- A recent study estimates that in 1997, **public health spending** for AIDS alone already exceeded 2% of gross domestic product (GDP) in 7 of 16 African countries sampled – a staggering figure in nations where total health spending accounts for 3–5% of GDP.

GDP.

- In **Zimbabwe**, by 1997 the likelihood of a 15-year-old woman dying before the end of her reproductive years quadrupled from around 11% in the early 1980s to over 40% by 1997. More than 2000 Zimbabweans die of AIDS each week.

- In **Botswana**, a shocking 35.8% of adults are now infected with HIV, while in **South Africa**, 19.9% are infected, up from 12.9% just two years ago. The adult HIV prevalence rate in Botswana has more than tripled since 1992, when it was an estimated 10%.

- With a total of 4.2 million infected people, **South Africa** has the largest number of people living with HIV/AIDS in the world, as well as one of the world's fastest-growing epidemics. Already, 1 in 4 South African women between ages 20 and 29 are infected with the virus.

- More than 1 in 4 adults living in **Zambian** cities are HIV-positive, and more than 1 in 7 Zambian adults are infected in the country's rural areas.

- On the other hand, the percentage of pregnant girls aged 15-19 infected with HIV in the capital, Lusaka, has on average dropped by almost half in the last six years. The percentage of unmarried women who were sexually active fell from 52% to 35% between 1990 and 1996.

- A study in Zambia showed that in one hospital, deaths among **health care workers** increased 13-fold over the 10-year period from 1980 to 1990, largely because of HIV.

- In **West Africa**, relatively less affected, prevalence rates in some countries are creeping up. **Côte d'Ivoire** is already among the 15 worst-affected countries in the world. In **Nigeria**, by far the most populous country in sub-Saharan Africa, over 2.7 million people are infected with HIV.

- By the year 2010, crude death rates in **Cameroon** will have more than doubled as a result of HIV/AIDS. An estimated 340,000 people in **Ghana** are currently living with HIV.

- Infection rates in **East Africa**, once the highest on the continent, hover above those in West Africa but have been exceeded by the rates now being seen in the southern cone.

  The prevalence rate among adults in **Ethiopia** and

- The prevalence rate among adults in **Ethiopia** and **Kenya** has reached double-digit figures and continues to rise.

- Since the epidemic began, AIDS has created some 12.1 million **orphans** in Africa, out of a global total of 13.2 million AIDS orphans. Before AIDS, about 2% of all children in developing countries were orphans. By 1997, the proportion of children with one or both parents dead had skyrocketed to 7% in many African countries.

- HIV-positive **patients** have occupied 39% of the beds in Kenyatta National Hospital in Nairobi, Kenya, and 70% of the beds in the Prince Regent Hospital in Bujumbura, Burundi.

- Through strong prevention programmes, **Uganda** has brought its estimated prevalence rate down to around 8% from a peak of close to 14% in the early 1990s. HIV prevalence among 13-19-year-old girls has fallen significantly over an eight-year period, while the rate in teenage boys – always much lower because boys are less likely than girls to have partners in the older, more heavily infected age groups – has remained roughly stable. The percentage of teenage girls who had ever used a condom tripled between 1994 and 1997.

HIV/AIDS IN ASIA

HIV/AIDS is a relatively recent but growing problem in many parts of Asia. With 60% of the world's population and widespread evidence of behaviour and situations that expose people to HIV, there is no room for complacency.

- In comparison with the rates of HIV infection in Africa, those in the general population of Asia are still low. The prevalence among 15-49-year-olds exceeds 1% in only three countries – Cambodia, Myanmar and Thailand. In other countries, it is often far lower. In Indonesia, the world's fourth most populous country, fewer than 5 people in 10,000 are living with HIV. In the Philippines, the rate of HIV infection is 7 per 10,000.
- Currently there are **tremendous variations** in the dynamics and trends of the epidemic within Asia. There are also significant variations within countries, especially within huge and populous nations such as China and India. For example, while some states of India show almost no HIV infection, others have reached adult prevalence rates of 2% and above.
- Despite this diversity, there are broadly **recognizable patterns**. In some countries, the virus has already spread considerably in the heterosexual population. In others, the epidemic is concentrated among injecting drug users and their sex partners, and HIV rates in the general population are low. In the latter countries, it is misleading to take the national HIV rate among adults as a yardstick of the severity of the epidemic or its scope for expansion.
- Epidemics driven by unsafe **drug-injecting practices** dominate in some provinces of China, Malaysia, Nepal and Viet Nam. Recent reports suggest that a similar situation is emerging in Indonesia, specifically in the capital, Jakarta.
- In parts of north-east India, too, widespread injecting drug use provided an early entry point for HIV. In Manipur, the prevalence of HIV infection among injecting drug users shot up from virtually nothing in 1988 to over 65% just four years later. It has remained at these high levels ever since. Most cases of infection among women appear to have been acquired from husbands who had been infected in turn by sex workers, themselves part of a longer chain of transmission. In other parts of the country, there is evidence that unsafe sex is spreading HIV within the general population.
- At present, **China**'s epidemic is mostly concentrated among injecting drug users in a few provinces in the south and west. There is huge potential for deterioration, however, not only through drug use but through unsafe sex. Against a backdrop of far-reaching social and economic change over the past decade, China has seen a dramatic rise in the classic sexually

transmitted diseases such as syphilis and gonorrhoea – evidence of widespread sexual risk behaviour.

- China and India between them account for around 36% of the world's population. With such huge populations, even low HIV prevalence rates translate into huge numbers of infections. In **India**, where only 7 adults in 1000 are infected, 3.7 million people were living with HIV/AIDS at the beginning of the millennium – more than in any other country in the world except South Africa.
- Countries where HIV has spread significantly through **unsafe sex** include Cambodia, Myanmar and Thailand.
- **Thailand**'s well-publicized success in curbing a rampant heterosexual epidemic has brought to light other routes of transmission against which HIV prevention programmes have been far less successful. HIV continues to spread virtually unchecked through the sharing of drug-injecting equipment and through unprotected sex between men.
- **Myanmar** is already in the throes of a major epidemic while **Cambodia** has the highest HIV prevalence rates in the region, fuelled by sexual transmission against a background of social and economic fragility.
- **Viet Nam**'s HIV epidemic, until now largely confined to the south and the central provinces, has expanded to the northern provinces as well. There, as in the rest of the country, the virus is spread through injecting drug use and there is ample evidence of steadily increasing sexual transmission.
- A number of factors have played a significant role in the spread of HIV in Asia and are likely to continue having an impact: injecting drug use, commercial sex, and migration and population mobility.

Search the site
Contact Us
Help

Fact Sheets - HIV/AIDS IN LATIN AMERICA

Home > Fact Sheets > HIV/AIDS IN LATIN AMERICA

Search this section

refine your search

Home
What's New
About UNAIDS
Publications
HIV/AIDS Info
Cosponsors
Best Practice
World AIDS Campaign
Africa Partnership
Links and more info

HIV/AIDS IN LATIN AMERICA

The HIV epidemic in Latin America is highly diverse. Several Caribbean island states have worse epidemics than any country outside of sub-Saharan Africa.

- In Central American countries and countries on the Caribbean coast, HIV is spreading mainly through sex between men and women.
- Brazil too is experiencing a major heterosexual epidemic, but there are also very high rates of infection among injecting drug users and men who have sex with men. In Mexico, Argentina and Colombia, HIV infection is also confined largely to these sub-populations. The Andean countries are currently among those least affected by HIV infection, although risky behaviour has been recorded in many groups.
- The countries with the highest HIV rates in the region tend to be found on the Caribbean side of the continent. According to the most recent figures, over 7% of pregnant women in urban Guyana tested positive for HIV.
- In Honduras, Guatemala and Belize there is also a fast-growing heterosexual epidemic, with HIV prevalence rates among adults in the general population of between 1 and 2%. In 1994, less than 1% of pregnant women using antenatal services in Belize District tested positive for HIV, while one year later the prevalence had risen to 2.5%.
- In the Honduran city of San Pedro Sula, the rate of HIV infection among pregnant women has fluctuated

HIV infection among pregnant women has fluctuated between 2% and 5% for several years. Much of the problem is concentrated in teenagers, suggesting that the worst is still to come.

- Heterosexual transmission of HIV is rarer in other countries of Central America. In Costa Rica, for example, HIV is transmitted mainly during unprotected sex between men. In Mexico, too, HIV has affected mainly men who have sex with men, more than 14% of whom are currently infected. According to one study, fewer than 1 in every 1000 women of childbearing age is infected.

- Brazil, where over half a million adults are living with HIV, has strong prevention programmes. While in 1986 less than 5% of young men reported using a condom the first time they had sex, the figure in 1999 was close to 50%, a tenfold increase. Among men with higher educational levels, over 70% surveyed in 1999 said they used a condom for their first act of intercourse.

- A low prevalence of HIV infection among heterosexuals is the norm in the Andean region, at least in countries where data are available. In Colombia, nowhere is the rate of HIV infection greater than 1 in 250 among pregnant women. Even among sex workers, the figure is below 2%.

- Argentina has typically high rates of HIV infection among injecting drug users and men who have sex with men, but a relatively low average prevalence of 0.4% among pregnant women.

- Haiti is the worst-affected nation in the Caribbean. In some areas, 13% of anonymously tested pregnant women were found to be HIV-positive. Overall, around 8% of adults in urban areas and 4% in rural areas are infected. It is estimated that 74,000 Haitian children had lost their mothers to AIDS by the end of 1999.

- In the Bahamas the adult prevalence rate is 4%. In the Dominican Republic 1 adult in 40 is HIV-infected, while in Trinidad and Tobago the rate is 1 adult in 100.

- At the other end of the spectrum lie Saint Lucia, the Cayman Islands and the British Virgin Islands, where fewer than 1 pregnant woman in 500 tested positive for HIV in recent surveillance studies.

- Heterosexual HIV transmission in the Caribbean is driven by the deadly combination of early sexual activity and frequent partner exchange by young

activity and frequent partner exchange by young people. In Saint Vincent and the Grenadines, a quarter of men and women in a recent national survey said they had started having sex before the age of 14, and half of both men and women were sexually active at the age of 16.

- In Trinidad and Tobago, in a large survey of men and women in their teens and early twenties, fewer than a fifth of the sexually active respondents said they always used condoms, and two-thirds did not use condoms at all.

- Age mixing – younger women having sex with older men – also drives the Caribbean epidemic. HIV rates are five times higher in girls than boys aged 15-19 in Trinidad and Tobago. At one surveillance centre for pregnant women in Jamaica, girls in their late teens had almost twice the prevalence rate of older women.

- While in some countries, even treatment for opportunistic infections is problematic, other countries have responded to demands from groups of patients, doctors and human rights organizations and now lead the developing world in providing access to antiretrovirals. Argentina, Brazil, Colombia, Costa Rica and Uruguay provide a legal right to some form of antiretroviral therapy, though the application of the law is somewhat patchy. Coverage of eligible patients has been reported to be 100% in Brazil, 70% in Argentina, 65% in Chile and Uruguay, 40% in Panama and 20% in Ecuador.

Search the site
Contact Us
Help

Fact Sheets - HIV/AIDS IN THE NEWLY INDEPENDENT STATES

Home > Fact Sheets > HIV/AIDS IN THE NEWLY INDEPENDENT STATES

Search this section

refine your search

Home
What's New
About UNAIDS
Publications
HIV/AIDS Info

Cosponsors
Best Practice
World AIDS Campaign
Africa Partnership
Links and more info

HIV/AIDS IN THE NEWLY INDEPENDENT STATES

Previously characterized by very low prevalence, the region is now experiencing an extremely steep increase in the number of people living with HIV/AIDS. While the estimated cumulative number of HIV/AIDS cases was 170,000 at the end of 1997, it climbed to 400,000 by end 1999.

- Parallel epidemics of HIV, injecting drug use and sexually transmitted infections are unfolding in a **social context** of economic crisis, rapid social change, increased poverty and unemployment, growing prostitution, and changes in sexual norms.
- The bulk of new HIV infections occurred in two countries, Russian Federation and Ukraine, and were caused by unsafe practices among **injecting drug users**. The potential for further spread is enormous: the Russian Federation, for example, has an estimated 1-2.5 million injecting drug users, compared with 130,000 people already infected. Clearly, hundreds of thousands of drug users and their sex partners are at immediate risk of infection.
- The skyrocketing prevalence of sexually transmitted infections – with reported rates of syphilis of more than 200 per 100,000 – is yet another warning sign that transmission through sex may grow in importance.

Russian Federation

- In the Russian Federation, the epidemic continues to spread, both in larger metropolitan areas and in smaller provincial cities.

- In **Moscow** city and region, more than 7000 new HIV cases were reported during 1999, and in **Irkutsk**, Siberia, more than 2200 new cases were reported during the same period. Here, as in other newly independent states, the actual number of new infections is higher than the number of officially reported cases.

- In St Petersburg, only 4 HIV-positive persons were identified among 1500 injecting drug users tested in 1996-1997. In 1999, surveys among injecting drug users found HIV prevalence rates of 12%, which rose six months later to 16%.

- Looking at recorded HIV cases alone, one sees a steep **upward trend** in the country. Up to the end of 1998 there were just over 10,000 cases. The year 1999 saw just over 16,000 new infections, while 10,000 new infections were recorded in just the first three months of this year.

Ukraine

- In Ukraine the annual number of diagnosed HIV infections jumped from virtually zero before 1995 to around 20,000 a year from 1996 onwards.

- As a result, the estimated number of people living with HIV/AIDS has grown from 110,000 in 1997 to 240,000 at the end of 1999. Ukraine is now estimated to have an HIV prevalence rate among adults (aged 15-49) of just under 1%, the highest rate in the region.

- The proportion of HIV diagnoses that are in injecting drug users seems to have decreased from about 80% to 60%, indicating that an increasing number of Ukrainians are becoming infected through unsafe sex.

Belarus

- In Belarus, an HIV **prevention programme** among drug users in Svetlogorsk, which included education about safe injecting and safe sex and provided clean syringes, seems to have led to far safer behaviour among drug users. In 1997, before the prevention programme began, 92% of those surveyed said they

programme began, 92% of those surveyed said they shared syringes. By 1999, this percentage had dropped to 35%. While some people did continue to reuse syringes, the proportion that cleaned them before using them again rose to 55%, from just 16% before the prevention campaign.

- Between 1996 and 1999 there was a significant drop in the proportion of **young people** aged 15-19 among those testing HIV-positive. During the same period, HIV prevalence among **army recruits** dropped sharply, from 670 to 210 per 100,000 tested. This demonstrates the impact of a strong national response in Belarus.

A rapidly closing window of opportunity

Representatives of UNAIDS Cosponsors, bilateral agencies and international non-governmental organizations have called for determined and urgent joint action to prevent large-scale epidemics through:

- expanded coverage of HIV prevention activities among injecting drug users in the region,
- curbing the epidemic of sexually transmitted infections as major public health problems in their own right and because these infections help fan the spread of HIV, and
- greater efforts to reduce the vulnerability of young people.

Fact Sheets - COUNTRY SUCCESSES

COUNTRY SUCCESSES

- **Uganda**, whose HIV rates peaked at a staggering 14% in the early 1990s, was the first country in sub-Saharan Africa to reverse its own epidemic. Now, it has nearly halved its HIV prevalence to around 8% by strong prevention measures. Even rural areas, which are frequently among the last to evidence signs of both the advent and the reversal of an HIV/AIDS epidemic, have shown a reduction in HIV rates. In some areas of rural Uganda, for example, HIV infection rates among teenage girls dropped to 1.4% in 1996-97, from 4.4% in 1989-90. This was matched by a fall in teen pregnancies.

- In **Belarus**, an HIV prevention programme for injecting drug users in Svetlogorsk appears to have increased safer behaviour among users. The programme included education about safe injecting and safe sex and provided clean syringes and condoms. The programme, which cost around US$0.36 per disposable syringe distributed, is estimated to have prevented over 2000 cases of HIV infection by its second year of operation, at a cost of around US$29 per infection prevented – far below the cost of an AIDS case to a family or a health system. The Belarus campaign was bolstered by a change in the law, which made it legal to carry syringes.

- In 1993, HIV rates among young women in **Lusaka** exceeded 25%, but they have been almost halved in just six years by effective HIV prevention. Premarital sex is losing popularity: only 35% of young women in Lusaka reported premarital sex in 1996 compared with 52% in 1990. Male sexual abstinence is also rising. In 1998, more than half of young unmarried men reported no sex in the past year compared with just over a third two years earlier. Additionally, the frequency of casual sex is decreasing, as shown by a fall in the proportion of men reporting two or more

a fall in the proportion of men reporting two or more casual partners in the past year.

- A candid safe sex campaign in the conservative Indian State of **Tamil Nadu**, which recently witnessed a tripling of HIV rates among pregnant women within a two-year period, has brought down HIV risk in males thought to have a greater likelihood of exposure to the virus. Repeated surveys of their behaviour show that the proportion of those reporting recent casual sex fell by half over two years while condom use during such encounters rose dramatically.

- The Egyptian government has helped set up an AIDS Hotline and Counselling Service (at the time of its evaluation, **Egypt** was the only Middle East government to have done so). Staffed by counsellors and widely advertised, this anonymous hotline attracts thousands of calls and provides a vital link to HIV information and counselling services that would not otherwise be accessible. This is a significant step in a society where HIV vulnerability is heightened by cultural taboos that prohibit open discussion of topics such as sexuality, condom use, premarital sex and homosexuality.

- In **Brazil**, where over half a million people are living with HIV, efforts against AIDS – bolstered by government prevention and care measures – are leading to safer sex. In a survey of Brazilian men, almost half reported condom use at first sex in 1999 – a tenfold increase from below 5% in 1986. Also, close to 90% of 16-25-year-old men reported consistent condom use with casual sex partners – an impressively high figure corroborated by an upsurge in the sale of male condoms, from 70 million in 1993 to 320 million in 1999. In a survey of Brazilian women at increased risk of HIV exposure who tried out female condoms for the first time, 75% said they were satisfied. Subsequently, 43% of these continued using them.

- **Zimbabwe** has established child-friendly courts in every province after finding that low rates of conviction in cases of sexual assault and rape, particularly of children, were usually due to lack of testimony. With the help of a friendly intermediary, abused children can testify in privacy without fear or embarrassment. They are also provided with male and female dolls to demonstrate the sexual acts to which they may have been subjected. More people are now bringing cases to trial, and the percentage of convictions is on the rise. The government also provides medical and psychological care to abused children through the Family Support Trust, a special

service located within a major hospital in Harare. In 1998-99, over 5% of children aged 13-16 seen at the Family Support Trust were estimated to have become infected with HIV at the hands of their abuser.

- A "100% condom use" programme, inspired by Thailand's successful effort, is being piloted in the town of Sihanoukville, **Cambodia**. The campaign has helped increase condom use by male clients during commercial sex. The same is true of brothel-based sex workers: almost four-fifths reported consistent condom use with clients in 1999, against two-fifths in 1997. A survey of women hired to promote beer reported a near four-fold increase in consistent condom use by men who paid them for sex, from just under 10% in 1997 to almost 40% in 1999.

Fact Sheets - HIV/AIDS AND DEVELOPMENT

HIV/AIDS AND DEVELOPMENT

Increasing illnesses and deaths due to AIDS in the world's hardest hit regions, particularly in sub-Saharan Africa, are reversing years of development at all levels and throughout society.

Impact on Households

- In urban areas of **Côte d'Ivoire**, spending on school education fell by half, food consumption went down 41% per capita, and health care expenditure more than quadrupled in households where a family member had AIDS.
- In **Thailand**, one-third of rural families affected by AIDS experienced a halving of their agriculture output, threatening their food security. Around 15% had to take their children out of school, and over half the elderly were left to fend for themselves.
- A common strategy in AIDS-affected households is to send one or more **children** away to extended family members to ensure that they are fed and cared for.
- Since the AIDS epidemic began, 13.2 million children – 95% of them in Africa – lost their mother or both parents to AIDS while they were under 15.

Impact on Education

- AIDS is eroding the supply of **teachers** and increasing class sizes, thus diluting the quality of education. It is eating into family budgets, reducing the money available for school fees and increasing pressure on children to drop out of school and join the workforce.
- In the **Central African Republic**, almost as many teachers died as retired between 1996 and 1998. Of those who died, some 85% were HIV-positive.
- In the first 10 months of 1998, **Zambia** lost 1300 teachers, equivalent to two-thirds of the new teachers the country trains each year.
- Interviews on commercial farms in **Zimbabwe** showed that 48% of orphans of primary-school age had dropped out of school, and not one orphan of secondary-school age was still in school.

Impact on the Health Sector

- Increased demand for **health care** from people with HIV-related illnesses is already over-stretching public health systems in many developing countries, and the pressure is expected to increase.
- Since the AIDS epidemic began, 18.8 million children and adults have fallen sick and died. Almost twice that number now live with HIV. In 1999, there were some 5.3 million new infections.
- According to recent estimates, in 1997 public health **spending on AIDS** alone exceeded 2% of gross domestic product in 7 of 16 African countries where total health expenditure from public and private sources on all diseases accounts for 3-5% of GDP.

- In recent years HIV-positive patients have occupied half the beds in big city **hospitals** in countries such as Burundi, Kenya and Thailand.
- At the same time, a **tuberculosis** epidemic is exploding in the countries most affected by AIDS. TB has become the leading cause of death among people with HIV infection, and accounts for about a third of all AIDS deaths worldwide.
- Health sector **costs** – infrastructure, drugs, training, personnel – will continue rising as new therapies are developed for HIV-infected persons.
- Sickness and death due to AIDS is increasing among **health care personnel**. In one Zambian hospital, deaths in health care workers increased 13-fold between 1980-1990, largely because of HIV.

Impact on Agriculture

- Agriculture provides a living for as many as 80% of all people in certain countries. As an infected farmer falls ill, family members spend more time caring for him/her and less time farming, with serious implications for **food security**. The family begins to lose income from cash crops and buys food. It may even sell off farm equipment or household goods to survive.
- In **West Africa**, many cases have been reported of reduced cultivation of cash crops or food products, including market gardening in Burkina Faso and cotton, coffee and cocoa plantations in Côte d'Ivoire.
- In one district of **Tanzania**, time spent on farming has shifted radically because of AIDS. A woman with a sick husband spent 60% less time on agricultural activities than usual.

Impact on the Economy and Business

- Some companies in Africa have already felt the impact of AIDS on their **bottom line**. Managers at one sugar estate quantified the cost of HIV infection as follows: 8000 days of labour lost to illness between 1995-1997; 50% drop in processed sugar recovered from raw cane between 1993-1997; higher overtime costs; fivefold increase on funerals between 1989-1997; tenfold increase in health costs. The company estimates over three-quarters of all illness is related to HIV infection.
- Illness and death have jumped from last to first place in the list of reasons for people **leaving a company**. Old age retirement slipped from the leading cause of employee attrition in the 1980s to just 2% by 1997.

Fact Sheets - AIDS AND POPULATION

AIDS AND POPULATION

In the hardest-hit countries, AIDS has begun to alter the structure of the population in unprecedented ways. While many diseases are fatal especially to infants and the elderly, AIDS picks off society's young adults.

- Since the epidemic began, over 18 million lives have been claimed by AIDS – almost 15 million of them in sub-Saharan Africa. The AIDS toll can be expected to double over the next decade since over 34 million people are now estimated to be living with HIV or AIDS, and around 5 million new infections occur annually.
- AIDS deaths are premature deaths. In developing countries where HIV spreads mainly through unsafe sex between men and women, the majority of infected people acquire HIV by the time they are in their 20s and 30s and, on average, die of AIDS around a decade later.
- Particularly in sub-Saharan African countries, where such large proportions of the population have HIV or have already died of AIDS, these premature deaths are radically altering the structure of the population.
- HIV will kill at least a third of the young men and women of countries where it has its firmest hold, and in some places up to two-thirds. Despite millennia of epidemics, war and famine, never before in history have death rates of this magnitude been seen among young adults of both sexes and from all walks of life.

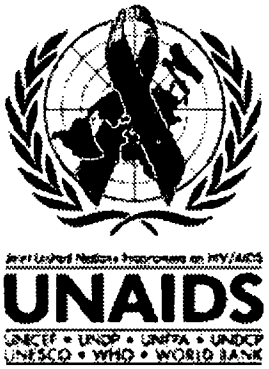
Lifetime risk of dying of AIDS

- The severity of an epidemic is often measured by the percentage of the population that is infected – the prevalence rate. The HIV prevalence rate among 15-49-year-olds has now reached or exceeded 10% in 16 of the world's countries, all of them located in sub-Saharan Africa.
- These rates greatly understate the demographic impact of AIDS. For example, in southern Africa, AIDS is set to wipe out half a century of development gains as measured by life expectancy at birth. From 44 years in the early 1950s, life expectancy rose to 59 in the early 1990s. Now, a child born between 2005 and 2010 can once again expect to die before his or her 45th birthday.
- New analyses have looked at the prospective risk of dying of AIDS that today's 15-year-olds will face throughout their lifetime. The analyses are based on the assumption that, in each country studied, AIDS prevention programmes will be successful enough to cut in half the risk of becoming HIV-infected over the next 15 years. They do not take into account possible improvements in treatment or the availability of an HIV vaccine. According to these conservative analyses, in countries where 15% of adults are currently infected, around a third of today's 15-year-olds will die of AIDS. Where adult prevalence rates exceed 15%, the lifetime risk of dying of AIDS is much greater:
- In countries such as South Africa and Zimbabwe, where a fifth or a quarter of the adult population is infected, AIDS is set to claim the lives of around half of all 15-year-olds.

- In Botswana, where about one in three adults are already HIV-infected – the highest prevalence rate in the world – no fewer than two-thirds of today's 15-year-old boys will die prematurely of AIDS.

The population chimney

- In developing countries, the population structure is generally described as a pyramid. The youngest age groups of the population – babies, children and healthy young people up to 19 – form the broad base of the pyramid, which then tapers up gradually through the older age groups who have begun shrinking through illness and death.
- Now, AIDS has begun to introduce a completely new shape – the "population chimney" – for Botswana's projected population structure in 2020.
- Compared with the population structure that Botswana would have in the absence of an AIDS epidemic, the base is less broad. Many HIV-infected women die or become infertile long before the end of their childbearing years, so fewer babies are born. And up to a third of the infants born to HIV-positive women become infected themselves before or during birth or through breast milk, so fewer babies survive to childhood and adolescence.
- By far the most dramatic change in the pyramid occurs at the ages when young adults infected early in their sex lives begin to die of AIDS. In sub-Saharan Africa, young women are typically two or three times more likely to have become infected by age 24 than young men. Thus, starting with women in their mid-20s and men in their mid-30s, the adult population shrinks radically.
- Only those adults who escape HIV infection can survive to middle and old age. In 2020, Botswana is expected to have more women in their 60s and 70s than women in their 40s and 50s.



Fact Sheets - Access to HIV/AIDS Care and Support

Access to HIV/AIDS Care and Support

When it comes to improving care for people with HIV infection, world attention has recently focused mainly on drug prices, in particular the price of antiretroviral drugs. But access to drugs is just one of the many things that people with HIV infection need if they are to live healthy, productive lives for as long as possible.

- **Millions of HIV-positive people do not benefit from care and support because they are unaware of being infected.** Many are hesitant to find out if they have HIV because of the shame and blame that can be associated with AIDS. Also, facilities for voluntary counselling and HIV testing are woefully inadequate.
- **HIV/AIDS-related care and support needs are extremely broad.**
- People with HIV infection develop "opportunistic diseases" and distressing symptoms such as itching, pain, and difficulty in breathing or swallowing that require medicines and other forms of health care.
- They need support to cope with the psychological strain of repeated bouts of illness, and to counter discrimination and social isolation.
- They and their families need help to alleviate the economic consequences of sickness and death due to AIDS.
- **There has been some progress in meeting their needs** in developing countries. Associations of people living with HIV/AIDS have been prime movers in bringing emotional and social support to those affected by the epidemic. Families and communities have stepped in with health care for those infected. Some governments have recently begun to invest more of their AIDS resources in

begun to invest more of their AIDS resources in care, not just in prevention.

- **But access to care and support is still poor in many developing countries.**

- In Africa, where most HIV-positive people live, health care systems were already weak and under-financed before the advent of AIDS, and now are buckling under the added strain of millions of new patients.

- In many places, facilities for diagnosis are inadequate and drug supplies are erratic, even for HIV-related conditions that are easy to diagnose and inexpensive to treat. A UNAIDS survey of 22 big teaching hospitals found that only half were equipped to relieve difficulty in breathing, and just two-fifths had strong painkillers available.

- Making health systems strong enough to ensure decent care for the millions of people living with HIV/AIDS requires an extraordinary push. "Business as usual" will not work. **In its comprehensive care strategy, UNAIDS puts the accent on seizing new opportunities** for prioritizing action and accelerating progress. The strategy has five strategic axes: mobilizing political will and resources, expanding voluntary counselling and HIV testing, increasing access to psycho-logical and social support, improving the staffing and infrastructure of the health services, and increasing access to drugs needed by HIV-positive people.

- **An underlying principle of the strategy is "first things first".** In places where there is extremely limited ability to mobilize resources (health staff, infrastructure and funding), at the very least people living with HIV must have access to pain relief and treatment for the simpler opportunistic infections including pneumonia and tuberculosis, which is the biggest killer of HIV-infected people. Individuals who have already started developing HIV-related illness should also receive cotrimoxazole, a combination pill that prevents some infections. An "intermediate" care package could add treatment for some common HIV-related cancers and preventive therapy for tuberculosis. In places where resources are relatively unrestricted, an "advanced" package would also include triple antiretroviral therapy, and care for opportunistic infections that are hard to diagnose or expensive to treat.

- **The UNAIDS strategy encourages flexibility and innovation.** As long as there is steadily-expanding access to the essential (or intermediate) care

access to the essential (or intermediate) care package, with the goal of universal coverage, health planners should generate or seize new opportunities for raising the level of care and support. For example, some countries have innovated by legislating access to HIV/AIDS care on the grounds of human rights and using public funds for antiretrovirals. Some have taken advantage of price reductions of drugs or commodities to offer a more advanced care package. Cost-recovery schemes have the potential to expand access dramatically; for example, individuals could be charged a small fee for voluntary counselling and testing where this service cannot be fully funded from the government budget.

- **Communities and community organizations, and especially people living with HIV, are critical.** They promote social solidarity with HIV-affected individuals and their families and survivors, provide them with emotional support, and attempt to protect them from discrimination, loss of inheritance and property-grabbing. As pressure groups, they have also encouraged government and private-sector institutions to expand resources for health care or reduce the prices of drugs. To ensure the greater involvement of people with HIV/AIDS (the GIPA principle) it is important for there to be systematic public support – and, where possible, financing -- for organizations of people living with HIV and other community groups working to reduce the adverse impact of the epidemic.

- Progress in improving the affordability of HIV-related drugs and commodities calls for **partnerships and collaborative ventures** of various kinds. In Latin America and the Caribbean, for example, a survey of the prices applied in various countries revealed major differences and led to price reductions through negotiations with pharmaceutical companies. A new initiative with five pharmaceutical companies holds out the promise of further price reductions on drugs currently under patent, especially for Africa.

- However, **affordability is just one of the factors** underlying poor access to drugs. Drug access will continue to be compromised unless countries find a way to pay not just for drugs but for the infrastructure and trained staff needed to prescribe the right drugs in the appropriate dosage, deliver a continuous supply of quality medicines, monitor patients' treatment progress and manage their side effects.

- To ensure the **sustainability of financing for the health system**, it is vital to allocate more money

health system, it is vital to allocate more money from national budgets and step up international development assistance and debt relief. In Africa, where two-thirds of the world's HIV-positive people live, governments are paying out four times more in debt service than they now spend on health and education. If the international community relieves some of their external debt, these countries can reinvest the savings in poverty alleviation and AIDS prevention and care.

- **Access to care can have important spin-offs for prevention**. Families who provide home care for a member with HIV show their neighbours that there is no reason to fear becoming infected through everyday contact. Curing tuberculosis in a person with HIV can prevent the disease from spreading to the rest of the community. Thus, developing countries and donor agencies are increasingly looking on AIDS-related care as a good investment having direct benefits for people with HIV/AIDS and indirect spin-offs for AIDS prevention in the wider community.

- Alongside an expansion of access to care, **prevention of HIV remains a high priority.** Despite the availability of new treatments, there is still no cure for HIV or AIDS.

Joint United Nations Programme on HIV/AIDS
UNAIDS
UNICEF • UNDP • UNFPA • UNDCP
UNESCO • WHO • WORLD BANK
US Media Office (212) 584-5024

PRESS RELEASE

UNDER EMBARGO UNTIL 16.00 GMT
Geneva, 27 June 2000

NEW UN REPORT ESTIMATES OVER ONE-THIRD OF TODAY'S 15-YEAR-OLDS WILL DIE OF AIDS IN WORST-AFFECTED COUNTRIES

- **HIV/AIDS is causing dramatic shifts in demographics, with long-ranging social consequences for hardest-hit nations**
- **Massive increase in resources needed to reduce the epidemic's spread and impact**

The ongoing spread of HIV in the world's hardest-hit regions, particularly in sub-Saharan Africa, is reversing years of declining death rates, causing drastic rises in mortality among young adults and dramatically altering population structures in the most affected regions.

While the epidemic of HIV, the virus that causes AIDS, is stabilizing in many high-income countries, as well as in a handful of developing nations, HIV prevalence rates among 15-49-year-olds have now reached or exceeded 10% in 16 countries, all of them in sub-Saharan Africa.

As high as these rates are, they greatly understate the demographic impact of AIDS. The probability of dying of AIDS is systematically higher than prevalence rates indicate. Conservative new analyses show that this is true even if countries manage to cut the risk of becoming HIV-infected in half over the next fifteen years. For example, where 15% of adults are currently infected, no fewer than a third of today's 15-year-olds will die of AIDS. In countries where adult prevalence rates exceed 15%, the lifetime risk of dying of AIDS is even greater, assuming again that successful prevention programmes manage to halve the HIV risk.

- In countries such as South Africa and Zimbabwe, where a fifth or a quarter of the adult population is infected, AIDS is set to claim the lives of around half of all 15-year-olds.

- In Botswana, where about one in three adults are already HIV-infected -- the highest prevalence rate in the world -- no fewer than two-thirds of today's 15-year-old boys will die prematurely of AIDS.

These findings are contained in a new United Nations report that shows that current trends in HIV infection will increasingly have an impact on rates of infant, child and adult mortality, life expectancy and economic growth in many countries. The latest *Report on the global HIV/AIDS epidemic*, which includes a country-by-country update on the global epidemic, was prepared by the

Joint United Nations Programme on HIV/AIDS (UNAIDS), and released today in advance of the XIIIth International AIDS Conference being held in Durban, South Africa, from 9 to 14 July.

Speaking at the release of the report in Geneva, Peter Piot, Executive Director of UNAIDS, warned: "The AIDS toll in hard-hit countries is altering the economic and social fabric of society. HIV will kill more than one-third of the young adults of countries where it has its firmest hold, yet the global response is still just a fraction of what it could be. We need to respond to this crisis on a massively different scale from what has been done so far."

Long-term demographic impacts threaten social stability

In developing countries, where HIV transmission occurs mainly through unsafe sex between men and women, the majority of infected people acquire HIV by the time they are in their 20s and 30s and, on average, succumb to AIDS around a decade later. The resulting decrease in the productive workforce and proportional increase in citizens in the oldest and youngest age groups -- those most likely to require aid from society -- is becoming a key contributor to social instability.

- So far, a total of 13.2 million children under 15 have lost their mother or both parents to AIDS since the epidemic began.

- The epidemic is undermining basic learning in certain parts of Africa: diminishing funds for school fees, forcing young people into the workforce earlier, and claiming the lives of teachers well before retirement age. In Côte d'Ivoire, 7 out of 10 teacher deaths are due to HIV. In 1998, Zambia lost 1300 teachers in the first ten months of the year - equivalent to two-thirds of the new teachers trained each year.

- Agriculture, which in many developing countries provides a living for as much as four-fifths of the population, is suffering serious disruption. In West Africa, for example, reduced cultivation of cash crops and food products is reported.

- Business is already seeing the impact of AIDS on their bottom line. On an agricultural estate in Kenya, new AIDS cases and health spending showed a massive ten-fold increase over a recent 8-year period.

- Increased demand for health care for HIV-related illness is taxing overstretched health services. In countries from Thailand to Burundi, HIV-positive patients are occupying 40-70% of the beds in big city hospitals. At the same time, the health sector is increasingly losing its own human resources to AIDS. One study in Zambia found a 13-fold increase in deaths in hospital staff, largely due to HIV, over a ten-year period.

"Because of AIDS, poverty is getting worse just as the need for more resources to curb the spread of HIV and alleviate the epidemic's impact on development is growing. It's time to make the connection between debt relief and epidemic relief", said Dr Piot. "Developing countries, who carry 95% of the HIVAIDS burden, owe in total around US$ 2 trillion. But Africa is the priority because this is the region with the most HIV infections, most AIDS deaths, and the vast majority of the world's heavily indebted poor countries. "

"African governments are paying out four times more in debt service than they now spend on health and education. If the international community relieves some of their external debt, these countries can reinvest the savings in poverty alleviation and AIDS prevention and care. If not, poverty will just continue to fan the flames of the epidemic."

HIV infection rates continue to increase in many countries

In sub-Saharan Africa, where the most severe epidemics are to be found, UNAIDS and the World Health Organization (WHO) estimate that some 24.5 million adults and children

HIV, and that the proportion of 15-49-year-olds infected with the virus is still increasing in most countries. In countries such as Cameroon, Ghana and South Africa - which now has 4.2 million people living with HIV/AIDS, the highest number in the world -, the adult prevalence rate has shot up by more than half in the past two years.

In all countries of the region, HIV prevalence rates in young women aged 15-24 are higher -- typically two or three times higher -- than those for young men the same age. In the 15-19 age bracket, the sex differential is even wider. Girls who consent or are coerced into early intercourse are especially vulnerable to infection, not only because of their immature genital tract but because they often have older partners, who are more likely to be infected.

On other continents, too, the epidemic has not lost its momentum.

- Determined HIV prevention programmes in several countries in Asia and Latin America have, for now, stemmed what threatened to be a massive rise in heterosexual infection rates. However, unsafe sex between men and women is contributing to a growing epidemic in some populous states of India where more than 2% of 15-49-year-olds are infected. Heterosexual transmission also dominates in the Caribbean, where the Bahamas and Haiti have adult HIV prevalence rates higher than anywhere in the world outside Africa.

- HIV is becoming more firmly entrenched among injecting drug users and men who have sex with men. Globally, injecting drug users continue to be exposed to the virus, and in many places at least one in three is infected. Over the past two years, the relative increase in the proportion of adults living with HIV has been steep in the Baltic states, but the number of infections is far higher and still growing in the Russian Federation and in Ukraine, where around 1 adult in 100 is now infected nationwide. Among men who have sex with men, the prevalence of HIV is 15-20% in many places and there is no sign that the rate of new infections is slowing down.

- AIDS deaths have declined drastically in high-income countries and parts of Latin America thanks to expensive therapy with antiretroviral drugs. However, there is good evidence that -- as a result of complacency and other factors -- risky sexual behaviour is on the rise. In San Francisco, the proportion of gay men reporting multiple partners and unprotected anal sex rose between 1994 and 1998, in parallel with a steep rise in rectal gonorrhoea after years of falling trends.

Signs of hope, but response needs urgent and massive expansion

While the overall picture is a sobering one, the UNAIDS report presents new information showing once again that the world is not helpless against the epidemic. Countries that tackled the epidemic with sound approaches years ago are already reaping the rewards in the form of falling or low and stable HIV rates, greater inclusiveness of people already affected by HIV or AIDS, and diminished suffering. Countries that began to apply those approaches more recently can look forward to similar gains.

- As a result of AIDS education and information campaigns, there is an encouraging increase -- though by no means sufficient -- in the number of young people using the full range of prevention approaches, from delaying their sexual debut to having fewer casual partners and engaging in protected sex.

- Developing countries and donor agencies are increasingly looking on AIDS-related care as a good investment having direct benefits for people with HIV/AIDS and indirect spin-offs for AIDS prevention in the wider community. Collaborative ventures of various kinds are opening the door to better access to care and support. In Latin America and the Caribbean, for example, a multicountry survey on the prices being paid for HIV-related drugs and commodities [illegible]

major price differences to light and led to reductions through negotiations with pharmaceutical companies.

- Inspired by Thailand's successful campaign, Cambodia launched a pilot programme in Sihanoukville promoting "100% condom use" in commercial sex. In just two years, 65-75% of male clients (military, police and motorbike taxi drivers) were reporting that they always used condoms with commercial partners -- up from less than 55% -- while similar high rates were reported by brothel-based sex workers.

- Experience from Malawi and Uganda shows that micro-credit schemes can work very successfully even in communities with high HIV prevalence. These schemes, which grant small loans to individuals who want to start up a small business and who seem likely to be able to repay, could play a greater role in alleviating poverty and mitigating the economic impact of AIDS.

- Condom use for first intercourse has become impressively high in Brazil, where the government has taken an active lead in HIV prevention, care and protection of the rights of people affected by AIDS. In 1986 less than 5% of young men reported using a condom the first time they had sex. The figure in 1999 was close to 50% -- and among men with higher education, it was over 70%.

- In Zambia, new surveillance data from the capital Lusaka show that the proportion of pregnant girls aged 15-19 infected with HIV dropped by almost half over the past six years. This holds out hope that Zambia might follow the course charted by Uganda, where a decline in infection rates in young urban women heralded the turnaround in the epidemic. Uganda's nationwide rate of adult HIV prevalence has now fallen to just over 8% from a peak of close to 14% in the early 1990s.

"Achievements like these keep hope alive by proving that the world is not powerless against the epidemic", said Dr Piot. "But up to now the gains have been scattered, not systematic. We need an all-out effort to turn the tide of the epidemic everywhere, with a massive increase in resources from domestic budgets and international development assistance."

For more information, please contact Anne Winter, UNAIDS, Geneva, (+41 22) 791 4577, Dominique De Santis, UNAIDS, Geneva, (+41 22) 791 4509 or Andrew Shih, UNAIDS, New York, (+1 212) 584 5024. *You may also visit the UNAIDS Home Page on the Internet for more information about the programme (http://www.unaids.org).*

EMBARGOED until July 2000

The AIDS Pandemic in the 21st Century

The Demographic Impact in Developing Countries

by

Karen A. Stanecki
Chief, Health Studies Branch
International Programs Center
Population Division
US Census Bureau

Paper prepared for presentation at the XIIIth International AIDS Conference, Durban, South Africa, 9-14 July 2000. Excerpts from US Census Bureau=s World Population Profile 2000 focus chapter, to be published 2000.

The AIDS pandemic in the 21st century continues to have its greatest impact in the developing world.

The overwhelming majority of people with HIV, 95 percent of the global total, live in the developing world. The Joint United Nations Programme on HIV/AIDS (UNAIDS) expects that this Aproportion will continue to rise in countries where poverty, poor health systems and limited resources for prevention and care fuel the spread of the virus.@[1]

An estimated 71 percent of the global total of HIV-positive people, 24.5 million out of 34.3 million, live in sub-Saharan Africa. Sub-Saharan Africa contains only 11 percent of the global population. Over eight percent (8.6%) of all adults in sub-Saharan Africa are HIV positive compared to 0.6 percent of Americans. Since the beginning of the epidemic, 14.8 million Africans have died from AIDS; 2.2 million AIDS deaths occurred in 1999.

Southern and eastern Africa have been the most severely affected regions. Seven countries now have an estimated[2] adult HIV prevalence of 20 percent or greater: Botswana, Lesotho, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe. In these countries, all in southern Africa, at least one adult in five is living with HIV. An additional 9 countries have adult HIV prevalence levels higher than 10 percent.

In comparison, HIV prevalence levels in Asia are relatively low. Adult HIV prevalence exceeds 1 percent in only three countries: Burma, Cambodia, and Thailand. In other countries, the prevalence rate is much lower.

In Latin America and the Caribbean, the HIV/AIDS epidemics vary from those than are concentrated among IV drug users and men who have sex with men to epidemics that seem to be mostly driven by heterosexual transmission. These include The Bahamas, Haiti, and Guyana, the countries with the highest adult HIV prevalence rates in the region.

In sub-Saharan Africa, more women than men are HIV positive.

At the end of 1999, UNAIDS estimated that 55 percent of all HIV infections in sub-Saharan Africa were among women. Peak HIV prevalence among women occurs at a younger age than among men. Among women, HIV prevalence tends to peak around 25 years of age. Peak HIV prevalence among men occurs 10 to 15 years later and generally at lower levels.

Several studies[3] comparing data from antenatal clinic with community based studies have shown that HIV prevalence among antenatal clinic (ANC) women still gives a reasonable overall estimate of HIV prevalence in the general adult population. ANC prevalence tends to underestimate the prevalence among women but overestimates HIV prevalence among men.

Mortality patterns are driven by HIV prevalence patterns.

Median survival with HIV/AIDS is estimated to be around 10 years. In South Africa, by 2020, mortality for adults ages 20 to 45 will be much higher than it would have been without AIDS. Mortality for women will peak during the ages of 30-34, earlier than the peak seen for men during the ages of 40-44.

---

[1] AAIDS epidemic update: December 1999,@ UNAIDS December 1999.

[2] AReport on the Global HIV/AIDS Epidemic, June 2000,@ UNAIDS.

[3] Fylkenes, Musonda, Sichone, *et al*, 1999.

At the beginning of the 21st century the growth rate in Zimbabwe has been reduced to nearly zero due to AIDS mortality.[4]

Other countries with sharply reduced growth rates include several other southern African countries: Botswana, Malawi, Namibia, South Africa, Swaziland, and Zambia.

The negative population growth seen in Guyana in 2000, is the impact of AIDS mortality compounded by out-migration. The underlying growth rate for Guyana is 0.1. with AIDS, the growth rate for Guyana is -0.1.

In Asia, AIDS mortality results in slightly lower growth rates in Burma, Cambodia and Thailand.

By the year 2003, Botswana, South Africa and Zimbabwe will be experiencing negative population growth.

By 2010, the growth rate for these countries will be around a -1 percent. This negative population growth is due to the high levels of HIV prevalence in these countries and relatively low fertility. This is the first time the Census Bureau is estimating negative population growth due to AIDS for any country. Previously, HIV/AIDS experts never expected HIV prevalence rates to reach such high levels, nationally, in any country. By the end of 1999, adult HIV prevalence had reached an estimated 36 percent in Botswana, 20 percent in South Africa, and 25 percent in Zimbabwe.[5]

Other countries in southern Africa will be experiencing a growth rate of nearly 0 including Lesotho, Malawi, Mozambique, Namibia, and Swaziland. Without AIDS, these countries would have been experiencing a growth rate of 2 percent or greater.

In Latin America and the Caribbean, The Bahamas and Guyana will be experiencing the greatest impact on their growth rates. Growth rates will be reduced from 1 percent to 0.4 percent.

In Asia, growth rates will be slightly reduced for Burma, Thailand, and Cambodia.

AIDS mortality will produce population pyramids that have never been seen before.

Particularly in those countries with projected negative population growth, Botswana, South Africa and Zimbabwe, population pyramids will have a new shapeBAthe population chimney.@ (See figure below). The implications of this new population structure are not clear. By 2020, between the ages of 15 and 44, there are more men than women in each of the 5-year-age cohorts which may push men to seek partners in younger and younger age cohorts. This factor in turn may increase HIV infection rates among younger women. Current evidence[6] indicates that older men are infecting younger women, who then go on to infect their partners, particularly through marriage. This vicious cycle could result in even higher HIV infection levels.

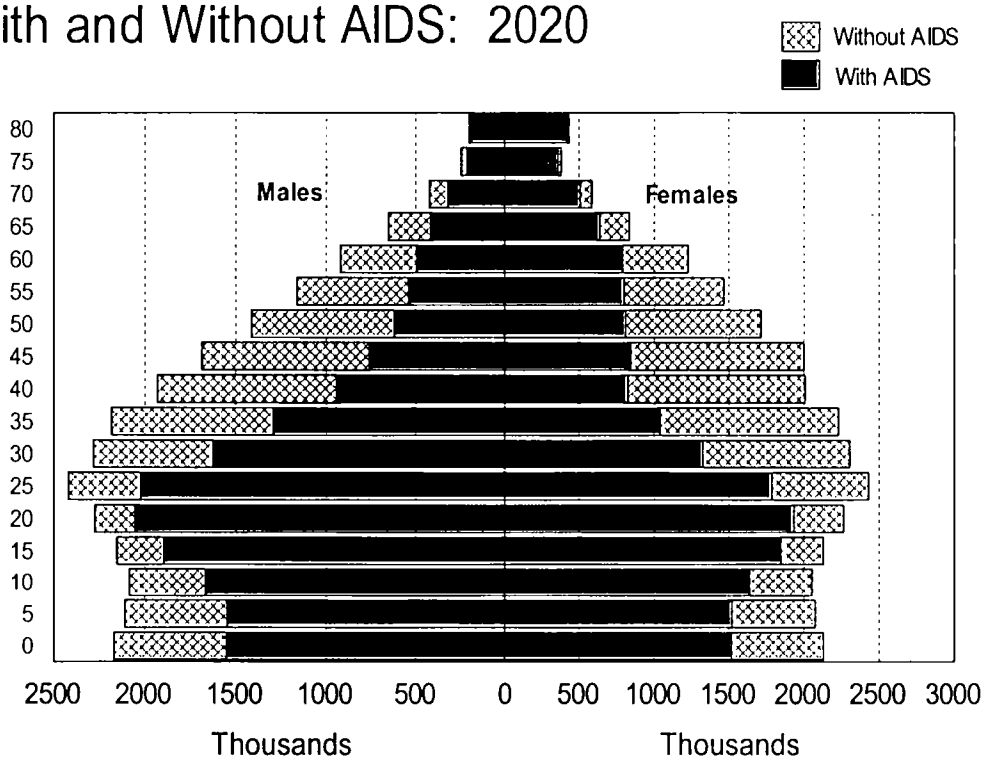
---

[4] Refer to appendix tables for country specific indicators.

[5] AReport on the Global HIV/AIDS Epidemic, June 2000", UNAIDS

[6] Multicentre Study on Factors Determining the Differential Spread of HIV in 4 African Towns. Buve, A., R. Musonda, M. Carael, *et al.* XI International Conference on AIDS and STDs in Africa, Lusaka, Zambia, Late Breaker Session, 1999.

Population of South Africa, With and Without AIDS: 2020



US Census Bureau, World Population Profile 2000

In countries with moderate epidemics, AIDS mortality will have less of an effect on the population structure.

For example, in Uganda, the greatest relative differences in future population size by cohort are evident in the youngest age groups and in those 30 to 50 years of age. However, the population pyramid still continues to maintain its traditional shape.

AIDS mortality is resulting in falling life expectancies.

Already, life expectancies have fallen in many countries in sub-Saharan Africa from levels they would have been without AIDS. In Botswana, life expectancy is now 39 instead of 71. In Zimbabwe, life expectancy is 38 instead of 70. In fact, six countries in sub-Saharan Africa: Botswana, Malawi, Mozambique, Rwanda, Zambia, and Zimbabwe have life expectancies below 40 years of age. They would have been 50 years or greater without AIDS.

In Latin America and the Caribbean, the impact on life expectancy is not as great as in sub-Saharan Africa because of lower HIV prevalence levels. However, they are still lower than they would have been without AIDS. In The Bahamas, life expectancy is now 71 instead of 80. And in Haiti, life expectancy is now 49 instead of 57.

In Asia, Thailand, Cambodia, and Burma have lost three years of life expectancy.

In ten years time, 2010, many countries in southern Africa will see life expectancies falling to near 30 years of age, levels not seen since the beginning of the 20th century.

In a region that would have expected life expectancies to reach 70 years of age by 2010, many will see life

expectancies falling to around 30:

- $ BotswanaB29
- $ NamibiaB33
- $ SwazilandB30
- $ ZimbabweB33

Many other countries will see life expectancies falling to 30-40 years of age instead of 50-60 years.

AIDS mortality will continue to result in falling life expectancies in Latin America, the Caribbean and Asia. In Latin America and the Caribbean, life expectancy will be 14-15 years lower in The Bahamas and Guyana than they would have been without AIDS. In Asia, life expectancies will be two years lower in Thailand and 4 years lower in Cambodia and Burma.

The most direct impact of AIDS is to increase the number of deaths in populations affected.

Crude death rates, the number of people dying per 1,000 population, have already been affected by AIDS.

In Africa, HIV epidemics have had their greatest impact in eastern and the southern regions. Adult HIV prevalence is 20 percent or higher in 7 countries and an additional 9 countries have HIV prevalence rates between 10 and 20 percent. In many of these countries, reports indicate the presence of the HIV virus since the early 1980s.

As a result of these long-term high levels of HIV infection, estimated crude death rates including AIDS mortality are greater by 50 to 500 percent in eastern and southern Africa over what they would have been without AIDS. For example, in Kenya with an adult HIV prevalence of 14 percent at the end of 1999, crude death rates are estimated to be twice as high, 14.1, than they would have been without AIDS, 6.5. In South Africa, with an estimated 20 percent adult HIV prevalence level, crude death rates are also twice as high, 14.7, than they would have been without AIDS. 7.4.

In Asia and Latin America the estimated crude death rates are also higher than they would have been without AIDS.

In many sub-Saharan African countries, crude death rates will be even higher in 2010 than in 2000, even though mortality due to non-AIDS causes will continue to decline.

In Botswana, crude death rates will increase from 22.8 in 2000 to 36.0 in 2010. In South Africa, crude death rates will increase from 14.7 to 30.3 and in Zimbabwe from 22.4 to 31.6. In all three of these countries, crude death rates would have been 5 to7 without AIDS.

In Latin America and the Caribbean, The Bahamas and Guyana will see a doubling of crude death rates with AIDS over what they would have been without AIDS.

In Asia, crude death rates will be slightly higher with AIDS than they would have been without AIDS. In Thailand crude death rates with AIDS will be 7.8 compared to 6.9 without AIDS. In Cambodia, crude death rates will be 9.5 with AIDS versus 7.7 without AIDS.

In some sub-Saharan African countries, infant mortality rates are now higher than they were in 1990.[7]

AIDS mortality has reversed the declines that had been occurring during the 1980s and early 1990s. Over

[7] U.S. Census Bureau, International Data Base and unpublished tables.

30 percent of all children born to HIV infected mothers in sub-Saharan Africa will be HIV positive either through the birth process or due to breast feeding. The relative impact of AIDS on infant mortality will depend on both the levels of HIV prevalence in the population and the infant mortality rate from other causes. In 1990[8] infant mortality in Zimbabwe was 54; in 2000 it is 62. In Kenya, infant mortality in 1990 was 67, in 2000 it is 69. Without AIDS infant mortality in Zimbabwe would have been 30 and in Kenya it would have been 55.

In countries with less severe epidemics, such as in western and central Africa, infant mortality rates are higher than they would have been without AIDS. The increase ranges from 3 percent in Benin to 12 percent in Côte d=Ivoire and 15 percent in Rwanda.

In those countries most affected by AIDS in Latin America, the Caribbean and Asia, infant mortality rates are also higher than they would have been without AIDS. In Latin America and the Caribbean, infant mortality rates are 2 to 6 percent higher. And in Asia, infant mortality is 1 to 3 percent higher in Thailand, Burma and Cambodia.

In four countries of sub-Saharan Africa, more infants will die from AIDS in 2010 than from all other causes.

In Botswana and Zimbabwe, twice as many infants will die from AIDS than from all other causes. South Africa and Namibia are the other two countries where more infants will die from AIDS than from all other causes. Although overall infant mortality rates are projected to decline between 2000 and 2010, infant mortality due to AIDS is projected to increase.

The only projected decline in AIDS mortality among infants are for Uganda and Thailand.

In 26 sub-Sahara African countries, child mortality rates have increased over what they would have been without AIDS.

The impact on child mortality is highest among those countries who had significantly reduced child mortality due to other causes and where HIV prevalence is high. Many HIV infected children survive their first birthdays, only to die before the age of 5. In Zimbabwe, 70 percent of all deaths among children less than 5 are due to AIDS. In South Africa that percentage is 45.

In The Bahamas, 60 percent of deaths among children less than 5 are due to AIDS.

In Burma, Cambodia and Thailand, 1 percent of deaths among children are due to AIDS.

Based on current trends, child mortality rates in 2010 will continue to be much higher with AIDS than they would have been without AIDS.

In Zimbabwe and Botswana, where child mortality rates may have been below 30 without AIDS, over 150 children per 1000 will die. Of that total, 80 percent will be due to AIDS. In many of the countries in southern Africa, over 50 percent of childhood deaths will be due to AIDS. In Malawi and Mozambique,. where child mortality rates due to other causes is already high, AIDS mortality will increase those rates by 30 percent.

In The Bahamas and Guyana, over 50 percent of childhood deaths will be due to AIDS.

In Asia, child mortality rates will be around 10 percent higher with AIDS mortality in Burma, Cambodia and Thailand, than they would have been without AIDS.

---

[8] Figures for 1990 also include AIDS mortality.

Populations in most sub-Saharan African countries will continue to increase, despite the high levels of mortality. The exceptions are Botswana, South Africa and Zimbabwe.

Although AIDS mortality has resulted in lower growth rates, fertility is still high and populations growth is still positive. Populations will continue to increase. The exceptions are Botswana, South Africa and Zimbabwe. These populations will take a long time to rebound from the current levels of HIV prevalence and AIDS mortality even if current AIDS control programs result in lowering future HIV incidence and prevalence.

At the beginning of the 21st Century, AIDS is the number one cause of death in Africa and 4th globally.[9]

Emerging just 20 years ago, few would have predicted the current state of the epidemic, particularly in sub-Saharan Africa. That 25 percent of adults would be living with HIV/AIDS in any country was unthinkable. Yet, this is the current situation in 4 countries. In seven sub-Saharan African countries, at least 1 out of 5 adults are living with HIV/AIDS and in an additional 9 sub-Saharan African countries, 1 out of 10 adults is HIV positive.[10]

Many individuals have difficulty grasping the results of these high prevalence levels. The resulting AIDS mortality is difficult to comprehend. Yet given these current rates, many more millions of individuals will die due to AIDS over the next decade than have over the past 2 decades. In many of the southern African countries, they are only beginning to see the impacts of these high levels of HIV prevalence.

There have been success stories: Thailand, Senegal, and Uganda. In Thailand and Uganda, concerted efforts at all levels of civil society have turned around increasing HIV prevalence rates. In Senegal, programs put into place early in the epidemic have kept HIV prevalence rates low. These success can be repeated. However, the current burden of disease, death and orphanhood, will be a significant problem in many countries of sub-Saharan Africa for the near future.

---

[9] The World Health Report 1999, Making a Difference. World Health Organization, 1999.

[10] Report on the Global HIV/AIDS epidemic. UNAIDS/WHO June 2000

AIDS in Africa is a Serious Crisis

But Opportunities Exist for Helping to Save Millions of Lives

AIDS IN SUB-SAHARAN AFRICA IS SHATTERING FAMILIES AND COMMUNITIES.

- About 24 million Africans south of the Sahara are HIV infected -- almost 70% of the world's total number infected in a region that accounts for only 10% of the world's population.
- In seven countries in southern Africa, including South Africa, 20% of the adult population (ages 15 to 49) is already infected.
- UNAIDS has declared HIV/AIDS in Africa "the worst infectious disease catastrophe since the bubonic plague."
- In sub-Saharan Africa, each and every day more than 11,000 additional people become HIV+. In South Africa alone, at least 1,600 people a day become HIV+.
- AIDS is now the leading killer in sub-Saharan Africa with 84% (13.7 million) of the 16.3 million AIDS deaths to date.
- There are over 5,500 AIDS related funerals a day in Africa. That number will rise to 13,000 a day by 2005.
- In 1998 in Africa, 200,000 people died as a result of war -- AIDS killed 2.2 million.
- By 2010, more than 40 million children in Africa will be orphaned by AIDS.

AIDS IS WIPING OUT DECADES OF PROGRESS ON A HOST OF DEVELOPMENT OBJECTIVES IN SUB-SAHARAN AFRICA.

- According to US Census Bureau, AIDS has already reduced life expectancy Zimbabwe from 65 to 39 years, in Uganda from 54 to 43 years, and in Zambia from 56 to 37years. In the next few years, AIDS will reduce life expectancy in South Africa by a third, from 68 to 45 years.
- In the coming decade, AIDS will double infant mortality (infants under the age of 1) in many sub-Saharan Africa countries and triple child mortality (children ages 1 to 5).

AIDS IS NOT ONLY CAUSING UNFATHOMABLE HUMAN SUFFERING IT IS JEOPARDIZING THE ECONOMIES, THE STABILITY, AND CIVIL SOCIETY OF MANY SUB-SAHARAN AFRICAN NATIONS.

- AIDS is a trade and investment issue. At the recent meeting with African trade and finance ministers, Professor Jeffrey Sachs, director of the Harvard Institute for International Development, stated that, "a frontal attack on AIDS in Africa may now be the single most important strategy for economic development."
- According to *The Economist*, a recent study in Namibia estimated that AIDS cost the country almost 8% of GNP in 1996. Another analysis predicts that Kenya's GNP will be 14.5% smaller in 2005 than it would have been without AIDS, and the per capita income will be 10% lower.

- A report released by the World Bank last week states: "The question is, will this pandemic destroy the developing nations' hard earned economic gains or will governments get their act together in time? Clearly time is running out."
- AIDS has hit professionals hard in sub-Saharan Africa, particularly civil servants, engineers, teachers, miners, and military personnel. According to one study in Kigali, Rwanda, 34% of people with post-secondary education were HIV positive, compared to 18% of those with primary education, and civil servants were more than three times more likely to be HIV positive than farmers. Increased benefits and training costs, and disruption due to sick and bereavement leave are seriously affecting both the private and public sectors. Companies like British Petroleum and Barclay Bank told us that they are now hiring two employees for every one skilled job, assuming that one will die of AIDS.
- AIDS is a security issue. According to the Economist, "the estimated HIV prevalence in the seven armies embroiled in the Congo range from 50% for the Angolans to 80% in Zimbabweans". Recent reports confirm that 40% of the South African military is already HIV positive. US military officials have raised this as a serious stability concern.
- A South African anti-crime institute has linked the growing number of children orphaned by AIDS to future increases in crime and civil unrest. Without appropriate intervention, many of the 2 million children projected to be orphaned by AIDS in South Africa will raise themselves on the streets, often turning to crime, drugs, commercial sex, and gangs for survival. This not only effects social stability but also dramatically increases their risk of HIV.

DETERMINED LEADERSHIP AND PARTNERSHIPS HAVE MADE, AND ARE CONTINUING TO MAKE, AN EXTRAORDINARY DIFFERENCE, SAVING MILLIONS OF LIVES.

- Uganda has been the world leader in demonstrating that even a country with limited resources and low levels of literacy could turn the tide on a burgeoning epidemic. President Museveni demonstrated bold leadership early on, making every government ministry take the problem seriously, and develop and implement its own plan for reducing stigma and transmission, and caring for those who become sick.
- Uganda has created an enabling environment for donors, such as the US, to be active partners in the battle against AIDS. The US has invested $46 million in HIV prevention and care in Uganda (26% of all donor AIDS funding), and as a result, HIV rates have been slashed by almost half to 8%.1
- . Through stigma reduction, education, HIV counseling and testing, treatment of STDs, and community based HIV care and support, Uganda has begun to turn the tide.
- Countries such as Zambia, Malawi, Uganda, and Kenya have begun to develop initiatives to respond to the growing number of children orphaned by AIDS. In the longstanding African tradition, communities are finding creative ways to support the village in its efforts to raise its children, but the growing number of orphaned children already overwhelms many of these villages.
- Through micro-finance programs like FINCA (Foundation for International Community Assistance), women are receiving loans, starting small businesses, and with increased household incomes, taking in children orphaned by AIDS. With support of non-governmental organizations, communities are coming together to deal with school fees, nutritional assistance, immunization and oral hydration, counseling, and the range of other needs that arise for orphaned children. These efforts are low cost strategies designed to empower

1 2000 UNAIDS Fact Sheet -- Country Successes

women, protect children, and support extended families and communities in carrying for their own. For a small fraction of the cost of one orphanage bed an entire community of vulnerable children can receive care. The problem is that only a very small number of children receive even this modest level of support.

AIDS IN INDIA WILL SOON COME TO DOMINATE THE HIV PICTURE.

- At the beginning of the millennium, 3.7 million people in India were living with HIV/AIDS -- more than any country in the world except for South Africa.1

- About 3 -5 million in India are HIV infected -- and while this is low in comparison to what we have seen in Africa, infection rates are increasingly rapidly and expected to double every 14 months.[2]

- Left unchecked, experts predict India to surpass Africa in total number of AIDS cases within the next 10 - 20 years.[3]

- India is the second most populous country accounting for nearly a billion people -- 16% of the world's population. A rise in infection rate of just 0.1% would add over half a million people to the total number living with HIV.[4]

- India also accounts for the highest concentration of poor in the world, with 300 million living in poverty and half of its children malnourished.[5]

- AIDS is moving from urban centers to rural villages, which account for 70% of the India's population. A recent survey of the countryside found that 2.1% of the adult population there was HIV infected compared with 0.7% of the urban population.[6]

- One in four cases of HIV in India is among women. Over 1 million women are living with HIV/AIDS -- and in 5 states, more than 1% of pregnant women were found HIV+. [7]

- According to UNAIDS, 120,000 children in India have been orphaned by AIDS since the beginning of the epidemic -- and infant mortality is projected to increase nearly 2% by the year 2015.[8]

- Surveillance of the disease is particularly difficult in India as cultural norms, gender inequities, and stigma continue to drive the epidemic underground -- and keeping pace with the epidemic in a population of 1 billion poses an enormous challenge. As a result, AIDS cases are thought to be under-diagnosed, and therefore, poorly treated.[9]

---

1 2000 UNAIDS Fact Sheet -- HIV/AIDS in Asia
2 1999 UNAIDS Update

3 Ibid.
4 Ibid.
5 USAID Country Brief. October 99
6 Ibid.
7 Ibid.
8 UNAIDS Update 99.

9 ONAP Africa Report.

AIDS POSES ONE OF THE BIGGEST THREATS TO INDIA'S ABILITY TO SUSTAIN PROGRESS ON A HOST OF ECONOMIC, CIVIL, AND POLITICAL FRONTS, AND ON ITS PLACE AS AN EMERGING GLOBAL POWER.

- AIDS in India has reduced life expectancy. In the coming decade, it is projected to drop from about 69 to 66 years old due to AIDS. [10]
- An estimated 90% of reported AIDS cases in India are among 20 -45 year olds, devastating the most economically productive segment of the population. As productivity falls and business costs rise, AIDS threatens India's progress in economic prosperity, foreign investment, and sustainable development.[11]
- By 2000 (?), AIDS will cost India $11 billion or 5% of GNP. [12]

DETERMINED LEADERSHIP AND PARTNERSHIPS HAVE THE POTENTIAL TO MAKE AN EXTRAORDINARY DIFFERENCE, SAVING MILLIONS OF LIVES.

- Without a successful intervention, India will be faced with the same devastation that many countries in Africa face today. However, a well-managed prevention program at the state and territorial level could keep HIV infection below 2% of the adult population in India. [13]
- Success has been shown at the community level. At least one progressive state government, in the southern state of Tamil Nadu, has taken the initiative to respond to AIDS through its State AIDS Society -- and similar societies now exist in all Indian states. Together with a multinational advertising agency, the SAS launched campaigns that address prevention and include stigma messages. Recent reports show that casual sex fell by half over two years, and condom use with casual partners rose to 50% in 1998 from just 17% in 1996, before the five wave of the campaign was launched.[14]
- Both President Clinton and Prime Minister Vajpayee have sounded the alarm on the AIDS crisis in India. The two countries released a "Joint Leadership Statement on HIV/AIDS", thereby pledging to work together through research, prevention and care to bolster the fight against AIDS. The statement calls for the highest levels of each government to work with the private sector to raise awareness and lessen the stigma faced by those living with HIV and AIDS.[15]

---

10 USAID Country Brief.
11 USAID Sentence 1. UNAIDS Sentence 2.
12 ONAP Africa Report.
13 USAID Country Brief.
14 UNAIDS Update 99.
15 India Op-Ed.