AIDS 2008

Conference Report

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Notes for the reader

To facilitate the retrieval of the presentations you will find in the report the code of the abstract (for ex MOPL0101 = Monday Plenary session 0101) and the date.

For more information on each session go to the AIDS2008 website to access the Conference Program http://www.aids2008.org/Pag/PAG.aspx

PowerPoint presentations and podcasts can be downloaded from the following website http://www.kaisernetwork.org/aids2008/

For expert analysis check Clinical Care Option HIV website (free registration) http://clinicaloptions.com/HIV/Conference%20Coverage/Mexico%20City%202008.aspx

A CD with the abstracts is available in STAO and copy can be made upon request.

Abbreviations

ARV	Antiretrovirals
AZT	Zidovudine
EFV	Efavirenz
FGD	Focus Group Discussion
FTC	Emtricitabine
GBV	Gender based violence
IDU	Injecting drug users
LPV/r	Lopinavir/ritinavir
MSM	Men who have sex with men
NVP	Nevirapine
OI	Opportunistic Infection
OST	Opioid Substitution Therapy
PEP	Post-exposure prophylaxis
PLHIV	People living with HIV
PMTCT	Prevention of Mother to Child Transmission
PPTCT	Prevention of Parents to Child Transmission
PrEP	Pre-exposure prophylaxis
SW	Sex workers
TB	Tuberculosis
TDF	Tenofovir
VL	Viral load

I. Introduction

Due to the lack of new advances concerning both ARV drugs and biomedical preventive interventions, this 2008 conference has mainly focused on **community and social-based prevention** and **combination prevention** (associating several preventive methods in a harm-reduction based approach). Large amounts of communications have also focused on hard-to reach and **marginalized populations**, such as MSM (especially in Africa), SW and Migrants.

The inutility of the debate between HIV-focused programs and **weakening of Health systems** has also been underlined, concluding that if the health systems are weak there is a need for increased funds rather than diverting HIV funds. Moreover some presentations have underlined the reverse effect, i.e. strengthening of Health systems thanks to the implementation of an HIV program. As a matter of fact while 3 millions PLHIV are on ARV worldwide, there are **2.7 millions new infections/year and 3 PLHIV out of 5 newly infected will die due to lack of access to ARV.**

Finally a large amount of communications (transversal issue) has underlined the need for emphasizing **Human Rights** which are violated in many countries.

II. Prevention

A. Comprehensive prevention approach

Need to re-focus on prevention activities, through a **combined approach** mixing: biomedical (condoms, male circumcision, cervical barriers, ART-microbicides, PeP, PreP…), behavioral and structural strategies (TUSY03; 05/08/08). Importance to go beyond the "ABC strategy" and to adapt prevention to local epidemic (depending on generalized, concentrated or mixed epidemic). Need to implement projects through a unified strategy: prevention + care and treatment.

Special series of the Lancet (Aug 08) on HIV prevention: The History and Challenge of HIV Prevention; Biomedical Interventions to Prevent HIV: Evidence, Challenges and the Way Forward; Behavioral Strategies to Reduce HIV Transmission: How to Make Them Work Better; Understanding and Addressing Structural Factors in HIV Prevention; Making HIV Prevention Programmes Work; Coming to Terms with Complexity: A Call to Action for HIV Prevention.

B. Positive prevention

Debates concerning the Swiss statement on **role of treatment in prevention** (MOPL0101 –04/08/08), stating that patient on ARV with undetectable VL do not transmit HIV, implicating that discordant couples are no longer submitted to condom use. This statement is still controversial and further research need to be carried out. Recent publication on discordant couples: Dunkle, Lancet 2008

Need to develop positive prevention strategies for **Young PLHIV** (cf. below and MOPL0104 – 04/08/08).

C. Prevention and sexuality

Combating "Prevention fatigue" → Harm reduction approach to sexual risk reduction: people who can not consistently use condoms are likely to try other strategies (diaphragm, sero-sorting etc. FRPL01; 08/08/08)

There was also interesting presentations raising the concerns of right to reproduction for PLHIV (Symposium TUSY09; 05/08/08 and WEAE01; 06/08/08)

Can safer sex be sexy? The pleasure project www.thepleasureproject.org

D. Biomedical prevention (Circumcision, Microbicides, PrEP, Vaccines)

Assays ongoing on **PrEP** using Truvada + Maraviroc (CCR5 blockade) – TUPL0101 – 05/08/08

Effectiveness of **circumcision** at a **large scale** still to be proven (ingoing trials TUPL0101 – 05/08/08) → need of large scale interventions. Interventions so far show that circumcision is a cost-effective measure, well accepted (South Africa) and could prevent HPV infection as well (decrease of 40% in men), thus potentially decreasing the incidence of women genital cancers. Safety for women should be further explored. (TUAC03; 05/08/08)

Vaccines and **microbicides** candidates have failed to demonstrate any preventive effect in clinical trials completed in 2007 and 2008 (Symposia – MOSY01; 04/08/08)

E. Health workers

Health workers have been underlined as a **higher risk group** (MOPL0101 – 04/08/08). Only about 30% of health services have access to PEP kits. It is essential to scale-up access to PEP kits for Health workers and understand Health workers needs in order to set up services which will meet these needs.

III. Testing

Importance to combine **several HIV testing approaches**, especially in high-prevalence countries (in particular, B. Spire, President of AIDES France; plenary session FRPL01 08/08/08).

A. Provider-initiated testing and counseling

Inclusion of HIV testing in basic package of care required (SUSAT 10; 03/08/08 + SUSAT 46; 03/08/08 + WEAC01; 06/08/08) – Experience from Mozambique (complete package including HIV testing, malaria prevention, mother and child health, STI screening, hypertension and diabetes management)
New guidelines from WHO on PITC (2007):
http://whqlibdoc.who.int/publications/2007/9789241595568_eng.pdf

B. Home-based testing

- Several examples of home based counseling and testing (Uganda, Malawi, Botswana…) with good results (by community health workers with rapid tests):
- Family-based approach (Cote d'Ivoire, Zimbabwe, Uganda): Elisabeth Glazer Pediatric Aids Foundation Satellite session http://www.pedaids.org/: couple counseling, child-friendly spaces, mixed support groups at community levels.

C. Mobile VCT & Community mobilization

Thailand experience: 40% of ethnic minorities. Door-to door visits, community meeting and FGD. Better accepted and increased number of person tested when testing campaigns done during the evening within social events => **Edutainment** = Education + Entertainment.

D. HIV testing and Human Rights

Criminalization of HIV transmission has been reported in many countries (transmission among couples but also mother to child transmission) → **High ineffective Laws**! The aim of this presentation is not to be against the law that criminalize the transmission but more to define which kind of law must be implemented (WEAE01; 06/08/08)

Problem of criminalization is that it was **made to protect women** but actually women can be arrested and moreover: women suffer more violence means that increase of vulnerability of HIV, women more alike to know if they are HIV when pregnant for the prenatal test, they are blamed for bringing HIV, fear of eviction if they talk about their disease, unable to enforce safe sex, violence against women → Jurisdiction should not criminalize transmission but **fight against violence and cultural practices, and promote equity.** Make the people understand that the **transmission is a co-responsibility** and that no law will protect you, better you protect yourself

Countries experiences: In Madagascar, carelessness, inattentiveness, negligence = 6 months to 2 years of jail and 10.000 to 40.000 dollars of fine. In Austria, Suisse and Sweden, 30 persons arrested for transmission, in France 19 people in 2007.

Finally a Canadian lawyer presented how to help developing countries to write/implement HIV and GBV related laws (WEAE0101).

IV. HIV in humanitarian settings & GBV

A. Refugees and IDPs

1.8 millions PLHIV live in humanitarian settings (data from 2006)
Food insecurity and increased vulnerability to HIV (International Food policy Research Institute)
Need for contingency plans before the onset of the emergency (MSF experience South Kivu and Zimbabwe) – No data yet on development of resistant viral strains after an emergency in PLHIV who experienced treatment interruption (**Oxfam Satellite;** MOSAT20 – Satellite 04/08/08)

Need to integrate refugees and IDP into national health/AIDS strategies (NEAE04; 06/08/08).

Experience in Kenya → problem of health access and discrimination in the camps after the events of the elections (THAX01; 07/08/08).

UNHCR, with several NGOs, have done an **assessment on HIV management** in **North Kivu** among **IDPs**, showing the non-respect of universal precautions, the high percentage of sexual violence, the poor knowledge of HIV prevention methods and the violation of human rights (mandatory testing suggested for IDPs). Experience in **South Sudan**, where HIV prevalence is unknown, has shown that involvement of military force (the SPLA) increased widespread of HIV prevention methods. In regions where there are chronically displaced people (**South Caucasus**), blood safety should be ensured. (WEAE04; 06/08/08)

Multicountry study: Spiegel PB et al., Lancet 2007, 369(9580): 2187-95. Future research: refugees outside camps, IDPs, effect of refugees returning home, KAP survey, IDUs during disasters.

B. GBV

A study in 7 post-conflict countries (Burundi, Sierra Leone, Rwanda, DRC, Liberia, Sudan and Uganda) shows that **widespread rape does not appear to increase HIV prevalence in conflict-affected countries**. This conclusion shall not reduce funding or activities (access to prevention/treatment) for these specific populations but projects shall be **based on evidence**. Second this conclusion tends to reduce strong existing stigma on IDP, refugees etc. (THAX01; 07/08/08).

Study case about Rwanda to avoid the discrimination against women who are raped during the conflicts: Rape seems not to increase HIV prevalence in conflict country for the general population → To calculate the risk: number of women at risk X probability of the soldiers already infected X risk of transmission. The rate is from 0% to 0,023%. This number **does not take into account** some figures like **HIV prevalence among soldier population** and the fact that **vulnerability increase for the women who are raped** (exclusion, pregnancy…). These figures are only at a country population level but it is important to take into account the **consequences at a community and personal level**. Some people suggested that this study is dangerous for its results. Two main arguments were presented to question the results: it does not contemplate the women who have already died from HIV and thus are not in the women population and problem of number of the population reference as in this case, the violation was against a minority that was the Tutsi, means that this must be the population of reference, not the all population of Rwanda. The answer of the specialist: this study does not analyse the personal level and do not deny the link between violation and HIV transmission

Besides **rape survivors**, it is important to address **perpetrators' needs** that tend to see themselves as victims. Need further **research** to study patterns and scope of sexual violence to better prevent it (Oxfam, gcolenquirier@oxfam.org.uk).

Address legal issues such as **impunity** of perpetrators in DRC. Address issues of HIV prevention among uniformed personnel (cases of MSM, sexual violence etc.). Increased risk of sexual violence in post-conflict situations rather than during an emergency. (WESY07; 06/08/08).

V. Hard-to reach populations

A. Migrants

IOL-IOM Satellite (SUSAT96 – Satellite 03/08/08)
Presentations from CARAM Asia, ITUC Kenya and IOM South Africa

Focus: labour migrations – Increased number of women
Recommendations: Assist governments (home and destination countries) to revise labour laws and abolish mandatory HIV testing. Set up Comprehensive care and prevention approaches.
Contacts: Barbara Rijks (brijks@iom.it); www.iom.org.za; www.caramasia.org; UNAIDS policy brief June 2008.

Migrants in the Mexico-US border (TUAD02; 05/08/08) → higher HIV prevalence among migrants. Risk factors: isolation, low access to health, increased use of drugs, increased visits to SW, high mobility, poverty. Are more protected when they are close to their families.

HIV prevalence among Drug users: 4% for males, 10% for females – increased risk among migrants.

Profile of the migrant	Profile of the non-migrant
Financial problems	No financial problems
Escape problems	Ask for more education
Follow or visit their families	Protect the family
Problem of citizenship	Postpone citizenship – has other priorities
Adventurous	Non interested in adventure

B. Injecting Drug users

Integrated approaches for IDUs including HIV services, TB services and OST. Advocate for access to ARV in conjunction with access to OST (see also TUPL0102 – 05/08/08). Need to empower DU. Presentations from France, Mauritius, Ukrain and Kazan. Experience from Brazil on non-heroin drug users; despite absence of OST, ARV provision is possible in a comprehensive care setting. (**Open Society Institute Satellite;** TUSAT07 – Satellite 05/08/08)

No data on **mobile drug users'** population (check the European working group on mobile drug users at www.correlation-net.org/)

Law enforcement against IDU precludes them access to prevention and care. Contradictions at high level (for ex. Contradictions between UNGASS AIDS and UNGASS Drugs!) – TUPL0102 – 05/08/08.

Experience from **Poland**: Richard Pearshour – WEPDE1; 06/08/08 – **Human Rights and Drug treatment access**. "With the HIV, the body becomes a State property!"
The drug dependence treatment is the highest attainable standard of physical and mental health.
Treatment is unavailable for drug users and there is stigma and legal barrier. Treatment is only available for the wealthy → Advocate for the abolition of DUs' criminalization, avoid discrimination, affordable treatment, involve people who use drug, ethical treatment, confidentiality.
Problem of compulsory drug treatment → In Poland, most of the time, it is necessary to do three years of "normal treatment" before being able to have access to the methadone treatment. But the "normal treatment" (detoxification) painful, situation of overdosis is the worst after the exit of such program, humiliating: ask to strip to prove that they have not being shooting → focus on **Human rights & UN convention against torture** to go against this kind of "normal treatment", which results to be of pain and abuses.

C. Men who have sex with men (MSM)

Only 40% of MSM are reached by services. Acknowledge the high diversity of the MSM population and the high number of Human Right violations among this population (TUPL0103 – 05/08/08)

HIV epidemics among MSM (MOAC0101 to MOAC0105 – 04/08/08)
HIV incidence among MSM still high (cohort from Thailand). In Australia researcher developed a 5min screening questionnaire to detect most-at risk MSM (contact Tania Gibbie t.gibbie@alfred.org.au). A peer-driven research from Togo has underlined the needs of MSM in terms of prevention and care (contact Michelle Geiss mgeiss@atms.tg). Alternative approaches such as mobile VCT in MSM venues (Peru) and e-animation to promote prevention (France) have been proven efficient.

MSM in Africa: Africagay Network (www.africagay.org) – Approach by empowering local associations.

D. Sex workers (SW)

Most of the presentation have focused on **SW empowerment** (TUAC0104 and TUAC0105 – 05/06/08). First time that a SW presents a communication during a plenary session (WEPL0103 – 06/08/08).

Possible to have peer education even among **illiterate SW** (India experience TUAC0102 – 05/08/08). Peer plus education manuals available at www.pepmodel.org (Nigeria experience; TUAC0103 – 05/08/08)

Need to identify community leaders and influencers such as the pimps and brothel owners – experience from a Muslim setting, Nigeria (MOAD0103 – 04/08/08).

Link between SWs and **human rights**: call to abolish legislation on criminalization of SW, abolish mandatory testing (WEPL0102 – 06/08/08).

VI. PMTCT

Pre-exposure prophylaxis in infants who are breast-fed: 14 weeks of NVP vs. NVP+AZT = high risk of resistance in children. Results of limited usage - ongoing transmission after cessation of PrEP (4 weeks of PrEP while children are brest-fed at least 6 months = 24 weeks) (THAC0403; 07/08/08).

Breast-feeding vs. formula feeding: No significant difference when comparing cumulative infant mortality, diarrhea or pneumonia related-mortality (THAC0404; 07/08/08).

Male involvement should go beyong clinic attendance (lack of time as men are working, lask of adequate space for men in antenatal clinics, societal stigma etc.) → offer VCT to men at alternative times and location. Integrated ANC with men may not be the best choice (THAC0406; 07/08/08).

The shift from PMTCT to PPTCT has been mentioned in various presentations.

VII. Children & Youth

Need to have evidence-based data on age-appropriate approach for disclosure **of HIV status to children**. Need to train health workers and to educate parents on children's needs (MOAX0405 – 04/08/08). Contact Fabienne Hejoaka hejoaka@club.fr). Experience in Uganda: test children < 12 years old if

mother HIV+ or dead (with parents/guardian consent); for children > 12 years old child's assentment is additionally required (WEAC01; 06/08/08).

Need to focus on living parents for **OVC** (for those who have one parent alive) as parents are the best persons to be able to care for children. Shift focus from OVC approach to a family approach. Target all vulnerable children (in rural areas no difference between OVC and other children in terms of education access etc.).
MOAX0406 – 04/08/08; WEPL0102 – 06/08/08

Inadequate counseling of **Young PLHIV** peri-natally infected – Need to reorganize services, identify pregnancies earlier (low PMTCT access), provide more information to Young PLHIV and counseling based on feelings. Experience from Uganda (MOAD0102 – 04/08/08).

Limit number of formulation to simplify supply chains. When introducing a new product think in advance about guidelines, training, implementation plan (THAB0105; 07/08/08). Lack of simplified wall charts for pediatric HIV management and lack of supervision (THBA0106; 07/08/08).

VIII. Antiretrovirals (ARV)

To date 25 ARV are on use. Main challenge: major accessibility problems and unforeseen toxicities (cardiovascular and renal toxicities etc.)

Recent trials have shown that once HAART is started it shouldn't be stopped. Randomized trials are ongoing to know whether earlier HAART initiation is beneficial (when CD4 > 350/mm3). When choosing among NNRTI, EFV is the best choice. Between EFV and LPV/r side effects are similar, efficacy in patients with low CD4 is greater then using EFV but there are more resistant cases in the long term with EFV. Ongoing studies on the use of Integrase inhibitor + Nuke backbone (THPL0101; 07/08/08). In the late breaker session (THAB03) results of trial ACTG 5202 has shown higher failure of ABC/3TC backbone vs. TDF/FTC with EFV in the high VL stratum. This increased failure was not related to higher incidence of ABC-related side effects such as hypersensitivity. However the HEAT study, a trial sponsored by GlaxoSmithKline, shows no difference (same backbones with LPV/r). Two new NNRTIs with less risk of resistance development, are entering Phase II trials.

Resistance in developing countries: NVP+d4T or AZT+3TC – high rates of non-nuc and nuc mutations, such as the Q151M, in patients with virological failure. Patients treated for very long time. Need to develop low-cost techniques for resistance testing. In the mean time, alternative to avoid doing resistance testing would be to use a 1st line: NNRTI + 2 nukes; 2nd line: boosted-PI + a new drug such ratelgavir which will avoid recycling the nuke backbone and allow giving a true second chance to a patient with several resistances.

In order to **eradicate HIV**, it is important to: stop viral replication, identify all the virus' reservoirs and eliminate all these **reservoirs**. Research has focused on identification and characterization of the virus reservoirs that persist after successful HAART. Intensification of HAART should not decrease further the residual viremia as there is no replication going on in the reservoirs. Resting CD4 cells are infected but these reservoirs are not accessible to treatment. One way to make them accessible is to induce an active state by transducing the cells with for example bcl2, a proliferation gene (WEPL01; 06/08/08).

Scale-up: involve PLHIV; have clear targets and timeline (UNAIDS report evasive), task-shifting; simplify monitoring and evaluation; stop the debate between HIV and health streghtening (THPL0102 and THPL0103; 07/08/08)

IX. Co-infections

2 billions persons infected with TB worldwide; 11 millions are co-infected TB-HIV – 85% are in Africa. Most common during the 1st three months of ARV (FRPL01; 08/08/08).

"3Is" = **I**sionazide preventive therapy (better if given with ARV); **I**ntensified RB case findings (TB screening still very low); **I**nfection control of TB (involve community)

TB is the **1st OI in PLHIV**. Survival after TB diagnosis is higher if patient on ARV and delay of HIV testing in TB patients decreases the likelihood of getting ARV (MOAB0304 – 04/08/08). Thus there is a need to **scale-up HIV testing of TB patients** (experience of Rwanda: 80% of TB patients are tested for HIV) **and ARV access for co-infected patients**.

New publications from WHO on HIV and TB:
http://www.who.int/tb/challenges/hiv/en/index.html

X. Human resources & Health systems

A. HIV / Health System Strengthening

Lots of debates on HIV and health system. Clear commitment of Global Fund, PEPFAR and main Foundations to support health system, through "diagonal projects" and HRH reinforcement activities. Must yet be seen as "partners for consolidating health system and a part of the solution in the global health". On this topic, it was suggested to increase % of HIV projects' funds applied to "transversal health system needs" like HR.

To overtake debates between vertical/horizontal approaches: identify at national level priorities according to national public health issues (HIV mixing with other topics) and national health system constraints (especially HRH):"diagnostic approach" integrated into the national health plan (SUSAT 10; 03/08/08).

B. Task shifting strategy: a solution to the gaps in human resources for Health (HRH)?

A few interesting implementation strategies in Haiti, Malawi, Ethiopia…through task-shifting to share workload due to the epidemic, mainly from physicians to nurses (initiation of ART and follow-up of patients) and from nurses to community health workers (for counseling and testing)**. This new tasks' organization might enable physicians to concentrate on complicated cases and non-HIV tasks.** Unfortunately, little was discussed about how to integrate this strategy in the national protocols, i.e. how to convince MoH to delegate such medical acts to other HRH.

Interesting oral presentation and posters from Partners in Health (in link with Harvard Medical School), about their experience in Haiti, Malawi, Rwanda
http://www.pih.org/inforesources/Fact_sheets/IAS_2008_presentation_schedule.pdf
WHO guidelines on task-shifting (2008): http://www.who.int/healthsystems/TTR-TaskShifting.pdf

XI. Funding opportunities

A. The Global Fund (GF)

How to influence the Country Coordination Mechanism (CCM) at national levels?

- the CCM shall reflect country-centered approach ("know your epidemic, know your response")
- multi-stakeholder partnership: civil society, implementing partners, private sector… (but the GF recommends 40% of the members to be representatives of NGO)
- importance to be member of national CCM to have inputs included in the country proposal
- the GF recommends "two Principal Recipient-proposals": one from government, one from civil society.
- Non-CCM proposals: NGO can submit proposals apart from CCM if: non government in place, natural disaster, no relationship between government and civil society, especially on MSM, IDU…

See in annex a brief guide on CCM mechanism.

Link with sexual and reproductive health:

- Satellite Session organized by the Global Fund; 03/08/08:
- The GF is expecting more proposals linking HIV with reproductive health activities. Activities that are currently under-required for funding: sexual health counseling, condom promotion, sexual health for PLHIV, adolescent activities, SGBV, male involvement, male circumcision, FGM. These activities could be included in the 9th Round's proposals.

Priorities before Vienna according to Kazaktchine:

- Human rights for PLHIV
- Operational research (as an integral part of programs); up to 10% of the GF proposals
- Health system strengthening: "Aids funding will be part of the solution"
- Sustainability of the response (predictability and long-term funding).

B. DFID

- "New Aids strategy" (June 08). DFID supports integration of HIV in sexual and reproductive health and health system in general. "Aids and SRH complementary, not competitive". Recognizes inter-linkages between Aids and other health issues. Provides an opportunity to integrate services (ex: comprehensive PMTCT into ANC or HIV testing integrated in family planning consultations).
- 6 billions GBP for health system (to 2015) within a multi-sector approach. (SUSAT 37; 03/08/08).

C. GATES Foundation

- Several interventions of representatives from the Gates Foundation underline:
- focus on prevention ("with a full range of technics" = combination prevention)
- fight against stigma and criminalization of PLWHA ("remove legal barriers")
- inclusion of sexual education and HIV sensitization in education program
- needed reform of mechanisms' funding (role of UNAIDS?).

XII. Future directions

For the **Asia-Pacific region** (MOSY 1001 to MOSY 1004 – 04/04/08) focus on marginalized populations (MSM, SW); GBV in Papua New Guinea and Pacific islands; Human Rights; HCV co-infection and access to treatment. Next conference 9th ICAAP (9th-13th August 2009 in Bali, Indonesia; www.icaap9.org)

For Sub-Saharian Africa (MOSY04; 04/08/08): focus on children (12 M orphans and vulnerable children in the SSA region); implementation of adequate prevention programs (including male circumcision); emerging issues: MSM (with high prevalence rates: 33% in Zambia, 22% in Senegal); IDU (Kenya, Senegal…).

Increase Operational research.

Annex I - Notes from the reporters session (08/08/08)

Track A – Biology and Pathogenesis of HIV

Vaccine
Improvement of DNA as an AIDS vaccine with adjuvants (IL12, IL15 …) Boyer – Weiner
Specificities of CD8 during primary infection determine later level of virus Streeck
Long term non-progressors → Virus fitness, cell restriction factors, host immune system

Interactions between HIV and the host immune system
Role of the chornic immune activation favoring HIV disease progression (model of immune tissue in vitro) Lisco - Margolis
CD20 depletion in SIV infection African Green monkeys (Gaufin-Apetrel) – non-progressors
Co-pathogenis: GBV-C protects from HIV disease protection (Stapleton)
PD-1, TIM3 and the exhaustion of the HIV-specific T cell response (Conrad-Addo)

Track B – Clinical research, Treatment and Care

Messages
Rx works as long patients have access and stay on oit
LTU challenge
Accelerate ART to decrease mortality
Task-shifting
Infrastructure lack barrier for children Rx
Being Simple
Community involvement

Treatment outcomes
5 year survival in Botswana =almost 90% = early initiation, political commitment, partners implementation
LTF and mortality rates in the 1st year of HAART in Latin America – differences in programs (comorbidity, maturity)

Task-shifting
Less doctors, more nurses and community involvmement
Mozambique: increase of facilities providing ARV (WEAX0105)
Rwanda

New drugs
Few data
Altegravir - TUAB0102
PrEP (plenary session – Cohen)
d4T is still the most used therapy in Africa – 300 000 patients – challenge for options and monitoring
Malawi: resistance profile of NRTI 22 to 50% of patients have no efficient drug in their regimen
ABC and MI risk: increased risk of myocardial infarction (DAD study, GSK cohort, SMART study)

TB/HIV
THRio Cohort starting HAART early reduces risk of mortality
Pushing IPT ahead

HIV in children
Good outcomes – increased from 75000 to 200000 on ARV
Limited diagnosis by PCR

When to start therapy
Therapy for early infection
Limit the HIV-related inflammatory process
Better tolerated drugs
Impact on ARV scale-up, human resources and cost

Effect of HIV, Host and ARV
Development of cardio-vascular events and atherosclerosis – multifactorial (inflammation, immune activation etc.)

Scale-up
Challenging – chronic disease among poorest
Strenghtening PHC
Strengthening HIV programs can catalyze PHC programs

More operational research

Track C – Epidemiology, Prevention and Prevention Research

MSM
Increasing risk/incidence in challenging or hostile environnements (California CT, identification of MSM in Togo, cohort-based incicdence in Thai MSMestimates 5.1% incidence/year)
UK: affected by other STI disproportionately
HCV: prevalence increased in AMsterdam

Heterosexual
Most new infections in urban African cities – couple-based prevention methods (CT)
Concurrent partnerships variable
Risk of transmission higher for a woman with 32y vs 17y old

DU
British Columbia university IDU: HIV prevalence decreased
Iran 25%
Tanzania: 26%

Incidence surveillance
CDC incidence 56000 new infections in the US
Germany BED-based system
France IDE-V3 assay
WHO pre-meeting to reach consensus on the approach to be used

Interventions
Combination prevention approaches
Risk compensation with biomedical interventions (circumcision) → sustain behavior interventions
Criminalization (30% MSM access prevention services vs. 60% if not criminialized)
Scale-up PMTCT (eastern and southern Africa) – No adequate resources

Circumcision
Protection up to 42 months (incidence HIV rates)
Significant protection for HPV and Trichomonas
Maximum long-term impact: men less than 34y old
Barriers: social, cultural, religious, women

Vaccine/Microbicides
Rethink strategies towards next generations

New vectors – Neutralizing Abs
2 ongoing trials on microbicidies
Waiting for ARV- based microbicides

Behavior – MSM
E-animation in internet
Intervention for HIV positive (MOAC01)

Behavior – Heterosexual
Package social, biomedical and behavior for African American
School-based interventions
Microfinance in South Africa
Peer intervention for female condom

NSEP
Taiwan: 50% reduction HIV preval
NYC: IDU are more infected through sex

What is risk?
Risk of transmission variable (anal vs. vaginal, circumcision, STI)
Cross-generational partners
Concentrated epidemics: MSM underscored in many countries – law and Human rights implications (decrease stigma and help these groups to come out from the shade)
HIV transmission on ART low: regularly monitoring of therapy, lack of STIs, 100% adherence.
Lack of access to populations due to stigmatization and criminalization

Future: more data on MSM in unfavorable and hostile environments
Incidence – RCT for microbicides, PrEP and vaccines

Track D – Social, Behavioral and Economic Science

Vulnerability
Exclusion based on gender, ethnicity, sexual orientation, stigma
Structure, culture and individual
Need for innovation in program design – multidimensional approaches to prevention and care
Empowerment

Stigma
Social exclusion
Promote self-organization
Shifts in policy - Advocacy and empowerment
Confront stigma by new dimension adding emotional dimension

MSM
Continued denial, invisibility and social exclusion
Limited surveillance and inadequate prevention and care
Criminalization, human right violations
Address vulnerability and risk
Take into account diversity of MSM population

Transgender
Transgerdice – concerns different from MSM concerns
Increasing organazations Community-based

IDU
Contradictory laws, guidelines and practices (prejudice? Ideology?)
Evidence too little too late, wrongly focused
Need for greater integration of IDU → comprehensive package (TB, prevention, care)

SW
Empowerment

Gender and sexuality
Contextual elements
Evidence of changes in sexual relation ships among men and women
Need to see women not only as victims but also as autonomous sexual subjects
Recognize people with disabilities
Rights to PLH to sexual and RH services – legal and political advocacy

HIV Prevention
Increase investment
Politics matters as much as interventions
Biomedical behavior and structural strategis
More research
Circumcision debate (not sufficient alone)

Young people and children
Need to move beyond orphan crisis
Education to empower young people
Condom promotion to be scaled-up
SRH services and HIV care services for young PLH
Lack of consensus (needs, desire)

Scale-up
Universalising HIV prevention and care
Vertical vs. health systems development – false controversy – individualize health system weakness which impairs program implementation

Economic
Microfinance and poverty
Task-shifting
Role of International Health Partnerships

Mobile populations

Track E – Policy and Political Science

International responses & funding mechanisms
Increased but insufficient
Domestic contribution lags behind
Increase resource for both health systems and HIV – do not divert HIV funds
Crisis: investments for buidluing accountable governments rather than serve survivors

Multiple funding mechanisms
Multiple models to reach different communities (hard-to reach)
Technical support and tech support capacity building in the communities
A new UN agency for women

Accountability
Does not translate in concrete actions

Civil society should be more involved

Policy, analysis, implementation and evaluation
More evidence-based policies – Harm reduction not yet implemented (first PEPFAR)
Linkages with HIV programs and RH services – no additional resources for RH by PEPFAR
Lack of policy leadership
Incoherent policies on Harm Reduction
UNAIDS and SW wrong message: reducing SW rather than reducing HIV in SW
Violence to SW in DRC despite supportive policies
Violence against women in Zimbabwe due to political orientation
Legal support for policy engagement
Transnational networks – use of ITC

Human Rights
Focus on women's rights
Race and equalities
Corruption and AIDS not addressed
Violation of MSM rights
Attention to transgender and indigenous issues
Laws and regulations impeding access to prevention and care for certain populations
No indicators for Human rights compliance
Useless laws with no public health benefit which criminalize transmission, disclosure, beahaviors and practices, travel restrictions and residence
Civil society for universal access

Missing: Intellectual property and trade – missing in action?
Address societal attitudes to reduce stigma and discrimination
Provide legal services and improve access to justice
Address social inequalities

Youth programs

Visibility
Prevention
Partnership
Leadership
Human Rights