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South Africa, 7/7-7/14/00 [1]

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301-986-
4870

Social & Scientific Systems
an employee-owned company

May 23, 2000

INVOICE FOR MICHAEL ISKOWITZ

XIII INTERNATIONAL AIDS CONFERENCE, DURBAN, SOUTH AFRICA
JULY 9-14, 2000

Accommodations

July 8 - July 15 (7 nights) 1 Standard Room at the Royal Hotel @ $327/night	U.S. $2,289

Registration

Conference Registration Fee	U.S. $ 700
TOTAL INVOICE:	U.S. $ 2,989

(Please make the check payable to Social & Scientific Systems, Inc.
and remit to the attention of Ms. Cathy Maimon at the address below)

PAYMENT DUE BY JUNE 26, 2000

Social & Scientific Systems, Inc. • 7101 Wisconsin Avenue, Suite 1300 • Bethesda, MD 20814-4805 • [redacted] FAX 301 652 1749

T-Dubon

Social & Scientific Systems

FAX COVER SHEET

Date: 8-17 **Total Pages:** _____
Including cover sheet

To: Cheryl Baurle
202-456-2438

From: C. Maimon

Social & Scientific Systems, Inc.
Conference/Publications Group
FAX: 301 913 0351
TELEPHONE: 301 986 4870

Remarks

For Michael's files

Sent By: SOCIAL & SCIENTIFIC; 3019130351; Aug-17-00 10:39; Page 1

Social &
Scientific
Systems

August 17, 2000

INVOICE FOR MICHAEL ISKOWITZ

XIII INTERNATIONAL AIDS CONFERENCE, DURBAN, SOUTH AFRICA
JULY 9-14, 2000

Accommodations

July 5 - July 7 (2 nights) 1 Standard Room at the Durban Hilton @ $171/night **(Paid by Mr. Iskowitz while in Durban)**	U.S.$305
July 7 - July 16 (9 nights) 1 Standard Room at the Royal Hotel @ $327/night	U.S.$2,943

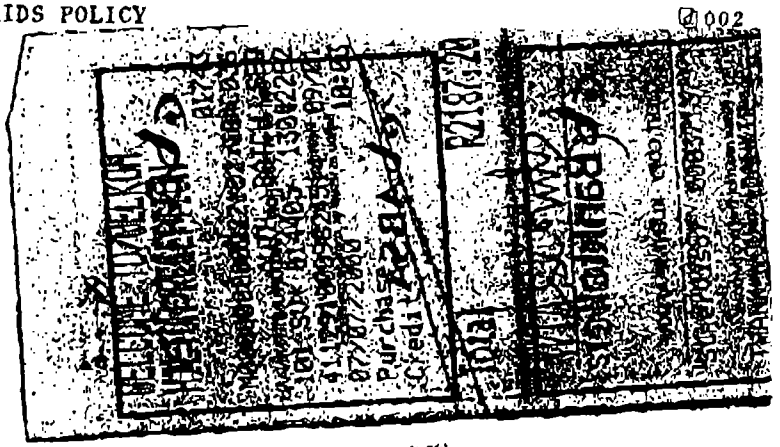
Registration

Conference Registration Fee	U.S.$700
TOTAL INVOICE:	**U.S.$3,643**

(Please make the check payable to Social & Scientific Systems, Inc.
and remit to the attention of Ms. Cathy Maimon at the address below)

Social & Scientific Systems, Inc. • 7101 Wisconsin Avenue, Suite 1300 • Bethesda, MD 20814-4805 • 301 986 4870 • FAX 301 652 1749

Sent By: SOCIAL & SCIENTIFIC; 3019130351; Aug-17-00 10:39; Page 2



Mr Michael Iskowitz
1715 15th Street
NW
Washington DC, DC 20009

USA

Room Number 0810
No of Person(s) 1
Cashier 36/SORAYA
Page 1
Rate Rand 1050.00
Frequent Flyer

Arrival 05/07/00
Departure 07/07/00

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Durban Hilton, 07/07/00 10:59 VAT No 4490163476

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05/07	Room Charge	1050.00	
05/07	-Tourism Levy	10.50	
05/07	-Telephone Auto #810 : 3043331	1.20	
05/07	-Telephone Auto #810 : 3040331	1.20	
06/07	In Room Service	14.00	
06/07	Room Charge	1050.00	
06/07	-Tourism Levy	10.50	
06/07	-Telephone Auto #810 : 3040331	3.60	
06/07	-Telephone Auto #810 : 3040331	1.20	
06/07	-Room Service Sundry #0810 : CHECK #6582	8.00	
06/07	-Room Service Tips #0810 : CHECK #6582	6.50	
07/07	In Room Service	14.00	
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07/07	-Room Service Tips #0810 : CHECK #6684	8.50	
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OFFICE OF SOUTHERN AFRICAN AFFAIRS (AF/S)
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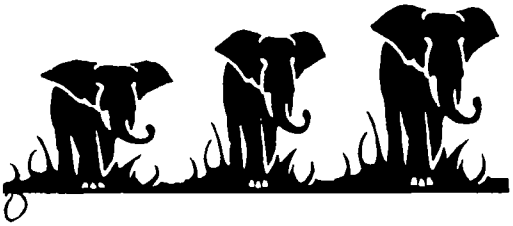

DATE: ~~7/5/00~~ 7/5/00 NO. OF PAGES (INCLUDING COVER): 5

TO: ~~Ms. Darlene Blocker, NSH~~
Ms. Cheryl Baverle, ONAP

FAX NUMBER: ~~(301) 402-3560 and~~ (202) 456-~~2459~~ ~~2439~~ 2438

FROM: Kim Murphy PHONE: 647-9862

COMMENTS:
Cable from Durban -
please distribute widely.

Thanks!

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

UNCLASSIFIED

DURBAN 110

Printed By: Kimberly Murphy 07/02/2000 03:24:17 PM
Subject: ADMINISTRATIVE ARRANGEMENTS FOR XIII INTERNATIONAL AIDS CONFERENCE

Cable Text:

TED4872
ACTION OES-01

INFO LOG-00 NP-00 AF-00 AID-00 AMAD-00 CIAE-00 COME-00
CTME-00 DODE-00 ITCE-00 EB-00 EXME-00 EUR-00 UTED-00
HHS-01 TEDE-00 INR-00 IO-00 ITC-01 LOC-01 NSAE-00
NSCE-00 OIC-02 OMB-01 OPIC-01 SS-00 STR-00 TRSE-00
DRL-02 NFAT-00 SAS-00 /010W
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R 301514Z JUN 00
FM AMCONSUL DURBAN
TO SECSTATE WASHDC 1782
INFO AMEMBASSY PRETORIA
AMCONSUL JOHANNESBURG
AMCONSUL CAPE TOWN
SOUTHERN AFRICAN DEVELOPMENT
AMEMBASSY LONDON
AMEMBASSY PARIS
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USMISSION GENEVA
WHITE HOUSE WASHDC 0031

UNCLAS SECTION 01 OF 02 DURBAN 0110

DEPT PASS USAID FOR GB/HPN JRIGGS
DEPT PASS HHS FOR EGOOSBY AND DHOHMAN
OI/T FOR NBOYER
OES FOR SCHOW
AF/S PLEASE PASS ALL DEPARTMENTS AND AGENCIES
CDC ATLANTA, NIH, FDA, LIBRARY OF CONGRESS
AND OTHER PARTICIPATING AGENCIES
WHITE HOUSE FOR THURMAN

LONDON FOR PFLAUMER
PARIS FOR WILLIAMS-MANIGAULT
LISBON FOR VERDUN

E.O. 12958: N/A
TAGS: OVIP, KHIV, OTRA, AORC, SOCI, WHO, ECON, TBIO,
EAID, UNAIDS, SMGT, CASC, SF
SUBJECT: ADMINISTRATIVE ARRANGEMENTS FOR XIII
INTERNATIONAL AIDS CONFERENCE

DURBAN 01 OF 02 110

1. THIS IS AN ACTION MESSAGE. AF/S PLEASE PASS TO ALL AGENCIES SENDING PARTICIPANTS TO THE XIII INTERNATIONAL AIDS CONFERENCE IN DURBAN JULY 9-14. ALL AGENCIES SEE PARAGRAPHS 6 AND 7 FOR FURTHER ACTION REQUEST.

2. THIS CABLE PROVIDES ADMINISTRATIVE INFORMATION FOR OFFICIAL USG PARTICIPANTS IN THE XIIITH INTERNATIONAL AIDS CONFERENCE AND REQUESTS AGENCIES REPRESENTED BY VERY SENIOR OFFICIALS TO PROVIDE CONGEN DURBAN WITH CERTAIN INFORMATION IN RETURN. (PARA 6)

3. CONGEN DURBAN WELCOMES ALL OFFICIAL USG PARTICIPANTS TO THE XIII INTERNATIONAL AIDS CONFERENCE. CONGEN DURBAN IS THE PRIMARY POINT OF CONTACT FOR ALL ADMINISTRATIVE QUESTIONS FOR THE CONFERENCE. BECAUSE OF EXTENSIVE SUPPORT OFFERED BY CONFERENCE ORGANIZERS AND BECAUSE CONSULATE STAFF IS VERY SMALL, WE ANTICIPATE THAT MOST USG PARTICIPANTS WILL HAVE NO NEED TO CONTACT THE CONSULATE DURING THEIR STAY IN DURBAN.

4. CONGEN DURBAN KEY CONTACT NUMBERS:

COUNTRY CODE FOR SOUTH AFRICA IS 27.

CONGEN DURBAN SWITCHBOARD: 31-304-4737
FAX:31-301-0265
CONSUL GENERAL CRAIG KUEHL
HOME: 31-563-3952
CELL: (0)82-858-2372
PUBLIC AFFAIRS OFFICER GERRI WILLIAMS
HOME: 31-564-4150
CELL: 082-858-2039
VICE CONSUL/POLITICAL OFFICER ELLEN HOFFMAN
HOME: 31-563-7039
CELL: 082-858-2369
VICE CONSUL JOSH GLAZEROFF (AMERICAN CITIZEN SERVICES)
HOME: 31-564-6823
CELL: 082-858-2371
CHARMAINE REDMAN (CITIZEN SERVICES LOCAL EMPLOYEE)
HOME: 31-464-5306
CELL: 082-858-2042

5. GENERAL ADMINISTRATIVE INFORMATION:

FOR THE VAST MAJORITY OF USG PARTICIPANTS, THERE WILL BE NO NEED TO CALL UPON THE SERVICES OF CONGEN DURBAN. IN CASE OF EMERGENCY, PLEASE USE THE NUMBERS ABOVE. THE CONSULATE SWITCHBOARD AFTER-HOURS RECORDING PROVIDES THE CELL PHONE NUMBER FOR THE DUTY OFFICER.

VISAS: ALL TRAVELERS TO SOUTH AFRICA USING DIPLOMATIC OF OFFICIAL PASSPORTS MUST HAVE VALID SOUTH AFRICAN VISAS.

TRANSPORTATION: PARTICIPANTS WILL BE MET AT DURBAN AIRPORT BY CONFERENCE-ORGANIZED GREETERS AND TRANSPORTATION. TRANSPORTATION BETWEEN HOTEL AND CONFERENCE VENUES IS PROVIDED BY CONFERENCE ORGANIZERS. CONGEN DURBAN HAS RECEIVED NO REQUESTS FOR DEDICATED TRANSPORTATION FOR INDIVIDUAL PARTICIPANTS, AND WOULD NOT BE ABLE TO SATISFY SUCH REQUESTS.

REGISTRATION: ALL PARTICIPANTS SHOULD HAVE RECEIVED REGISTRATION INFORMATION WITH THEIR CONFIRMATION OF ATTENDANCE. CHECK-IN IS AT THE PARKING LEVEL OF THE DURBAN INTERNATIONAL CONFERENCE CENTER (ICC) BEGINNING FRIDAY, JULY 7 FROM 0800-1800. REGISTRATION CONTINUES THE SAME HOURS ON SATURDAY. SUNDAY, JULY 9, REGISTRATION IS FROM 0700-1900. FROM JULY 10-13 REGISTRATION IS FROM 0630-1800.

LODGING: NO ONE SHOULD COME TO DURBAN WITHOUT CONFIRMED LODGING. THE OFFICIAL CONFERENCE TRAVEL AGENCY, TURNER TRAVEL, CONTROLS ALL AVAILABLE LODGING IN THE DURBAN AREA. CONGEN DURBAN WILL NOT BE ABLE TO ASSIST TRAVELERS WHO DO NOT HAVE HOTEL RESERVATIONS. TURNER TRAVEL CAN BE REACHED AT (0)31 332-1451, FAX 368-6623, E-MAIL, TURNERS22@GALILEOSA.CO.ZA.

ACCOMMODATION EXCHANGE. THERE WILL BE EXCHANGE FACILITIES AT THE DURBAN INTERNATIONAL AIRPORT. AUTOMATIC TELLER MACHINES ARE READILY AVAILABLE, INCLUDING IN THE CONFERENCE CENTER. MANY MACHINES LIMIT

DURBAN 02 OF 02 110

EACH TRANSACTION TO SOUTH AFRICAN RAND 1,000 OR 2,000 (USD 150-300). CREDIT CARDS ARE ACCEPTED NEARLY EVERYWHERE. CONGEN DURBAN DOES NOT HAVE THE CAPACITY TO PROVIDE EXCHANGE FACILITIES.

MEDICAL: THERE WILL BE A MEDICAL FACILITY AT THE CONFERENCE SITE. IN ADDITION, STATE DEPARTMENT REGIONAL MEDICAL OFFICER DR. LARRY HILL WILL BE IN DURBAN FROM JULY 9. HE CAN BE REACHED IN AN EMERGENCY BY CELL PHONE AT 082-858-2334.

COUNTRY CLEARANCE: EMBASSY AND CONGEN DURBAN REQUEST THAT AGENCIES GROUP COUNTRY CLEARANCE REQUESTS AS MUCH AS POSSIBLE TO MINIMIZE THE NUMBER OF COUNTRY CLEARANCE CABLES THAT MUST BE SENT.
PUBLIC AFFAIRS/PRESS: DURBAN PUBLIC AFFAIRS OFFICER GERRI WILLIAMS IS THE POINT OF CONTACT FOR AGENCIES HOLDING PUBLIC AND PRESS EVENTS.

OTHER INFORMATION: THE COUNTRY CLEARANCE CABLE PROVIDES SECURITY AND OTHER PERTINENT INFORMATION.

6. ACTION REQUEST: CONGEN DURBAN REQUESTS AGENCIES SENDING SENIOR OFFICIALS TO PROVIDE THE FOLLOWING INFORMATION FOR EACH SENIOR OFFICIAL. POST INTENDS TO COMPILE THIS INFORMATION AND MAKE IT AVAILABLE TO AGENCY STAFF TO FACILITATE COMMUNICATION AMONG SENIOR OFFICIALS.

NAME

TITLE
AGENCY
ETA/ETD
NOTE: PLEASE PROVIDE FULL FLIGHT ITINERARY INCLUDING TRANSIT INFORMATION IN CAPE TOWN OR JOHANNESBURG. HOTEL INCLUDING PHONE NUMBEROTHER CONTACT NUMBER IF KNOWN (E.G., CELL PHONE NUMBER) RESPONSIBLE STAFF PERSON NAME, HOTEL AND CONTACT DATA AS ABOVE.

7. ACTION REQUEST CONTINUED: CONGEN DURBAN FURTHER REQUESTS ALL AGENCIES TO COMPILE AND FORWARD THROUGH AF/S DON GATTO IN THE STATE DEPARTMENT (TEL 647-9838, FAX 647-5007) A COMPREHENSIVE LIST OF ALL AGENCY PARTICIPANTS IN THE CONFERENCE. PLEASE PROVIDE HOTEL, OTHER CONTACT INFORMATION AND ETA/ETD WHENEVER POSSIBLE.

PUBLIC AFFAIRS/PRESS: DURBAN PUBLIC AFFAIRS OFFICER GERRI WILLIAMS REQUESTS THAT AGENCIES WITH PUBLIC AFFAIRS/PRESS PROGRAMS AT THE CONFERENCE CONTACT HER AT THE NUMBER PROVIDED PARAGRAPH 4 ABOVE.

8. CONGEN DURBAN LOOKS FORWARD TO ASSISTING USG OFFICIALS ATTENDING THE CONFERENCE AND WISHES EVERYONE A PRODUCTIVE AND PLEASANT STAY IN THIS WONDERFUL CITY.

KUEHL
NNNN

End Cable Text

Printed By: Kimberly Murphy 07/02/2000 03:24:17 PM

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*** TX REPORT ***
****

+ 01/20

TRANSMISSION OK

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CONNECTION TEL	901127313049743
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RESULT	OK

OFFICE OF NATIONAL AIDS POLICY

EXECUTIVE OFFICE OF THE PRESIDENT
THE WHITE HOUSE

FACSIMILE TRANSMITTAL SHEET

TO: **Mark Heywood and Promise Mtembo**

FROM: Cheryl Bauerle

COMPANY:

DATE: July 6 2000

FAX NUMBER: 011-27-403-2341

TOTAL NO. OF PAGES INCLUDING COVER: 2

PHONE NUMBER:

RE.

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

NOTES/COMMENTS:

Sandy Thurman asked me to respond to your fax of June 29th. Unfortunately, a long-standing scheduling conflict will keep her from being able to join you on the 9th. However, if scheduling permits, she would be pleased to meet with you while in Durban at another time. She can be reached via her office in Durban starting on the 9th at Tel: 27 31 336 2534; Fax: 27 31 336 2620. Thank you.

OFFICE OF NATIONAL AIDS POLICY

EXECUTIVE OFFICE OF THE PRESIDENT

THE WHITE HOUSE

FACSIMILE TRANSMITTAL SHEET

TO:	FROM:
Mark Heywood and Promise Mtembo	Cheryl Bauerle
COMPANY:	DATE: July [redacted] 2000
FAX NUMBER: 011-27-403-2341	TOTAL NO. OF PAGES INCLUDING COVER: 2
PHONE NUMBER:	
RE:	

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

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

TAC

HIV & AIDS Treatment Action Campaign
PO Box 31104, Braamfontein 2017, Johannesburg. Tel: 011-403-6918 Fax: 011-403 2341
E-mail: shasha@netactive.co.za or zackie@pixie.co.za
Web-site: www.tac.org.za

5 July 2000 **URGENT**

Ms Sandra Thurman, Director
Office of National AIDS Policy
The White House
736 Jackson PL NW
WASHINGTON D.C. 20503-0007
U.S.A.

Fax: (091) 202 456 2439

Dear Ms Thurman

INVITATION TO RECEIVE A MEMORANDUM FROM THE GLOBAL MARCH FOR ACCESS TO HIV/AIDS TREATMENT

We have not yet received a response from you in relation to our request that you be present to receive the memorandum of the Global March for Access to HIV/AIDS Treatment.

I am leaving for Durban today. Please could you contact me on my cell number 083 634 8806 as soon as possible. Alternatively, you can fax your response to the TAC office in Durban - (031) 304 9743

We would be grateful for your response as soon as possible.

Yours sincerely

MARK HEYWOOD
Deputy Chairperson
Treatment Action Campaign

MH/ac

FILE No.225 05.07.'00 14:23 ID:CALS FAX:+0114032341 PAGE 1

+. Durban

FHI Reception

6:30 - 8:30 PM

Royal Hotel
'The Top of the Royal'

You will receive the 1st ever FHI Global Award for HIV/AIDS Prevention & Care in the Third Millennium.

2 minutes of informal welcome and thanks, you're glad to be doing this work, the Administration remains committed, building community, working together, encouragement…

Attendees	300 people, Gayle, DeLay, Piot (if in country)
Press	No press invited

Contact	Sheila Mitchell	27 82 858 0815

Contact Mary O'Grady @ 703-516-9779

+- Durban

Aids conference becomes Mbeki-bashing circus

By Lynne Altenroxel and Sapa

The government's worst fears have been realised: no sooner had the 13th International Aids Conference opened than it became an Mbeki-bashing event.

Among the voice of dissent has been that of Edwin Cameron, a Constitutional Court acting judge, who used one of the first sessions, in which he delivered a memorial lecture to a hall packed with more than a thousand delegates, to slam the government.

In a rousing speech that received a standing ovation, Judge Cameron accused the government of mismanaging the HIV epidemic "almost at every conceivable turn" and declared his disappointment at President Thabo Mbeki's opening night speech.

'Why should Mbeki deny something he has not said'

The speech, in which Mbeki insisted that his government was committed to the fight against HIV, did not do enough to counter government blunders, Cameron said.

He said that, to his "grief and consternation", Mbeki had made no announcement about providing pregnant women with AZT.

Delegates expressed bitter disappointment with President Thabo's Mbeki's failure to come clean on his controversial HIV/Aids position.

While the health minister, Manto Tshabalala-Msimang, defended Mbeki's interest in the revisionist theory that HIV does not cause Aids, Mbeki was criticised by a number of eminent delegates.

Tshabalala-Msimang said South Africa would not be dictated to by the world on how it should formulate it's health policy. Mbeki, she said, was fully committed to fighting the HIV/Aids scourge holistically.

"The president of this country has never denied either the existence of Aids nor this casual connection between HIV and Aids," Tshabalala-Msimang said. "Why should he deny something he has not said?"

Conference chairperson Jerry Coovadia said there was an air of disappointment among thousands of conference delegates from across the globe that Mbeki did not reverse perceptions that he supported the dissident view that HIV was not the cause of Aids when he officially opened the conference on Sunday night.

Mbeki instead maintained his stance that poverty was the biggest "disease" causing death in Africa. Mbeki also questioned the effectiveness of the conference in dealing with the major issues surrounding Aids in Africa.

Coovadia said while he understood that Mbeki, as a president, could not simply backtrack on his position, "delegates expected him to make a major policy announcement to shift away from controversial issues".

This did not happen and disappointment was most acute in the address of Cameron.

Cameron has publicly confessed to being gay and living with HIV for the past three years.

On Monday he said he was only still alive because he was able to "pay for life itself".

Cameron criticised Mbeki and his government for failing South Africans suffering from HIV/Aids. He also criticised the government's decision not to give the anti-retroviral drug AZT to HIV positive pregnant women dependent on the public health care system. He said because of this, about 5 000 HIV-positive babies were born every month.

Cameron added that Mbeki's "intractably puzzling" statement and his flirtation with revisionists had shocked almost everyone involved in fighting the pandemic.

He said as a Constitutional Court judge, responsible for maintaining human rights in the country, he felt compelled to speak out about what was keeping him alive, while millions of South Africans were dying.

Oxford University's Professor Roy Anderson said the South African government had failed to intervene timeously to curb the spread of HIV/Aids. Referring to a recent UNAIDS report which stated that South Africa had one of the highest HIV/Aids incidences globally, he said political will and leadership could act as catalysts to slow down the spread of the scourge.

Anderson was also critical of the dissident theorists and said he was disappointed that Mbeki had failed to publicly reject their view.

He said the explosive spread of Aids in Africa, of which South Africa had one of the highest rates, could have been curtailed over the past 13 years had it been nipped in the bud, since it was already known back in 1987 how to prevent the transmission of Aids.

Anderson urged the industrialised world to assist developing nations with affordable anti-retroviral medicine so the "patchy" pattern in the global fight against Aids could change. He said a cure for Aids was still a long way off. "Vaccines are the only hope for the future... and that is not going to happen quickly."

Coovadia agreed that the South African government had started its Aids awareness campaign far too late. The government had also made serious mistakes along the way, including the fiascos surrounding the Aids play, Sarafina II, and the purported Aids drug Virodene, followed by the revisionist statements.

He said Uganda, one of the only African countries where the HIV infection rate was dropping, started its campaign in 1990. South Africa's Aids campaign only kicked off in 1994, when the African National Congress took over from the apartheid government, which had spectacularly failed to address the disease.

Tshabalala-Msimang said prior to the election of the ANC government, there had been hardly any Aids fighting infrastructure in place. The ANC had set in place structures to start fighting the killer disease, she said.

The United States government on Monday applauded Mbeki's commitment to fighting Aids in South Africa, but warned that the window of opportunity was closing fast to do something about it.

Director in the Office of National Aids Policy in the White House, Sandra Thurman, agreed with Mbeki's stance that poverty was indeed a primary Aids issue, but said that in the absence of poverty, HIV/Aids still existed.

"It is true that we will never win the battle against HIV/Aids unless we reduce poverty. But it is also true that even in the absence of poverty, we still have HIV/Aids," Thurman said. - Sapa

The Star

Health minister defends Mbeki's stand on Aids

By Phindile Ngubane, Patrick Leeman and Reuters

President Thabo Mbeki came under fresh criticism from Aids activists on Monday after ducking an opportunity to end a damaging debate on the causes of the disease.

Mbeki, who has been attacked by activists and health experts for appearing to give credence to dissidents who deny that HIV causes Aids, was back in the firing line after his opening speech to the 13th International Aids Conference in Durban on Sunday.

His eagerly awaited speech gave no insight as to whether Mbeki believed that HIV led inevitably to Aids.

'He talks about a plan. He doesn't talk about action'

"I was hoping and praying that he would find a way to gracefully back out of this madness," said Phil Wilson of the African-American Aids Initiative.

"The house is on fire and Mr Mbeki is sitting around trying to decide whether it was started by a lighter or a match," Wilson said.

"He talks about a plan. He doesn't talk about action. This should have been a call to action."

Chief organiser of the conference Professor Hoosen Coovadia said the speech had disappointed a lot of people.

'Mbeki is not going to come out and say he was wrong'

"What I'm sensing from people is an absolute sense of disappointment ... Many people believed the president would use the occasion to try to quell some of the disquiet around the government's position on HIV/Aids."

At a plenary session, HIV-positive constitutional court judge Edwin Cameron took a swipe at the government, which he accused of mismanaging the pandemic.

Judge Cameron said that in 1998 South Africa already had the highest rate of infection in the world, but had done nothing to tackle this.

He said that, to South Africans' shame, the government had not implemented a strategy to prevent mother-to-child transmission: "The result has been that every month 5 000 children are unnecessarily born with HIV.

"In our national struggle to come to grips with the epidemic, perhaps the most intractably puzzling episode has been our president's flirtation with those who, in the face of all reason and evidence, have sought to dispute the aetiology of Aids."

But the government said on Monday it would not apologise for its view that HIV could not be looked at as the sole reason behind the Aids scourge.

Speaking at a press conference, Health Minister Manto Tshabalala-Msimang said the government would not respond to "narrow sectoral agendas and interests".

"We reiterate our view that it is inappropriate to blame everything around this epidemic on the HIV virus, " she said.

"Clearly the relationship between HIV and other social ills afflicting our society, such as poverty and disease, particularly TB and STDs, is complex. We reaffirm, unapologetically, our view that a comprehensive response in our country needs to recognise this reality."

Professor Roy Anderson, a renowned Aids expert at Oxford University, said he, too, saw the speech as a lost opportunity. "I was disappointed, to put it bluntly," he said.

However, others said the activists were expecting too much of Mbeki.

Dr Helene Gayle, head of HIV programmes at the United States Centres for Disease Control and Prevention, said some people would be disappointed that Mbeki had not gone further.

"But he is not going to come out and say, 'I was wrong'," she said.

The office of national Aids policy in the White House, saluted Mbeki's pledge to intensify South Africa's efforts to combat HIV/Aids.

Director Sandra Thurman said she wanted to reaffirm the United States' partnership in the growing effort to expand prevention programmes, prevent mother-to-child transmission and to provide the best care to people living with Aids.

THE MERCURY

Published on the Web by IOL on 2000-07-10 21:25:06

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Book travel at home too...maybe your dog
could be trained to start the computer?


July 11, 2000

South Africa Faults Critics of Its President on AIDS Stance

By RACHEL L. SWARNS

DURBAN, South Africa, July 10 -- Striking a defiant and combative tone, the South African government today lashed out at its increasingly vocal critics at the 13th International AIDS Conference, saying there was no need for President Thabo Mbeki to affirm that the human immunodeficiency virus, H.I.V., causes AIDS.

In Today's Times
• AIDS Conference Continues in South Africa

Issue in Depth
• Health: The AIDS Epidemic

The government was responding to the chorus of criticism from prominent scientists, physicians and activists here who today expressed their disappointment with Mr. Mbeki. He opened this conference on Sunday night with a speech in which he described extreme poverty, rather than AIDS, as the biggest killer in this country.

In recent months, Mr. Mbeki has consulted with two American researchers who argue that poverty and malnutrition -- and not H.I.V. -- cause AIDS, an argument that most established scientists say was debunked years ago. Today, in panel sessions and interviews, several participants said the president had squandered an opportunity to clarify his position and to take a leadership role in fighting the disease and preventing the spread of the virus, which has infected four million people here.

Health Minister Manto Tshabalala-Msimang dismissed the criticism and accused the news media of distorting Mr. Mbeki's message. "The president of this country has never denied either the existence of AIDS nor this causal connection between H.I.V. and AIDS," she said at a news conference today. "But we reiterate our view that it is inappropriate to blame everything around this epidemic on the H.I.V. virus."

She added that "clearly, the relationship between H.I.V. and other social ills afflicting our society such as poverty and disease" is complex.

But in the corridors and halls of the conference here, many participants remained perplexed and confused by the president's reluctance to say what so many people wanted to hear. Some wondered whether he was too proud to back down. Others wondered whether Mr. Mbeki, who is an economist and an intellectual, simply remains unconvinced of the links between H.I.V. and AIDS.

No one disputes the link between poverty and H.I.V. and AIDS. Prostitutes, migrant laborers, the uneducated and victims of sexual violence are more vulnerable to infection. And poor people typically lack access to drugs that might prolong their lives.

But scientists and researchers fear that Mr. Mbeki's heavy emphasis on poverty may confuse people and cause them to continue risky sexual behavior.

Mark Wainberg, the president of the International Aids Society, the co-organizer of this conference, described Mr. Mbeki's speech, which was broadcast live on national television, as a "lost opportunity." American officials said privately that they feared that Mr. Mbeki had raised broader questions about the quality of his leadership.

A South African judge, Edwin Cameron, received a standing ovation after he delivered the conference's opening speech today and condemned Mr. Mbeki for wasting time on discredited theories while people were dying.

"This has shaken almost everyone responsible for engaging the epidemic," Judge Cameron, who is infected with H.I.V., said of Mr. Mbeki's stance. "It has created an air of unbelief among scientists, confusion among those at risk of H.I.V., and consternation among AIDS workers."

The health minister emphasized today that Mr. Mbeki was committed to combating the disease vigorously by encouraging safe sex and by sponsoring research on drug therapies and a possible vaccine, which has been applauded by researchers here.

Dr. Awa Coll-Seck, the director of the United Nations' department of aids policy, said she was encouraged to hear Mr. Mbeki mention the program in his speech on Sunday night. But Dr. Coll-Seck, who is from Senegal, said she feared that the safe-sex message might get lost in the emphasis on poverty.

"I was discouraged," Dr. Coll-Seck said.

"We were expecting him to be a leader."

July 11, 2000

Mystery Factor Is Pondered at AIDS Talk: Circumcision

By LAWRENCE K. ALTMAN

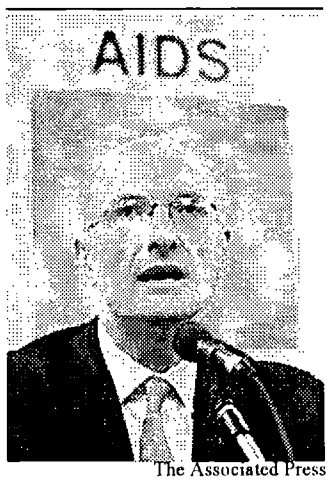
DURBAN, South Africa, July 10 -- Scientists meeting here debated today what to do about a puzzling but potentially important finding about AIDS: that circumcised men are much less likely to become infected than uncircumcised men.

The finding was first made in Africa more than a decade ago and has been noted in more than 40 studies since then. Now many scientists, some of whom are in Durban taking part in the 13th international conference on AIDS, have come to suspect that circumcision is an important factor in the vast differences among African countries in rates of infection from H.I.V., the virus that causes AIDS.

In many countries in southern Africa the rates of H.I.V. infection among adults exceed 20 percent, while among central and west African countries the rates are lower, some below 3 percent.

No one believes that circumcision, which has been widely and traditionally practiced in Africa, could be the sole explanation of such differences. Differing rates could be caused by other cultural or religious practices, or by differences in hygiene or other factors.

Yet compelling evidence from



The Associated Press

Justice Edwin Cameron of South Africa's High Court, who is H.I.V.-positive, at the conference.

Issue in Depth
• The AIDS Epidemic

Forum
• Join a Discussion on The AIDS Epidemic

epidemiologic studies has led scientists to debate whether to promote large-scale circumcision programs as a means to help stop the AIDS epidemic.

Agence France-Presse

Magdaline Ramaota, a South African traditional healer, spoke to patients in Durban on the second day of the international AIDS meeting.

While discussion at the session devoted to circumcision was largely academic, one participant, Dr. Daniel T. Halperin, an anthropologist at the University of California at San Francisco, addressed the reality.

"Let's not fool ourselves into thinking that we experts will decide whether men will get circumcised," Dr. Halperin said. "It is happening right now" as a small number of clinics have sprung up in Africa to offer circumcision to adult men, he said.

In studying the Luo people in Kenya, who do not practice circumcision, Dr. Robert C. Bailey of the University of Illinois at Chicago said he had found that most Luo men and women voiced the opinion that sex would be more pleasurable if the man was circumcised and that most men would prefer to be circumcised.

Dr. Bailey and other experts expressed concern about the safety of the procedure in Africa, because many of those performing it lack medical expertise and do not secure informed consent. Hygiene is a problem, and only one of eight clinics surveyed had all of the instruments needed to perform a circumcision safely, Dr. Bailey said.

Ann Buve of the Institute of Tropical Medicine in Antwerp, Belgium, studied two African cities with high H.I.V. rates and two with low rates. In Yaoundé, Cameroon, and Cotonou, Benin, where the prevalence of H.I.V. among sexually active men was 3.8 and 4.4 percent, respectively, 99 percent of the men were circumcised. The practice was less common in Kisumu, Kenya, and Ndola, Zambia, where infection rates were 26.8 percent and 25.9 percent.

Dr. Ronald Gray of the Johns Hopkins University School of Public Health expressed reservations about recommending circumcision, based on his team's studies in Rakai, Uganda. A rigorous type of study, known as a randomized controlled trial, is needed to scientifically determine the degree of protection from circumcising males at birth and as adults, Dr. Gray and others said.

Such trials could determine whether religious, cultural, behavorial and hygienic factors account for an important part of the protection that seems to be related to circumcision. But the impact of rigorous trials on the epidemic could be limited, because answers might not come until 15 to 20 years after they are started.

Researchers must decide between scientific rigor and immediate need, said Dr. Roy M. Anderson of Oxford University at a separate session about the general problem of conducting research in the face of the AIDS pandemic.

"Rigor should be adopted in some instances, particularly where controversy exists about cost-effectiveness," he said. "But common sense argues that rough and ready observational studies should be used in high-incidence regions with limited resources."

In providing a possible biological explanation, a paper in a recent issue of the British Medical Journal said the inner surface of the foreskin contains so-called Langerhans cells that have an area on their surface that allows the entry of H.I.V.

And in a new report, the Population Council in New York City urged more research to determine the cost-effectiveness of male circumcision.

In the United States, 40,000 people become infected with H.I.V. each year. Although officials of the Centers for Disease Control and Prevention consider that number unacceptably high, they gave a more encouraging view of the H.I.V. epidemic in the United States, saying American teenagers were heeding warnings about the virus. Surveys found that in 1999, 50 percent of teenagers reported having had sex at least once, compared with 54 percent in 1991. And 58 percent of teenagers said they used a condom the last time they had sex, up from 46 percent.

H.I.V. infections among American women fell by 9 percent from 1994 to 1998. But the number of women 21 to 25 years old had more than doubled in that period, suggesting that the downward trend among women overall may be masking increases in incidence among young women, said Dr. Rob Janssen of the C.D.C.

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The New York Times

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Aids chipping away at African life expectancy

The populations of some Aids-stricken African countries will soon begin to fall as millions die of the disease, and life expectancy by the end of the decade will plunge to about 30 - a level not seen in at least a century, according to new estimates.

The figures, released on Monday, are the latest attempt by demographers to grasp the devastation of the Aids pandemic, which has swept across southern Africa during the past few years with staggering speed and range.

"It's hard to comprehend the amount of mortality we will see in these countries," said Karen Stanecki, of the US Census Bureau, which compiled the projections.

Stanecki presented the new figures at the 13th International Aids Conference, which is being held for the first time in Africa - ground zero of the pandemic.

'Africa's worst social catastrophe since slavery'

Speakers at the meeting struggled for strong enough words to describe the scope of this disease in the poorest parts of the world, especially sub-Saharan Africa, where nearly three-quarters of all HIV-infected people live.

"The problem will get much worse before it gets better," said Dr Roy Anderson of Oxford University. "This is undoubtedly the most serious infectious disease threat in recorded human history."

Dr Kevin DeCock of the US Centres for Disease Control called the pandemic "Africa's worst social catastrophe since slavery".

Experts estimate that 25 million Africans already are infected with HIV, and most of them will die within the next five to eight years. In Botswana, the world's worst-hit country, more than one-third of all adults carry the virus.

'The problem will get much worse before it gets better'

Stanecki said that by 2003, the populations of Botswana, South Africa and Zimbabwe would begin to fall because of Aids deaths and dropping fertility resulting from the pandemic. In these countries, the populations would drop between 0,1 percent and 0,3 percent. Without Aids, they would have grown between one and three percent.

She said this was the first time the bureau had projected negative population growth due to Aids. The population growth of several other countries - including Malawi, Namibia, Swaziland and Zambia - would be near zero because of Aids.

Aids already has sharply reduced life expectancy in many African countries. For instance, it is now 39 in Botswana, instead of 71, as it would have been without the disease. And this will get much worse.

Stanecki projected that by 2010, life expectancy would be 29 in Botswana, 30 in Swaziland and 33 in Namibia and Zimbabwe. Without Aids, it would have been about 70 in these countries.

Experts note that programmes to educate people about condoms and other ways of avoiding infection clearly can work in southern Africa. Because of early efforts, the pandemic never happened in Senegal, and Uganda has reversed its high infection level.

Aids medicines had dramatically improved survival in the United States and Europe, but these drugs were simply too expensive and hard to deliver for most of the world's infected people. Five drug companies had pledged to lower their prices for the developing world, although health officials noted that they lacked the healthcare services necessary to offer these medicines to the sick.

On Monday, the Bill and Melinda Gates Foundation, created by Microsoft's founder, said it would spend $50-million (about R340-million) in Botswana to strengthen its healthcare system. Merck & Co said it would match the donation in Botswana, mostly by providing Aids drugs. - Sapa-AP

The Star

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Scientist warns Mbeki of 'legacy of tragedy'

By Steven Swindells

A leading US Aids researcher added his voice on Tuesday to a growing chorus of criticism of South African President Thabo Mbeki for his attitude to the causes of the deadly disease.

"President Mbeki, I beg you not to let your legacy be defined by inaction on this human tragedy," Dr David Ho said in a speech to the 13th International Aids Conference.

The fears of the South African government that the conference would become a "Mbeki-bashing affair" were realised as fresh salvoes were launched against him for courting so-called "Aids dissidents" who deny that HIV causes Aids.

South Africa was in severe danger from Aids

Ho, of the Aaron Diamond Aids research centre at New York's Rockefeller University and the researcher best known for showing that strong drug cocktails can keep Aid at bay, showed a microscope photograph of the HIV virus attacking a cell.

"This, ladies and gentlemen, is the cause of Aids," he declared.

Ho later said South Africa was in severe danger from Aids because of the controversy.

His attack was the latest in a string of criticisms of Mbeki's opening speech to the conference on Sunday night.

'Programmes to fight Aids are continuing'

Many of the 10 000 delegates saw the speech as a wasted opportunity for Mbeki to draw a line under his controversial stance on the disease.

The furore surrounding Mbeki has overshadowed the conference's purpose of fighting the scourge of HIV-Aids which now infects about 35 million people and poses a major economic and security threat to the developing world.

The London-based Panos Institute told the meeting that at least 12 million people with the HIV virus worldwide needed drugs to suppress it which would cost an estimated $60-billion a year at current prices.

Scientists also said the first Aids vaccine designed specifically to fight the strain of virus seen in Africa had been cleared for testing in humans in Britain.

But Mbeki's role in the debate remained centre stage.

"It is incumbent on him to give a clear message about the cause of Aids. His job is not to orchestrate debate in a quiet college classroom. It is giving the best scientific information to the people in his country...(He is) failing miserably," said Kenneth Roth, executive director of Human Rights Watch.

Eminent researchers from the United States, Europe and South Africa have hit out

at Mbeki's speech which, though repeating the government's determination to fight Aids, focused more on the devastating role of poverty.

Mbeki has been condemned by the medical establishment since he invited "Aids dissidents" onto his own advisory panel on the disease which has infected at least four million South Africans.

His decision to deny the anti-Aids drug AZT to pregnant women and rape victims on cost grounds has also landed Mbeki in hot water.

The president's office dismissed Ho's criticism.

"It's unfair to jump to the conclusion that, because he (Mbeki) has the right to ask questions, we are going backwards," Mbeki's spokesperson said.

"None of our programmes to fight the disease has stopped. Everything is continuing as it was before."

Mbeki's health minister said on Monday that Mbeki had never denied the existence of Aids or the causal connection between HIV and Aids. - Reuters

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Circumcision Debated In Control of AIDS

By David Brown
Washington Post Staff Writer
Tuesday , July 11, 2000 ; A17

DURBAN, South Africa, July 10 — Millions of cases of AIDS around the world might have been avoided if circumcision of men were more customary in sub-Saharan African countries where the disease is prevalent. On the other hand, it may be that circumcision is simply more common in populations at low risk for AIDS for different reasons.

Those were the possibilities pondered today by AIDS researchers who heard provocative--although far from definitive--information about the links between male circumcision and infection with HIV, the virus that causes AIDS.

Papers presented at the 13th International AIDS Conference here noted that while circumcision is common in broad swaths of Africa, it is uncommon in precisely those parts of the continent where HIV infection is most prevalent and the epidemic is spreading most rapidly.

"If there were a vaccine announced at this conference that could be given in one procedure, no booster needed, that was safe and culturally acceptable, and which was effective 50, 75 or 100 percent of the time, would that be news or not?" Daniel T. Halperin, an AIDS researcher at the University of California at San Francisco, asked delegates.

His question suggested that circumcision might be the equivalent of such a treatment but has been overlooked. Only a controlled experiment could prove or disprove that idea, and delegates appeared to agree that one is urgently needed.

At the level of national populations, circumcision is highly associated with relatively low rates of HIV infection. Southern Africa contains six countries in which at least 20 percent of adults are HIV-positive and less than 20 percent of men are circumcised. In such West African countries as Nigeria, Liberia and Benin, however, infection with HIV, the human immunodeficiency virus, is only one-fourth as common, while the circumcision rate is four times as high.

In various studies, HIV has infected uncircumcised men two to eight times as readily as those who are circumcised. If even the low end of that range is correct, nearly half the infections in men in such high-prevalence countries as Zambia may be "attributable" to lack of circumcision, Halperin said.

But data presented at the conference here today demonstrated how tricky such conclusions may be.

In the Rakai District of Uganda, 17 percent of men are circumcised. Among Muslims, the rate is 99 percent; among non-Muslims, 4 percent. Overall, the infection rate among circumcised men is about half that among the uncircumcised. But in the subgroup of circumcised non-Muslims, it has virtually no effect on risk.

Those findings suggest that religion, not circumcision, may be the protective characteristic. Possible explanations are that Muslim men may have fewer casual sex partners--because they are allowed multiple wives--or that religious teaching requires frequent washing, which may decrease viral transmission.

Among married couples, the benefit of circumcision seems more apparent. In the Rakai study, 50 circumcised men were married to HIV-positive women, and none acquired the virus over more than a year's observation. In couples in which the man was infected and the woman not, circumcision did

not affect the woman's risk of acquiring HIV.

There was a major exception, however. None of the circumcised men who had relatively small amounts of virus circulating in their bloodstream passed HIV to their partners, while many uncircumcised--but otherwise similar--men did.

Researchers at the University of Illinois at Chicago and the health ministry of Kenya are running a study in which circumcision is being introduced to a region of about 3 million people in western Kenya, where the practice is currently rare.

Researchers recently interviewed residents of the region in 36 focus groups and found high enthusiasm for circumcision, although only a half-dozen procedures had been performed in the region the previous year. Forty-eight percent of men and 56 percent of women said they thought uncircumcised men enjoyed sex less than circumcised men. At the same time, 60 percent of uncircumcised men said they would prefer to be circumcised, and a similar proportion of women said they'd prefer a circumcised partner.

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PRESS RELEASE

UNDER EMBARGO UNTIL 9.00GMT
Durban, 12 July 2000

UNAIDS CALLS FOR CONTINUED COMMITMENT TO MICROBICIDES

Durban, South Africa, 12 July 2000 – The Joint United Nations Programme on HIV/AIDS (UNAIDS) has called for continued commitment to finding a microbicide against HIV despite the negative results of recent trials of the spermicide nonoxynol-9.

Test results released on 13 June revealed that the product, marketed under the trade name 'Advantage S' in the United States and China, was not only ineffective against HIV but actually harmful as a microbicide.

"We were dismayed to find out that the group using the N-9 gel had a higher rate of HIV infection than the group using a placebo," said Dr Joseph Perriëns, who heads the UNAIDS microbicide effort. "The active group had 59 infections, while the placebo group had 41. This is a significant difference."

"While the incidence of HIV infection in both groups in this study was lower than that seen in the untreated population from which volunteers were recruited, it is clear that the rate of infection was greater with the N-9 gel compared to its placebo control preparation," Dr Perriëns added. "Despite these results, we have lost a battle, not the war. We know N-9 is not the answer – so we need to continue our search."

As a result of the trial, UNAIDS is calling for an acceleration of the introduction of new more promising microbicides into large-scale Phase III trials. "A microbicide can allow women to protect themselves and their partners from infection without necessarily having to secure male cooperation," said Awa Coll-Seck, Director of Policy, Strategy and Research for UNAIDS. Three products currently in advanced safety testing in women could be available for inclusion in combined safety/efficacy evaluation within months, and the safety testing of a further 10 products, including two antiretrovirals, should also be accelerated. Ten public agencies are currently members of the International Working Group on Microbicides working on microbicide development. These efforts, however, lack adequate funding.

Meanwhile, UNAIDS believes that women at high-risk of HIV infection should not use N-9, given that the bulk of the data now suggests that it is either ineffective or harmful as an anti-HIV agent.

The study was conducted as a triple-blind multicentre trial among female sex workers. Women were chosen at random from volunteers who were informed of the risks and who agreed in writing to take part in the tests. They benefited from condom promotion, free condoms and free treatment of sexually transmitted infections. Test sites were located in Benin, Côte d'Ivoire, Thailand and South Africa.

The main objective of the study was to determine whether there was a statistically significant difference in the incidence of HIV infection between the two groups of women.

Nonoxynol-9 is a spermicidal agent used in contraceptive spermicide products and as a complementary component in the lubricant of barrier methods of contraception, such as the male condom.

Microbicides are chemical substances – in the form of gel, cream, suppository or film – which kill viruses and bacteria when applied vaginally or rectally before sexual intercourse. The large-scale efficacy trial, known as a Phase III trial, was sponsored jointly by UNAIDS and US-based Columbia Laboratories. It was initially funded by the World Health Organization's Global Programme on AIDS in 1995, and by UNAIDS from 1996.

Note to Editors:

- The Trial Coordinator was Dr Lut Van Damme of the Institute of Tropical Medicine in Antwerp, Belgium.
- The trial sites were: Abidjan (Côte d'Ivoire), Cotonou (Benin), Durban and Johannesburg (South Africa), Hat Yai and Bangkok (Thailand).
- Principal Investigators were:
  - Abidjan – Dr Virginie Traoré
  - Bangkok – Dr Pachara Sirivongrangson
  - Cotonou – Dr Michel Alary
  - Hat Yai – Dr Verapol Chandeying
  - Durban – Dr S Salim Abdool Karim
  - Johannesburg – Dr Helen Rees
- The data centre was Centre Hospitalier Affilié de Québec, Pavillon Saint-Sacrement, Quebec City, Canada. Study Statistician: Dr Benoit Masse

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For more information, please contact Anne Winter, UNAIDS, Media Center, Durban, (+27 31) 332.2031, mobiles (+41 79) 213.4312 and (+27 82) 858.0891, Mark Aurigemma, UNAIDS, Durban, (+27 82) 858.0720, Dominique de Santis, UNAIDS, Geneva, (+41 22) 791.4509 or Emily Krasnor, 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).

COMMUNIQUE DE PRESSE

SOUS EMBARGO JUSQU'A 9.00hrs GMT
Durban, le 12 juillet 2000

L'ONUSIDA SOUHAITE UN ENGAGEMENT SOUTENU EN FAVEUR DES MICROBICIDES

Durban, Afrique du Sud, 12 juillet 2000 – Le Programme commun des Nations Unies sur le VIH/SIDA (ONUSIDA) appelle à poursuivre les travaux visant à découvrir un microbicide contre le VIH malgré les résultats négatifs des récents essais effectués avec le spermicide nonoxynol-9.

Les résultats de l'essai, publiés le 13 juin, ont révélé que le produit, commercialisé sous la marque 'Advantage S' aux Etats-Unis et en Chine, n'était pas seulement inefficace contre le VIH mais était néfaste en tant que microbicide.

Nous avons été consternés de découvrir que le groupe utilisant le gel N-9 avait un taux d'infection à VIH plus élevé que le groupe utilisant un placebo, a déclaré le Dr Joseph Perriëns, qui dirige les activités de l'ONUSIDA sur les microbicides. Le groupe test comptait 59 infections, contre 41 dans le groupe placebo, ce qui représente une différence significative.

Bien que l'incidence de l'infection à VIH dans les deux groupes de cette étude ait été plus faible que celle observée dans la population non traitée dans laquelle les volontaires avaient été recrutées, il est certain que le taux d'infection a été plus élevé avec le gel N-9 qu'avec la préparation placebo utilisée comme contrôle, a ajouté le Dr Perriëns. Malgré ces résultats, nous avons perdu une bataille, mais nous n'avons pas perdu la guerre. Nous savons que le N-9 n'est pas la solution et nous devons poursuivre notre quête.

A la suite de cet essai, l'ONUSIDA demande que soit accélérée l'introduction de nouveaux microbicides plus prometteurs dans des essais à grande échelle de Phase III. Un microbicide pourrait permettre à la femme de se protéger et de protéger ses partenaires de l'infection sans pour autant devoir obtenir la coopération de l'homme, déclare Awa Coll-Seck, Directeur du Département des Politiques, des Stratégies et de la Recherche à l'ONUSIDA. Trois produits qui subissent actuellement des tests avancés d'innocuité chez la femme pourraient faire l'objet d'une évaluation combinée d'innocuité/efficacité dans les mois à venir et les tests d'innocuité de 10 autres produits, y compris deux antirétroviraux, devraient également être accélérés. Dix institutions publiques sont actuellement membres du Groupe international de travail sur les microbicides qui s'occupe de la mise au point de ces substances. Cependant, ces activités sont insuffisamment financées.

En attendant, l'ONUSIDA estime que les femmes très exposées au risque d'infection par le VIH ne devraient pas utiliser le N-9, étant donné que la plupart des données suggèrent maintenant qu'il est soit inefficace soit dangereux en tant qu'agent anti-VIH.

L'étude était un essai multicentres en triple aveugle réalisé parmi des professionnelles du sexe. Les femmes ont été choisies de manière aléatoire parmi des volontaires qui étaient informées des risques et qui avaient donné par écrit leur accord pour participer à l'essai. Elles ont bénéficié de la promotion des préservatifs, de préservatifs gratuits ainsi que du traitement gratuit des infections sexuellement transmissibles. Les sites de l'essai se trouvaient en Afrique du Sud, au Bénin, en Côte d'Ivoire et en Thaïlande.

L'objectif principal de l'étude était de déterminer s'il existait une différence statistiquement significative dans l'incidence de l'infection à VIH entre les deux groupes de volontaires.

Le nonoxynol-9 est un spermicide utilisé dans des produits contraceptifs ainsi que comme composante complémentaire dans le lubrifiant des méthodes mécaniques de prévention de la contraception, comme le préservatif masculin.

Les microbicides sont des substances chimiques – sous forme de gels, de crèmes, de suppositoires ou de films – qui, lorsqu'elles sont appliquées par voie vaginale ou rectale avant le rapport sexuel tuent les virus et les bactéries. L'essai d'efficacité à grande échelle, connu sous le nom d'essai de Phase III, parrainé en commun par l'ONUSIDA et les Columbia Laboratories aux Etats-Unis, a été initialement financé en 1995 par le Programme mondial de Lutte contre le SIDA de l'Organisation mondiale de la Santé, puis par l'ONUSIDA dès 1996.

Note à l'intention des rédacteurs :

- Coordonnateur de l'essai : Dr Lut Van Damme, de l'Institut de Médecine tropicale d'Anvers, Belgique.
- Sites de l'essai : Abidjan (Côte d'Ivoire), Cotonou (Bénin), Durban et Johannesburg (Afrique du Sud), Hat Yai et Bangkok (Thaïlande).
- Principaux investigateurs :
    - Abidjan – Dr Virginie Traoré
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    - Cotonou – Dr Michel Alary
    - Hat Yai – Dr Verapol Chandeying
    - Durban – Dr S Salim Abdool Karim
    - Johannesburg – Dr Helen Rees
- Les données étaient centralisées au Centre Hospitalier Affilié de Québec, Pavillon Saint-Sacrement, Québec, Canada. Statisticien de l'étude : Dr Benoît Masse.

Pour plus de renseignements, veuillez contacter Anne Winter, ONUSIDA, Salle de presse, Durban, (+27 31) 332.2031, téléphones mobiles (+41 79) 213.4312 et (+27 82) 858.0891, Dominique De Santis, ONUSIDA, Genève, (+41 22) 791.4509 ou Michel Aublanc, Conseils Relations Presse, Paris, 01.69.286.286, téléphone mobile 06.08.719.795. *Pour en savoir davantage sur le Programme, consulter l'Internet (http://www.unaids.org).*

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"While the incidence of HIV infection in both groups in this study was lower than that seen in the untreated population from which volunteers were recruited, it is clear that the rate of infection was greater with the N-9 gel compared to its placebo control preparation," Dr Perriëns added. "Despite these results, we have lost a battle, not the war. We know N-9 is not the answer – so we need to continue our search."

As a result of the trial, UNAIDS is calling for an acceleration of the introduction of new more promising microbicides into large-scale Phase III trials. "A microbicide can allow women to protect themselves and their partners from infection without necessarily having to secure male cooperation," said Awa Coll-Seck, Director of Policy, Strategy and Research for UNAIDS. Three products currently in advanced safety testing in women could be available for inclusion in combined safety/efficacy evaluation within months, and the safety testing of a further 10 products, including two antiretrovirals, should also be accelerated. Ten public agencies are currently members of the International Working Group on Microbicides working on microbicide development. These efforts, however, lack adequate funding.

Meanwhile, UNAIDS believes that women at high-risk of HIV infection should not use N-9, given that the bulk of the data now suggests that it is either ineffective or harmful as an anti-HIV agent.

The study was conducted as a triple-blind multicentre trial among female sex workers. Women were chosen at random from volunteers who were informed of the risks and who agreed in writing to take part in the tests. They benefited from condom promotion, free condoms and free treatment of sexually transmitted infections. Test sites were located in Benin, Côte d'Ivoire, Thailand and South Africa.

The main objective of the study was to determine whether there was a statistically significant difference in the incidence of HIV infection between the two groups of women.

Nonoxynol-9 is a spermicidal agent used in contraceptive spermicide products and as a complementary component in the lubricant of barrier methods of contraception, such as the male condom.

Microbicides are chemical substances – in the form of gel, cream, suppository or film – which kill viruses and bacteria when applied vaginally or rectally before sexual intercourse. The large-scale efficacy trial, known as a Phase III trial, was sponsored jointly by UNAIDS and US-based Columbia Laboratories. It was initially funded by the World Health Organization's Global Programme on AIDS in 1995, and by UNAIDS from 1996.

Note to Editors:

- The Trial Coordinator was Dr Lut Van Damme of the Institute of Tropical Medicine in Antwerp, Belgium.
- The trial sites were: Abidjan (Côte d'Ivoire), Cotonou (Benin), Durban and Johannesburg (South Africa), Hat Yai and Bangkok (Thailand).
- Principal Investigators were:
  - Abidjan – Dr Virginie Traoré
  - Bangkok – Dr Pachara Sirivongrangson
  - Cotonou – Dr Michel Alary
  - Hat Yai – Dr Verapol Chandeying
  - Durban – Dr S Salim Abdool Karim
  - Johannesburg – Dr Helen Rees
- The data centre was Centre Hospitalier Affilié de Québec, Pavillon Saint-Sacrement, Quebec City, Canada. Study Statistician: Dr Benoit Masse

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JOINT UNAIDS/WORLD BANK PRESS RELEASE

AIDS HINDERING ECONOMIC GROWTH, WORSENING POVERTY IN HARD-HIT COUNTRIES

Durban, South Africa, 11 July 2000 – HIV/AIDS is already starting to have immense impact on the economies of hard-hit countries, hurting not only individuals, families and firms, but also significantly slowing economic growth and worsening poverty, according to new research presented here at a meeting of economists at the XIII International Conference on AIDS here.

There is growing evidence that in the hardest hit countries of Southern Africa, national wealth will be reduced by 15-20 percent over the next ten years as a result of HIV/AIDS.

Lower economic growth and increased poverty threaten to form a vicious cycle, in which HIV/AIDS drives many families into deepening poverty, and at the same time poverty accelerates the spread of HIV.

"Breaking this cycle will require not only greatly increased investments in more effective HIV prevention and care, but also more effective measures to combat poverty," said Robert Hecht, UNAIDS Associate Director for Policy, Strategy and Research.

The large impact of AIDS on economic growth, and the close link between poverty and AIDS, were among the findings emerging from a two-day symposium of the International AIDS Economics Network (IAEN), a global partnership backed by UNAIDS and the World Bank. The symposium, sponsored in part by Merck & Co. Inc, attracted nearly 100 economists from around the world who presented new evidence on economic aspects of the fast-moving epidemic.

"The world has never seen a problem of this magnitude," Callisto Madavo, World Bank Vice-President for Africa told the gathering. "We need to know more about the economic causes and consequences of the epidemic, and how donor countries and governments in the developing world can work together to prevent new infections and help people who are already ill."

Measuring the economic impact of the epidemic is difficult and controversial, since changes in Gross Domestic Product (GDP) do not reflect the suffering and loss caused by fatal illness. Some countries hard-hit by the epidemic, such as Botswana and Uganda, have sustained good rates of economic growth, lending support to the idea that despite the immense suffering that HIV/AIDS causes, it may not necessarily undermine overall economic progress.

But three new studies presented at the symposium suggest that high levels of HIV infection do significantly reduce growth, making it harder for countries to reduce poverty and to generate the resources needed to cope with the epidemic.

In South Africa, where an estimated 20% of the population is infected with HIV, researchers forecast that GDP will be 17 percent lower by 2010 than it would have been without AIDS. Individual families will also find their incomes reduced.

Another study in Jamaica and Trinidad and Tobago also warned that AIDS would significantly harm economic growth.

A study of diamond-rich Botswana, which has a 36% HIV prevalence rate – the highest in the world – warned that the country would face "a rapid increase in the number of very poor and destitute households in the coming decade." Although income from diamond exports would cushion the impact on GDP growth, per capita household income for the poorest quarter of all households is likely to fall by 13%, the study said.

One of the most profound impacts of the epidemic is the lasting damage done to poor children who are orphaned as one or both parents succumb to HIV. A study in Zambia found that 65% of the households in which the mother had died dissolved, with the children usually going to live with elderly female relatives who were themselves very poor and unable to provide adequately for their grandchildren.

As a result, these AIDS orphans were more likely to have to drop out of school and to have worse nutritional status than other children living in intact families. Lack of education and malnutrition would almost certainly condemn these orphans to poverty and social stresses when they grow to adulthood.

There was wide agreement that stemming the HIV/AIDS epidemic will require both more money and efforts to direct these funds to the most effective AIDS programmes. "Africa is burning," said Hans Binswanger, a World Bank economist who is playing a leading role in expanding the Bank's support for AIDS in Africa. "African governments and the international community need to act faster and on a massive scale to stem the epidemic", he said.

Before attending the economics symposium, the Bank's Vice President, Mr. Madavo, announced that the World Bank was developing a US$ 500 million fund to help African governments pay for expanded AIDS programmes. "Dealing with the epidemic requires money and commitment – and it also requires knowledge", he said at the Durban meeting. "We will be drawing on what you have learned in helping countries".

The articles presented at the symposium were selected from among 80 abstracts submitted in response to an IAEN call for papers. Ten of the authors are researchers from developing countries.

The articles are being revised based on comments from assigned discussants and are scheduled to be published in September 2000 in the South African Journal of Economics. The articles will also be available on the IAEN web site. For more information, see http://www.worldbank.org.

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COMMUNIQUE DE PRESSE DE L'ONUSIDA

SOUS EMBARGO JUSQU'A 17.30 GMT
Durban, 9 juillet 2000

LE DIRECTEUR D'ONUSIDA DEMANDE AU MOINS 3 MILLIARDS DE DOLLARS POUR LA PREVENTION ET LA PRISE EN CHARGE DU VIH EN AFRIQUE, SOIT PRES DE DIX FOIS LES MONTANTS ACTUELS

A L'OUVERTURE DE LA CONFERENCE INTERNATIONALE SUR LE SIDA A DURBAN, LE DR PETER PIOT, DIRECTEUR EXECUTIF DE L'ONUSIDA, DEMANDE UNE AUGMENTATION DES RESSOURCES

Durban, Afrique du Sud, 9 juillet 2000 – Selon le Dr Peter Piot, Directeur exécutif du Programme commun des Nations Unies sur le VIH/SIDA (ONUSIDA), il faut augmenter considérablement les montants destinés au VIH/SIDA, pour satisfaire les besoins les plus élémentaires en matière de prévention et de prise en charge en Afrique subsaharienne.

« Le déséquilibre croissant des ressources observé dans le monde est le moteur du VIH/SIDA en Afrique, » a déclaré le Dr Piot. « Il nous faut dans l'immédiat 3 milliards de dollars pour la prévention et la prise en charge les plus élémentaires en Afrique, sans même envisager la question des thérapies associées. Et ce chiffre, incroyablement, représente près de dix fois les dépenses d'aujourd'hui. »

Dans sa déclaration à la Cérémonie d'ouverture de la XIIIème Conférence internationale sur le SIDA, ici aujourd'hui, le Dr Piot a demandé aux gouvernements des pays touchés de l'Afrique subsaharienne, aux gouvernements donateurs et aux autres secteurs importants, y compris le monde des affaires, d'augmenter de manière spectaculaire les ressources destinées à la prise en charge et à la prévention du VIH/SIDA en Afrique subsaharienne. Le Dr Piot a noté que plusieurs pays développés dans le monde avaient récemment accru leurs contributions pour s'attaquer à l'épidémie mondiale, mais a ajouté qu'il fallait faire bien davantage encore.

Le Dr Piot a également demandé instamment aux gouvernements des pays les plus riches de la planète d'annuler la dette d'un grand nombre des nations africaines les plus touchées, afin qu'une partie des milliards de dollars employés aujourd'hui au service de la dette puisse être consacrée aux soins de santé et à la prévention du VIH/SIDA. Plusieurs des pays dont la dette extérieure est la plus élevée figurent aussi parmi les pays les plus touchés par le VIH/SIDA et les économies réalisées sur le service de la dette pourraient être consacrées à des programmes de fourniture de soins et de réduction de la transmission du VIH. Le Dr Piot a fait observer que les pays africains remboursaient chaque année aux pays les plus riches du monde 15 milliards de dollars pour le service de la dette, alors que la totalité des dépenses intérieures et internationales sur le SIDA en Afrique dépassaient à peine 300 millions de dollars.

« Ce tragique déséquilibre des ressources coûte des millions de vie chaque année, » a déclaré le Dr Piot.

« Les efforts actuels sont tout simplement insuffisants. Le monde entier doit en faire davantage. »

Cette année, pour la première fois, la Conférence internationale sur le SIDA se déroule en Afrique, où les taux d'infection à VIH chez l'adulte dépassent 25% dans plusieurs pays. Il y a une semaine, l'ONUSIDA a publié un rapport mondial sur l'épidémie, qui précise que dans les nations africaines les plus touchées comme le Botswana, jusqu'à deux adolescents de 15 ans sur trois peuvent s'attendre à décéder du SIDA.

En Afrique subsaharienne, la région la plus lourdement frappée par le SIDA, on a compté, en 1999, 4 millions de nouvelles infections à VIH et l'épidémie continue à se propager. Le SIDA tue aujourd'hui chaque année dix fois plus de personnes que la guerre sur le continent africain. Dans ce contexte, les activistes, les scientifiques et les responsables politiques se sont réunis à Durban entre le 9 et le 14 juillet, afin de trouver les moyens de ralentir la propagation de l'épidémie et de rompre le silence qui l'entoure.

La lutte contre la stigmatisation liée au VIH/SIDA au coeur des discussions de la Conférence

Une conférence de presse de l'ONUSIDA qui a également eu lieu ici aujourd'hui, a exposé les stratégies susceptibles de lutter contre la stigmatisation qui s'attache au VIH/SIDA. La stigmatisation est responsable d'une grande partie des ravages causés par le SIDA et le thème de la Conférence de Durban est « Rompre le silence ». De nombreuses personnes infectées par le VIH sont confrontées à la discrimination de leurs collègues, de leurs amis, et parfois de leurs proches. Il leur arrive de perdre leur foyer ou leur travail et certains ont même été assassinés. Le déni marche main dans la main avec la discrimination et il est encore fréquent que les gens nient l'existence du VIH dans leurs communautés. Cette attitude empêche les personnes infectées de demander des soins et entrave les discussions franches qui aideraient la population à prendre des mesures préventives.

« A l'aube d'un nouveau millénaire dominé par l'incontestable destruction provoquée par ce virus, la conférence SIDA 2000 se centrera sur la nécessité de continuer à abattre les préjugés et les obstacles qui entravent la mise en place d'une riposte efficace, » a déclaré le Professeur Hoosen Coovadia, Président de la Conférence. « Dans ce forum ouvert, nous chercherons ensemble les moyens d'appeler l'attention du public, des gouvernements et des organisations internationales sur l'urgence du défi consistant à s'attaquer pleinement aux questions de soins de santé, de politiques sociales, de recherche et d'économie liées au VIH/SIDA. »

« Le silence entourant le VIH/SIDA dans le monde est fondé sur l'ignorance, la crainte et le déni. Si une partie de ce silence a été rompu, le monde connaît encore trop d'ignorance et de crainte, qui pourraient être levées si nous jouons tous le rôle qui nous est dévolu, » a déclaré Shaun Mellors, Coordonnateur communautaire de la Conférence.

Alors que le VIH est principalement transmis, partout dans le monde, par les comportements sexuels, le sexe et les infections sexuellement transmissibles demeurent des sujets tabous. Cependant, l'ONUSIDA a relevé des signes prometteurs, car de plus en plus d'individus et de responsables politiques s'expriment ouvertement. Plusieurs chefs d'Etat ont commencé à parler publiquement du SIDA, rompant le silence et montrant l'exemple. Mais le silence demeure la règle, pour le moins dans la vie de tous les jours.

Parmi les autres participants à la conférence de presse d'aujourd'hui se trouvait Fezeka Kuzwayo, l'une des rares personnes sur les 4,2 millions d'individus vivant avec le VIH en Afrique du Sud à avoir publiquement parlé de sa maladie.

Pour plus de renseignements, veuillez contacter Anne Winter, ONUSIDA, Salle de presse, Durban, (+27 31) 332.2031, téléphones mobiles (+41 79) 213.4312 et (+27 82) 858.0891, Dominique De Santis, ONUSIDA, Genève, (+41 22) 791.4509 ou Michel Aublanc, Conseils Relations Presse, Paris, 01.69.286.286, téléphone mobile 06.08.719.795. Pour en savoir davantage sur le Programme, consulter l'Internet (http://www.unaids.org).

PRESS RELEASE

UNDER EMBARGO UNTIL 17.30 GMT
Durban, 9 July 2000

UNAIDS DIRECTOR CALLS FOR MINIMUM US$ 3 BILLION FOR HIV CARE AND PREVENTION IN AFRICA, NEARLY TEN TIMES CURRENT SPENDING

DR PETER PIOT, EXECUTIVE DIRECTOR OF UNAIDS, CALLS FOR INCREASED RESOURCES IN OPENING SESSION OF INTERNATIONAL AIDS CONFERENCE IN DURBAN

Durban, South Africa, 9 July 2000 – Spending on HIV/AIDS must be dramatically increased in order to meet even the most basic care and prevention needs in sub-Saharan Africa, according to Peter Piot, Executive Director of the United Nations Joint Programme on HIV/AIDS (UNAIDS).

"The increasing global imbalance in resources fuels the fire of HIV/AIDS in Africa," said Dr Piot. "Right now, US$ 3 billion is needed for basic care and prevention in Africa -- before we even consider the issue of combination therapy. Incredibly, this figure is almost ten times what is being spent today."

In remarks delivered today at the Opening Ceremony of the XIII International AIDS Conference here, Dr Piot called upon the governments of affected countries in sub-Saharan Africa, donor governments, and other important sectors, including business, to dramatically increase the resources dedicated to HIV/AIDS care and prevention in sub-Saharan Africa. Dr Piot noted that several developed world nations have recently increased their contributions to address the global epidemic, but said that much more remains to be done.

Dr Piot also urged the governments of the world's wealthiest countries to cancel the debt of many of the hardest hit African nations, so that some of the billions of dollars now spent on debt service can be dedicated to health care and HIV/AIDS prevention. Many of the countries with the highest overseas debt are also among the most severely affected by HIV/AIDS, and debt service savings could be used for programs to provide care and reduce HIV transmission. Dr Piot noted that African countries pay the world's richest nations $15 billion in debt repayment every year, while the total domestic and international spending on AIDS in Africa barely tops $300 million.

"This drastic imbalance in resources is costing millions of lives a year," said Dr Piot. "Current efforts are simply inadequate. The entire world must do more."

This year's International AIDS Conference is being held for the first time in Africa, where adult HIV infection rates top 25% in several nations. Last week, UNAIDS released a global report on the

epidemic that stated that as many as two out of three15-year-olds in the hardest hit African nations, such as Botswana, are expected to die of AIDS.

In sub-Saharan Africa, the region hardest hit by AIDS, there were 4 million new HIV infections during 1999 and the epidemic continues to spread. AIDS now kills ten times more people a year than war on the African continent. Against this backdrop, activists, scientists and political leaders have gathered in Durban from 9-14 July to find ways to slow the epidemic's spread and to break the silence that surrounds it.

Conference Focuses on Addressing and Combating the Stigma of HIV/AIDS

A UNAIDS press conference also held here today addressed strategies to combat the stigma attached to HIV/AIDS. Stigma is blamed for much of the harm caused by AIDS, and the Durban conference theme is "Break the Silence." Many people infected with HIV face discrimination from colleagues, friends, and at times loved ones. They may lose their homes or jobs, and some have even been killed. Denial goes hand in hand with discrimination, and many people deny that HIV exists in their communities. This prevents those infected from seeking care and hampers open discussion that could help people take preventive action.

"As we stand on the threshold of a new millennium overshadowed by the real destruction caused by this virus, AIDS 2000 will focus on the pressing need to further break down the prejudices and barriers that prevent the full development of an effective response," said Professor Hoosen Coovadia, Conference Chair. "In the spirit of an open forum, we will look collectively for ways to bring the attention of the public, governments, and international organizations to the urgent challenge of fully addressing HIV/AIDS in health care, social policy, research and economic issues."

"The global silences on HIV/AIDS have been based in ignorance, fear, and denial. Although some of these silences have been broken, the world is still surrounded by far too much ignorance and fear, which could so easily be changed if we all play our part," said Shaun Mellors, Conference Community Coordinator.

While HIV is primarily spread globally through sexual behaviour, the subjects of sex and sexually transmitted infections remain taboo. Still, UNAIDS has noted hopeful signs that more individuals and political leaders are speaking out. A number of heads of state have begun speaking publicly about AIDS, breaking the silence and leading by example. But silence usually remains the rule, at least in everyday life.

Another of the speakers at today's press conference was Fezeka Kuzwayo, one of the few of South Africa's 4.2 million individuals living with HIV who has spoken publicly about her disease.

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UNAIDS PRESS STATEMENT

UNAIDS WELCOMES OFFER BY BOEHRINGER INGELHEIM TO OFFER NEVIRAPINE FREE OF CHARGE TO DEVELOPING COUNTRIES FOR PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV

STATEMENT BY PETER PIOT, EXECUTIVE DIRECTOR, UNAIDS, IN DURBAN, SOUTH AFRICA, ON THE EVE OF THE XIII INTERNATIONAL CONFERENCE ON AIDS

Durban, South Africa, 7 July 2000 – "Boehringer Ingelheim's offer is a significant development in helping to make the prevention of mother-to-child transmission of HIV a reality in the developing world. While more needs to be known and done before nevirapine can be safely administered on a wide scale in many countries, this offer holds out great hope for many millions of women. "

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Boehringer Ingelheim

Press Release

Boehringer Ingelheim Offers VIRAMUNE® (nevirapine) Free of Charge to Developing Economies for the Prevention of HIV-1 Mother-to-child Transmission

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Ingelheim, 7 July 2000 – Boehringer Ingelheim announced today that VIRAMUNE® will be offered free of charge for a period of five years for the prevention of mother-to-child transmission (MTCT) of HIV-1 in developing economies.

This initiative is part of Boehringer Ingelheim's commitment to the collaborative effort with five companies (Boehringer Ingelheim, Bristol-Myers Squibb, F. Hoffman-La Roche, Glaxo Wellcome and Merck & Co., Inc.), United Nations agencies (World Health Organisation (WHO), World Bank, UNICEF, UNFPA and UNAIDS) and committed governments to explore practical ways of working together to make HIV/AIDS care available and affordable to a significantly greater number of people in developing countries.

"VIRAMUNE can fill a critical need in the developing world," said Prof Rolf Krebs, Vice Chairman of the Board of Managing Directors at Boehringer Ingelheim. "We hope that our initiative for the prevention of mother-to-child transmission will help make an impact on the HIV/AIDS epidemic."

A recent publication in the June 17 issue of *The Lancet* presents hope for reducing newborn HIV infections in the developing world.[1] Findings indicated that antiviral intervention can have a significant impact on the prevention of MTCT. Researchers projected that if all pregnant women in South Africa took a short course of antiretroviral medication during labor, as many as 110,000 infant HIV infections could be prevented over the next five years.

Authors of *The Lancet* article cited that a single dose of VIRAMUNE to mother-baby pairs is likely the most cost effective, efficacious and most easily administered antiretroviral agent for the prevention of MTCT to date. Researchers have been investigating the drug since 1997 for this important use. The outcome of these investigations encouraged the WHO to place VIRAMUNE on its Model List of Essential Drugs for MTCT in December 1999.

- more -

Boehringer Ingelheim

"Viramune, which has been studied in women in Uganda and South Africa, holds great promise for reducing mother-to-child HIV transmissions in the developing world because it represents a short and simple regimen, which can be easily administered in a resource-poor environment," said Dr. Brooks Jackson, principal investigator, HIVNET 012, Johns Hopkins University, Baltimore.

Boehringer Ingelheim will adhere to the WHO guidelines for drug donations to ensure that VIRAMUNE is donated to the developing countries with the greatest need. The WHO guidelines require that donations be based on an expressed need by the country in question. Further, donations must be relevant to the needs of the recipient country. Boehringer Ingelheim will rely on interested local governments that approve the use of VIRAMUNE in MTCT and global organisations, such as UNAIDS, UNICEF and the WHO to optimise existing infrastructures so that safe and proper administration of VIRAMUNE is possible.

Boehringer Ingelheim will make every effort to see that VIRAMUNE is available in every country around the world. VIRAMUNE has now been registered in more than 75 countries and registration packages have been submitted in almost every country worldwide.

"Providing Viramune is only one component of making prevention of HIV-1 mother-to-child transmission possible in the developing world," said Prof. Krebs. "However, a successful program to reduce MTCT of HIV entails additionally education of mothers and health service personnel, testing for infection, and counseling of infected mothers-to-be."

VIRAMUNE was shown to be a well-tolerated and effective option for the prevention of MTCT in the Ugandan HIVNET 012 trial.[2] The study was published in the September 4, 1999 issue of *The Lancet* and demonstrated that a simple regimen of one oral dose of VIRAMUNE given to an HIV-infected mother in labour and another dose to her newborn within three days of birth was almost twice as effective in reducing MTCT as a short course of zidovudine (AZT).

To date about 1700 mothers and babies have been treated with the simple one-dose treatment regimen of nevirapine in MTCT and no safety concerns have been raised. While there are still scientific questions to be answered, the overwhelming opinion of experts is strongly in favour of treatment.

Boehringer Ingelheim

The company acknowledges the importance of continued research into the role of VIRAMUNE in preventing MTCT. Boehringer Ingelheim is sponsoring the SAINT study, a large, multicenter trial designed to further evaluate the safety and efficacy of two doses of VIRAMUNE compared to a weeklong regimen of two drugs, ZDV+3TC, in reducing MTCT. Preliminary results of this study, as well as twelve-month HIVNET 012 data, will be presented at the 13th International AIDS Conference in Durban, South Africa (9 – 14 July).

A critical area of research into the prevention of MTCT is the extent to which HIV is transmitted during breastfeeding. Healthy babies born to HIV-infected mothers may contract HIV through breastmilk. This risk appears to be highest in the early months of breastfeeding.[3]

Another critical area of research is the development of drug resistance after treatment. An abstract presented at the 7th Conference on Retroviruses and Opportunistic Infections (HINVET 006) suggests that a minority of patients may develop resistance to VIRAMUNE after a single dose.[4] At least in some patients this resistance is transient.[5] Further studies are evaluating the clinical relevance of these findings.

VIRAMUNE has been investigated for the MTCT indication because of its potency, pharmacokinetic profile and affordability. VIRAMUNE is rapidly absorbed and transferred across the placenta to the infant and is passed into breast milk. VIRAMUNE can be stored at room temperature, an important consideration in developing countries.

VIRAMUNE is registered for the chronic treatment of HIV-1 infection in combination with other antiretroviral agents. Major adverse events associated with VIRAMUNE in the treatment of chronic HIV infections are rash and increases in liver function enzymes. Hypersensitivity reactions have also been observed. Severe and life-threatening skin reactions and hepatotoxicity, with fatal outcome, have occurred in chronically infected HIV patients treated with VIRAMUNE.

VIRAMUNE was the first member of the non-nucleoside reverse transcriptase inhibitor (NNRTI) class of anti-HIV drugs to be approved for combination HIV therapy. VIRAMUNE's approval is based on analysis of changes in surrogate end-points, such as reduction in viral load or increases in CD4+ cell count. VIRAMUNE should always be administered in combination with other antiretroviral agents.

Boehringer Ingelheim

VIRAMUNE is a product of original research done at Boehringer Ingelheim Pharmaceuticals, Inc., a member of the Boehringer Ingelheim group of companies. VIRAMUNE is marketed world-wide by Boehringer Ingelheim and in the United States by Roxane Laboratories, also a member of the Boehringer Ingelheim group of companies. Boehringer Ingelheim recently acquired world-wide marketing rights to an additional anti-HIV drug, an investigational protease inhibitor, tipranavir.

Boehringer Ingelheim has focused a number of years on HIV drug research to prevent new infections and to treat HIV-infected people around the world. In addition to high investments in research and development and sponsoring initiatives (such as to the Elizabeth Glaser Pediatric AIDS Foundation), Boehringer Ingelheim supports training initiatives for the developing world as a partner of the IAS-SHARE Treating Program for Physicians.

For more information on Boehringer Ingelheim or VIRAMUNE, please see www.boehringer-ingelheim.com.

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The Washington Times
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U.N.: AIDS being spread by its peacekeepers

Betsy Pisik
THE WASHINGTON TIMES

Published 7/7/00

NEW YORK — The U.N. Security Council, under pressure from the United States, said Thursday that U.N. peacekeepers are spreading the AIDS virus.

"Six months ago, countries didn't want to have a discussion on AIDS," said U.S. Ambassador Richard C. Holbrooke. "Today, we have been told by every member of the Security Council that they are ready to go with this."

Mr. Holbrooke cited cases in which Finnish soldiers had brought the virus home after peacekeeping tours.

The United Nations currently has some 38,000 peacekeepers engaged in 14 missions around the world, not including locally hired staff. They are often sent to places where prostitution is openly practiced.

The United Nations currently issues one condom per day to peacekeepers and urges them not to patronize brothels or engage in sexual activity that is not locally permitted.

A U.S.-sponsored resolution calls on the U.N. Department of Peacekeeping Operations, or DPKO, to train all peacekeepers on how to block the spread of HIV, the virus that causes AIDS.

The resolution also urges troop-contributing nations to offer comprehensive education, counseling and HIV testing for all members of the armed services.

Some were unimpressed by the latest U.N. move.

"They're just printing up a bunch of pamphlets," said one Western envoy of the latest attempt to halt the proliferation of AIDS by peacekeepers.

There are no hard statistics about the rates of infection or transmission, but many of the U.N. troops come from nations where the disease is already rampant and introduce it in local populations.

Separately, Mr. Holbrooke announced a $10 million item in the this year's Defense Department budget to underwrite AIDS-related programs for foreign soldiers and the United Nations. The money must still be approved by Congress.

"This resolution is not solely addressed to Africa and it is not addressed solely to U.N. peacekeepers, but by definition that is where the bulk of the problems we're addressing today lie," Mr. Holbrooke said.

"AIDS is spread in so many different ways by so many different people. Sometimes, people bring it to regions; sometimes, they take it with them."

This is not the first time the council has sought to address peacekeepers' role in spreading of the AIDS virus.

Beginning in February, the council began adding a boiler-plate paragraph to every peacekeeping resolution "encouraging efforts by the United Nations to sensitize peacekeeping personnel in the prevention and control of HIV/AIDS and other communicable diseases in all its peacekeeping operations."

Mr. Holbrooke was careful to note that the resolution, which could come to a vote early next week, grew out of the council's January session on HIV/AIDS. At the time, the world body for the first time labeled the AIDS epidemic a threat to global peace and security.

At the time, Mr. Holbrooke defended the expansion of the council's agenda, convincing reluctant governments that AIDS could be a security threat.

"You can't cordon off a continent," he said Thursday.

In the U.S. military, AIDS testing is mandatory upon entering the service and before deployment

overseas.

Mr. Holbrooke said that those who test positive for HIV are not deployed, but held back for treatment.

Not every country is as wealthy as ours, he said, nor can the Security Council order mandatory testing, because it exceeds the authority of the United Nations.

"That is not something U.N. can obligate member states to do," he said.

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Disease Spread Faster Than the Word

By Karl Vick
Washington Post Foreign Service
Friday , July 7, 2000 ; A01

Last of three articles

MASOGO, Kenya — Andrecus Miruka was a son of the lake. Born in his father's house not 20 miles from Lake Victoria, he spent the years before the plague aboard a steamship, ferrying freight across the heart of Africa and passengers from Kenya to Tanzania to Uganda and back. There were women among the men, but if at times the decks of the MV Victoria thrummed with more than the power of diesel, it still meant life.

By the time the ship's pilot retired to the town of Masogo in 1992, the virus was already there. But Miruka, who relishes his role of protector--his black cane holds a concealed saber--saw no threat. It was a routine matter when a cousin named Hezron fell ill, his body erupting with boils and diarrhea. Miruka paid an elder of his tribe, the Luo, to conduct a traditional diagnosis involving thrown shells.

When the "Luo X-ray" came up blank, Hezron was carried to the provincial hospital. The doctors diagnosed one thing but told the family another--"typhoid," they said--before sending Hezron home to die. In 1997, when his widow fell ill, the real diagnosis was finally shared: AIDS.

It was a word Miruka had first heard in 1990. But only now, most of a decade later, could he bind it to the suffering he had been seeing in the huts around his birthplace every year since. And with understanding, there was hope for change.

"For me, I learned about it and immediately set about mobilizing the community," said Miruka, 63. "I didn't keep quiet about that message."

In wealthier parts of the world, information is an industry, a commodity available with such speed and abundance that the word defines the age. But in sub-Saharan Africa, where 71 percent of the world's HIV-infected population lives and which has contributed 61 percent of the lives sacrificed to AIDS, information provides more than context for the disease. In places without money or medicine to fight back--almost all of Africa--it is the whole story.

In Masogo, information that might save lives came to local leaders almost 20 years into the epidemic. From the town's dilapidated health center, useful knowledge about AIDS took four more years to travel three miles down a gravel road worn smooth on the shoulder by the constant traffic of bicycle taxis.

But by then, an estimated 30 percent of the local population had HIV, the virus that causes AIDS. The most recent U.N. statistics predict that, across Kenya, half of the girls who turn 15 this year will be infected with the virus during their lifetimes. Here among the Luo, the second largest of Kenya's tribes, that projection reaches 70 percent.

How those most at risk for AIDS were left in the dark for so long is not a question that preoccupies the people here. They say without apparent resentment that they are accustomed to being overlooked.


Mourners stand by a grave following the funeral of a suspected AIDS victim. An African funeral traditionally takes place on Saturdays, but so many were dying of AIDS by the late 1990's that communities were forced to bury every day of the week. Malcolm Linton - Liason

But the nature of their isolation is crucial to understanding how Africa has been left to die alone. When the history is written of what the people on the eastern shore of Lake Victoria long knew only as maduong, or "the big disease," the chapter on outside intervention--from the Kenyan government, from Western countries that had arrested the disease at home--will be remarkably short.

In the neglected countryside where the vast majority of Africans reside, the virus encountered nothing so much as opportunity. It fell to local communities to conjure a way to confront an enemy that was hard to identify, and even then could hide in a thicket of fear and the most intimate aspects of human behavior.

"We were the first ones," Miruka declared of local elders' efforts to raise the belated alarm. "We were the pioneers."

Armed with the information that might save his neighbors' lives, Miruka repeated it wherever people gathered: storefronts, schoolyards, shade trees. But by then, the best place to spread the word was funerals.

Remote From the Truth

The main street of Masogo is like a movie set: a line of shops, and nothing behind. Communities in Africa are not towns but strolls. One finds a cluster of huts beside a field of maize bordering a meadow that gives onto four more huts, all linked by looping footpaths, the webbing that binds the continent.

One day last month, Domtila Awino, wife No. 3 in Miruka's polygamous household, strode purposefully down the path from her house, across the Nyando River bridge and above the children bobbing naked in the brown water. Twenty minutes later she was seated on a wooden stool beside a man who was barely alive. Joseph Oloo, 38, had been ill since December. Both of his wives and three of their five children are already dead. "This lady," he said in a breathy voice, "is the only one who comes."

It's her job, Awino said. Last November she was trained as a "community health worker," sitting for a week in hotel conference rooms, learning the basics about the disease that killed her brother. The training was funded by the British government, through an aid agency called Futures Group International, in partnership with Kenya's Ministry of Health. The ministry maintains clinics throughout the nation of 30 million. It also has programs devoted to AIDS. But by all accounts, the two have not combined to much effect.

"I blame--because I'm the government--myself," said Jack Okeyo, a nurse at the Masogo health

center. Others look up the line to longtime President Daniel arap Moi, who until recently paid the epidemic only the passing mention that was the norm among African leaders. Only since October, when Moi declared AIDS a "national disaster," has his government begun to act with anything resembling urgency, health workers and officials say.

"When you have a government that's reluctant to say we have AIDS, you definitely have a late start," said Richard Odindo, who coordinates training for Futures.

Left to their own devices, people applied the knowledge they had. Among the Luo, there was a word for persistent diarrhea, rashes and weight loss. "Chira" was illness brought on by breaking the norms that have regulated community life for centuries. A wife beating her husband with a cooking stick invited chira. Likewise a boy who, older than 15, entered his mother's bedroom.

But chira could be cured. Between 1988 and 1993, Helida Owiti was summoned 15 times to the bedsides of people diagnosed with chira. The wizened grandmother is one of Masogo's traditional healers, and she knew what to do: Pour a bit of one herb into a calabash, mix it with a second herb, have the patient drink it.

"We were not succeeding," Owiti said. "People kept dying."

She learned why in 1993, when towns and cities suddenly featured billboards bidding, "Let's Talk," the slogan for a new condom called Trust. It was soon on sale almost everywhere at a mere 10 shillings (now about 7 cents) for a packet of three, a price heavily subsidized by Western donors. On main roads, other billboards advised in the local language that "AIDS is not Chira. AIDS is real."


Health worker Alfred Abande tests Teresa Ogwe for HIV at the Masogo Health Centre. Malcolm Linton - Liason

But the message went only so far. In Masogo, it went only as far as people like Owiti, who lived in the town proper. She was visited in person by a nurse from the local health center. The nurse explained the symptoms of AIDS, the mode of transmission and the terrible prognosis. After listening to the presentation, the old woman put away her herbs.

"We just waited for people to die," she said.

Andrecus Miruka, living in retirement not three miles away, would not get the same information for more than four years. Logistics was one reason: The Ministry of Health--which, like health authorities across Africa, relies almost entirely on foreign aid for capital purchases--had equipped Masogo's health center with neither a vehicle nor anyone assigned to roam the farms where almost everyone lived.

The other reason would be whispered by Owiti, the traditional healer, peering from beneath a wrinkled brow with a look of titillated embarrassment: "I didn't want to mention sex," she said.

Almost no one does in rural Africa. Traditional societies were generally conservative even before

missionaries arrived a century ago. Some AIDS experts complain that Christianity added a layer of shame to sex that made frank discussion that much more difficult.

"It's not that people stopped having sex, but they stopped talking about it," said Elizabeth Pisani, a medical demographer and consultant in Nairobi.

Certainly Miruka's eldest son, Bernard Otieno, held his peace when he returned from Nairobi. During five years in the capital, he had watched the epidemic emerge before him. During visits to the city's largest hospital, he heard as early as 1991 of an isolation ward. At the yarn factory where he worked, he saw a colleague who was considered a ladies' man grow thin and die a year later.

"That's when I realized that what I had been told at Kenyatta National Hospital was true," Otieno said. He feared for himself only until the risk factors were explained by a shop steward, in a welfare assembly called at the factory.

"The advantage of working in Nairobi was you get information quite fast," he said, "while in rural areas it takes quite some time for information to trickle down."

Yet when Miruka's son returned with his wife in 1993 to the family compound here, he kept what he had learned to himself. "It was difficult to tell if other people knew, because people did not want to talk about it," Otieno said.

Some of the reluctance was a matter of private fears kept private. Much, undoubtedly, was denial, which found a ready haven in chira, even though chira had never before been regarded as fatal.

But then what little was known about AIDS hardly invited association. Advertising campaigns targeted prostitutes and the men who used them. Ambrose Oungdha, 64, was apparently infected by a wife 30 years his junior, who died in 1998. The only man in Masogo known to have made his condition public, he said he is shunned by neighbors who answer his request for help with a question of their own: "Did we tell you to go out and get that disease?"

'We Bury Every Day'

In the silence, infections soared. No one knows where AIDS began, but researchers have traced the spread of the epidemic from Congo, the remote heart of Africa, eastward across the Great Lakes of Kivu, Tanganyika, Albert and Victoria.

In Kenya, the virus showed up first and most virulently on Victoria's eastern shore, where the Luo settled hundreds of years ago after traveling up the Nile from Sudan. Some of the customs that came with them would help AIDS along: Luo men are uncircumcised, a condition that in poor countries parallels increased risk of all sexually transmitted diseases. (In West Africa, where circumcision is far more common, there is a markedly lower AIDS rate.) The tribe also requires that a widow be wed to a relative of her late husband--a caretaking custom common across Africa, but practiced with particular strictness by the Luo.

The virus also created its own opportunities. Lake fishermen had always looked for female company after dragging their long, narrow boats ashore each morning. But only in recent years, after AIDS created widows with no other means of support, have women come down to the beach in numbers, trading sex for a portion of the catch.

"They call it 'extending the boat,' " said Jane Uwuor, a merchant in Usenge Beach.

By 1993, 20 percent of the residents of the area's large port city, Kisumu, tested positive for HIV. By

1998, the rate had galloped to 35 percent. Although rates varied widely, the same acceleration was seen across much of Africa, where 24.5 million people are estimated to carry the virus. In most places, because the disease can incubate in the body for more than 10 years, communities were slow to recognize how deeply it had settled in their midst.

"People don't believe anybody who hasn't got full-blown AIDS is infected," said Eric Otieng, a peer counselor.

The Luo saw the proof of the connection before most. So many in the tribe were infected in the early '90s that the approach of the millennium brought the reality home. The death toll of AIDS in Africa--5,500 a day, 2 million a year--became a family affair. While Andrecus Miruka's third wife watched her brother die, his second, Mary Anyango, lost two brothers, their wives, and four cousins.

And although the deaths were private, the burials were not. An African funeral is a major public occasion, a ritual of eulogy, burial, feasting and music that takes an entire day. Traditionally, that day is Saturday. But by the late '90s, so many were dying that "we bury every day of week," said Elijah Owaga, a Masogo minister.

People here say it was the explosion of funerals in the late 1990s that finally pushed AIDS into the open. As it happened, the first effective information campaign arrived in Masogo around the same time. With the British aid funds and a gifted local health worker named Alfred Abande, the Futures Group set about offering training on AIDS and other sexually transmitted diseases to a legion of community health workers.

The health workers, almost entirely women, were mostly midwives and traditional healers. They took what they learned into the homes around them--each assuming responsibility for 10 neighbors under the ambitious but geographically limited Futures plan. The agency even pays a stipend, though the women are urged to regard the $13 a month as temporary, and to generate income from chicken farms or other small trade that might sustain the program after the outside donor departs.

There are other compensations. The health worker positions carry a status that the women reinforced by sewing themselves uniforms of forest green. And to cement local support, "opinion leaders" were designated among the elders who retain significant authority even in a changing Africa. Miruka, named head of the Masogo panel, beams when he is called "chairman."

But if basic information on AIDS was, at long last, arriving in at least a few patches of western Kenya, there remained the question of what people would do with it. Infectious disease experts note with distress that the countries in Africa whose infection rates are among the highest--Botswana, Zimbabwe, South Africa--also boast the continent's best communication systems.

"The biggest gap is not in information," said Pisani, the medical demographer. "The biggest gap is turning that information into safer practice."

A little bit of knowledge, moreover, can be a dangerous thing. Along Kisumu's Beer Belt, a string of bars where commercial sex workers charge the equivalent of $2 for intercourse, health workers pressing the bar girls about condom use were stunned recently to hear this reply: Having heard that AIDS in Africa was a "heterosexual disease," the prostitutes had figured they could outfox the virus. They were offering customers unprotected anal sex--an extremely high-risk practice that spread the disease among gay men 20 years ago.

But there was also a hopeful precedent for changing behavior taking shape next door in Uganda. Ravaged by the disease in the early 1990s, the country was one of the first to launch an aggressive public education and prevention campaign. Led by President Yoweri Museveni, the abjectly poor country solicited foreign donors to support the effort. Although millions had perished, by the late '90s Uganda was the first African nation where the rate of new infections had declined. It became a model

for the continent.

In Masogo, leaders, at least, appeared to be getting the message. Besides wearing the tall white cap of his office, Owaga, the minister, also worked as a "trainer of trainers," responsible for teaching basic primary health care to other lay health workers in his division, population 66,220. But as recently as two years ago he was still too poorly grounded about AIDS to feel comfortable enough to help a woman deliver a child, out of fear that the contact might infect him.

"I came with much fear," Owaga said. "I had not been so much informed on modes of transmission and infection."

Finally, in September 1998, he spent days learning specifics at a government health seminar. It made all the difference.

"Now I'm eager" to meet AIDS patients, Owaga said. "I even look for them. I don't want my people to suffer. I'm fully trained. Before, I could be suspicious, even resist. Now I feel like somebody involved. Because of the training."

A Dying Custom

There are other encouraging signs. The condom dispenser at the Masogo health center needs refilling every morning. The message Miruka took to delivering at funerals against wife inheritance appeared to be sinking in: Seven widows in his area have remained unmarried.

And, at least in the town center, the flow of information has reached a point where Jael Achieng, a community health worker, asked an American visitor about antiretroviral drugs, the still-expensive medicines that are extending life indefinitely among AIDS patients in the West.

"Would you mind sending us those drugs?" she asked. "Because our people are dying so much."

Despite drug companies' promise this year to lower prices on some treatments for AIDS, the life-saving drugs that cost $11,000 a year in the United States are not likely to slip under the $17 per capita Kenya now budgets each year for health care.

As a practical matter, medical experts are more encouraged by the Kenyan government's decision to allow AIDS awareness to be taught in school. The emphasis must be on children, they say, because after 20 years running almost unchecked in Africa, the virus has a depressingly firm grip on the sexually active adult population.

And as the epidemic reaches ever farther into the countryside, Masogo nurse Jane Nam noted another advantage of concentrating on youth.

"Schools are very near," she said. "It is health centers that are far away."

Ogilo Primary School stands just a couple of hundred yards behind Miruka's compound, a long house made of the same resilient mixture of cattle manure and soil as the homes. In the eight grades taught inside, the government curriculum includes daily religious studies; teachers spend perhaps 20 minutes a year on AIDS.

"We are not teaching it," said Lawrence Onyango, a teacher. Only in the STD unit in science, taught before the oldest (and most sparsely populated) classes, is the virus mentioned. "And maybe the prevention measures," he added.

In his role as an elder, Miruka also comes by to talk to the younger kids outside class. But as a Catholic in a country where bishops have burned condoms in public, he refrains from any mention of prophylactics for fear that it would amount to encouraging sex. (However, "If the school is for it, I'm ready to tell the children," he said.)

The Luo, like many African cultures, traditionally provided sex education of sorts in the home. Even 20 years ago, Miruka's eldest son was called into his grandfather's hut after the old man figured out that he had a girlfriend. "He used to tell me to lead a moral life, a disciplined life," Bernard Otieno said. The chat included a warning about sexually transmitted diseases.

Girls approaching puberty would share sleeping huts with a grandmother. She would tell them how to behave, and perhaps how, if her avid cousins could report from the wedding night sheets that she had been a virgin, her mother would be showered with cooking ash in congratulations.

By the time Domtila Awino was bunking with her "old mama," morals had relaxed enough that a girl might slip out for a few hours. But she had had only one boyfriend before Miruka gave her parents the five cows and 500 shillings that sealed their union.

"That's a dying custom," said Alfred Abande, the health worker, smiling at the sight of two men driving three hump-backed cattle down a lane at dusk. The suit jackets over their arms mean they are on their way to the bride's house, to pay dowry. "Most couples just run off to the city now."

And by the time they marry, surveys show that they have had perhaps a dozen sexual partners between them.

'The End Days'

"We don't follow customs anymore," declared Moses Omondi, 20, one of six modishly dressed young men who were seated recently in the shade behind Miruka's compound. "We live in the current world."

The men, aged 17 to 32 and free at midday on a workday, each nodded when Omondi said he almost never uses a condom.

"It's very rare," said Eric Owino, 23. The reasons he recites echo those of the male teachers at the Ogilo Primary School. Myths about reliability. Objections from women. ("She says it means you don't trust her.") Most of all, the lack of sensation.

"And then there is this thing in the Bible, too," said Moses Mbeda, 18. "In the Bible they say these are the End Days, and there will be a disease that has no cure."

"I believe so," said Omondi, to more nods. "The end of the world is about to come."

It's a matter of selecting what you want to believe. If a dying person has not been tested for AIDS, maybe he has chira, Omondi said: "Because you are married and you did not follow the rules."

Such a possibility--that AIDS is really not killing us--can also ease the way at a funeral, which has proven to be another tradition of Luo life still honored among the young. After the burial and the feast, there's almost always music. It might be Luo benga, or reggae. But usually it's the Congolese rock that all of Africa seems to love--dance music, endless and hypnotic and almost all hips.

"You talk, you dance, and at the end you end up engaging in sex," Owino said. "You don't have a

condom. . . ." He shrugged. "Sometimes it's very hard to reverse nature."

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HIV Facts

AIDS has become the leading cause of death in sub-Saharan Africa, and 1,700 people are newly infected in South Africa alone every day.

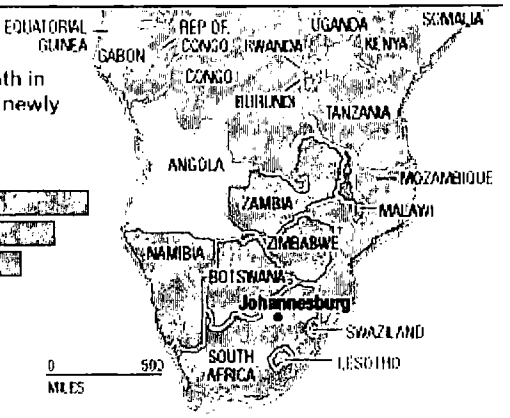
World

1. Heart disease	12.7%	
2. Cerebrovascular disease*	9.9	
3. Acute lower respiratory infections	7.1	
4. HIV/AIDS	**4.8**	
5. Chronic obstructive pulmonary disease	4.8	

Sub-Saharan Africa

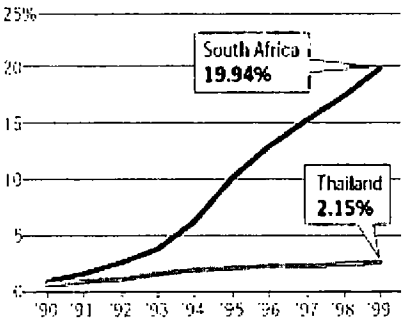
1. HIV/AIDS	**20.6%**	
2. Acute lower respiratory infections	7.1	
3. Malaria	9.1	
4. Diarrheal diseases	7.3	
5. Perinatal conditions	5.9	

*For example: stroke



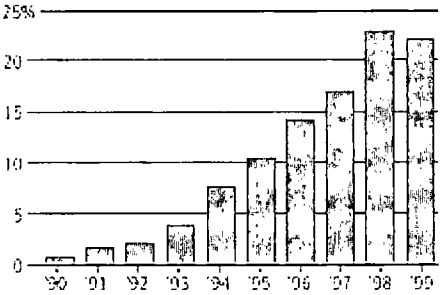
While the HIV infection rate was less than 1 percent in South Africa and Thailand in 1990, South Africa's has risen dramatically and is still growing . . .

Estimated HIV infection rate
As a percentage of adult population



. . . One indication that the epidemic is still growing is an increase in the number of women at prenatal clinics who test positive for HIV. It means their babies will likely be infected, too.

Estimated HIV infection rate among women attending prenatal health clinics in South Africa
As a percentage of women tested



SOURCE: UNAIDS, Center for the Study of AIDS, University of Pretoria
GRAPHICS BY DITA SMITH, RICHARD FURNO AND LAURA STANTON—THE WASHINGTON POST

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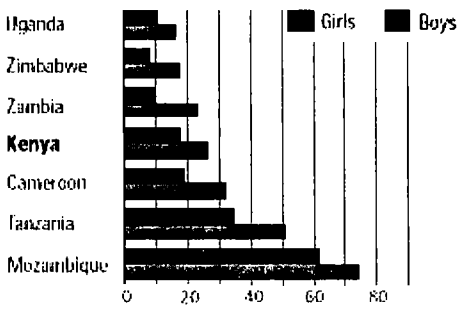
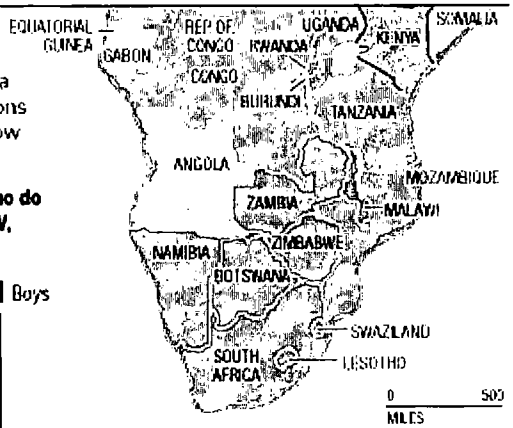
AIDS in Numbers

Almost no one in rural sub-Saharan Africa talks about sex, and in the silence, infections soar. Many young people do not know how to protect themselves.

Proportion of girls and boys aged 15 to 19 who do not know how to protect themselves from HIV, in percent of those asked



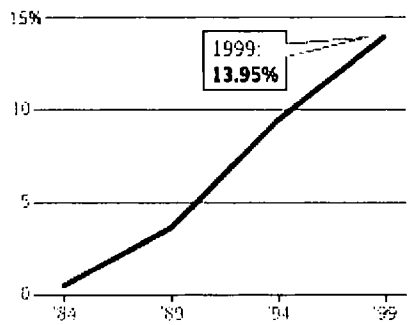


Adult HIV/AIDS infection rate

- 15 - 35%
- 5 - 15%
- 1 - 5%
- 0.5 - 1%
- 0.1 - 0.5%
- 0.0 - 0.1%
- not available

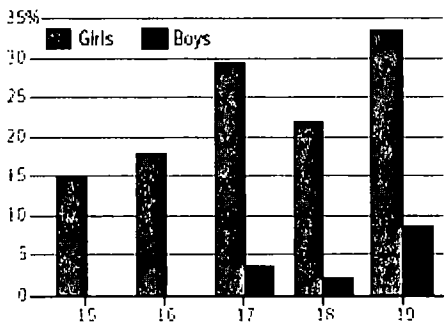
The HIV infection rate in Kenya has grown from below 1 percent 15 years ago to almost 14 percent now, and the rate is still growing. . .

Estimated HIV infection rate in Kenya, in percent of adult population



. . . One indication of the growth is that the infection rate among teenagers, particularly girls beginning their childbearing years, is high. They will likely pass the virus on to their babies.

Estimated HIV infection rate among teenagers in Kisumu, **Kenya,** by age



SOURCE: UNAIDS

GRAPHICS BY DITA SMITH, RICHARD FURNO AND LAURA STANTON—THE WASHINGTON POST

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AIDS in Numbers

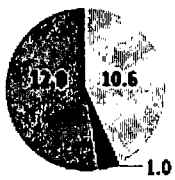
Women

In sub-Saharan Africa, a higher proportion of women than men live with HIV infection or suffer from AIDS. The infection rate is particularly high among girls.*

Number of people living with HIV/AIDS, in millions

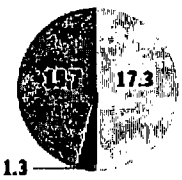
Women Men Children under 15

Sub-Saharan Africa



Total: 24.5 million

Worldwide



Total: 34.3 million

* Male to female infection is more likely than female to male, particularly among girls who are physically not fully developed. Also, young girls often have sexual relations with men in their 20s and 30s who often already are infected.

Deaths

5,500 people die of AIDS in sub-Saharan Africa every day—the equivalent of almost half the student body of Howard University or American University. By 2010, about 13,000 people will die daily of AIDS.

Sub-Saharan Africa Elsewhere

People who have died
since the start of the epidemic:

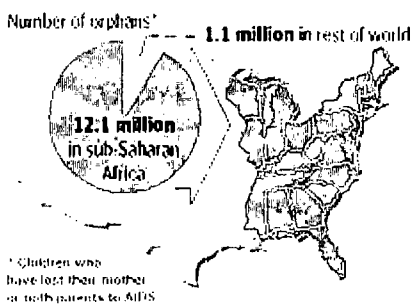
7.3 million | 18.8 million total

People now living with HIV/AIDS:

9.8 million | 34.3 million total

Orphans

AIDS has created 13.2 million orphans, most of them in sub-Saharan Africa. By 2010, UNAIDS estimates, there may be 42 million orphans—the number of children in the United States living east of the Mississippi.



Life expectancy

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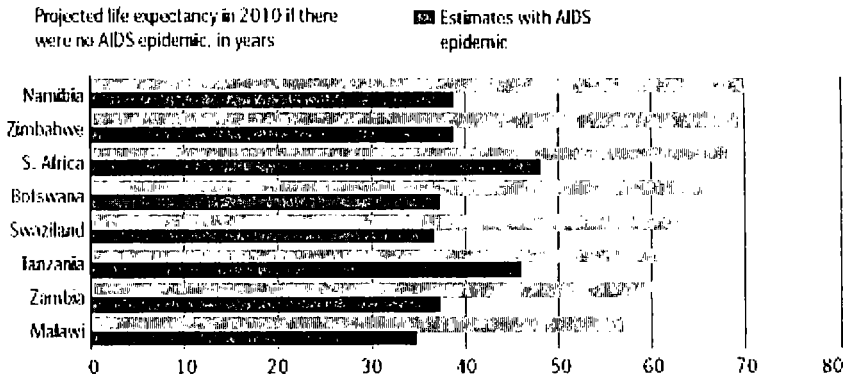
Life expectancy, already cut by AIDS in many sub-Saharan countries, is expected to fall further by 2010.



SOURCES: UNAIDS, staff reports

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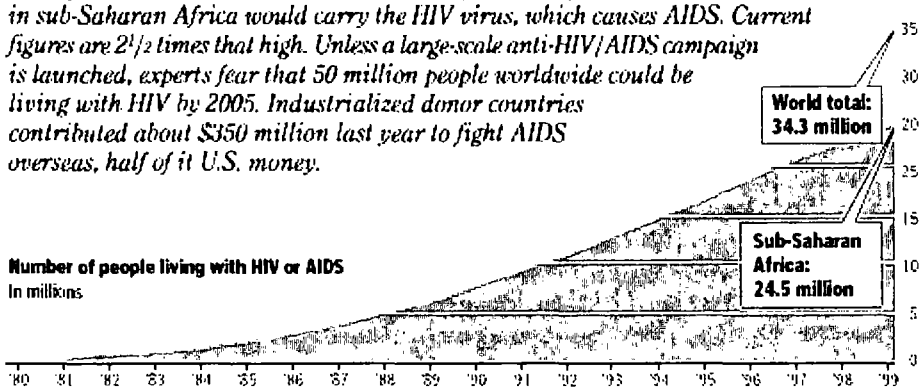
Waking Up to Devastation

U.N. epidemiologists predicted in 1991 that by the end of the decade, 9 million people in sub-Saharan Africa would carry the HIV virus, which causes AIDS. Current figures are 2½ times that high. Unless a large-scale anti-HIV/AIDS campaign is launched, experts fear that 50 million people worldwide could be living with HIV by 2005. Industrialized donor countries contributed about $350 million last year to fight AIDS overseas, half of it U.S. money.



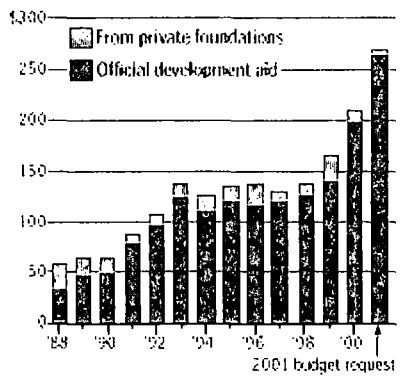
Cost of treatment

The U.N. AIDS office has estimated that at least $1 billion is needed to establish an effective HIV-fighting program in sub-Saharan Africa. U.N. epidemiologists estimate that it would cost between $1,400 and $4,200 a year per patient in sub-Saharan Africa to treat the infection and the disease effectively with antiretroviral drugs.

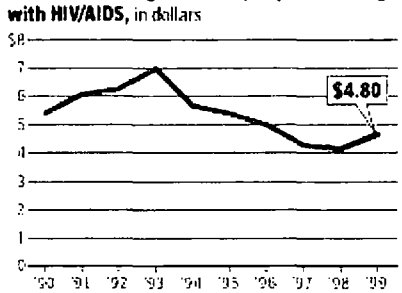
Funds available

In 1997, the United States spent $7 billion in development aid overseas, with $121 million of it going toward fighting AIDS. Only last year were appreciably more funds allocated. U.S. funds to fight the epidemic now make up about half of all donor nations' contributions.

U.S. funding to fight HIV/AIDS overseas and grants from private foundations, in millions of dollars



Total U.S. funding overseas per person living with HIV/AIDS, in dollars



SOURCES: UNAIDS, USAID, private foundations

NOTE: All infection rates are based on estimates. The vast majority of sub-Saharan Africans are never tested for HIV and do not know if they carry the virus. The only basis available to UNAIDS are tests from prenatal clinics and tests administered to people in high-risk categories, such as sex workers.

THE WASHINGTON POST

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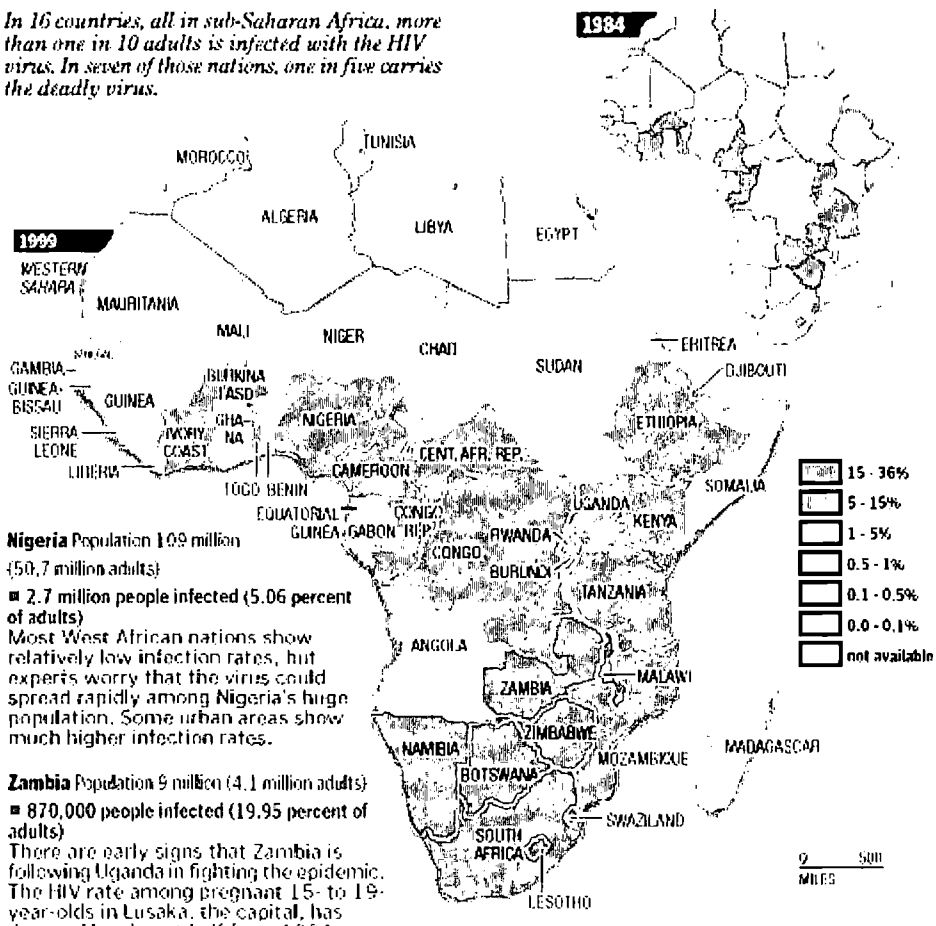
A Difference of 15 Years

In 16 countries, all in sub-Saharan Africa, more than one in 10 adults is infected with the HIV virus. In seven of those nations, one in five carries the deadly virus.



Nigeria Population 109 million (50.7 million adults)

- 2.7 million people infected (5.06 percent of adults)

Most West African nations show relatively low infection rates, but experts worry that the virus could spread rapidly among Nigeria's huge population. Some urban areas show much higher infection rates.

Zambia Population 9 million (4.1 million adults)

- 870,000 people infected (19.95 percent of adults)

There are early signs that Zambia is following Uganda in fighting the epidemic. The HIV rate among pregnant 15- to 19-year-olds in Lusaka, the capital, has dropped by almost half from 1994.

Botswana Population 1.6 million (775,000 adults)

- 290,000 people infected (35.8 percent of adults)

The country has a well-developed road system and is a hub for truckers from across southern Africa. This high mobility of people facilitates the spread of HIV. Although relatively prosperous, Botswana has spent little on anti-HIV programs.

South Africa Population 39.8 million (20.6 million adults)

- 4.2 million people infected (19.94 percent of adults)

More people are infected with HIV in South Africa than in any other nation, and the infection rate is among the fastest growing in the world. Anti-AIDS programs are mired in controversy.

Uganda Population 21.2 million (9.2 million adults)

- 820,000 people infected (8.3 percent of adults)

Uganda was the first African government to respond aggressively to the danger of AIDS. A prevention drive cut the infection rate from 14 percent in 1990.

SOURCE: UNAIDS

The worst affected

Adult infection rate as of December 1999

Botswana	35.8%
Swaziland	25.3
Zimbabwe	25.1
Lesotho	23.6
Zambia	20.0
S. Africa	19.9
Namibia	19.5
Malawi	16.0
Kenya	14.0
Cent. Afr. Rep.	13.8

Infection rates elsewhere for comparison:

U.S.	0.61%
India	0.70
Thailand	2.15

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XIII International AIDS Conference
Physical address: Suite 301, The Station Building, 160 Pine St, Durban 4001, RSA
Postal address: PO Box 1620, Durban, 4000
Tel : +27 31- 301 0400
Fax : +27 31- 301 0191
E mail : aids2000@aids2000.com
Website: www.aids2000.com

XIII INTERNATIONAL AIDS
DURBAN - SOUTH AFRICA - 9 14 JULY 2000

2000-06-01

Sandy Thurman
Office of National AIDS Policy
The White House

Dear Sandy

Your assistance is deeply appreciated. Please find enclosed a copy of the proposal that I sent to USAID and CDC. Please let me know if there is anything I need to change in the proposal.

Regards

Clarence Mini

HM Coovadia (Conference Chair), SS Abdool Karim (Scientific Programme Committee Chair),
C Mini (Community Programme Committee Co-chair), P Busse (Community Programme Committee Co-chair),
GG Wolvaardt (Organising Committee Chair)
Association Incorporated under Section 21. Registration Number: 97 16981

[redacted]
To: Sandy Thurman
Subject: FW: funding proposal

-----Original Message-----
From: [redacted]
Sent: 2000 May, 01
To: Sandy Thurman
Subject: RE: funding proposal

----Original Message----
From: Clarence Mini [SMTP:cmini@icon.co.za]
To: **Subject:** funding proposal

-----Original Message-----
From: Clarence Mini
To: Conference Secretariat
Subject: funding proposal

INTRODUCTION: IMPACT OF THE INTERNATIONAL AIDS CONFERENCE
THE CONFERENCE
>From 9 - 14 July 2000, the Global AIDS Community will convene in Durban, South Africa to share knowledge, ideas and experiences that will further the world's efforts against HIV/AIDS. South Africa was chosen by the International AIDS Society (IAS) to host the XIII International AIDS Conference. This is the largest medical/scientific conference in the world and will be the largest conference ever held in Africa. The of the Conference is "Break the Silence".
Conference co- organisers:
The Global Network of People Living with HIV/AIDS (GNP+)
The International AIDS Society (IAS)
The International Council of AIDS Service Organisations (ICASO)
The International Community of Women Living with HIV/AIDS (ICW)
The Joint United Nations Programme on HIV/AIDS.
Over 10,000 delegates from around the world are expected to attend the Durban Conference, including people living with AIDS, leading scientists and clinicians, health care workers, public health agencies, community representatives, politicians and about 1500 media.
South Africa is an appropriate choice for the first of these conferences in the new millenium, as it will highlight the plight of the continent where two thirds of all HIV positive people live. South Africa is both a country recently reborn and sadly, a country with a rapidly growing HIV epidemic. At present South Africa accounts for one third of the 33 million infected people worlwide.
The XIII International AIDS Conference is organised as a non-profit venture. Any surplus generated by the Conference will be dedicated to promoting research and community action on HIV/AIDS.
The Conference Organising Committee would therefore like to invite you

to consider becoming a supporter of the scholarship programme to enable us to increase access to the conference to delegates who do not have the organisational or industry support to participate in this Conference. Tailor - made opportunities to support the Conference can also be explored with me should you so desire.

SCHOLARSHIP OBJECTIVES

It is the objective of the Conference Organising Committee to make the XIII International AIDS Conference as accessible and as beneficial as possible to a wide variety of scientists, health professionals, community workers and persons living with HIV/AIDS from all regions of the globe, especially resource poor settings.

Scholarship support will not only allow participants to attend the Conference and present their abstracts, but also be able to take part in an innovative and extensive hands-on training programme with professional facilitators and community based practitioners from all over the world.

The Scholarship Programme will;

facilitate and administer the selection process and awarding of full/partial scholarships to a number of delegates who would otherwise not be able to benefit from the conference experience.

ensure equitable participation of those global communities from areas of the world most affected by HIV/AIDS.

ensure equitable participation of scientists from areas of the world most affected by HIV/AIDS.

develop and apply transparent and uniform guidelines for scholarsip selection (these are in place)

provide extensive , hands - on training opportunities through Skills Building Workshops.

provide pre-Conference information and on-site support to facilitate the scholarship participants' travel and to promote their participation at the Conference.

A Scholarship Working Group has been set up to manage the Scholarship Programme objectives and selection.

The Scholarship Working Group will;

ensure equitable regional, gender and where possible PWA representation.

identify candidates who could share their knowledge and contribute to

the Conference, and

identify candidates who would be able to acquire, use and transfer skills required.

The Scholarship Programme funds will be used exclusively for de facto scholarship recipients' registration, travel, per diem and accommodation and not to offset administrative overheads.

ROLE OF SPONSORS:

The Conference Organising Committee of the XIII International AIDS Conference is looking to you to support the Scholarship Programme for optimising participation of delegates who do not have the means of attending this high level gathering without the commitment and intervention of sponsors.

This conference will help determine direction for the global response to

HIV/AIDS. The fact that it is held in Africa will help e developing country issues high on the agenda. This event will bring leading scientists, doctors, health care workers, politicians, care givers and community representatives to Africa, creating unique opportunities for interaction with the local communities.
A wealth of knowledge will be made available to the health sector in South Africa and will also be one of the most effective ways of stimulating local and regional awareness of HIV/AIDS issues in Sub Saharan Africa.
The XII International AIDS Conference held in Geneva in 1998 raised sponsorship for 1,000 scholarship participants. It is our objective to raise sponsorship for 2,000 international scholarships, 500 South African scholarships and 350 media scholarships at a cost of US$2,000 per participant to cover registration,travel, per diem and accomodation. The media scholarships are aimed mostly at radio journalists. The scholaship pool will be drawn from an expected number of 6,000 applicants and will be selected according to objective and transparent criteria which have been determined by the Scholaship Working Group. The selection of the Scholarship Working Group itself took into account regional representation. We believe that your contribution will bring us closer to our goals by creating institutional capacity amongst our communities that are faced with HIV/AIDS and effects thereof.

Clarence Mini
Conference Fundraiser
XIII International AIDS Conference

OFFICE OF NATIONAL AIDS POLICY

EXECUTIVE OFFICE OF THE PRESIDENT

THE WHITE HOUSE

FACSIMILE TRANSMITTAL SHEET

TO:	FROM:
Clarence Mini	Sandy Thurman
COMPANY:	DATE:
XIII International AIDS Conference	May 31, 2000
FAX NUMBER:	TOTAL NO. OF PAGES INCLUDING COVER:
27 31 301 0191	1
PHONE NUMBER:	
27 31 301 0400	
RE:	
Proposal	

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

NOTES/COMMENTS:

Dear Clarence,

Thank you for your letter. I have been out of the country, but wanted to get back to you as quickly as I could.

I know that this is an important program and will try to help in any way that I am able. Would you mind sending me the proposal along with specifics as to the funding amounts from CDC and the Gates Foundation? We'll then see what we can do from this end.

Thanks!

Take care,

Sandy

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

XIII International AIDS Conference
Physical address: Suite 301, The Station Building, 160 Pine St, Durban 4001, RSA
Postal address: PO Box 1620, Durban, 4000
Tel : +27 31- 301 0400
Fax : +27 31- 301 0191
E-mail : aids2000@aids2000.com
Website: www.aids2000.com

XIII INTERNATIONAL AIDS CONFERENCE
DURBAN • SOUTH AFRICA • 9-14 JULY 2000

2000-05-23

Sandra L. Thurman
Director
Office of National AIDS Policy
The White House

XIII International AIDS Conference scholarship funding

Dear Sandy

I would like to update you about the responses I received from USAID and UN agencies to the proposals I sent to them.
The standard reply that I received from various people in USAID Pretoria and Washington is that USAID supports the Conference and the scholarship program through the various organisations it funds. Well as someone who has worked with two of these organisations over a number of years I happen to know that very well. CDC has been an exception in that they have been supportive indeed.
With the UN agencies only WHO gave US$10,000 to the scholarship program.
Others wanted to know when we were sending personal invitations to their directors to play a prominent role in the Conference. I know if you have a way of mobilising more funds for scholarships you will certainly do so. On my side I am ready at any time to send you a proposal.
Any thing you can do Sandy please.

Yours truly

Clarence Mini

Cmini@icon.co.za
0824996631

HM Coovadia (Conference Chair), SS Abdool Karim (Scientific Programme Committee Chair),
C Mini (Community Programme Committee Co-chair), P Busse (Community Programme Committee Co-chair),
GG Wolvaardt (Organising Committee Chair)
Association Incorporated under Section 21. Registration Number: 97 16981

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RESULT	OK

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EXECUTIVE OFFICE OF THE PRESIDENT
THE WHITE HOUSE

FACSIMILE TRANSMITTAL SHEET

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PHONE NUMBER:	
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Thanks!

OFFICE OF NATIONAL AIDS POLICY

EXECUTIVE OFFICE OF THE PRESIDENT

THE WHITE HOUSE

FACSIMILE TRANSMITTAL SHEET

TO:	FROM:
Clarence Mini	Sarah For Sandy Thurman
COMPANY:	DATE:
	June 1, 2000
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PHONE NUMBER:	

RE: Please re-send proposal with specific funding information

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NOTES/COMMENTS:

Good Afternoon,

I wanted to let you know that we received two pages of a fax, but nothing more. Could you possibly re-send the information for Director Thurman?

Thank you so much!

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

****
*** TX REPORT ***
****

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OFFICE OF NATIONAL AIDS POLICY

EXECUTIVE OFFICE OF THE PRESIDENT
THE WHITE HOUSE

FACSIMILE TRANSMITTAL SHEET

TO: Clarence Mini

FROM: Sarah For Sandy Thurman

COMPANY:

DATE: June 1, 2000

FAX NUMBER: 27 31 301-0191

TOTAL NO. OF PAGES INCLUDING COVER: 1

PHONE NUMBER:

RE: Please re-send proposal with specific funding information

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

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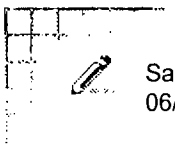

Sarah T. Holewinski
06/01/2000 02:05:31 PM

Record Type: Record

To: cmini@icon.co.za @ inet

cc:
Subject: From Sandy Thurman's Office

Hello Ms. Mini,

This is Sarah Holewinski from Sandy Thurman's Office....

I am writing to ask you for some more specific information, in order that Sandy might provide what assistance she is able.

Could you possibly send us the actual proposal and not the emailed version? It will go over much better if it is in an official format. If you have it as a computer document, you may be better off attaching it to an email and sending it to me for Sandy.

Also, we need to know about USAID and CDC funding specifics...including whether there is any funding coming from the Gates Foundation.

As soon as we have that information, we will be able to evaluate what is possible from our end. Thanks!

Sarah
(202) 395-1441

Last printed 07/07/00 4:09 PM

THURSDAY, JULY 13, 2000

DURBAN

Sandy Thurman, White House Advisor – HIV/AIDS

Control Officer: Caroline Connolly
Cellphone: 083 417 6860

07:45	Vivian Lowery-Derryck and Eilene Oldwine depart Mount Edgecombe Golf Lodge with USAID Driver, for Royal Hotel and shuttle to ICC USAID Vehicle Driver: Benjamin Vehicle Telephone: 083 443 6621
08:30	Sandy Thurman departs Royal Hotel for Press Conference at ICC
09:00-10:00	USAID Press Conference on Ground Level of ICC: "Children on the Brink"
10:00-14:00	ICC
14:00-16:00	Ambassador's speech and plenary at ICC
16:00	International Chauffeur Drive on standby at Royal Hotel USAID vehicle and driver on standby at Royal Hotel
16:15	ICC or Mount Edgecombe Golf Lodge
17:30	Web MD Daily Update: Vaccines
18:15	"The Cost of Non-Intervention" in Hall 1, ICC

Vivian Lowery Derryck, AA/AFR
Control Officer: Eilene Oldwine
Cellphone: 083 306 9553

FRIDAY, JULY 14, 2000

DURBAN

Sandy Thurman, White House Advisor – HIV/AIDS

Control Officer: Caroline Connolly
Cellphone: 083 417 6860

06:00	Eilene (with bags) and Vivian depart Mount Edgecombe for The Royal Hotel, Ulundi Street entrance USAID Vehicle Driver: Benjamin Vehicle Telephone: 083 443 6621
07:00-12:00	Same schedule as that of Sandy Thurman's, set out below
07:00	Depart Royal Hotel for site visit
07:30	Site Visit to Children's Home/Hospital/School - with Media, Ambassador Lewis, Sandra Thurman, Eilene Oldwine, Achmat Dangor, Vivian Lowery Derryck, USAID/W
	AT ROYAL HOTEL – NELSON MANDELA CHILDREN'S FUND SIGNING CEREMONY
08:40	USAID/South Africa at door to greet guests: Anita Sampson, Nellie Gqwaru and Pamela Wyville-Staples
09:25	Choir and Dancers start performing. Guests arrive
09:45	Ambassador Lewis, Sandra Thurman, Achmat Dangor, Vivian Lowery Derryck arrive. Choir sings in the background
09:55	Mr Nelson Mandela arrives
10:00	Welcome by Mr Achmat Dangor – Chief Executive Officer of Nelson Mandela Children's Fund
10:05	Welcome by Ms Vivian Lowery Derryck, Assistant Administrator for the Africa Bureau, USAID/Washington
10:10	Ms Derryck introduces Ambassador Delano E. Lewis Remarks by Ambassador Lewis, US Ambassador to South Africa • Mr Dangor introduces Ms Thurman
10:15	Remarks by Ms Thurman, White House Advisor on AIDS • Mr Dangor introduces Mr Mandela
10:20	Remarks by Mr Nelson Mandela, Founder, Nelson Mandela Children's Fund
10:30	Grant signing
10:35	Choir closes ceremony
10:40	Brief remarks to the Press
11:00	Leave Royal Hotel for ICC (via USAID vehicles)
12:00	Closing ceremony. Vivian Lowery Derryck, AA/AFR

Control Officer: Eilene Oldwine
Cellphone: 083 306 9553

14:45 Eilene Oldwine departs Royal Hotel for Durban Airport, for flight CE417 at 16:30
Benjamin to drive Eilene to airport

SATURDAY, JULY 15, 2000

DURBAN

Vivian Lowery Derryck, AA/AFR

Control Officer: Pamela Wyville-Staples
Cellphone: 082 858 2423

International Chauffeur Drive on standby at Mount Edgecombe Golf Lodge
Driver: Sagran Moodley Vehicle: 083 355 6695

08:00-12:00	Free time
12:00	Depart Mount Edgecombe Hotel en route to Durban Airport
12:45	Collect Pamela Wyville-Staples at 583 Marine Drive, The Bluff, Durban and proceed to Airport
15:30	Depart Durban for Washington DC, Flight BA 6218.

Sandy Thurman, White House Advisor – HIV/AIDS

18:00	Depart South Africa on SA 524 DBN/JHB

+27 12 3284412

Last printed 07/07/00 4:09 PM

CELL PHONE NUMBERS

Benjamin	083 276 5343
Bill Brands	083 471 6855
Buck Buckingham	082 858 4219
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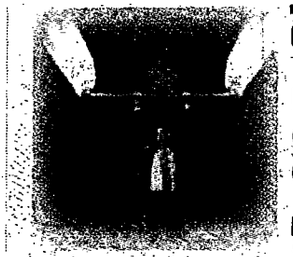
Week ahead

Markets refocus on real economic prospects

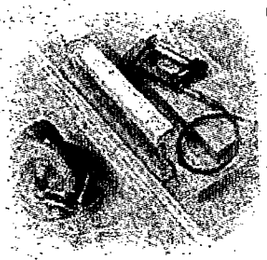
Page 2



Greta Steyn

Row erupts over welfare delivery contracts

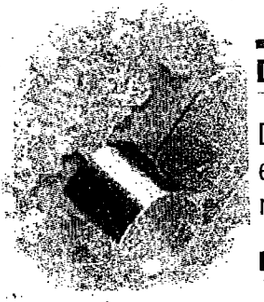
Page 7



Small business

Kick-starting entrepreneurial creativity

Page 8



Diamonds

De Beers enters a new era

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TWENTY-FOUR HOURS

News

New bond proposed

THE Congress of SA Trade Unions has thrown its weight behind President Thabo Mbeki's proposal that government start a Reconstruction Bond, while business has reacted cautiously.

Mbeki told the Millennium Labour Council at the weekend "some unions" wanted a portion of workers' savings, invested in retirement funds, to be spent on social investment. **Page 3**

Public-private partners

OUTSOURCING, concessions, leases, service contracts and management contracts are some of the forms of public private partnerships that have captured the imagination of government and its parastatals. **Page 2**

No takers for scheme

THERE have been no takers for the US Export-Import Bank's year-old scheme to boost flagging US exports to SA. **Page 3**

Police deny miscarriage

PREGNANT SA captive Monique Strydom had not suffered a miscarriage as claimed by Islamist extremists holding 20 hostages in a Philippine jungle, police said yesterday. **Page 5**

Application to be [illegible]d

Business

MICROLENDERS are acting to stop panic selling of their shares following the announcement by government that it is terminating nonstatutory deductions for microloans from the state payroll system.

Shares of microlenders, particularly African Bank Investments Limited (Abil), Unifer Holdings and Thuthukani, have slumped since government's announcement late last month. All three issued statements to shareholders last week in a bid to allay fears, but analysts said these did little to convince the market they would not be profoundly affected. **Page 9**

US STOCKS rose on Friday after employment data showed job creation was beginning to slow.

The Dow Jones industrial average rose 1,47% to 10 635,98, while the Nasdaq composite index ended 1,58% higher at 4 023,2, closing above the psychologically significant 4 000-point level for the first time in two weeks. **Page 14**

TRADITIONAL beverage and food products group Awethu Breweries says it expects to stage a turnaround in its current financial [illegible] on the back of greater market penetration and

Mbeki still sceptical about gravity of AIDS epidemic

President tells conference 'extreme poverty is the world's biggest killer'

Pat Sidley, Nicola Jenvey and Nirode Bramdaw

PRESIDENT Thabo Mbeki dashed hopes yesterday that he had revised his controversial opinions on AIDS.

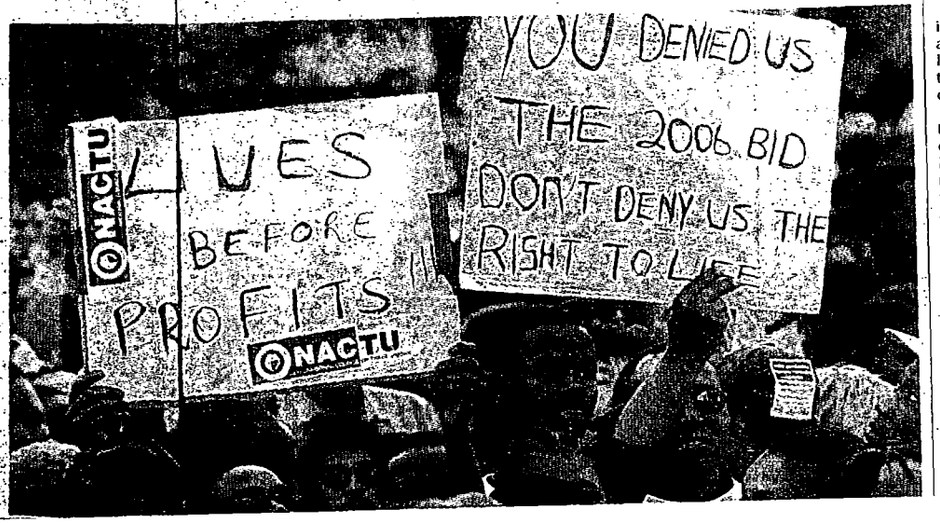
His speech at the opening of the 13th International AIDS Conference in Durban last night was delivered against the background of a letter he wrote to Democratic Party leader Tony Leon and published at the weekend. In it, Mbeki repeats many of his doubts about the effectiveness of AIDS drugs that have alarmed respected HIV/AIDS scientists.

He also questioned the conference's effectiveness: "Perhaps in thinking your conference will help us to overcome our problems as Africans, we overestimate what the 13th international AIDS conference can do."

Again stressing the role of poverty in Africa's miseries, he quoted the World Health Organisation executive summary as saying: "Extreme poverty is the world's biggest killer and the greatest cause of ill health and suffering."

He questioned the gravity of the AIDS epidemic and said he had also "heard stories" about malaria, tuberculosis, hepatitis B and other diseases.

In contrast, shortly before the offi-



Ernst & Young splits auditing, consulting arms

Hilary Joffe

ERNST & Young SA has split its consulting and auditing arms, selling its management consultancy to empowerment group Worldwide African Investment Holdings for an undisclosed sum.

The transaction builds on the existing relationship between Worldwide and Ernst &Young Consulting, which last year formed a 60:40 joint venture, the Argil consultancy, into which both companies injected skills.

The new company, to be formed after the Worldwide acquisition, will be called Argil Ernst & Young Consulting. It boosts the financial services component of Worldwide, which has defined the oil industry, telecommunications and financial services as its core focus.

The SA deal comes after Ernst & Young's international parent firm sold its consulting arm to French consultancy Cap Gemini in an $11bn deal earlier this year. A local merger of the two was unlikely, however, since Cap Gemini's SA subsidiary was sold recently to a management consortium.

Ernst & Young, which is one of the five leading global professional services firms, has been one of the first to respond to the trend towards separating consulting and and accounting services. The firms have come under pressure to do this, particularly in the US, where the Securities and Exchange

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AIDS In KwaZulu-Natal

Fighting AIDS through Good Governance of KwaZulu-Natal

Policy Statement Department of the Premier

The Department of the PREMIER is committed to the fight against AIDS by ensuring that its core business service delivery is as cost-effective and as meaningful as possible to the province of KwaZulu-Natal.

Overall Action Plan Linked to Core Business

A) Department of the Premier service delivery

The future success of KwaZulu-Natal is the responsiblity of the government of the day and to ensure that this province becomes the great success it has the potential to become it must be governed well. A commitment to Good Governance includes sound financial management, value-for-money service delivery, establishment of private/public partnerships to stimulate the economy, providing stability to encourage investment and ensuring that fraud and corruption is rooted out of our system. In this way Good Governance provides the basic foundatiin that this society needs for launching the war against HIV/AIDS.

B) Specific Actions within Department

1 Featuring AIDS information in internal publications.
2 Distributing AIDS material throughout the Department.
3 Ensuring that AIDS is included on all Management meeting agendas.
4 Liaising with Government, private and NGO organisations that provide AIDS counselling - for referral of staff requiring their services - or that run promotions/projects that could be of benefit to staff.
5 Liaising with Government, private and NGO organisations to be of assistance where possible by providing an infrastructure for dissemination of AIDS information.
6 Ensuring that the Departments KIDACO (KwaZulu-Natal Inter Departmental AIDS Committee) member is encouraged to improve inter-departmental liaison and has access to the Head of Department at all times.
7 Encouraging all to adopt the AIDS Champions pledge
   a) I will inform myself of all developments in the fight against AIDS.
   b) I will promote AIDS prevention at every opportunity.
   c) I will reach out and help someone affected by AIDS.
8 Operating within all non-discriminatory norms in line with National Government Policy.

in parallel to commercial development household food security can contribute to good nutrition, a major factor in creating good health status in a community. Both contribute towards the reduction and elimination of poverty, disease, violence, social stability and AIDS. Ensuring that the environment is utilised in a sustainable manner and is well protected, contributes to improved human health and well-being. This Department networks throughout the region and provides an infrastructure capable of reaching the very poorest.

Works service delivery

The maintenance upkeep and provision of facilities for the entire KwaZulu-Natal provision administration at the best possible value for money ensures that a comprehensive network for reaching the community at large is provided. This allows for the affective dissemination of information to all areas of our province through the provision of the full range of government services. Utilisation of contractors through the full spectrum provides job and entrepreneunal opportunities and helps fight poverty and its closely related conditions, such as disease, including AIDS.

Safety and Security service delivery

Safety, security, peace and stability are essential elements in creating a society free of violence, crime and abuse. In providing a secure society through effective policing this Department contributes towards creating a climate in which development and upliftment can take place. This, in turn reverses the negative effects of poverty and societal instability that are major contributors to the spread of all diseases, including HIV/AIDS.

Education service delivery

The provision of formal education to a society has highly positive effects on the overall health status of people. People who can read can process vital information and assimilate this into their daily lives. Ensuring the delivery of the best suited, most relevant and cost-effective education to as many young people as possible provides society with a firm hasis for fighting poverty and the negative factors that accompanies it - including the rapid spread of HIV/AIDS.

Local Government service delivery

The provisioin of infrastructural services to a society is crucial in improving the overall health status of people. It is only on the foundation of a solid infrastructure and local government systems that people can begin the process of creating a developing economy that will improve their daily lives. Ensuring the delivery of the best possible services to people at local level and ensuring that effective and entrepreneurial governance systems are place will allow for community involvement in fighting poverty and the negative health risks that accompany it - including the rapid spread of HIV/AIDS.