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THE WHITE HOUSE

WASHINGTON

MEMORANDUM

From: Sandra L. Thurman
Director
Office of National AIDS Policy

Date: June 27, 2000

Re: **Background for meeting on the 13th International AIDS Conference**

The 13th International AIDS Conference, which is the largest medical conference ever to be held in Africa, will take place July 9-14, 2000 in Durban, South Africa. This year's theme, "Break the Silence" was chosen to emphasize the obstacles to local/global efforts to turn the tide of the HIV/AIDS epidemic. Since the beginning of the pandemic, the "conspiracy of silence" and the stigma associated with AIDS has stymied progress in all countries and at all levels – among Presidents and in communities. Over 12,000 participants, including representatives from governments, NGOs and the scientific community are registered to attend. Some of the principal sponsors include Glaxo Wellcome, Abbot Laboratories, Bristol Myers Squibb Company and Merck Sharp & Dohme.

The Conference is primarily a bi-annual scientific conference, having last occurred in 1998 in Geneva, Switzerland. This is the first time that the conference is being held in the developing world. Given that sub-Saharan Africa is home to more than 70% of people living with HIV, and South Africa is home to more people living with AIDS than any other single country, the site is both timely and appropriate. President Mbeki will give welcoming remarks at the Opening ceremony, and former President Mandela may give the closing remarks.

The goal of the Conference is to build bridges between the scientific and community aspects of the AIDS pandemic. The Conference itself consists of a scientific programme and a community programme, supplemented by satellite meetings. The scientific programme strives to address the extent to which these Conferences direct research priorities and policies, and whether these priorities and policies accurately respond to community needs. It is structured towards providing information on the significant achievements and important issues that have come up since the last Conference in 1998. Plenary session topics include "The Evolving Virus", and "Prevention and Vaccines". These sessions, led by renowned scientists, community leaders and policy specialists, will be supplemented by roundtable discussions, and oral and poster presentations selected through a blind review process by the Conference organizers. The oral and poster presentations are based on four tracks -- Basic Science, Clinical Science, Epidemiology,

Prevention and Public Health, and Rights, Politics, Commitment and Action. The debates and roundtable discussions address many specific concerns within these broad categories.

The community programme serves to identify the needs of the community, so that the scientists may tailor their efforts to those who are truly in need. The three themes of the community programme are Gender and Diversity, Treatment and Care, and Human Security and Development. Though there is an activist component to the Conference, it is important to stress that it is not a political forum. The primary foci of the Conference are the dissemination of information and the collaboration of scientific efforts in a truly effective manner.

The satellite meetings serve as a major connection between the scientific and community programmes. Satellite meetings are fully organized and supported by their sponsoring organizations, and must meet certain scientific and ethical criteria put forth by the Conference. They deal specifically with HIV/AIDS in the context of the overall Conference Programme, and are organized by institutions such as the CDC, UNAIDS, the Harvard AIDS Institute, the International AIDS Society, the U.S. Department of Health and Human Services, WHO, USAID, the American Medical Association, Merck, Peoples Health Organisation (India), and Hong Kong AIDS Foundation, to name only a few. These satellite meetings serve to bring a more region-specific, program-oriented perspective to the Conference, and allow various organizations to share the progress they have made and the challenges they face.

The International Conferences on AIDS have always served as crucial meeting grounds for dedicated people conducting innovative programs worlds away from one another. The 13th International Conference on AIDS carries on this tradition and emphasizes the need for collaboration as we struggle to put an end to AIDS.

The AIDS Pandemic in the 21st Century

The Demographic Impact in Developing Countries

by

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

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

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

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

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

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

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

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

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

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

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

Mortality patterns are driven by HIV prevalence patterns.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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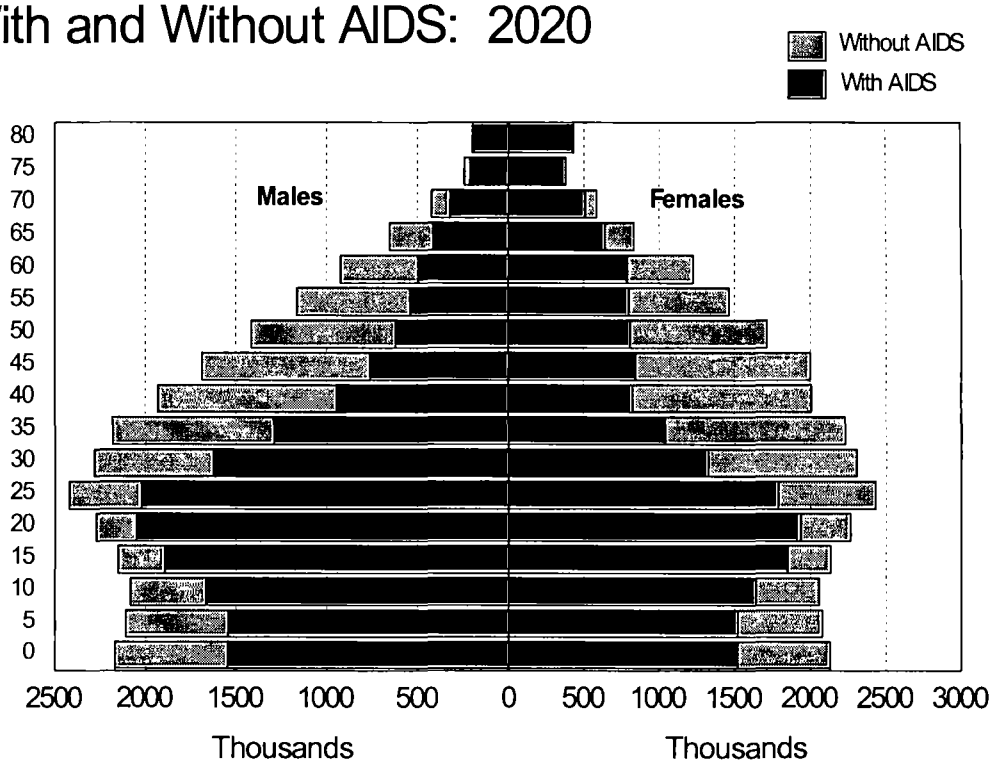
[4]Refer to appendix tables for country specific indicators.

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

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

Population of South Africa, With and Without AIDS: 2020



US Census Bureau, World Population Profile 2000

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

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

AIDS mortality is resulting in falling life expectancies.

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

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

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

In ten years time, 2010, many countries in southern Africa will see life

expectancies falling to near 30 years of age, levels not seen since the beginning of the 20th century.

In a region that would have expected life expectancies to reach 70 years of age by 2010, many will see life expectancies falling to around 30:

- BotswanaB29
- NamibiaB33
- SwazilandB30
- ZimbabweB33

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

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

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

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

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

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

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

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

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

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

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

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

AIDS mortality has reversed the declines that had been occurring during the 1980s and early 1990s. Over 30 percent of all children born to HIV infected mothers in sub-Saharan Africa will be HIV positive either through the birth process or due to breast feeding. The relative impact of AIDS on infant mortality will depend on both the levels of HIV prevalence in the population and the infant mortality rate from other causes. In 1990[8] infant mortality in Zimbabwe was 54; in 2000 it is 62. In Kenya, infant mortality in 1990 was 67, in 2000 it is 69. Without AIDS infant mortality in Zimbabwe would have been 30 and in Kenya it would have been 55.

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

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

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

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

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

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

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

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

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

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

In Zimbabwe and Botswana, where child mortality rates may have been below 30 without AIDS,

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

[8]Figures for 1990 also include AIDS mortality.

over 150 children per 1000 will die. Of that total, 80 percent will be due to AIDS. In many of the countries in southern Africa, over 50 percent of childhood deaths will be due to AIDS. In Malawi and Mozambique, where child mortality rates due to other causes is already high, AIDS mortality will increase those rates by 30 percent.

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

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

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

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

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

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

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

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

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

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

Joint United Nations Programme on HIV/AIDS
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US Media Office (212) 584-5024

PRESS RELEASE

UNDER EMBARGO UNTIL 16.00 GMT
Geneva, 27 June 2000

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

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

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

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

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

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

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

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

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

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

Long-term demographic impacts threaten social stability

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

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

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

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

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

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

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

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

HIV infection rates continue to increase in many countries

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

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

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

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

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

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

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

Signs of hope, but response needs urgent and massive expansion

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

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

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

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

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

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

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

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

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

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

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

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

SATURDAY, 8 JULY 2000					
Time	I.C.C. 5	UNISA 1,2,3,4,5	UNISA 6	PLAYHOUSE 11 & 12	TBD
08:00		NGO SAT:	NGO SAT:		
09:00		**Breaking the Silence at all fronts in fighting the HIV epidemic in India**	**Nursing partnerships to break the HIV/AIDS silence**	NGO SAT: **Third International prevention works symposium**	NGO SAT: **HIV/AIDS media briefing with new research from JAMA being presented**
09:30	NGO SAT:				
10:00	**Indaba symposium of global Christian perspectives to HIV/AIDS**				
13:00					
15:00					
17:00					
19:00					

SUNDAY, 9 JULY 2000				
Time	I.C.C. 4	I.C.C. 5	UNISA 1	UNISA 3
08:00		NGO SAT:		
09:00		**Gender, Human Rights, Sexuality & HIV: New challenges for women in prevention, care, treatment and support**	NGO SAT: **Better practices in AIDS prevention social marketing**	
10:00	NGO SAT: **S.A.D.C. Regional Meeting**			NGO SAT: **Local responses to HIV/AIDS**
12:00				
13:00				NGO SAT: **Care for HIV & TB: Considerations for prevention, prophylaxis and integration**
16:00				
16:15				
16:30				
18:00				

SUNDAY, 9 JULY 2000				
Time	UNISA 4	UNISA 6	CITY HALL 3	HILTON 10
08:00		NGO SAT:		
09:00		**Supportive care and care for the caregiver**		NGO SAT:
09:30			NGO SAT:	**The UNAIDS drug access initiative : Status and preliminary results of early evaluation**
10:00	NGO SAT: **Intestinal worms - a major impact on AIDS and TB**		**Improving access to AIDS drugs in developing countries: tested strategies**	
13:00				
13:30				
14:00				
15:00				NGO SAT:
16:00		NGO SAT: **AIDS in India**		**Adherence issues for children, youth & families: A family focused model**
17:30				
18:00				

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

MONDAY, 10 JULY 2000

Time	I.C.C. 1	I.C.C. 2	I.C.C. 3	I.C.C. 4	I.C.C. 5	I.C.C. 6	ROYAL 14
09:00 - 11:00	PL01: The Jonathan Mann Memorial Lecture Chairs: Hoosen Coovadia; Salim Abdool Karim The declining stigma of AIDS in Africa *Cameron Edwin* PL02: The Jonathan Mann Memorial Lecture Chairs: Manto Tshabalala-Msimang; Peter Piot Development assistance, economics and AIDS *Bell Jeffrey* Successes in HIV control (fact or fiction) *Anderson Roy* Inequity in treatment access *Kaleeba Noerine*						
13:00 - 14:30	Sy01 : Symposium: Science of HIV/AIDS : Evolution & Impact	Db01 : Debate Donor Agencies are too focused on prevention & pay insufficient attention to the social and economic impacts of the epidemic *Paul Farmer/Mead Over*	Rt01 : Roundtable Exposing the Silence	E01 : Oral Abstract Testing & Informed Consent	E02 : Oral Abstract Empowerment, Advocacy and Activism	B01 : Oral Abstract HIV/AIDS in children *R. Biggar, NCI*	C02 : Oral Abstract Female condoms : Where are we now?
14:45 - 16:15	Db02 : Debate Social Theory offers solutions and understanding of the HIV epidemic *Paula Treichler* *Dennis Altman*	Sy02 : Symposium: Prevention & Treatment Rights	Sy03 : Symposium: Mother-to-child transmission of HIV	E03 : Oral Abstract Innovative approaches to reach migrants & mobile populations	Rt02 : Roundtable Vaccines for developing countries: Development, access and delivery	B03 : Oral Abstract Paediatric anti-retroviral therapy	C04 : Oral Abstract Male circumcision : An ignored intervention
16:30 - 18:00	Db03 : Debate Vaccines for testing in developing countries should be matched to the dominant local HIV strain/subtype *Carolyn Williamson/Rosemary Musonda*	Db04 : Debate Innate immunity is as important as adaptive immunity in preventing HIV infection and progression to disease *Jay Levy/Giuseppe Pantaleo*	Sy04 : Symposium Policy Dialogue : Engaging youth in the fight against AIDS	E04 : Oral Abstract Role of religion & religious institutions "Access or Avoidance"	E05 : Oral Abstract Notification, reporting and disclosure	Sy05 : Symposium Management of drug resistance	C06 : Oral Abstract Male condoms
18:30 20:00 20.30 21:00			NGO SAT: **Global update on HIV in women**	NGO SAT: **The joint commitment of ANRS and developing countries to fight HIV/AIDS**	NGO SAT: **Access to Microbicides: Overcoming policy barriers**		

MONDAY, 10 JULY 2000

Time	D.E.C. 7	D.E.C. 8	D.E.C. 9	HILTON 10	PLAYHOUSE 11	PLAYHOUSE 12	CITY HALL 13
11:30 - 13:00	Vukani Session: CV01 Criminalisation of HIV Transmission is a preventative measure (partner notification)			Mamelang. CM03 Chair: Jurek Domaradzki Facts of life : living with HIV/AIDS Notification Criminalisation Travel restrictions	Mamelang Sess: CM01 Chair: Robin Gorna Female controlled prevention **Mitchell Warren* **Megan Gottemoeller* **Rosemarie Munhoz*	Mamelang. CM04 The role of the Church in addressing HIV/AIDS in African and African-American communities	Mamelang CM02 Chair: Joseph Scheich Keeping it safe - maintaining gay safe sex practices in the light of treatment for HIV **Andy Quan* **Rainer Schilling* **Brenton Wong* **Jorge Huerdo*
13:00 - 14:30	D01 : Oral Abstract HIV prevention in Educational institutions	D02 : Oral Abstract Communities. Catalyst for change	D03 : Oral Abstract Reducing risky sexual behaviour : Insights & interventions	B02 : Oral Abstract Access to care across the Continuum	A01 : Oral Abstract Animal Models - interventions	A02 : Oral Abstract HIV Diagnostics	C01 : Oral Abstract Vaccine preparedness
14:45 - 16:15	D04 : Oral Abstract Methods in behavioural research on HIV risks	D05 : Oral Abstract Mother-to-child transmission: Issues in breastfeeding transmission	D06 : Oral Abstract Male condoms - challenges, opportunities and distribution	B04 : Oral Abstract Quality nursing care makes a difference	A03 : Oral Abstract HIV molecular evolution	A04 : Oral Abstract HIV replication and pathogenesis *Suresh Arya, NCI*	C03 : Oral Abstract Tuberculosis and HIV/AIDS interventions
16.30 - 18:00	D07 : Oral Abstract Speaking & listening: Parents & Children	D08 : Oral Abstract Reaching out : Male & Female sex workers	D09 : Oral Abstract Breaking the Silence : Reversing denial and facing our fears	B05 : Oral Abstract Gynaecological complications in HIV-positive women	A05 : Oral Abstract Methodology and epitope identity	A06 : Oral Abstract Biological correlates of HIV transmission	C05 : Oral Abstract Reducing mother-to-child transmission

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

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

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

TUESDAY, 11 JULY 2000							
Time	I.C.C. 1	I.C.C. 2	I.C.C. 3	I.C.C. 4	I.C.C. 5	I.C.C. 6	ROYAL 14
09:00 - 11:00	Pl03 : Plenary : Living with HIV **Viral Factors in HIV disease progression** *David Ho / Unassigned* **Host Factors in HIV disease** *Anthony Fauci / Unassigned* **Advances in Treatment of HIV/AIDS** *Mathilde Krim / Unassigned* **Human Rights / Global Security and HIV/AIDS** *TBD / TBD*						
13:00 - 14:30	Db05 . Debate HIV-positive women should be encouraged to exclusively breastfeed *Ann Coutsoudis/Mary Glenn Fowler*	Rt03 : Roundtable Living with HIV	B06 . Oral Abstract Anti-retroviral therapy in resource poor settings : Real world data	Sy07 : Symposium Public policy : Implementation and Impact	E06 : Oral Abstract Evaluation of responses	Sy06 : Symposium: Tuberculosis in HIV patients	C08 : Oral Abstract Post-exposure prophylaxis
14:45 - 16:15	Db06 . Debate Research participants in developed and developing countries should receive the same standard of care *Jorge Beloqui/Solomon Benatar*	14:45 - 18:00 Sy08 : Symposium Outstanding issues in the international response to HIV/AIDS	B08 : Oral Abstract Mother-to-child transmission	E07 : Oral Abstract Innovative approaches to reach disadvantaged women	E08 : Oral Abstract Media responses and responsibility	B09 : Oral Abstract Opportunistic infections	C09 : Oral Abstract Determinants of disease progression
16:30 - 18:00	Db07 : Debate Until there are more affordable drugs, anti-retroviral therapy less than HAART is acceptable in developing countries *Praphan Phanuphak/Julio Montaner*		Rt05 : Roundtable Mother-to-child transmission - obstacles in implementation	E09 : Oral Abstract Global action to expand national response in Africa	E10 : Oral Abstract Intellectual property and Human Rights : Access to drugs	B11 . Oral Abstract Adherence to anti-retroviral therapy - why so low?	C11 : Oral Abstract Natural history of HIV/AIDS in developing countries
18.30 - 20 30 - 21:00 - 21:30				NGO SAT: **Understanding HIV vaccine development & what NGO's can do to move things forward**	NGO SAT: **Building political commitment for effective HIV/AIDS policies and programs**		

TUESDAY, 11 JULY 2000							
Time	D.E.C. 7	D.E.C. 8	D.E.C. 9	HILTON 10	PLAYHOUSE 11	PLAYHOUSE 12	CITY HALL 13
06:30 - 08:50				NGO SAT: **HIV Care and prevention - North & South : An international case conference I**			
11:30 - 13:00	Vukani : CV02 NGO's should advocate against treatment to prevent mother-to-child transmission without treatment for the mother			Mamelang: CM05 International and national NGO's - a funding dilemma or identity crisis	Mamelang : CM06 Successes and obstacle - Human rights lessons learnt in five Latin American countries	Mamelang : CM08 The risk of HIV transmission within the family and community	Mamelang: CM07 Sexual and reproductive rights of positive women
13:00 - 14:30	D10 Oral Abstract Behind walls - HIV in prison	D11 . Oral Abstract Intensifying the response	D12 : Oral Abstract Behavioural predictors and outcomes of HAART	B07 : Oral Abstract HIV related malignancies	A07 : Oral Abstract Immune response in the context of treatment	A08 : Oral Abstract New vaccine designs I ***M. Robert-Guroff, NCI***	C07 : Oral Abstract Voluntary counselling and testing
14:45 - 16.15	D13 : Oral Abstract Peer interventions strategies	D14 : Oral Abstract Economic impact of AIDS on households & organisations	D15 : Oral Abstract Strategies for adherence to therapy	B10 : Oral Abstract Home care models	A09 : Oral Abstract Cytokine / Chemokine and Receptors	A10 : Oral Abstract Molecular biology of viral resistance	Rt04 Roundtable AIDS vaccine development for Africa
16:30 - 18:00	D16 Oral Abstract Sexual behaviour of students: From primary school to university	D17 . Oral Abstract Sex work and HIV, lessons and challenges	D18 : Oral Abstract Stigma	Sy09 : Symposium Gender issues in disease progression	A11 : Oral Abstract New antivirals/Targets II	A12 : Oral Abstract HIV diversity	C10 : Oral Abstract Biological determinants of transmission
18:30 - 21:00				NGO SAT: **Getting the most out of PLHA involvement**			

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

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

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

WEDNESDAY, 12 JULY 2000

Time	I.C.C. 1	I.C.C. 2	I.C.C. 3	I.C.C. 4	I.C.C. 5	I.C.C. 6	ROYAL 14
09:00 - 11:00	Pl04 : Plenary: HIV Prevention Prevention does work Peter Piot Gender/Sexuality and HIV Gender and the Epidemic Strategies to reduce mother-to-child transmission of HIV Chantal Biya Advances in topical microbicides Dr Yvet Dennis						
13:00 - 14:30	Db08 : Debate Population-based STD treatment programmes should be implemented to reduce HIV transmission *TBD*	Rt06 : Roundtable Prevention of HIV	Sy10 : Symposium The AIDS epidemic: Can the Health Sector respond?	Sy11 : Symposium Accessing vulnerable groups : Youth ***D. Satcher, DHHS***	E11 : Oral Abstract Public health and Human Rights	B12 : Oral Abstract Switching anti-retroviral regimens	C13 : Oral Abstract Injecting drug use and HIV
14:45 - 16:15	Db09 : Debate Sufficient immune reconstitution is possible in context of HAART *TBD*	Db15 : Debate Compulsory licencing & parallel imports: Will they improve access to AIDS drugs? *TBD*	Sy12 : Symposium Caring for the child with HIV infection	E12 : Oral Abstract Ethics of care : Strategies for improving care	E13 : Oral Abstract Innovative approaches to reach sex workers	B14 : Oral Abstract Immune based therapies	C15 : Oral Abstract HIV vaccine trials ***J. McNamara, NIAID***
16:30 -	Db10 : Debate Hydroxyurea has an important role as a component of anti-retroviral therapy *Franco Lori/Bernard Hirschel*	Db11 : Debate Structural adjustment fuels the AIDS epidemic *John Garrison/Mary Bassett*	Sy13 : Symposium Effects of HIV interventions	E14 : Oral Abstract Regulating HIV prevention and therapeutic goods and services	E15 : Oral Abstract Innovative approaches to reach injecting drug users	B16 : Oral Abstract Clinical trials of anti-retroviral therapy	Rt07 : Roundtable Blood safety
18:00 18:30 20:30 21:00			NGO SAT: **Prevention of mother-to-child transmission of HIV: Pilot project implementation issues**	NGO SAT: **Developing an African AIDS vaccine strategy**	NGO SAT. **What can simulation modeling tell us about the impacts of prevention interventions in different contexts?**		

WEDNESDAY, 12 JULY 2000

Time	D.E.C. 7	D.E.C. 8	D.E.C. 9	HILTON 10	PLAYHOUSE 11	PLAYHOUSE 12	CITY HALL 13
11:30 - 13:00	Vukani Session: CV03 People should go for HIV testing if treatment is not available	Mamelang : CM09 Mobility and migration	Vukani Session : CV04 Decriminalisation of "sex work(ers)" leads to decreased transmission		Mamelang : CM12 "Making a difference - Men and AIDS"	Mamelang : CM11 Shooting it up - IDU's and needle exchange, keeping it safe!	Mamelang : CM10 Drug donations
13:00 - 14:30	D19 : Oral Abstract Gender & sexuality : Still on the agenda	D20 : Oral Abstract Community-based interventions: How effective are they?	D21 : Oral Abstract How mobile is the virus? Migrants and their partners	B13 : Oral Abstract Immune reconstruction ***C. Lane and A. Kinter NIAID***	A13 : Oral Abstract Human Herpes Virus-8 (HHV-8)	A14 : Oral Abstract New vaccine designs	C12 : Oral Abstract New developments in breastfeeding transmission of HIV
14:45 - 16:15	D22 : Oral Abstract Violence against women : Cries & whispers	D23 : Oral Abstract Dollars and Sense - cost of medical care	D24 : Oral Abstract Injecting - an international epidemic	B15 : Oral Abstract Pharmacology and pharmacokinetics	A15 : Oral Abstract Co-infection of HIV and Hepatitis viruses	A16 : Oral Abstract New anti-virals-I	C14 : Oral Abstract Implementing Mother-to-child intervention programmes: Successes and challenges
16:30 - 18:00	D25 : Oral Abstract "Hope or Hindrance" custom, religion and sexuality	D26 : Oral Abstract Making voluntary testing work	D27 : Oral Abstract Pushing the agenda: advocacy and involvement	B17 : Oral Abstract Management of HIV disease in real life	A17 : Oral Abstract CD8/CD4 cells: Implication for vaccine development	A18 : Oral Abstract Ethics of research	C16 : Oral Abstract Cost-effectiveness of mother-to-child transmission
19:00 21:00				NGO SAT: **Social marketing: An effective strategy in prevention of HIV/AIDS & STD**			

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

WEDNESDAY, 12 JULY 2000	
Time	UNISA 6
18:30 21:00	NGO SAT: **HIV/AIDS & migration-specific needs & appropriate interventions in the field of policies, prevention and care**

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

THURSDAY, 13 JULY 2000

Time	I.C.C. 1	I.C.C. 2	I.C.C. 3	I.C.C. 4	I.C.C. 5	I.C.C. 6	ROYAL 14
09:00 - 11:00	Pl05 : Plenary: Challenges of HIV Vaccine **Genetics and transmission of HIV** *Francine McCutchan/[illegible]* **An AIDS vaccine by 2007? myth or reality?** *Mervat [illegible]* **AIDS vaccine challenges to the pharmaceutical industry** *Peter Youngblood [illegible]* **Ethics of AIDS research in developing countries** *Melbourne Hovood*						
13:00 - 14.30	Db12 : Debate Prevention policy should be directed to changing the behaviour of those who display the highest risk behaviour *Tom Coates/Tun Brown*	Rt08 : Roundtable Challenges of HIV Vaccine	Sy15 : Symposium Intersectoral response to HIV/AIDS	Sy16 : Symposium HIV vaccine trials : Ethics	E16 : Oral Abstract Protecting the children: Orphan care and support	Sy14 : Symposium: Issues in anti-retroviral therapy	C19 : Oral Abstract HIV prevalence and risk factors
14:45 - 16:15	Db13 : Debate TB Prophylaxis should be given to all HIV infected persons *Alwyn Mwauga/Gary Maartens*	LB01 : Late Breakers See supplement for details	LB02 : Late Breakers New Developments in Affordable Antiretroviral Therapy ***M. Dybul, NIAID*** (16:00)	Rt09 : Roundtable International support for the prevention of mother-to-child transmission	Sy18 . Symposium Personal accounts in dealing with AIDS ***Neal Nathanson, OAR***	Sy20 : Symposium Report back on the 3rd International HIV Prevention Works meeting	C22 : Oral Abstract Association of STI and HIV
16:30 - 18.00	Db14 Debate Future microbicides research should focus on specific anti-HIV approaches *Kenneth Mayer/Zeda Rosenberg*	LB03 : Late Breakers See supplement for details	LB04 : Late Breakers See supplement for details	LB05 : Late Breakers Vaccines Immunotherapy & Immunopathogenesis ***C. Womack, NIAID***	E17 : Oral Abstract The Multisectoral Response: Making programmes work	B21 : Oral Abstract Structured treatment interruptions	C23 : Oral Abstract Sexually transmitted disease control interventions
18:30 - 21:00				NGO SAT: **Networking for effective responses to HIV/AIDS: Evidence from regional harm reduction networks**			

THURSDAY, 13 JULY 2000

Time	D.E.C. 7	D.E.C. 8	D.E.C. 9	HILTON 10	PLAYHOUSE 11	PLAYHOUSE 12	CITY HALL 13
06:30 - 08:50				NGO SAT: **HIV care & prevention - North & South: An international case conference II**			
11:30 - 13:00	Vukani Session CV05 How can anti retrovirals be made available with/without the required or weak infrastructure?	Mamelang . CM13 Nutrition in resource poor settings - the importance of education and counselling	Vukani . CV06 And the media plays on . . .		Mamelang . CM14 Are the counsellors counselling? - Quality and effectiveness of counselling	Mamelang : CM15 Home and community care - challenging stigma	Mamelang : CM16 HIV/AIDS vaccines and the work for communities in Africa
13 00 - 14:30	D28 : Oral Abstract Recruitment for HIV vaccine trials	D29 : Oral Abstract Prevention and action: Men who have sex with Men	D30 : Oral Abstract Caring for caregivers	B18 : Oral Abstract Hepatitis C and HIV Co-infection : Clinical aspects	C17 : Oral Abstract Microbicides	Sy17 : Symposium Immune recognition and immune escape	C18 : Oral Abstract Measuring the epidemic
14 45 - 16.15	Sy19 : Symposium HIV/AIDS families and communities	D31 . Oral Abstract "Where are we now?" Gays, Lesbians, Bisexual and Transgendered voices	D32 : Oral Abstract Positive people . Leading initiatives	B19 : Oral Abstract Palliative and Terminal care	C20 : Oral Abstract HIV in Men who have sex with Men	B20 : Oral Abstract Risk factors for lipodystrophy syndrome	C21 : Oral Abstract Trends in the epidemic
16:30 - 18:00	D33 : Oral Abstract Protecting the children: Orphan care & support	D34 : Oral Abstract HIV discordant couples: Living with HIV	E18 : Oral Abstract Breaking the silence around traditional medicine for HIV/AIDS prevention and care	B22 : Oral Abstract Training community and health care workers	E19 . Oral Abstract Responding to stigma and discrimination	B23 : Oral Abstract Lipid metabolism and cariovascular risk	Sy21 : Symposium Effect of HAART on HIV trends
18:30 - 21:00				NGO SAT: **Children on the brink: Principles and issues in program implementation**			

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

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

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