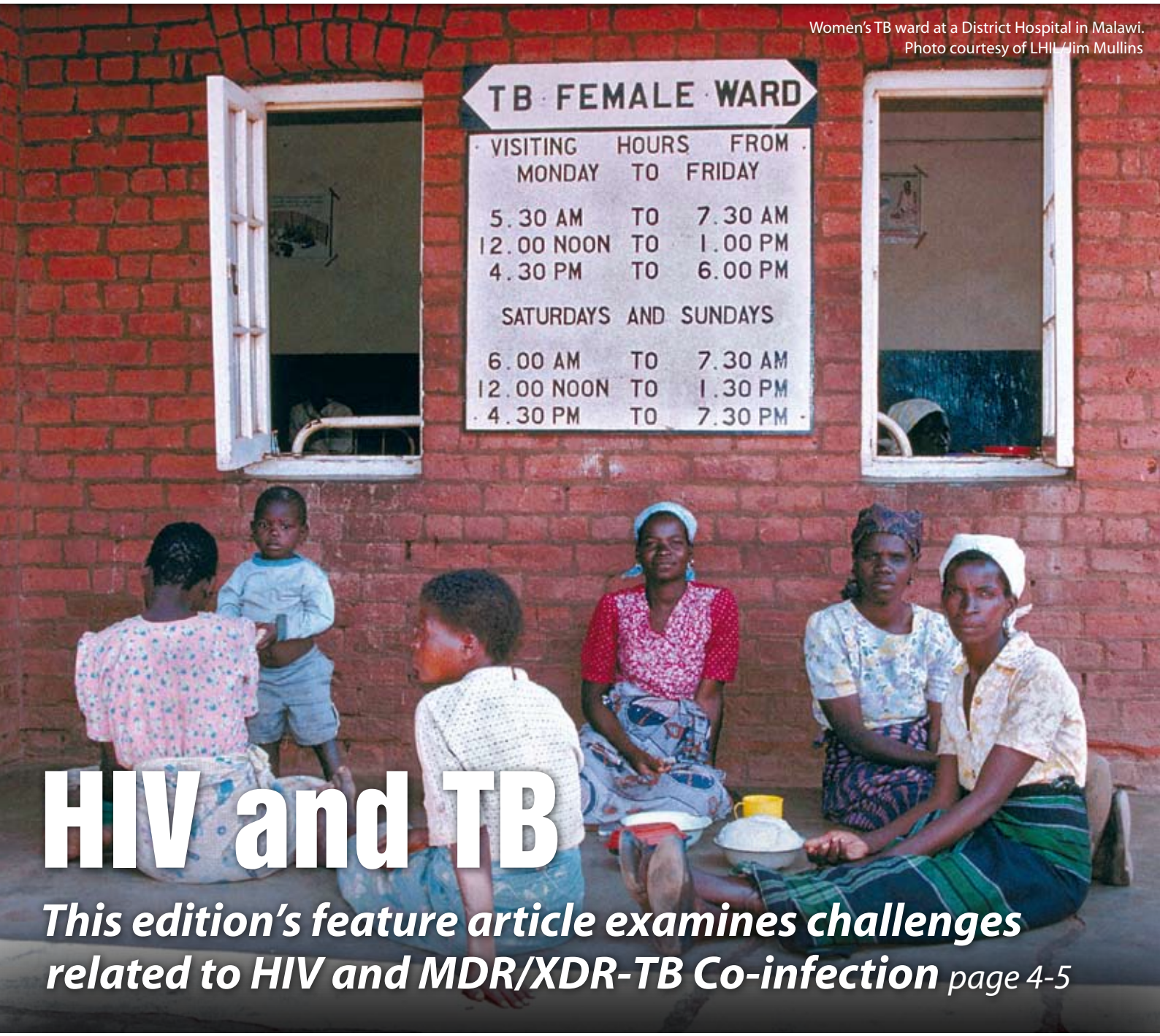
NEWSLETTER

International AIDS Society

Stronger Together

July 2007

The International AIDS Society (IAS) is a global membership organization of professionals committed to the fight against HIV/AIDS. The IAS Newsletter is a tool for the organization's diverse members to find out more about past, ongoing and future activities at the IAS and to learn how to become involved. For more information about the IAS, to search for and contact other members, or to find breaking news in HIV/AIDS prevention, care and treatment, and updates on upcoming IAS conferences, please visit the website at www.iasociety.org



Women's TB ward at a District Hospital in Malawi. Photo courtesy of LHIL/Jim Mullins

HIV and TB

This edition's feature article examines challenges related to HIV and MDR/XDR-TB Co-infection *page 4-5*

Message from the President

IN ADVANCE OF the 4th IAS Conference on HIV Pathogenesis, Treatment and Prevention, the IAS and our local partner, the Australasian Society for HIV Medicine (ASHM), released the Sydney Declaration. The declaration calls for bilateral donors, private foundations and multilateral financing agencies to dedicate 10% of all funding for prevention, care and treatment programmes in the developing world to research. This research, including operations research as well as basic, clinical, social and policy research, will provide us with critical information on what works, what doesn't and why in scaling up prevention, treatment and care programmes in low and middle-income countries, and ensure that we adapt our response to the changing landscape in the future.

WE NEED RESEARCH that will tell us how to adjust our clinical management, care and prevention interventions to ensure the best possible outcomes. Furthermore, improved, robust, well-tolerated, standardized first and second line drug regimens must be made available in the field in order to optimize treatment outcomes. Good research drives evidence-based policy and practice.

I AM DELIGHTED that so many leading scientists, clinicians and community advocates have signed on to this important document and encourage all IAS members to read the declaration and consider appending their signatures. I hope that this declaration will spur action and resources in the same way that the Durban Declaration, released prior to the International AIDS Conference in Durban, called attention to the overwhelming scientific evidence that HIV was the cause of AIDS, dispelling misinformation that at the time was widely circulated by AIDS denialists. I hope that the Sydney Declaration will be a catalyzing force for action.

I WISH THOSE of you who are able to attend IAS 2007 a great conference. If you are unable to attend, I encourage you to follow the conference via the many online resources available at *www.ias2007.org.* ■

Pedro Cahn
IAS President

Message from the Executive Director

I AM PLEASED to introduce Ron MacInnis as our Director of Policy and Programmes. Ron has worked in HIV for over 15 years, gaining experience in a number of senior positions with USAID, the Global Health Council and, more recently, with Internews Network. He has worked in Mali, Democratic Republic of the Congo, Senegal, Cote d'Ivoire and the United States and is openly living with HIV. Ron is leading the team responsible for policy and advocacy, initiatives and regional development at the IAS.

GEORGE VALIOTIS ALSO joined the IAS earlier this year as our Education Programme Coordinator. He brings almost 10 years of experience in workforce development and adult education in the areas of HIV and Hepatitis C to the IAS. George is coordinating an expanding suite of IAS education and training initiatives, including a pilot education programme at IAS 2007 aimed at young investigators working in basic, clinical and prevention science.

IN REGIONAL DEVELOPMENT news, it was recently announced that the 2nd Eastern Europe and Central Asia AIDS Conference (EECAAC) will be held in Moscow in 2008; the IAS is working with the Russian Federation, UNAIDS, the Global Fund and the local conference secretariat in Moscow, AIDS Infoshare, on planning that conference. The IAS is also supporting work with the Society for AIDS in Africa on strengthening governance and planning of the International Conference on AIDS and Sexually Transmitted Infections in Africa (ICASA). Our work with these and other regional conferences is ultimately aimed at improving knowledge transfer among conferences and thereby strengthening HIV prevention, care and treatment programmes.

I WAS RECENTLY invited by the the Centre for Strategic and International Studies (CSIS) and the Kaiser Family Foundation (KFF) to speak at a webcast forum in Washington DC that focused on recent moves to revisit the legislation prohibiting entry of people living with HIV (PLHIV) to the United States (U.S.). The U.S. is one of only a handful of countries that bar people living with HIV from short term visits, and the IAS has not held a conference in the U.S. for 17 years as a result of this discriminatory law. We are working with our U.S. colleagues in advocating for change to this legislation. The webcast is available on both the IAS and KFF websites. ■

Craig McClure
IAS Executive Director

Letters to the Editor

Dear IAS Member:

OUR EDITORIAL COMMITTEE strives to include newsletter content that is relevant to you and your work. As part of our ongoing efforts to improve the newsletter and to increase the space devoted to members, we are introducing a new "Letters to the Editor" feature. Let us know what you enjoyed reading most and least in this edition, and what you'd like to see more of in the future. Your letter could include general comments about the newsletter and its content, such as your view on our feature article, or it could raise a topical issue that you think is relevant to a global audience of HIV professionals.

LETTERS SHOULD BE emailed to *editor@iasociety.org*, and should be a maximum of 250 words in length (we reserve the right to edit letters for publication). Unless otherwise specified, letters selected for publication will include your full name and country of residence. If you wish to remain anonymous, kindly state this clearly at the bottom of your letter.

We look forward to hearing from you. ■

Editor: Rodney Kort
Editorial Committee: Rodney Kort, Erika Lundström, Mallory Smuts, Karen Bennett
Web Coordinator: Nicolas Faurès

Visit *www.iasociety.org* to view the IAS' recent public statements

Sign Your Support For The Sydney Declaration

Not less than 10% of all resources dedicated to HIV programming should be used for research towards optimizing interventions utilized and health outcomes achieved.

Visit the IAS website to read and sign the Sydney Declaration at *www.iasociety.org/declaration*

Planning for AIDS 2008 Gets Underway

WHAT IS YOUR vision of a successful conference, with lasting impact? How do we create exceptional opportunities for learning and professional development? What are the most critical issues emerging at this particular moment in the pandemic? These are just some of the questions discussed at a recent meeting in Mexico City, where members of the three programme planning committees for the XVII International AIDS Conference (AIDS 2008) -- to be held in Mexico City in August 2008 -- met to lay the foundations of the conference programme. As the first International AIDS Conference to be held in Latin America, AIDS 2008 is expected to increase awareness of the disease and its impact throughout the region.

Developing the conference programme is a major planning feat, involving dozens of international stakeholders who have agreed to donate their time over the next 15 months. The planning structure includes three main committees (for the Scientific, Community and Leadership Programmes) and five working groups (responsible for the skills-building workshops and the programme activities: the Global Village and the Youth, Cultural and Outreach Programmes). The AIDS 2008 Conference Coordinating Committee has overall responsibility for the conference, including the selection of the theme.

AS PART OF a new governing structure adopted last year, the International AIDS Society will, for the first time, provide staff support for all elements of the AIDS 2008 programme, relying on existing and new secretariat staff based in Geneva and Mexico City. In addition to the Federal Government of Mexico, the Government of Mexico City, and Mexican civil society and scientific leaders, the IAS is pleased to work with eight international partners for AIDS 2008: UNAIDS, WHO, the World Food Programme, International Council of AIDS Service Organizations, Global Network of People Living with HIV/AIDS, International Community of Women Living with HIV/AIDS, World YWCA, and the Asian Harm Reduction Network.

BEGINNING LATER THIS year, the AIDS 2008 website (*www.aids2008.org*) will provide detailed information on how to register, submit an abstract, propose a skills building workshop and much more. In Mexico, the local secretariat will also hold regular meetings to solicit input and brief community members on plans, as they unfold. As planning moves forward, we encourage you to get involved in what we hope will be the most successful International AIDS Conference yet. ■

AIDS 2008
XVII INTERNATIONAL AIDS CONFERENCE
Mexico City, 3-8 August

Cange, Haiti: Local residents awaiting medical examination in the TB clinic in the sociomedical complex (Photo: WHO/TDR/Crump)

Patrolling the Deadly Intersection of HIV and MDR/XDR-TB

By Mark Mascolini

Every second, one more person in the world gets tuberculosis (TB). Someone living with HIV runs twice the chance of being that one person than people without HIV. And nine out of 10 people with HIV die within months of TB infection if they fail to receive proper care. [1]

THOSE BLEAK STATISTICS from the World Health Organization (WHO) only partly explain why the International AIDS Society (IAS) Governing Council made integrating HIV and TB a key policy and advocacy priority last year. Another reason is the deadly crescendo of multi drug-resistant (MDR) TB and extensively drug-resistant (XDR) TB across the globe. Because MDR-TB and XDR-TB arise most readily in countries with struggling healthcare systems and limited treatment access, they pose a particular threat in poor HIV-endemic regions.

MOST PEOPLE CO-INFECTED with HIV and TB live in sub-Saharan Africa, and WHO estimates that one third of the 40 million people living with HIV across the world also carry *Mycobacterium tuberculosis*.[1] Because HIV assaults the immune system, it not only makes people more vulnerable to TB infection, it also prompts progression of latent TB to active disease and promotes relapse after treatment.

IN REGIONS WITH a high TB burden, between 30% and 40% of HIV-infected people also pick up *M tuberculosis* if they do not receive isoniazid prophylaxis, a preventative treatment for TB. The risk of TB doubles in the first year of HIV infection, then rises inexorably with each passing year.[1]

TB DEVELOPS EARLIER in the course of HIV infection than any other opportunistic infection; it is harder to diagnose in people with HIV, and it is almost invariably lethal if left untreated. Co-infection with TB kills as many of half of all AIDS patients worldwide, according to WHO.[1] Approximately 2.5 million women between the ages of 15 and 44 will become infected with TB this year[1]—an age group that is now the most vulnerable to HIV infection in many low- and middle-income countries.[2]

Meeting the threat of MDR- and XDR-TB

THE THREAT OF XDR-TB in people with HIV came into sharp focus at the XVI International AIDS Conference (AIDS 2006) in Toronto last year, when South African and U.S. researchers reported an outbreak of XDR cases in a rural KwaZulu-Natal hospital that killed 52 of 53 people infected.[3] Among 544 sputum samples culture-positive for *M tuberculosis*, 221 (41%) were rated MDR and 53 (24%) XDR. Health workers accounted for 2 XDR cases. Among 44 people with XDR-TB who had an HIV test, all had HIV infection.

IN OCTOBER 2006 the WHO Global Task Force on XDR-TB defined MDR-TB as *M tuberculosis* resistant to at least isoniazid and rifampicin, two of the most powerful anti-TB drugs.[1] XDR-TB is resistant to isoniazid and rifampicin, any fluoroquinolone (such as ciprofloxacin and cefotaxime), and at least one of three injectable second-line drugs (such as capreomycin, kanamycin, and amikacin).[1]

WORLDWIDE SURVEILLANCE CHARTS substantial and rising rates of MDR-TB across the globe. A survey by WHO and the International Union Against Tuberculosis and Lung Disease found evidence of MDR-TB on five continents and in 40 of 45 countries surveyed.[4] Rates of XDR-TB are much lower, but emergence of XDR bacteria in resource-poor areas with high HIV prevalence raises the spectre of a virtually untreatable TB epidemic.

WHO FIGURES WORLDWIDE MDR-TB prevalence at a half million, and an international study by the Centers for Disease Control and Prevention (CDC) found that as many as one in five MDR cases may in fact be XDR. Of 17,690 isolates collected from 2000 through 2004, the CDC rated 20% MDR and 2% XDR.[5] Separate analyses determined that 4% of MDR cases in the United States, 15% in South Korea, and 19% in Latvia were actually XDR.

THE CDC SURVEY did not include samples from sub-Saharan Africa, but other work suggests KwaZulu-Natal has the highest MDR rate among new TB cases in South Africa. The Medical Research Council (MRC) of South Africa estimates that the country now has 600 cases of XDR-TB, representing 10% of MDR-TB prevalence. Forty South African hospitals—at least one in all nine provinces—have diagnosed one or more cases of XDR-TB. At least six South African XDR cases involve health workers, a

group with a 30% HIV rate. The MRC figures that 85% of people coinfected with HIV and XDR-TB have died.[6,7]

IN COUNTRIES WITH XDR statistics, WHO estimates the highest rates in South Africa, South Korea and Eastern Europe.[5] At least 28 countries now report cases of XDR-TB, compared with 17 in March 2007.[6,7] China, Russia and India lead the world in prevalence of MDR, which can evolve to XDR-TB if second-line anti-TB drugs are not used appropriately. Rates of MDR- and XDR-TB in other African countries remain unknown because those countries largely lack facilities that can test for resistant TB.

FURTHER SPREAD OF MDR- and XDR-TB raises particular concerns in health systems marked by misuse of antibiotics, failure to segregate high-risk TB patients in hospitals, and cuts in government spending for drugs and lab testing.[8]

Clinical care of HIV/TB coinfection

HIV INFECTION GREATLY complicates TB care, even when the mycobacterium remains susceptible to first-line antibiotics (see Table 1). WHO guidelines on treating MDR-TB maintain that resistant disease can be treated effectively—even in people with HIV—though there are problems: Second-line drugs for resistant TB are more toxic and more expensive than first-line drugs; their availability often remains limited in low-income countries; and they are generally less effective than first-line drugs, especially in HIV-infected people[1] (see Table 2). WHO stresses that HIV-infected individuals with MDR-TB "should receive routine care outside of normal HIV care settings" because of the high risk of MDR-TB transmission.

Table 1: How HIV Complicates TB Management[1]

- Overdiagnosis of sputum smear-negative pulmonary TB (because of diagnostic difficulties)
- Underdiagnosis of sputum smear-positive pulmonary TB (because of excess lab workload)
- Inadequate supervision of anti-TB chemotherapy
- Low cure rates
- High morbidity and mortality during treatment
- High treatment dropout rates (raising MDR-TB risk) because of adverse drug reactions
- High TB recurrence rates
- Increased transmission of drug-resistant strains among HIV-infected patients in group settings

St Peter's TB Clinic, Addis Ababa, Ethiopia: Standard examination card and chest X-ray (Photo: WHO/TDR/Crump)

AS THE MORTALITY estimates cited above indicate, treating XDR-TB remains a daunting prospect. In countries with good TB control programmes, according to WHO, XDR-TB cure rates approach 30%. But success depends on at least four factors: (1) extent of drug resistance, (2) severity of the disease, (3) whether the patient has a compromised immune system, and (4) availability of all six classes of second-line drugs and clinicians with "special expertise" in treating resistant TB.[1]

WHO URGES RAPID dissemination and field testing of an algorithm designed for diagnosing and managing MDR- and XDR-TB in people with HIV (see page 23 of the WHO Global Task Force report of 9-10 October 2006; *http://www.who.int/tb/xdr/globaltaskforcereport_oct06.pdf*). The plan depends on a rapid test for resistance to rifampicin. WHO's Global Task Force on XDR-TB stressed that global TB control should be strengthened immediately and concurrently with universal access to antiretroviral therapy.[1]

Table 2: First- and Second-line Drugs for Tuberculosis

First-line drugs
- Isoniazid
- Rifampicin (rifampin)
- Pyrazinamide
- Ethambutol
- Streptomycin
- Thioacetazone

Second-line drugs
- Aminoglycosides (such as amikacin and kanamycin)
- Polypeptides (such as capreomycin, enviomycin, and viomycin)
- Fluoroquinolones (such as ciprofloxacin and moxifloxacin)
- Thioamides (such as ethionamide and prothionamide)
- Cycloserine
- p-Aminosalicylic acid

Also used for prophylaxis
- Isoniazid
- Cotrimoxazole

The IAS steps up in the fight against XDR-TB

THE IAS HAS moved HIV and TB to the forefront of its agenda, co-sponsoring forward-looking symposia on co-infection and urging formal integration of HIV and TB health services. The IAS sponsored a satellite meeting at AIDS 2006 in collaboration with WHO, the Forum for Collaborative HIV Research, and others. The symposium aimed at strengthening a joint response to the HIV/TB epidemic by bolstering partnerships between groups fighting these diseases.

A SIMILAR SYMPOSIUM is planned for the 4th IAS Conference on HIV Pathogenesis, Treatment, and Prevention (IAS 2007) and will address similar issues in the context of the most recent findings on MDR/XDR-TB in people with HIV.

"HIV CONTINUES TO devastate working-age populations, children and adolescents across the world," says IAS Executive Director, Craig McClure. "TB makes the already difficult job of stopping HIV even tougher. We can't end one epidemic without ending the other. IAS is working with our partners to end both." ■

References:

1. World Health Organization. *http://www.who.int*

2. UNAIDS/WHO AIDS Epidemic Update: December 2006.

3. Gandhi NR, Moll A, Pawinski R, et al. High prevalence and Mortality from Extensively-Drug Resistant (XDR) TB in TB/HIV Coinfected Patients in Rural South Africa. XVI International AIDS Conference. THLB0210.

4. Friedland G. Drug resistant TB and HIV: Is it an Emerging Threat? 2006.

5. Centers for Disease Control. Emergence of Mycobacterium tuberculosis with extensive resistance to second-line drugs--worldwide, 2000-2004. MMWR Morb Mortal Wkly Rep. 2006 Mar 24;55(11):301-305.

6. Russell S. TB that kills HIV Patients is Spreading. San Francisco Chronicle. February 26, 2007.

7. Chong JR. HIV, Drug-resistant TB a Deadly Combo. Los Angeles Times. February 26, 2007.

8. Altman LK. Rise of a Deadly TB Reveals a Global System in Crisis. New York Times. March 20, 2007.

Welcome to Sydney

We are delighted to welcome all IAS members to the 4th IAS Conference on HIV Pathogenesis, Treatment and Prevention, held in Sydney, Australia, 22-25 July 2007. The conference is organized by the International AIDS Society (IAS) in partnership with the Australasian Society for HIV Medicine (ASHM).

THE GOAL OF this unique conference series is to deliver programmes that bridge the gap between science and practice. The IAS 2007 programme features the latest developments in basic, clinical and biomedical prevention science, and also provides opportunities to explore the practical implications of this research for the global response to HIV/AIDS – in particular, efforts to expand access to HIV prevention and treatment in the developing world. The record number of abstracts submitted to the conference is testimony to the growing commitment to this goal.

THE ON-SITE IAS office is located in the Sydney Convention and Exhibition Centre, Bayside Level 1, Office 103.

IN ADDITION, THE IAS is hosting or co-sponsoring a number of events listed in the table on *page 7*.

We look forward to seeing you in Sydney. ■

IAS-Sponsored Prizes and Awards at IAS 2007

THE IAS SPONSORS a number of scientific prizes and awards aimed at rewarding promising young researchers doing outstanding work in HIV/AIDS.

ANRS/IAS Prize

THE US$3,000 PRIZE is funded by France's Agence Nationale de Recherches sur le SIDA and supports young researchers who demonstrate excellence in the area of research programmes related to the scale up of prevention and treatment interventions in resource-limited settings.

Abstracts must meet the following criteria to be eligible:
- The presenting author must be under 35 years of age as of 7 March 2007
- The presenting author must be a citizen of a non-OECD country
- The research must have been carried out in a non-OECD country
- The research must, directly or indirectly, be related to increasing access to prevention and/or treatment in resource-constrained settings

Young Investigator Awards

TO ENCOURAGE YOUNG researchers, the IAS has established Young Investigator Awards of US$1,000 each, awarded to the highest scoring abstract in each track. To be eligible, the presenting author of an abstract must be less than 35 years of age on 7 March 2007. The Young Investigator Awards are given to the top-scoring abstract in each of the three track categories of IAS 2007:
Track A: HIV Basic Science
Track B: Clinical Research, Treatment and Care
Track C: Biomedical Prevention

ALL PRIZE WINNERS will be listed on the IAS and IAS 2007 websites (*www.iasociety.org* and *www.ias2007.org*)

IAS General Members Meeting:

"IAS Members Working Together for a Stronger Health Workforce"

The IAS invites members and guests to a general meeting and policy discussion, led by IAS President, Pedro Cahn, in conjunction with the 4th IAS Conference on HIV Pathogenesis, Treatment and Prevention in Sydney, Australia.

IAS Members Working Together for a Stronger Health Workforce

"Unsafe working conditions, low salaries and lack of bio-safety measures have led to a significant brain drain in developing countries. Addressing this requires a joint effort on the part of the international community. It is time we worked together to deliver on this."
Dr. Pedro Cahn,
IAS President, at AIDS 2006

Date: Tuesday, 24 July. 18:30-20:30
Place: Parkside A2, Sydney Convention and Exhibition Centre, Darling Harbour, Sydney

Purpose:

THE PURPOSE OF this IAS Members Meeting is to provide a platform for sharing the experiences of members from various regions in dealing with the health workforce crisis. The meeting will also encourage proposals from members on how the IAS can add value to current regional and international advocacy efforts aimed at expanding and sustaining a health workforce able to meet the demands of scaling up to universal access to HIV/AIDS prevention, care and treatment services .

Background:

THE 2006 WORLD Health Report from WHO estimates that there is a global health care worker shortage approaching 4.3 million. Sub-Saharan Africa alone urgently will need an additional one million health workers by 2015. In the most heavily affected countries, chronic shortages of a trained health workforce was cited by UNAIDS regional and national consultations on 'Universal Access' as the single biggest obstacle to scaling up effective HIV/AIDS prevention, treatment and care services. The epidemic is not only increasing demands on the health workforce at all levels of the health system, but also undermining our capacity to deliver on targets through AIDS-related deaths in the workforce.

THE IAS IDENTIFIED strengthening health care systems as a priority in its policy and advocacy strategy. We are using the unique opportunity presented by IAS 2007 to seek input from our members on how best to address a challenge that continues to impede HIV prevention, care and treatment efforts in the developing world. ■

IAS Events at IAS 2007	Date, Time and Location	Description
Education Programme on Current Research and Cross-Disciplinary Research Issues in Basic, Clinical and Prevention Science	**Friday 20 July** – all day event Additional details are available on *www.ias2007.org*	This event is for pre- and post-doctoral students and junior faculty to build their skills and knowledge of critical research questions and cross-disciplinary research issues. The programme will help participants build clear and meaningful pathways for involvement in the conference and include skills-building workshops on writing for publication and grant proposal writing.
Industry Liaison Forum Satellite: Are We Prepared for PREP?: The Challenges of Implementing Proven Biomedical Prevention Technologies	**Sunday 22 July 2007**, 08:00-10:00 Parkside Ballroom B, Sydney Convention and Exhibition Centre	IAS continues its leadership role in supporting dialogue on PREP, a promising new biomedical prevention technology. The IAS Industry Liaison Forum satellite addresses the challenges of implementing proven biomedical technologies in the context of prevention, care and treatment programme scale up.
IAS Exhibition Booth	**Sunday 22 July- Wednesday 25 July** Hall 5, Sydney Convention and Exhibition Centre, Darling Harbour *Sunday 22 July 12:00-18:00, Monday 23 July-Wednesday 25 July, 11:00-18:30*	At the IAS booth, delegates can find out more about the organization and its initiatives, as well as the upcoming AIDS 2008 and IAS 2009 conferences. Visitors will have the opportunity to talk with IAS staff and Governing Council members, and to sign up for or renew their IAS membership.
IAS/Collaborative Forum for HIV Research Satellite: HIV-TB Co-Infection: Meeting the Challenge	**Sunday July 22**, 12:30-14:30, Hall B	This satellite will look at current issues in HIV/TB programming as well as clinical management strategies, particularly in the context of the rise of M/XDR TB in low- and middle-income countries. The satellite is organized in collaboration with WHO HIV-TB Working Group, CREATE; ANRS; the Bill & Melinda Gates Foundation; Tibotec; EDCTP; National Institutes of Health
IAS General Members Meeting	**Tuesday 24 July**, 18:30-20:30 Parkside A2, Sydney Convention and Exhibition Centre, Darling Harbour	Information on this meeting may be found on *page 6* of this newsletter.

IAS 2007 Scholarship Programme

Almost 200 applicants have been offered support by the International Scholarship Programme from a pool of over 3,000 applicants from 145 different countries. We were impressed by the standard of applications and would like to have funded more of the committed and hard-working professionals who applied.

HOWEVER, AS WITH every year, the demand for support to attend the conference is far greater than the available funding. For IAS 2007, priority was given to scholarship applicants who were chosen to present their abstracts at an oral session or poster discussion session, and youth who were invited for the poster exhibition. The programme also supported a number of qualified media representatives, advocates, researchers and students.

AS PART OF the scholarship application, candidates responded to questions regarding their work, motivation to attend the conference and the benefits that they would bring back to their organization and community after attending the conference. All applications were thoroughly reviewed by the International Scholarship Department, with support from the IAS Governing Council. The selection of recipients was made according to recommendations and criteria established by the Conference Organizing Committee, the Scientific Programme Committee and the Community Advisory Group.

AS WITH EACH conference scholarship programme, the available budget was divided by region. For IAS 2007, 30% of the budget was spent in Africa, 25% in Asia and the Pacific Islands, 20% in Latin America and the Caribbean, 15% in Europe and 10% in the USA and Canada. Seventy-eight delegates who are presenting their abstract at the conference were offered a scholarship along with seven media representatives, 21 community-based delegates and 88 researchers and students.

THE IAS COMMENDS these recipients for their commitment to transferring the knowledge gained at the conference to their colleagues and their community. ■

Restricting Travel of People Living with HIV is a Discriminatory and Ineffective Means to Control the Epidemic

By Pedro Cahn, IAS President and Craig McClure, IAS Executive Director

Under current law, people who are restricted from obtaining visas to enter the United States (U.S.) include drug traffickers, international child abductors and participants in Nazi persecution or genocide. And people living with HIV and AIDS.

THE INITIAL IMPETUS for this "HIV inadmissibility" policy 20 years ago was fear of a new and poorly-understood communicable disease. Some also justified it on the basis that people living with HIV coming to the U.S. would place an undue financial burden on the health care system. In practice, other provisions of U.S. immigration law exist to address such circumstances and are routinely applied to cases of other chronic health conditions, such as cardiovascular or kidney disease. However, U.S. law specifically singles out HIV for presumptive inadmissibility, both for short-term entry as a visitor and for immigration. The U.S. Congress codified this policy in the early 1990s, after an attempt by the Department of Health and Human Services to eliminate the exclusion.

INDIVIDUALS APPLYING FOR a visa for a short-term visit to the U.S. must disclose their HIV status, and those requesting permission to immigrate must undergo a full medical examination, including an HIV test. If HIV-positive, applicants are automatically deemed "inadmissible," and are prohibited from entering the country unless granted an exception or waiver by the U.S. Citizenship and Immigration Service. These waivers are notoriously difficult to obtain.

THE HIV INADMISSIBILITY law serves, in effect, as a modern day scarlet letter, stigmatizing those with HIV by requiring disclosure of personal medical information. It stands in sharp contrast to the leadership role the U.S. plays in the global response to HIV and AIDS. A recent report by the non-partisan Center for Strategic and International Studies recommends that the law be changed.

IN 1992, THE IAS protested the U.S. Congress' decision to codify the HIV travel exclusion in law by moving the International AIDS Conference from its original location in Boston to Amsterdam. In doing so, the IAS also adopted a policy that such restrictions would make a country ineligible to host the conference in the future. As a result, while the U.S. has emerged as one of the largest funders of AIDS programmes internationally and is home to many of the world's top scientists, it has not hosted the premier meeting of global HIV stakeholders for the last 17 years. This represents a major missed opportunity to showcase U.S. programmes and innovation.

IN HIS DECEMBER 2006 World AIDS Day announcement, President Bush spoke against the stigma and discrimination faced by people living with HIV/AIDS, and announced plans to create a "categorical waiver" that would apply to short-term travelers. This could be an important first step and provide a way to circumvent the outdated legislation, at least for those coming for short visits. However, if such a waiver continues to require that people with HIV disclose their sero-status, it would fall far short of what international public health and human rights leaders deem appropriate, and would represent a lost opportunity for combating the stigma and discrimination against people living with HIV/AIDS.

THE U.S. IS by no means the only country to require prospective immigrants be tested for HIV, and to deny entry to applicants who are HIV-positive. Earlier this year Australian Prime Minister John Howard was widely criticized for commenting that stricter measures were required to prevent HIV-positive migrants from entering Australia. Public health experts throughout the world agree that such measures do nothing to prevent the spread of HIV.

WITH RESPECT TO short-term visitors, only a small number of countries, including China, a handful of Middle Eastern states, and the U.S., ban people living with HIV. A few others continue to require that people living with HIV disclose their HIV status before entering. Not long ago, the Canadian government had a similar requirement for short-term visas. But in a nod to public health the Canadian government revised its visa requirements to permanently eliminate the need for applicants to disclose their HIV status as part of its preparations to host the 2006 International AIDS Conference in Toronto. Similar action by the Bush Administration would align U.S. policy with current best practice in public health, and set an important example for other countries, most notably China, where such policies are currently under review. It would also send a clear message against stigma and discrimination, which threaten to undermine HIV prevention, treatment and care worldwide. ■

HIV Travel Inadmissibility – Will Evidence Reform Policies Informed by Stigma?

By Jacqueline Bataringaya

In 1984, CDC researchers conducted a study to confirm that AIDS was a transmittable disease. Although by the mid-eighties research had proved that HIV could not be transmitted by casual contact, fear, prejudice and stigma against people living with HIV (PLHIV) contributed to the emerging culture of blame directed towards travelers and immigrants and strongly influenced development of policies and laws restricting HIV admissibility into the U.S.[1]

IN 1987, AIDS was added to the Public Health Service (PHS) list of "dangerous, contagious diseases for excluding persons from the U.S.". In 1993 the policy was signed into law by President Clinton through Congressional designation of HIV as a "communicable disease of public health significance" in the Immigration and Nationality Act.[2] ■

Leveraging the Added Value of the International AIDS Conference

THE ARREST OF activists demonstrating against Vice-President George Bush's speech opening the III International AIDS Conference in Washington in 1987, contributed to amplifying the debate on discriminatory HIV testing policies.[1] A study by Duckett and Orkin presented at the V International AIDS Conference in Montreal two years later cited 35 countries with policies that discriminated against travelers with HIV/AIDS through mandatory HIV screening and exclusion or deportation. The study called attention to the negative impact such policies have on an effective global response.[3] In 1989 Dutch HIV prevention expert Hans Paul Verhoef was jailed for four days in Minneapolis en route to an AIDS meeting in San Francisco after AZT was discovered in his suitcase. The subsequent demonstrations and mass boycott of the VI International AIDS Conference in San Francisco in 1990 affirmed the role of the International AIDS Conference as a platform for international advocacy and an opportunity for challenging HIV-related travel restrictions. In 1992 the XIII International AIDS Conference was moved by the IAS from Boston to Amsterdam as a result of U.S. policies barring PLHIV from entering

the country, and for the last 17 years the conference has not been hosted by a U.S. city. The Amsterdam conference provided a platform for engaging the media, and to mobilize activists against travel discrimination.[4] By 1999, a study conducted by the German non-governmental organization, Deutsche AIDS Hilfe, found that over 100 of 164 countries surveyed imposed some form of HIV-related travel restrictions including mandatory HIV testing.[5] Prior to the XV International AIDS Conference in Bangkok (AIDS 2004), the Swiss HIV information site, aidsnet, profiled 15 countries which effectively ban HIV-positive visitors including the U.S., Iraq, Libya, Saudi Arabia and China.[6]

AT THE XVI International AIDS Conference in Toronto (AIDS 2006), advocacy was energized by a formal policy session in the Global Village which focused on challenging travel entry barriers for PLHIV. Participants at the session saluted Canadian civil society and government efforts that resulted in permanently removing the requirement for short term visitors to Canada to disclose their HIV status. This move recognized that HIV was not a barrier to visiting Canada, was not a risk to public health or safety, and that short-term visitors would not place a burden on the Canadian health care system.[7]

MARGARET WENTE, A columnist writing in *The Globe and Mail*, Canada's largest national daily, questioned this change in Canadian immigration policy, asserting that "we are importing HIV from sub-Saharan Africa". Wente's column was seen by many conference participants as casting a shadow on the leadership shown by Canada in repealing discriminatory travel policies aimed at PLHIV. Rhon Reynolds countered in *Panoscope* by challenging arguments for restrictive immigration policies, highlighting research showing that people did not travel to countries hoping to get HIV/AIDS treatment, but migrated primarily for employment, to study, or to seek refuge; many do not know their HIV status.[8] News coverage of the conference reflected the desire of AIDS 2006 participants to galvanize action against stigma and discrimination with the same level of focus, passion and commitment that characterizes the search for effective HIV prevention and treatment.[9]

Why Challenge Policies Restricting Entry for People Living with HIV/AIDS?

GUIDING PRINCIPLES FROM the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the International Organization for Migration (IOM), issued in 2004, affirm recommendations from public health experts that HIV infection should not be considered a condition that poses a threat to public health in relation to travel because, although infectious, HIV cannot be transmitted by casual contact.[10] According to the 1998 International Guidelines on HIV/AIDS and Human Rights, any restriction on the right to freedom of movement based on suspected or real HIV status alone, including HIV screening of international travellers, is not only unjust, but also discriminatory and cannot be justified by public health concerns.[11]

STUDIES HAVE SHOWN that restricting entry on the basis of HIV status has not been effective in keeping HIV-positive people out of the U.S.; in fact, it has been counterproductive by pushing the issue underground, as many PLHIV choose to lie about their status rather than risk being turned away. The fear of getting "caught" forces HIV-positive people to take unauthorized drug holidays while traveling, and such treatment interruptions invariably increase the chances of developing additional mutations and drug resistant strains of HIV, which then increase the risk of treatment failure.[12]

MANY HIV INADMISSIBILITY laws and policies were put into place many years before the development and application of current knowledge, tools and technologies in HIV prevention and treatment. Twenty-five years of experience with the epidemic shows that such laws are impractical and ineffective in limiting HIV transmission.[13] While infected foreigners and short term visitors capture political and public attention, their discriminatory exclusion from entry into a country as a way to protect public health denies society's collective responsibility for HIV/AIDS. It also creates a false sense of security among residents that counteract efforts to raise awareness of HIV transmission risks.[14] And while international efforts continue to provide universal access to HIV prevention, testing, care and treatment by 2010, discriminatory policies that do not respect the rights of people living with HIV/AIDS may in fact encourage individuals to avoid getting tested.[15]

THE WASHINGTON-BASED BIPARTISAN Center for Strategic and International Studies (CSIS) recently released a report which explored policy options for moving beyond the current U.S. HIV inadmissibility policy. In addition, the 2006 World AIDS Day announcement from the White House proposing a "categorical waiver" to allow HIV-infected visitors to enter the U.S. has reopened debate and brought hope for possible policy change. [13]

IAS in Action

THE IAS RECOGNIZES the power of partnership in seeking greater accountability and influencing policy. There are several organizations that have been working on removing travel barriers against people living with HIV/AIDS since the early years of the epidemic.[16] The International AIDS Conferences have provided a platform for promoting evidence-based policy change, and opportunities to mobilize and connect community groups fighting for freedom of movement for PLHIV. The IAS is adding its voice, through public statements and collaboration with other organizations, to influence legislators and policymakers in countries yet to repeal laws and policies restricting short term entry of HIV-positive people. ■

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8th International Congress on AIDS in Asia and the Pacific (Colombo, Sri Lanka)

Organizers are expecting up to 3,500 people to converge on Colombo for the 8th International Congress on AIDS in Asia and the Pacific (ICAAP) to be held 19-23 August 2007. This year the theme is "*Waves of Change, Waves of Hope*".

THE SCIENTIFIC PROGRAMME will feature eight concurrent sessions, three times per day. There will be 36 skills-building workshops in addition to the scientific sessions, with morning and pre-lunch plenary sessions setting each day's pace. A total of 1,084 abstracts were received, of which 288 were chosen for oral presentations at the congress and 750 as poster presentations. Participating organizations are facilitating 24 panel discussions addressing a wide range of issues in HIV prevention, care and treatment.

THE LOCAL ORGANIZING committee is working hard to raise scholarship funding for people who will be able to contribute significantly to the HIV/AIDS response in Asia. "The success of ICAAP depends upon having the right people attend, and our scholarship programme is an important vehicle for ensuring that. We give priority to civil society representatives and people living with HIV/AIDS," said Visakha Tillekeratne, Scholarship Sub-committee Chair.

THE MARATHON MEETING to review and select the abstracts of papers to be presented was held in Colombo in April 2007. Twelve international community and scientific advisors participated from the AIDS Society for Asia and the Pacific, the International AIDS Society, and UNAIDS, as well as members of the International Advisory Committee and Local Organizing Committee. The IAS was represented by Dr. NM Samuel, IAS Governing Council Member and Regional Representative for the Asia and the Pacific Islands region, and Neil Chatterjee, Manager, Commercial Sponsorship and Regional Logistics.

"THE MARATHON MEETING was exciting. A lot of effort was made to develop a programme that addressed specific epidemics in each of the sub-regions and in each of the populations across the Asia Pacific region. We think the programme will be relevant to all regional stakeholders and are very happy with the outcome," said Kamanee Hapugalle, Congress Coordinator.

SHIBA PHURAILATPAM, REGIONAL Coordinator of the Asia Pacific Network of People Living with HIV/AIDS said, "We hope there will be good participation from marginalized groups, despite the security situation in Sri Lanka, and that the congress will address stigma and bring about discussion on care and treatment in the region."

PROSPECTIVE PARTICIPANTS ARE encouraged to register at *www.icaap8.lk* ■

The IAS Talks with Sukhontha Kongsin, IAS Governing Council Member from Asia and the Pacific Islands

Sukhontha Kongsin, PhD, is Deputy Dean for Finance and Budgeting and Assistant Professor in health economics, Faculty of Public Health, at Thailand's Mahidol University. She graduated from the College of Nursing in Thailand, recognized with a Gold Medal as the most outstanding student of the class. She received a PhD from the London School of Hygiene and Tropical Medicine after gaining a Master of Economics in health economics at the Faculty of Economics of Chulalongkorn University.

Professor Kongsin has extensive experience conducting research, and analyzing the consequences of Thailand's AIDS epidemic. She also has broad international experience in collaborative research and exchanges with various United Nations agencies and the European Union. Her research has focused on the development of techniques for evaluating HIV prevention activities and participatory methods to monitor and evaluate TB/HIV/Dengue programmes in Thailand. She received an IAS Young Investigator Award at the XI International AIDS Conference in 1996 and was awarded the Franz Redeker Prize at the 29th World Conference of the International Union Against Tuberculosis and Lung Disease in November 1998.

Q: How do you see your role as an IAS Governing Council (GC) member in the Asia and the Pacific Islands region?

A: AIDS presents a serious threat to both public health and socio-economic development in countries in this region, many of which face high HIV prevalence among their labour forces. Without timely prevention and effective responses to alleviate the impact of the epidemic, HIV/AIDS could undermine the productivity of the working population and hinder its development. The challenge for me is to empower communities and create an environment to respond successfully to HIV/AIDS. We need to develop a response to HIV/AIDS that protects the rights of people living with HIV (PLHIV) and their families.

I think that strengthening links between HIV and development programmes, as well as more effective and expanded coordination of AIDS planning at national and regional levels is important in mounting a successful response to the epidemic. Closer co-operation among GC members in the region will also be helpful in combating HIV/AIDS.

An effective regional response should include developing national plans in the region and strengthening regional co-operation to mobilize political commitment, dedicated human resources, civil society participation and financial resources.

The emphasis should be on enhancing the role of local authorities and communities in responding to the epidemic, as well as strengthening and promoting the role of PLHIV and groups most at risk of HIV infection.Community-based and non-governmental organizations must be adequately funded to support PLHIV and their families. If these steps are taken, the AIDS response will be more consistent and sustainable.

Q: What are the main challenges in your region and how are they being addressed?

A: With at least 10 million PLHIV currently living in this region, there is enormous pressure to provide access to antiretrovirals (ARV), and most countries have invested the majority of their AIDS budget in treatment, care and support for HIV-positive people and their families. There is, however, growing recognition that prevention must also be stressed, and governments in the region are seeking funding to strengthen prevention programmes among migrant populations, youth and other at-risk groups.

Women are infected at higher rates than men, mostly through unprotected sex, and these infections sometimes occur in a context of violence and sexual abuse. Many women have also been affected socially and economically by stigma and employment discrimination, so gender equity issues need to be addressed if we are going to mount an effective, sustainable response.

Civil society has played a large role in HIV prevention and reducing HIV-related stigma. However, NGOs have also recognized the need to improve their monitoring and evaluation capacity in order to develop long-term sustainability.

There has been significant investment in treatment over the past few years to develop and test inexpensive ARV combinations. In Thailand, the Government Pharmaceutical Organisation (GPO) has produced a generic triple-combination treatment called GPO-VIR, sold for20 baht (about US$0.50) per tablet. According to the GPO's calculations, a monthly dosage would cost 1,200 baht (U.S. $30).

Review of care and support needs have shown that we need to use diagnostics and prophylaxis for opportunistic infections more effectively. We also need a stronger community response that diminishes stigma and provides psychosocial support and economic opportunities for affected families.

Q: What can the IAS do to better link with the regions?

A: The IAS should raise the profile of HIV/AIDS among regional policymakers and set clear direction for future collaboration among countries in the region. The IAS should continue to promote international co-operation for HIV prevention, care and treatment by focusing first on co-operation among countries in the region and then on the exchange of technology and scientific knowledge. Another important point is how we can best maximize benefits from the resources allocated for the regional development strategy.

Q: Why would you advise someone to become a member of the IAS?

A: HIV/AIDS is not just a health matter. It has had an enormous, devastating impact on every aspect of human life. Despite continuous efforts to orchestrate prevention, treatment, and care interventions in our region, HIV is still on the rise in many areas. We need to understand how globalization, trade liberalisation and transportation are factors that lead to the spread of HIV, and how prevention and care interventions should address these issues.

To tackle this problem effectively, we need to improve on our effort to strengthen political commitment. We also need to build partnerships among individuals working professionally in HIV/AIDS; as more HIV professionals become IAS members, we will have more opportunities to exchange information and discuss how to curb the impact of the disease on development in the Asia and the Pacific Islands region and around the world ■

IAS Member World Map: Profiles from Asia and the Pacific Islands

China

HUANG BAOHUA WORKS for the Yunnan Health and Development Research Association (YHDRA), the first NGO registered in China. YHDRA devotes itself to health and development research, capacity building, social services, information and technical support to government and private sectors. More information is available at *www.yhdra.org*

India

ADITYA BONDYOPADHYAY IS a lawyer based in Delhi, and the Director of the National MSM & HIV, Policy Advocacy and Human Rights Task Force. He is also the legal advisor to Naz Foundation International, a governing board member of the Indian Network of NGOs working on HIV, and the coordinator of the Secretariat of the Asia Pacific Coalition on Male Sexual Health and HIV. Information on the Naz Foundation is available at *www.nfi.net*

Japan

DR. KATSUMI NAKASE is an epidemiologist, a board member of the Japanese Society for AIDS Research and Director of Okayama City Health Centre in Japan. The health centre provides AIDS education to more than 15,000 adolescents and voluntary testing and counselling for 500 citizens a year. The centre's website is *www.city.okayama.okayama.jp/hofuku/hokensyo/index.htm*

Philippines

DON ELISEO LUCERO-PRISNO III is a medical doctor and AIDS researcher from Manila. He studies HIV/AIDS in the maritime industry. The Philippines has 30% of the world's seafarers, an occupation with a high HIV prevalence. He is a Nippon Foundation Fellow at the Seafarers International Research Centre, *www.sirc.cf.ac.uk*

Sri Lanka

DR. SUJATHA SAMARAKOON works as a senior consultant to the Sri Lankan Ministry of Health's National STD/AIDS Control Programme. The aim of the programme is to maintain the current low prevalence of HIV infection in the country. Dr. Samarakoon can be reached at *s.samarakoon@gmail.com* ■