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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. receipt	Airline ticket stub, Cheryl Bauerle, IAD to DUR and return (partial) (1 page)	06/30/2000	b(6)
002. receipt	Airline ticket stub, Cheryl Bauerle, miscellaeous charges (partial) (1 page)	06/30/2000	b(6)
003. form	SF 1012, Travel Voucher Untitled, Sandra Thurman (partial) (1 page)	06/08/2000	b(6)
004. form	OA Form 22, Travel Authorization number TOJONA27 (partial) (1 page)	06/08/2000	b(6)
005. form	OA Form 22, Travel Authorization number TOJONA27-01 (partial) (1 page)	06/08/2000	b(6)
006. form	SF 1012, Travel Voucher number TOJONA30, Cheryl Bauerle (partial) (1 page)	08/09/2000	b(6)
007. form	OA Form 22, Travel Authorization number TOJONA29, Sandra Thurman (partial) (1 page)	06/28/2000	b(6)
008. passport	copy of identity page, Sandra Thurman (1 page)	02/14/1997	b(6)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office

OA/Box Number: 21066

FOLDER TITLE:
South Africa 7/7-7/14/00 [3]

2007-1550-F
kc1260

RESTRICTION CODES

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

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Folder Title:
South Africa, 7/7-7/14/00 [3]

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

From: Greg Folkers [GFOLKERS@niaid.nih.gov]
Sent: Saturday, July 08, 2000 9:24 PM
Subject: AIDS2000--day one

> AIDS2000 - Day One
> By Ed Susman, Special to Aegis News
> ----------
>
> DURBAN, South Africa -- Even before the XIII International AIDS
> Conference officially opened here in the third largest city in the nation
> with more AIDS cases -- 4.3 million -- than any other nation on earth,
> controversy swirled.
>
> The pharmaceutical company Boehringer Ingelheim has announced it
> will give an anti-AIDS medication free to pregnant AIDS-infected women in
> developing countries to prevent transmission of the virus to the woman's
> newborn child.
>
> The announcement came as an expected 10,000 delegates to the
> conference gathered and made plans to march in protest against
> pharmaceutical companies' pricing and governments inaction against the
> disease that now infects 34.5 million people worldwide. Pharmaceutical
> companies have come under attack for charging more than developing
> countries can afford. More than 90 percent of those people live in the
> developing world.
>
> In a statement, Rolf Krebs, vice chairman of the board of
> managing
> directors at Boehringer Ingelheim, Ingelheim, Germany, Boehringer
> Ingelheim, said that nevirapine (marketed as Viramune) will be offered
> free
> of charge for a period of five years for the prevention of mother-to-child
> transmission of HIV in developing economies.
>
> Dr. Peter Piot, executive director of UNAIDS, said, "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."
>
> But Philadelphia-based Kate Krauss, a spokesperson for ACT UP,
> said
> the offer by the drug company was "a half measure." She said women also
> new

> education and treatment so they can have the opportunity to raise the
> child. Children also need care as well, Krauss said.
>
> Krebs said the initiative is part of Boehringer Ingelheim's
> commitment to the collaborative effort with five companies -- also
> Bristol-Myers Squibb, F. Hoffman-La Roche, Glaxo Wellcome and Merck & Co.,
> Inc., international organizations such as the World Health Organization,,
> World Bank, UNICEF and UNAIDS and committed governments to explore
> practical ways of working together to make HIV/AIDS care available.
>
> In other news arising from an American Medical Association
> satellite news briefing, US government officials said they are concerned
> over about trends that indicate AIDS rates could rise again after years of
>
> steady decline or stability -- especially due to risky behavior among
> young
> men and women.
>
> "We should not have to have another generation of gay men suffer
> though HIV infection as a right of passage,' said Dr. Helene Gayle,
> director of the National Center for HIV, STD and TB Prevention at CDC.
>
> "These new figures do paint a picture of a real potential for
> resurgence." Gayle said increases seen in high risk activity --
> unprotected
> sex and injecting drug abuse -- lead to increased sexually transmitted
> diseases and then to AIDS. "Despite the dramatic benefits new treatment
> have had in extending the lives of individuals with HIV, the overall
> shortfalls of AIDS treatments are becoming increasingly apparent, and HIV
> infection and risk behavior continue at levels far too high," said Gayle.
>
> "Now more than ever, it is critical that we expand successful HIV
> prevention programs to bring infection rates down." Gayle said that since
> July 1998, the number of AIDS deaths and news cases of the disease have
> remained steady at about 12,000 deaths and 40,000 new cases a year. Before
> then, deaths had steadily declined since 1993; and cases of AIDS had been
> declining since 1995 as combination therapy for HIV infection became the
> standard of treatment for the disease.
>
> In another report at the AMA session, researchers said a drug
> that
> helps the body fight infections apparently improves a key marker of the
> status of the immune systems of people living with HIV.

>
> Researchers said laboratory-engineered Interleukin-2 (IL-2) more
> than doubled the CD4 cell counts of patients getting standard treatment
> for
> HIV. Clifford Lane, MD, clinical director of the National Institute of
> Allergy and Infectious Diseases (NIAID), Bethesda, Md., found that after
> one year of treatment with IL-2, CD4 counts increased by an average of 112
> percent for these patients compared to an average increase of 18 percent
> for the patients who were receiving only the regular highly active
> antiretroviral therapy (HAART).
>
> CD4 cell counts can indicate the strength of a person's immune
> system CD4 T cell levels can indicate a person's susceptibility to
> infection by measuring the concentration in the blood of a type of white
> blood cell known as a T helper cell. These cells are depleted when a
> person is infected with HIV permitting dangerous and deadly opportunistic
> infections to ravage a patient.
>
> IL-2 is modeled after a substance the body makes that promotes
> T-cell growth. The study was supported by Chiron Corp., which manufactures
> IL-2. The substance is currently approved in the United States for
> treating
> metastatic melanoma and kidney cell carcinoma.
>
> In addition to finding that CD4 cells increase, doctors
> determined
> that use of IL-2 apparently decreased levels of virus circulation in the
> blood. That decrease was small, but was considered statistically
> significant. "However, larger trials need to confirm this preliminary
> finding," Lane said.
> ---
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> or via the AEGiS Email News Service, do not necessarily state or
> reflect those of AEGiS. Originally published on Jul 8 2000

From: Greg Folkers [GFOLKERS@niaid.nih.gov]
Sent: Saturday, July 08, 2000 11:52 AM
Subject: LA Times: Experts Fear Resurgence of HIV Infection

http://www.latimes.com/print/asection/20000708/t000064162.html

Saturday, July 8,
2000

Experts Fear Resurgence of HIV
Infection

By THOMAS H. MAUGH II, Times Medical
Writer

The numbers of AIDS deaths and
new HIV
infections in the United States have
remained stable for
the second year in a row, public
health authorities will
announce today. But increases in
risky behaviors and
growing infection rates among the
young are setting the
stage for a resurgence of the
disease, officials
cautioned.
An estimated 16,000 Americans
died of AIDS last
year and 40,000 became HIV-positive,
according to
the newest figures compiled by the
Centers for Disease
Control and Prevention. But as many
as 5 million
Americans engage in sexual and drug
behaviors that
place them at high risk of
contracting the virus,
according to new studies released in
Durban, South

Africa, in advance of Sunday's start of the 13th International AIDS Conference.

A separate study of more than 3,400 young gay men found that 7.2% of them were HIV positive, with the rate among young black gay men soaring to 19%.

In Los Angeles, the rate for young gay men was 8.3%, while in New York City, the incidence was 12.2%.

More than 80% of those who were infected did not know it, according to CDC researchers.

Data released last week showed that the rate of new HIV infections in San Francisco grew by more than 60% last year as a result of increases in sexually risky behavior.

"HIV infection and risky behavior continue at levels far too high," said Dr. Helene Gayle, director of CDC's National Center for HIV, STD and TB Prevention.

"Now, more than ever, it is critical that we expand successful HIV prevention programs to bring infection rates down."

Health officials say that, overall, as many as 900,000 Americans may be infected.

In other pre-meeting news, researchers from the National Institutes of Health reported that adding an anti-cancer drug called

interleukin-2, or IL-2, to cocktails of AIDS drugs can substantially improve restoration of the immune system. And the German drug company Boehringer Ingelheim said Friday that it will donate the anti-AIDS drug nevirapine to developing countries to help reduce mother-to-child transmission of the AIDS virus. A report in last month's Lancet said that nevirapine was

the most cost-effective, efficacious and easily administered drug for that purpose. The number of new AIDS cases in the United States peaked in the first quarter of 1993, then began a sharp decline as a result of growing efforts focused on prevention programs. AIDS deaths peaked two years later, and then also began to drop as cocktails of anti-AIDS drugs--including the new protease inhibitors--were introduced to control infections. But both rates have remained roughly the same since July 1998, Gayle said. She attributed the lack of further progress to treatment failures caused by viral resistance to the drugs; treatments' having already reached most people who can benefit; the lack of

early testing and
treatment for some victims; and the difficulties of
adhering to the complicated treatment regimens.
Another reason is that large segments of the
population, at least 2% to 4% of adult Americans,
continue to engage in risky behaviors, according to
another CDC study. Researchers defined risky
behaviors as including: having six or more heterosexual
sex partners in a year, having unprotected sex with
people known to be HIV-positive, exchanging sex for
money or drugs, using injected drugs, and having
male-to-male sexual contact.
The study also found that even though condom use
has increased during the last two decades, only 40% of
unmarried people and 23% of drug users employ
condoms.
One of the greatest successes in combating the
AIDS epidemic has been in halting HIV transmission
among intravenous drug users. The incidence of
infections in this group peaked at between 10% and
14% in the early 1990s, but has now fallen to less than
2%. Nonetheless, Gayle noted, at least 20% of such
users still share needles, a major risk factor.

In contrast, risks taken by young gay males remain a major problem, as illustrated by the Young Men's Survey, conducted in six U.S. cities from 1994 through 1998. Researchers went to clubs, bars and other locations regularly visited by young gay men and ultimately enrolled 3,492 males, ages 15 to 22. The men were interviewed and given an HIV test.

The team reports in next Wednesday's Journal of the American Medical Assn. that 7.2% of the men were HIV-positive, with the incidence ranging from zero among 15-year-olds to 9.7% among 22-year-olds.

Only 46 of the 249 men who tested positive for HIV knew before the test that they were infected.

"This rate is alarming when you consider these young men have very short sexual histories," said Wesley Ford of the Los Angeles County Department of Health Services, who worked on the study.

Moreover, 41% of the youths reported having had unprotected anal sex within the previous six months.

The message of safe sex "is not reaching these groups," Ford added.

Some good news is coming out today, however. In

another paper in the medical association journal, Dr. Richard T. Davey and his colleagues at the National Institute of Allergy and Infectious Diseases report on the first studies of IL-2 in patients receiving standard AIDS therapy.

IL-2, a protein produced by white blood cells, stimulates the production of immune system cells called CD4 T-cells, which play a key role in fighting infections by bacteria and viruses. HIV infection sharply reduces the number of CD4 cells, making the victim susceptible to a variety of opportunistic infections.

Davey's team studied 78 HIV-positive patients receiving cocktails of anti-HIV drugs. Half received IL-2 in addition to those drugs, and half received a placebo. They found that patients receiving IL-2 had a 112% increase in their CD4 counts, while those receiving the placebo had only an 18% increase.

"I'm very heartened" by the response, Davey said.

Even more heartening is the planned donation of nevirapine, trade-named Viramune. Studies in Uganda have shown that one dose of the drug is twice as effective as multiple doses of AZT in preventing HIV

transmission by pregnant women. Researchers projected that using the drug in South Africa alone would prevent as many as 110,000 infant HIV infections over the next five years.

"This offer holds out great hope for many millions of women," said Dr. Peter Piot, executive director of UNAIDS.

Critics cautioned, however, that an offer earlier this year by five major drug companies to provide AIDS drugs to African nations at reduced prices has been bogged down in squabbling over such issues as how to distribute the drugs in the absence of an effective health care infrastructure. No drugs have actually reached their destinations.

* * *

Stable, for Now

The number of AIDS deaths and new HIV infections in the United States has plateaued, but increases in risky behaviors and growing infection rates among the young may cause a resurgence of the disease, public health authorities say.

* * *

*figures for January through June 1999

Source: Centers for Disease Control and Prevention

From: Greg Folkers [GFOLKERS@niaid.nih.gov]
Sent: Saturday, July 08, 2000 12:43 PM
Subject: South Africa Skeptical of German AIDS Drug Offer

> Story Filed: Saturday, July 08, 2000 8:34 AM EST
>
> DURBAN, South Africa (Reuters) - South Africa said Saturday it was
> skeptical of a German company's offer to provide the AIDS drug Viramune
> free of charge to help prevent mother-to-child HIV infections in
> developing countries.
>
> Pharmaceutical firm Boehringer Ingelheim said Friday the drug, also known
> as nevirapine, would be offered for five years. Dr. Humphrey Zokufa, South
> Africa's chief director of pharmaceutical and food services, said the
> government was concerned Boehringer had not discussed the offer with
> Pretoria.
>
> ``The company did not make a formal offer to us and did not have a
> meaningful discussion with us. Therefore, we don't know the merits or the
> demerits of the offer," Zokufa told Reuters.
>
> ``I hope that the company approaches the department of health so that we
> can have a meaningful talk about the conditions of the offer and see how
> that can impact on what we are trying to do," he added.
>
> Five major Western drugmakers have offered to slash the cost of
> treatments for HIV, the virus that causes AIDS, in the impoverished
> regions that can scarcely afford them.
>
> Boehringer, citing a June 17 article in Britain's Lancet medical journal,
> said that if all pregnant women in South Africa received anti-retroviral
> treatment, up to 110,000 HIV infections in newborns would be avoidable in
> the next five years.
>
> According to United Nations AIDS experts, there are about 1.3 million
> children living with HIV/AIDS globally and the majority of them were born
> to HIV-infected mothers.
>
> ``Viramune can fill a critical need in the developing world. We hope that
> our initiative for the prevention of mother-to-child transmission will
> help make an impact on the HIV/AIDS epidemic," Boehringer Vice Chairman
> Rolf Krebs said in a statement Friday.

>
> INFANTS INFECTED THROUGH BREAST-FEEDING
>
> Giving a single dose of the drug to a woman just before she delivers, and
> one dose to the baby soon after birth, greatly reduces the risk a baby
> will be infected.
>
> Experts have pushed to get the drug distributed in the developing world,
> but it has not yet been approved in South Africa. The results of clinical
> trials of nevirapine in South Africa and Uganda are to be released at the
> 13th International Conference on AIDS that begins Sunday in Durban.
>
> Dr. James McIntyre, director of the PeriNatal unit at Chris Hani
> Baragwanath Hospital in Johannesburg said South Africa would in August
> launch a pilot project on the implementation of a program to give
> nevirapine to pregnant HIV-infected women.
>
> McIntyre was involved in the clinical trials for nevirapine and said they
> proved that the drug worked in reducing mother-to-child transmission.
>
> ``We know that it (nevirapine) works...The project is to determine what
> do we need to do to make it accessible, the supervision of the dosages,
> counseling and follow-ups," he said.
>
> The New York Times said Saturday a United Nations-sponsored study
> confirmed that a simple drug regimen could prevent mothers from infecting
> their children during pregnancy and childbirth.
>
> But it also found that by 18 months the benefit of the initial treatment
> had worn off because the infants got infected through breast-feeding. The
> problem is particularly acute in Africa where the majority of women
> breast-feed their children.
>
> ``It was naive to believe that continued breast-feeding would not make an
> impact," the newspaper quoted Dr. Hoosen Coovadia, chairman of the AIDS
> conference, as saying.
>
> The study was conducted in South Africa, Tanzania and Uganda and its
> findings will be reported at the Durban conference, the newspaper said.
>
From: Greg Folkers [GFOLKERS@niaid.nih.gov]
Sent: Saturday, July 08, 2000 12:25 PM
Subject: Drugs for Third World tops debate (Mail and Guradian, SA)

http://www.mg.co.za/mg/news/2000july1/07jul-aids1.html

Johannesburg, South Africa. July 7 2000

Drugs for Third World tops debate

The high price of anti-Aids drugs, socio-economic issues, wars, disrupted family lives, untreated sexual diseases and now possible genetic mutations - all factors in the epidemic that is Aids.

BELINDA BERESFORD and KHADIJA MAGARDIE report

The leading scientists who will address the Aids 2000 conference in Durban next week are expected to give much attention to the latest research into adapting First World drug regimes for developing countries.

Aids is a socio-economic disease - if you're rich you're more likely to avoid full-blown Aids for longer than if you're poor, because you can afford the medical care.

International aid agency MΘdΘcins sans FrontiΦres says the South African government currently pays $4,15 (R29) for a daily dose of fluconazole, an anti-fungal medication needed to treat opportunistic infections in Aids patients. In Thailand a generic of the drug is sold for $0,29. There are hopes that the international gathering of experts will unveil movements on the much-trumpeted agreement between pharmaceutical companies and United Nations agencies to cut the price of Aids drugs.

Aids activists have been concerned that any deal with drugs

companies would require participating countries to agree to conditions - such as promising not to allow the import or production of generic drugs.

According to UNAids research, where generic competition was allowed, drug prices fell by an average of 80%. Where there was no such competition, prices dropped by less than 20%. One American consumer organisation says Asian producers of generic Aids drugs could offer a triple-drug regime for about $0,63 a day, if sufficient economies of scale were achieved.

Aids is also a social issue. Dr Anthony Fauci, who is the director of the United States National Institute of Allergy and Infectious Diseases, says it's the social, economic and other health issues which lie at the heart of HIV's rampage across sub-Saharan Africa. Fauci, a leading international Aids expert, says disrupted family lives, truck routes across the continent, wars and untreated sexually transmitted diseases all assist the virus along its way.

But there are suggestions that genetics may play a role. Researchers have found that a small number of whites (about 1%) have a genetic mutation that makes it extremely unlikely that they will catch the virus. Other research has suggested that there are other genetic mutations that make it likely that a proportion of African-Americans are more predisposed than the population as a whole to catch the virus. Genetic differences between racial groups are known to play a factor in how people succumb and respond to diseases and treatments, say doctors, although such differences are likely to be less

significant than external factors such as poverty.

Whatever the reasons behind the epidemic, responding to it is an ethical minefield, where a step in any direction appears to raise more issues and problems.

Anti-retroviral cocktails of drugs have led to a large decline in the number of Aids deaths in the US. But the drugs are expensive and using them brings problems.

HIV is highly adaptable and can become resistant to an individual drug in just a couple of days. If an individual doesn't follow the treatment plan, the drugs taken become useless as the virus becomes resistant. That's a problem for the individual concerned since there is a limited range of drugs available. But it's potentially a minefield for the population as a whole. If an HIV-infected person with a resistant form of the virus passes the infection on, eventually that particular drug will become useless for everyone.

One leading South African epidemiologist says even if cost were not an issue, one needs the infrastructure to hand them out. "You need some control of the supply because if you put these drugs out like Smarties, they will end up with them being abused and lose a wonderful drug." But Aids experts and the South African government have repeatedly pointed out that the price of medication is only one of the costs involved in controlling the HIV pandemic. Additional costs include testing people to ensure they're on the correct medication, counselling them, and the additional strain on the health system as a whole. All of which means that the

way that the drugs are used can dramatically affect cost.

For example, giving Neviropine to women in the last stages of pregnancy appears to dramatically cut the chances of the child being infected. The medication required costs just under R30. But according to one World Health Organisation expert the true price is much higher once you factor in all the infrastructure costs behind giving that pill - about R10 000 a life.

Meanwhile, the international scientific community is bracing itself for President Thabo Mbeki's opening address at the conference to hear whether he will backtrack on his controversial quest to probe basic Aids science.

The weeks preceding the conference have been dogged by controversy, culminating in the signing by 5 000 doctors of the "Durban declaration" - a document that reaffirmed the accepted scientific belief that HIV indeed cause Aids.

This week Mbeki's 30-strong panel appointed to settle the matter resolved to re-examine the reliability and accuracy of the standard Aids test used to determine HIV positivity. Influential scientists like Dr Helene Gayle of the Atlanta-based Center for Disease Control and the Medical Research Council's Professor Malegapuru Makgoba are some of the prominent names who will be involved in "testing the test".

According to a dissident advisory panel member, Dr Harvey Bialy, the decision to re-evaluate the Elisa Test is a sign of Mbeki's integrity and refusal to be swayed by external pressures. Bialy is an internationally renowned molecular

biologist and was one of the first PhD graduates from the first molecular biology
department in the world, at the University of California.

He was highly critical of the fact that the lure of financial incentives and lucrative
research funding has come to dominate Aids research, and was diluting the purity
of science as a result.

-- The Mail&Guardian, July 7 2000.

From: Greg Folkers [GFOLKERS@niaid.nih.gov]
Sent: Saturday, July 08, 2000 3:07 PM
Subject: Awaiting the Durban declaration (Mail and Gurardian, SA)

http://www.mg.co.za/mg/news/2000july1/07jul-aids4.html

Johannesburg, South Africa. July 7 2000

Awaiting the Durban declaration

Aids 2000 will be remembered for the document signed by 5 000 people testifying in their belief that HIV causes Aids.

OWN CORRESPONDENT reports

Breaking the silence surrounding the realities of Aids is the theme of Aids 2000, the international Aids conference to be held in Durban this week.

But it is likely that Aids 2000 will be remembered more for the "Durban declaration": a document signed by 5 000 people testifying in their belief that HIV causes Aids.

The declaration followed the controversies surrounding President Thabo Mbeki's discussions with the so-called "Aids dissidents". Mbeki is scheduled to deliver the opening address at the Aids 2000 opening ceremony.

The hope is that Aids 2000 will see the announcement of breakthroughs in Aids treatment, drugs and management. There has also been speculation that it may be used as a platform to announce dramatic cuts in the price of Aids drugs.

Although the epidemic is a global problem, the siting of the conference and the fact that sub-Saharan Africa is home to most of the world's known

Aids cases
are likely to focus attention on the continent.

Aids 2000 is the 13th international Aids conference to be held since 1985 and the first to be held in Africa. It is fitting that this year's conference is being held in South Africa, a country with the fastest-known growing HIV epidemic.

The conferences are designed as a forum for people involved in all aspects of dealing with HIV to get together and discuss issues. It is considered the place to go to hear the latest news on the medical, social and ethical aspects of HIV.

This year more than 12 000 people are expected to attend the conference, which runs formally from July 9 to 15. Satellite sessions begin on July 7.

Some of the biggest names in the Aids world will be at the conference. High-profile attendees include:

David Ho: Described as "a god in the Aids world" by one doctor, and voted Time Man of the Year in 1995 for his work relating to the virus.

Anthony Fauci: Director of the United States National Institute of Allergy and Infectious Diseases and one of the pioneers in understanding how HIV destroys the body's immune system, among other advances.

William Makgoba: President of the South African Medical Research Council and an internationally recognised scientist. He has played an important role in advancing local vaccine research and

development.

Geeta Gupta: President of the International Centre for Research on Women based in Washington, and a leading researcher on the health and social implications of Aids on women.

Edwin Cameron: The South African acting Constitutional Court judge who publicly stated last year that he was HIV- positive.

Hoosen Coovadia: Chair of the Aids 2000 conference and head of paediatrics at the University of Natal, and one of South Africa's most prominent Aids specialists.

The discussions go beyond medicine and science to include social, political and ethical issues surrounding the Aids epidemic. A community programme will be running in parallel with the scientific programme, and there are several satellite sessions including a joint conference hosted by MΘdΘcins sans FrontiΦres and the Treatment Action Campaign on increasing access to drugs.

-- The Mail&Guardian, July 7 2000.

The White House

Office of National AIDS Policy

Statement by the Director, Sandra Thurman

For Immediate Release

Durban, South Africa, July 10, 2000

Contact: Jeff Kamen 082 858 6059

With deep respect for the many challenges he faces, I salute President Mbeki's pledge last night to intensify South Africa's efforts against HIV/AIDS. I want to reaffirm the United States' partnership in the growing effort to expand prevention programs, prevent mother to child transmission and to provide the best possible care and treatment for people living with HIV/AIDS. We must act quickly. We have a brief window of opportunity to turn the tide here in South Africa and elsewhere but that window is closing fast. Every single day brings an avalanche of new infections especially among the poor.

This is a pivotal moment in the fight against HIV/AIDS as the pandemic increasingly grips families and communities across the globe. Poverty is indeed a primary AIDS issue. However, we must not forget the negative impact that racism, homophobia and gender inequity continue to have on our efforts to save lives. 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. We must dramatically step up our prevention efforts now.

The White House

Office of National AIDS Policy

Statement by the Director, Sandra Thurman

For Immediate Release

Durban, South Africa, July 10, 2000

Contact: Jeff Kamen 082 858 6059

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THE WHITE HOUSE

WASHINGTON

MEMORANDUM TO ELAINE ROSKI, OFFICE OF INTERNATIONAL AND REFUGEE HEALH, USAID

From: Cheryl S. Bauerle CSB
Associate Director
Office of National AIDS Policy
736 Jackson Place, NW
Washington, DC 20503
(202) 456-2959

Date: August 9, 2000

Re: **Reimbursement for travel to Durban, South Africa**
XIII International AIDS Conference

Recorded below are the expenses incurred during my recent travel to Africa for the 13th International AIDS Conference. I have enclosed all lodging receipts and a copy of my travel authorization. I have not included meal expenses as I assume them to be covered under a set per diem for the designated locations. Please call Sarah Holewinski, at (202) 395-1441, if you require any additional information.

Air Travel - Ticket #7103570028

Taxi to Washington, Dulles	07/05	USD	45.00
Taxi - Holiday Inn to Royal	07/07	USD	4.10
[The Royal Hotel, Exchange Rate: 6.09]			
Room Charge[1]	07/07	USD	261.00
Business Calls	07/07	USD	15.21
Room Charge	07/08	USD	261.00
Business Calls	07/08	USD	9.30
Guest Link Charge	07/08	USD	7.39
Room Charge	07/09	USD	261.00
Business Calls	07/09	USD	3.08
Room Charge	07/10	USD	261.00
Business Calls	07/10	USD	7.08
Room Charge	07/11	USD	261.00

[1] (Room Charges pre-paid by Social & Scientific Systems. To be reimbursed by USAID)

Business Calls	07/11	USD	4.58
Business Fax	07/11	USD	1.64
Room Charge	07/12	USD	261.00
Business Calls	07/12	USD	2.52
Business Fax	07/12	USD	1.64
Room Charge	07/13	USD	261.00
Business Calls	07/13	USD	6.48
Room Charge	07/14	USD	261.00
Business Calls	07/14	USD	0.41
Taxi - Royal to Durban Airport	07/15	USD	3.28
Taxi from Dulles	07/16	USD	45.00

Total **USD 2244.71**

U.S. Department of Health and Human Services
***** Travel Order *****

Travel Order No. :	0225BAU001	Trans. :	8270.60
Appropriation No.:	7500120	Per Diem:	4198.00
Traveler Name :	CHERYL S BAUERLE	Other :	600.00
Region/Division :	REG99A/OS/HQ	Total :	13068.60
Duty Station :	WASHINGTON DC	Atm Authorized Amt:	1140.00
Approx. Departure:	07/05/00		
Approx. Return :	07/16/00		

********** PURPOSE **********
PURPOSE: ATTENDING THE NATIONAL HIV/AIDS CONFERENCE.
PREPARED BY: ELAINE ROSKI 443-7293 ROOM 18-75
BUSINESS CLASS IS AUTHORIZED WHEN DEPARTURE AND ARRIVAL TIMES EXCEED 14 HOURS.
FOREIGN FLAG JUSTIFICATION: ONLY FLIGHTS AVAILABLE TO REACH DESTINATION
TICKETS TO BE DELIVERED BY SATO TO 736 JACKSON PLACE, N W, NATIONAL AIDS POLICY OFFICE, WASHINGTON, DC 20503
GTA FOR TICKETS IS AUTHORIZED, NO GOVT. CREDIT CARD

********** ITINERARY **********	LODGING	M&IE
WASHINGTON TO DURBAN	367.00	44.00
DURBAN TO WASHINGTON		

Justification:
EXCESS BAGGAGE
ACTUAL/NECESSARY

**** Accounting Information ****

CAN	OBJECT CLASS	AMOUNT
001990225	21.52	13040.10
001990225	21.9M	28.50

****** Funds Certifier ******
JEROME RUTKOSKI

Type of Travel:
PER DIEM = IN U.S.
TYPE = ACTUAL/NECESSARY

Special Authorizations: Taxicab

Recommended by:
Name: THOMAS E NOVOTNY
Position: DASH/DIRECTOR OIRH
Date: 06/28/00

Regional Travel Approvals
Signature:_____ Date:_____
Position :_____

Authorized by:
Name: HAROLD P THOMPSON
Position: EXEC OFFICER
Date: 06/28/00

No signature required. This Travel Order has been electronically approved by the person named to the left of this statement. For verification call: 301 443 4131

HHS-1A

Name: CHERYL BAUERLE Itinerary Order No: 0225BAU001

Depart WASHINGTON	DC Date: 07/05/00	Travel Mode: AIR
Arrive DURBAN	NS Date: 07/07/00	
Via	Carrier: NW 36	
Hotel Name:		
Hotel Street:	Phone: --	
Hotel City/St: NS		
Rent-Car Name:	Phone:	
Rent-Car City:		

Depart DURBAN	NS Date: 07/15/00	Travel Mode: AIR
Arrive WASHINGTON	DC Date: 07/16/00	
Via	Carrier: SA 518	
Hotel Name:		
Hotel Street:	Phone:	
Hotel City/St:		
Rent-Car Name:	Phone:	
Rent-Car City:		

Name: CHERYL BAUERLE ** Travel Order No: 0225BAU001

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GTA FOR TICKETS IS AUTHORIZED, NO GOVT. CREDIT CARD

*** EXCESS BAGGAGE ***
WILL BE TAKING A LAPTOP COMPUTER AND SUPPLIES.

*** ACTUAL/NECESSARY ***
HOTELS ARE ALL BOOKED THROUGH AN AGENCY. PER DIEM WILL NOT COVER COSTS.

REGION	OPDIV	CAN	OBJECT CLASS	PROJECT CODE	OBLIGATED AMT.
99	A	001990225	21.52		13040.10
99	A	001990225	21.9M		28.50

Sa oT ave.®

EMERGENCY SERVICE
1-800-827-7777

SALES PERSON: Ø2 ITINERARY/INVOICE NO. ØØ75423 DATE: 3Ø JUN
CUSTOMER NBR: 553100 WTLCXH PAGE: Ø1

TO: CHERYL BAUERLE-HHS
736 JACKSON PLACE NW
WASHINGTON DC 2Ø5Ø3
**FEDEX 2Ø2-456-2959

FOR: BAUERLE/CHERYL REF: 0,217,7500W

Ø5 JUL ØØ - WEDNESDAY
AIR NORTHWEST AIRLINES FLT:36 BUSINESS MULTI MEALS
LV WASHINGTON DULLES 6Ø5P EQP: DC-1Ø
Ø7HR 4ØMIN

Ø6 JUL ØØ - THURSDAY
AR AMSTERDAM 745A NON-STOP
REF: L3CXXC

BAUERLE/CHERYL SEAT- 5C
AIR NORTHWEST AIRLINES FLT:8593 BUSINESS MULTI MEALS
AMSTERDAM-JOHANNESBURG OPERATED BY KLM ROYAL DUTCH AIRLINES
LV AMSTERDAM 81ØP EQP: BOEING 747
1ØHR 4ØMIN

Ø7 JUL ØØ - FRIDAY
AR JOHANNESBURG 65ØA NON-STOP
REF: L3CXXC

BAUERLE/CHERYL SEAT- 2B
AIR SOUTH AFRICAN FLT:5Ø5 ECONOMY BREAKFAST
LV JOHANNESBURG 8ØØA EQP: BOEING 737-2ØØ
Ø1HR 1ØMIN
AR DURBAN 91ØA NON-STOP

15 JUL ØØ - SATURDAY
AIR SOUTH AFRICAN FLT:518 BUSINESS SNACK
LV DURBAN 3ØØP EQP: AIRBUS A3ØØ
Ø1HR 1ØMIN
AR JOHANNESBURG 41ØP NON-STOP
AIR NORTHWEST AIRLINES FLT:8594 BUSINESS MULTI MEALS
JOHANNESBURG-AMSTERDAM OPERATED BY KLM ROYAL DUTCH AIRLINES
LV JOHANNESBURG 655P EQP: BOEING 747 COMB
1ØHR 5ØMIN

16 JUL ØØ - SUNDAY
AR AMSTERDAM 545A NON-STOP
REF: L3CXXC

BAUERLE/CHERYL SEAT- 1B

CONTINUED ON PAGE 2

ORIGINAL

SatoTravel

24-HOUR
EMERGENCY SERVICE
1-800-827-7777

SALES PERSON: Ø2 ITINERARY/INVOICE NO. Ø075423
CUSTOMER NBR: 553100 UTLCXH
DATE: 3Ø JUN
PAGE: Ø2

TO: CHERYL BAUERLE-HHS
736 JACKSON PLACE NW
WASHINGTON DC 2Ø5Ø3
**FEDEX 2Ø2-456-2959

FOR: BAUERLE/CHERYL REF: Ø,217,75ØØW

16 JUL ØØ - SUNDAY

AIR	NORTHWEST AIRLINES	FLT:37	BUSINESS	
	LV AMSTERDAM		1135A	MULTI MEALS
				EQP: DC-1Ø
	AR WASHINGTON DULLES		2Ø5P	Ø8HR 3ØMIN
				NON-STOP
	BAUERLE/CHERYL SEAT- 5C			REF: L3CXXC

MCO XD8111141418

BILLED TO VISA

AIR TICKETS NW71Ø357ØØ28/29

BAUERLE CHERYL
BILLED TO VISA

	13.5
	8,242.1
SUB TOTAL	
NET CC BILLING	8,255.6
	8,255.6
TOTAL AMOUNT DUE	Ø.Ø

THANK YOU FOR USING SATOTRAVEL.
LOCAL PHONE NUMBER 3Ø1-984-8894 MON-FRI 73ØAM-53ØP
ON TRAVEL STATUS CALL 8ØØ-496-3623 MON-FRI 73ØAM-53ØP
FOR AFTER HOURS EMERGENCY SERVICE, CALL 8ØØ 827-7777.
YOUR REFERENCE CODE IS ***SABRE VO75***
FREQUENT FLYER MILES ARE PROPERTY OF THE US GOVERNMENT
EFF FEB 21, 2ØØØ TRX FEE OF 13.5Ø WILL BE CHARGED
GOVERNMENT FARE 8242.1Ø AS OF 6/26

G1-HHSOS
G3-Ø225BAUØØ1
G4-ØØ199Ø225
G5-2152
N-8242.1Ø#C4
G6-2Ø2-456-2959

ORIGINAL

GUEST ACCOUNT

Durban Hotels Limited
Reg. No. 05/00522/06
267 Smith Street, Durban 4001
P.O. Box 1041, Durban 4000
Telephone: (031) 304-0331
Fax: (031) Res: 307-6884
Admin: 305-2807
Telex: 6-22454 SA
VAT Reg. No. 4190103343
E-Mail: theroyal@iafrica.com
Internet Site : http://www.lhw.com.

The Royal

* * * * *

A member of The Leading Hotels of the World

MANAGED BY Hyatt International GROUP

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Durban Hotels Limited
Reg. No. 05/00522/06
267 Smith Street, Durban 4001
P.O. Box 1041, Durban 4000
Telephone: (031) 304-0331
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VAT Reg. No. 4190103343
E-Mail: theroyal@iafrica.com
Internet Site : http://www.lhw.com.

Copy On Fax

1835	BDBL/	TURNS
~~1835~~	~~BDBL/~~	~~TURNS~~

Doctor C Baurle
Turners Travel-SSS-NIH
Box 1935
Durban
4000

FRI 07JUL 00	8	SAT 15JUL 00
[illegible]	INTCONTEN	
NB	9:44	

PAYABLE ON PRESENTATION

	.00

07JUL	PABX Call	091407	19.43+	
07JUL	PABX Call	091407	15.52+	
07JUL	PABX Call	091814	19.78+	
07JUL	PABX Call	091814	19.11+	
07JUL	PABX Call	091814	18.76+	
08JUL	PABX Call	082858	4.96+	
08JUL	PABX Call	082858	4.96+	
08JUL	Coffee Shop On	38673	6.00+	CM
08JUL	Coffee Shop Tw	38740	18.50+	CM
08JUL	Guest Link Cha		45.00+	
08JUL	PABX Call	091407	17.89+	
08JUL	PABX Call	091407	12.96+	
08JUL	PABX Call	091814	15.86+	
09JUL	Laundry	17578	60.00+	CM
09JUL	Laundry	17581	20.00+	CM
09JUL	Coffee Shop Tw	13185	59.75+	RG
09JUL	PABX Call	091202	18.76+	
10JUL	Coffee Shop On	40308	19.50+	TM
10JUL	PABX Call	082858	6.96+	
10JUL	PABX Call	091814	17.89+	
10JUL	PABX Call	091814	18.24+	
11JUL	Facsimile	REC 1	10.00+	MU
11JUL	PABX Call	082858	3.31+	
11JUL	PABX Call	082858	3.31+	
11JUL	PABX Call	336253	1.45+	
11JUL	PABX Call	082858	3.31+	

Your signature on this account denotes that you have scrutinised all relevant supporting dockets and have accepted all charges detailed hereon.

ROBERTS 2084451

The Royal

* * * * *

A member of The Leading Hotels of the World

MANAGED BY Hotel Edition GROUP

GUEST ACCOUNT

Durban Hotels Limited
Reg. No. 05/00522/06
267 Smith Street, Durban 4001
P.O. Box 1041, Durban 4000
Telephone (031) 304-0331
Fax (031) Res. 307-6884
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Internet Site : http://www.lhw.com.

Room	Type	Plan
1835	BDBL/	TURNS
1835	BDBL/	TURNS

Doctor C Baurle
Turners Travel-SSS-NIH
Box 1935
Durban
4000

Arrival	Nights	Departure
FRI 07JUL.00	8	SAT 15JUL.00

Folio	Number	Currency
006318	INTCOIDBN	

Cashier	Time
NB	9:44

Date	Description	Reference	Amount	
11JUL	PABX Call	082858	3.31+	
11JUL	PABX Call	082858	3.31+	
11JUL	PABX Call	082858	6.61+	
11JUL	PABX Call	082858	3.31+	
12JUL	PABX Call	083417	13.92+	
12JUL	PABX Call	33682	1.45+	
12JUL	Facsimile	REC 10	10.00+	MU
12JUL	Room Service T	90389	34.00+	MJ
12JUL	Exchange Bar	042746	16.80+	SR
13JUL	PABX Call	082858	4.64+	
13JUL	PABX Call	082858	4.64+	
13JUL	PABX Call	082858	25.52+	
13JUL	PABX Call	082858	4.64+	
13JUL	Room Service T	90728	7.50+	YM
13JUL	Room Srvce Thr	90887	83.00+	MJ
13JUL	Laundry	18386	20.00+	DS
14JUL	Room Service D	91069	6.00+	YM
14JUL	Room Srvce Thr	91420	69.00+	MJ
14JUL	PABX Call	082858	2.49+	
15JUL	Bank Card		780.35-	NB

DEBIT NOTE SF 18857

24 HOURS SERVICE
TEL: 309 6771
FAX: 309 6772
A/C: 309 7495

Driver 235 ND 587146

M

Dr. to

SWIFT FALCON TAXI CABS

RADIO CONTROLLED

Price City
350 Umgeni Road
Durban 4001

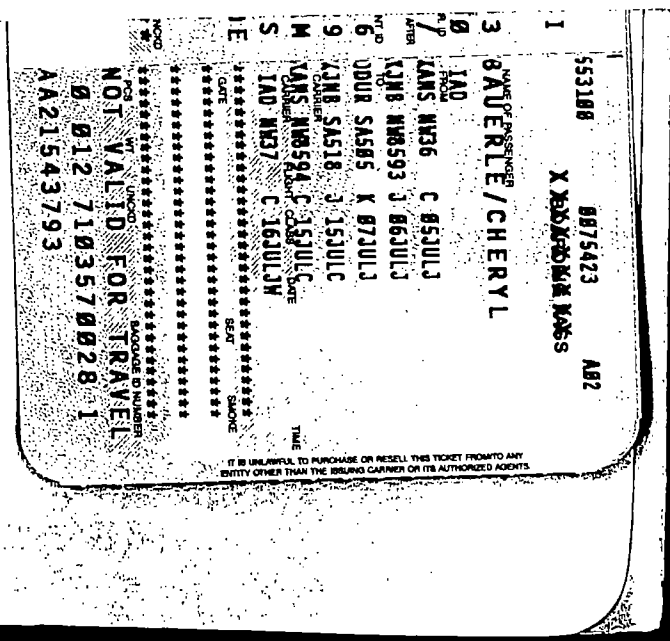
19

FROM	TO	AMOUNT	
MARINE	ROYAL		
PARADE			
	TOTAL R	25	00

Customer Smith

THANK YOU - CALL AGAIN

LEMON TREE 255 355



SAA SOUTH AFRICAN AIRWAYS

NM BAUERLE

DULLES

IAD NW 37 16JUL

AMS NW 8594 15JUL

JNB SA 518 15JUL

SA 048787

0083

00 3428 9533

PASSENGER TICKET AND BAGGAGE CHECK

SUBJECT TO CONDITIONS OF CONTRACT

NOT TRANSFERABLE

0,217,7500W

PASSENGER RECEIPT SITI

ARC XXXX

XXXXX

TOUR CODE

AGENT CODE A21543793

ROCKVILLE PLACE OF ISSUE MD US30JUN00 DATE OF ISSUE

FARE BASIS/TICKET DESIGNATOR 6 0011/

PNR/CARRIER CODE WTLCXH/AA MULTI

THIS IS YOUR RECEIPT

ISSUING AGENT ID X/ V075*16

C28-29

590*1210/ 080059 /FCWAS NW X/AM

A DUR M3934.25J SA X/JNB NW X/AMS

Q5.00 2803.00JW NUC8173.57END ROE

A6.80RN1.00VV18.50ZA3.00XF XFIAD3

ALLOW PCS WT UNCKD **********

TAX US 24.80

TAX YC 5.00

USD 8242.10

63670374784

CPN DOCUMENT NUMBER CK

0 012 7103570028 1

553100 0075423 A02

XXXXXXXXXX

NAME OF PASSENGER BAUERLE/CHERYL

FROM IAD

TO	CARRIER	FLIGHT	CLASS	DATE
XAMS	NW	36	C	05JULJ
XJNB	NW	8593	J	06JULJ
DUR	SA	505	K	07JULJ
XJNB	SA	518	J	15JULC
XAMS	NW	8594	C	15JULC
IAD	NW	37	C	16JULJW

GATE SEAT SMOKE

PCS WT UNCKD BAGGAGE ID NUMBER

NOT VALID FOR TRAVEL

0 012 7103570028 1

AA21543793

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. receipt	Airline ticket stub, Cheryl Bauerle, IAD to DUR and return (partial) (1 page)	06/30/2000	b(6)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office

OA/Box Number: 21066

FOLDER TITLE:
South Africa 7/7-7/14/00 [3]

2007-1550-F
kc1260

RESTRICTION CODES

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

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

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

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

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

[001]

[redacted]

PASSENGER TICKET AND BAGGAGE CHECK 0 217 7508W
SUBJECT TO CONDITIONS OF CONTRACT
NOT TRANSFERABLE

PASSENGER RECEIPT SITI

$531.00 0975423 A02

ARC XXXXXXXX TOUR CODE XXXXX AGENT CODE A21543793

ISSUED BY NORTHWEST AIRLINES
ISSUING AGENT SATO TRAVEL 217-T
NAME OF PASSENGER BAUERLE/CHERYL
EMP

PLACE OF ISSUE ROCKVILLE MD US 30JUN00
FC 6 0011/
FARE BASIS/TICKET DESIGNATOR WTLCXH/AA MUL I I
CARRIER CLASS CLASS/DATE TIME STATUS NOT VALID BEFORE NOT VALID AFTER
** NOT VALID FOR ** THIS IS YOUR RECEIPT
** TRANSPORTATION *
ENDORSEMENTS/RESTRICTIONS

NAME OF PASSENGER BAUERLE/CHERYL

FROM IAD
XANS NW136 C 05JUL J
TO XJNB NW8593 J 06JUL J
XDUR SA505 K 07JUL J
XJNB SA518 J 15JUL C
CARRIER XANS NW8594 C 15JUL
CARRIER FLIGHT CLASS DATE TIME
IAD NW37 C 16JULJW
GATE SEAT SMOKE

FP VI (b)(6) 1210/ 08005S9 /FCWAS NW X/AM
S Q5.00 NW X/JNB SA DUR M3934.25J SA X/JNB NW X/AMS
M1426.32C NW WAS Q5.00 2803.00JW NUC8173.57END ROE
1.00XT6.00XY3.00XA6.80RN1.00VV18.50ZA3.00XF XFIAD3

XT 38.30
USD 8174.00
US 24.80
YC 5.00 6367037478 4
USD 8242.10

EQUIV. FARE PD
STOCK CONTROL NO. TX 000 CK
CPN DOCUMENT NUMBER CK
0 012 7103570028 1

ALLOW PCS WT UNCKD BAGGAGE ID NUMBER
NOT VALID FOR TRAVEL
0 012 7103570028 1
AA21543793

IF UNLAWFUL TO PURCHASE OR RESELL THIS TICKET FROM ANY ENTITY OTHER THAN AN AIR CARRIER OR ITS AUTHORIZED AGENTS

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002. receipt	Airline ticket stub, Cheryl Bauerle, miscellaeous charges (partial) (1 page)	06/30/2000	b(6)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office

OA/Box Number: 21066

FOLDER TITLE:
South Africa 7/7-7/14/00 [3]

2007-1550-F
kc1260

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002

PASSENGER TICKET AND BAGGAGE CHECK

NOT TRANSFERABLE

MISCELLANEOUS CHARGES ORDER

ARC XXXX PASSENGER RECEIPT

TOUR CODE

AGENT CODE A21543793

ISSUED BY AIRLINES REPORTING CRP

ROCKVILLE

PLACE OF ISSUE / DATE OF ISSUE MDUS30JUN00

NAME OF ISSUING AGENT SATO TRAVEL 217-T

PNR/CARRIER CODE WTLCXH/AA

FARE BASIS/TICKET DESIGNATOR

FCI / SERV CARR ID 7 0011/

NAME OF PASSENGER BAUERLE/CHERYL

FROM AIRLINES REPORTING CORP

TO TRAVEL RELATED SERVICE FEE TR

CARRIER FLIGHT CLASS DATE TIME STATUS NOT VALID BEFORE NOT VALID AFTER

ISSUING AGENT ID V075A16

ENDORSEMENTS/RESTRICTIONS

FP V (b)(6) 1210 / 083344

ALLOW PCS WT UNCKD

FARE USD 13.50

TAX US 0.00

TAX

TOTAL USD 13.50

EQUIV. FARE PD.

STOCK CONTROL NO TX 660 CK 63670374810

CPN DOCUMENT NUMBER CK 890 8111141418 6

553100 0075423 A02

NAME OF PASSENGER MISCELLANEOUS CHARGES ORDER

FROM

TO

CARRIER

CARRIER FLIGHT CLASS DATE TIME

GATE SEAT SMOKE

NOT VALID FOR TRAVEL

PCS WT UNCKD BAGGAGE ID NUMBER

8901 AA21543793

Social &
Scientific
Systems

August 1, 2000

INVOICE FOR CHERYL BAURLE

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

Accommodations

July 7 - July 15 (8 nights)
1 Standard Room at the Royal Hotel @ $261/night U.S. $2,088

TOTAL INVOICE: U.S. $ 2,088

(Please make the check payable to Social & Scientific Systems, Inc.
and remit to the attention of Ms. Cathy Maimon at the address below or if you would like to pay by credit card, please contact Ms. Maimon directly at 301-986-4870, ext. 341.)

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

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003. form	SF 1012, Travel Voucher Untitled, Sandra Thurman (partial) (1 page)	06/08/2000	b(6)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office

OA/Box Number: 21066

FOLDER TITLE:
South Africa 7/7-7/14/00 [3]

2007-1550-F
kc1260

RESTRICTION CODES

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

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

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

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

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

[003]

TRAVEL VOUCHER

(Read Privacy Act Statement on the back)

1. DEPARTMENT OR ESTABLISHMENT BUREAU DIVISION OR OFFICE: OPD

2. TYPE OF TRAVEL: [X] TEMPORARY DUTY [ ] PERMANENT CHANGE OF STATION

3. VOUCHER NO.: UNTITLED

4. SCHEDULE NO.:

5. a. NAME (Last, first, middle initial): THURMAN, SANDRA L.

b. SOCIAL SECURITY NO.: (b)(6)

6. PERIOD OF TRAVEL: a. FROM 06/10/00 b. TO 06/21/00

c. MAILING ADDRESS (Include ZIP Code):
OEOB, ROOM 145
MGT&ADMIN
WASHINGTON, DC 20502

d. OFFICE TELEPHONE NO.:

7. TRAVEL AUTHORIZATION: a. NUMBER(S): b. DATE(S): 06/08/00

e. PRESENT DUTY STATION: WASHINGTON, DC

f. RESIDENCE (City and State): Washington, DC

10. CHECK NO.:

8. TRAVEL ADVANCE

a. Outstanding	0.00
b. Amount to be applied	0.00
c. Amount due Government (Attached [ ] Check [ ] Cash)	
D. Balance outstanding	

9. CASH PAYMENT RECEIPT: a. DATE RECEIVED: b. AMOUNT RECEIVED: $

c. PAYEE'S SIGNATURE:

11. PAID BY:

12. GOVERNMENT TRANSPORTATION REQUESTS, OR TRANSPORTATION TICKETS, IF PURCHASED WITH CASH (List by number below and attach passenger coupon; if cash is used show claim on reverse side)

I hereby assign the United States any right I may have against any parties in connection with reimbursable transportation charges described below, purchased under cash payment procedures (FPMR 101-7) ▶ Traveler's Initials

AGENT'S VALUATION OF TICKET (a)	ISSUING CARRIER (Initials) (b)	MODE CLASS OF SERVICE AND ACCOMMODATIONS (c)	DATE ISSUED (d)	POINTS OF TRAVEL FROM (e)	POINTS OF TRAVEL TO (f)
			(* Amendment attached)		

COMMENTS:
Trip Number 1. All costs associated with travel are reimbursed by USAID.

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

TRAVELER SIGN HERE ▶ X Sandra L Thurman DATE 8/16/00 AMOUNT CLAIMED ▶ 0.00

NOTE: Falsification of an item in an expense account works a forfeiture of claim (28 U.S.C. 2514) and may result in a fine of not more than $10,000 or imprisonment for not more than 5 years or both (18 U.S.C. 287; i.d. 1001).

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

APPROVING OFFICIAL SIGN HERE ▶ DATE

17. FOR FINANCE OFFICE USE ONLY COMPUTATION

a. DIFFERENCES, IF ANY (Explain and show amount) $

b. TOTAL VERIFIED CORRECT FOR CHARGE TO APPROPRIATION Certifier's initials: $

c. APPLIED TO TRAVEL ADVANCE (Appropriation symbol): 0.00 $

d. NET TO TRAVELER ▶ $ 0.00

15. LAST PRECEDING VOUCHER PAID UNDER SAME TRAVEL AUTHORIZATION

a. VOUCHER NO.	b. D.O. SYMBOL	c. MONTH & YEAR

16. THIS VOUCHER IS CERTIFIED CORRECT AND PROPER FOR PAYMENT

AUTHORIZED CERTIFYING OFFICIAL SIGN HERE ▶ DATE

18. ACCOUNTING CLASSIFICATION
SEE BLOCK 12 ABOVE

SCHEDULE OF EXPENSES AND AMOUNTS CLAIMED

INSTRUCTIONS TO TRAVELER *(Unlisted items are self explanatory)*

Col. (c) If the voucher includes per diem allowances for members of employee's immediate family, show members' names, ages, and relationships to employee and marital status of children (unless information is shown on the travel authorization.)

Complete only for actual expense travel

Col. (d) thru (g) Show amount incurred for each meal, including tax and tips, and daily total meal cost.

(h) Show expenses, such as: laundry, cleaning and pressing of clothes, tips to bellboys, porters, etc. (other than for meals).

(i) Complete for per diem and actual expense travel.

(j) Show total subsistence expense incurred for actual expense travel.

(m) Show per diem amount, limited to maximum rate, or travel on actual expense, show the lesser of the amount from col. (j) or maximum rate.

(n) Show expenses, such as: taxi/limousine fares, air fare (if purchased with cash), local or long distance telephone calls for Government business, car rental, relocation other than subsistence, etc.

Complete this information if this is a continuation sheet. PAGE 2 OF

TRIP# 1 PAGES

TRAVEL AUTHORIZATION NO.

TRAVELER'S LAST NAME

THURMAN

DATE 19 00 (a)	TIME (Hour and am/pm) (b)	DESCRIPTION (Departure/arrival city, per diem computation, or other explanation of expenses) (c)	ITEMIZED SUBSISTENCE EXPENSES — MEALS: BREAKFAST (d)	LUNCH (e)	DINNER (f)	TOTAL (g)	MISCELLANEOUS SUBSISTENCE (h)	LODGING (i)	TOTAL SUBSISTENCE EXPENSE (j)	MILEAGE RATE: 0.000 NO. OF MILES (k)	AMOUNT CLAIMED: MILEAGE (l)	SUBSISTENCE (m)	OTHER (n)
06/10		D-:Andrews AFB											
06/10		A-:ABUJA,NGR											
06/11		Subsistence											
06/12		D-:ABUJA,NGR											
06/12		A-:DAR ES SALAAM,TAN											
06/13		Subsistence											
06/14		D-:DAR ES SALAAM,TAN											
06/14		A-:PRETORIA,SAF											
06/15		Subsistence											
06/16		D-:PRETORIA,SAF											
06/16		A-:MAPUTO,MOZ											
06/17		Subsistence											
06/18		D-:MAPUTO,MOZ											
06/18		A-:CAIRO,EGY											
06/19		Subsistence											
06/20		D-:CAIRO,EGY											
06/20		Subsistence											
06/21		A:Andrews AFB											
06/21		Subsistence											
										SUBTOTALS ▶	0 00	0 00	0 00
										TOTALS ▶	0 00	0 00	0 00

If additional space is required, continue on another 1012-A BACK, leaving the front blank.

Enter grand total of columns (l), (m) and (n), below and in item 13 on the front of this form.

TOTAL AMOUNT CLAIMED ▶ 0.00

In compliance with the Privacy Act of 1974, the following information is provided: Solicitation of the information on this form is authorized by 5 U.S.C. Chap. 57 as implemented by the Federal Travel Regulations (FPMR 101 7), E.O. 11609 of July 22, 1971, E.O. 11012 of March 27, 1962, E.O. 9397 of November 22, 1943, and 26 U.S.C. 6011(b) and 6109. The primary purpose of the requested information is to determine payment or reimbursement to eligible individuals for allowable travel and/or relocation expenses incurred under appropriate administrative authorization and to record and maintain costs of such reimbursements to the Government. The information will be used by officers and employees who have a need for the information in the performance of their official duties. The information may be disclosed to criminal, or regulatory investigations or prosecutions, or when pursuant to a requirement by this agency in connection with the hiring or firing of an employee, the issuance of a security clearance, or investigations of the performance of official duty while in Government service. Your Social Security Account Number (SSN) is solicited under the authority of the Internal Revenue Code (26 U.S.C. 6011(b) and 6109) and E.O. 9397, November 22, 1943, for use as a tax payer and/or employee identification number; disclosure is MANDATORY on vouchers claiming travel and/or relocation allowance expense reimbursement which is, or may be, taxable income. Disclosure of you SSN and other requested information is voluntary in all other instances; however, failure to provide the information (other than SSN) required to support the claim may result in delay or loss of reimbursement.

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
004. form	OA Form 22, Travel Authorization number TOJONA27 (partial) (1 page)	06/08/2000	b(6)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office

OA/Box Number: 21066

FOLDER TITLE:
South Africa 7/7-7/14/00 [3]

2007-1550-F
kc1260

RESTRICTION CODES

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

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

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

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

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

[004]

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICIAL TRAVEL AUTHORIZATION
(Privacy Act Statement on back)

1. TRAVEL AUTHORIZATION NO.	2. DATE
TOSONA07	06/08/00

3. TYPE OF TRAVEL
- [X] Official
- [ ] Relocation
- [ ] Mixed
- [ ] Political
- [ ] Invitational (Non EOP Employees Only)
- [ ] Amendment (Show items amended)
- [ ] Funded by Non-Federal Sources

4. TRAVELER (First name, middle initial, last name)
S. RA L. THURMAN

5. TITLE OF TRAVELER	6. SOCIAL SECURITY NUMBER	7. DIVISION	8. AGENCY
DIRECTOR, AIDS POLICY	(b)(6)		736 JP

9. OFFICE PHONE	10. OFFICIAL DUTY STATION	11.
456-2959	WASHINGTON, DC	[X] Per Diem [ ] Actual Subsistence (unusual circumstances)* Rate(s):

12. TRAVEL INFORMATION

PURPOSE: Participating in delegation led by Sect Summers.Issues to include the imp AIDS on the African economy.Please see attached itinerary.

DATE(S): Travel Begin On 6/10/2000 Travel End On 6/18/2000

ITINERARY: (Point of Origin/Place(s) of Official Visitation/Point of Return)

From: Andrews AFB
To: DAR ES SALAAM,TAN 180/ 65
To: MAPUTO,MOZ 155/ 68
To:
To:
To:

To: ABUJA,NGR 159/ 72
To: PRETORIA,SAF 96/ 57
To:
To:
To:
Return to: Andrews AFB

13. MODE OF TRAVEL

- [ ] Commercial Air
- [ ] Private Vehicle 0.000 Mileage Rate
- [ ] Rail
- [ ] Military Air
- [ ] Government Owned Vehicle
- [X] Other (specify)

14. SPECIAL EXPENSE AUTHORIZED

- [ ] Registration Fees (meeting, training, etc.)
- [ ] Commercial Rental Car
- [ ] Excess Baggage not to exceed
- [X] Other (Please identify)

15. ESTIMATED COST

	AMOUNT
Per Diem/Lodging	$ 0.00
Per Diem/M&IE	0.00
Transportation	0.00
Rental Car	0.00
Miscellaneous	0.00
16. TOTAL	$ 0.00

17. * SPECIAL PROVISIONS/REMARKS (Justification for first class/business/extra fare travel, annual leave enroute, actual subsistence, etc.)
All costs associated with travel to be covered by USAID.

18. ACCOUNTING DATA (Appropriation, division, project, vendor number)
J108C 1102200

19. REQUESTED BY

nds are available to defray travel cost specified above
ds Manager's Certification (Signature)

20. I certify the travel herein was reviewed and determined to be essential for the accomplishment of agency programs and missions in the most economical means available.
Approval Official (Signature and Title)
Bradley J. Kiley

OA FORM 22
REVISED JUNE 1994

___ 1. Original (Return with voucher) ___ 2. FMD copy ___ 3. Travelers copy
___ 4. Teleticketing Office ___ 5. Funds Manager copy

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
005. form	OA Form 22, Travel Authorization number TOJONA27-01 (partial) (1 page)	06/08/2000	b(6)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office

OA/Box Number: 21066

FOLDER TITLE:
South Africa 7/7-7/14/00 [3]

2007-1550-F
kc1260

RESTRICTION CODES

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

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
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P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

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

b(1) National security classified information [(b)(1) of the FOIA]
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b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

[005]

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICIAL TRAVEL AUTHORIZATION

(Privacy Act Statement on back)

1. TRAVEL AUTHORIZATION NO.	2. DATE
TOSONA07-01	06/08/00

3. TYPE OF TRAVEL

- [X] Official
- [ ] Relocation
- [ ] Mixed
- [ ] Political
- [ ] Invitational (Non EOP Employees Only)
- [X] Amendment (Show items amended)
- [ ] Funded by Non-Federal Sources

4. TRAVELER (First name, middle initial, last name)

SANDRA L. THURMAN

5. TITLE OF TRAVELER	6. SOCIAL SECURITY NUMBER	7. DIVISION	8. AGENCY
DIRECTOR, AIDS POLICY	(b)(6)		736 JP

9. OFFICE PHONE	10. OFFICIAL DUTY STATION	11.
456-2959	WASHINGTON, DC	[X] Per Diem [ ] Actual Subsistence (unusual circumstances)* Rate(s):

12. TRAVEL INFORMATION

PURPOSE: Participating in delegation led by Sect Summers.Issues to include the imp AIDS on the African economy.Please see attached itinerary.

DATE(S): Travel Begin On 6/10/2000 Travel End On 6/18/2000

ITINERARY: (Point of Origin/Place(s) of Official Visitation/Point of Return)

From: Andrews AFB
To: DAR ES SALAAM,TAN 180/ 65
To: MAPUTO,MOZ 155/ 68
To:
To:
To:

To: ABUJA,NGR 103/ 70
To: PRETORIA,SAF 96/ 57
To: CAIRO,EGY
To:
To:
Return to: Andrews AFB

13. MODE OF TRAVEL

- [ ] Commercial Air
- [ ] Private Vehicle 0.000 Mileage Rate
- [ ] Rail
- [ ] Military Air
- [ ] Government Owned Vehicle
- [X] Other (specify)

14. SPECIAL EXPENSE AUTHORIZED	15. ESTIMATED COST	AMOUNT
[ ] Registration Fees (meeting, training, etc.)	Per Diem/Lodging	$ 0.00
[ ] Commercial Rental Car	Per Diem/M&IE	0.00
[ ] Excess Baggage not to exceed	Transportation	0.00
[X] Other (Please identify)	Rental Car	0.00
	Miscellaneous	0.00
	16. TOTAL	$ 0.00

17. * SPECIAL PROVISIONS/REMARKS (Justification for first class/business/extra fare travel, annual leave enroute, actual subsistence, etc.)

Amendment adds Egypt. All expenses covered by USAID.

18. ACCOUNTING DATA (Appropriation, division, project, vendor number)

19. REQUESTED BY

20. I certify the travel herein was reviewed and determined to be essential for the accomplishment of agency programs and missions in the most economical means available. Approval Official (Signature and Title)

21. Funds are available to defray travel cost specified above Funds Manager's Certification (Signature)

OA FORM 22
REVISED JUNE 1994

____ 1. Original (Return with voucher) ____ 2. FMD copy ____ 3. Travelers copy
____ 4. Teleticketing Office ____ 5. Funds Manager copy

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
006. form	SF 1012, Travel Voucher number TOJONA30, Cheryl Bauerle (partial) (1 page)	08/09/2000	b(6)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office

OA/Box Number: 21066

FOLDER TITLE:
South Africa 7/7-7/14/00 [3]

2007-1550-F
kc1260

RESTRICTION CODES

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

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

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

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

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

[006]

TRAVEL VOUCHER

(Read Privacy Act Statement on the back)

1. DEPARTMENT OR ESTABLISHMENT BUREAU DIVISION OR OFFICE: ONAP

2. TYPE OF TRAVEL: [X] TEMPORARY DUTY [ ] PERMANENT CHANGE OF STATION

3. VOUCHER NO.: TOJONA30

4. SCHEDULE NO.:

5. a. NAME (Last, first, middle initial): Bauerle, Cheryl S.

b. SOCIAL SECURITY NO.: (b)(6)

6. PERIOD OF TRAVEL: a. FROM 07/05/00 b. TO 07/16/00

c. MAILING ADDRESS (Include ZIP Code): 736 Jackson Place NW, Washington, DC 20503

d. OFFICE TELEPHONE NO.: (202) 456-2959

7. TRAVEL AUTHORIZATION: a. NUMBER(S): b. DATE(S): 08/09/00

e. PRESENT DUTY STATION: Washington, DC

f. RESIDENCE (City and State): Washington, DC

10. CHECK NO.:

8. TRAVEL ADVANCE

a. Outstanding	0.00
b. Amount to be applied	0.00
c. Amount due Government (Attached [ ] Check [ ] Cash)	
D. Balance outstanding	

9. CASH PAYMENT RECEIPT

a. DATE RECEIVED:

b. AMOUNT RECEIVED: $

c. PAYEE'S SIGNATURE:

11. PAID BY

12. GOVERNMENT TRANSPORTATION REQUESTS, OR TRANSPORTATION TICKETS, IF PURCHASED WITH CASH (List by number below and attach passenger coupon; if cash is used show claim on reverse side)

I hereby assign the United States any right I may have against any parties in connection with reimbursable transportation charges described below, purchased under cash payment procedures (FPMR 101-7) ▶ Traveler's Initials

AGENT'S VALUATION OF TICKET (a)	ISSUING CARRIER (Initials) (b)	MODE CLASS OF SERVICE AND ACCOMMODATIONS (c)	DATE ISSUED (d)	POINTS OF TRAVEL FROM (e)	POINTS OF TRAVEL TO (f)

COMMENTS:
Trip Number 1 All expenses provided for by USAID/Department of State.

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

TRAVELER SIGN HERE ▶ Cheryl S. Bauerle DATE 8/9/00 AMOUNT CLAIMED ▶ 0.00

NOTE: Falsification of an item in an expense account works a forfeiture of claim (28 U.S.C. 2514) and may result in a fine of not more than $10,000 or imprisonment for not more than 5 years or both (18 U.S.C. 287; i.d. 1001).

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

APPROVING OFFICIAL SIGN HERE ▶ DATE

17. FOR FINANCE OFFICE USE ONLY COMPUTATION

a. DIFFERENCES, IF ANY (Explain and show amount) $

b. TOTAL VERIFIED CORRECT FOR CHARGE TO APPROPRIATION Certifier's initials: $

c. APPLIED TO TRAVEL ADVANCE (Appropriation symbol): $ 0.00

d. NET TO TRAVELER ▶ $ 0.00

15. LAST PRECEDING VOUCHER PAID UNDER SAME TRAVEL AUTHORIZATION

a. VOUCHER NO. | b. D.O. SYMBOL | c. MONTH & YEAR

16. THIS VOUCHER IS CERTIFIED CORRECT AND PROPER FOR PAYMENT

AUTHORIZED CERTIFYING OFFICIAL SIGN HERE ▶ DATE

18. ACCOUNTING CLASSIFICATION
SEE BLOCK 12 ABOVE

SCHEDULE OF EXPENSES AND AMOUNTS CLAIMED

INSTRUCTIONS TO TRAVELER *(Unlisted items are self explanatory)*

Col. (c) If the voucher includes per diem allowances for members of employee's immediate family, show members' names, ages, and relationships to employee and marital status of children (unless information is shown on the travel authorization.)

Complete only for actual expense travel — Col. thru

- *(d)* Show amount incurred for each meal, including tax and tips, and daily total meal cost. *(g)*
- *(h)* Show expenses, such as: laundry, cleaning and pressing of clothes, tips to bellboys, porters, etc. (other than for meals).
- *(i)* Complete for per diem and actual expense travel.
- *(j)* Show total subsistence expense incurred for actual expense travel.
- *(m)* Show per diem amount, limited to maximum rate, or travel on actual expense, show the lesser of the amount from col. (j) or maximum rate.
- *(n)* Show expenses, such as: taxi/limousine fares, air fare (if purchased with cash), local or long distance telephone calls for Government business, car rental, relocation other than subsistence, etc.

Complete this information if this is a continuation sheet. PAGE 2 OF TRIP# 1 PAGES

TRAVEL AUTHORIZATION NO.

TRAVELER'S LAST NAME
Bauerle

DATE 19 00 (a)	TIME (Hour and am/pm) (b)	DESCRIPTION (Departure/arrival city, per diem computation, or other explanation of expenses) (c)	ITEMIZED SUBSISTENCE EXPENSES — MEALS: BREAKFAST (d)	LUNCH (e)	DINNER (f)	TOTAL (g)	MISCELLANEOUS SUBSISTENCE (h)	LODGING (i)	TOTAL SUBSISTENCE EXPENSE (j)	MILEAGE RATE: 0.000 NO. OF MILES (k)	AMOUNT CLAIMED: MILEAGE (l)	SUBSISTENCE (m)	OTHER (n)
07/05		D-:Washington, DC											
07/05		A-:DURBAN,SAF											
07/06		Subsistence											
07/07		Subsistence											
07/08		Subsistence											
07/09		Subsistence											
07/10		Subsistence											
07/11		Subsistence											
07/12		Subsistence											
07/13		Subsistence											
07/14		Subsistence											
07/15		Subsistence											
07/16		D-:DURBAN,SAF											
07/16		A:Washington, DC											
07/16		Subsistence											
									SUBTOTALS ▶		0 00	0 00	0 00
									TOTALS ▶		0 00	0 00	0 00

If additional space is required, continue on another 1012-A BACK, leaving the front blank.

Enter grand total of columns (l), (m) and (n), below and in item 13 on the front of this form.

TOTAL AMOUNT CLAIMED ▶ 0.00

In compliance with the Privacy Act of 1974, the following information is provided: Solicitation of the information on this form is authorized by 5 U.S.C. Chap. 57 as implemented by the Federal Travel Regulations (FPMR 101 7), E.O. 11609 of July 22, 1971, E.O. 11012 of March 27, 1962, E.O. 9397 of November 22, 1943, and 26 U.S.C. 6011(b) and 6109. The primary purpose of the requested information is to determine payment or reimbursement to eligible individuals for allowable travel and/or relocation expenses incurred under appropriate administrative authorization and to record and maintain costs of such reimbursements to the Government. The information will be used by officers and employees who have a need for the information in the performance of their official duties. The information may be disclosed to criminal, or regulatory investigations or prosecutions, or when pursuant to a requirement by this agency in connection with the hiring or firing of an employee, the issuance of a security clearance, or investigations of the performance of official duty while in Government service. Your Social Security Account Number (SSN) is solicited under the authority of the Internal Revenue Code (26 U.S.C. 6011(b) and 6109) and E.O. 9397, November 22, 1943, for use as a tax payer and/or employee identification number; disclosure is MANDATORY on vouchers claiming travel and/or relocation allowance expense reimbursement which is, or may be, taxable income. Disclosure of you SSN and other requested information is voluntary in all other instances; however, failure to provide the information (other than SSN) required to support the claim may result in delay or loss of reimbursement

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICIAL TRAVEL AUTHORIZATION

(Privacy Act Statement and instructions on back)

1. TYPE OF AUTHORIZATION

☒ TDY ☐ Amendment *(Show items amended)*

☐ Invitational *(Non EOP Employees Only)* ☐ Relocation

2. Traveler *(First name, middle initial, last name)*
Cheryl S. Bauerle

3. Title of Traveler
Associate Director

4. AGENCY/DIVISION

5. Office Phone
6-2959

6. Official Duty Station
736 Jackson Place

7. ☐ Per Diem
☐ Actual Subsistence *(unusual circumstances)** *Rate(s):*

8. TRAVEL INFORMATION

PURPOSE: To attend 13th International AIDS Conference and Staff Director Thurman.

DATE(S): Travel Begin On 7/5/00 Travel End On 7/16/00

ITINERARY: Point of Origin *(City, State)* Washington, DC

Place(s) of Official Visitation *(City, State)* Durban, SA

Point of Return *(City, State)*

9. MODE OF TRAVEL

(a) Commercial Transportation

Rail		Air		
Coach	Extra Fare*	Coach Tourist	Business *	First Class ‡

‡ First Class must have approval of Agency Head or Deputy

(b) Privately Owned Vehicle

Auto	Other	Rate auth per mile	
			☐ Determined more advantageous to government *
			☐ For convenience of traveler NTE common carrier cost

(c) ☒ **Gov't Owned Vehicle**

(d) ☐ **Other (specify)**

10. ESTIMATED COST	AMOUNT
Per Diem/Actual Subsistence	$ —
Transportation	—
Rental Car	—
Miscellaneous	—
TOTAL	$ 0

11. SPECIAL EXPENSE AUTHORIZED

☐ Registration Fees *(meeting, training, etc.)*
☐ Commercial Rental Car
☐ Excess Baggage not to exceed
☐ Other *(Please identify)*

12. ADVANCE REQUESTED $
(meals and miscellaneous expenses only)

13. * Special Provisions/Remarks *(Justification for first class /business /extra fare travel, annual leave enroute, actual subsistence, etc.)*
Travel being paid by USAID.

14(a) Requested by
Sandra L. Thurman

15. Accounting data *(Appropriation, division, project, vendor number)*
1102200 J108E

14(b) I certify that the travel herein was reviewed and determined to be essential for the accomplishment of agency programs and missions
Approval Official *(Signature and Title)*

16. Funds are available to defray travel cost specified above
Funds Manager's Certification *(Signature)*

17. Date

18. Travel Authorization No.
TOJONA30

OA FORM 22
REVISED FEBRUARY 1993

ORIGINAL (RETURN WITH TRAVEL VOUCHER)

OFFICE OF NATIONAL AIDS POLICY

EXECUTIVE OFFICE OF THE PRESIDENT

THE WHITE HOUSE

FACSIMILE TRANSMITTAL SHEET

TO:	FROM:
Ambassador Stith	Cheryl Bauerle for Sandy Thurman
COMPANY:	DATE:
US Embassy, Tanzania	June 16, 2000
FAX NUMBER:	TOTAL NO. OF PAGES INCLUDING COVER:
255 51 666-701	3
PHONE NUMBER:	

RE: Please see attached Memorandum

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

NOTES/COMMENTS:

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

THE WHITE HOUSE

WASHINGTON

MEMORANDUM TO U.S. AMBASSADOR TO TANZANIA CHARLES R. STITH

From: Cheryl S. Bauerle
Associate Director
Office of National AIDS Policy

Date: June 16, 2000

Re: XIII International Conference on AIDS and 'ER' cast visit

Sandy Thurman asked me to write to you on her behalf, as she continues her travel in Africa with the delegation led by Secretary Summers. She has asked that I forward information regarding the XIII International Conference on AIDS to be held in Durban, South Africa as well as your recent discussion concerning the 'ER' cast visit to Tanzania.

Our tentative schedule for Sandy has her arriving in South Africa on July 7th, and departing on the 14th. President Mbeki is scheduled to open the Conference on July 9th at 7:30 PM. In addition, a U.S. delegation reception with Ambassador Lewis is being held on July 12th at the Durban Holiday Inn, 63 Snell Parade, from 5:30pm to 7:30pm, that Sandy hopes you might place under consideration. Attached is a brief description outlining the purpose of the conference. I would be happy to forward any additional information you may find helpful.

With regard to the 'ER' cast visit, it appears that their schedule is still tentative and that two of the main players may not be able to make the trip. She will keep you posted with regard to their plans.

Sandy will return to the States on Monday, and would be happy to answer any questions you may have. Should you or your staff need more information in the interim, please feel free to contact me at Cheryl_S._Bauerle@opd.eop.gov or by phone at (202) 456-2959.

THE XIII INTERNATIONAL AIDS CONFERENCE

The XIII International AIDS Conference will be held in Durban, South Africa at the International Convention Centre from 9-14 July 2000. This is the International AIDS Conference on the medical calendar and the largest international medical conference to be hosted in Africa.

Up to 12 000 people from all over the world are expected to attend the Conference. The participants will include leading scientists and clinicians, health care workers, public health agencies, People Living With AIDS, politicians, AIDS non-governmental organisations (NGOs) , AIDS services organisations (ASOs) and the media.

Since 1985, the International AIDS Conference has taken place regularly and enables participants to take stock of the spread of HIV, evaluate progress made in the field of medical research, and investigate and resolve many related social issues. Sub-Saharan Africa leads the world with the largest number of people living with HIV- the choice of South Africa is therefore welcome, as it will serve to highlight the crucial need for action and response to the epidemic in developing countries.

The theme of the conference is Break The Silence, referring to the urgent need to break the silence on issues such as equal access to treatment and care; improved and ongoing HIV transmission prevention; governmental and private sector support in terms of providing education and resources; human rights; access of appropriate and meaningful information to all sectors and enabling a supportive environment for People Living with HIV/AIDS (PWA) in society.

For additional information, please refer to the conference web site at www.aids2000.com.

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
007. form	OA Form 22, Travel Authorization number TOJONA29, Sandra Thurman (partial) (1 page)	06/28/2000	b(6)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office

OA/Box Number: 21066

FOLDER TITLE:
South Africa 7/7-7/14/00 [3]

2007-1550-F
kc1260

RESTRICTION CODES

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

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

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

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

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

[007]

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICIAL TRAVEL AUTHORIZATION

(Privacy Act Statement on back)

1. TRAVEL AUTHORIZATION NO.	2. DATE
TOJONA89	06/28/00

3. TYPE OF TRAVEL

- [X] Official
- [ ] Relocation
- [ ] Mixed
- [ ] Political
- [ ] Invitational (Non EOP Employees Only)
- [ ] Amendment (Show items amended)
- [ ] Funded by Non-Federal Sources

4. TRAVELER (First name, middle initial, last name)

SANDRA L. THURMAN

5. TITLE OF TRAVELER	6. SOCIAL SECURITY NUMBER	7. DIVISION	8. AGENCY
DIRECTOR, AIDS POLICY	(b)(6)		736 JP

9. OFFICE PHONE	10. OFFICIAL DUTY STATION	11.
456-2959	WASHINGTON, DC	[X] Per Diem [ ] Actual Subsistence (unusual circumstances)* Rate(s):

12. TRAVEL INFORMATION

PURPOSE: Attend and participate in the XIII International Conference on AIDS, site and surrounding activities (see calendar).

DATE(S): Travel Begin On 7/ 4/2000 — Travel End On 7/21/2000

ITINERARY: (Point of Origin/Place(s) of Official Visitation/Point of Return)

From: Washington, DC	To: JOHANNESBURG,SAF 64/ 43
To: DURBAN,SAF 93/ 44	To: KIGALI,RWA 115/ 73
To:	To:
To:	To:
To:	To:
To:	Return to: Washington, DC

13. MODE OF TRAVEL

- [ ] Commercial Air
- [ ] Private Vehicle 0.000 Mileage Rate
- [ ] Rail
- [ ] Military Air
- [ ] Government Owned Vehicle
- [X] Other (specify)

14. SPECIAL EXPENSES (Not Prepaid) — **15. ESTIMATED COSTS** — **AMOUNT**

- [ ] Registration Fees (meeting, training, etc.)
- [ ] Commercial Rental Car
- [ ] Excess Baggage not to exceed
- [X] Other (Please identify)

Per Diem/Lodging	$	0.00
Per Diem/M&IE		0.00
Transportation		0.00
Rental Car		0.00
Miscellaneous		0.00
16. TOTAL	$	0.00

17. * SPECIAL PROVISIONS/REMARKS (Justification for first class/business/extra fare travel, annual leave enroute, actual subsistence, etc.)

The National Institutes of Health will cover all costs associated with travel.
See attached NIH Travel Authorizations.

18. ACCOUNTING DATA (Appropriation, division, project, vendor number)

19. REQUESTED BY

20. I certify the travel herein was reviewed and determined to be essential for the accomplishment of agency programs and missions in the most economical means available. Approval Official (Signature and Title)

21. Funds are available to defray travel cost specified above Funds Manager's Certification (Signature)

OA FORM 22 RE') JUNE 1994

___ 1. Original (Return with voucher) ___ 2. FMD copy ___ 3. Travelers copy
___ 4. Teleticketing Office ___ 5. Funds Manager copy

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

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

OFFICE OF NATIONAL AIDS POLICY

EXECUTIVE OFFICE OF THE PRESIDENT

THE WHITE HOUSE

FACSIMILE TRANSMITTAL SHEET

TO: Rita

FROM: Cheryl

COMPANY:

DATE: June 23 2000

FAX NUMBER: 301-402-3360

TOTAL NO. OF PAGES INCLUDING COVER:

PHONE NUMBER:

RE:

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

NOTES/COMMENTS:

Hi Rita-these are Sandy's FINAL (finally!) Flights. Please call me with questions.

Thank YOU!!!

Cheryl

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

Ginger Greene <gingerg@go2wts.com>
06/28/2000 02:52:40 PM

Please respond to Ginger Greene <gingerg@go2wts.com>

Record Type: Record

To: Cheryl S. Bauerle/OPD/EOP

cc:
Subject: Finalized Itinerary for Sandra Thurman

THURMAN/SANDRA
US GOVERNMENT TRAVEL

NATIONAL INSTITUTES OF HEALTH - STA SANDRA THURMAN
9000 ROCKVILLE PIKE DLVR TO BLDG 10
BETHESDA MD. 20892 NIDA
ATTN: LINDA JACKSON
JULY 4. 2000

JUN 28 2000 INV/ITN:ITIN CUST:3000 BR:35 AGT:DPK10

04 JUL 00 - TUESDAY
DELTA 746 FIRST CLASS EQUIP-MD-80 JET
LV: WASH/REAGAN 315P NONSTOP MILES- 213 CONFIRMED
AR: NYC/KENNEDY 425P ELAPSED TIME- 1:10
SEAT- 3B

DELTA 7004 BUSINESS CL EQUIP-BOEING 747 JET
LV: NYC/KENNEDY 555P ONE STOP MILES- 7963 CONFIRMED
AR: JOHANNESBURG 400P ELAPSED TIME-16:05 ARVL DATE-05 JUL
OPERATED BY-SOUTH AFRICAN AIRW
DINNER-BREAKFAST SEAT-27C
STOP-SAL ISLAND

05 JUL 00 - WEDNESDAY
SO. AFRICAN 525 BUSINESS CL EQUIP-BOEING 737 JET
LV: JOHANNESBURG 600P NONSTOP MILES- 311 CONFIRMED
AR: DURBAN 710P ELAPSED TIME- 1:10

15 JUL 00 - SATURDAY
SO. AFRICAN 9576 BUSINESS CL EQUIP-AIRBUS A300 JET
LV: DURBAN 700A NONSTOP MILES- 311 CONFIRMED
AR: JOHANNESBURG 810A ELAPSED TIME- 1:10

AIR TANZANIA 766 BUSINESS CL
LV: JOHANNESBURG 105P NONSTOP MILES- 1668 CONFIRMED
AR: KILIMANJARO 550P ELAPSED TIME- 3:45

16 JUL 00 - SUNDAY
AIR TANZANIA 772 BUSINESS CL EQUIP-BOEING 737 JET
LV: KILIMANJARO 930A NONSTOP MILES- 489 CONFIRMED
AR: KIGALI RWANDA 950A ELAPSED TIME- 1:20
SNACK

THURMAN/SANDRA
US GOVERNMENT TRAVEL

NATIONAL INSTITUTES OF HEALTH - STA SANDRA THURMAN
9000 ROCKVILLE PIKE DLVR TO BLDG 10
BETHESDA MD. 20892 NIDA
ATTN: LINDA JACKSON
JULY 4. 2000

JUN 28 2000 INV/ITN:ITIN CUST:3000 BR:35 AGT:DPK10

20 JUL 00 - THURSDAY
KENYA AWYS 473 FIRST CLASS EQUIP-BOEING 737 JET
LV: KIGALI RWANDA 850A NONSTOP MILES- 472 CONFIRMED
AR: NAIROBI 1110A ELAPSED TIME- 1:20

NORTHWST AIR 8566 BUSINESS CL EQUIP-BOEING 767 JET
LV: NAIROBI 1015P NONSTOP MILES- 4139 CONFIRMED
AR: AMSTERDAM 610A ELAPSED TIME- 8:55 ARVL DATE-21 JUL
OPERATED BY-KLM ROYAL DUTCH AI
BREAKFAST-HOT MEAL

21 JUL 00 - FRIDAY
NORTHWST AIR 37 BUSINESS CL EQUIP-DC-10 JET
LV: AMSTERDAM 1135A NONSTOP MILES- 3867 CONFIRMED
AR: WASH/DULLES 205P ELAPSED TIME- 8:30
DINNER-SNACK SEAT- 4C

TRAVEL ADVISORY EXISTS FOR: RWANDA

AIR TRANSPORTATION 7689.00 TAX 67.09 TTL 7756.09
SUB TOTAL 7756.09
CREDIT CARD PAYMENT 7756.09-
AMOUNT DUE 0.00

 - att1.htm

CDC HIV/AIDS PREVENTION

CENTERS FOR DISEASE CONTROL AND PREVENTION

Centers for Disease Control and Prevention
Division of HIV/AIDS
1600 Clifton Road, N.E.
Building 26, Executive Park
Atlanta, Georgia 30333
MAILSTOP E40

FACSIMILE TRANSMISSION

TO: Runa Hatti	FROM: Laura Coker
Address:	Address:
Telephone No.:	Telephone No.: (404) 639-1941
Facsimile No.: 202-456-2438	Facsimile No.: (404) 639-0944

Date: 6-20-00 Number of Pages: (Excluding cover sheet)

Subject:

Comments:

OIRH List

CDC Participants in the 13th International AIDS Conference

Name	CIO	Division	Branch	Title	Role	Arrive	Depart
Blount, Steve	CDC-OD	OGH	OD	Director	Key Policy Maker	DL#7021 July 8th 6:10pm	DL#7028 July 13th 4:00pm
Kolbe, Lloyd	NCCDPHP	DASH	OD	Director	Key Policy Maker	BA #6211 July 11th	SA #609 July 14th
Kann, Laura	NCCDPHP	DASH	SER	Chief, Health Education Specialist	Poster	DL #7045 July 9th	DL #7032 July 13th
Bryan, Gloria	NCCDPHP	DASH	PDS	Health Education Specialist	Key Policy Maker	BA #6203 July 6th 10:40 am	DL #7032 July 18th 5:00 pm
Rose, Ken	NCCDPHP	DASH	OD	Program Analyst	Key Policy Maker	DL #7059 July 10th 11:10 am	BA #6224 July 15th 10:00 am
Duerr, Ann	NCCDPHP	DRH	WHF	Medical Officer	Oral	BA #6229 July 7th 5:40 pm	BA #6306 July 23rd 5:00 pm
Beck-Sague, Consuelo	NCCDPHP	DRH	OD	HIV Coordinator	Key Policy Maker	AF #8052 July 9th 2:10 pm	BA #6212 July 15th 11:45 am
Galavotti, Christine	NCCDPHP	DRH	WHF	Research Psychologist	Poster	AF #8052 July 9th 2:10 pm	BA #6212 July 15th 11:45 am
Stall, Ron	NCHSTP	DHAP-IRS	BIRB	Branch Chief	Oral	DL #7045 July 7th 11:10 am	DL #7028 July 19th 4:00 pm
O'Leary, Ann	NCHSTP	DHAP-IRS	BIRB	Behavioral Scientist	Oral	BA #6311 July 9th 1:45 pm	DL #7010 July 15th 3:00 pm
Roberts, George	NCHSTP	DHAP-IRS	OD	Behavioral Scientist	Oral	SA #515 July 8th 2:10 pm	SWA #9645 July 15th 6:00 pm
Holtgrave, David	NCHSTP	DHAP-IRS	OD	Director	Oral	SA #515 July 7th 2:10 pm	DL #7010 July 15th 3:00 pm
Taveras, Samuel	NCHSTP	DHAP-IRS	TTSSB	Team Leader	Oral	SA #632 July 8th 4:10 pm	SA #605 July 15th 12:15 pm
Barnes, Victor	NCHSTP	DHAP-IRS	OD	Acting Deputy Director	Poster	BA #6213 July 8th 6:35 pm	BA #6224 July 15th 10:00 am
Garza, Brenda	NCHSTP	DHAP-IRS	TICB	Deputy Branch Chief	Support	SA #521 July 7th 5:10 pm	BA #6214 July 15th 2:10 pm
Jones, T. Stephen	NCHSTP	DHAP-IRS	OD	Associate Director for Science	Poster	July 4th	July 13th
Isoke, Sheila	NCHSTP	DHAP-IRS	TTSSB	Team Leader	Key Policy Maker	DL #7035 July 6th 7:10 pm	BA #6218 July 15th 3:30 pm

6/20/00
11:18 AM

OIRH List

CDC Participants in the 13th International AIDS Conference

Gilliam, Aisha	NCHSTP	DHAP-IRS	PERB	Behavioral Scientist	Poster	July 7th 11:10 am	July 16th 6:15 pm
Ali, Qairo	NCHSTP	DHAP-IRS	TTSSB	Public Health Advisor	Poster	DL July 8th 5:10pm	DL#605 July 15th 12:15pm
Neumann, Mary Spink	NCHSTP	DHAP-IRS	BIRB	Behavioral Scientist	Oral	DL #7045 July 5th 9:15 am	BA #6224 July 15th 10:00 am
Holmberg Scott	NCHSTP	DHAP-SE	EPI	Branch Chief	Oral	BA #6211 July 7th 12:35 pm	BA #6303 July 16th 5:00 pm
Bulterys, Marc	NCHSTP	DHAP-SE	EPI	Visiting Scientist	Oral	DL #7059 July 6th 11:10am	DL # 7028 July 12th 4:00 pm
Mansergh, Gordon	NCHSTP	DHAP-SE	EPI	Behavioral Scientist	Oral	DL #7045 July 7th 11:10 am	DL #7028 July 15th 6:15 pm
Hladik, Wolfgang	NCHSTP	DHAP-SE	IAB	EIS Officer	Oral	SA #515 July 7th 1:00 pm	SA #504 July 16th 8:00 am
Clark, Kenneth	NCHSTP	DHAP-SE	PSRB	Supervisory Chemist	Oral	DL #7035 July 7th 7:10 pm	DL #7028 July 16th 4:00 pm
Withum, David	NCHSTP	DHAP-SE	PSRB	Deputy Branch Chief	Oral	SA #7045 July 7th 9:15am	DL #7028 July 16th 4:00 pm
Campsmith, Michael	NCHSTP	DHAP-SE	SURV	Epidemiologist	Oral	DL #7059 July 6th 11:10am	DL #7003 July 15th 6:05 pm
Denning, Paul	NCHSTP	DHAP-SE	SURV	Medical Officer	Oral	DL #7045 July 7th 11:10 am	BA #6218 July 15th 3:30 pm
Lindegren, Mary Lou	NCHSTP	DHAP-SE	SURV	Medical Epidemiologist	Oral	DL #7000 July 7th 11:10 am	BA #6224 July 15th 10:00 am
Lansky, Amy	NCHSTP	DHAP-SE	SURV	Epidemiologist	Oral	DL #7061 July 6th 5:10 pm	DL #7028 July 16th 4:00 pm
Finlayson, Teresa	NCHSTP	DHAP-SE	PSRB	Epidemiologist	Oral	DL #7011 July 8th 12:00 pm	DL #7032 July 17th 5:00 pm
Kellerman, Scott	NCHSTP	DHAP-SE	SURV	Medical Officer	Oral	BA #6211 July 7th 12:35 pm	BA #6308 July 15th 11:10 am
Do, Ann	NCHSTP	DHAP-SE	SURV	Visiting Scientist	Oral	BA #6211 July 6th 12:35 pm	BA #6220 July 13th 5:15 pm
Fowler, Mary Glen	NCHSTP	DHAP-SE	EPI	Medical Officer	Oral	July 6th	July 16th

6/20/00
11:18 AM

OIRH List

CDC Participants in the 13th International AIDS Conference

Paxton, Lynne	NCHSTP	DHAP-SE	EPI	Medical Officer	Oral	BA #6215 July 7th 2:40 pm	SA #514 July 15th 1:00 pm
Smith, Dawn	NCHSTP	DHAP-SE	EPI	Medical Epidemiologist	Oral	DL #7011 July 8th	DL #7020 July 15th 6:00 pm
Lackritz, Eve	NCHSTP	DHAP-SE	IAB	Assistant Chief of Science	Oral	BA #6209 July 7th 4:10 pm	SA #518 July 16th 3:00 pm
Varghese, Beena	NCHSTP	DHAP-SE	PSRB	Visiting Research Economist	Poster	BA #6203 July 6th 10:40 am	SA #518 July 13th 3:00 pm
Janssen, Rob	NCHSTP	DHAP-SE	OD	Director	Key Policy Maker	DL #7011 July 8th 12:10pm	DL #7028 July 14th 4:00 pm
Kaplan, Jon	NCHSTP	DHAP-SE	OD	Assistant Director	Key Policy Maker	SA #7011 July 8th 12:10pm	SA #512 July 14th 12:00 pm
Williams, Janice	NCHSTP	DHAP-SE	OD	Secretary	Support	BA #6211 July 6th 12:35 pm	BA #6306 July 16th 5:00 pm
Peterman, Thomas	NCHSTP	DHAP-SE	PSRB	Medical Officer	Poster	BA #6303 July 7th 9:50 am	DL # 7032 July 17th 5:00 pm
Chesson, Harrell	NCHSTP	DSTD	PEPHSRB	Health Economist	Oral	BA #6215 July 7th 2:40 pm	BA #6214 July 14th 2:10 pm
St. Lawrence, Janet S.	NCHSTP	DSTD	BIRB	Branch Chief	Poster	SA #509 July 6th 11:10 am	BA #6214 July 14th 2:10 pm
Aral, Sevgi	NCHSTP	DSTD	OD	Associate Director for Science	Poster	SA #505 July 8th 9:10 am	SA #510 July 14th 11:00 am
Ryan, Caroline	NCHSTP	DSTD	OD	Associate Director for International Activities	Key Policy Maker	SA #535 July 9th 5:40 pm	DL #7032 July 17th 5:00 pm
Wasserheit, Judy	NCHSTP	DSTD	OD	Director	Key Policy Maker	SA #515 July 9th 2:10 pm	DL #7007 July 28th 8:45 pm
Ridzon, Renee	NCHSTP	DTBE	SEB	Medical Officer	Oral	DL #7059 July 4th 11:10 am	BA #6214 July 15th 2:10 pm
Spradling, Phillip	NCHSTP	DTBE	SEB	EIS Officer	Oral	BA #6311 July 9th 1:45 pm	DL #7003 July 22nd 8:05 pm
Castro, Ken	NCHSTP	DTBE	OD	Director	Oral	July 8th	DL #7003 July 16th 8:05 pm
Bina, Kittie	NCHSTP	OD	OC	Writer/Editor	Support	#7021 July 7th 6:10 pm	#7028 July 16th 4:00 pm

6/20/00
11:18 AM

Campbell, Carl	NCHSTP	DHAP-SE	IAB	Public Health Advisor	Key Policy Maker		
Gayle, Helene	NCHSTP	OD	OD	Director	Oral	July 7th 11:45 am	July 15th 3:30 pm
Valdiserri, Ronald	NCHSTP	OD	OD	Deputy Director	Poster	DL July 6th 11:10 am	DL July 14th 2:10 pm
Glocker, Cynthia	NCHSTP	OD	OC	Health Communications Specialist	Support	July 7th 11:45 am	July 16th 6:20 pm
Hammond, Terry	NCHSTP	OD	OC	Health Communications Specialist	Support	DL #7021 July 6th 6:10 pm	DL #7028 July 16th 4:00 pm
Keenlyside, Dick	NCHSTP	OD	OD	Medical Officer	Key Policy Maker	SA #602 July 9th 11:10 am	BA #6220 July 13th 5:15 pm
McCray, Eugene	NCHSTP	GAA		Medical Epidemiologist	Oral	DL #7059 July 3rd 11:10 am	BA #6306 July 14th 5:00 pm
Nunnally, Tammy	NCHSTP	OD	OC	Information and Communications Specialist	Support	DL #7021 July 7th 6:10 pm	DL #7028 July 16th 4:00 pm
Rugg, Deborah	NCHSTP	GAA		Research Psychologist	Key Policy Maker	DL #7059 July 4th 11:10 am	BA #6214 July 15th 2:10 pm
St. Louis, Michael	NCHSTP	GAA		Chief, Epidemiology Research Branch	Oral	DL #7002 July 7th	DL #7007 July 14th
Earl Baum	NCHSTP	OD	IS	Computer Specialist	Support	BA #6303 July 7th 11:45 am	BA#5214 July 15th 2:10 pm
Vance, Michael	NCHSTP	OD	OD	Secretary	Support	BA #6211 July 6th 12:35 pm	BA #6306 July 16th 5:00 pm
Weidle, Paul	NCHSTP	DHAP-SE	EPI	Senior Staff Epidemiologist	Poster	DL #7011 July 8th 11:00 am	DL #7032 July 17th 5:00 pm
Morgan, Mead	NCHSTP	DHAP-SE	OD	Associate Director	Key Policy Maker	July 10th	July 15th

XIII International AIDS Conference in Durban, South Africa

July 9-14, 2000

Name	Agency	Division	Office	Title	Activities
CDC Participants:					
Blount,Stevens	CDC-OD	OGH	OD	Director	Key Policy Maker
Kolbe,Lloyd	NCCDPHP	DASH	OD	Director	Key Policy Maker
Kann,Laura	NCCDPHP	DASH	SER	Chief Health Education Specialist	Poster
Bryan,Gloria	NCCDPHP	DASH	PDS	Health Education Specialist	Key Policy Maker
Rose,Ken	NCCDPHP	DASH	OD	Program Analyst	Key Policy Maker
Duerr,Ann	NCCDPHP	DRH	WHF	Medical Officer	Oral
Beck, Consuelo	NCCDPHP	DRH	OD	HIV Coordinator	Key Policy Maker
Galavotti,Christine	NCCDPHP	DRH	WHF	Research Psychologist	Poster
Roca,Angel	NCHSTP	OD	OD	Deputy Associate Director	Key Policy Maker
Stall,Ron	NCHSTP	DHAP-IRS	BIRB	Branch Chief	Oral
O'Leary,Ann	NCHSTP	DHAP-IRS	BIRB	Behavioral Scientist	Oral
Roberts,George	NCHSTP	DHAP-IRS	OD	Behavioral Scientist	Oral
Holtgrave,David	NCHSTP	DHAP-IRS	OD	Director	Oral
Taveras,Samuel	NCHSTP	DHAP-IRS	TTSSB	Team Leader	Oral
Barnes,Victor	NCHSTP	DHAP-IRS	OD	Acting Deputy Director	Poster
Garza,Brenda	NCHSTP	DHAP-IRS	TICB	Deputy Branch Chief	Support
Jones,T.Stephen	NCHSTP	DHAP-IRS	OD	Associate Director for Science	Poster
Isoke,Sheila	NCHSTP	DHAP-IRS	TTSSB	Team Leader	Key Policy Maker
Gilliam,Aisha	NCHSTP	DHAP-IRS	PERB	Behavioral Scientist	Poster
Ali,Qalre	NCHSTP	DHAP-IRS	TTSSB	Public Health Advisor	Poster
Neumann,Mary Spink	NCHSTP	DHAP-IRS	BIRB	Behavioral Scientist	Oral
Holmberg,Scott	NCHSTP	DHAP-SE	EPI	Branch Chief	Oral
Butterys,Marc	NCHSTP	DHAP-SE	EPI	Visiting Scientist	Oral
Mansergh,Gordon	NCHSTP	DHAP-SE	EPI	Behavioral Scientist	Oral
Hladik,Wolfgang	NCHSTP	DHAP-SE	IAB	EIS	Oral
Clark,Kenneth	NCHSTP	DHAP-SE	PSRB	Supervisory Chemist	Oral
Witham,David	NCHSTP	DHAP-SE	PSRB	Deputy Branch Chief	Oral
Campsmith,Micheal	NCHSTP	DHAP-SE	SURV	Epidemiologist	Oral
Denning,Paul	NCHSTP	DHAP-SE	SURV	Medical Officer	Oral
Lindegren,Mary Lou	NCHSTP	DHAP-SE	SURV	Medical Epidemiologist	Oral
Lansky,Amy	NCHSTP	DHAP-SE	SURV	Epidemiologist	Oral
Finlayson,Teresa	NCHSTP	DHAP-SE	PSRB	Epidemiologist	Oral
Kellerman, Scott	NCHSTP	DHAP-SE	SURV	Medical Officer	Oral

Name	Agency	Division	Office	Title	Activities
Sullivan,Patrick	NCHSTP	DHAP-SE	SURV	Epidemiologist	Oral
Do,Ann	NCHSTP	DHAP-SE	SURV	Visiting Scientist	Oral
Fowler,Mary Glen	NCHSTP	DHAP-SE	EPI	Medical Officer	Oral
Paxton,Lynne	NCHSTP	DHAP-SE	EPI	Medical Officer	Oral
Smith,Dawn	NCHSTP	DHAP-SE	EPI	Medical Epidemiologist	Oral
Lackritz,Eye	NCHSTP	DHAP-SE	IAB	Assistant Chief of Science	Oral
Varghese,Beena	NCHSTP	DHAP-SE	PSRB	Visiting Research Economist	Poster
Janssen,Rob	NCHSTP	DHAP-SE	OD	Director	Key Policy Maker
Kaplan,Jon	NCHSTP	DHAP-SE	OD	Assistant Director	Key Policy Maker
Williams,Janice	NCHSTP	DHAP-SE	OD	Secretary	Support
Peterman,Thomas	NCHSTP	DHAP-SE	PSRB	Medical Officer	Poster
Chesson,Harrell	NCHSTP	DSTD	PEPHSRB	Health Economist	Oral
St.Lawrence,Janet	NCHSTP	DSTD	BIRB	Branch Chief	Poster
Aral,Sevgi	NCHSTP	DSTD	OD	Associate Director for Science	Poster
Ryan,Caroline	NCHSTP	DSTD	OD	Associate International Activities	Key Policy Maker
Wasserheit,Judy	NCHSTP	DSTD	OD	Director	Key Policy Maker
Ridzon,Renee	NCHSTP	DTBE	SEB	Medical Officer	Oral
Spradling,Phillip	NCHSTP	DTBE	SEB	EIS Officer	Oral
Castro,Ken	NCHSTP	DTBE	OD	Director	Oral
Bina,Kittie	NCHSTP	OD	OC	Writer/Editor	Support
Campbell,Carl	NCHSTP	DHAP-SE	IAB	Public Health Advisor	Key Policy Maker
Baum,Earl	NCHSTP	DHAP-SE	OD	Assoc. Director	Key Policy Maker
Gayle,Helene	NCHSTP	OD	OD	Director	Oral
Glocker,Cynthia	NCHSTP	OD	OD	Health Communication Specialist	Support
Hammond,Terry	NCHSTP	OD	OD	Health Communication Specialist	Support
Keenlyside,Dick	NCHSTP	OD	OD	Medical Officer	Key Policy Maker
McCray,Eugene	NCHSTP	GAA	GAA	Medical Epidemiologist	Oral
Nunnally,Tammy	NCHSTP	OD	OD	Information Specialist	Support
Rugg,Deborah	NCHSTP	GAA	GAA	Research Psychologist	Key Policy Maker
St.Louis,Micheal	NCHSTP	GAA	GAA	Chief,Epidemiology	Oral
Valdiserri,Ronald	NCHSTP	OD	OD	Deputy Director	Oral
Vance,Michael	NCHSTP	OD	OD	Secretary	Support
Weidle,Paul	NCHSTP	DHAP-SE	EPI	Senior Staff Epidemiologist	Poster

Name	Agency	Division	Office	Title	Activities

FDA: Participants

Name:	CIO:			Title:	Role:
Dr Jay Epstein	CBER			Director of Blood&Res.	Attending
Dr. Indira Hewlett	CBER			Branch Chief,Lab Mol Biol	Poster
Dr. Micheal Norcross	CBER			Senior Investigator	Attending
Richard Klein	OSHI			Associate Director	Attending
Dr. Owen McMaster	CDER			Pharmacology/Toxicology	Attending
Betty J. Dodson	ORA			Natl Fraud Coordinator	Oral

NIH: Participants

Name:	Institutes Center:				Role:
Anthony Fauci	NIAID				Invited speaker
Janet Young	NIAID				Poster
Thomas LaSalvia	NIAID				Invited speaker
Carla Pettinelli	NIAID				Invited speaker
Jack Killen	NIAID				Invited speaker
Margaret Johnston	NIAID				Oral
Jorge Flores	NIAID				Invited speaker
Paolo Miotti	NIAID				Invited speaker
Lawrence Fox	NIAID				Invited speaker
Barbara Laughon	NIAID				Invited speaker
Bill Duncan	NIAID				Invited speaker
Rodney Hoff	NIAID				Invited speaker
Steve Bende	NIAID				Invited speaker
Jim McNamara	NIAID				Invited speaker
Barbara Savarese	NIAID				Invited speaker
Ed Berger	NIAID				Invited speaker
Audrey Kinter	NIAID				Invited speaker
Mark Dybul	NIAID				Invited speaker
Micheal Polis	NIAID				Invited speaker
Mark Connors	NIAID				Invited speaker
James Arthos	NIAID				Invited speaker
Angela Malaspina	NIAID				Invited speaker
Andrew Malaspina	NIAID				Invited speaker
Andrew McNeil	NIAID				Poster
Tom Quinn	NIAID				Invited speaker

Name	Agency	Division	Office	Title	Activities
Chad Womack	NIAID				Invited speaker
Cliff Lane	NIAID				Oral
Hiroyu Hatano	NIAID				Poster
Karl Western	NIAID				Invited speaker
Leslie Cooper	NIAID				Invited speaker
Dionne Jones	NIAID				Invited speaker
Helen Cesari	NIAID				Invited speaker
Richard Needle	NIAID				Invited speaker
Arnold Mills	NIAID				Invited speaker
Robert J. Biggar	NCI				Invited speaker
Suresh Arya	NCI				Oral
Barbara Felber	NCI				Oral
Marjorie Robert-Guroff	NCI				Oral
Frank Ruscetti	NCI				Poster
Vaurice Starks	NCI				Invited speaker
Lauren Woods	NCI				Poster
Yasaman Shirazi	NIDCR				Invited speaker
Mary Ann Redford	NIDCR				Invited speaker
Denise Russo	NIDCR				Invited speaker
Eleni Kouvelari	NIDCR				Invited speaker

Name	Agency	Division	Office	Title	Activities
William J. Caspary	NIEHS				Invited speaker
Sharon Krynkow	FIC				Management
Kenneth Bridbord	FIC				Management
Jeanne McDermott	FIC				Management
F. Gray Handley	NICHD				Management
Leonid Margolis	NICHD				Oral
Lynne Mofenson	NICHD				Oral
Susan Newcomer	NICHD				Management
Patricia Reichelderfer	NICHD				Poster
Ellen Stover	NIMH				Invited speaker
Richard Weise	NIMH				Management
Wayne Fenton	NIMH				Management
Willo Pequegnat	NIMH				Management
Rayford Kytle	NIMH				
Geoffrey Garnett	NIMH				Management
Steven Riley	NIMH				Management
Neal Nathanson	OD				Invited Speaker
Jack Whitescarver	OD				Management
Wendy Wertheimer	OD				Management
Bonnie Mathieson	OD				Management
Robert Eisinger	OD				Management
Judith Auerbach	OD				Management
Fulvia Veronese	OD				Management
Linda Jackson	OD				Coordinator
Rita Grant	OD				Coordinator
Michael Leonardo	NIAID				Invited Speaker
Zvi Grossman	NIAID				Management
OFFICE ON WOMEN'S HEALTH:					
NAME:					
Frances Page	OWH			Senior Public Health Advisor	
HEALTH RESOURCES AND SERVICES ADMINIS					
Angela Powell-Young	HRSA	DTTA			2 Posters Women's roundtable
John Fulcrickok	HRSA	OPPD			Speaking, policy session
Joan Holloway	HRSA	OEA			Poster coordinating satellite

Name	Agency	Division	Office	Title	Activities
Joe O'Neill	HRSA	OAA			Speaking abstract poster
Doug Morgan	HRSA	DSS			Speaking
Micheal Johnson	HRSA	DTTA			Speaking
Deborah Parham	HRSA	DCBP			2 Posters
Tom Flavin	HRSA	OC			Staffing the Booth
Brenda Woods-Francis	HRSA	DTTA			Staffing the Booth
Sonya Hunt Gray	HRSA	DSS			Staffing the Booth
Antigone Hodgins	HRSA				Speaking women's meeting
Frances Hodge	HRSA				Staffing booth

Name	Agency	Division	Office	Title	Activities
Others from DHHS					
NAME:					
Roscoe Moore	OIRH			Assistant Surgeon General, Rear Admiral, U.S. Public Health Service	
Jason Wright	OIRH			International Health Officer	
Linda Hoffman	OIRH			International Health Officer	
Eric Goosby	OS			Director Office of HIV/AIDS	
Miguel Gomez	OS			Director, The Leadership Campaign	
Deborah von Zinkernagel	OS			Deputy Director, Office of HIV/AIDS	
Marsha Martin	OS			Special Assistant to the Secretary	
David Satcher, M.D. Ph.D	OS			Assistant Secretary for Health and	
Beverly Malone	OS			Deputy Assistant to the Surgeon General	
Kaye Hayes	OS			Special Assistant to the Surgeon General	
Damon Thompson	OS			Director of Communications for the Surgeon General	
Sandy Thurman	WHITE HOUSE			Director of the Office of HIV Policy	
Daniel Thompson	WHITE HOUSE			Director,President's Advisory Council on HIV/AIDS	

Note the following notified OIRH that they will not Participate in this conference:

SAMHSA
The Office of Disease Prevention and Health Promotion
The Assistant Secretary for Aging (Office)
The Office of the Inspector General
Agency for Health Care Research and Quality

Effective: 6/15/2000
N: Dr Roscoe Moore/Book2

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CDC HIV/AIDS PREVENTION

CENTERS FOR DISEASE CONTROL AND PREVENTION

Centers for Disease Control and Prevention
Division of HIV/AIDS
1600 Clifton Road, N.E.
Building 26, Executive Park
Atlanta, Georgia 30333
MAILSTOP E40

FACSIMILE TRANSMISSION

TO: Runa Hatti	FROM: Laura Coker
Address:	Address:
Telephone No.:	Telephone No.: (404) 639-1941
Facsimile No.: 202-456-2438	Facsimile No.: (404) 639-0946

Date: 6-20-00 Number of Pages: (Excluding cover sheet)

Subject:

Comments:

OIRH List

CDC Participants in the 13th International AIDS Conference

Name	CIO	Division	Branch	Title	Role	Arrive	Depart
Blount, Steve	CDC-OD	OGH	OD	Director	Key Policy Maker	DL#7021 July 8th 6:10pm	DL#7028 July 13th 4:00pm
Kolbe, Lloyd	NCCDPHP	DASH	OD	Director	Key Policy Maker	BA #6211 July 11th	SA #809 July 14th
Kann, Laura	NCCDPHP	DASH	SER	Chief, Health Education Specialist	Poster	DL #7045 July 9th	DL #7032 July 13th
Bryan, Gloria	NCCDPHP	DASH	PDS	Health Education Specialist	Key Policy Maker	BA #6203 July 6th 10:40 am	DL #7032 July 18th 5:00 pm
Rose, Ken	NCCDPHP	DASH	OD	Program Analyst	Key Policy Maker	DL #7059 July 10th 11:10 am	BA #6224 July 15th 10:00 am
Duerr, Ann	NCCDPHP	DRH	WHF	Medical Officer	Oral	BA #6229 July 7th 5:40 pm	BA #6306 July 23rd 5:00 pm
Beck-Sague, Consuelo	NCCDPHP	DRH	OD	HIV Coordinator	Key Policy Maker	AF #8052 July 9th 2:10 pm	BA #6212 July 15th 11:45 am
Galavotti, Christine	NCCDPHP	DRH	WHF	Research Psychologist	Poster	AF #8052 July 9th 2:10 pm	BA #6212 July 15th 11:45 am
Stall, Ron	NCHSTP	DHAP-IRS	BIRB	Branch Chief	Oral	DL #7045 July 7th 11:10 am	DL #7028 July 19th 4:00 pm
O'Leary, Ann	NCHSTP	DHAP-IRS	BIRB	Behavioral Scientist	Oral	BA #6311 July 9th 1:45 pm	DL #7010 July 15th 3:00 pm
Roberts, George	NCHSTP	DHAP-IRS	OD	Behavioral Scientist	Oral	SA #515 July 8th 2:10 pm	SWA #9645 July 15th 6:00 pm
Holtgrave, David	NCHSTP	DHAP-IRS	OD	Director	Oral	SA #515 July 7th 2:10 pm	DL #7010 July 15th 3:00 pm
Taveras, Samuel	NCHSTP	DHAP-IRS	TTSSB	Team Leader	Oral	SA #632 July 8th 4:10 pm	SA #605 July 15th 12:15 pm
Barnes, Victor	NCHSTP	DHAP-IRS	OD	Acting Deputy Director	Poster	BA #6213 July 8th 6:35 pm	BA #6224 July 15th 10:00 am
Garza, Brenda	NCHSTP	DHAP-IRS	TICB	Deputy Branch Chief	Support	SA #521 July 7th 5:10 pm	BA #6214 July 15th 2:10 pm
Jones, T. Stephen	NCHSTP	DHAP-IRS	OD	Associate Director for Science	Poster	July 4th	July 13th
Isoke, Sheila	NCHSTP	DHAP-IRS	TTSSB	Team Leader	Key Policy Maker	DL #7035 July 6th 7:10 pm	BA #6218 July 15th 3:30 pm

6/20/00
11:18 AM

OIRH List

CDC Participants in the 13th International AIDS Conference

Gilliam, Aisha	NCHSTP	DHAP-IRS	PERB	Behavioral Scientist	Poster	July 7th 11:10 am	July 16th 6:15 pm
Ali, Qairo	NCHSTP	DHAP-IRS	TTSSB	Public Health Advisor	Poster	DL July 8th 5:10pm	DL#605 July 15th 12:15pm
Neumann, Mary Spink	NCHSTP	DHAP-IRS	BIRB	Behavioral Scientist	Oral	DL #7045 July 5th 9:15 am	BA #6224 July 15th 10:00 am
Holmberg Scott	NCHSTP	DHAP-SE	EPI	Branch Chief	Oral	BA #6211 July 7th 12:35 pm	BA #6303 July 16th 5:00 pm
Bulterys, Marc	NCHSTP	DHAP-SE	EPI	Visiting Scientist	Oral	DL #7059 July 6th 11:10am	DL # 7028 July 12th 4:00 pm
Mansergh, Gordon	NCHSTP	DHAP-SE	EPI	Behavioral Scientist	Oral	DL #7045 July 7th 11:10 am	DL #7028 July 15th 6:15 pm
Hladik, Wolfgang	NCHSTP	DHAP-SE	IAB	EIS Officer	Oral	SA #515 July 7th 1:00 pm	SA #504 July 16th 8:00 am
Clark, Kenneth	NCHSTP	DHAP-SE	PSRB	Supervisory Chemist	Oral	DL #7035 July 7th 7:10 pm	DL #7028 July 16th 4:00 pm
Withum, David	NCHSTP	DHAP-SE	PSRB	Deputy Branch Chief	Oral	SA #7045 July 7th 9:15am	DL #7028 July 16th 4:00 pm
Campsmith, Michael	NCHSTP	DHAP-SE	SURV	Epidemiologist	Oral	DL #7059 July 6th 11:10am	DL #7003 July 15th 8:05 pm
Denning, Paul	NCHSTP	DHAP-SE	SURV	Medical Officer	Oral	DL #7045 July 7th 11:10 am	BA #6218 July 15th 3:30 pm
Lindegren, Mary Lou	NCHSTP	DHAP-SE	SURV	Medical Epidemiologist	Oral	DL #7000 July 7th 11:10 am	BA #6224 July 15th 10:00 am
Lansky, Amy	NCHSTP	DHAP-SE	SURV	Epidemiologist	Oral	DL #7061 July 6th 5:10 pm	DL #7028 July 16th 4:00 pm
Finlayson, Teresa	NCHSTP	DHAP-SE	PSRB	Epidemiologist	Oral	DL #7011 July 8th 12:00 pm	DL #7032 July 17th 5:00 pm
Kellerman, Scott	NCHSTP	DHAP-SE	SURV	Medical Officer	Oral	BA #6211 July 7th 12:35 pm	BA #6308 July 15th 11:10 am
Do, Ann	NCHSTP	DHAP-SE	SURV	Visiting Scientist	Oral	BA #6211 July 6th 12:35 pm	BA #6220 July 13th 5:15 pm
Fowler, Mary Glen	NCHSTP	DHAP-SE	EPI	Medical Officer	Oral	July 6th	July 16th

6/20/00
11:18 AM

OIRH List

CDC Participants in the 13th International AIDS Conference

Paxton, Lynne	NCHSTP	DHAP-SE	EPI	Medical Officer	Oral	BA #6215 July 7th 2:40 pm	SA #514 July 15th 1:00 pm
Smith, Dawn	NCHSTP	DHAP-SE	EPI	Medical Epidemiologist	Oral	DL #7011 July 8th	DL #7020 July 15th 6:00 pm
Lackritz, Eve	NCHSTP	DHAP-SE	IAB	Assistant Chief of Science	Oral	BA #6209 July 7th 4:10 pm	SA #518 July 16th 3:00 pm
Varghese, Beena	NCHSTP	DHAP-SE	PSRB	Visiting Research Economist	Poster	BA #6203 July 6th 10:40 am	SA #518 July 13th 3:00 pm
Janssen, Rob	NCHSTP	DHAP-SE	OD	Director	Key Policy Maker	DL #7011 July 8th 12:10pm	DL #7028 July 14th 4:00 pm
Kaplan, Jon	NCHSTP	DHAP-SE	OD	Assistant Director	Key Policy Maker	SA #7011 July 8th 12:10pm	SA #512 July 14th 12:00 pm
Williams, Janice	NCHSTP	DHAP-SE	OD	Secretary	Support	BA #6211 July 6th 12:35 pm	BA #6306 July 16th 5:00 pm
Peterman, Thomas	NCHSTP	DHAP-SE	PSRB	Medical Officer	Poster	BA #6303 July 7th 9:50 am	DL # 7032 July 17th 5:00 pm
Chesson, Harrell	NCHSTP	DSTD	PEPHS RB	Health Economist	Oral	BA #6215 July 7th 2:40 pm	BA #6214 July 14th 2:10 pm
St. Lawrence, Janet S.	NCHSTP	DSTD	BIRB	Branch Chief	Poster	SA #509 July 6th 11:10 am	BA #6214 July 14th 2:10 pm
Aral, Sevgi	NCHSTP	DSTD	OD	Associate Director for Science	Poster	SA #505 July 8th 9:10 am	SA #510 July 14th 11:00 am
Ryan, Caroline	NCHSTP	DSTD	OD	Associate Director for International Activities	Key Policy Maker	SA #535 July 9th 5:40 pm	DL #7032 July 17th 5:00 pm
Wasserheit, Judy	NCHSTP	DSTD	OD	Director	Key Policy Maker	SA #515 July 9th 2:10 pm	DL #7007 July 28th 8:45 pm
Ridzon, Renee	NCHSTP	DTBE	SEB	Medical Officer	Oral	DL #7059 July 4th 11:10 am	BA #6214 July 15th 2:10 pm
Spradling, Phillip	NCHSTP	DTBE	SEB	EIS Officer	Oral	BA #6311 July 9th 1:45 pm	DL #7003 July 22nd 8:05 pm
Castro, Ken	NCHSTP	DTBE	OD	Director	Oral	July 8th	DL #7003 July 16th 8:05 pm
Bina, Kittie	NCHSTP	OD	OC	Writer/Editor	Support	#7021 July 7th 6:10 pm	#7028 July 16th 4:00 pm

6/20/00
11:18 AM

OIRH List
CDC Participants in the 13th International AIDS Conference

Campbell, Carl	NCHSTP	DHAP-SE	IAB	Public Health Advisor	Key Policy Maker		
Gayle, Helene	NCHSTP	OD	OD	Director	Oral	July 7th 11:45 am	July 15th 3:30 pm
Valdiserri, Ronald	NCHSTP	OD	OD	Deputy Director	Poster	DL July 6th 11:10 am	DL July 14th 2:10 pm
Glocker, Cynthia	NCHSTP	OD	OC	Health Communications Specialist	Support	July 7th 11:45 am	July 16th 6:20 pm
Hammond, Terry	NCHSTP	OD	OC	Health Communications Specialist	Support	DL #7021 July 6th 6:10 pm	DL #7028 July 16th 4:00 pm
Keenlyside, Dick	NCHSTP	OD	OD	Medical Officer	Key Policy Maker	SA #602 July 9th 11:10 am	BA #6220 July 13th 5:15 pm
McCray, Eugene	NCHSTP	GAA		Medical Epidemiologist	Oral	DL #7059 July 3rd 11:10 am	BA #6306 July 14th 5:00 pm
Nunnally, Tammy	NCHSTP	OD	OC	Information and Communications Specialist	Support	DL #7021 July 7th 6:10 pm	DL #7028 July 16th 4:00 pm
Rugg, Deborah	NCHSTP	GAA		Research Psychologist	Key Policy Maker	DL #7059 July 4th 11:10 am	BA #6214 July 15th 2:10 pm
St. Louis, Michael	NCHSTP	GAA		Chief, Epidemiology Research Branch	Oral	DL #7002 July 7th	DL #7007 July 14th
Earl Baum	NCHSTP	OD	IS	Computer Specialist	Support	BA #6303 July 7th 11:45 am	BA#5214 July 15th 2:10 pm
Vance, Michael	NCHSTP	OD	OD	Secretary	Support	BA #6211 July 6th 12:35 pm	BA #6306 July 16th 5:00 pm
Weidle, Paul	NCHSTP	DHAP-SE	EPI	Senior Staff Epidemiologist	Poster	DL #7011 July 8th 11:00 am	DL #7032 July 17th 5:00 pm
Morgan, Mead	NCHSTP	DHAP-SE	OD	Associate Director	Key Policy Maker	July 10th	July 15th

Objectives

The flagship facility "SHEPHERD'S KEEP" on the Bluff, Durban. S.A, with founders Colin and Cheryl Pratley, together with appointed day and nightime staff , care for abandoned babies, until such time as they are fostered or adopted.

This facility provides 24 hour care in a homely, happy and healthy environment.

As the statistics for abandoned babies are dramatically on the increase, there is a demand for such a facility, which has been commended by the Dept of Welfare, and functions to serve the needs of Durban, Kwazulu Natal.

This facility provides a much needed link between the desperate circumstances under which the child was abandoned and the normality of a foster home, helping to pave the way and easing the burden of the foster parents, who take responsiblity for a far less traumatised baby.

"SHEPHERD'S KEEP" is preparing to become an ISO 9002 SABS accredited facility.

Management Committee

Chairman:
Colin Pratley
12 Keston Crescent
Marlborough Park
Bluff
4052 Dbn SA
Tel: 466-6106

Vice Chairman:
James McCarthy
13 Kingdom Rd
Malvern
Queensburgh Dbn SA
Tel: 465-0064

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188 Frere Rd
Glenwood Dbn SA
Tel: 202-7640

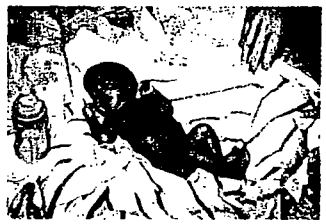
Hon. Secretary:
Elaine Thomas
77 Andora Rd
Bluff
4052 Dbn SA
Tel: 47-4911

Member:
David Malengret
Owner MD
Quicklift Planthire
401 Edwin Swales Dve
Dbn SA
Tel: 465-0064

Member:
Florence Yon
136 Benjamin Rd
Bluff
4052 Dbn SA
Tel: 466-5740

Media Coverage

"We've been using the home as an emergency facility, especially after hours and it's been wonderful not having to run around desperately looking for a place of safety. I've visited the Prately home and I know the children will be well taken care of."
Head of Durban Child protection Unit - Supt. Mahommed Dawood Sunday Tribune Sept. 6 1998



"It's really wonderful, someone has finally decided to do something about sheltering abandoned babies"
Child Family and Community Care Centre of Durban Oona Yellen - Sunday Tribune Sept. 6 1998

"The future of a lot of kids are in the hands of not only the people running the charities, but also in the rest of society, and I am confident after meeting you that "SHEPHERD"S KEEP" will keep on doing good work, God bless you and Cheryl"
Testimonial - Francois Pienaar and the Saracens - United Kingdom - 25-9-98

"The home is an asset to the unit"
Child Protection Unit Spokesman - Capt Small Southlands Sun News - Nov 1998

SALES PERSON: 22 ITINERARY DATE: 22 JUN 00
CUSTOMER NBR: 544215 RYUPQH PAGE: 01

TO: SATOTRAVEL
10 CORP SQ BLVD
BLDG10RM1303
ATLANTA,GA30329

FOR: ISKOWITZ/MICHAEL REF: 0,121,75232

28 JUN 00 - WEDNESDAY

AIR	NORTHWEST AIRLINES	FLT:36	BUSINESS	MULTI MEALS
	LV WASHINGTON DULLES		605P	EQP: DC-10
				07HR 40MIN

29 JUN 00 - THURSDAY

	AR AMSTERDAM		745A	NON-STOP
				REF: NAQR6E
	ISKOWITZ/MICHAE SEAT- 2C			
AIR	NORTHWEST AIRLINES	FLT:8565	BUSINESS	MULTI MEALS
	AMSTERDAM-NAIROBI KENYATTA OPERATED BY KLM ROYAL DUTCH AIRLINES			
	LV AMSTERDAM		1035A	EQP: BOEING 767
				08HR 40MIN
	AR NAIROBI KENYATTA		815P	NON-STOP
				REF: NAQR6E
	ISKOWITZ/MICHAE SEAT- 6F			

05 JUL 00 - WEDNESDAY

AIR	KENYA AIRWAYS	FLT:460	STANDARD	
	LV NAIROBI KENYATTA		755A	EQP: AIRBUS A310
				04HR 05MIN
	AR JOHANNESBURG		1100A	NON-STOP
				REF: IZJ4XU
AIR	SOUTH AFRICAN	FLT:525	ECONOMY	DINNER
	LV JOHANNESBURG		600P	EQP: BOEING 737-200
				01HR 10MIN
	AR DURBAN		710P	NON-STOP
				REF: RBCAP7

16 JUL 00 - SUNDAY

AIR	DELTA AIR LINES INC	FLT:7010	BUSINESS CLASS	SNACK
	DURBAN-JOHANNESBURG OPERATED BY SOUTH AFRICAN AIRWAYS			
	LV DURBAN		300P	EQP: AIRBUS A320
				01HR 10MIN
	AR JOHANNESBURG		410P	NON-STOP
				REF: D58RUF

CONTINUED ON PAGE 2

SALES PERSON: 22 ITINERARY DATE: 22 JUN 00
CUSTOMER NBR: 544215 RYUPQH PAGE: 02

TO: SATOTRAVEL
10 CORP SQ BLVD
BLDG10RM1303
ATLANTA,GA30329

FOR: ISKOWITZ/MICHAEL REF: O,121,75232

16 JUL 00 - SUNDAY
AIR DELTA AIR LINES INC FLT:7005 BUSINESS CLASS MULTI MEALS
JOHANNESBURG-NEW YORK JFK OPERATED BY SOUTH AFRICAN AIRWAYS
LV JOHANNESBURG 820P EQP: BOEING 747 400
17HR 00MIN

17 JUL 00 - MONDAY
AR NEW YORK JFK 720A 1-STOP
ARRIVE: TERMINAL 3 REF: D58RUF
ISKOWITZ/MICHAE SEAT-28H
VIA SAL
AIR DELTA AIR LINES INC FLT:6213 COACH
NEW YORK JFK-WASHINGTON REAGAN OPERATED BY TRANS STATES AIR
LV NEW YORK JFK 925A EQP: JETSTREAM 41 TURB
DEPART: TERMINAL 3 01HR 35MIN
AR WASHINGTON REAGAN 1100A NON-STOP
ARRIVE: TERMINAL B REF: D58RUF
ISKOWITZ/MICHAE SEAT-10A

SATOTRAVEL CORPORATE SQUARE HRS MON-FRI 8AM-430PM
24 HRS EMERGENCY SERVICE 800-827-7777 SATO ID/JT52
CORPORATE SQUARE PHONE 404-633-0520
PLEASE RETURN ALL UNUSED OFFICIAL TICKETS TO
FMO-CLIFTON RD D-49 TO INSURE A TIMELY REFUND
FREQUENT TRAVELER BENEFITS EARNED IN CONNECTION WITH
OFFICIAL TRAVEL MAY BE USED ONLY FOR OFFICIAL TRAVEL
SHOW GOVT ID FOR PARKING DISCOUNTS AT THE FOLLOWING
LOCATIONS PARK N FLY....PARK AIR EXPRESS...PARK N GO
AND PRESTIGE PARKING...

EFFECTIVE 2/16/00 THERE WILL
BE A 9.19USD SERVICE FEE
CHARGED FOR EACH AIRLINE
TICKET ISSUED

GOVERNMENT FARE - 8993.30 PAPER FEDEX

PRINT REVIEW

(PRV FUNCTION) TRAVEL VOUCHER 09/19/00 13:39

ORDER#: WQN00577 ENTRY DATE: 08/16/00 FY/CAN: 08321429
OC: 2197 BID: OD CLERK ID: VRG
AO: CII AO APPROVAL DATE: 09/19/00 UPDATE: 09/19/00

TRAVELER: SANDRA THURMAN SSN: ----------
TITLE: DIR, EXE.OFFICE OF THE PRESIDENT VOUCHER STATUS: AO APPROVED
MAIL ADDRESS: WHITE HOUSE OFFICE OF NATL AID TRIP START DATE: 07/04/00
736 JACKSON PL NW END DATE: 07/21/00
WASHINGTON, DC 20503
DUTY STATION: WASHINGTON, DC BLDG: 736 RM: 0 TEL: 202-456-2437
CONTACT: VICTORIA GRAY BLDG: 2 RM: 5E21 TEL: 301-402-3357
EMPLOYEE CODE: CIVILIAN

RECOMMENDED BY: JACK WHITESCARVER, PH.D TITLE: DIR, SPO
AUTHORIZED BY: DARLENE BLOCKER TITLE: ADMIN. OFFICER

PURPOSE: TO PARTICIPATE IN XIII INTERNATIONAL AIDS CONFERENCE IN DURBAN, S AFRICA 9-14, JULY 2000.

ITINERARY: KENNEDY/JOHANNESBURG/DURBAN/JOHANNESBURG/KILIMANJARO/KIGALI RWANDA/

********** SUMMARY **********

	OC	COST
TRANSPORTATION/MISC. EXPENSES (EXCLUDING GTA):		.00
REGISTRATION COST:	252W	.00
PER DIEM (MEALS & LODGING):	2197	1,919.02
OTHER EXPENSES:	2197	363.61
TOTAL EXPENSES:		2,282.63
GTR# APPROP#: 0846 GTA COST:		7,756.09
SPONSOR(S) OWE NIH: .00 SPONSOR(S) IN CASH/KIND:		.00
TOTAL COST:		10,038.72
PAID TRAVEL ADVANCE:		.00
ADDITIONAL AMOUNT DUE TRAVELER:		2,282.63

********** AUTHORIZATION **********

DATE SIGNATURE (AUTHORIZED BY) TITLE

I HEREBY CERTIFY THAT I HAVE REVIEWED THE ITEMIZED EXPENSES AND ATTACHED DOCUMENTATION. PAYMENT IS RECOMMENDED.

9/20/00 Sandra Thurman

DATE SIGNATURE (TRAVELER)

I CERTIFY, TO THE BEST OF MY KNOWLEDGE, THIS VOUCHER IS CORRECT AND COMPLETE.

(PRV FUNCTION) TRAVEL VOUCHER 09/19/0_ 13:39
ORDER#: WQN00577 TRAVELER: SANDRA THURMAN

********** TRANSPORTATION/MISCELLANEOUS EXPENSES **********

FARE: BLANKET GTA	GTR#	COST:	7,756.09
POV - EST. MILES:	MILEAGE RATE: .325	COST:	.00
CAR RENTAL(S) RECEIPT #:		COST:	.00
REGISTRATION: RECEIPT #:		COST:	.00

********** PER DIEM EXPENSES (MEALS & LODGING) **********

LOCATION	TYPE OF EXPENSE	NO. OF DAYS	@ RATE	= MAXIMUM PERDIEM	ITEMZD MEALS LODG RCPTS	AMOUNT
KENNEDY	MEALS					
	LODGING					$.00
JOHANNESBURG	MEALS					
	LODGING					$.00
DURBAN	MEALS	10.75	44	$473.00		
	LODGING					$473.00
JOHANNESBURG	MEALS					
	LODGING					$.00
KILIMANJARO	MEALS	1.00	58	$58.00		
	LODGING	1	116	$116.00	$54.52	$112.52
KIGALI RWANDA	MEALS	5.75	58	$333.50		
(AEA LODGING)	LODGING	4	116	$1,392.00	$1,000.00	$1,333.50
NAIROBI	MEALS					
	LODGING					$.00
AMSTERDAM	MEALS					
	LODGING					$.00
DC	MEALS					
	LODGING					$.00

********** OTHER EXPENSES **********

01 DATE: 07/03/00 FY/CAN: 08321429 OC: 2197 RECPT#: N/A AMT: $45.00
REMARKS: TAXI FROM HOME TO AIRPORT

02 DATE: 07/06/00 FY/CAN: 08321429 OC: 2197 RECPT#: 1 AMT: $72.61
REMARKS: BUSINESS CENTER FROM 7/6-11, AND 7/14.

03 DATE: 07/11/00 FY/CAN: 08321429 OC: 2197 RECPT#: 1 AMT: $1.48
REMARKS: AUTHORIZED FAXES

********** OTHER EXPENSES **********

04 DATE: 07/06/00 FY/CAN: 08321429 OC: 2197 RECPT#: 1 AMT: $7.24
REMARKS: LAUNDRY FOR 7/6, 7/9 AND 7/11.

05 DATE: 07/05/00 FY/CAN: 08321429 OC: 2197 RECPT#: 1 AMT: $117.56
REMARKS: INTERNET CONNECTIONS FROM 7/5-7/15.

06 DATE: 07/15/00 FY/CAN: 08321429 OC: 2197 RECPT#: N/A AMT: $50.00
REMARKS: VISA

07 DATE: 07/18/00 FY/CAN: 08321429 OC: 2197 RECPT#: 2 AMT: $24.72
REMARKS: AUTHORIZED PHONE CALLS FROM 7/18-7/20.

08 DATE: 07/20/00 FY/CAN: 08321429 OC: 2197 RECPT#: N/A AMT: $45.00
REMARKS: TAXI FROM AIRPORT TO HOME

THE WHITE HOUSE

WASHINGTON

MEMORADUM TO DARLENE BLOCKER, OAR

From: Sandra L. Thurman
Director
Office of National AIDS Policy
736 Jackson Place, NW
Washington, DC 20503
(202) 456-2959

Date: September 12, 2000

RE: **Reimbursement for travel expenses over country per diem**

During my recent travel to Rwanda following the XIII International AIDS Conference in Durban, South Africa, I incurred expenses over that of my authorized per diem.

The Mille de Collines Hotel, for which I was originally authorized the government lodging per diem of 115.00/night, instead charged me 200.00/night. Though I have tried to persuade the hotel to lower the rate of their room to the amount afforded me, all attempts have proven unsuccessful. Considering the security issues of traveling and staying in Rwanda, I had little choice but to continue my stay at the Mille de Collines Hotel.

It is therefore the purpose of this memorandum to request reimbursement for my actual expenses rather than for the established per diem. Please find attached a copy of my voucher to OAR, which I have already been submitted for review. In addition, please know that I am more than happy to provide any further information that may be helpful.

Thank you for your kind attention to this request.

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

TRANSMISSION OK

TX/RX NO	2247
CONNECTION TEL	96470810
SUBADDRESS	
CONNECTION ID	
ST. TIME	07/10 14:23
USAGE T	02'17
PGS. SENT	2
RESULT	OK

OFFICE OF NATIONAL AIDS POLICY

EXECUTIVE OFFICE OF THE PRESIDENT
THE WHITE HOUSE

FACSIMILE TRANSMITTAL SHEET

TO:	FROM:
Ricardo Zuniga	Sarah for Sandy Thurman
COMPANY:	DATE:
Tanzania desk	July 10, 2000
FAX NUMBER:	TOTAL NO. OF PAGES INCLUDING COVER:
647-0810	2
PHONE NUMBER:	

RE: Sandy Thurman's Tanzania Visa

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

NOTES/COMMENTS:

Hello Ricardo,

Here is Sandy's Itinerary from Durban to her overnight in Tanzania before traveling on to Rwanda as well as a copy of her passport. We cannot thank you enough for your help and time on this, and please do let me know how we can help in the next step...

Saturday July 15th - 7:00 AM Depart Durban, SAA #9576

OFFICE OF NATIONAL AIDS POLICY

EXECUTIVE OFFICE OF THE PRESIDENT

THE WHITE HOUSE

FACSIMILE TRANSMITTAL SHEET

TO:	FROM:
Ricardo Zuniga	Sarah for Sandy Thurman
COMPANY:	DATE:
Tanzania desk	July 10, 2000
FAX NUMBER:	TOTAL NO. OF PAGES INCLUDING COVER:
647-0810	2
PHONE NUMBER:	

RE:

Sandy Thurman's Tanzania Visa

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

NOTES/COMMENTS

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Saturday July 15th	-	7:00 AM Depart Durban, SAA #9576
		8:10 AM Arrive Jo'burg
		1:05 PM Depart Jo'burg, Air Tanzania # 766
		5:50 PM Arrive Kilimanjaro
Sunday, July 16th	-	9:30 AM Depart Kilimanjaro Air Tanzania #772
		9:50 AM Arrive Kigali, Rwanda

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

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
008. passport	copy of identity page, Sandra Thurman (1 page)	02/14/1997	b(6)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office

OA/Box Number: 21066

FOLDER TITLE:
South Africa 7/7-7/14/00 [3]

2007-1550-F
kc1260

RESTRICTION CODES

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

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

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

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

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

HIV PREVENTION NOW more than EVER

XIII INTERNATIONAL AIDS CONFERENCE
DURBAN, SOUTH AFRIC

EMBARGOED
UNTIL DATE AND TIME
OF PRESENTATION

OUR WORLD depends on it

MEDIA KIT

Centers for Disease Control and Prevention

HIV prevention saves lives

Overwhelming evidence proves that HIV prevention efforts have saved countless lives, both in the U.S. and worldwide:

- Prevention efforts have helped slow the rate of new infections in the U.S. from over 150,000 per year in the late 1980's to 40,000 today.
- HIV prevalence among young white men in the U.S. declined by 50% between 1988 and 1993. Occurring at a time of high overall HIV prevalence, this decline marks a notable prevention success.
- Prevention efforts in New York City have contributed to a drop in HIV prevalence among injection-drug users in drug treatment from almost 34% in 1990 to just over 4% in 1998.
- The number of U.S. infants who acquire AIDS through mother-to-child transmission has declined 73% from 1992 through 1998.
- Concentrated prevention efforts have turned around HIV epidemics in Uganda (where AIDS cases in urban areas have fallen by 50% since 1996) and Thailand, and have prevented an expected epidemic in Senegal.

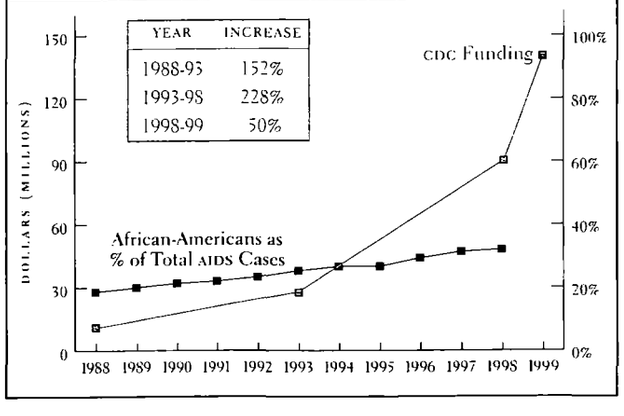
For America and the world, the message is clear...

Fighting HIV where it's hitting hardest

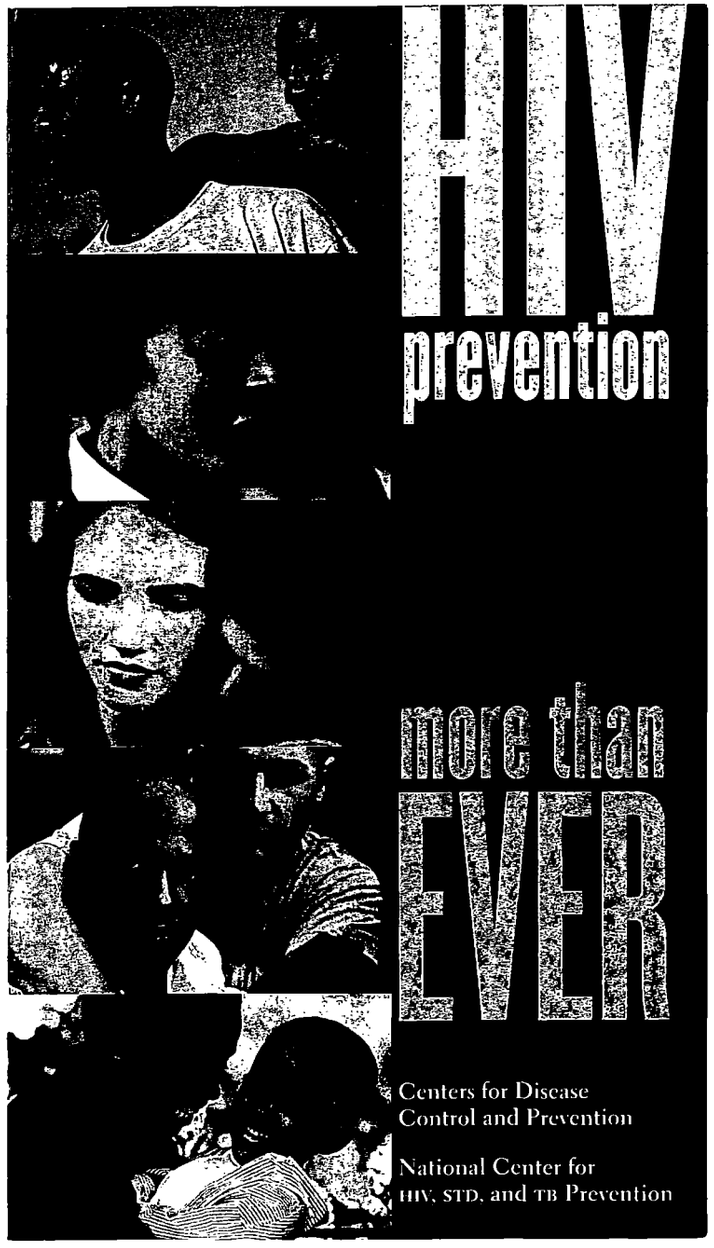
The CDC directs the largest portion of its HIV prevention efforts to the African-American communities that have been hardest hit by HIV/AIDS:

- AIDS is the leading cause of death among African Americans ages 25-44.
- African Americans represent an estimated 13% of the U.S. population, yet they are believed to represent half of new HIV infections.
- Among African Americans, young gay men and young heterosexual women are hardest hit.

CDC's funding of HIV prevention programs specifically targeted to the African-American community has increased substantially over the last decade:



Since 1987, CDC has steadily built and supported innovative programs in African-American communities through national, regional and local organizations, including community and faith-based organizations. CDC also continues to work with Latino communities and others hard hit by the epidemic to build and sustain effective prevention programs.



HIV prevention more than EVER

More critical than ever

There is still no cure for AIDS, and an estimated 40,000 Americans become infected with HIV every year. With recent advances in treatment, more people are living with HIV infection and AIDS. This means an increasing need for prevention efforts to help those infected maintain safer behaviors and to help others at risk stay uninfected.

More diverse than ever

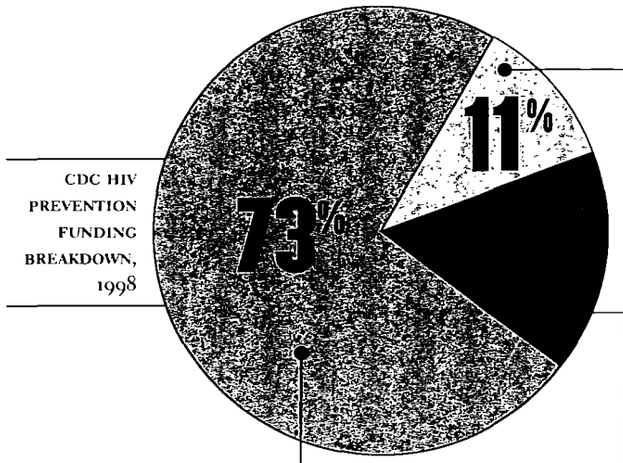
Prevention efforts are aggressively targeting a wider range of communities than ever before, including gay men of color, African-American and Hispanic women, white gay men, injection-drug users, and adolescents as they come of age.

More hope than ever

We are entering a new era in HIV prevention, one in which scientific research provides cutting-edge behavioral and biomedical approaches to prevention. Effective risk reduction strategies, combined with new treatments for HIV and other sexually transmitted diseases, offer more hope than ever of further reducing the spread of HIV.

CDC: the nation's leader in HIV prevention

HIV prevention means using every effective weapon to stop new HIV infections from occurring. The CDC works on these three fronts:



1. Helping communities

Each year, the CDC provides over $400 million to build and support innovative prevention efforts, including:

- Funding programs run by 65 state, local and territorial health departments, 22 national and regional minority organizations, and 94 local organizations.
- Helping community organizations to implement and sustain prevention programs.
- Conducting training programs in effective approaches to prevention.

2. Researching prevention

Biomedical The CDC conducts basic research on the mechanics of HIV infection and disease progression. It also conducts research on new HIV prevention technologies:

- Impact of HIV treatment on transmission
- Prevention of mother-to-child HIV transmission
- STD treatment as a method of HIV prevention
- Vaccines
- Microbicides

Behavioral The CDC develops and evaluates prevention programs nationwide, many of which provide information and social support to groups at risk for HIV, such as:

- Peer outreach for gay men
- Street outreach for injection-drug users
- Education programs for youth in and out of school
- Faith-based initiatives in African-American communities

3. Tracking HIV/AIDS

The CDC's unparalleled information-gathering systems track the occurrence and course of HIV throughout the U.S., indicating where prevention programs are most urgently needed now and in the future.

HIV
PREVENTION
NOW more than EVER, OUR WORLD depends on it

FOR RELEASE:
Saturday, 8 July, 2000
11:00 (5:00 AM EDT)

Contact: NCHSTP Office of Communications
(404) 639-8895
On-site: CDC Media Center
011-27-82-858-0333

AMA PRESS BRIEFING: SATURDAY, 8 JULY 2000, 11:00 local time

U.S. AIDS CASES, DEATHS, AND HIV INFECTIONS APPEAR STABLE

– 4 to 5 Million Americans Remain at High Risk for HIV Infection –

– First Comprehensive Analysis of HIV Incidence Studies Since 1978 Suggests Gay Men and IDUs Continue to Face Dangerously High Rates of Infection –

DURBAN, South Africa – Both HIV and AIDS have stabilized in the U.S., indicating a need for expanded HIV prevention efforts and new treatment strategies, according to Helene D. Gayle, M.D., M.P.H., Director of the National Center for HIV, STD, and TB Prevention at the Centers for Disease Control and Prevention. Speaking at a special AMA media briefing on HIV prevention at the XIII International AIDS Conference in Durban, South Africa, Gayle released the latest U.S. data on AIDS cases, deaths, and HIV diagnoses through June 1999. Gayle also discussed new risk behavior data, and the preliminary results of the first wide-scale analysis of HIV incidence studies conducted between 1978 and 1998.

"Despite the dramatic benefits new treatments have had in extending the lives of individuals with HIV, the overall shortfalls of AIDS treatments are becoming increasingly apparent, and HIV infection and risk behavior continue at levels far too high," said Gayle. "Now more than ever, it is critical that we expand successful HIV prevention programs to bring infection rates down."

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

AIDS and HIV Data

The latest CDC surveillance data confirm a trend which began in mid-1998. Since July 1998, the number of AIDS cases and deaths diagnosed in the United States each quarter (three-month period) has remained roughly stable. Gayle presented data for the first two quarters of 1999, which demonstrate a continued stabilization, with roughly 4,000 AIDS deaths and 10,000 AIDS cases diagnosed each quarter. Prior to 1998, deaths and cases had been declining dramatically since the availability of highly active antiretroviral treatment (HAART). (See attached graph.)

Gayle said that lack of progress in further reducing AIDS cases and deaths is likely due to several factors, including: treatment failure; having already reached most people who are susceptible to treatment; the lack of early testing and treatment for some; and difficulty adhering to new treatment regimens. Other CDC data to be presented in Durban will show that a minority of patients on combination therapy benefit for more than a year from HAART, and that patients are having to switch drug regimens frequently to maintain efficacy.

Gayle also presented data demonstrating that HIV and AIDS diagnoses among young people (13 to 24 years of age) in 25 states remained stable through June 1999. HIV trends can only be examined in the 25 states that have had HIV reporting for at least five years. Because diagnoses in young people represent recent infections, these data suggest no significant change in the level of new HIV infections. (See attached graph.) CDC estimates that 40,000 Americans continue to become infected each year.

HIV Risk

A new CDC analysis of data from several large-scale national surveys conducted in the United States from 1978 through 1998 was released today. Findings show that a minimum of two to four percent of the U.S. population, or roughly 4 to 5 million people, remain at high behavioral risk for HIV infection. The study defined high-risk behavior as: having six or more sexual partners in the last year; having sex with people known to

be HIV-infected; exchanging sex for money or drugs; using crack cocaine; using injection drugs during the past three years; and male-to-male sexual contact.

The analysis also indicated that while condom use has increased since the 1980s, only 40 percent of unmarried people, and only 23 percent of drug users, report using condoms. And while prevention programs have helped to increase the number of injection drug users (IDUs) using clean needles, roughly 20 percent continue to share needles.

The report found that the level of HIV testing has increased substantially, with roughly 40 percent of the population overall having been tested. Most importantly, data suggest that more than 70 percent of people at risk have been tested for HIV.

HIV Infection Analysis

The first wide-scale analysis of HIV incidence studies from 1978 to 1998, compiled by CDC epidemiologist Vu Minh Quan also demonstrated some disturbing trends. The analysis, which examined 83 studies of new HIV infections in different populations, indicates that infection rates continue to be troublingly high in some populations, especially gay men.

Infection rates among gay men in several cities dropped precipitously after the intense prevention efforts in 1980s. Yet, over the last decade, studies suggest that infection rates among gay men have remained roughly stable, with rates of new infection generally averaging from one to four percent, depending on the group of men studied. Among particularly high-risk populations (e.g., those being treated in STD clinics), much higher levels of infection have been documented. For example, the most recent CDC multi-state study of HIV incidence found that roughly eight percent of gay men attending STD clinics were being infected annually, with rates as high as 11 percent among African-American gay men. Gay men in that study were 17 times more likely to be infected than heterosexuals.

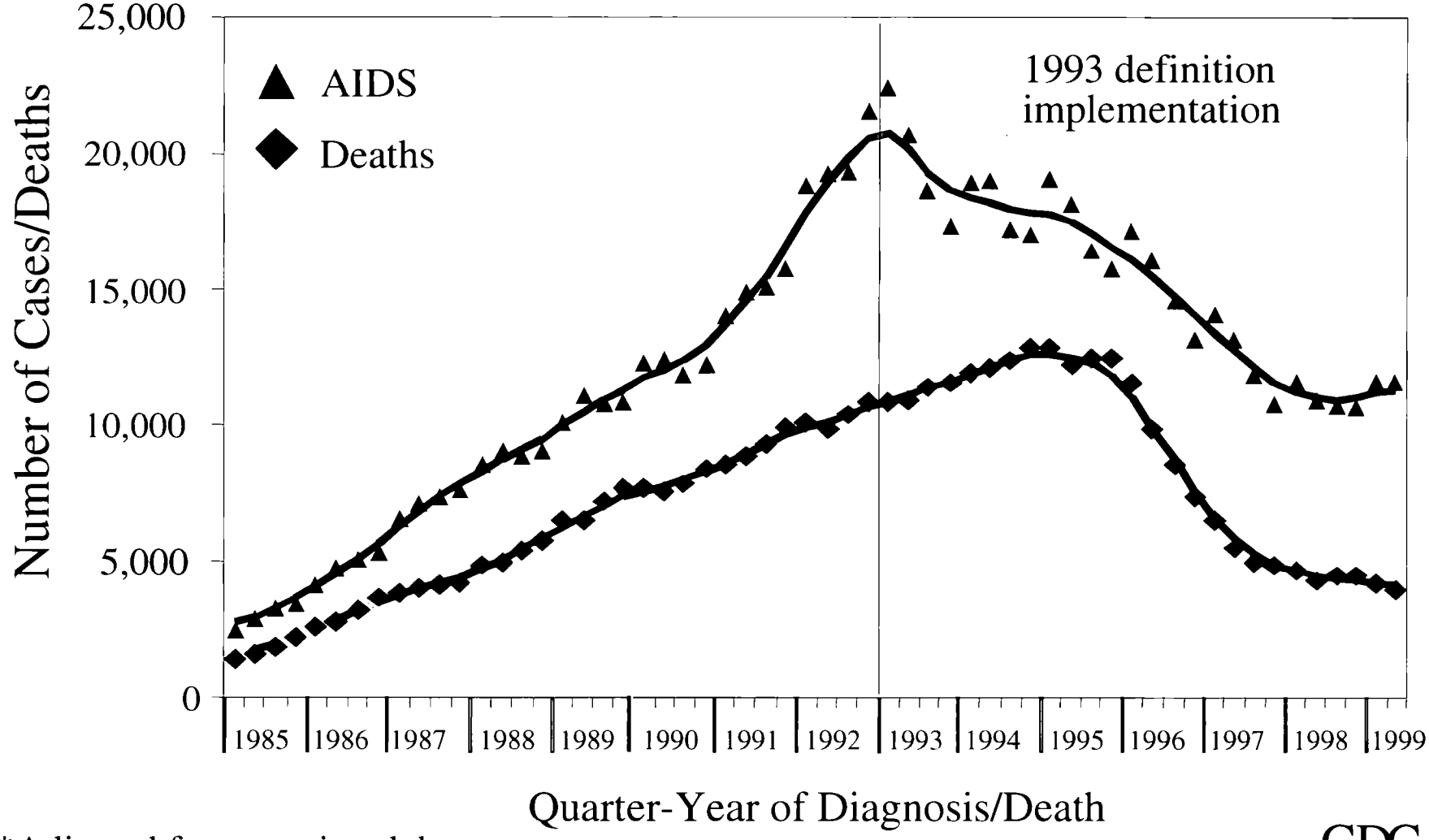
Among IDUs, incidence appears to have peaked in the early 1990s (with documented incidence of between 10 and 14 percent). Since that time, incidence has dropped dramatically, falling to levels of less than two percent in recent years. Incidence rates varied greatly depending on location of the study and access to substance abuse treatment, with incidence highest in the Northeast and among out-of-treatment IDUs.

According to Gayle, the greatest declines have been seen in cities such as New York, where successful efforts have been implemented to provide substance abuse treatment, HIV prevention counseling and testing, risk reduction programs, and access to sterile needles. HIV incidence in New York City declined from between five and 14 percent in the late 1980s to less than two percent a decade later.

"While we are pleased that we have been able to maintain progress and prevent increases in HIV infection in recent years, we are allowing far too many infections to continue," said Gayle. "We have the tools to essentially stop the U.S. epidemic. What we need is the will and the resources to do it."

# # #

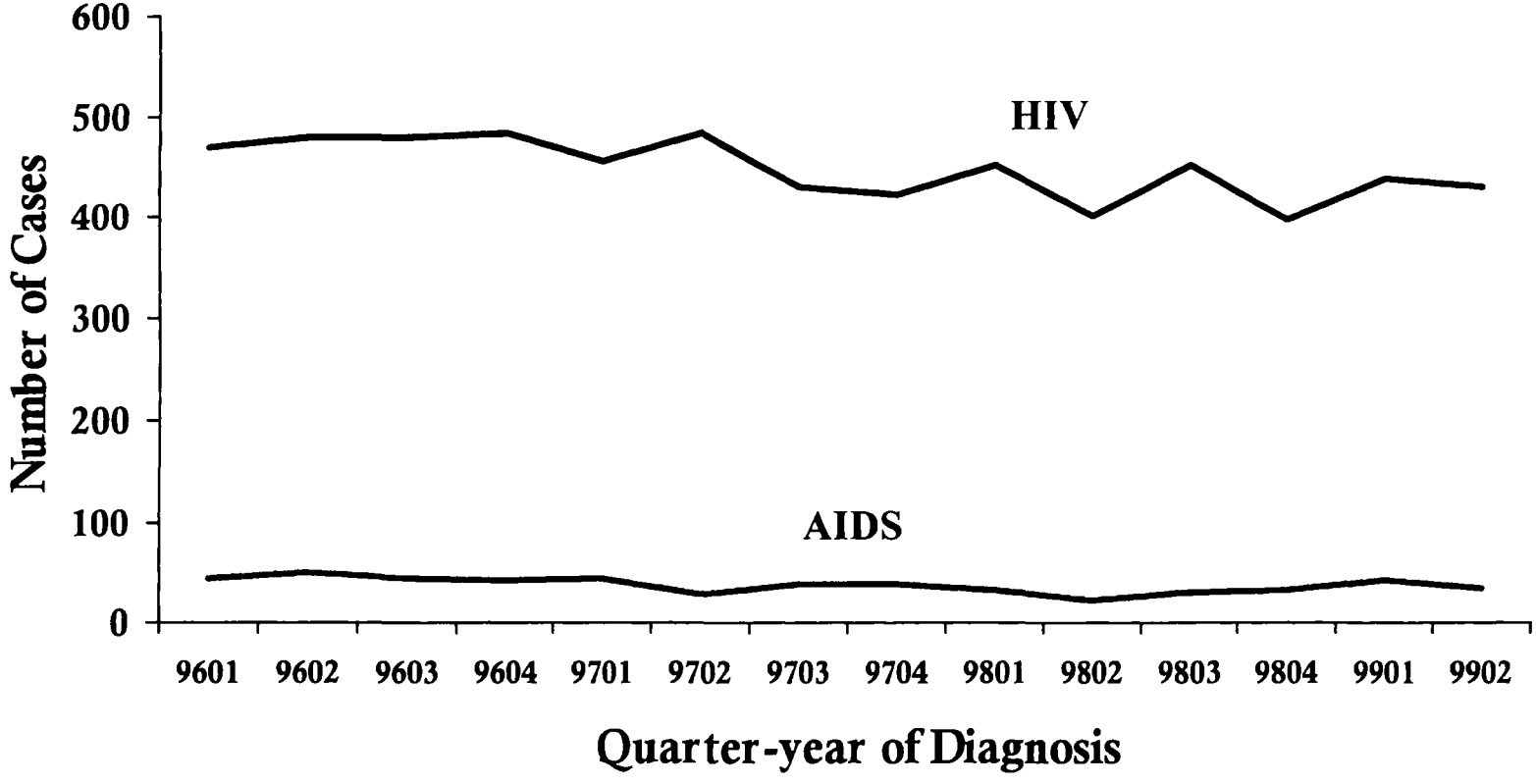
Estimated Incidence of AIDS and Deaths of Adults with AIDS*, 1985 - June 1999, United States



*Adjusted for reporting delays

CDC
Centers for Disease Control and Prevention

Estimated number of persons aged 13-24 years with HIV infection, by disease status at the time of initial diagnosis with HIV—25 states*, January 1996 through June 1999**



*Alabama, Arizona, Arkansas, Colorado, Idaho, Indiana, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nevada, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.

** Data reported to CDC through March 2000, adjusted for delays in case reporting.

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Contact: NCHSTP Office of Communications
(404) 639-8895
On-site: CDC Media Center
011-27-82-858-0333

PRESS BRIEFING: SUNDAY, 9 JULY 2000, 15:30 local time

CDC RESEARCH UNDERSCORES DEADLY TIE BETWEEN HIV AND TB PANDEMICS

– U.S. Study Shows HIV and TB Treatments May Be Incompatible –

– TB Surges in Côte d'Ivoire –

– TB Screening for HIV-Positive People Lags in the United States –

DURBAN, South Africa – The U.S. Centers for Disease Control and Prevention (CDC) presented new findings on the link between the HIV and tuberculosis (TB) pandemics. Researchers identified new challenges in the treatment and prevention of TB, which accounts for one-third of AIDS-related deaths worldwide. The studies were discussed today in a CDC press briefing at the XIII International AIDS Conference.

"TB is the leading infectious cause of death in adults worldwide. It is also the most common cause of suffering and death in people with HIV infection. Therefore, it is critical that we educate patients and health care providers about the link between these two diseases," said Kenneth Castro, M.D., director of CDC's Division of TB Elimination, and moderator of today's briefing. "Both screening and treatment strategies must consider the deadly ties between the HIV and TB pandemics."

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Common TB/HIV Drug Combination May Adversely Affect Treatment of Both Diseases: CDC discussed new research indicating the drug combination of rifabutin and complex highly active antiretroviral therapy (HAART) used to treat people with TB and HIV may adversely affect the treatment of both diseases. The study of a TB outbreak in a U.S. prison showed that one in five HIV patients who were on complex HAART, which includes the use of two protease inhibitors or one protease inhibitor and a non-nucleoside reverse transcriptase inhibitor, had a 100-fold increase in their viral load after being treated with the drug rifabutin. In the same study, CDC researcher Philip Spradling, M.D., and colleagues measured levels of rifabutin. They found that those patients taking complex HAART were more likely to have low levels of rifabutin in the bloodstream compared to those patients who were not taking complex HAART. Previous recommendations had suggested that rifabutin was a reasonable alternative to rifampin for patients also taking protease inhibitors for their HIV care. These findings illustrate the complexity of providing optimal care to HIV-infected patients at risk of TB regardless of the setting. ***[Abstract TuOrB8277, "Concurrent Use of Rifabutin and HAART: Evidence for Reduced Efficacy?" Philip Spradling, M.D., Symposium, Tuesday, 11 July 2000, 14:00 (8:00 AM EDT)]***

"Physicians unfamiliar with the interactions of treatment regimens for TB and HIV may be doing their patients more harm than good," said Castro. " It is important to identify ways to provide the best possible care for people afflicted with both TB and HIV worldwide."

TB Cases on the Rise in Abidjan: From Project RETRO-CI, a cooperative program between CDC, the Côte d'Ivoire Ministry of Health, and the Institute of Tropical Medicine, researchers found that the number of new TB cases in Abidjan, the largest city in Côte d'Ivoire, has dramatically increased in the HIV-negative population, while TB cases remained stable in the HIV-positive population. Between 1992 and 1998, the number of new TB cases nearly doubled, from 3,706 newly diagnosed TB patients in 1992 to 6,884 in 1998, an increase of approximately 85 percent. The rate of new TB infections among patients infected with HIV peaked in 1996 (1,330 cases per 100,000

people) and has since remained stable. The rate of new TB cases in the general population, however, continues to rise (from 297 cases per 100,000 people in 1992 to 404 cases per 100,000 people in 1998). The percentage of all new TB cases occurring among HIV-infected individuals was estimated to be 36 percent in 1998. The study, led by A. Ackah, M.D., confirmed the need to strengthen TB detection and treatment activities to reduce the source of new infections in the developing world. ***[Abstract WePeC4445, "Impact of the HIV Epidemic on Tuberculosis (TB) Incidence in Abidjan, Côte d'Ivoire," A. Ackah, M.D., Poster Presentation, Wednesday, 12 July 2000, 11:15 (5:15 AM EDT)]***

OTHER KEY U.S. FINDINGS

TB Screening and Treatment Lag Among HIV-infected

Another study underscored a key remaining obstacle in the fight against TB in the United States, reporting that a surprisingly high percentage of individuals living with HIV in the study population were not tested for TB. The study also found that those patients who do test positive for the disease may not be receiving proper medical treatment.

During 1995 to 1999, interviews conducted with more than 10,000 individuals living with HIV in 12 states found that nearly one in five reported they had not been screened for TB. The five-year study, led by Michael Campsmith, also found that nearly 30 percent of the patients who tested positive for TB reported they had never taken TB medication. Patients who received their care from private medical providers were less likely to be screened for TB than patients cared for in public health clinics. Similarly, TB-positive patients seen at a public clinic were more likely to be prescribed TB medication than those cared for at a private health setting. People with HIV are at dramatically increased risk for developing active TB disease. These findings suggest the need for widespread implementation of recently updated CDC and American Thoracic Society

recommendations that all HIV-infected individuals be screened and provided preventative treatment for TB if infected. ***[Abstract MoOrC215, "Self-Reported TB Testing and Treatment in an HIV-infected Population: Results from an Interview Project in the United States," Michael Campsmith, D.D.S., M.P.H., Oral Presentation, Monday, 10 July 2000, 16:00 (10:00 AM EDT)]***

OTHER KEY INTERNATIONAL FINDINGS

Another international study discussed at today's press conference demonstrated the continuing toll of the twin epidemics of TB and HIV. Researchers from Project RETRO-CI, based in Abidjan, found extremely high prevalence of HIV among TB patients, with higher prevalence among women than men.

- **Women in Côte d'Ivoire Disproportionately Affected by the HIV Epidemic**: While the overall prevalence of HIV among TB patients has stabilized throughout the country, the prevalence of HIV among women has surpassed the prevalence among men, according to a new CDC study. The study was discussed by lead researcher Angennes Akaki-Okiere of Project RETRO-CI. In 1999, among TB patients living in Abidjan, 51 percent of women were HIV infected, compared to 43 percent of men. In the interior of Côte d'Ivoire, 42 percent of female TB patients were HIV positive, compare to 32 percent of male TB patients. In the study, all newly diagnosed TB patients received voluntary HIV counseling and testing at two TB centers in Abidjan from 1989 to 1999 and at six TB centers located throughout the interior of Côte d'Ivoire from 1994 to 1999. ***[Abstract MoPeC2437, "Trends in HIV Infection in the Main Tuberculosis (TB) Outpatient Centers of Côte d'Ivoire: Analysis of Data from 1989 to 1999," Angennes Akaki-Okiere, M.D., Poster Presentation, Monday, 10 July 2000, 11:15 (5:15 AM EDT)]***

Cheap Drugs Offer Promise for Treating Opportunistic Infections in the Developing World

In addition to TB, HIV-positive individuals are at increased risk of developing a range of other opportunistic infections. CDC researchers discussed findings on the use of an inexpensive drug called Bactrim – also commonly referred to as cotrimoxazole (in Africa), Septra, or trimethoprim/sulfamethoxazole (TMP/SMX) – to treat diseases that disproportionately affect people living with HIV from around the world.

- **Adherence to Cotrimoxazole Preventive Therapy in HIV-TB Patients Strong in Abidjan:** Cotrimoxazole reduces both disease and death among TB patients who are also HIV-infected, and costs about $1.50 per month. A study on adherence to contrimoxazole, led by CDC researcher Stefan Wiktor, M.D., was conducted from 1995 to 1998 and assessed the drug adherence of nearly 400 HIV-infected TB patients at four outpatient TB centers in Abidjan. The patients, for the most part, had low levels of formal schooling and employment. The results showed that in at least 80 percent of the follow-up visits, approximately half (50.3 percent) of the patients had detectable levels of sulfa metabolites, which are found in cotrimoxazole, indicating strong adherence to the drug treatment regimen. Wiktor was encouraged by the results, noting that one might have expected a lower level of adherence in a patient population with low levels of education. ***[Abstract ThPeB5230, "Adherence to Cotrimoxazole Prophylaxis for the Prevention of Opportunistic Infections among HIV-Infected Tuberculosis Patients in Abidjan, Côte d'Ivoire," Stefan Wiktor, M.D., Poster Presentation, Thursday, 13 July 2000, 11:15 (5:15 AM EDT)]***

- **PCP Prophylaxis Also Reduces Risk of Other AIDS-Related Infections**: Use of TMP-SMX (Bactrim), a common prophylactic against AIDS-related *Pneumocystis carinii* pneumonia (PCP) in the U.S. that costs about $ .09 per pill, also prevented a wide range of other infections associated with HIV in a new CDC study. The study of more than 19,000 people in the United States, conducted by Mark Dworkin, M.D., and colleagues at CDC, assessed the efficacy of TMP-SMX in reducing the risk of

PCP and other common AIDS-related infections. The study showed that in addition to reducing the risk of PCP by 40 percent, TMP-SMX reduced the risk of toxoplasmosis by 30 percent, salmonellosis by 60 percent, haemophilus species infection by 40 percent, and invasive staphylococcal infections by 40 percent. This study confirms earlier findings indicating that this low-cost, easily-administered antibiotic can help developing nations significantly reduce illness and death caused by these opportunistic infections. ***["The Impact of Trimethoprim-Sulfamethoxazole Prophylaxis for* Pneumocystis carinii *Pneumonia (PCP) on the Risk for Other Infections in Persons with AIDS," Mark Dworkin, M.D., Poster Presentation, Tuesday, 11 July 2000, 11:15 (5:15 AM EDT)]***

"While global attention focuses on access to protease inhibitors and HAART in the developing world, other drugs that are cheaper and often easier to use, offer enormous promise in reducing morbidity and mortality associated with HIV-related disease," added Castro.

# # #

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PRESS BRIEFING: MONDAY, 10 JULY 2000, 08:00 local time

HIV TRENDS IN U.S. HIGHLIGHT NEED FOR EXPANDED PREVENTION

– High Levels of Infection Continue Among Many Communities of Color –

– Resurgence of Risk Among Gay Men, and High Rates of Infection Among Young Gay Men –

– Sex Among U.S. Teens Overall Declines in 1990s –

– CDC International Research Highlights Prevention Successes and Challenges –

DURBAN, South Africa – More people in the United States are living with HIV than ever before, and the epidemic continues to spread among increasingly diverse populations, according to research discussed today at a press conference sponsored by the U.S. Centers for Disease Control and Prevention (CDC) at the XIII International AIDS Conference. The findings underscore the need for expanded HIV prevention services to address a complex HIV epidemic.

"We now have extensive evidence that prevention can and does work among the highest risk populations in the United States and abroad," said Ronald O. Valdiserri, M.D., Deputy Director of CDC's National Center for HIV, STD, and TB Prevention (NCHSTP) and moderator of today's press briefing. "The challenge is maintaining efforts that are

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already working and expanding prevention programs to reach the multitude of groups now at risk."

CDC data demonstrate that HIV and AIDS are dramatically affecting many African-American and Latino communities throughout the United States, although the risk varies significantly by region of the country. Trends also appear to vary dramatically by state. Other CDC studies present continued evidence of a resurgence of risk among gay men and high levels of infection among young gay men.

"In this third decade of the HIV epidemic, prevention approaches will have to become increasingly sophisticated," said Valdiserri. "For HIV-negative populations, strategies must be adapted to the unique needs of each group affected. And for HIV-positive individuals, for whom safer behavior has become a lifetime proposition, prevention services must be expanded and sustained."

CDC also stressed the need for expanded HIV surveillance in light of treatment success. "In the United States, HIV is the epidemic, not AIDS," said Robert Janssen, M.D., Director of NCHSTP's HIV Surveillance and Epidemiology Division, who summarized the latest CDC surveillance data. "Knowing the number of AIDS cases in the United States reveals very little about the leading edge of the epidemic, while details on HIV infections give public health officials information they need to respond to the epidemic most effectively within their communities."

In addition to U.S. study findings, CDC researchers at the press conference also presented studies highlighting successful prevention programs and epidemiologic data from sub-Saharan Africa and Southeast Asia (see page 8).

KEY U.S. FINDINGS

HIV Trends Among Key Demographic Groups

- **Among African Americans & Latinos, Reported HIV/AIDS Prevalence Rates Vary Widely by City:** A CDC study examined the number of people diagnosed with HIV and AIDS in metropolitan areas with populations of more than 50,000 African Americans or Latinos. Results revealed that the rate of African Americans living with HIV and AIDS in Jersey City, New Jersey, the highest in the study, was 13 times higher than the rate for Flint, Michigan, the lowest. Among Latinos, the rate for those living in Newark, New Jersey, was more than five times higher than for those in Albuquerque, New Mexico. The study, conducted by Hazel Dean-Gaitor, M.D., and colleagues at CDC, included only cities in the 25 states that have reported HIV infections as well as AIDS cases since 1994[1]. Rates were examined for the period 1994 to 1998. For all 51 cities in the study, the combined prevalence rate of HIV and AIDS cases far exceeded the prevalence rate of AIDS cases alone, confirming that without the HIV data, most cities would be significantly underestimating the disease's prevalence among African Americans and Latinos. (See attached appendix for full list of city rates and rankings.) ***[Abstract MoPeC2452, "Prevalence of HIV and AIDS among African Americans and Hispanics in Metropolitan Statistical Areas – United States, 1998," Hazel Dean-Gaitor, M.D., Poster Presentation, Monday, 10 July 2000, 11:15 (5:15 AM EDT)]***

  For information on CDC's HIV prevention efforts targeting African-American and Latino communities at risk, see www.cdc.gov/nchstp/od/nchstp.html for a summary of national, regional, and local programs.

- **Overall HIV Diagnoses Fall Among Women, but Rise in Youngest Group:** In the same 25 states in which HIV trends can be examined, the number of women diagnosed with HIV overall decreased by 9 percent from 1994 to 1998, although the

[1] Alabama, Arizona, Arkansas, Colorado, Idaho, Indiana, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nevada, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Utah, Virginia, West Virginia, Wisconsin, and Wyoming

number of young women (those born between 1975 and 1979) diagnosed with HIV more than doubled during that period, according to a study led by CDC epidemiologist Lisa M. Lee. The overall decline, from 5,038 diagnoses among women in 1994 to 4,560 in 1998, was led primarily by a steep drop in HIV diagnoses among women born before 1970 who were infected through injection drug use (IDU). Among the youngest group of women, both IDU-related cases and heterosexual cases increased. IDU-related HIV diagnoses in this age group increased from 39 in 1994 to 78 in 1998, and HIV cases attributed to heterosexual contact increased from 194 cases in 1994 to 420 in 1998. ***[Abstract MoPeC2446, "Trends in HIV Diagnoses by Birth Cohort among Women in 25 HIV-Reporting States, United States, 1994-1998," Lisa M. Lee, Poster Presentation, Monday, 10 July 2000, 11:15 (5:15 AM EDT)]***

- **Injection Drug Infections Remain High in New York and New Jersey:** The annual rate of HIV infection (HIV incidence) among injection drug users in treatment in Newark, New Jersey, and New York City remained relatively stable from 1994 to 1997. The study, conducted by Keith Sabin and colleagues at CDC, examined trends in new infections among 18,837 people admitted to 12 drug treatment centers in four cities. Over the four-year period, annual infection rates among injection drug users in New York (2.3 percent) and Newark (3.1 percent) were much higher than in Los Angeles (0.2 percent) or Seattle (0.3 percent). The study also found high incidence among non-injection drug users in New York (2.9 percent), suggesting that sexual risk may also be contributing significantly to the spread of infection. Overall, 14 percent of the study participants were HIV positive, most of them in New York or Newark. The authors conclude that a reduction in infections will require increased access to drug treatment, coupled with increased HIV testing, prevention, and treatment services. ***[Abstract ThPeD5506, "HIV Incidence and Prevalence among Persons Admitted to U.S. Drug Treatment Centers, 1994-1997," Keith Sabin, Poster Presentation, Thursday, 13 July 2000, 11:15 (5:15 AM EDT)]***

Gay Men Remain Population at Greatest Risk

David Holtgrave, Ph.D., Director of NCHSTP's HIV Prevention Division, summarized the latest data on risk and infection among U.S. gay men, concluding that gay men remain the population at greatest risk for HIV infection in the United States.

"The evidence continues to mount that gay men of all races remain at alarming risk for infection. In fact, risk may again be increasing in some communities," said Holtgrave. "To address the urgent need for HIV prevention in this population, we will need to address multiple factors, including prevention burn-out among older men, beliefs that HIV is no longer a serious disease, a new generation of gay and bisexual men who must be reached, and cultural issues for gay men of color."

CDC data discussed today show an increase in gonorrhea among HIV-infected gay men in nine cities, which health officials fear could foreshadow increases in HIV incidence. A separate CDC study indicates that an increasing number of HIV-positive gay men are engaging in unprotected anal sex.

- **Gonorrhea among HIV-Infected Patients:** An analysis of data on HIV-infected patients treated in more than 100 health care facilities located in nine U.S. cities found high rates of gonorrhea during the period 1991-1998. Despite overall decreases in reported gonorrhea incidence in the general U.S. population during this time, this analysis identified no significant decrease in gonorrhea incidence among HIV-infected individuals. On closer examination of these data, the researchers, led by CDC's Ann Do, found that trends differed significantly by exposure risk group. Although there was a decrease in gonorrhea incidence among HIV-infected individuals who were infected through heterosexual contact, increases in incidence were detected among both HIV-infected gay and bisexual men and injection drug users. Most of the increase in gonorrhea incidence among gay and bisexual men in the study occurred from 1993 (5.9 cases/1,000 person-years) to 1998 (13.9 cases/1,000 person-years). The increases in gonorrhea incidence among injection

drug users occurred from 1997 (3.9 cases/1,000 person-years) to 1998 (16.3 cases/1,000 person-years). These findings suggest a high rate of risk behavior among HIV-infected gay and bisexual men and injection drug users and point to the need for sustained prevention efforts. ***[Abstract WePeC4397, "Risk Factors and Trends of Gonorrhea Incidence among HIV-Infected Patients, United States," Ann Do, Poster Presentation, Wednesday, 12 July 2000, 11:15 (5:15 AM EDT)]***

- **Unsafe Sex Increasing among HIV-Infected Gay Men:** A study of 1,942 HIV-infected gay and bisexual men in 12 cities and states found that a small but growing percentage reported engaging in unprotected anal sex. The study, conducted by Paul Denning, M.D., found that the proportion of HIV-infected gay and bisexual men who had unprotected anal sex during the previous 12 months rose from 13 percent in 1995-1996 to 19 percent in 1997-1998, an increase of nearly 50 percent. HIV-infected gay and bisexual men who engaged in unprotected anal sex were more likely to have multiple partners, use injection drugs or crack cocaine, and have less than 12 years of education. ***[Abstract ThOrC714, "Increasing Rates of Unprotected Anal Intercourse among HIV-Infected Men Who Have Sex With Men in the United States," Paul Denning, M.D., Oral Presentation, Thursday, 13 July 2000, 14:45 (8:45 AM EDT)]***

CDC data presented today also found high levels of risk behavior among young men who have sex with men, many of whom also have sex with women, and a low level of HIV testing, despite high risk.

- **Bisexual Behavior Increasing Spread of HIV Infection:** One in six young men who have sex with men had recently had sex with women, and nearly one-fourth of those men had recently had unprotected sex with both men and women, according to a CDC study of 3,492 gay and bisexual men, ages 15 to 22, in seven U.S. cities. Conducted by Linda Valleroy and colleagues at CDC, the study confirms that young bisexual men are a "bridge" for HIV transmission to women, particularly given that 6.6 percent of bisexual men in the study were HIV positive. The findings are derived

from CDC's five-year Young Men's Survey of gay and bisexual men in Baltimore, Dallas, Los Angeles, Miami, New York City, Seattle, and the San Francisco Bay area. Final results of the study, published in this week's *Journal of the American Medical Association*, indicate that 7.2 percent of young men in the study were infected, with dramatically higher prevalence among African-American (14.1 percent infected) and Hispanic (6.9 percent infected) young men, as well as young men of mixed race (12.6 percent), compared with Asian and Pacific Islanders (3.0 percent) and whites (3.3 percent). ***[Abstract WePeC4300, "The Bisexual Bridge for HIV among 15- to 22-Year-Old Men Who Have Sex with Men in 7 U.S. Cities," Linda Valleroy, Poster Presentation, Wednesday, 12 July 2000, 11:15 (5:15 AM EDT)]***

- **Attitudes About HIV May be Associated with HIV Sex Risk Behavior among Young Gay Men:** Optimistic attitudes about highly active antiretroviral therapy (HAART) may be contributing to increased risk behavior among young gay men, according to a CDC study led by Bradford Bartholow and Linda Valleroy. Examining risk behaviors among 1,887 gay men, ages 23 to 29, in six U.S. cities, the study found that men whose anxieties and concerns about HIV infection were reduced because of the availability of HAART, and who perceived that sex partners with low viral loads present less risk of HIV infection than those with high viral loads, had more sex partners than men who did not. Men who had unprotected anal sex with non-monogamous partners were more likely than men who did not to report a reduced concern of HIV infection related to the availability of HAART. ***[Abstract ThPeD6320, "Knowledge and Attitudes Regarding Post-Exposure Prophylaxis (PEP) and Highly Active Antiretroviral Therapy (HAART) as Correlates of HIV Risk Behavior among Young Men Who Have Sex with Men (MSM) in the United States," Bradford Bartholow and Linda Valleroy, Poster Presentation, Thursday, 13 July 2000, 11:15 (5:15 AM EDT)]***

- **Many Young Gay Men Not Getting Tested for HIV:** More than one-fifth (22 percent) of young gay or bisexual men have never been tested for HIV, and over half have not been tested in the past six months, according to CDC researcher Esther

Sumartojo and colleagues. The 10-city study of 2,621 gay and bisexual men, ages 15 to 25, found that these men are more likely to get tested if they know of a place where they feel "comfortable", or at ease, to get tested and if they have been exposed to a variety of types of prevention strategies (e.g., flyers, workshops, advertisements, etc.). Men reporting unprotected anal sex during their last encounter with a non-main partner were about half as likely to have been tested as those who did not have risky sex with their most recent non-main partner. ***[Abstract ThPeD5804, "Prevalence and Predictors of HIV Testing in a Multi-Site Sample of Young Men Who Have Sex with Men," Esther Sumartojo, Poster Presentation, Thursday, 13 July 2000, 11:15 (5:15 AM EDT)]***

Sex and High-Risk Behavior Down among Teens in 1990s; Perinatally Infected Children Coming of Age

While risk remains high among young gay men, risk among teens overall is decreasing. Sexual intercourse among U.S. high school students declined by 8 percent in the 1990s, while condom use among teens increased by more than 25 percent, according to a nationally representative CDC study of 14- to 18-year-olds discussed at today's press conference. The figures represent the first sustained reversal of risk behaviors among teens in the last two decades.

"Fewer high school students in the United States are engaging in behaviors that place them at risk for HIV infection," said Laura Kann, who led the CDC study. "These data point to the success of comprehensive prevention efforts to both delay first intercourse among teens and to increase condom use among young people who are sexually active."

- **Decline in Sexual Risk Behaviors among Teens:** The percentage of 14- to 18-year-olds who reported having sex declined from 54.1 percent to 49.9 percent between 1991 and 1999. In addition, fewer high school students reported having sex with multiple partners (declining from 18.7 percent to 16.2 percent), and fewer reported having sex before age 13 (declining from 10.2 percent to 8.3 percent). The downturn

in sexual experiences for teens was accompanied by a substantial increase in condom use (increasing from 46.2 percent to 58 percent) among those who were sexually active. The data on teenagers' sexual behavior was gathered as part of CDC's Youth Risk Behavior Surveillance System, which includes biennial surveys of high school students. ***[Abstract MoPeC2442, "Sexual Risk Behaviors among U.S. Adolescents: A Decade in Review," Laura Kann, Poster Presentation, Monday, 10 July 2000, 11:15 (5:15 AM EDT)]***

According to session moderator Ronald O. Valdiserri, M.D., prevention efforts for teens will have to increasingly deal with the needs of both HIV-negative and HIV-positive teens. New CDC estimates discussed at the press briefing indicate that more than 10,000 perinatally infected children are living in the United States today.

"Treatment advances have increased the length and quality of life for children, and the number of HIV-infected children who survive into their teens will continue to increase," said Valdiserri. "We are going to have to design programs to meet their unique needs."

- **More HIV-Infected Children Reaching Adolescence:** Approximately 2,100 children born with HIV due to mother-to-child transmission are now teenagers, according to the study by Mary Lou Lindegren, M.D., and colleagues at CDC. Of the estimated 10,000 perinatally infected children living in the United States today, an increasing number will enter their teenage years during the next five years. ***[Abstract TuPeC3351, "Increasing Numbers of Adolescents Living with Perinatal HIV Infection in the United States," Mary Lou Lindegren, M.D., Poster Presentation, Tuesday, 11 July 2000, 11:15 (5:15 AM EDT)]***

KEY CDC INTERNATIONAL FINDINGS

As CDC works to expand HIV prevention efforts in the United States, the agency is also working in partnership with governments in the developing world to increase access to

not only treatment and care, but also prevention. Progress in areas such as Senegal and Uganda demonstrates that prevention can make a tremendous difference.

"Preventing infection is always better than treating disease. And, without the resources and infrastructure to deliver the complex AIDS treatments in most of the developing world, HIV prevention is the most ethical and realistic solution. Now more than ever, our world depends on it," stressed Valdiserri.

At the press conference, CDC discussed research findings demonstrating a successful HIV prevention program in Zimbabwe. Another international study provided important data on emerging prevention needs in Thailand.

ZIMBABWE: Negotiation Strategies Increase Condom Use

Condom use increased 35-fold, from two percent to 70 percent, after 14 weeks, for 296 HIV-negative women who received counseling on strategies for negotiating condom use with their partners, according to a study by Ann O'Leary and colleagues at CDC. Women received two individualized initial counseling sessions and one "booster" session during the trial, which took place in primary care settings in Zimbabwe. Before counseling began, the researchers conducted interviews to identify arguments for condom use that would be most likely to appeal to women's partners. Negotiation strategies were developed that took into account a number of survey findings in this setting, including the fact that all respondents had lost friends to AIDS, children and reproduction are highly valued, and health care workers are a respected source of information and advice.

According to the authors, these findings confirm that women can significantly increase condom use even in societies where it goes against cultural norms. Success depends on developing counseling and negotiation strategies that are based on research of a society's attitudes and perceptions about HIV/AIDS, sex, and other important domestic factors. ***[Abstract WePpC1394, "Development of a Male Condom Intervention for HIV-***

Seronegative Zimbabwean Women," Ann O'Leary, Oral Poster Presentation, Wednesday, 12 July 2000, 12:00, (6:00 AM EDT)]

THAILAND: Risk Behaviors High among Youth in Northern Province

Less then 10 percent of teenagers and young adults, ages 15 to 21, in Thailand's northernmost province of Chiang Rai used condoms with their steady sexual partners, and only 30 percent used them with their casual sexual partners, according to a study conducted by Frits van Griensven, and colleagues from the Thai Ministry of Public Health and the HIV/AIDS Collaboration. Roughly 60 percent of the 1,725 students enrolled in the study reported being sexually experienced, while 25 percent of males and 15 percent of females reported having had more than five sexual partners in their lifetime. Seven percent of all males said they had ever paid for sex, while three percent of both males and females had ever sold sex. The prevalence of HIV in this study population was low (0.3 percent), but sexually active males and females had high rates of chlamydial infection (4 and 6 percent, respectively).

"HIV infection rates, overall, in this province remain among the highest in Asia, and there is a critical need to expand HIV prevention among our young people," van Griensven said. "New generations require new and alternative approaches to prevention. This study shows that we can't afford to sit back and wait for HIV to spread. We need to be proactive about prevention." ***[Abstract WePeC4347, "Sex, Drugs, HIV and STD among Adolescents and Young Adults in Northern Thailand: An Innovative, Rapid Biologic and Behavioral Assessment," Frits van Griensven, Poster Presentation, Wednesday, 12 July 2000, 11:15 (5:15 AM EDT)]***

For more information on CDC's current HIV prevention programs, as well HIV prevention approaches proven effective for populations at greatest risk, see www.cdc.gov/nchstp/od/nchstp.html.

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Table 1
(see study, page 3)

HIV and AIDS Prevalence Rates in Metropolitan Areas with Populations of More than 50,000 African Americans*

TOTAL PREVALENCE RANK	METROPOLITAN STATISTICAL AREA	AIDS PREVALENCE	TOTAL HIV AND AIDS PREVALENCE	RATIO AIDS TO TOTAL HIV AND AIDS PREVALENCE
1	JERSEY CITY, NJ	1469	2570	1.7
2	NEWARK, NJ	1203	2273	1.9
3	BERGEN-PASSAIC, NJ	843	1499	1.8
4	MONMOUTH-OCEAN, NJ	679	1386	2.0
5	TRENTON, NJ	650	1354	2.1
6	COLUMBIA, SC	514	1336	2.6
7	MIDDLESEX-SOMERSET-HUNTERDON, NJ	640	1134	1.8
8	BATON ROUGE, LA	376	1123	3.0
9	JACKSON, MS	342	1106	3.2
10	CHARLOTTE, NC	261	1040	4.0
11	LAS VEGAS, NV	422	1039	2.5
12	NASHVILLE, TN	395	1018	2.6
13	DENVER, CO	325	977	3.0
14	MINNEAPOLIS-ST. PAUL, MN	346	967	2.8
15	NEW ORLEANS, LA	387	939	2.4
16	RICHMOND-PETERSBURG, VA	316	835	2.6
17	RALEIGH-DURHAM-CHAPEL HILL, NC	265	810	3.1
18	NORFOLK-VA BEACH-NEWPORT NEWS, VA	280	787	2.8
19	CHARLESTON, SC	289	780	2.7
20	MEMPHIS, TN	268	768	2.9
21	MOBILE, AL	267	756	2.8
22	MONTGOMERY, AL	214	749	3.5
23	FAYETTEVILLE, NC	187	713	3.8
24	GREENSBORO/WINSTN-SALEM/H.PT, NC	207	697	3.4
25	BIRMINGHAM, AL	238	673	2.8
26	MILWAUKEE-WAUKESHA, WI	225	635	2.8
27	PHOENIX-MESA, AZ	243	634	2.6
28	GREENVILLE-SPARTANBURG-ANDERSON,SC	218	577	2.6
29	CHATTANOOGA, TN	259	563	2.2
30	LITTLE ROCK-N. LITTLE ROCK, AR	234	549	2.3
31	ST. LOUIS, MO	256	543	2.1
32	INDIANAPOLIS, IN	205	535	2.6
33	DETROIT, MI	246	512	2.1
34	KANSAS CITY, MO	258	505	2.0
35	COLUMBUS, OH	123	487	3.9
36	CLEVELAND-LORAIN-ELYRIA, OH	210	478	2.3
37	BILOXI-GULFPORT-PASCAGOULA, MS	126	431	3.4
38	GARY, IN	126	376	3.0
39	CINCINNATI, OH	177	367	2.1
40	TOLEDO, OH	132	354	2.7
41	OKLAHOMA CITY, OK	151	351	2.3
42	HUNTSVILLE, AL	172	343	2.0
43	LAFAYETTE, LA	117	321	2.7
44	SHREVEPORT-BOSSIER CITY, LA	133	300	2.3
45	DAYTON-SPRINGFIELD, OH	118	283	2.4
46	AKRON, OH	108	238	2.2
47	GRAND RAPIDS-MUSKEGON-HOLLAND, MI	94	233	2.5
48	FLINT, MI	80	195	2.4

*Among 25 states with HIV infection reporting since 1994: Alabama, Arizona, Arkansas, Colorado, Idaho, Indiana, Louisiana, Michigan, Mississippi, Missouri, Nevada, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.

Table 2

(see study, page 3)

HIV and AIDS Prevalence Rates in Metropolitan Areas with Populations of More than 50,000 Latinos*

TOTAL PREVALENCE RANK	METROPOLITAN STATISTICAL AREA	AIDS PREVALENCE	TOTAL HIV AND AIDS PREVALENCE	RATIO AIDS TO TOTAL HIV AND AIDS PREVALENCE
1	NEWARK, NJ	383	726	1.9
2	JERSEY CITY, NJ	385	694	1.8
3	BERGEN-PASSAIC, NJ	278	518	1.9
4	MIDDLESEX-SOMERSET-HUNTERDON, NJ	296	506	1.7
5	DENVER, CO	146	390	2.7
6	NEW ORLEANS, LA	174	337	1.9
7	LAS VEGAS, NV	158	329	2.1
8	SALT LAKE CITY-OGDEN, UT	114	220	1.9
9	PHOENIX-MESA, AZ	88	198	2.2
10	TUCSON, AZ	100	196	2.0
11	DETROIT, MI	84	162	1.9
12	ALBUQUERQUE, NM	74	130	1.8

*Among 25 states with HIV infection reporting since 1994: Alabama, Arizona, Arkansas, Colorado, Idaho, Indiana, Louisiana, Michigan, Mississippi, Missouri, Nevada, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.

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PRESS BRIEFING: TUESDAY, 11 JULY 2000, 15:00 local time

STUDIES HIGHLIGHT SHORTCOMINGS OF AIDS TREATMENTS

– Only One-Third of Patients Receive Long-Term Suppression of HIV from Combination Therapy –

– Studies Find Sharp Disparities in HAART Prescription and Use by Race and Gender –

– Pilot Programs in Developing Countries Show Drug Efficacy, but High Levels of Viral Resistance Found –

DURBAN, South Africa – New studies from the U.S. Centers for Disease Control and Prevention (CDC) discussed today highlight the growing shortcomings of existing treatment regimens. The studies were discussed at a press briefing held by CDC at the XIII International AIDS Conference.

One study discussed today suggests that only one-third of U.S. patients may receive long-term suppression of HIV from highly active antiretroviral therapy (HAART), and that those patients who have changed HAART regimens in the course of AIDS treatment are less likely to experience long-term viral suppression.

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Other CDC studies revealed continued racial and gender disparities in access to the most effective therapies, and examined the contributing role stress may play in poor adherence among women. In one study, women and African Americans were less likely to be prescribed HAART than white men. Another study found that women, particularly women who were depressed or dealing with issues such as job loss, family illness, and other stressful events, were less able to adhere to HAART regimens, which cost as much as $15,000 a year and demand that patients adhere to complicated dietary and time restrictions.

"All of these studies underscore the importance of distinguishing between the hope for a 'magic bullet' against AIDS and the reality of existing treatments," said Helene D. Gayle, M.D., M.P.H., Director of CDC's National Center for HIV, STD, and TB Prevention. "While we clearly need new treatment options and a better understanding of how to combat viral resistance, these studies remind us that HIV prevention is still our best hope – both in the United States and throughout the world, especially here in Africa."

CDC studies conducted in Uganda and Côte d'Ivoire, also presented today, reveal that while expanding access to HAART remains critical, issues of resistance and adherence also pose significant challenges. Patients in developing nations were found to have extremely high levels of viral resistance to the drugs and potential problems in adhering to the complicated regimens. These studies are among the first to evaluate pilot programs providing HAART in the developing world.

KEY U.S. FINDINGS

HAART: Working, But For How Long and For Whom?

CDC presented a number of studies highlighting growing concern about existing AIDS treatments. Some studies raised questions about the long-term efficacy of HAART, while others highlighted disparities in the prescription of the regimens and problems with their use.

"Patients are struggling – to get on these regimens, to stay on them once prescribed, and to benefit from them over the long-term," said CDC researcher Scott Holmberg, M.D., author of several studies and a presenter at the briefing. "We will need strategies to assist HIV-infected men and women with adherence, and we will need more drug options, since those we have are increasingly being exhausted by the people who need them."

HAART involves a combination of three or more AIDS drugs, including two of the drugs known as nucleoside analog reverse transcriptase inhibitors (NARTIs), as well as one or more protease inhibitors or non-nucleoside analog reverse transcriptase inhibitors (NNRTIs).

- **Patients Forced to Change Regimens with Increasing Frequency:** HAART continues to be effective, according to data presented by Holmberg, but patients are having to change drugs and regimens increasingly often to maintain those benefits. Holmberg's study, which analyzed medical data from more than 1,600 U.S. AIDS patients nationwide, found that HAART use had climbed from below 4 percent at the end of 1995 to 87 percent in the third quarter of 1999. Corresponding declines were noted in both rates of AIDS deaths – which fell by 93 percent from 1994 to 1999 among patients studied – and in rates of opportunistic infections, which on average declined by 87 percent in the same period.

  On average, patients stayed on their first course of HAART for only 10.6 months before the treatment proved ineffective or intolerable; those on their second course of HAART remained on that regimen for only 8.1 months; and those on a third course of HAART remained on it for 6.4 months. ***[Abstract ThOrC723, "Continued Low Morbidity and Mortality Among Patients with Advanced HIV Infection and Their Patterns of Highly Active Antiretroviral Therapy (HAART) Usage," Scott Holmberg, M.D., Oral Presentation, Thursday, 13 July 2000, 15:30 (9:30 AM EDT)]***

- **Virus Suppressed Long-term in Only About One-third of HAART Patients:** Significant questions about the long-term efficacy of HAART also were raised by Holmberg's data, which showed that the combination therapies successfully suppressed the virus for twelve months or more in only approximately one-third (36%) of patients who were observed for at least 15 months. Patients were more likely to achieve long-term treatment success with first HAART (49 percent), than with second HAART (30 percent), or third or more HAART (15 percent). This analysis, completed on a subset of 366 patients from the larger study (above), found that factors associated with increased likelihood of treatment success included never having taken antiretroviral therapy prior to beginning HAART, and receiving HAART with a single protease inhibitor (especially indinavir or nelfinavir), rather than receiving HAART with two protease inhibitors (especially saquinavir or ritonavir). ***[Abstract TuPpB1166, "Correlates of Durable Treatment Success among Long-Term Highly Active Anitretroviral Therapy (HAART) Recipients in the HIV Outpatient Study (HOPS)," Scott Holmberg, M.D., Oral Poster Presentation, Tuesday, 11 July 2000, 11:30 (5:30 AM EDT)]***

- **Treatment Disparities by Race and Gender:** Women and African Americans may be less likely to be prescribed HAART than men and whites, according to another study presented today. The study, by CDC researcher A.D. McNaghten, followed 9,113 patients in 11 U.S. cities to assess prescription patterns for HIV antiretroviral therapy among those eligible for such treatment under recommended guidelines. More than 80 percent of eligible patients were prescribed some type of antiretroviral therapy; 56 percent were prescribed HAART; and 18 percent were not prescribed any antiretroviral therapy. Women in the study were 24 percent less likely than men, and African Americans were 12 percent less likely than whites, to be prescribed HAART. The inequities found require further study to determine if certain factors (including health coverage or health care providers' perceptions of which groups are more likely to adhere to HAART regimens) affect the likelihood of HAART prescription for these populations. ***(Abstract ThPeB5286, "Inequities Between Gender and Racial***

Groups in Prescription of Highly Active Antiretroviral Therapy," A.D. McNaghten, Poster Presentation, Thursday, 13 July 2000, 11:15 (5:15 AM EDT)]

- **Once Prescribed, Initial HAART Therapy More Likely to Fail for Women:** Among patients new to HAART, women were less likely than men to develop the level of viral suppression that defines treatment success, according to a CDC study discussed today. A study of 76 patients who were prescribed HAART for the first time at an inner-city clinic in the Southeastern United States, led by CDC researcher Linda Koenig, found that women were significantly more likely to experience treatment failure within the first five months of HAART than men. Almost 30 percent of women failed to show a significant decrease in viral load after initiating treatment. Women who failed therapy reported more depression, more perceived stress, less social support, and more misconceptions about HAART, compared to men and women whose therapy was successful. A small number of men (10 percent) also failed HAART, but more research is needed to better understand the factors associated with failure. In the study, age, race, income, and history of crack cocaine or injection drug use were not associated with treatment failure. ***[Abstract WePeB4148, "Predictors of Early Failure of Highly Active Antiretroviral Therapy (HAART)," Linda Koenig, Poster Presentation, Wednesday, 12 July 2000, 11:15 (5:15 AM EDT)]***

Another study, which focused specifically on HIV-infected women and their ability to adhere to antiretroviral therapy, also found that recent illicit drug use, race and income had no bearing on adherence. This study, of 520 HIV-infected women eligible for antiretroviral therapy in four U.S. cities, was conducted by CDC researcher Jan Moore, and found that only 288 (55 percent) were taking any antiretroviral medication. An estimated 26 percent of women taking HIV medication were unable to adhere completely to their treatment regimens. Depression, HIV-related stress, and adverse events such as loss of income or family illness, were

associated with failure to adhere fully to HIV treatment regimens. ***[Abstract WePeD4598, "Predictors of Adherence to Antiretroviral Therapy Among HIV-infected Women," Jan Moore, Poster Presentation, Wednesday, 12 July 2000, 11:15 (5:15 AM EDT)]***

KEY INTERNATIONAL FINDINGS

Combination AIDS Therapy – and Viral Resistance – in the Developing World

There has been little study of the effectiveness of HAART on viral strains prevalent in sub-Saharan Africa, which is home to more than 23 million adults and children living with HIV and AIDS. A new CDC study finds that HAART is proving to be more effective than two-drug therapy alone for patients in the UNAIDS drug access pilot programs in Uganda and Côte d'Ivoire. These findings are consistent with studies in the United States and Europe. Yet, several CDC studies highlight the problem posed by viral resistance in the drug access initiatives.

"As the use of antiretroviral therapy in Africa and other parts of the developing world increases, it will be essential to monitor viral resistance and learn more about patient adherence to medications," said Gayle. "Clearly, cost and access are not the only barriers to effective care."

A separate study found that women in Côte d'Ivoire might require AIDS therapy earlier than men, due to newly identified differences between men and women in the relationship between viral load and CD4+ immune cell counts.

HAART Better than Two-drug Therapy in Africa

- ***Uganda:*** In a 20-month program evaluation of patients in the Ugandan UNAIDS HIV Drug Access Initiative begun in 1998, patients who remained on HAART for more than one year experienced greater benefit than those on a regimen which only

included two nucleoside analog reverse transcriptase inhibitors (NARTIs). The observational evaluation, led by CDC researcher Paul Weidle, M.D., found that among patients on the two NARTI regimen, both their CD4 counts (a measure of immune suppression) and their viral load had almost returned to baseline levels one year after initiation of therapy. People on HAART, however, continued to experience substantial improvements, by both measures, after one year of therapy. Although less expensive than HAART, dual NARTI therapy is still costly to patients and has a less durable benefit. In Uganda, lowering the costs of protease inhibitors and NNRTIs could help ensure that patients benefit from optimal treatment strategies. ***[Abstract ThPeB5231, "Evaluation of Patients Accessing Antiretroviral Therapy in the UNAIDS HIV Drug Access Initiative in Uganda," Paul J. Weidle, M.D., Poster Presentation, Thursday, 13 July 2000, 11:15 (5:15 AM EDT)]***

- ***Côte d'Ivoire:*** In Abidjan, Côte d'Ivoire, patients on HAART also received greater benefit than those on a two-drug regimen. The study, of 422 previously untreated patients in the UNAIDS/Ministry of Health drug access initiative in Abidjan, found that patients on HAART received a more pronounced and sustained virologic response than patients on two NARTIs. After 300 days of therapy, 17 percent of those on NARTIs achieved undetectable viral load levels, compared to 38 percent on HAART. ***[Abstract TuOrB295, "Virologic and Immunologic Response to Antiretroviral Therapy among Patients Participating in the UNAIDS/Ministry of Health Initiative to Improve Access to Therapy for HIV-infected Persons in Côte d'Ivoire," Gaston Djomand, M.D., Oral Presentation by Madeleine Sassan-Morokro, M.D., Tuesday, 11 July 2000, 13:15 (7:15 AM EDT)]***

High Levels of Resistance Found

- ***Uganda:*** While HAART was found to be effective against HIV, high levels of resistance were documented in the UNAIDS drug access initiative in Uganda, according to the lead study author, Paul Weidle, M.D. After testing blood drawn from a subsample of 30 patients in the program, Weidle and colleagues found that

phenotypic resistance[1] to at least one AIDS drug was present in 74 percent of the samples. Resistance was highest to lamivudine (3TC), with 78 percent of patients taking the drug exhibiting some signs of resistance. By comparison, 20 percent of specimens from patients on zidovudine (AZT) demonstrated resistance. Because of the high level of 3TC resistance found in this setting, which has also been documented in North America and Europe, Weidle's findings suggest that 3TC should only be used in Uganda as part of a maximally suppressive regimen to decrease the development of resistance. ***[Abstract TuPeB3293, "Development of Phenotypic and Genotypic Resistance to Antiretroviral Therapy in the UNAIDS HIV Drug Access Initiative – Uganda," Paul J. Weidle, M.D., Poster Presentation, Tuesday, 11 July 2000, 11:15 (5:15 AM EDT)]***

- ***Côte d'Ivoire***: CDC also documented high rates of antiretroviral drug resistance among patients with a history of antiretroviral therapy seeking care in the UNAIDS initiative in Abidjan, Côte d'Ivoire. The study, by CDC researcher Christiane Adje, tested blood drawn from 68 patients with a history of current or past therapy. Of those, 57 percent had resistance to at least one reverse transcriptase inhibitor or protease inhibitor. Resistance to AZT was found in 43 percent of patients, while resistance to 3TC was found in 15 percent of the sample. ***[Abstract TuOrB280, "High Prevalence of Genotypic and Phenotypic Antiretroviral (ARV) Drug Resistant HIV-1 Strains among Patients Receiving ARV in Abidjan, Côte d'Ivoire," Christiane Adje, Oral Presentation, Tuesday, 11 July 2000, 14:00 (8:00 AM EDT)]***

- **Women in Côte d'Ivoire May Need Different Treatment Guidelines:** While the immune systems of all of the patients accessing the UNAIDS/Ministry of Health Initiative in Abidjan were severely compromised, women may need treatment at higher CD4+ immune cell levels than men. The study of 1,864 patients, by Mireille Kalou, M.D., found that women had a significantly higher median number of CD4+ cells than men (183 for women and 126 for men), in spite of the fact that average

[1] Resistance found through phenotypic testing, which measures the actual sensitivity of a patient's HIV to particular drugs by isolating virus from the patient and measuring its growth against common HIV medications.

viral load in both groups was similar. This finding is significant because it raises the possibility of initiating antiretroviral therapy differently for men and women. ***[Abstract TuPeA3109, "CD4+T-cell counts, HIV-1 RNA Viral Load (VL), and Viral Phenotypes among Drug-Naïve HIV-infected Adults Seeking Care through the UNAIDS/Ministry of Health Drug-Access Initiative (DAI) in Abidjan, Côte d'Ivoire," Mireille Kalou, M.D., Poster Presentation, Tuesday, 11 July 2000, 11:15 (5:15 AM EDT)]***

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PRESS BRIEFING: WEDNESDAY, 12 JULY 2000, 08:00 local time

IMPORTANT ADVANCES IN STEMMING MOTHER-TO-CHILD TRANSMISSION OF HIV

– In United States, Sharp Drop in Perinatally-Acquired HIV and AIDS; Lack of Universal Screening and Prenatal Care Pose Final Hurdles –

– Thai Program Demonstrates Success of Large-Scale Perinatal Prevention Program in Developing World –

– New Data Show Promise and Obstacles of African Perinatal Prevention; Transmission through Breast-feeding Remains High –

DURBAN, South Africa – Comprehensive prevention and treatment efforts in the United States have brought sharp drops in mother-to-child (perinatal) transmission of HIV, according to new data released today by the Centers for Disease Control and Prevention (CDC), while other CDC studies demonstrate the continuing challenges in significantly reducing perinatal transmission in the developing world. The studies were discussed at a press conference hosted by CDC at the XIII International AIDS Conference.

Other CDC research in the United States examined the relationship between maternal resistance and perinatal transmission, and suggested that a combination of anti-HIV therapies might further reduce the risk of perinatal HIV transmission.

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Studies from CDC-sponsored international programs highlighted new successes in international efforts to prevent perinatal transmission of HIV, as well as key obstacles to such efforts. One study documented the success of the first large-scale perinatal prevention program in Thailand in increasing access to testing and treatment. Other research, from CDC programs in Africa, found perinatal prevention efforts to be effective, but suggested that transmission through breast-feeding – and high drop-out rates in perinatal prevention programs – remained powerful obstacles to significant reduction of perinatal transmission of HIV, even when anti-HIV drugs are available.

"These studies show us how far we have come toward eliminating mother-to-child HIV transmission in the United States, and how far we have yet to go in the developing world where such efforts are urgently needed," said Helene D. Gayle, M.D., M.P.H., Director of CDC's National Center for HIV, STD, and TB Prevention and moderator of the CDC press conference.

Perinatal Transmission Background Information

Transmission risk: In the absence of preventive drug treatment, there is a 25 to 30 percent chance that a woman will infect her newborn with HIV, either during pregnancy, during delivery, or through breast-feeding. Approximately two-thirds of perinatal infections are contracted during pregnancy or birth, and one-third are contracted through breast-feeding. It is estimated that approximately 600,000 infants are infected with HIV worldwide each year—90 percent of whom live in the developing world.

U.S. drug regimen: In 1994, researchers found that a three-part AZT drug regimen could decrease the rate of perinatal transmission by approximately two-thirds. This three-part regimen – now the standard preventive treatment in the United States – consists of a course of oral AZT for three to four months prior to giving birth, intravenous AZT during delivery, and a six-week course of oral AZT given to infants following birth.

"Short-course" regimen: In 1998, CDC researchers found that a shorter course of AZT is also effective, reducing the rate of transmission by approximately 50 percent. In short-course regimens, AZT is given only to the mother, and is administered orally beginning three to four weeks before delivery, throughout labor, and for one week following delivery. The short-course regimen, which is much less expensive and easier to administer than the longer course of treatment, was hailed as a major advance for women in developing countries, where access to drugs and prenatal care is extremely limited. Subsequent to these findings, another simple regimen, using a single dose of nevirapine for both mother and infant, also has proven effective in reducing perinatal transmission. Public health officials and program planners worldwide are now working to translate these findings into practice.

KEY U.S. FINDINGS

Declining Rates of Perinatal Transmission in the United States

Perinatal transmission of HIV dropped by half between 1993 and 1997 in 32 states that track perinatal HIV exposure and HIV infection[1], according to new data presented today by CDC epidemiologist Mary Lou Lindegren, M.D., and colleagues. The study also provides updated national data on cases of perinatally acquired AIDS, which declined 75 percent between 1992 and 1998. Declines in HIV and AIDS among children are due to successful perinatal prevention efforts and improved treatment for infected infants.

Using data from seven states[2] with enhanced HIV surveillance, Lindegren was able to identify factors contributing to continued transmission. "These data show significant progress, but they also highlight the importance of reaching all women, especially substance abusing women, with early prenatal care, HIV testing, and access to preventive therapy," said Lindegren.

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[1] Alabama, Alaska, Arizona, Arkansas, Colorado, Connecticut, Idaho, Indiana, Iowa, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming. This study did not include Florida because it did not have any exposed children, or Kansas because it had just begun HIV reporting.

[2] Colorado, Indiana, Louisiana, Michigan, Missouri, New Jersey, and South Carolina

She also noted that more than one-third (35 percent) of women giving birth to HIV-infected infants were using illicit drugs. These women also will require access to substance abuse treatment. For women who seek care late in pregnancy, other interventions, such as rapid HIV testing during labor, followed by initiation of therapy, will be important. Increased education and outreach to physicians to encourage them to test all pregnant patients may also contribute to further reductions.

- **Perinatal HIV transmission falls by 50 percent in 32 states, perinatally-acquired AIDS cases by 75 percent nationally:** HIV transmission from mother to child fell by 50 percent in the 32 states reporting pediatric HIV infections from 1993 to 1997, with the incidence of perinatal HIV transmission declining from 20.7 percent in 1993 to 10.6 percent in 1997 (1998 analysis still pending). In these states, the study was able to track factors contributing to this success, including a sharp rise in the number of HIV-infected pregnant women who were tested for HIV (from 80 percent in 1994 to 96 percent in 1998), a doubling in the use of AZT among pregnant women (from 30 percent in 1994 to 69 percent in 1998), and a tripling of AZT use among exposed infants (from 27 percent in 1994 to 84 percent in 1998). The percent of women and infants receiving all three components increased from 14 percent in 1994 to 58 percent in 1998.

  Enhanced data collected from seven of the 32 states reporting pediatric HIV infection provided greater detail about those mothers who gave birth to HIV-infected infants: 17 percent received no prenatal care; 14 percent received prenatal care, but were not tested for HIV; 17 percent did not receive prenatal AZT, despite prenatal care and testing. Thirty-nine percent of the infected infants received the complete AZT regimen. ***[Abstract MoOrC239, "Progress Towards Elimination of Perinatal HIV Infection in the United States," Teresa Hammett, Oral Presentation, Monday, 10 July 2000, 16:45 (10:45 AM EDT)]***

New Data on Viral Load, Combination Therapy and Resistance

Additional CDC data presented here shed new light on the effect of maternal viral load and viral resistance on perinatal HIV transmission.

One study, led by CDC researcher Marc Bulterys, M.D., demonstrated that a higher level of HIV in the blood of the mother, known as maternal viral load, was the single most significant factor in those mothers who transmitted HIV to their infants. "Given this link, combination therapy, which can suppress viral load more effectively than single agents, may be our best tool for reducing the rate of mother-to-child transmission even further," said Bulterys.

The role of viral resistance in perinatal transmission was the subject of another study presented by Bulterys. The research indicates that maternal drug resistance was not associated with increased risk of perinatal transmission of HIV. Because other studies have found an increased risk of transmission among women with viral resistance, further research will be needed.

- **Risk Factors for Perinatal Transmission:** In a multi-center study of perinatal transmission in Atlanta, Baltimore, Newark, and New York City, Bulterys and colleagues examined factors influencing HIV transmission, analyzing data on infants born infected despite exposure to AZT. Over the more than four-year period examined (January 1994 to September 1998), 583 infants received AZT during pregnancy and delivery and as newborns, and 7.4 percent of these infants were infected. In addition to maternal viral load, which was the single most important predictor of transmission, the study found other risk factors associated with transmission, including more advanced disease, premature birth, and treatment with AZT alone, rather than combination antiretroviral treatment. ***[Abstract WePpC1390, "Risk Factors for Perinatal HIV-1 Transmission in Patients Receiving a 3-Part Regimen of Zidovudine Prophylaxis: The Perinatal AIDS Collaborative***

Transmission Study (PACTS) in 4 U.S. Cities," Marc Bulterys, M.D., Oral Poster Presentation, Wednesday, 12 July 2000, 12:00 (6:00 AM EDT)]

- **Impact of HIV Drug Resistance on Perinatal Transmission:** HIV-infected pregnant women with resistance to AZT may still reduce the risk of HIV transmission to their infants by taking the drug while pregnant. In the same four-city study (above), Bulterys and colleagues examined the impact of maternal resistance on perinatal transmission. The study examined blood samples from 167 pregnant women who received AZT during pregnancy from 1991 to 1997. While 19 percent of the blood samples showed genotypic mutation associated with AZT resistance, these resistance patterns had no demonstrable impact on transmission of the virus from mothers to infants. Tests revealed that only two children born to these mothers had viral mutations associated with drug resistance, but that these mutations were different than those of their mothers. While consistent with data from the 1994 efficacy trial of the three-part AZT regimen, these findings appear to contrast two other U.S. studies which found a higher rate of perinatal transmission among women with resistant virus. Bulterys said that because of the contrasting findings to date and the small sample size in this study, further research will be needed to confirm the effect of HIV-drug resistance on perinatal transmission. ***[Abstract TuPpB1230, "Antiretroviral (ARV) Resistance Mutations among Pregnant, HIV-infected Women and their Newborns in the U.S.: Vertical Transmission and Clades," P. Palumbo, Oral Poster Presentation, Tuesday, 11 July 2000, 12:00 (6:00 AM EDT)]***

KEY INTERNATIONAL FINDINGS

Perinatal Prevention Success in Thailand

Data released today demonstrated the marked success of one of the first large-scale perinatal prevention programs to be implemented in a developing country. The pilot initiative in Northeastern Thailand, conducted by the Thai Ministry of Public Health in collaboration with CDC and UNICEF, provided HIV testing to 80 percent of the 95,000

women who gave birth in this region during the period evaluated. Moreover, AZT use among infected pregnant women increased to 80 percent. Dr. Siripon Kanshana, who led the project, reported that the program's success has already led to implementation of a nationwide Thai perinatal prevention program.

"This program and others demonstrate that effective perinatal HIV prevention programs can be implemented in developing nations," said R.J. Simonds, of the HIV/AIDS Collaboration, a joint activity of the Thai Ministry of Public Health and CDC, based in Bangkok.

- **Increased Access to Prenatal Care Through Large-Scale Pilot Program:** In the pilot project led by Kanshana, the proportion of pregnant women tested for HIV increased significantly over the course of the program, from approximately 60 percent at the beginning to 80 percent by the end of the 15-month study. Even more importantly, the proportion of HIV-infected women receiving short-course AZT therapy increased from approximately 50 percent at the beginning of the program to 80 percent after only 15 months. These findings include data from July 1998 to September 1999. Data updated through March 2000, as well as efficacy results, will be presented at the conference. ***["Pilot Program to Implement Short-course AZT to Reduce Perinatal HIV Transmission in Northeastern Thailand, 1998-1999," Siripon Kanshana, Oral Presentation, Wednesday, 12 July 2000, 16:00 (10:00 AM EDT)]***

In another Thai study with international implications, CDC researchers reported that the first randomized trial in a developing country found no adverse side effects among infants exposed to the short-course AZT regimen.

- **Short-course AZT Therapy Found Safe for Children at 18 Months Follow-Up:** In a study of 196 children exposed to short-course AZT in utero and 199 unexposed children, no adverse side effects have been found to be related to the drug-regimen, according to data presented today by the Thai Ministry of Public Health, Mahidol

University, and CDC. Adverse effects among both groups were compared over the first 18 months of life. Researchers led by Tawee Chotpitayasunondh found no statistically significant differences between the groups. This study provides additional reassurance about the short-term safety of AZT in children exposed in utero. Findings are consistent with data from the U.S. and other industrialized nations which to date have found no serious short-term side effects associated with AZT exposure during labor, delivery, and infancy. Continued follow-up is important both in the U.S. and internationally to monitor for possible late effects of perinatal antiretroviral exposures. ***[Abstract ThPeC5306, "Safety of Short-course Antenatal Zidovudine for Children Born to HIV-Infected Women, Bangkok, Thailand," Tawee Chotpitayasunondh, Poster Presentation, Thursday, 13 July 2000, 11:15 (5:15 AM EDT)]***

Perinatal Prevention Barriers in Africa

In Côte d'Ivoire, significant cultural and economic barriers remain to effectively prevent perinatal transmission of HIV, several CDC studies revealed, even though rapid HIV testing, HIV counseling, short-course AZT, and infant formula are offered free of charge. Follow-up with HIV-infected pregnant women to provide therapy has been difficult, and many new mothers may find it difficult to abstain from breast-feeding because of a lack of family and community support. Further, formula may not be a safe option in areas where water-storage practices result in significant levels of bacteria in water. Project RETRO-CI, a co-operative program between the CDC, the Côte d'Ivoire Ministry of Health and the Institute of Tropical Medicine, carried out these studies.

- **Same-Day HIV Testing Slightly Boosts Perinatal Use of AZT:** Although rapid HIV testing with same-day counseling and test results increased the proportion of pregnant African women who received their HIV test results, it only slightly increased the proportion of infected women taking short-course AZT therapy, according to a CDC study of 15,125 women in a prenatal clinic in Abidjan. The researchers, led by Toussaint Severin Sibailly, had believed that removing the two-

week wait for standard (ELISA) HIV test results might significantly increase the number of women receiving preventive treatment, since only 46 percent of those testing positive with the ELISA test were returning for their results. Use of the rapid test did significantly increase the number of women learning their results – 90 percent of the infected women stayed to receive their test results. Preliminary findings show that the proportion of women receiving AZT remains low due to a high number of women who were lost to follow-up prior to 36 weeks gestation, when therapy can begin. Overall, a slightly higher percentage of infected women (19 percent) tested with the rapid HIV test, compared with 12.6 percent with the standard test, ultimately received the short-course AZT treatment, indicating that lack of knowledge of HIV status is not the only barrier to delivering short-course therapy. ***[Abstract WeOrC549, "Impact of On-site HIV Rapid Testing with Same-day Post-Test Counseling on Acceptance of Short-course Zidovudine for the Prevention of Mother-to-Child Transmission of HIV in Abidjan, Côte d'Ivoire," TS Sibailly, Oral Presentation, Wednesday, 12 July 2000, 15:00 (9:00 AM EDT)]***

Breast-Feeding a Major Impediment to Reducing HIV Transmission

Additional CDC studies – the majority in Côte d'Ivoire – showed that short-course AZT can significantly reduce the risk of perinatal HIV transmission overall, even in breast-feeding populations, but that the therapy does not appear to reduce the risk of postnatal transmission. Because transmission through breast-feeding does offset some of the reduction in transmission achieved by AZT therapy before and during birth, safe and acceptable alternatives to breast-feeding remain critical.

Breast-feeding is a customary practice in West Africa with an average duration of nearly 14 months. In many places in sub-Saharan Africa, it also is a necessity for women who are unable to afford infant formula or do not have access to clean water to prepare formula.

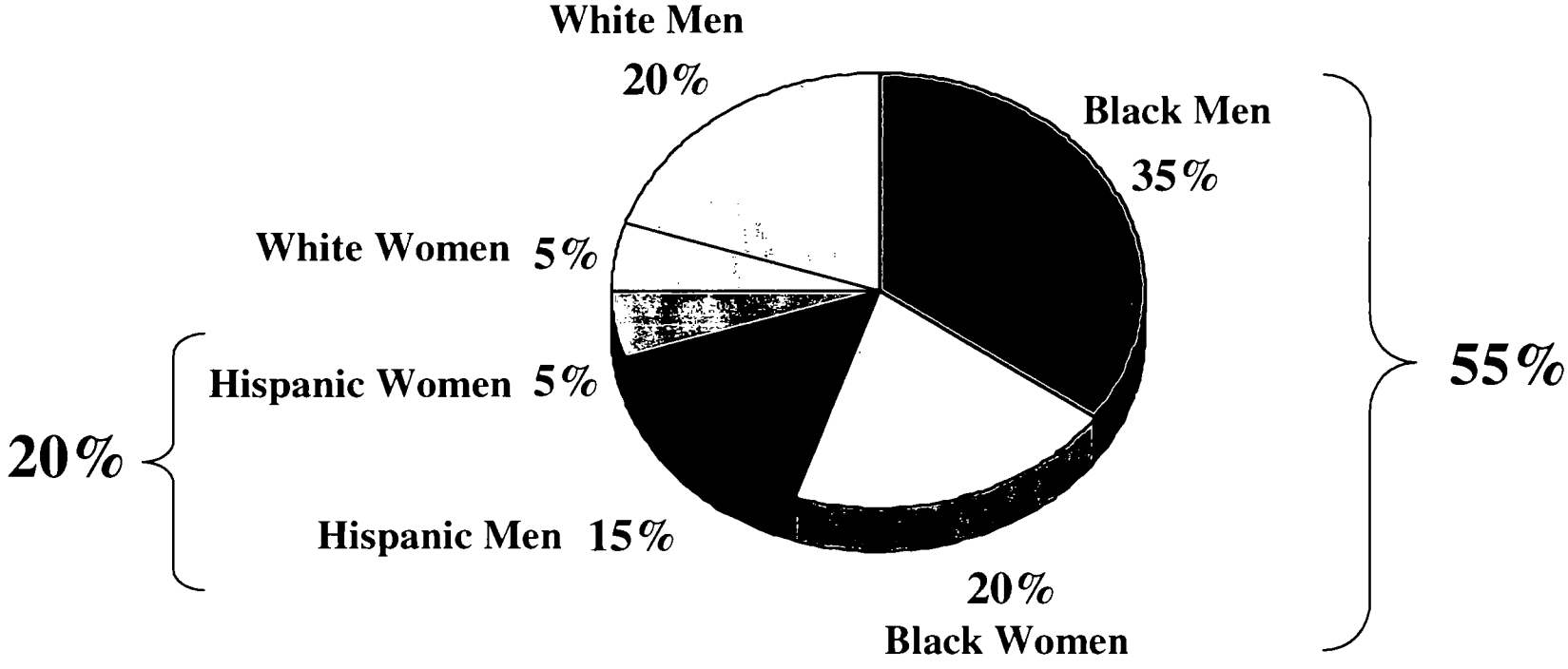
"Breast-feeding transmits HIV, but remains a difficult practice to replace, particularly with the lack of viable alternatives," said CDC researcher Stefan Wiktor, M.D., who discussed the Project RETRO-CI findings.

- **Postnatal Transmission Through Breast-feeding:** In analyzing data from two clinical trials conducted in the West African cities of Abidjan, Côte d'Ivoire and Bobo-Dioulasso, Burkina-Faso, CDC researchers found that short-course AZT significantly reduced the overall risk of perinatal HIV transmission, despite having no impact on postnatal transmission. Many of the infants born uninfected became infected by the age of two through breast-feeding. At six weeks of age, 14 percent of infants whose mothers took AZT were infected with HIV, compared to 23 percent of the children whose mothers did not take AZT – a 40 percent reduction with short-course AZT. At two years, 22 percent of children whose mothers took AZT were infected, while 30 percent of children whose mothers did not take AZT were infected – a 27 percent reduction with short-course AZT. The studies, authored by Wiktor and colleagues, found that there was no statistical difference in the risk of postnatal HIV transmission from mother to infant between the two groups, with just over nine percent (9.4 percent) of the 354 women given short-course AZT transmitting infection through breast-feeding, compared to nearly nine percent (8.6 percent) of the 357 women in the control group. While the results show that short-course AZT given to the women alone does reduce perinatal transmission, the high risk of postnatal HIV transmission highlights the need to develop additional interventions to prevent this mode of transmission. Data from Burkina-Faso was provided by the Agence Nationale de Recherche sur le SIDA. ***[Abstract TuOrB354, "24-month Efficacy of Short-course Maternal Zidovudine for the Prevention of Mother-to-Child HIV-1 Transmission in a Breast-feeding Population: A Pooled Analysis of Two Randomized Clinical Trials in West Africa," Stefan Wiktor, M.D., Oral Presentation, Tuesday, 11 July 2000, 15:15 (9:15 AM EDT)]***

- **Barriers to Replacement Feeding:** A survey of 120 households in Abidjan conducted by CDC researcher Hortense Angoran, M.D., and colleagues, found that water storage practices are important to examine when considering replacement feeding to prevent perinatal transmission. All the households studied had access to safe municipal drinking water at a community tap and 93 percent (112) of households used this water, either directly or by storing it in a container. Stored water was much more susceptible to contamination. Of the houses that stored water, researchers detected *E. coli* in 41 percent of household water samples. At the time of the interview, the youngest child was regularly drinking stored water in 74 percent (89) of households. Only three percent (3) of mothers treated drinking water for the youngest child; all three did so by boiling the water. The study highlights the need for sanitary water cans to reduce the risk of diarrheal disease in infants, particularly in places where many women are encouraged to use replacement feeding (formula) to reduce transmission of HIV. ***[Abstract WePpC1316, "Implications of Household Water Storage Practices on Replacement Feeding of Children Born to HIV-Infected Women, Abidjan, Côte d'Ivoire," Hortense Angoran, M.D., Oral Poster Presentation, Wednesday, 12 July 2000, 11:30 (5:30 AM EDT)]***

# # #

Estimates of New Infections Occurring by Gender and Race, 1999, United States



Total estimated new infections = 40,000

CDC
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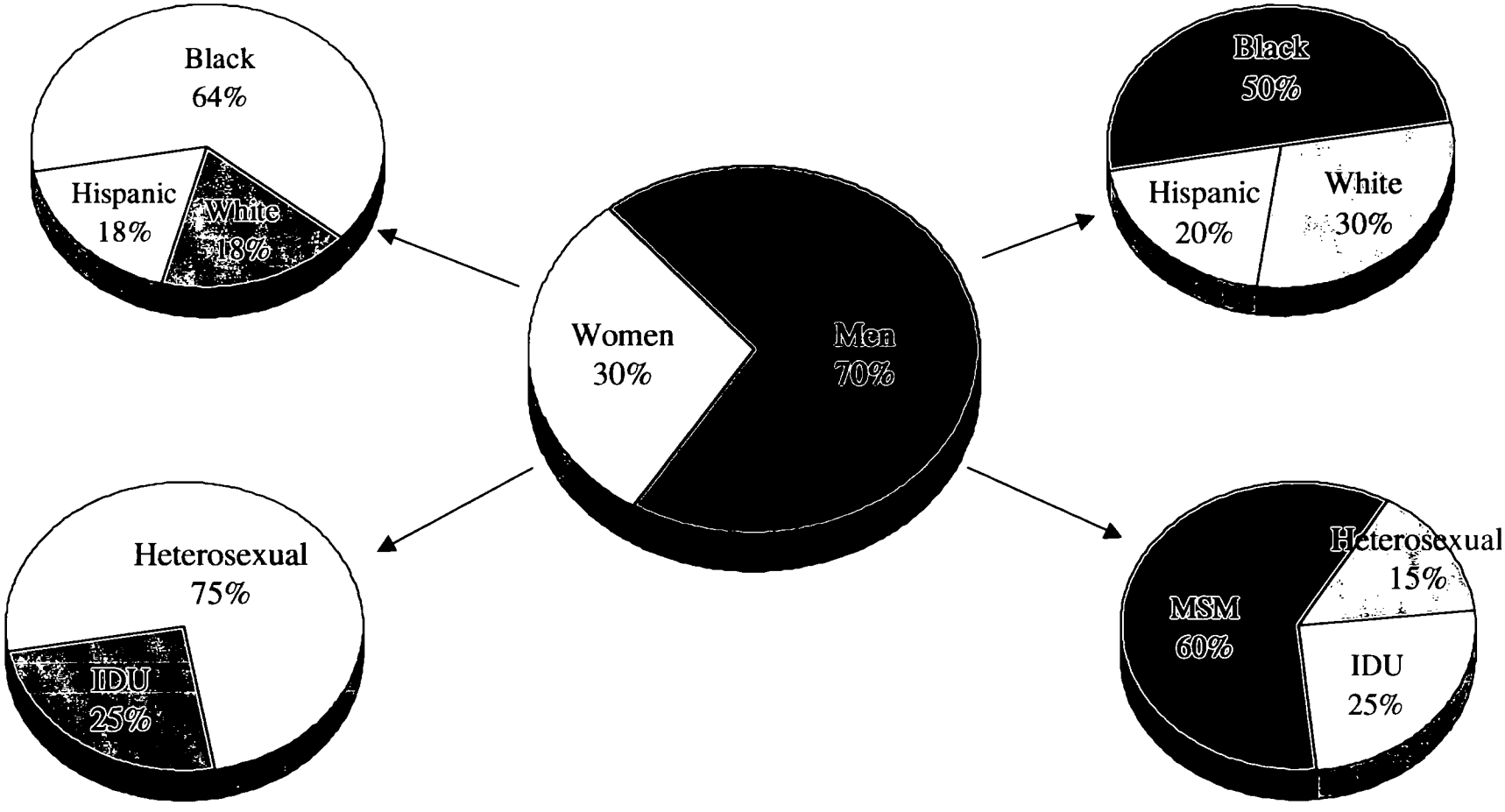
Estimates of New HIV Infections Occurring Among Men and Women, by Race and Risk, 1999, United States



Total estimated new infections = 40,000

CDC
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Global Estimates of the HIV/AIDS Epidemic, as of End of 1999

People newly infected with HIV in 1999	**Total**	**5.4 million**
	Adults	4.7 million
	Women	*2.3 million*
	Children <15 years	620,000
Number of people living with HIV/AIDS	**Total**	**34.3 million**
	Adults	33.0 million
	Women	*15.7 million*
	Children <15 years	1.3 million
AIDS deaths in 1999	**Total**	**2.8 million**
	Adults	2.3 million
	Women	*1.2 million*
	Children <15 years	500,000
Total number of AIDS deaths since the beginning of the epidemic	**Total**	**18.8 million**
	Adults	15.0 million
	Women	*7.7 million*
	Children <15 years	3.8 million
Total number of AIDS orphans* since the beginning of the epidemic		**13.2 million**

Source: UNAIDS Report on the Global HIV/AIDS Epidemic – June 2000.

* Defined as children who lost their mother or both parents to AIDS when they were under the age of 15.

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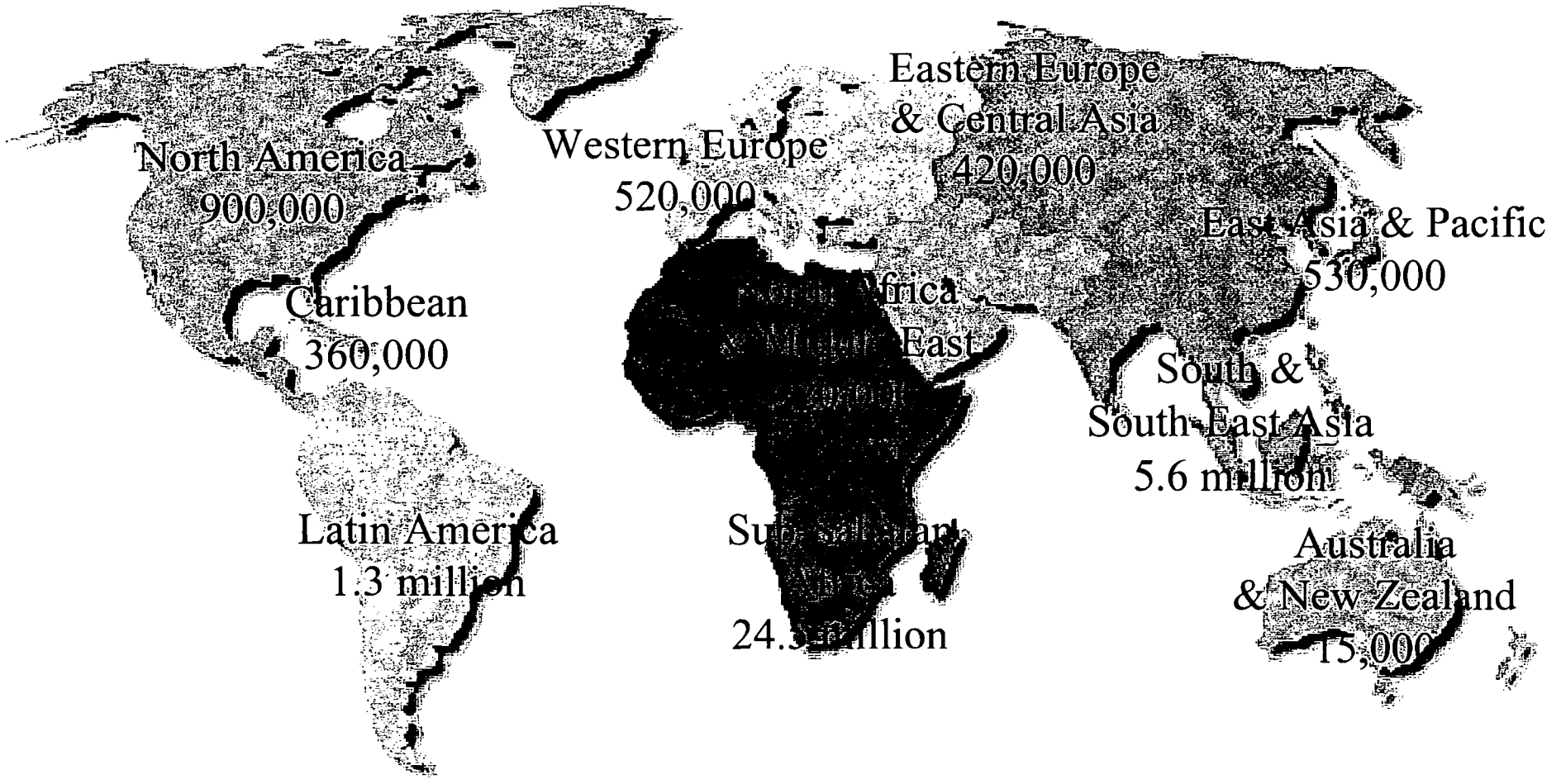
Adults and Children Living with HIV/AIDS
Total: 34.3 million



Source: UNAIDS Report on the Global HIV/AIDS Epidemic – June 2000.

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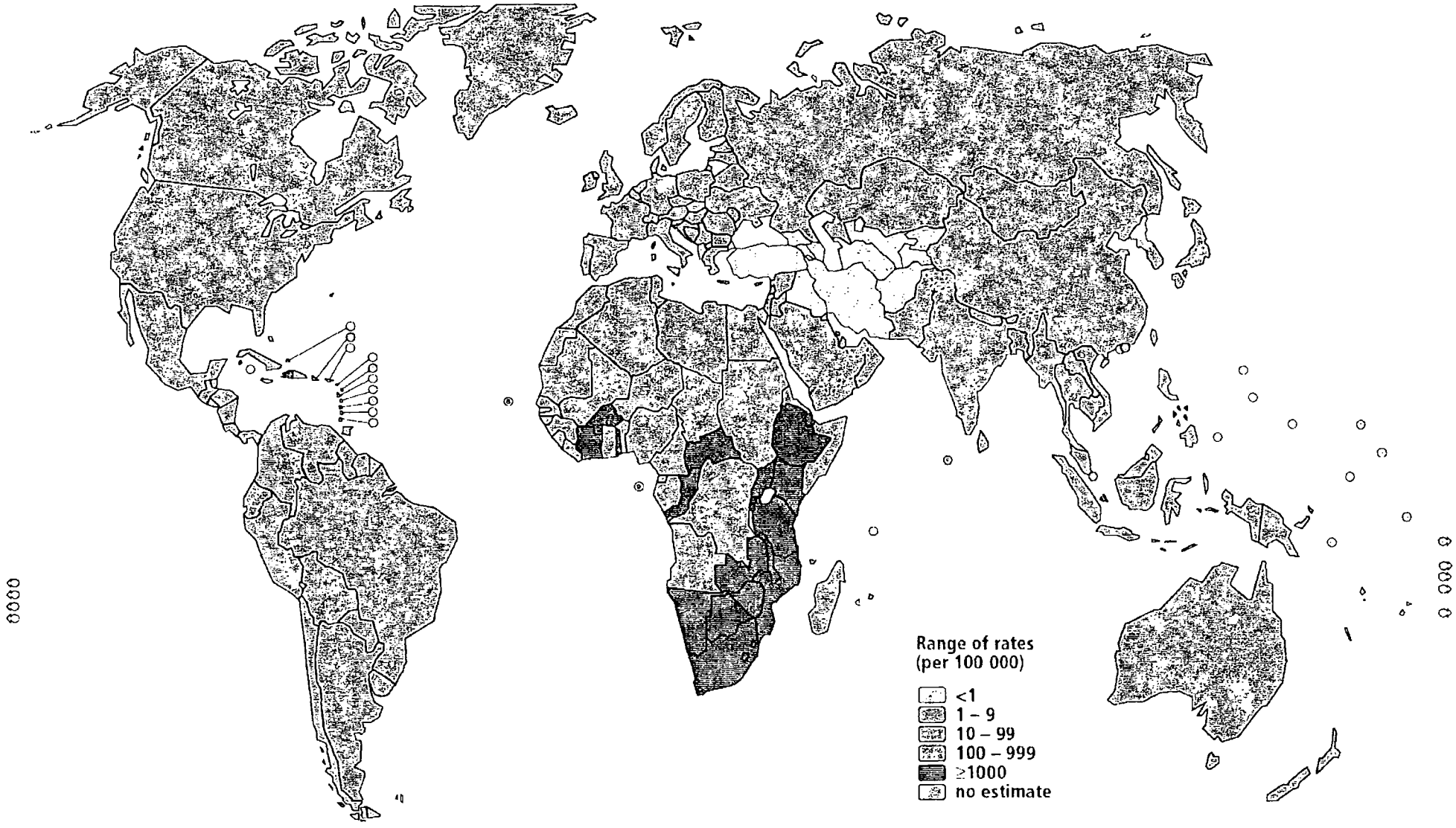
Estimated TB/HIV Co-infection Rates, 1997



Source: World Health Organization Global TB Report, 2000.

CDC
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XIII INTERNATIONAL AIDS CONFERENCE
FEATURED CDC RESEARCH
In order of embargo time
All times local Durban time (GMT + 2 hours; EDT + 6 hours)

Monday, July 10

Time		
11:15	Trends in HIV diagnoses by birth cohort among women in 25 HIV-reporting states, United States 1994-1998 *Lee, LM; Wortley, PM* Session: **Posters: Track C Monday**	Abstract # MoPeC2446
11:15	Trends in HIV infection in the main tuberculosis (TB) outpatients centers of Côte d'Ivoire: Analysis of data from 1989 to 1999 *Angennes, AO; Kassim, S; Ackah, AN; Abouya, L; Lobognon, LR; Maurice, C; Tossou, O; Sassan – Morokro, M; Coulibaly, D* Session: **Posters: Track C Monday**	Abstract # MoPeC2437
11:15	Prevalence of HIV and AIDS among African-Americans and Hispanics in metropolitan statistical areas – United States, 1998. *Dean-Gaitor, H; Wortley, P; Fleming, PL* Session: **Posters: Track C Monday**	Abstract # MoPeC2452
11:15	Sexual risk behaviors among U.S. adolescents: A decade in review *Kann, L; Lowry, Richard; Brener, N; Kolbe, L* Session: **Posters: Track C Monday**	Abstract # MoPeC2442
16:00	Self-reported TB testing and treatment in an HIV-infected population: Results from an interview project in the United States *Campsmith, M; Nakashima, AK; Fleming, PL; Burgess, DA* Session: **Oral: C03 Tuberculosis and HIV/AIDS Interventions** Room: **Hall City Hall XIII**	Abstract # MoOrC215
16:45	Progress towards elimination of perinatal HIV infection in the United States *Hammet, T; Lindegren, ML; Byers, R; Wortley, P; Bi, D* Session: **Oral: C05 Reducing Mother-to-Child Transmission** Room: **Hall City Hall XIII**	Abstract # MoOrC239

Tuesday, July 11

Time		
11:15	CD4+ T-cell counts, HIV-1 RNA viral load (VL) and viral phenotypes among drug-naive HIV-infected adults seeking care through the UNAIDS/Ministry of Health drug-access initiative (DAI) in Abidjan, Cote d'Ivoire *Kalou, M; Nkengasong, JN; Borget, MY; Boateng, E; Maurice, C; Djomand, G; Eholie, S; Bissagnene, E; Monga, B; Wiktor, SZ; Roels, TH* Session: **Posters: Track A Tuesday**	Abstract # TuPeA3109
11:15	Development of phenotypic and genotypic resistance to antiretroviral therapy in the UNAIDS HIV drug access initiative--Uganda. *Weidle, P; Sozi, C; Mwebaze, R; Bahendeka, S; Moss, V; Rukundu, G; Katabira, E; Downing, R; Hertogs, K; Larder, B; Respess, R; Ochola, D; Lackritz, E* Session: **Posters: Track B Tuesday**	Abstract # TuPeB3293
11:15	The impact of trimethoprim-sulfamethoxazole prophylaxis for Pneumocystis carinii pneumonia on the risk for other infections in persons with AIDS *Dworkin, M; Williamson, J; Jones, J; Kaplan, J; Adult & Adolescent Spectrum of HIV Disease Project* Session: **Posters: Track B Tuesday**	Abstract # N/A
11:15	Increasing numbers of adolescents living with perinatal HIV-infection in the United States. *Lindegren, ML; Byers, R; Bertolli, J; Dominguez, K; Thomas, P* Session: **Posters: Track C Tuesday**	Abstract # TuPeC3351
11:30	Correlates of durable treatment success among long term highly active antiretroviral therapy (HAART) recipients in the HIV outpatient study (HOPS) *Holmberg, S; Palella, F; Chmiel, J; Moorman, A; Chan, C; HOPS Investigators* Session: **Oral Poster Session: ARV Clinical Trials II** Room: **Poster Tent B, Fourth Corner**	Abstract # TuPpB1166
12:00	Antiretroviral (ARV) Resistance mutations among pregnant, HIV-infected women and their newborns in the US: Vertical transmission and clades *Palumbo, P; Dobbs, T; Holland, B; Luo, C; Pau, C; Respess, R; Buterys, M; Pacts, D* Session: **Oral Poster Session: Correlates/Risk Factors for MTCT** Room: **Poster Tent B, First Corner**	Abstract # TuPpB1230
13:15	Virologic and immunologic response to antiretroviral therapy among patients participating in the UNAIDS/Ministry of Health initiative to improve access to therapy for HIV-infected persons in Côte d'Ivoire. *Djomand, G; Roels, TH; Coulibaly, M; Diomande, F; Ebah, L; Nkengasong, J; Aka, R; Monga, B; Maurice, C; Bissagnene, E; Wiktor, SZ; Chorba, T* Session: **Oral: B06 Antiretroviral Therapy in Resource Poor Settings: Real World Data** Room: **Hall ICC III**	Abstract # TuOrB295

14:00	High prevalence of genotypic and phenotypic antiretroviral (ARV) drug resistant HIV-1 strains among patients receiving ARV in Abidjan, Côte d'Ivoire. *Adje, C; Cheingsong Popov, R; Roels, W; Verbiest, W; Djomand, G; Hertogs, K; Larder, B; Monga, B; Peeters, M* Session: **Oral: B06 Antiretroviral Therapy in Resource Poor Settings: Real World Data** Room: **Hall ICC III**	Abstract # TuOrB280
14:00	Concurrent use of rifabutin and HAART: Evidence for reduced efficacy *Spradling, P; McLaughlin, S; Drociuk, D; Ridzon, R; Pozsik, C; Onorato, I* Session: **Symposium: Tuberculosis in HIV Patients** Room: **Hall ICC VI**	Abstract # TuOrB8277
15:15	24-month efficacy of short-course maternal zidovudine for the prevention of mother-to-child HIV-1 transmission in a breast feeding population: A pooled analysis of two randomized clinical trials in West Africa. *Wiktor, S Z; Leroy, V; Ekpini, ER; Alioum, A; Karon, J; Msellati, P; Hudgens, M; Meda, M; Greenberg, AE* Session: **Oral: B08 Mother-to-Child Transmission** Room: **Hall ICC III**	Abstract # TuOrB354

Wednesday, July 12

Time

11:15	Predictors of adherence to antiretroviral therapy among HIV-infected women *Moore, J; Hamburger, M; Schoenbaum, E; Schuman, P; Rompalo, A; Mayer, K* Session: **Posters: Track D Wednesday**	Abstract # WePeD4598
11:15	Predictors of early failure of highly active antiretroviral therapy (HAART) *Koenig, L; Ellerbrock, TV; Pratt-Palmore, M; Stratford, D; Malatino, E; Todd-Turner, M; Bush, T; Stewart, KA; Schnell, C* Session: **Posters: Track B Wednesday**	Abstract # WePeB4148
11:15	Impact of the HIV epidemic on tuberculosis (TB) incidence in Abidjan, Côte d'Ivoire. *Ackah, A; Kassim, S; Abouya, L; Lobognon, LR; Akaki-Okiere, A; Maurice, C; Monga, B; Sassan-Morokro, M; Coulibaly, D; Sanogo, A; Greenberg, A E; Roels, T H; Wiktor, S Z; Chorba, T* Session: **Posters: Track C Wednesday**	Abstract # WePeC4445
11:15	Risk factors and trends of gonorrhea incidence among HIV-infected patients, United States *Do, A; Hanson, DL; Dworkin, MS; Jones, JL; ASD Project Group* Session: **Posters: Track C Wednesday**	Abstract # WePeC4397
11:15	The bisexual bridge for HIV among 15- to 22-year-old men who have sex with men in the 7 US cities. *Valleroy, L; Prentiss, D; MacKellar, DA; Secura, G* Session: **Posters: Track C Wednesday**	Abstract # WePeC4300

11:15	Sex, drugs, HIV and STD among adolescents and young adults in northern Thailand: An innovative, rapid biologic and behavioral assessment *Van Griensven, F; Supawitkul, S; Kilmarx, PH; Limpakarnjanarat, K; Young, NL; Manopaiboon, C; Manopaiboon, C; Mock, P; Korattana, S; Mastro, TD* Session: **Posters: Track C Wednesday**	Abstract # WePeC4347
11:30	Implications of household water storage practices on replacement feeding of children born to HIV-infected women, Abidjan, Côte D´Ivoire. *Angoran, H; Dunne, EF; Kamelan-Tano, Y; Sibailly, TS; Monga, B; Kouadio, L; Roels, TH; Mintz, E; Lackritz, E* Session: **Oral Poster Session: Breast Feeding** Room: **Poster Tent C, Second Corner**	Abstract # WePpC1316
12:00	Risk factors for perinatal HIV-1 transmission in patients receiving a 3-part regimen of Zidovudine Prophylaxis: the perinatal AIDS collaborative transmission study (PACTS) in 4 US cities *Bulterys, M; Palumbo, P; Abrams, E; Nesheim, S; Vink, P; Wiener, J; Lee, F; Fowler, MG; Simonds, RJ* Session: **Oral Poster Session: Mother to Child Transmission: Reduction of Transmission** Room: **Poster Tent C, Second Corner**	Abstract # WePeC1390
12:00	Development of a male condom intervention for HIV-seronegative Zimbabwean women *O'Leary, A; Sakutukwa, G; Loeb, L; Padian, N; Moore, J* Session: **Oral Poster Session: Male Condoms** Room: **Poster Tent C, Fourth Corner**	Abstract # WePpC1394
15:00	Impact of on-site HIV rapid testing with same-day post-test counseling on acceptance of short-couse zidovudine for the prevention of mother-to-child transmission of HIV in Abidjan, Côte d'Ivoire *Sibailly, TS; Ekpini, ER; Kamelan-Tanoh, A; Yavo, D; Maurice, C; Nkengasong, J; Roels, TH; Wiktor, SZ; Chorba, TL* Session: **Oral: C14 Implementing Mother-to-Child Intervention Programmes: Successes and Challenges** Room: **Hall City Hall XIII**	Abstract # WeOrC549
16:00	Pilot program to implement short-course AZT to reduce perinatal HIV transmission in Northeastern Thailand, 1998-1999 *Kanshana, S; Thewanda, D; Teeraratkul, A; Limpakarnjanarat, K; Amornwichet, P; Kullerk, N; Mastro, TD; Simonds, RJ* Session: **Oral: C14 Implementing Mother-to-Child Intervention Programmes: Successes and Challenges** Room: **Hall City Hall XIII**	Abstract # N/A

Thursday, July 13

Time		
11:15	Inequities between gender and racial groups in prescription of highly active antiretroviral therapy. *McNaghten, AD; Hanson, DL; Dworkin, MS; Jones, JL* Session: **Posters: Track B Thursday Session II**	Abstract # ThPeB5286
11:15	Safety of short-course antenatal zidovudine for children born to HIV-infected women, Bangkok, Thailand *Chotpitayasunondh, T; Chearskul, S; Vanprapa, N; Waranawat, N; Shaffer, N; Mock, P; Simonds, RJ; Mastro, TD* Session: **Posters: Track C Thursday**	Abstract # ThPeC5306
11:15	Knowledge and attitudes regarding post-exposure prophylaxis (PEP) and highly active antiretroviral therapy (HAART) as correlates of HIV risk behavior among young men who have sex with men (MSM) in the US. *Bartholow, B; Valleroy, L; MacKellar, D* Session: **Posters: Track D Thursday**	Abstract # ThPeD6320
11:15	Prevalence and predictors of HIV testing in a multi-site sample of young men who have sex with men *Sumartojo, E; Lyles, C; Guenther-Grey, C; Choi, KH; Clark, L; Collins, C; Lin, L; Peterson, J; Remafedi, G* Session: **Posters: Track D Thursday**	Abstract # ThPeD5804
11:15	Adherence to cotrimoxazole prophylaxis for the prevention of opportunistic infections among HIV-infected tuberculosis patients in Abidjan, Côte d'Ivoire *Wiktor, S; Sassan Morokro, M; Maurice, C; Ackah, A; Abouya, L; Odum, R; Roels, TH; Coulibaly, D; Decock, KM,* Session: **Posters: Track B Thursday Session II**	Abstract # ThPeB5230
11:15	Evalution of patients accessing antiretroviral therapy in the UNAIDS HIV drug access initiative in Uganda. *Weidle, P; Mwebaze, R; Sozi, S; Bahendeka, S; Moss, V; Rukundo, G; Katabira, E; Malamba, S; Downing, R; Ochola, D; Mermin, J; Lackritz, E* Session: **Posters: Track B Thursday Session II**	Abstract # ThPeB5231
11:15	HIV incidence and prevalence among persons admitted to U.S. drug treatment centers, 1994-1997 *Sabin, K; Bordelon, KA; Murrill, CS; Miller, MS* Session: **Posters: Track D Thursday**	Abstract # ThPeD5506
14:45	Increasing rates of unprotected anal intercourse among HIV-infected men who have sex with men in the United States *Denning, P; Nakashima, AK; Wortley, P* Session: **Oral: C20 HIV in Men who Have Sex with Men** Room: **Hall Playhouse XI**	Abstract # ThOrC714
15:30	Continued low morbidity and mortality among patients with advanced HIV infection and their patterns of highly active antiretroviral therapy (HAART) usage. *Holmberg, S; Palella, F; Moorman, A; Chmiel, J; Chan, C; Hops Investigators* Session: **Oral: Trends in the Epidemic** Room: **Hall City Hall XIII**	Abstract # ThOrC723

HIV PREVENTION

NOW more than EVER, OUR WORLD depends on it

BIOGRAPHIES

Helene D. Gayle, M.D., M.P.H.

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CDC

CENTERS FOR DISEASE CONTROL AND PREVENTION

Helene D. Gayle, M.D., M.P.H.

Dr. Helene D. Gayle is the Director of the Centers for Disease Control and Prevention's National Center for HIV, STD and TB Prevention (NCHSTP). As a physician, epidemiologist, and public health practitioner, Dr. Gayle's experience has well prepared her to lead our nation's response to the prevention of HIV/AIDS, other sexually transmitted diseases, and tuberculosis.

As Director of NCHSTP, Dr. Gayle is responsible for overseeing programs and operations of the largest of CDC's 11 Centers, Institutes, and Offices, with a budget of over $650 million. NCHSTP employs a staff of over 1,000 researchers, public health professionals, and support personnel in all 50 states and 6 territories, the Commonwealth of Puerto Rico, the Virgin Islands, and 6 countries in Africa and Asia.

Central to the activities of NCHSTP is its largest program, the HIV/AIDS prevention program, whose mission is enhancement of our nation's efforts to prevent the spread of HIV infection. A world-recognized leader in HIV prevention, Dr. Gayle's work in this area dates back to the early 1980s. It was then, as an epidemiologist with CDC, that she conducted pioneering research that led to a better understanding of HIV among adolescents and children both domestically and internationally.

On the occasion of Dr. Gayle's appointment as Director of NCHSTP in 1995, CDC Director Dr. David Satcher remarked, "Dr. Gayle's record as a world-class scientist and public health official with impeccable credibility and awareness extends far beyond U.S. borders. Her contributions to public health and commitment to improving lives globally make her an excellent choice to lead the National Center for HIV, STD, and TB Prevention."

Among its many accomplishments under Dr. Gayle's leadership, NCHSTP has:

- Strengthened support for community planning and community-based HIV and STD prevention activities;
- Expanded efforts for national chlamydia control and syphilis elimination;
- Established an innovative activity in corrections health; and
- Strengthened CDC involvement in international HIV, STD, and TB prevention and prevention research activities.

Prior to her current appointment, Dr. Gayle served as an Associate Director of CDC and Director of the CDC Washington office. In this position, she represented the Director of CDC on legislative, policy, program management, and intergovernmental matters, playing a key role in shaping and implementing CDC policies.

Dr. Gayle was Chief of the HIV/AIDS Division in the Agency for International Development (USAID) from 1992 until 1994. As a CDC employee assigned to USAID, she provided leadership and technical, managerial, and policy guidance for programs

funded by USAID, and served as the Agency's chief representative on HIV/AIDS and related health issues.
Dr. Gayle came to CDC in 1984 as an Epidemic Intelligence Service (EIS) officer. She completed a Preventive Medicine Residency (PMR) at CDC in 1987, after which she remained at CDC as a staff epidemiologist with the Division of HIV/AIDS.
Over the next several years, from 1987 until 1992, she focused on designing and conducting original epidemiological research in HIV/AIDS related to women, children and adolescents, and minority and international populations. She provided leadership and technical assistance to outside investigators in these areas and helped launch some of the early work leading to better understanding of HIV in adolescents and children nationally and internationally.

Dr. Gayle also pioneered development of community-based prevention activities, particularly for minority and underserved communities. She was instrumental in facilitating communication between CDC and groups representing many different communities and fostering greater minority input into CDC HIV prevention activities.
Dr. Gayle, a Rear Admiral in the Commission Corps and Assistant Surgeon General, has received wide recognition during her career. She was recently presented with the Columbia University Medal of Excellence and has been featured in magazines such as *Ebony, Essence,* and *Atlanta Magazine.* Public Health Service awards she has received include the Meritorious Service Medal, the Outstanding Service Medal, and the Poindexter Award.

Dr. Gayle has authored numerous articles on HIV and public health. She has a faculty appointment at Emory University School of Medicine and is on the editorial board of *The American Journal of Public Health.*

A native of Buffalo, New York, Dr. Gayle graduated from Columbia University in 1976. She received her M.D. from the University of Pennsylvania and her M.P.H. from Johns Hopkins University, both in 1981. She completed a Pediatric Internship and Residency at Children's Hospital National Medical Center in Washington, D.C.

Ronald O. Valdiserri, M.D., M.P.H.

Ronald O. Valdiserri, M.D., M.P.H. is the Deputy Director of the National Center for HIV, STD and TB Prevention (NCHSTP) at the Centers for Disease Control and Prevention (CDC). During his tenure at CDC, Dr. Valdiserri has held several public health leadership positions, including Director of the Division of Public Health Laboratory Systems and Deputy Director for HIV in the former National Center for Prevention Services. Among his other accomplishments, Dr. Valdiserri played a key role in guiding the national implementation of HIV Prevention Community Planning – an innovative approach to improving the targeting, cultural relevance, and scientific underpinnings of publicly funded HIV prevention activities nationwide.

Dr. Valdiserri joined the CDC in January 1989 as the Director of the Division of Laboratory Systems. Prior to entering public service, Dr. Valdiserri was on faculty at the University of Pittsburgh Schools of Medicine and Public Health for nearly a decade. In addition to working with various community groups in Pittsburgh, he served as a co-investigator for two National Institutes of Health (NIH) AIDS research projects: the Pittsburgh component of the Multicenter AIDS Cohort Study (MACS) and the AIDS Clinical Trials Group. Dr. Valdiserri has written numerous scholarly articles on the scientific and policy aspects of HIV/AIDS prevention and has authored a textbook on the design, implementation, and evaluation of AIDS prevention programs, published in 1989 by Rutgers University Press. In May 1994, Cornell University Press published Dr. Valdiserri's book of essays on AIDS, "Gardening in Clay."

Robert S. Janssen, M.D.

Dr. Janssen received his Medical Degree from the University of Southern California School of Medicine in Los Angeles and did his neurology residency at the Hospital of the University of Pennsylvania in Philadelphia. Dr. Janssen holds an active medical license in the State of Georgia and is board certified in neurology.

Dr. Janssen currently serves as the Director, Division of HIV/AIDS Prevention – Surveillance and Epidemiology. He previously was the Deputy Director of the Division of HIV/AIDS Prevention – Surveillance and Epidemiology and was Chief of the HIV Seroepidemiology Branch and Population Studies Section, Division of HIV/AIDS Prevention. Dr. Janssen also served as the "Focal Point" for Neuropsychiatric Aspects of HIV Infection, Global Program on AIDS, World Health Organization (WHO) in Geneva, Switzerland.

Dr. Janssen has been active on various professional committees and advisory groups, including chairing the American Academy of Neurology's AIDS Task Force, and participating on the WHO Consultation Neuropsychiatric Aspects of HIV Infection, the Organizing Committee for meetings on the Neurological and Neuropsychological Complications of HIV Infection and numerous other advisory groups and committees, both nationally and internationally. He has been the beneficiary of numerous honors and awards during his education and in the Public Health Service.

Dr. Janssen has published over 80 scientific articles in a variety of journals and publications and has served as a referee for leading scientific journals. He published work on the neurologic aspects of HIV and HIV seroepidemiology in US hospitals. He lead the team that developed the "detuned assay" for use in measuring HIV incidence.

David R. Holtgrave, Ph.D.

Since August 1997, Dr. David Holtgrave has been the Director of the Division of HIV/AIDS Prevention – Intervention Research and Support in the National Center for HIV, STD and TB Prevention at the Centers for Disease Control and Prevention in Atlanta, Georgia. He has worked almost exclusively in the field of HIV prevention since 1991. From 1991 until 1995, he worked at CDC in HIV prevention; from 1995 until 1997 he was an Associate Professor and Associate Center Director for Programs at the Center for AIDS Intervention Research at the Medical College of Wisconsin (in 1997 he returned to CDC). His research has focused on the effectiveness and cost-effectiveness of a variety of HIV prevention interventions, and the relation of the findings of these studies to HIV prevention policy making. He has worked extensively on HIV prevention community planning, and has served as a member of the Wisconsin HIV Prevention Community Planning group.

Dr. Holtgrave received his Ph.D. in quantitative psychology in 1988 from the University of Illinois at Urbana/Champaign, and then completed a post-doctoral research fellowship in public health and public policy in the Interdisciplinary Programs in Health at the Harvard University School of Public Health. He has authored or co-authored over 80 professional publications, and has recently edited the volume, *Handbook of Economic Evaluation for HIV Prevention Programs* (Plenum, 1998). He has been the Principal Investigator on two NIH RO1 grants focused on the cost-effectiveness of HIV primary prevention interventions.

Kenneth G. Castro, M.D.

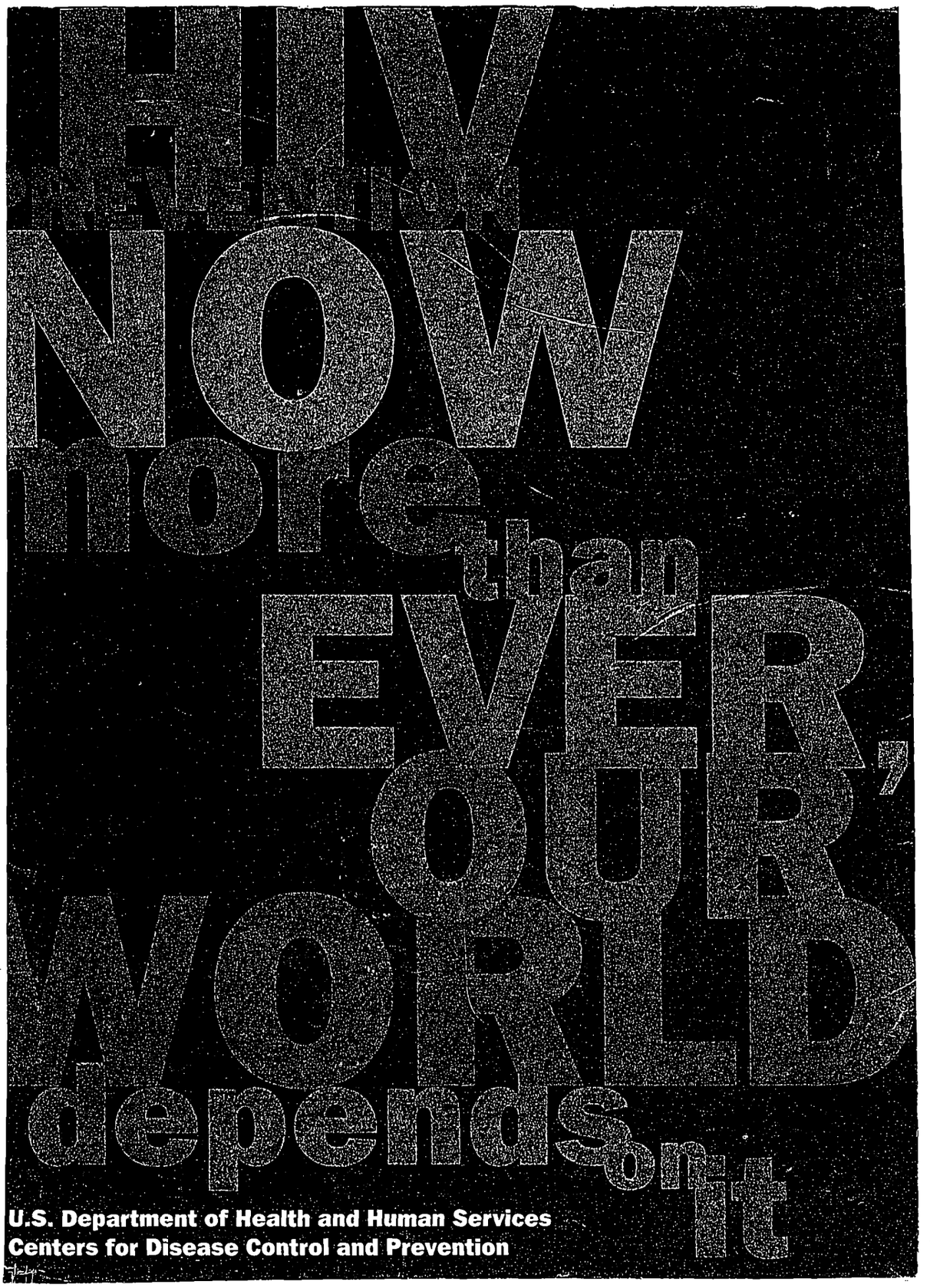
Kenneth G. Castro as served as the Director, Division of Tuberculosis Elimination, National Center for HIV, STD and TB Prevention (NCHSTP), Centers for Disease Control and Prevention (CDC), since January 1993. Previously he was Assistant Director for TB and HIV, Office of HIV/AIDS, CDC (May - December 1992), and Assistant Chief, Epidemiology Branch, Division of HIV/AIDS (formerly the AIDS Program), National Center for Infectious Diseases, CDC (September 1990 – May 1992); Clinician at the Infectious Diseases Clinic, Grady Memorial Hospital since 1988; Advisor and Temporary Consultant, Pan American Health Organization, and World Health Organization since 1985. Dr. Castro is a physician-scientist trained in epidemiology, has a specialty in internal medicine and subspecialty in infectious diseases, with thirteen years of experience with the U.S. Public Health Service (USPHS) at CDC.

Dr. Castro began his career with CDC in 1983 as an Epidemic Intelligence Officer with the AIDS Program, where he became a staff medial epidemiologist. From 1988 until 1989, he completed a fellowship in infectious diseases at the Emory University School of Medicine, where his work focused on describing the increase in the number of persons with tuberculosis and its association with the HIV/AIDS epidemic. From July 1989 until August 1990 he served in the capacity of Special Assistant to the Director for Science, Division of HIV/AIDS. His subsequent work as Assistant Chief for Science, Epidemiology Branch, Division of HIV/AIDS, included: the 1993 revision of CDC's classification system for HIV infection in adolescents and adults, and the expanded surveillance AIDS case definition; coordination of outbreak investigations of nosocomial transmission of multidrug-resistant strains of *Mycobacterium tuberculosis* in HIV-infected patients; the development of guidelines for the management of persons exposed to multidrug-resistant tuberculosis; and recommendations for the use of alternative preventive therapy in persons infected with multidrug-resistant strains of *Mycobacterium tuberculosis*. In May 1992, he was appointed to the office of the Associate Director of HIV/AIDS to coordinate CDC-wide HIV-associated tuberculosis activities.

In January 1993, Dr. Castro was selected Director, Division of Tuberculosis Elimination, where his work has focused on leading the national tuberculosis prevention and control efforts and research activities through the various tuberculosis control programs and clinical consortia sponsored by CDC. Additionally, Dr. Castro has become increasingly involved in the international aspects of tuberculosis control, and has served as an expert advisor to the World Health Organization and the International Union Against Tuberculosis and Lung Diseases. A native Puerto Rican and Spanish-speaker, he has frequently served as advisor to the Puerto Rico Department of Health, the Pan American Health Organization, and several Ministries of Health throughout Latin America and Spain.

The author of more than 70 scholarly publications, Dr. Castro received his B.S. in 1974 from the University of Puerto Rico; completed post-graduate biology studies in 1976 as an M.S. candidate at Northeastern University in Massachusetts; received his M.D. in 1980 from the State University of New York at Stony Brook School of Medicine; completed his internal medicine postgraduate training in 1983 at the Residency Program in Social Medicine, Montefiore Medical Center, Albert Einstein College of Medicine in New York; concluded his epidemiology training

in 1985 at CDC's Epidemic Intelligence Service; and completed an Infectious Diseases Fellowship in 1989 at the Emory University School of Medicine in Georgia. He has received the following USPHS awards: Unit Commendation Awards in 1983, 1990, 1991, 1993, 1994, and 1995; the Commendation Medal in 1987 and 1991; the Outstanding Unit Award in 1988 and 1995; and the Outstanding Service Medal in 1992. He is a member of the Infectious Diseases Society of America, the American College of Physicians, the American Medical Association, the American Public Health Association, the American Association for the Advancement of Science, the Commissioned Officers Association, and the American Thoracic Society. Dr. Castro also serves as a peer reviewer for numerous scientific journals.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