

XVI International AIDS Conference  
Toronto, Canada  
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HIV/AIDS Resources,  
Selected Topic Guides  
And  
Selected Session Summaries



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November 27, 2006

To the Loyola University Medical Center community:

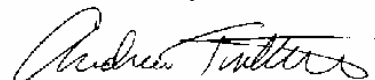
Through my work with Solidarity and Action Against the HIV Infection in India (SAATHI) and the financial support of the SSOM community and other sponsors, I was given the exciting opportunity to attend the XVI International AIDS Conference in August 2006 in Toronto, Canada. Over a one week period, over 24,000 clinicians, researchers, activists, governmental representatives, politicians and dignitaries from 170 countries converged on Toronto to meet, discuss, educate and share with one another ways to combat the HIV/AIDS epidemic on a global scale. This conference gave me the opportunity to learn about the latest advances in treatment and testing, the status of the HIV epidemic in various parts of the world and countless other topics that impact HIV care worldwide including nutrition, orphans and vulnerable children, faith-based responses, sex worker rights, indigenous and aboriginal populations, men who have sex with men, refugee and migrant populations, education and harm reduction programs.

Suddenly, I became aware of the vast complexity of the HIV epidemic on a global level. A problem that I once considered to be basically medical in nature became exceedingly complicated, involving politics, medicine, social justice, public health, business sectors, stigma, discrimination, basic science research and anthropology. The utter lack of basic human rights and access to treatment, prevention and testing that opened up before me when I talked to people living with HIV (PLWHA) left me speechless. The “human rights hostile” environment that many PLWHA shared with me was simply unimaginable.

Yet through all of this and 25 years into the epidemic, there were hints of hope. We continue to find medical and scientific advancements to prevent and treat HIV infection. Civil society continues to push national governments and the international community to strive for better access to prevention, care and treatment as well as other initiatives to improve the lives of PLWHA. One thing that has now become crystal clear is that amidst all the scientific breakthroughs, the HIV infection continues on and will not be defeated until the world addresses the stigma, discrimination and poverty that continues to this day and is intimately entwined in the HIV epidemic.

I would like to thank those in the SSOM community that have helped make my attendance in the conference possible. It is my hope that the summaries of sessions I have attended in addition to the resource of 86 reports, brochures, DVDs and CD-ROMs I have collected will be helpful to anyone interested in learning more about the HIV epidemic in the LUMC community.

Sincerely,



Andrew Trotter, Class of 2007  
Loyola University Chicago  
Stritch School of Medicine

Index of Terms:

ABC	Refers to a Prevention Strategy: Abstinence, Be faithful, use a Condom
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Clinic
ARV/ART	Antiretroviral drugs/Antiretroviral Therapy
CTL	Cytotoxic T cell
EU	European Union
GLBT	Gay, Lesbian, Bisexual and Transgender
HAART	Highly Active Antiretroviral Treatment
HIV	Human Immunodeficiency Virus
IDU	Intravenous Drug User
MMT	Methadone Maintenance Therapy
MMWR	Mortality and Morbidity Weekly Review (from the CDC)
MSM	Men who have Sex with Men
NACO	National AIDS Control Organization (India)
NEP	Needle Exchange Program
NGO	Non-Governmental Organization
OVC	Orphans and Vulnerable Children
PEPFAR	President's Emergency Plan For AIDS Relief (USA)
PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother To Child Transmission
PPTCT	Prevention of Parent To Child Transmission
STI	Sexually Transmitted Infection
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNDP	United Nations Development Program
UNESCO	United Nations Educational, Scientific and Cultural Organizations
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNHCR	United Nations Refugee Agency
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WFP	World Food Programme
WHO	World Health Organization

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\*\*\* Note: Each section of the resource is labeled A-O. Within the section, each item is labeled with a letter and number (ie C2, item number 2 in section C). Use this guide to locate each item within the appropriate section by its letter and number.

## Section A - China

A1: “China Population Today: Integrating HIV/AIDS Prevention with RH/FP Services.” 2006

A2: “China-UK HIV/AIDS Prevention and Care Project.” 2006.

## Section B - Civil Society Involvement

B1: [“Civil Society Perspective on TB/HIV” Public Health Watch and Treatment Action Group.](#)

## Section C - Clinical Guidelines and Scientific Publications:

C1: [“AIDS Vaccine Blueprint 2006: Actions to strengthen global research and development.” International AIDS Vaccine Initiative. 2006.](#)

C2: [“Finding your way: A guide to understanding ethical issues related to participation in clinical trials for preventive HIV vaccines.” International Council of AIDS Service Organizations and AIDS Vaccine Advocacy Coalition. 2005.](#)

C3: “HIV/AIDS surveillance data base.” CD-ROM. USAID and the US Census Bureau Population Division of International Programs Center. 2006

C4: [“New Approaches to HIV Prevention: Accelerating research and ensuring future access.” Global HIV Prevention Working Group. 2006](#)

C5: “The WHO public-health approach to ARV against HIV in resource-limited settings.” *Lancet* 368. August 5 2006

C6: [“WHO HIV Prevention and Treatment Guidelines.” CD-ROM. WHO. 2006](#)

C7: [“Working together to accelerate progress.” International AIDS Vaccine Initiative.](#)

## Section D - Faith-Based Response and Religious issues

D1: [“AIDS Related stigma - Thinking outside the box: The theological challenge” Ecumenical Advocacy Alliance and World Council of Churches. 2005.](#)

D2: “Faith based response to HIV and AIDS.” Faith in Action. 2006

D3: [“From faith to action: Strengthening family and community care for orphans and vulnerable children in Sub-Saharan Africa.” Firelight Foundation.](#)

D4: [“HIV, AIDS & Islam: Reflections based on compassion, responsibility and justice.” Positive Muslims.2004.](#)

D5: “Many clouds, little rain? - the global fund and local faith-based responses to HIV/AIDS.” Tearfund - Christian Action with the World’s Poor. 2005.

D6: [“Signs of Hope; Steps for Change.” CD-ROM. Ecumenical Advocacy Alliance. 2003.](#)

D7: [“Tearfund and partner HIV resources CD-ROM. Tearfund. 2006.](#)

D8: [“The Catholic Church’s Response to HIV/AIDS in Thailand.” Catholic Committee of HIV/AIDS of the Catholic Bishop’s Conference of Thailand.](#)

D9: [“What religious leaders can do about HIV/AIDS: Action for children and young people” UNICEF, UNAIDS, World Conferences of Religions for Peace.](#)

## Section E - General Organizational Reports:

E1: [“2006 Report on the global AIDS epidemic: A UNAIDS 10<sup>th</sup> anniversary special edition.” CD-ROM. UNAIDS. 2006](#)

E2: [“Alliance: Publications and Resources.” CD-ROM. International HIV/AIDS Alliance. 2006.](#)

E3: “Report on the global AIDS epidemic: Executive Summary.” UNAIDS. 2006

E4: [“Selected Publications of the Global Health Council.” CD-ROM. Global Health Council. 2006.](#)

E5: “Supporting Community Advocates on HIV and AIDS.” International Council of AIDS Service Organizations.” Annual Report 2005.

E6: [“The World Bank’s Global HIV/AIDS Program of Action.” World Bank. 2005](#)

E7: “UNAIDS Library.” CD-ROM. UNAIDS. 2005.

E8: [“UNESCO Library of materials on HIV and AIDS.” CD-ROM. United Nations Educational, Scientific and Cultural Organization. 2006.](#)

E9: “UNFPA Publications of HIV/AIDS 2006.” CD-ROM. United Nations Population Fund. 2006.

E10: [“What does it take to defeat disease?” Partners in Health 2004 Annual Report.](#)

E11: [Annual Report 2005 of the Global Fund to Fight AIDS, Tuberculosis and Malaria.](#)

E12: [United Nations Development Fund for Women \(UNIFEM\). Annual Report 2005-2006.](#)

E13: [XVI International AIDS Conference Abstracts. 2006](#)

## Section F - Human Rights

F1: “Human Rights and HIV/AIDS: Now More than Ever - 10 Reasons why human rights should occupy the center of the global AIDS struggle.” Law and Health Initiative of the Open Society Institute.

F2: Law and Human Rights Publications from UNAIDS.” UNAIDS.

F3: [“Reducing Vulnerability to HIV/AIDS.” CD-ROM. International Federation of Red Cross and Red Crescent Societies. 2006.](#)

F4: [“Understanding and Challenging HIV Stigma.” CD-ROM. International Center for Research on Women, Academy for Educational Development, USAID. January 2004.](#)

F5: “HIV and AIDS: Law, Ethics and Human Rights.” CD-ROM. UNAIDS, Canadian HIV/AIDS Legal Network. 2006.

F6: [“International Guidelines on HIV/AIDS and Human Rights.” Office of the United Nations High Commissioner for Human Rights. UNAIDS. 2002](#)

F7: [“Courting Rights: Case Studies in Litigating the Human Rights of People Living with HIV.” UNAIDS. Canadian HIV/AIDS Legal Network.](#)

F8: [“HIV/AIDS Stigma: Finding Solutions to Strengthen HIV/AIDS Programs.” International Center For Research on Women. 2006.](#)

## Section G - Indigenous and Aboriginal Populations

G1: [“Aboriginal and Islander Health Worker Journal.” July/August 2006](#)

G2: “Aboriginal and Islander Health Worker Journal.” September/October 2006.

G3: “Aboriginal peoples making the health system equitable.” National (Australian) Aboriginal Community Controlled Health Organization.

G4: “Aboriginal Readings.” Canadian Aboriginal AIDS Network.

G5: [“Creating environments that respect the privacy and confidentiality of Aboriginal people living with HIV/AIDS.” Canadian Aboriginal AIDS Network. 2006](#)

G6: “HIV/AIDS policy for aboriginal persons living with HIV/AIDS.” British Columbia Aboriginal HIV/AIDS Society.

G7: “Nine Lives: treatment stories of positive people.” Trust for Indigenous Culture and Health.

G8: “Our positive bodies: mapping our treatment, sharing our choices.” Trust for Indigenous Culture and Health.

## Section H - Intravenous Drug Users and Harm Reduction Programs

H1: [“Delivering HIV care and treatment for people who use drugs: Lessons from research and practice.” Open Society Institute. 2006.](#)

H2: [“Spreading the light of science: Guidelines on harm reduction related to IDU.” International Federation of Red Cross and Red Crescent Societies. 2003.](#)

H3: “The Sleeping Giant: A Day in the Life of a Needle Exchange Program.” CD/DVD. Ontario Needle Exchange Coordinating Committee. 2006.

## Section I - Organization Information

I1: [“AIDS Research Institute of University of California, San Francisco.”](#)

I2: [“Global Network of People Living with HIV/AIDS.”](#)

I3: [“Twinning Center: American International Health Alliance.”](#)

## Section J - Orphans and Vulnerable Children; Nutrition; Maternal-Child Health; Education

J1: [“A Call to Action - Children: The missing face of AIDS.” UNAIDS, UNICEF. 2006](#)

J2: [“Africa’s Orphaned and Vulnerable Generations: Children Affected by AIDS.” UNAIDS, UNICEF, PEPFAR. 2006.](#)

J3: "Education and HIV/AIDS: Window of Hope." DVD. The World Bank. 2006.

J4: "Guidelines for an integrated approach to the nutritional care of HIV infected children." WHO

J5: "HIV and Food Issues" - Fact sheets from the World Food Programme.

J6: "Literature review of the impact of education levels on HIV/AIDS prevalence rates." World Food Programme.

J7: "Making a difference in countries: Strategic approaches to improving maternal and newborn survival and health." WHO. 2006

J8: ["Missing Mothers: meeting the needs of children affected by AIDS." Save the Children Fund. 2006.](#)

J9: ["Preventing HIV/AIDS in Young People: A Systemic Review of the Evidence from Developing Countries." CD-ROM. WHO, UNAIDS, UNICEF, UNFPA. 2006](#)

J10: ["Save the Children: Policy Reports and Reference Documents." CD-ROM. Save the Children. 2006.](#)

J11: "Scaling up the response for children." UNICEF, UNAIDS, USAID, WHO. 2006

J12: "World Food Programme Portfolio of HIV/AIDS Publications." CD-ROM. World Food Programme.

## Section K - Prevention Strategies

K1: ["Standing Up for HIV Prevention." DVD. Face of AIDS - Global AIDS Film Archive. 2006](#)

## Section L - Refugee and Migrant Populations

L1: ["Fighting HIV/AIDS Together with Refugees." UNHCR.](#)

L2: ["PHAMIT: Prevention of HIV/AIDS Among Migrant Workers in Thailand." Prevention of HIV/AIDS Among Migrant Workers in Thailand \(PHAMIT\). 2005.](#)

L3: ["Strategies to support the HIV-related needs of refugees and host populations." UNAIDS and UNHCR.](#)

L4: “The Committee for Accessible AIDS Treatment (CAAT): Publications and Resources on HIV and Immigration.” CAAT. 2006.

L5: “Trucking Against AIDS: We care enough to act.” DVD. Sida and the National Bargaining Council for the Road Freight Industry. 2005.

## Section M - Scaling Up of Efforts and Funding:

M1: [“Funding the global fight against HIV/AIDS, Tuberculosis and Malaria.” The Global Fund to Fight AIDS, TB and Malaria. 2006.](#)

M2: “HIV/AIDS Laboratory capacity: How far we have come and where we are going.” WHO, Southern African HIV/AIDS Information Dissemination Service. 2005.

M3: [“Intensifying HIV Prevention: Key Principles, Policy and Programmatic Actions.” UNAIDS. 2005.](#)

M4: [“Intensifying HIV Prevention: UNAIDS policy position paper.” UNAIDS. 2005.](#)

M5: “Parliaments, Politics and AIDS: A comparative study of five African countries.” Idasa. 2006.

M6: “Scaling up access to HIV Prevention, treatment, care and support: The next steps.” UNAIDS. 2006.

M7: “The World Bank’s Global HIV/AIDS Program of Action.” CD-ROM. World Bank. 2005.

M8: “WHO consultation on technical and operational recommendations for scale-up of laboratory services and monitoring HIV antiretroviral therapy in resource-limited settings.” World Health Organization. 2004.

## Section N - South Asia and India

N1: [“Gaining Ground: accountability and delivering for women.” NACO and UNIFEM. 2006](#)

N2: [“MSM and HIV/AIDS risk in Asia: What is fueling the epidemic among MSM and how can it be stopped?” CD-ROM. Treat Asia and AMFAR. 2006](#)

N3: [“National AIDS Control Programme Brochures.” NACO. 2006.](#)

N4: [“No safety in numbers - AIDS inundates India.” Business & AIDS. 2006](#)

N5: “Reaching out to help PLWHA in India.” EngenderHealth. 2006

N6: [“SANKALP: International AIDS Vaccine Initiative India Newsletter.” International AIDS Vaccine Initiative.](#)

N7: [“Supporting community action on AIDS in India.” International HIV/AIDS Alliance in India.](#)

N8: [“Transformation across borders: Addressing HIV/AIDS in the Asia Pacific region.” UNDP. 2006](#)

N9: “Treat Asia: A cooperative approach to expanding capacity for the broader introduction of HIV/AIDS therapeutics in Asia and the Pacific.” AmFAR.

N10: [Hindustan latex Family Planning Promotion Trust: Partners for Better Health.](#)

N11: [“Socioeconomic Impact of HIV/AIDS in India.” NACO, NCAER and UNDP. 2005](#)

N12: [“Media Campaign on HIV/AIDS: NACO, Doordarshan and BBC World Service Trust.”](#)

N13: [“Reducing AIDS-Related Stigma and Discrimination in Indian Hospitals.” Horizons Program, Sharan, Institute of Economic Growth, Tata Institute of Social Sciences. 2006.](#)

N14: “Reducing Stigma and Discrimination in Hospitals: Positive Findings from India.” Horizons Program, Population Council, USAID. 2006

N15: [“Reducing HIV/AIDS Stigma, Discrimination and Gender Based Violence Among Health Care Providers in Andhra Pradesh, India.” International Center for Research on Women. 2006.](#)

## Section O - Universal Access:

O1: “People living with HIV leading the way toward universal access.” The Collaborative Fund for HIV Treatment and Preparedness.

O2: [“Progress on Global Access to HIV Antiretroviral Therapy: A report on ‘3 by 5’ and Beyond.” WHO and UNAIDS. 2006](#)

O3: [“Towards Universal Access by 2010: How WHO is strengthening health services to fight HIV/AIDS.” World Health Organization. 2006](#)

Section C  
Clinical Guidelines and Scientific Publications

Objectives:

- Review the current WHO guidelines of prevention and treatment of HIV
- Better understand the logistical, technical and ethical issues relating to AIDS vaccine development
- Identify all the HIV prevention methods currently being used or in development including cervical barriers, pre-exposure prophylaxis, male circumcision, microbicides and HIV vaccines
- Understand the need and relevance of resources and guidelines on how to manage and treat HIV in resource limited settings

Questions:

1. What are the basic principles of vaccine development and what characteristics of HIV present challenges to this process?
2. What strategies are being used to attempt to address the challenges to HIV vaccine development?
3. HIV vaccine trials require the participation of individuals at high risk for HIV infection, but the same factors that make them high risk for HIV infection also highlight the need to protect them from exploitation. What safeguards can be utilized that still allow them to participate in HIV vaccine trials?
4. What benefits and risks are involved in HIV vaccine development?
5. What trials have been undertaken to date that investigate all the methods of HIV prevention?
6. What are the WHO recommendations for ARV treatment in resource-limited settings and why are they necessary?
7. When working in resource limited settings, what responsibility do research institutions have to provide treatment and care to those who become HIV infected in their trial? For how long would they be responsible to provide treatment, if at all?

Further resources:

[International AIDS Vaccine Initiative](http://www.iavi.org)

www.iavi.org

[Gates Foundation](http://www.gatesfoundation.org)

www.gatesfoundation.org

[International Council of AIDS Service Organizations](http://www.icaso.org)

www.icaso.org

[HIV/AIDS Vaccines Ethics Group](http://www.saavi.org.za/haveg.htm)

www.saavi.org.za/haveg.htm

[AIDS Vaccine Advocacy Coalition](http://www.avac.org)

www.avac.org

[AIDS Vaccine Clearinghouse](http://www.aidsvaccineclearinghouse.org)

www.aidsvaccineclearinghouse.org

[World Health Organization](http://www.who.org)

www.who.org

Section D  
Faith Based Responses and Religious Issues

Objectives:

- To better understand faith based organizations in the context of the HIV epidemic and how they are advocating for increased involvement in HIV through reinterpretation of religious ideas
- To appreciate how faith based organizations are reevaluating the religious based standpoints that are used to increase stigma and discrimination of PLWHA

Questions:

1. In “AIDS related stigma,” the authors analyze the different conceptual bases of stigma of those living with HIV (see pages 3-5). Which of these ideas are major players in stigma and discrimination against PLWHA?
2. What role do you think religious organizations have to act on the issue of HIV/AIDS from a social justice standpoint?
3. Some of the publications stress the importance of approaching HIV/AIDS from a faith-based prospective, especially in places in the developing world. Why do you think this might be true? How do other related issues such as basic health care and poverty relate to HIV in areas such as these?
4. By surveying the materials in this section, it can be seen that these faith based organizations stress the issue of OVCs. Why do you think this is? Do you think other topics related to sexual behavior offer a more difficult subject for these organizations to confront?
5. Some faith based organizations are concerned that international funding organizations do not adequately fund faith based organizations. Why do you think that this may be? Considering that local faith based organizations can be very important to local responses (especially in the developing world), why do you think faith based organizations feel they are under funded?

Resources:

[The Tearfund](http://www.tearfund.org/hiv)

www.tearfund.org/hiv

[Ecumenical Advocacy Alliance](http://www.e-alliance.ch)

www.e-alliance.ch

[Catholic Committee on HIV/AIDS Under the Catholic Bishops Conference of Thailand](http://www.aidsatholic.com)

www.aidsatholic.com

[World Conference of Religious Organizations for Peace](http://www.religionsforpeace.org)

www.religionsforpeace.org

[Positive Muslims](http://www.positivemuslims.org.za)

www.positivemuslims.org.za

[World Council of Churches](http://www.wcc-coe.org)

www.wcc-coe.org

[The Firelight Foundation](http://www.firelightfoundation.org)

www.firelightfoundation.org

[Catholic AIDS Action](http://www.caa.org.na)

www.caa.org.na

[American Jewish World Service](http://www.ajws.org)

www.ajws.org

Section E  
General Organizational Reports

Objectives:

- Better appreciate the status of the HIV epidemic on the global scale
- Realize that as a global community we:
  - continue to fail to reach global goals on funding and targeted interventions (PMTCT, prevention, education, etc) as set by the United Nations Commitments (See 2006 Report of Global AIDS epidemic in this section).
  - still fail to intervene against the stigma and discrimination still pervasive in over thirty countries
  - fail at providing universal access to prevention, care and treatment
- Explore possible barriers to expanding access to care

Questions:

1. Access to prevention, care and treatment continues to be a major problem with less than twenty percent of IVDA, less than nine percent of MSM having access to prevention services, less than nine percent of pregnant women having access to PMTCT programs and less than twenty percent of PLWHA having access to ART worldwide. What factors do you think contribute to these shortfalls?
2. What do you think is the role of organizations that represent PLWHA? Why are they important?
3. Much funding originates from multilateral organizations such as those in this section. How much power do you think these outside organizations should have on the approach to HIV prevention, care and treatment in a specific country?
4. What unique approaches have groups like Partners In Health taken in approaching HIV and other infectious diseases as public health problems? How has it challenged the traditional approach to these problems?

Resources:

[UNAIDS](http://www.unaids.org)

www.unaids.org

[The World Bank](http://www.worldbank.org/AIDS)

www.worldbank.org/AIDS

[The Global Health Council](http://www.globalhealth.org)

www.globalhealth.org

[Partners In Health](http://www.pih.org)

www.pih.org

[International HIV/AIDS Alliance](http://www.aidsalliance.org)

www.aidsalliance.org

[The Global Fund to Fight AIDS,  
Tuberculosis and Malaria](http://www.theglobalfund.org)

www.theglobalfund.org

[International Council of AIDS Service  
Organizations](http://www.icaso.org)

www.icaso.org

Section F  
Human Rights

Objectives:

- Appreciate the human rights arguments for universal access to prevention, care and treatment and how they could be uniquely suited for an approach to the HIV epidemic
- Understand the role that stigma and discrimination has in separating HIV from other medical conditions and how the continued prominence of stigma and discrimination relates to basic human rights
- Understand how human rights violations could play a role in propagating stigma and discrimination against PLWHA

Questions:

1. In what ways do you think the field of human rights discourse could provide a unique framework in which to consider the HIV epidemic?
2. How do you think human rights violations and HIV/AIDS related stigma could be connected?
3. How do existing laws that create links between criminal penalties and groups at risk for HIV (ie penalties for injecting drug use, sex workers, MSM or transgendered individuals) constitute human right violations? How do these laws affect the risk of these individuals to contract HIV?
4. Discuss how these topics/groups of people could be considered in the realm of human rights?
  - gender inequality
  - harm reduction programs
  - access to affordable treatment
  - orphans and vulnerable children
  - recognition of GLBT rights
  - sex workers
  - discrimination
  - confidentiality of HIV status

Resources:

[Accion Ciudadana Contra el Sida \(Venezuela\)](http://www.accsi.org.ve)

www.accsi.org.ve

[AIDS Law Project \(South Africa\)](http://www.alp.org.za)

www.alp.org.za

[Canadian HIV/AIDS Legal Network](http://www.aidslaw.ca)

www.aidslaw.ca

[Health Action AIDS \(US\)](http://www.phrusa.org/campaigns/aids/index.html)

www.phrusa.org/campaigns/aids/index.html

[Human Rights Watch](http://www.hrw.org)

www.hrw.org

[Hungarian Civil Liberties Union](http://www.tasz.hu)

www.tasz.hu

[Lawyers Collective HIV/AIDS Unit \(India\)](http://www.lawyerscollective.org)

www.lawyerscollective.org

[Program on Int'l Health and Human Rights \(US\)](http://www.hsph.harvard.edu/pihhr/index.html)

www.hsph.harvard.edu/pihhr/index.html

[UK AIDS and Human Rights Project](http://www.aidsrightsproject.org.uk)

www.aidsrightsproject.org.uk

[Office of the UN High Commissioner for Human Rights](http://www.ohchr.org/english/issues/hiv/index.htm)

www.ohchr.org/english/issues/hiv/index.htm

Section H  
Intravenous Drug Users and Harm Reduction Programs

Objectives:

- Understand the basic epidemiology of intravenous drug use globally and how it interacts with the HIV epidemic
- Identify intravenous drug use as a risk factor for both HIV and other health problems including HCV
- Recognize harm reduction programs such as prevention education, needle exchange programs and methadone maintenance therapy as ways to reduce the health risks of IVDA
- Consider the possible reasons why the United States fails to identify harm reduction programs as valid and effective despite their acceptance by UNAIDS, EU, WHO and numerous other national and international organizations
- Consider the human rights aspects of harm reduction programs and advocating for those who are IVDA especially in settings such as prisons

Questions:

1. What is the epidemiology of IVDA and its intersection with the global HIV epidemic?
2. What are the components of harm reduction programs? What organizations accept harm reduction programs as legitimate and evidence based strategies to fight IVDA and its health consequences? Why do they accept the value of harm reduction programs?
3. What human rights issues are at stake with IVDA and the institution of harm reduction programs (see “Spreading the light of science”, pg 22)?
4. What are the justifications that harm reduction programs are cost effective (see pg 25)?
5. What is the interaction between IVDA and risk of co-infections with HCV, tuberculosis and HIV?
6. What role does pharmacokinetic and other drug-drug interactions play in IVDA who also take ARV?
7. How is adherence uniquely affected by IVDA who are on ART (see “Delivering HIV Care and Treatment. . . Chapter 1)?

Resources:

[International Federation of Red Cross and Red Crescent Societies](http://www.ifrc.org)

www.ifrc.org

[Australian National Council of Drugs](http://www.ancd.org.au)

www.ancd.org.au

[Open Society Institute](http://www.soros.org/harm-reduction)

www.soros.org/harm-reduction

[The Ontario Needle Exchange Coordinating Committee](http://www.ohtn.on.ca)

www.ohtn.on.ca

Section J

Orphans and Vulnerable Children; Nutrition; Maternal Child Health; Education

Objectives:

- Better appreciate the complex ways that children can be affected by the HIV epidemic whether or not they are HIV infected themselves
- Understand the devastating effect HIV has on children and why access to care and prevention is so important
- Understand the World Bank’s campaign entitled “education is the social vaccine to HIV”

Questions:

1. List and discuss some of the ways that the HIV infection can affect a child regardless of their own HIV status. Consider factors such as social issues, stigma, nutritional issues, development and access/quality of education.
2. What is meant by the World Bank’s view that “education is the social vaccine to HIV?” Do you agree with this view?
3. How are mothers and grandmothers affected by HIV and how does this impact the family as a whole?
4. What evidence is available about methods to prevent HIV infection among young people in developing countries?
5. What methods are being used and proposed to help scale up efforts concerning responding to the HIV infection in children?
6. What are the impacts of child headed households that result from the HIV epidemic? How do these households effect the socio-economic situation of the community?

Resources:

[UNICEF](http://www.unicef.org)

[www.unicef.org](http://www.unicef.org)

[WHO](http://www.who.int.org)

[www.who.int.org](http://www.who.int.org)

[Family Health International](http://www.fhi.org/en/HIVAIDS/index.htm)

<http://www.fhi.org/en/HIVAIDS/index.htm>

[World Food Program](http://www.wfp.org)

[www.wfp.org](http://www.wfp.org)

[Save the Children](http://www.savethechildren.org)

[www.savethechildren.org](http://www.savethechildren.org)

[World Bank](http://www.worldbank.org)

[www.worldbank.org](http://www.worldbank.org)

Section L  
Refugee and Migrant Populations

Objectives:

- Understand the dynamic and complex reasons why refugee and migrant populations are at risk for HIV infection
- Recognize migrant workers/truck drivers as a risk group that, although present in much of the world, are not targeted enough for HIV prevention and educational programs
- Better understand the unique socio-cultural situation of immigrant or migrant populations and how their situation requires targeted interventions to better serve them in terms of HIV prevention and education programs

Questions:

1. What factors do you think make migrant workers at increased risk of HIV infection?
2. What is the interaction between refugee crises and the HIV epidemic? How do these interact in unstable areas such as parts of sub-Saharan Africa?
3. In what ways are the United Nations and other global organizations attempting to address and stabilize the lives of refugee populations to minimize their risk for HIV infection?
4. In what ways can migrant workers be targeted for HIV prevention and education initiatives?
5. Explore some of the articles on the CAAT CD-ROM and identify immigrant populations that live in your community. What barriers exist in your community which might make it difficult to target these populations? Consider factors such as language, culture, religion, socio-economic status, citizenship status, ability to pay for services/ability to attain public aid for health care and educational level.
6. How can the barriers in question 5 be addressed in your community? Have they already? If so, how has this be accomplished?
7. Consider the role of peer community health care workers within an immigrant community where you live. Why are peer health care workers important in effectively implementing an HIV prevention or education program?

Resources:

[PHAMIT](http://www.phamit.org)  
www.phamit.org

[UNHCR](http://www.unhcr.org)  
www.unhcr.org

[UNAIDS](http://www.unaids.org)  
www.unaids.org

[Raks Thai Foundation](http://www.raksthai.org/eng/projects/project_aids.php)  
http://www.raksthai.org/eng/projects/project\_aids.php

Section M  
Scaling Up of Efforts and Funding

Objectives:

- Better appreciate the complex factors in play with the issue of poor access to prevention, care and treatment
- To explore the current attempts to increase access to basic laboratory services in order to fight HIV in resource poor settings
- Identify possible barriers to adequate funding of the HIV epidemic and the commitment to those funding goals

Questions:

1. Do you think it is ethically permissible to use a different set of clinical guidelines for diagnosis or treatment than what would be used in developed countries because of lack of laboratory or other ancillary services?
2. What is the role of rapid HIV testing in locations where there is limited access to blood testing methods? What are the pros and cons of rapid testing?
3. It is generally accepted that the UNAIDS/WHO guidelines in this section (see “Intensifying HIV Prevention”) are comprehensive. Do you agree? How feasible do you think they are in developing countries?
4. What evidence presented in the material in this chapter substantiates the success of scaling up of some projects in prevention and treatment? (see “Scaling up access to HIV prevention, treatment, care and support: The next steps”)
5. In the international community, what barriers exist in commitment and delivery of adequate funding of the HIV epidemic? What shortfalls have occurred in the past in this regard and why do you think they have occurred?
6. “Scaling up” requires interest and funding in established programs as well as a commitment to the eradication of the HIV infection. Why do you think there have been shortfalls in these areas? Do you think that there is a feeling amongst the general public and international community (especially in Europe and the United States) that the HIV epidemic is under control? How does this effect funding?

Resources:

[The World Bank](http://www.worldbank.org/AIDS)

www.worldbank.org/AIDS

[WHO-Africa](http://www.afro.who.int/AIDS)

www.afro.who.int/AIDS

[The Global Fund to Fight AIDS,  
Tuberculosis and Malaria](http://www.theglobalfund.org)

www.theglobalfund.org

[IDASA](http://www.idasa.org.za)

www.idasa.org.za

Objectives:

- Gain a better appreciation of the status of the HIV infection in South Asia and India
- Better understand how some groups such as women, migrant workers and MSM are being targeted, why they are considered at risk and the socio-cultural issues that make these groups at risk and more difficult to target with interventions
- Describe the ways in which media is being used to disseminate and educate people in India about prevention and treatment of HIV
- Recognize that although India is often sited as a growing economic power, organizations have made predictions about the detrimental effects of the HIV epidemic on the economy of India

Questions:

1. Now that you have an idea of the HIV epidemic in India and Asia, why do you think that the international community is not making it a priority? Why do you think there is so little publicity about the epidemic there?
2. How do you think socio-cultural factors play a role in allowing the epidemic to continue in the developing world (ie Asia and India)? How does gender inequality, social taboos and other cultural issues play a role? What strategies can be used to help address these important issues in a culturally sensitive manner?
3. What strategies are being used to expand services into rural India?
4. What are the socio-economic impacts of HIV on the economy of India? Are HIV affected households more likely to suffer economically because of the HIV epidemic and how can the government and civil society respond to help alleviate this issue?

Resources:

[National AIDS Control Organization,  
India](http://www.nacoonline.org)

www.nacoonline.org

[National Council for Applied  
Economics Research](http://www.ncaer.org)

www.ncaer.org

[AmFAR AIDS Research](http://www.amfar.org)

www.amfar.org

[UNIFEM](http://www.unifem.org)

www.unifem.org

[EngenderHealth](http://www.engenderhealth.org)

www.engenderhealth.org

[International AIDS Alliance in India](http://www.aidsalliance.org/india)

www.aidsalliance.org/india

[UNDP](http://www.undp.org)

www.undp.org

[BBC World Service Trust](http://www.bbcworldservicetrust.org)

www.bbcworldservicetrust.org

[Sharan Project](http://www.sharan.net)

www.sharan.net

Objectives:

- Appreciate the central problem that limited access to prevention (ie PMTCT), treatment (ARV) and care presents in fighting the global HIV epidemic
- Understand the major barriers to access to HIV services on a global scale and strategies to address these issues
- Understand the “3 by 5” approach of UNAIDS and the WHO on increasing global access to ARV and assess the success of the initiative with global statistics

Questions:

1. What strategies are being used to attempt to move towards global universal access to treatment and prevention services? Do you think universal access is feasible? Why or why not?
2. What role is the WHO taking in attempting to increase universal access?
3. How do health infrastructure issues contribute to the challenge of universal access?
4. Review the statistics and the percent of people receiving ARV presented in the UNAIDS/WHO report on “3 by 5” (O2). What do you think about the statistics? How far are we in terms of reaching universal access? What factors do you believe are preventing universal access?
5. Do you think greater involvement of people living with HIV is important to achieving universal access? What roles could they take in order to move towards universal access?
6. In what ways do you think politics on a local, domestic or international level has a role in helping or hindering the goals of universal access to prevention and care of HIV?
7. After reviewing the material in this section, what barriers still exist that is preventing universal access from becoming a reality?

Resources:

[World Health Organization](http://www.who.int/hiv)

[www.who.int/hiv](http://www.who.int/hiv)

[The Collaborative Fund for HIV Treatment Preparedness](http://www.hivcollaborativefund.org)

[www.hivcollaborativefund.org](http://www.hivcollaborativefund.org)

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### **Food and nutrition in care and treatment programs in developing countries**

Dr. Paul Farmer, Partners in Health, Harvard Medical School, USA

Leonard Palombi, Director of Drug Resource Enhancement Against AIDS and Malnutrition

Dr. Christine Nabiryo, Director of Projects and Planning of Uganda, Uganda

### **Changing the Future of Indigenous Peoples/Populations**

Yvonne Davis, University of New Mexico, USA

Dr. Clive Aspen, University of Auckland, Australia

### **Global PMTCT Programs**

Dr. Elaine Adams, International Center for AIDS Care and Treatment, Columbia University School of Public Health, USA

Dr. Max Bweupe, OB/GYN and PMTCT Coordinator in the Ministry of Health, Zambia

Dr. B Singh - Country experiences: Successful scaling up approaches in India

### **Emerging and Re-Emerging HIV epidemics among Gay and non-Gay identified MSM**

C. Caceres, University of Buenos Aires, Argentina

Dr. Ron Stall, Professor of Community and Behavior Health Sciences, University of Pittsburgh, USA

Frits van Griensven, CDC-Thai Research collaboration, USA

Othoman Mellouk, President, Assoc de Lutte Contre le Sida en Morocco, Morocco

## Taking Stock: Current Challenges in the Global Response

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Louise Binder, co-founder of the Canadian Treatment Action Council, Canada

### Chris Beyrer, USA

- Ukraine has largest number of IDU in Europe
- In Ukraine, the goal is harm reduction - counseling, needle exchange programs and methadone replacement programs
- African American MSM in US have high rates of STI/syphilis, low testing rates and low knowledge of HIV status, but yet studies show that they do not take part in any more risky behavior either in type or frequency then Caucasian counterparts
- <10% of MSM worldwide have access to care and treatment services

### Julie Overbaugh, USA

- there are interactions between host factors and HIV
- non-modifiable risk factors - CCR5 cell receptor as a cofactor in infection pathogenesis. One identified mutation CCR5 $\Delta$ 52 mutation that confers to immunity to most strains of HIV-1
- modifiable risk factors - presence of STI, male circumcision, oral contraceptives in females (controversial)
- Innate antiviral factors are proteins that block viral infection intracellularly (TRIM5 alpha, APOBEC3G)
- Questions related to superinfection in HIV-1 - how common is it? Can an established CTL/Antibody response from an initial infection help prevent later superinfection?

### Viral factors in pathogenesis

- high viral load confers increased risk of infection in heterosexual contact and mother to child transmission
- A question now: How important is cell-free viral load?
- Questions of how virus self selection is accomplished - many times an individual is exposed to many strains in one exposure, what makes one strain the infecting strain and not others?

### Anand Grover, India

- Cartesian idea of health - there is either healthy or unhealthy. This has impact on employment because an employer's subjective judgment of health determines if someone is able to be employed

### Idea of Opt-out routine testing:

- standard now is VCT
- in Botswana, there is active protest against opt out testing because there is little pretest counseling and a minimal consent requirement
- Proponents say: now that treatment is available opt-out routine testing is acceptable; pretest counseling common in VCT is resource consuming
- Opponents say: since opt out testing assumes universality of all patients, all patients must be tested and treated the same (which in reality does not happen); opt out testing has minimal consent (a basic human right), it assumes incorrectly that the doctor-patient relationship is equal; there is little pretest counseling which is important in a time when HIV has become a chronic disease
- Stigma with HIV is a way for people/governments to not do the right thing, we need education to decrease stigma.
- We mistakenly stress some groups as “vulnerable populations” (IDU, MSM, sex workers) when race, ethnicity, poverty and class are also important
- examples are African Americans in the US and prisoners (no access to condoms)
- 50% of ARVs in the developing world come from India, but yet only about 10% of Indians have access to treatment
- US trade reps and Pharmaceutical lobby is pushing for patent law in India to be more like patent law in the US – this would result in more expensive drugs in India
- This challenges the sovereignty of a foreign country and affects human rights

### **Hot Topics in Human Rights and HIV/AIDS**

#### Panelists:

Fatima Hassan, South Africa

Sunil Pant, Nepal, Founder of the Blue Diamond Society

Kayan Kayal, Thailand

Jon Amon, US, Human Rights Watch

Fatima Hassan, South Africa: The contribution of human rights activists to access to HIV treatment in South Africa

- 1998 was the first call in South Africa for PMTCT
- some amount of irrationality on the part of the Pharmaceutical industry in South Africa - required challenges of patents and strategic litigation to decrease prices
- national civil disobedience activism
- struggle still today that the government still refuses to challenge Pharmaceutical industry, with drugs still being expensive

Jon Amin, USA - Overview of human rights violations fueling the HIV epidemic

- activists continue to push for changes today, but governments are not changing
- many of these issues have been there since the beginning of the epidemic

- a sense of denial at UNGASS - US could not commit to meeting established targets; Islamic council could not agree to list vulnerable populations in declaration

Sunil Pant, Nepal - Fighting AIDS in rights-hostile environment: The case of Nepal

- There were initial demands for a group addressing GLBT issues in Nepal in 2001, the same year of the massacre of the Royal Family
- there is decreased education and employment because of exclusion of GLBT youth from school and jobs
- Many of the peer educators from our group were harassed, attempted murder took place with no investigation by the government or police
- in 2004, 34 educators were jailed for 2 weeks with no legal recourse
- continued discrimination of GLBT individuals in health care
- as a result of stigma, many HIV patients present at late stages of AIDS (high morbidity and mortality)
- need support to promote better health
- education of the community and health care workers
- HIV and GLBT not considered part of human rights in Nepal

Kayan Kayal, Thailand - Protecting the rights of IDU is essential to universal access

- in Thailand it is essential to include PLWHA for human rights advocacy
- however, it is dangerous to stand up publicly as a PLWHA

### **Oral Presentation: Sexual Networking and HIV risk in Migrant Workers in India**

L Gelmon, K Singh, P Singh, P Bhattacharjee, S Moses, A Costigan, J Blanchard

- Networking studies across 133 villages
- Used focus groups, polling groups and surveys
- questions were targeted at eliciting participant's perceptions
- found high rates of sexual networking in migrants as well as their home communities
- Migrant situation: migrants took their sexual behaviors to other communities that had high HIV/AIDS rates; it was NOT true that migrants were at higher risk necessarily because of increased risk behaviors when compared to their home communities

### **Scaling Up HIV Prevention in the Context of Universal Access**

Speakers:

Michel Sidibe, Director of Country and Regional Support, UNAIDS

Dr. Carol Jacobs, Chair of the Global Fund for HIV, TB and Malaria

Professor Ruth Nduati, Assoc Prof of Pediatrics, University of Nairobi, Kenya

Ashok Alexander, Director of Avahan Project of the Gates Foundation, India

Dr. Zunyou Wu, Dir of National AIDS Control and Prevention Program, China

Dr. Geeta Rao Gupta, International Center for Research in Women

Carlos Passerelli, Brazilian STD/AIDS Programme, Brazil

Michel Sidibe, Director of Country and Regional Support, UNAIDS

- Worldwide, for every one person getting treatment, 10 are newly infected
- Worldwide, about 50% of new infections are women, in parts of Africa this exceeds 75%
- stress on sustainability of response
- when planning targets, scaling up needs to be exponential instead of linear

Key Obstacles:

- Credible and evidence based national AIDS programs funded and implemented by national governments
- Strengthening policy and programming in AIDS and reproductive health
- Deal with stigma and discrimination against PLWHA
- Eliminate gender inequality

Dr. Carol Jacobs, Chair of the Global Fund for HIV, TB and Malaria

Scaling Up in the Caribbean Region

- 1.6 million living with HIV in 2005 in the Caribbean region
- high level commitment by the government
- focus on youth and other vulnerable populations (IDU, sex workers, prisoners, MSM, mobile populations, young women, OVC)
- focus on stigma and discrimination
- partnerships with faith based organizations which is important for eliminating stigma and discrimination
- create open dialogue of gender roles, vulnerabilities; lobby governments to make legal changes that help these populations
- strengthen international and regional cooperation

Professor Ruth Nduati, Assoc Prof of Pediatrics, University of Nairobi, Kenya

- Kenya's population about 30 million, > 2.5 million infected since 1984, 1.5 million have died of AIDS
- During this time life expectancy has decreased by 20 years
- Annually, about 90,000 children are born to HIV + mothers, about 50,000 are infected themselves
- >1 million children under age of 15 y/o have been orphaned
- Available interventions include ART, prophylaxis against opportunistic infections, treatment, counseling, prevention and nutritional support
- Policy changes that need to occur - prevention of HIV, access to HIV testing, increased access to ARV and long term care
- Now: 1,000 PMTCT sites, >700 VCT sites, 280 Adult ARV sites, 76 pediatric ARV sites
- Current policy on testing: requires competency, >18 y/o
- Children become complicated because of guardianship questions, since many children are taken care of by non-related guardians; if child is >10 y/o agreement to testing is required by the child
- children's early access to care is important to decrease morbidity and mortality

- there are adverse outcomes to testing - one study showed that when domestic violence is already present, there is a 4-5 times increase in incidence of violence

Ashok Alexander, Director of Avahan Project of the Gates Foundation, India

- works with IDUs, MSM, sex workers in six states
- Obstacles have included: lack of large scale programs, focus on high risk and geographical orientation, no systemic monetary or quality assurance of programs, significant gaps in services
- focused prevention but must be integrated with advocacy, communication and capacity building
- importance of mobilizing the community
- Ways to address challenges - must make programs sustainable, focus on areas that have the greatest impact, implementation of standards with a common minimal standard for programs along with intensive support for partners

Dr. Zunyou Wu, Dir of National AIDS Control and Prevention Program, China

- IDUs account for 39% of reported new HIV cases in China
- in 2005, there were 70,000 new cases
- Goals for programs:
  - Access to urban MMT programs (2007 to 2010): >40% to 70%
  - Access to needle exchange programs (2007 to 2010): >30% to >50%
- now there are 101 MMT programs in 22 provinces with daily visits up to 486/day in some clinics
- interventions shown to reduce drop out include group activities, entertainment and lectures

Dr. Geeta Rao Gupta, International Center for Research in Women

- Gender inequality and power
- Women need to:
  - control own sexual actions
  - recognize partner's sexual actions
  - have access to products and services
  - have economic security and services
  - be safe and have freedom from fear
  - live in a supportive legal environment

Key principles to move ahead:

- Identify strategic opportunities to intervene
- use whatever strategy seems most feasible (not every possible one)
- process is as important as context and can create context for empowerment of women
- doing something is better than nothing
- monitor outcomes and build on these with sustained motivation

Carlos Passerelli, Brazilian STD/AIDS Programme, Brazil

- Cultural diversities and their impact on scaling up treatment

- universality, equity and ability to integrate
- real goals of scaling up - planning on acquisition of 1 billion male condoms (1/4 of the world's production) and 6 million female condoms

### **Gender, Culture and Male Sexual Identities: Implications for HIV/STI Prevention** EngenderHealth

Mokgethi Tshabalala, South Africa

- problems of gender based violence and gender equality still a problem in South Africa
- related to gender norms, sexual identity of men
- Men As Partners program volunteers were assumed gay in community because educators started to challenge established gender norms
- homophobic remarks were common
- studied "forced choice elicited values" - where participants were forced to make value based choices
- found that it was common for responses to be related to religion and culture, but that homophobia was linked to sexism and racism

Gary Barker, Instituto Promundo, Brazil ([www.promundo.org.br](http://www.promundo.org.br))

- areas of Rio de Janeiro called *favelas* - low income areas with strong influence of drugs; 70% of young men had no primary education
- In these areas male identity and masculinity linked to multiple sexual partners and gender based violence; manhood=working + heterosexual affirmations
- However, found 6% of 15-59 y/o reported sex with man at least once in life
- Racial aspect - common view that whites can be gay but not Africans
- Gay slurs were used against those not conforming to the accepted male identity - those that were cheated on by a female or those who were still virgins
- fear of gay by association with gay friends
- 1/3 of parents do not want their children to have gay classmates
- 1/4 of students expressed the same view
- 64% of gay youth reported experience with some sort of discrimination
- hypothesis that less stress on male identity with its association with many heterosexual partners and high degree of gender inequality could decrease rates of STIs and HIV

Ale Trossero, International Planned Parenthood Federation, United Kingdom

- work with MSM in Columbia has shown that different approaches need to be used to target men who identify as gay versus those that do not but are MSM

Phillip Banks, AIDS Vancouver Director of HIV Prevention and Awareness, Canada

- Importance of social programming in the gay community to decrease vulnerability to STI/HIV
- In Vancouver, have seen an 4x increase in syphilis from 2002-2006

Gary Dowsett, ([www.latrobe.edu.au](http://www.latrobe.edu.au))

- importance of epidemiological linking MSM with the recognition that their partners may be primarily heterosexual
- power issues that take place between men and men, women and women and men and women
- impact of HIV – GLBT liberation movement’s goal was initially for all people to be able to enjoy whatever sexuality they wanted. But HIV forced gay community into defensive position that galvanized it to create its own identity. Initially it wanted to be integrated into mainstream culture, but instead it became separated

### **Prevention: Proven Approaches and New Technologies**

Dr. Cristina Pimenta, past executive director of Brazilian Interdisciplinary AIDS Assoc, Brazil

Dr. Gita Ramjee, Director of South African Medical Research Council HIV/AIDS Programme, South Africa

Dr. Francoise Barre-Sinoussi, Dir of the retrovirus biology unit of the Institut Pasteur, France

Dr. Alex Wodak, Dir of the Alcohol & drug service of St. Vincent’s Hospital, Australia

Dr. Cristina Pimenta - Conceptual frameworks and HIV/AIDS prevention paradigms

- In Brazil, 90% of MSM get preventative services, but <20% of IDU do and 9% of pregnant women access services for HIV prevention
- HIV research requires complex interdisciplinary approach
- Several determinants of social vulnerability - poor social or economic status and special vulnerabilities of young men and women (esp women with little power - violence is common and little control over sexual rights)
- Intersection of structural inequality with gender, culture, social factors, stigma and discrimination
- Challenges include critical reflection and collaborative empowerment and combating stigma and discrimination related to sexuality, HIV, TB, malaria through solidarity and social mobilization
- Approaches: address structural and physical violence, interactions of poverty, urban violence and HIV, considering gender interactions not just gender roles and prevention targeted at traditional risk groups and the general public
- We are all living with HIV/AIDS, whether we are infected or not - recognize the complex social, cultural and economic factors

Dr. Gita Ramjee - Microbicides and other prevention technologies

- HIV prevention include a diverse set of potential tools - VCT, STI prevention and treatment, ABC, treatment and testing, microbicides, vaginal diaphragm, exposure prophylaxis, male circumcision, HSV-2 suppressive therapy and vaccine
- Microbicides as a way to give women power since they are women initiated. There have been some compelling recent research to support this option

- Mechanism of action of microbicides - physical barrier, prevention of STIs, viral disruption to decrease adherence to epithelium, fusion attachment inhibitor actions
- Types of microbicides include acid buffers, entry inhibitors, surfactants and ARV containing products
- Target properties include high anti-HIV activity, low toxicity, high activity against other STIs and the option of contraceptive and non-contraceptive formulations
- Trials underway now include phase IIB and III in sub-Saharan Africa, India and Philadelphia
- Male circumcision has recently been shown to decrease HIV transmission - theoretical mechanism is via removal of target cells of HIV in the foreskin and keratinization of the skin surface.
- Challenges to prevention strategies include:
  1. Lack of biological markers of protection
  2. Adherence of product use (usually self-reported, adherence hard to control for in studies)
  3. Problems related to study design - pregnancy causes patients to drop out of study making it hard for the study to have sufficient power
  4. Recent controversy in the field of ethics and the proper standard of care

Dr. Francoise Barre-Sinoussi, Dynamics of HIV/AIDS vaccine research: From dream and nightmare to reality and hope

- 1987- first phase I trial of a vaccine
- Since then 85 phase I trials have been conducted
- 2003 - First phase III efficacy trial that showed lack of efficacy of gp120 target
- Goals of vaccine - produces a broadly cross reactive immune response, with long lasting T cell response
- Potential targets include recombinant proteins (gp120, gp160, ref, tat), viral vectors (adenovirus, poxvirus, measles virus, alpha virus), DNA (env, gag, rev)
- Scientific gaps include:
  1. lack of knowledge of mechanisms of protection
  2. no new immunological concepts to apply to HIV
  3. Insufficient knowledge of crosstalk of innate and adaptive immunity
- New advancements:
  - resistance seems to be related to activity of early TGF beta, smad 4, FoxP3
  - what is the role of natural killer cell response?
- vaccine candidates must target early pathogenic signals that are activated in response to HIV
- Specific interest now in novel treatment modalities and gene silencing

Dr. Alex Wodak - Global Harm Reduction efforts to control HIV among IDUs

- IDU account for 1/10 of new global HIV infections
- generalized epidemics have started as IDU mini-epidemics
- IDU is common in 144 countries, and 128/144 of those countries now have HIV in their IDU populations
- How to control IDU = “harm reduction”

1. Education - peer based, simple
  2. Needle exchange programs
  3. Substitution therapy (ie MMT) - has been shown to increase ARV adherence
  4. Community programs addressing IDU
- Harm reduction:
    - is especially important in closed populations (prisons)
    - needs realistic goals (25% of a change is better than no change)
    - opposed by USA
    - accepted by UNAIDS, WHO, UNICEF, World Bank and International Red Cross
    - All of European Union countries have NEP and MMT programs
  - Barriers to harm reduction implementation
    - excessive reliance on drug law enforcement
    - no legal measures have ever been quantitatively shown to decrease IDU; instead it has been shown to increase IDU

### **Advancing Treatment and Universal Access: A Report on State-of-the-Art Progress**

Dr. Julio Montaner, Canada

Dr. Ruth Nduati, Assoc Prof of Pediatrics University of Nairobi, Kenya

Dr. Agnes Binagwaho, Executive Secretary of Rwanda's National ADIS Control Commission, Rwanda

Dr. Kevin De Cock, Director of the WHO Dept of HIV/AIDS

Dr. Julio Montaner - Re-evaluation of the cost-effectiveness of HAART - The case for expanding treatment access to curb the growth of the epidemic

- Key consensus of WHO guidelines in resource-poor settings and common clinical practice:
  1. Symptomatic, any CD4 count - treat
  2. Asymptomatic: <200 - treat; 200-350 consider individually; >350 defer treatment
- key aspect to initiating treatment - ability of patient to commit to treatment regimen
- Practical advancements in treatment
  - new LPV/rtv - now heat stable
  - SQV - more compact 500 mg tab
  - ENF - needle free gas injection available
  - New second line drugs - tipranavir/rtv; darunavir (a large number in development)
  - 90% of ARV drugs are used in the North; globally about 10% have access to ARV
  - studies have proven universal efficacy of HAART across all countries, race, ethnicity
  - PMTCT can be reduced from 25% to <1% with modern HAART
  - In discordant couples, there is increased transmission with one partner not on HAART versus if they have HAART (Castilla et al JAIDS 2005)
  - A study in British Columbia has shown that HAART is cost effective

- Challenges of HAART expansion
  - Resistance
  - Toxicity
  - Individual rights issues
  - Logistics
  - Hidden Epidemics
- Conclusions:
  - HAART has evolved dramatically over last decade
  - HAART is cost effective

#### Dr. Ruth Nduati - Children and AIDS

- Children account for 14% of new world cases of HIV
- Children account for 5.6% of PLWHA
- Estimated 14 million orphans resulting from HIV by end of 2005
- 5 year mortality of children living with HIV
  - 41% in sub-Saharan Africa
  - 38% Southeast Asia
  - 21% Rest of the world
- Mortality of children living with HIV is 21 times higher in Africa than in developed countries
- Without ARV there is rapid sickness and mortality of children
  - 35.2% mortality without treatment by 1 y/o
  - 52.5% mortality without treatment by 2 y/o
- A study in Zambia has shown the cotrimazole decreases mortality by 43% with 19 month treatment
- Children are capable of good adherence (Wamalwa et al 2006)
  - 87% full compliance
  - 19% serious non-adherence
  - 33% some degree of non compliance
  - the largest factor that correlated with non-adherence was conflict between parents
- Malnutrition is an independent predictor of mortality and morbidity in HIV + children (Fontanat et al 1999)
- 25 years into the HIV epidemic:
  - <10% of pregnant women get PMTCT (600,000 infected annually)
  - <10% OVC receive public support or services
  - <33% in Sub-Saharan Africa between 15-24 y/o understand how to protect themselves from HIV
- Routine offering of HIV testing is important to offer pregnant women and babies, since late treatment of children can greatly increase mortality/morbidity

Dr. Agnes Binagwaho - Prevention and universal access: An issue of sustainability

- In Rwanda
  - poverty rate 55%
  - Literacy rate 49%
  - Life expectancy 49 years
- Across all of sub-Saharan Africa:
  - 57% of infected adults are women
  - 75% of HIV positive people <25 y/o are women
- regional and international frameworks of coordination and action are needed because HIV does not respect borders
- Nutrition component of treatment is extremely underfunded

Dr. Kevin De Cock - From “3 by 5” to universal access

- 6.8 million people in mid to low income countries on ARV
- 24% coverage average worldwide: 3% in some parts of Africa to 75% in Caribbean and Latin America
- sub-Saharan Africa accounts for 70% of current ARV need
- Children’s access to ARV (June 2006): Africa 8%; Latin America 8%; Asia 5%
- Studies have shown 75% lower mortality in 1 year with free (ie no cost to patient) ARV
- Requirements for universal access
  - Expanding testing and counseling
  - Maximize prevention
  - Maximize scaling up efforts
  - Strengthening of health system

### **Food and nutrition in care and treatment programs in developing countries**

Speakers:

Dr. Paul Farmer, Partners in Health, Harvard Medical School, US

- Cannot cure TB/HIV without proper nutrition
- proper nutrition improves compliance to ARV treatment
- Study in Haiti showed that household income was used for:
  - 48% spent 50% of income on food
  - 15% spent 100% of income on food
  - 18% spent <50% on food
  - Most commonly do not eat regular meals
- Need to increase these “wrap-around services” - food, water, primary school fees
- Breast feeding debate boils down to two viewpoints:
  - agency/choice (mothers have the choice to breast feed); HIV positive mothers make a choice to breast feed
  - poverty/inequity - of course, mother does not have choice in the matter, they must breast feed because they do not have money for alternatives

Leonard Palombi, Director of Drug Resource Enhancement Against AIDS and Malnutrition

- Increased need for nutrition in HIV positive individuals because of:
  - increased oxidative stress
  - increased metabolic demands from infection
  - malabsorption because of opportunistic infections

Dr. Christine Nabiryo, Director of Projects and Planning of Uganda, Uganda

- Uganda - 24 million population
- ARV started in 2004
- Basic care package includes: counseling, testing, sensitization and treatment
- Crucial to advocate for food in relation to ARV - children NEED FOOD, not just the primary patient or else they will just give the food to their children
- Need strategies of exit programming to encourage them to become self-sufficient once on a food assistance program
- Lessons learned that Nutritional support:
  - Key of family based model to social context
  - Foster adherence to ART
  - Promotes community participation
- Challenges:
  - High demand for food
  - Inability to wean off of food program once enrolled secondary to sickness
  - Need to address underlying poverty

### **Changing the Future of Indigenous Peoples/Populations**

Speakers:

Yvonne Davis, University of New Mexico, US

Dr. Clive Aspen, University of Auckland, Australia

Yvonne Davis - Advancing HIV/AIDS prevention in indigenous communities

- need for collaborative models to include indigenous populations
- inclusion of traditional indigenous medical treatments especially with HIV
- enhance partnerships with other indigenous populations in the world
- Social factors impact HIV response in indigenous populations:
  - stigma
  - distrust of health system because of legacy of colonialism
  - sexual violence

Dr. Clive Aspen - Reconciling academic/scientific priorities with indigenous HIV/AIDS realities

- Indigenous populations popularly portrayed as weak, deprived, infirm, uncivilized, in need of beneficence of (Western) civilization
- Need for research in indigenous populations, but requires:

- research reflects their genuine needs
- collaboration with the community under study
- need for ethical approval
- needs to lead to community benefit
- outcomes need to make a difference
- HIV/AIDS in indigenous populations
  - disproportionate burden on indigenous populations
  - poor data causes poor account of impact of HIV
  - in general indigenous people have poorer health than others

\*\*\*CANADA - aboriginal people make up 6% of population, BUT account for about 20% of new HIV cases\*\*\*\*

Lessons:

- indigenous control over indigenous health
- more indigenous leadership needed
- consolidation of international networks of indigenous populations

### **Global PMTCT Programs**

Speakers:

Dr. Elaine Adams, International Center for AIDS Care and Treatment, Columbia University School of Public Health, USA

Dr. Max Bweupe, OB/GYN and PMTCT Coordinator in the Ministry of Health, Zambia

Dr. B Singh - Country experiences: Successful schooling up approaches in India

Dr. Elaine Adams - Current scientific evidence and programmatic experiences in PMTCT: Scenarios for achieving the global goal of eliminating HIV/AIDS in children

- Heavy burden of HIV in children - 12.5 million HIV positive children live in developing countries
- Women take central role because they are central to community, family and caregiving
- Notable successes of PMTCT
  - initial success were in high resource settings
  - now occurring more in moderate-resource settings
  - still lacking in resource-poor settings
- Challenges:
  - <10% of pregnant women worldwide have access to PMTCT
  - single dose nevirapine used which has been shown to increase resistance and has limited efficacy; also associated hepatotoxicity
  - poor follow up after delivery of child
  - minimal outcome data available
  - Primary treatment of mother's HIV is eclipsed by PMTCT

- Women with high viral loads, low CD4 counts or are symptomatic, have increased risk of mother to child transmission antenatally, peripartum and postpartum (breast feeding)
- many PMTCT programs in existence in developing world do not have the infrastructure to accommodate complex ARV, they use single therapy
- Now MTCT (+) initiative has combined PMTCT, ANC and ARV
- Need to transfer from nevirapine to HAART

Dr. Max Bweupe - Country experiences: Successful scaling up approaches in Zambia

- Zambia's population 11 million
- 500,000 births/year
- HIV prevalence in women is about 19%
- baseline MTCT is about 40% without treatment in some areas of Zambia; reach about 25% in areas where pregnant women have access to PMTCT services
- extensive collaboration with UNICEF, Global Fund, PEPFAR

Challenges:

- need decentralized approach which is integrated with other health services
- the influx of many partnering organizations has caused some complication, need to be coordinated
- duplication of cost and resources in some areas
- data capture is challenging
- areas with human resources deficits
- in context of PMTCT programs, children after birth are inadequately covered

Dr. B Singh - Country experiences: Successful schooling up approaches in India

- in India PMTCT=PPTCT (Prevention of Parent To Child Transmission) stresses role of both parents!
- In India - 25% of population below poverty level; about 70% of population is rural; about 40% of births occur in institutions
- about 65.1% of women get some type of ANC; women and girls account for 39% of PLWHA
- Services in place include:
  - ANC, group education, institutional based birth services
  - pretest and posttest counseling
  - other care and support services
- Challenges
  - Low coverage, especially in rural areas
  - Quality control issues with services and programs
  - infant feeding programs have presented challenges in implementation
  - need to involve the private sector

## **Emerging and Re-Emerging HIV epidemics among Gay and non-Gay identified MSM**

C. Caceres, University of Buenos Aires, Argentina

Ron Stall, Professor University of Pittsburgh, US

Frits van Griensven, CDC-Thai Research collaboration, US

Othoman Mellouk, President, Assoc de Lutte Contre le Sida en Morocco, Morocco

C. Caceres - Global overview of HIV prevalence and risk behaviors among MSM in low and middle income countries

- Current estimates of HIV prevalence in MSM populations
  - South America 24%
  - Southeast Asia and Pacific 33%
  - Latin America 10-20%
- Challenges to study MSM
  - Overall, limited amount of data on MSM
  - stigma makes challenges for research, let alone prevention and treatment
  - research must seek to protect study subjects from stigma not expose them to it

Ron Stall – Re-emerging HIV epidemics among MSM in the United States and other industrialized nations: Evidence and insight

- Risk factors for MSM that increase risk of HIV infection
  - substance use (Seattle) - prevalence in those who abuse: Methamphetamines (42%); Poppers (47%), Viagra (21%); Ecstasy (16%)
  - Race: 2001 MMWR, - African American MSM 23-29 y/o prevalence 15%; 2005 MMWR prevalence of HIV in MSM: African American (46%); White (21%); Multiracial (19%); Hispanic (17%)
- Conclusions:
  - Contribution of stigma and discrimination makes African Americans have a very high HIV prevalence rate
  - Risk factors include race and substance use but there have not been any PROVEN interventions
- Recommendations
  - Need extensive surveillance of HIV rates
  - Use social justice framework to guide future funding

Frits van Griensven - Recognizing and confronting the epidemic of HIV among MSM in southeast Asia

- Southeast Asia has very diverse identities that draw from traditional and modern culture
- High rates of unprotected sex among MSM: Beijing (2001) - 49%; Ho Chi Minh City -28%; Laos -61%; Cambodia- 67%; Thailand- 45%
- Also insurgence of syphilis amongst MSM: Bangkok (6.8%); Phnom Penh (5.5%); Ho Chi Minh City (7%); Shang Hai (13.5%)
- Conclusions:

- MSM is common in Southeast Asia
- Resurgence of syphilis in MSM
- Sub epidemics in some areas, but hope to avert these from spreading with interventions
- Steps in the right direction:
  - MSM are now politically recognized and included into national HIV plans
  - MSM-focused clinics have increased in many places such as Bangkok
  - New, more regular surveillance plans are being implemented
  - New peer and Internet driven interventions are being planned

Othoman. Mellouk - HIV prevention challenge facing MSM in the Middle East and North Africa: An NGO perspective

- Background of situation in Morocco
  - Muslim country where sexuality is taboo, homosexuality illegal (3-6 months in jail)
  - homophobic stigma and discrimination common
  - no legal recognition of sex workers
  - no GLBT community as such in Western cultures
  - majority of AIDS cases are due to heterosexual contact
  - lack of specific epidemiology data on MSM and HIV
- Initial studies of MSM in Morocco showed
  - lack of awareness of prevention and transmission
  - most (57%) have NEVER used condoms with homosexual OR heterosexual contact
  - male sex workers are powerless to clients
  - increased violence in cruising areas by police and others
- Initial program
  - outreach program in high risk areas by peer educators
  - provide access to condoms and educational materials
  - free STI testing as well as confidential VCT
- Challenges
  - Police arresting MSM as well as outreach workers
  - outreach workers exposed to violence in the field
  - attacks from the media (especially religiously affiliated)
  - no infrastructure to refer those that were attacked as a result of their sexual orientation since it is illegal
  - financial resources initially had to come from outside the country - EU and UNAIDS
- Solutions
  - Advocacy, training of journalists, judges, lawyers and police students
  - Good communication with the media
  - Demonstration and coverage of human rights violations by police by media
  - Involvement of human rights NGOs
  - Advocacy with Ministry of Justice and Health

- Recent developments
  - High political commitment
  - in 2002 MSM and male sex workers included in government HIV program and goals
  - Commitments by Ministry of Health and Justice
  - New regional dynamics from collaboration from other organizations from Lebanon, Algeria and Tunisia
  - From April 2005-March 2006: 16767 outreach worker contacts; 4334 participants in education workshops; 859 HIV tests; 100,000 condoms distributed

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