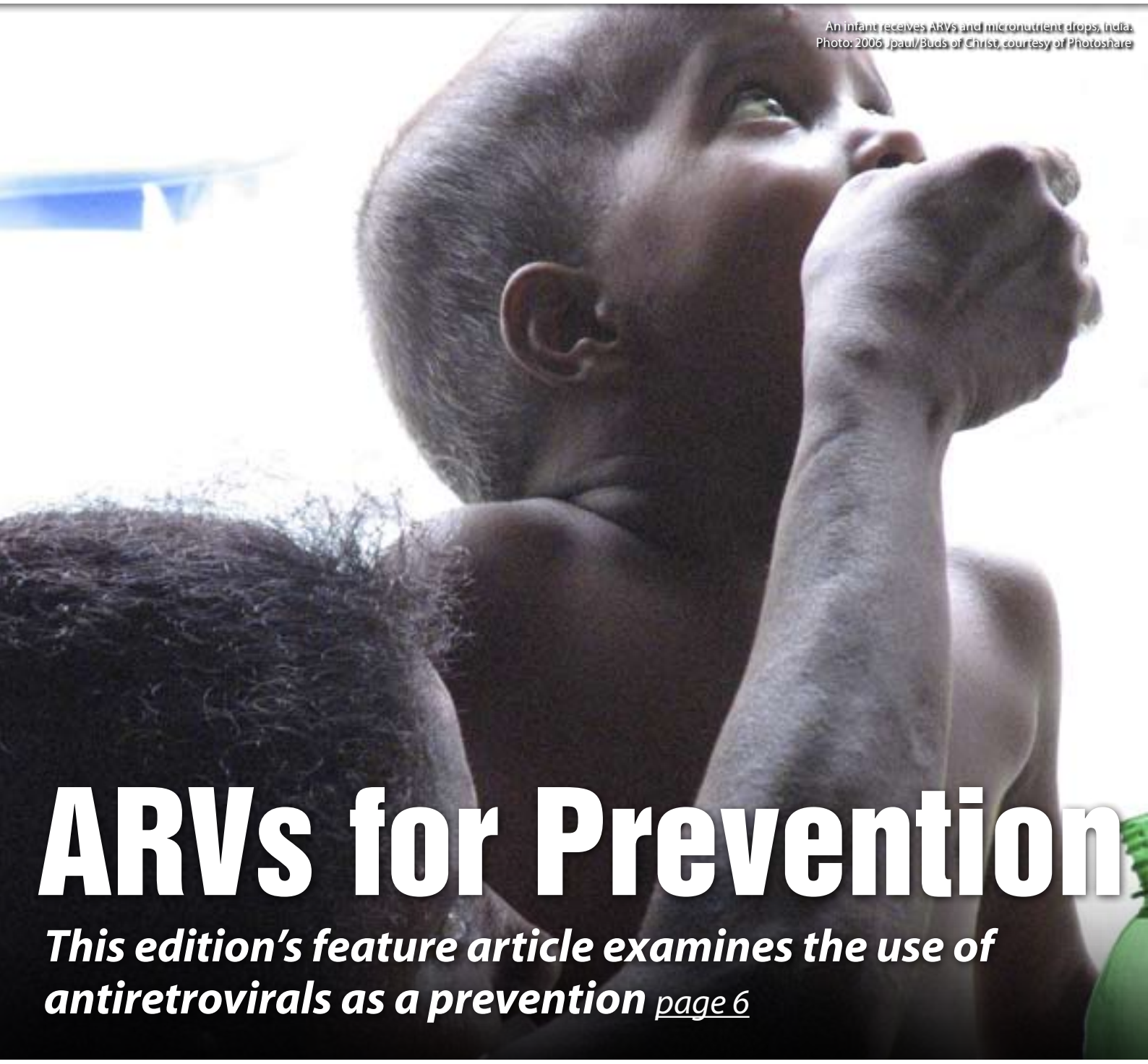
NEWSLETTER

International AIDS Society

Stronger Together

August 2008

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



An infant receives ARVs and micronutrient drops, India. Photo: 2006 Jpaul/Buds of Christ, courtesy of Photoshare

ARVs for Prevention

This edition's feature article examines the use of antiretrovirals as a prevention *page 6*

Message from the President

THIS IS MY farewell message as IAS President. In the coming days, I will end my tasks as a member of the IAS Governing Council, in which I have served for the last 12 years, first as a Representative of the Latin America and Caribbean Region, and then as President-Elect and President.

IN THESE 12 years the epidemic has changed dramatically. The International AIDS Conference held in Vancouver in 1996 provided scientific evidence about the power of HAART to change the natural history of the disease in people living with HIV/AIDS. Today, the IAS strongly supports HAART rollout to avoid unnecessary morbidity and mortality, and as a public health tool, which together with other prevention interventions may help to curb the epidemic. Our Society has been at the frontline of the battle against stigma and discrimination. It has also played an increasingly important advocacy role, and as such has been recognized as a major stakeholder by the AIDS community and by international organizations like UNAIDS, WHO and the World Bank. The IAS has also been a major part of the struggle for the recognition of the human resources crisis particularly in resource limited settings. Last but not least, our voice denouncing poverty and the unequal distribution of wealth all over the world, as a major driving force of the epidemic, has been heard loud and clear.

UNDER OUR GOVERNING Council (GC) leadership, the IAS is now a mature organization, with a strong professional Secretariat. As I complete my tenure, I express my gratitude to the GC and the Secretariat for their commitment, support and help to move our Society forward.

WHEN I TOOK the responsibility of leading the IAS, I expressed my commitment to further expand the transparency and democracy of our procedures. I am sure that we will continue on the same path under the leadership of our new President and President-elect. I welcome Elly Katabira, our new President-elect, who will lead the IAS from 2010 to 2012 and will be the first IAS president from Africa. I give my warmest welcome to our next president, Julio Montaner, who I am sure, will give the IAS all his wisdom and passion in order to enhance the Society's role in the future.

HAVING SERVED AS IAS President has certainly been one of the biggest honours of my professional career. I look forward to meeting you all in Mexico and in future IAS activities. As we say in our theme, we will remain stronger together. ■

Pedro Cahn
IAS President

Message from the Executive Director

PLANNING THE BIENNIAL International AIDS Conference is an enormous effort that brings together partners from across the response to HIV. Together, international and local scientific, community and political leaders work tirelessly over a two-year period to organize a programme that reflects the broad spectrum of activities aimed at reversing the epidemic: scaling up treatment and prevention programmes; protecting human rights and eliminating stigma and discrimination; expanding and accelerating research and strengthening countries' capacity to do so; and building and sustaining political and societal commitment. To some degree, the International AIDS Conference aims to be all things to all people. Everyone involved in the fight against AIDS owns a piece of the conference – it belongs and is shaped by the movement that built it.

TWENTY YEARS AGO the International AIDS Society was created to act as a "custodian" for the conference. Back then, the conference was primarily a scientific meeting, but one that from the beginning was highly politicized. Activists pushed for more research and accelerated approval of new treatments, as well as human rights and political commitment.

THE CONFERENCE HAS changed. Science now shares the programme equally with community and leadership. Resources to address AIDS globally have increased from a few million to US$ 10 billion per year (though sadly, if more was spent earlier we would not need so much now). Thirty-one percent of people in low- and middle-income countries who need antiretroviral therapy now have access; 69% do not. Twenty years ago there were no effective treatments and a diagnosis of HIV infection was truly a death sentence.

WE HAVE MADE progress, but we still have so far to go. The AIDS movement, so successful in the end at reversing the apathy of the world, is now charged with leading the way for strengthening health systems overall, for all people for all diseases. The fight for global health is now firmly on the agenda as never before, and make no mistake, the AIDS movement has been the driving force for global health in the past twenty years.

THE INTERNATIONAL AIDS Society is proud to have played its part in the fight against HIV and the fight for global health. The theme of the XVII International AIDS Conference – Universal Action *Now* – reflects the urgency with which we must continue to work together, at the local, national, regional and international levels, for universal access to HIV prevention, treatment, care and support, for an end to stigma and discrimination against people living with HIV and the communities most at risk, and for the protection of human rights for all people everywhere. ■

Craig McClure
IAS Executive Director

AIDS 2008 Special Sessions Reinforce Call for Universal Action Now

The AIDS 2008 theme, Universal Action *Now*, emphasizes that it is only through individual and collective action that we will reach the goal of ensuring universal access to HIV prevention, treatment, care and support by 2010. Universal Action *Now* is also an important reminder that the HIV/AIDS epidemic does not exist in a vacuum.

Strengthening health systems in poor countries and addressing underlying social injustices – such as poverty, gender inequality and homophobia – that contribute to HIV risk and vulnerability are essential strategies in the global response to HIV.

AS IN TORONTO in 2006, the AIDS 2008 programme will include special sessions designed to spotlight a number of key issues at the forefront of the AIDS policy agenda. One such session, entitled "Moving from Promises to Actions: Building Global and National Commitment for Evidence-based Approaches to Addressing Stigma and Discrimination" will feature presentations on the growing number of effective strategies to reduce HIV stigma and discrimination, which the United Nations Joint Programme on HIV/AIDS (UNAIDS) and others have identified as major barriers to universal access, as well as violations of human rights. "Scaling Up Operations Research in the Era of ART" will emphasize the importance of operations research to continually assess and improve the effectiveness of HIV programmes during treatment scale up. A third special session on Monday will give HIV clinicians an opportunity to test their knowledge of treatment guidelines using case studies and interactive touchpad technology.

The AIDS 2008 theme, Universal Action Now, calls for individual and collective action.

ON TUESDAY, A three-hour special session, entitled "Global Financial Architecture", will bring together representatives from major AIDS donors and recipient countries, as well as leading civil society advocates, to jointly reflect upon the challenges posed by the current global AIDS funding architecture. The session is a follow up to an initial dialogue begun at IAS 2007 in Sydney. A second session, entitled "Travel Restrictions on PLHIV: Going Against the Grain of Human Rights and Public Health", will include speakers from a number of countries with travel restrictions and a discussion of how such policies lack a public health rationale.

AT ANOTHER SPECIAL session, delegates will hear a report back from the Positive Leadership Summit, an international consultation among people living with HIV (PLHIV) networks that will be held in Mexico City just before the International AIDS Conference. The session, "Reclaiming Our Lives: Developing Accountability for Positive Leadership and Our Advocacy Priorities", will also feature a moderated panel discussion of the types of accountability mechanisms necessary to ensure meaningful PLHIV leadership. In "The Future of the Epidemic: Research and the Global Response", Dr. Anthony Fauci, the Director of the National Institute of Allergy and Infectious Diseases, will explore unanswered scientific questions, and Dr. Peter Piot, the UNAIDS Executive Director, will talk about the 2031 Initiative. This initiative is an effort to look long-term and explore where the epidemic and the global response should be 50 years after the discovery of HIV. On the same panel, three prominent community leaders will talk about the future community response.

TWO ADDITIONAL SPECIAL sessions, to be held on Thursday, will feature a panel of national AIDS ambassadors and a discussion of the current debate over whether and how HIV-specific funding is contributing to health systems strengthening in poor countries. In the first session, a number of national AIDS ambassadors will discuss political leadership and accountability for universal action against AIDS, with opportunities for interaction with delegates. "Strengthening Health Systems through the AIDS Response" will feature different perspectives on a hot button policy issue that has garnered a great deal of attention in the AIDS policy community. With the success of prevention and treatment scale up so closely tied to the strengthening of health systems overall, this will be a timely discussion, with important implications moving forward.

FOR IAS MEMBERS who are unable to attend AIDS 2008, the conference website will again make it easy to follow the event remotely. The website will feature free English-language webcasts and transcripts from all key sessions, bilingual podcasts from all conference sessions, as well as the fully-searchable Programme-at-a-Glance, which will include direct links to the full text of all accepted abstracts, as well as copies of presenters' slides and speeches. Onsite rapporteurs will prepare short summaries of all sessions, which will be posted online each evening. The new Abstract Plus system will allow all abstract presenters to supplement their 300-word abstracts with supporting text, data or photos. Additional online programming will be available through the Youth Programme's website (*www.youthaids2008.org*) and through the Global Village page of the website.

IN ADDITION, FOR the first time in the history of the conference, organizers have arranged for remote hubs, or viewing sites, where individuals can view webcasts of sessions and participate in follow-up discussion with local colleagues. An official hub will be sited in South Africa, with many others hosted independently by local AIDS organizations or educational institutions. For a list of hub sites and information about the full conference programme, visit *www.aids2008.org*. ■

Regional Sessions at AIDS 2008

Sub-Saharan Africa
Monday, 4 August
Time: 11:00 – 12:30
Session Room: 8
Session in English and French

Asia-Pacific
Monday, 4 August
Time: 16:30 – 18:00
Session Room: 8
Session in English and Spanish

Latin America
Tuesday, 5 August
Time: 16:30 – 18:00
Session Room: 8
Session in Spanish and English

Eastern Europe and Central Asia
Wednesday, 6 August
Time: 11:00 – 12:30
Session Room: 8
Session in Russian and English

Caribbean
Thursday, 7 August
Time: 11:00 – 12:30
Session Room: 7
Session in English and Spanish

Middle East and North Africa
Thursday, 7 August
Time: 16:30 – 18:00
Session Room: 8
Session in English and French


Centro Banamex, venue for AIDS 2008

IAS Activities at AIDS 2008

In addition to the conference sessions at the upcoming XVII International AIDS Conference (AIDS 2008) in Mexico City, there are a number of other activities that are integral to delegates' experience. These include satellite meetings, exhibitions, the Global Village and the Cultural Programme.

THE INTERNATIONAL AIDS Society (IAS) will be hosting a range of organization-specific activities before and during the conference, celebrating the 20th anniversary of the organization, and highlighting its current role, areas of focus and the new initiatives it is undertaking.

THE FOLLOWING ACTIVITIES are confirmed to date. For more up-to-date information in the run up to the conference, please visit *www.aids2008.org*.

Satellite Sessions

IAS Anniversary Special Satellite: The International AIDS Society at 20 Years – Reflecting Back and Looking Forward: Special Session and General Members Meeting

THE YEAR 2008 marks the 20th anniversary of the IAS. To commemorate this event, the IAS invites delegates to a special satellite session, reflecting back on the early years of the IAS and the epidemic, and looking to the future.

OVER THE PAST 20 years, many of the world's scientific and public health leaders in HIV have served on the IAS Governing Council. As part of this session, a number of past IAS Presidents, as well as one of the world's most respected and long-standing advocates for the involvement of people living with HIV/AIDS in the response, will speak on their particular areas of expertise:

Prof. Lars Kallings, UN Secretary-General's Special Envoy for AIDS in Eastern Europe and Central Asia (founding IAS President, 1988-1990)
Dr. Peter Piot, Executive Director, UNAIDS (IAS President, 1992-1994)
Dr. Mark Wainberg, Director, McGill University AIDS Centre (IAS President, 1998-2000)
Ms. Kate Thomson, Senior Partnership Advisor, UNAIDS
Dr. Stefano Vella, Research Director, Instituto Superiore di Sanità (IAS President, 2000-2002)
Dr. Helene Gayle, President and CEO, CARE (IAS President, 2004-2006)
Dr. Elly Katabira, Associate Professor of Medicine and former Dean of Research, Faculty of Medicine, Makerere University (IAS President-Elect, 2008-2010).

THIS MEETING WILL also serve as the IAS General Members' Meeting. Meeting participants will be introduced to the newly-elected members of the Governing Council, as well as to current and former council members.

DATE: Tuesday, 5 August
TIME: 18:15 - 21:00
ROOM: Session Room 9, Ground Floor

Universal Access of TB services to PLHIV: Harnessing Collaboration and Coordination

Tuberculosis (TB) is a curable and preventable disease that still kills 4,000 people every day. There are nearly 700,000 HIV-positive TB patients globally and most have not yet received HIV treatment and care. TB is the leading cause of death among people living with HIV (PLHIV) in Africa and a major cause of death elsewhere. It is also the most common presenting illness among PLHIV on antiretroviral (ARV) treatment worldwide. The increasing emergence of extensively drug resistant (XDR) TB and the associated high mortality rate among PLHIV calls for urgent actions to be taken by all stakeholders, particularly HIV policy makers and service providers.

THE SATELLITE SESSION is co-sponsored by the World Health Organization, the IAS, the Global Fund, the Forum on Collaborative HIV Research and the United Nations Joint Programme on HIV/AIDS (UNAIDS). The session, organized on behalf of the Global TB/HIV Working Group, will address the key practical activities that need to be implemented in order to reduce the burden of TB in PLHIV and ensure universal access to TB prevention, diagnosis and treatment services. Particular emphasis will be given to the challenges and opportunities of mainstreaming intensified TB case finding, the use of Isoniazid preventive therapy and TB infection control in HIV care services in order to advocate for their inclusion as core functions of HIV care services. Successful implementation experiences from pioneer countries will be presented, what works and what doesn't will be discussed, and next steps will be laid out. Recent advances in the monitoring and evaluation of collaborative TB/HIV activities and harmonizing the core indicators will also be addressed and shared.

THE SATELLITE SESSION will be co-chaired by the IAS President, Pedro Cahn.

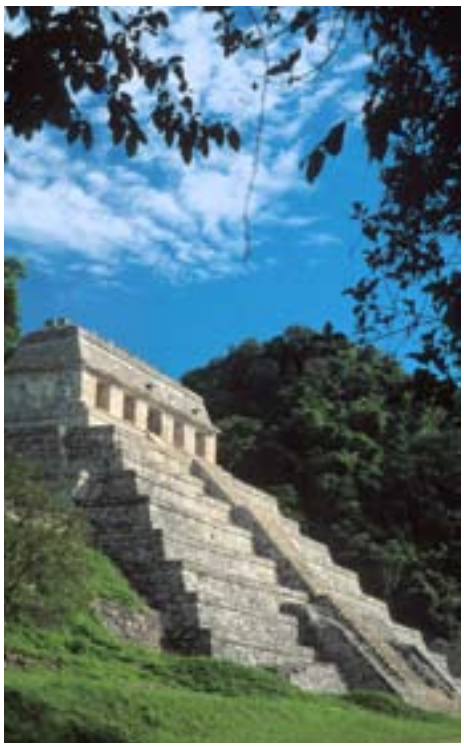
DATE: Sunday, 3 August
TIME: 15:30
ROOM: Session Room 10, Ground Level

Industry Liaison Forum (ILF) TITLE: The role of industry in development of ARV-based prevention technologies for women

THE ILF, AN initiative of the IAS, promotes scientific, intellectual and financial commitment from research-based pharmaceutical and diagnostic companies to research in resource-limited settings.

THE ILF SATELLITE at AIDS 2008 is bringing together scientists from pharmaceutical industries, academia and international organizations, as well as representatives from civil society and government to identify the scientific, operational and political challenges that impede new prevention technologies for women.

THE SPEAKERS WILL present an update on ongoing and planned trials in the field of pre-exposure prophylaxis, as well as antiretroviral-based microbicides. A roundtable discussion will further provide insight into partnerships between organizations and the



pharmaceutical industry with the purpose of promoting research and accelerating development of new prevention technologies. The session will help identify challenges and opportunities in the development of new antiretroviral-based prevention technologies for women and propose ways to address those challenges through ethical, efficient and sustainable methodologies.

DATE: Monday, 4 August
TIME: 18:30 – 20:30
ROOM: Session Room 10, Ground Floor

For more information on the ILF, visit *www.iasociety.org/initiatives.aspx*.

IAS Journal Satellite

The *Journal of the International AIDS Society (JIAS)* is an online, open-access, peer-reviewed HIV/AIDS journal. JIAS publishes HIV-related research from various disciplines, strongly encouraging research carried out by investigators from low- and middle-income countries.

THE PURPOSE OF the session is to have a lively dialogue on how scientific journals can participate in raising research capacity so as to generate more high-quality research from researchers in resource-limited settings; this research is severely lacking, yet necessary. The satellite will help identify possible approaches and specific mechanisms in which scientific journals can contribute to raising research capacity in resource-limited settings.

DATE: August 6, 2008
TIME: 07:00 – 08:30
ROOM: SBR4

For more information on JIAS, visit *www.iasociety.org/initiatives.aspx*. ■

IAS Exhibition Booth

At the IAS Exhibition Booth, delegates can find out more about the International AIDS Society and its conferences and initiatives. Visitors will have an opportunity to meet representatives from the upcoming IAS 2009 and AIDS 2010 conferences, as well as IAS staff and members of the IAS Governing Council. It is also possible for delegates to apply for or renew their IAS membership at the Member Services desk in the booth.

DATES AND TIMES: Sunday, 3 August 12:00 – 18:00; Monday, 4 August to Thursday, 7 August 10:30 – 18:30; Level 2

Stigma Campaign

The International AIDS Society and the French non-governmental organization, AIDES, will launch a joint awareness campaign against stigma and discrimination at the IAS booth. Delegates will be invited to participate in this interactive campaign during the conference, creating their own messages and visuals, which will be available for download on the IAS website.

Education Stand

The Education Stand, part of the IAS booth, will comprise a showcase of the IAS online educational repository.

Education Programme

HIV Prevention Research Advocacy

In conjunction with the Global Network of People Living with HIV/AIDS, the International Community of Women Living with HIV/AIDS, the International Council of AIDS Service Organizations and the Mexican Network of People living with HIV, and in partnership with the AIDS Vaccine Advocacy Coalition, the International AIDS Society is delivering a mentoring and education programme on HIV prevention research advocacy.

THE PROGRAMME IS aimed at community HIV advocates, and is intended to build their capacity in prevention research technology and implementation issues.

THE PROGRAMME INCLUDES participation at a one-day seminar in Mexico City on 2 August 2008, focused mentoring around relevant conference sessions, and facilitated discussions at the end of each conference day. The seminar is designed as a learning cycle around the knowledge, skills and awareness required for enhanced prevention research advocacy. Beyond the conference, an advocates' network will be established to ensure continuous provision of information about ongoing research in the field, and the cross-fertilization of experiences and ideas related to prevention research advocacy.

DATE: Saturday, 2 August
TIME: 08:30 – 17:30
ROOM: Fiesta Americana Reforma Hotel

Meetings at IAS Offices

Regional Partnerships Meeting

At this meeting of regional AIDS societies and networks, representatives of the societies and networks will be joined by invited key people from the IAS, United Nations agencies, bilateral and multilateral agencies, public and private foundations, and the pharmaceutical industry.

THE MEETING WILL explore opportunities for increased collaboration among the networks and between them and other major stakeholders in the HIV/AIDS response. In particular, they will discuss how to ensure that what happens at the regional and international AIDS conferences forms the basis for continuing exchange, learning, dialogue and action.

PARTICIPATION WILL BE by invitation only.

DATE: Monday, 4 August
TIME: 15:00 – 17:00
ROOM: IAS Offices, Banamex Conference Centre

Skills Building Workshops

Publish or Perish

The IAS workshop, "Publish or Perish", is for investigators from resource-limited settings who wish to strengthen their skills in successfully publishing their research/project findings.

IT WILL BE led by the editors-in-chief of the Journal of the International AIDS Society, Dr. Mark Wainberg, and Dr. Elly Katabira.

DATE: Wednesday, 6 August
TIME: 14:30 – 18:00
ROOM: TBA ■

Visit the Regional Conferences booths

All delegates participating at the XVII International AIDS Conference in Mexico, 3 – 8 August, are invited to visit the Regional Conferences booths in the exhibition area which is located on the Nivel Expociones (Salon Expos D) of the conference centre.

The Exhibition Hours are:
Sunday, 3 August – 12.00 to 18.00
Monday, 4 August to Thursday, 6 August – 10.30 to 18.30
Friday, 8 August – Closed

An Overlooked HIV Prevention Tactic: Antiretrovirals for All

Mark Mascolini

Depressing news on candidate vaccines and vaginal microbicides monopolized HIV prevention headlines for much of the past year as a Merck vaccine and the Carraguard and cellulose sulfate microbicides all failed to show any preventive effect in clinical trials.

THROUGHOUT THIS REMORSELESS bad-news drumbeat, a few HIV mavens turned media attention to a prevention tactic that clinical trials, cohort studies, and epidemiologic data validated time and again in the past decade – antiretroviral (ARV) therapy.

SPEAKING AT THE 2002 International AIDS Conference in Barcelona, former International AIDS Society (IAS) President David Cooper offered one of the first extended proposals for a trial testing ARV therapy as a tool to thwart the spread of HIV. IAS President-Elect Julio Montaner made the same case – with an added four years of trenchant data – at Toronto's 2006 International AIDS Conference and then in a Lancet essay.[1] In that treatise, Montaner and colleagues framed a sturdy three-pronged polemic for ARV therapy for prevention: the most-familiar HIV prevention strategies are only partly effective and much underused; lower viral loads slice the risk of sexual or mother-to-child HIV transmission; and ARVs lowers viral loads in plasma and sexual fluids.

INDEED, ARVS ALREADY enjoy routine (though hardly rife) use in preventing HIV infection via mother-to-child transmission (MTCT) and as post-exposure prophylaxis for health workers and laypeople. Three large trials are testing tenofovir or tenofovir/emtricitabine as pre-exposure prophylaxis (PrEP) in diverse at-risk populations. Modelling studies suggest that PrEP with one or more antiretrovirals could ward off more than 3 million new HIV infections in southern Africa over the next decade.[2]

ARV Therapy as Prevention in Infants and Couples

IN THE DAYS before highly active antiretroviral therapy (HAART), when antiretroviral news ranged from bleak to dour, paediatricians reversed that trend by showing that simple zidovudine monotherapy slashed MTCT risk by two thirds.[3] Before the eye-opening results of that trial, MTCT risk was around 25%; today, it is below 1% in populations taking modern antiretroviral combinations.

THE REASON FOR this remarkable success is hardly recondite: lower plasma viremia in mothers means the fetus and newborn get exposed to less HIV in blood and breast milk. A pre-HAART study of 30 women found that eight of 10 mothers with more than 190,000 HIV RNA copies/ml at delivery transmitted HIV to their infants, while none of 20 with a load below 156,000 copies/ml did.[4]

IN THE FIRST eight years of the HAART era, European investigators found that antenatal ARV use rose from 5% to 92% as the MTCT rate dropped from 2.87% to 0.9%.[5] In 885 mother-child pairs, higher maternal HIV load hoisted MTCT risk 12 times. In a French study of 5,271 women taking ARVs during pregnancy from 1997 through 2004 and not breastfeeding, overall MTCT measured 1.3%.[6] Among 1,338 women with fewer than 50 copies/ml at delivery, only 5 (0.4%) passed HIV to their infants.

THE SAME LINK between viral load and MTCT risk holds true in resource-poor areas for both HIV-1 and HIV-2.[7] A blinded comparison of 144 Gambian women with HIV-1, 294 with HIV-2, and 565 without HIV measured an average HIV load of 15,100 copies/ml with HIV-1 and 410 copies/ml with HIV-2 in these ARV-naive women. Estimated MTCT rates measured 24.4% in the HIV-1 group and 4% in the HIV-2 group. Every 10-fold higher maternal viral load upped the risk of HIV transmission 2.9 times.

SEXUAL TRANSMISSION EXPLAINS most of the world's 33 million HIV cases, and handcuffing HIV replication could prevent perhaps nearly all of them. The seminal study of HIV transmission in untreated serodiscordant couples (one infected partner and one uninfected partner) came from the rural Ugandan Rakai cohort in 2000.[8] That study, of 415 couples monitored for up to 30 months, yielded three critical findings:

- Average viral load was significantly higher in infected partners who transmitted HIV than in those who did not – 90,254 versus 38,029 copies/ml.
- No partner with a load below 1,500 copies/ml transmitted HIV.
- Every 10-fold higher viral load inflated chances of HIV transmission by 2.45 times.

SINCE THEN, RESEARCH consistently confirmed lower transmission risk from partners with lower HIV levels, regardless of study site, transmission mode or antiretroviral use (Table). Perhaps the most revealing of these studies focused on a South African township, where researchers analyzed how when-to-start guidelines may affect transmission risk.[11] In a random sample of about 1,000 sexually-active men and women, this team estimated that starting ARV therapy according to 2004 World Health Organization guidelines (<200 CD4 cells/µL) would lower annual HIV transmission risk by 12%, but starting with 2004 U.S. guidelines (<350 cells/µL) would lower that risk by 72%.

Lower HIV Load Consistently Lowers Risk of Sexual HIV Transmission

Author	Year	Site	Participants	ARV use?	Key findings
Quinn[8]	2000	Rural Uganda	415 heterosexual couples	No	Every 10-fold higher viral load more than doubles HIV transmission risk; no transmissions from partners with <1,500 copies/ml.
Gray[9]	2001	Rural Uganda	174 heterosexual couples	No	HIV transmission probability is 0.0023 per act at 38,500 copies/ml and 0.0001 per act at <1,700 copies/ml.
Tovanabutra[10]	2002	Thailand	493 heterosexual couples	No	Every 10-fold higher viral load in men raises HIV transmission risk to women by 81%; no transmissions from men with <1,094 copies/ml.
Auvert[11]	2004	South Africa	1,000 heterosexual men and women	No	ARVs would lower annual HIV transmission risk by 11.9% with WHO guidelines tfor starting ARVs and by 71.8% with more liberal U.S. guidelines.
Porco[12]	2004	San Francisco	534 men who have sex with men (MSM)	Yes	Estimated per-partner HIV transmission risk falls from 0.120 before HAART to 0.048 with widespread HAART.
Fang[13]	2004	Taiwan	4,390 prevalent HIV cases	Yes	Estimated HIV transmission rate falls from 0.391 new cases per prevalent case-year before free HAART to 0.184 new cases afterwards.
Castilla[14]	2005	Spain	393 heterosexual couples	Yes	HIV rate is 8.6% when partner is not taking ARVs versus 0% when partner is taking ARVs; HIV prevalence falls from 10.3% pre-HAART (1991-1995) to 1.9% with HAART (1999-2003).

Hurdles to Slowing Epidemic with ARVs

NO ONE SUGGESTS stifling HIV transmission by expanding ARV coverage will be easy. Even the modest antiretroviral access gains made since the 2000 Durban International AIDS Conference have come only by dint of diligent planning and the will to overcome inevitable setbacks. And promoting ARVs for prevention carries distinct risks. The Swiss Federal Commission of HIV/AIDS touched off countless concerned rebuttals when it declared that people with an undetectable HIV load and no sexually transmitted infections (STIs) have no "relevant risk" of infecting partners with the virus.[15] Citing some of the same studies outlined in the Table, the Swiss maintained that a person in whom ARV therapy successfully stymies HIV "is not sexually infectious, i.e., cannot transmit HIV through sexual contact".

THE SWISS STANCE inflamed fears that people with an undetectable load would assume they can forget about condoms. Critics pointed out that anal intercourse – homosexual or heterosexual – carries a higher HIV transmission risk than vaginal intercourse and could undercut the Swiss advice. And as Julio Montaner stressed in his Lancet tract,[1] modelling studies suggest that the prophylactic potential of ARVs may be readily undermined by a return to riskier sex among people who assume ARV therapy absolutely abolishes transmission risk.[16-18]

SEVERAL COHORT STUDIES buttress those modelling projections by linking ARV therapy to looser attitudes about sexual behavior in both heterosexuals[19,20] and MSM.[19,21-23] But a study of 420 London MSM suggests ARV therapy can make people more responsible sex partners.[24] This cross-sectional analysis found that ARV-treated men had fewer sex partners, less unprotected anal intercourse with new partners, and fewer acute STIs than men not on ARVs. The investigators believe their findings "suggest it is unlikely that taking HAART itself leads HIV-positive homosexual men to throw caution to the winds". What makes some ARV-treated people more cautious, and some more cavalier, requires closer study.

A Hypothetical Proposal: ARVs for Everyone

UNLEASHING ARV THERAPY to prevent new HIV infections globally rests on the premise that "treating 100% of HIV-infected individuals at once would greatly reduce HIV transmission", Montaner proposes.[1] No one thinks policy-makers can flip a switch to accomplish such an ambitious venture overnight; low-income countries would be much closer to Millennium Development Goals for ARV therapy if they had the personnel, clinics and drugs needed to treat everyone losing CD4 cells.

BUT MONTANER AND colleagues argue that total antiretroviral access – though costly today – would prove cost-effective before long. Stoking debate on the cost question, they built a population-based model to gauge the impact of universal access on the pandemic, based on some bold assumptions[1]:

- All HIV-infected people would be treated in the programme's first year.
- After the first year, there would be no new HIV infections.
- ARV costs would rise from the $365 per person yearly at a 3% annual inflation rate.
- Mortality would fall initially but rebound to baseline levels as the treated population requires more complicated regimens.

THE MODEL PREDICTS that after 45 years, HIV prevalence would plunge from seven cases per 1,000 people to less than 0.1. Worldwide HIV prevalence would dwindle to 1 million. The cost of ARV therapy would fade from $15 billion to $1 billion yearly and would total $338 billion over 45 years – hardly an outlandish sum when one considers the benefits. And by preventing new infections tomorrow, Montaner's model predicts that treating all infected people today would save $10.3 billion in lifetime ARV costs in North America alone.[1]

BEYOND STEEP LOGISTICAL and economic challenges, marshalling ARVs for prevention raises questions of safety, individual rights and resistance. But the huge potential benefit, at a conceivable cost[25], robustly bolsters arguments that prophylactic ARV therapy deserves a prime place on the global research agenda. ■

Katabura Hospital, Windhoek, Namibia. Photo: Alfredo L Fort, courtesy of Photoshare

References

1. Montaner JSG, Hogg R, Wood E, et al. The case for expanding access to highly active antiretroviral therapy to curb the growth of the HIV epidemic. Lancet, 2006, 368:531-536. (*http://download.thelancet.com/pdfs/journals/0140-6736/PIIS0140673606691629.pdf*)

2. Abbas UL, Anderson RM, Mellors JW. Potential impact of antiretroviral chemoprophylaxis on HIV-1 transmission in resource- limited settings. PLoS One, 2007, 2(9):e875. (*http://www.plosone.org/article/info:doi/10.1371/journal.pone.0000875*)

3. Centers for Disease Control and Prevention. Zidovudine for the prevention of HIV transmission from mother to infant. Morbidity and Mortality Weekly Report, 1994, 43:285-287.

4. Fang G, Burger H, Grimson R, et al. Maternal plasma human immunodeficiency virus type 1 RNA level: a determinant and projected threshold for mother-to-child transmission. Proceedings of the National Academy of Sciences USA, 1995, 92:12100-12104.

5. European Collaborative Study. Mother-to-child transmission of HIV infection in the era of highly active antiretroviral therapy. Clin Infect Dis, 2005;40:458-465.

6. Warszawski J, Tubiana R, Le Chenadec J, et al. Mother-to-child HIV transmission despite antiretroviral therapy in the ANRS French Perinatal Cohort. AIDS, 2008, 22:289-299.

7. O'Donovan D, Ariyoshi K, Milligan P, et al. Maternal plasma viral RNA levels determine marked differences in mother-to-child transmission rates of HIV-1 and HIV-2 in the Gambia. AIDS, 2000, 14:441-448.

8. Quinn TC, Wawer MJ, Sewankambo N, et al. Viral load and heterosexual transmission of human immunodeficiency virus type 1. Rakai Project Study Group. New England Journal of Medicine, 2000, 342:921-929.

9. Gray RH, Wawer MJ, Brookmeyer R, et al. Probability of HIV-1 transmission per coital act in monogamous, heterosexual, HIV-1-discordant couples in Rakai, Uganda.

Lancet, 2001, 357:1149-1153.

10. Tovanabutra S, Robison V, Wongtrakul J, et al. Male viral load and heterosexual transmission of HIV-1 subtype E in northern Thailand. Journal of Acquired Immune Deficiency Syndromes, 2002, 29:275-283.

11. Auvert B, Males S, Puren A, et al. Can highly active antiretroviral therapy reduce the spread of HIV? A study in a township of South Africa. Journal of Acquired Immune Deficiency Syndromes, 2004, 36:613-621.

12. Porco TC, Martin JN, Page-Shafer KA, et al. Decline in HIV infectivity following the introduction of highly active antiretroviral therapy. AIDS, 2004, 18:81-88.

13. Fang CT, Hsu HM, Twu SJ, et al. Decreased HIV transmission after a policy of providing free access to highly active antiretroviral therapy in Taiwan. Journal of Infectious Diseases, 2004, 190:879-885.

14. Castilla J, Del Romero J, Hernando V, et al. Effectiveness of highly active antiretroviral therapy in reducing heterosexual transmission of HIV. Journal of Acquired Immune Deficiency Syndromes, 2005, 40:96-101.

15. Vernazza P, Hirschel B, Bernasconi E, Flepp M. Les personnes séropositives ne souffrant d'aucune autre MST et suivant un traitment antirétroviral efficace ne transmettent pas le VIH par voie sexuelle. Bull Med Suisses, 2008, 89(5).

16. Blower SM, Gershengorn HB, Grant RM. A tale of two futures: HIV and antiretroviral therapy in San Francisco. Science, 2000, 287:650-654.

17. Law MG, Prestage G, Grulich A, et al. Modelling the effect of combination antiretroviral treatments on HIV incidence. AIDS, 2001, 15:1287-1294.

18. Velasco-Hernandez JX, Gershengorn HB, Blower SM. Could widespread use of combination antiretroviral therapy eradicate HIV epidemics? Lancet Infectious Diseases, 2002, 2:487-493.

19. Desquilbet L, Deveau C, Goujard C, PRIMO Cohort Study Group. Increase in at-risk sexual behaviour among HIV-1-infected patients followed in the French PRIMO cohort. AIDS, 2002, 16:2329-2333.

20. Wilson TE, Gore ME, Greenblatt R, et al. Changes in sexual behaviour among HIV-infected women after initiation of HAART. American Journal of Public Health, 2004, 94:1141-1146.

21. Ostrow DE, Fox KJ, Chmiel JS, et al. Attitudes towards highly active antiretroviral therapy are associated with sexual risk taking among HIV-infected and uninfected homosexual men. AIDS, 2002, 16:775-780.

22. Stolte IG, de Wit JB, van Eeden A, et al. Perceived viral load, but not actual HIV-1-RNA load, is associated with sexual risk behaviour among HIV-infected homosexual men. AIDS, 2004, 18:1943-1949.

23. Stolte IG, Dukers NH, Geskus RB, et al. Homosexual men change to risky sex when perceiving less threat of HIV/AIDS since availability of highly active antiretroviral therapy: a longitudinal study. AIDS, 2004, 18:303-309.

24. Stephenson JM, Imrie J, Davis MM, et al. Is use of antiretroviral therapy among homosexual men associated with increased risk of transmission of HIV infection? Sex Transm Infect, 2003, 79:7-10.

25. According to the CIA World Factbook, gross domestic product calculated by purchasing power parity in 2007 exceeded $2,000 billion in China, France, India, Italy, Russia, the United Kingdom and the United States. In 2006, the U.S. Congress appropriated $399 billion for defence.


Nelson Mandela, Bill Clinton and delegates at the XIV International AIDS Conference, Barcelona, Spain (2002)

20 Years of the International AIDS Society

HIV Professionals Working Together to Fight AIDS

Adapted by Rodney Kort

This year marks the 20th anniversary of the IAS, and to honour the work and dedication of its current and past members, staff and Governing Council, the IAS is publishing a short history of the organization, written by Lars Kallings and Craig McClure.

THIS ARTICLE SUMMARIZES the highlights of that history, and we encourage our members and other stakeholders to read the full story of the IAS - a story which, in many ways, reflects the evolution of the epidemic itself.

MUCH OF THE IAS' history lies in its conferences, and the struggle for evidence and experience to prevail over ignorance and political expediency in the global response to HIV/AIDS. For an epidemic that was initially identified with stigmatized communities, and which quickly emerged among the poorest and most vulnerable populations on the globe, this was – and continues to be – an enormous challenge.

THREE INTERNATIONAL AIDS Conferences were held – in 1985 (Atlanta), 1986 (Paris) and 1987 (Washington) – before the IAS was established in 1988 to take over their planning and implementation. Those first conferences focused almost exclusively on biomedical and epidemiological issues, with socio-behavioural research not included until the 1987 conference. The early conferences also took place during a period of rising concern and sometimes outright hysteria about this new and deadly disease. By May 1987, when the conference was held, over 20,000 Americans had died of AIDS and over 36,000 had been diagnosed with HIV, but President Reagan had yet to make a public statement about the epidemic. Activists were furious with the poor leadership by the U.S. federal government, the sluggish pace of the U.S. Food and Drug Administration drug approval process and the lack of effective treatment for thousands of people dying of the disease.

THE IAS WAS established as a non-profit organization in Stockholm in 1988, where the International AIDS Conference took place that year, and where its first (part-time) Secretary General, Lars Kallings, was based. An Advisory Board was established which later became the 28-member Governing Council (five members elected from IAS members in each of five regions: North America, Latin America and the Caribbean, Europe and Israel, Africa, and Asia and the Pacific Islands), with the three executive positions of President, President-elect and Treasurer elected by the GC. The mission and objectives of the International AIDS Conferences were drafted in close collaboration with Jonathan Mann, then Director of the WHO Global Programme on AIDS. They established important principles that would guide future IAS policy: the international and inter-disciplinary approach (including ethical, legal, economic and political aspects of HIV/AIDS), promotion of global solidarity between people working in HIV, and fighting discrimination against people living with HIV and those most vulnerable to infection.

THE MONTREAL (1989) and San Francisco (1990) conferences were marked by significant activism; in addition to pressing for stronger government leadership and more resources in the response to AIDS, protesters also called for greater community involvement in organizing the conferences. U.S. activists were particularly incensed by the 1987 U.S. government ban on entry to people living with HIV. Despite the pleas of the IAS, prominent U.S. public health officials and activists, the ban remained and was eventually written into law. As a result, the 1992 conference, originally scheduled to be held in Boston, was relocated to Amsterdam. IAS policy since then has been to hold the conferences only in countries which admit entry to people living with HIV. Recent work by the IAS, U.S. organizations and other international partners has resulted in some movement on this issue among U.S. legislators, and after 20 years one of the most egregious examples of anti-HIV discrimination in the U.S. may finally end.

INTERNATIONAL AIDS CONFERENCES in the late 1980s and early 1990s were marked by important advances in our understanding of HIV pathogenesis, epidemiology and transmission dynamics, but little in the way of effective treatment options. The enormous scope of the epidemic had also become apparent in the developing world, particularly sub-Saharan Africa, which bore the brunt of the epidemic. The 1993 conference in Berlin dashed hopes for the only promising HIV treatment when the Concorde trial revealed no medium or long-term benefit of Zidovudine (AZT) monotherapy.

THAT ALL CHANGED with the 1996 International AIDS Conference in Vancouver. Clinical researchers using a combination of antiretrovirals–nucleoside reverse transcriptase inhibitors and protease inhibitors or non-nucleoside reverse transcriptase inhibitors – had achieved remarkable results. Highly active antiretroviral therapy (HAART) reduced viral load in peripheral blood to undetectable levels, allowed CD4+ cells, key markers of immune function, to increase and mortality and morbidity among patients plummeted. HAART revolutionized HIV treatment and care, and for most patients in high-income countries, the prognosis improved dramatically. However, it quickly became clear that the complex and expensive regimens of antiretrovirals, coupled with sophisticated clinical and laboratory monitoring requirements, meant that areas of the world where the epidemic was most devastating would be unlikely to reap the benefits of these new treatments. The theme of the Vancouver conference - One World, One Hope - began to ring increasingly hollow.

THE CONFERENCE ITSELF was evolving to address the complex range of social, political and economic issues that an epidemic of this scope and complexity demanded. The Geneva Principle, established in 1998, provided for a balance between community and science in the conference programme. In 2004 the IAS piloted the Leadership Programme, in an effort to increase the profile and participation of political and other leaders in the global response to the epidemic, and thereafter the conference became a balance of science, community and leadership. That year the IAS secretariat moved from Stockholm to Geneva, and the organization began a three-year scale-up of professional staff to ensure greater oversight and fiscal accountability for the conferences and to expand its capacity for engaging in policy, advocacy and educational activities with its partners and members.

XV International AIDS Conference, Bangkok, Thailand (2004)

BY THE 2000 International AIDS Conference in Durban, the demands for a change in the approach to global public health had reached a crescendo. In the first Jonathan Mann Memorial Lecture, established in honour of the pioneering HIV scientist and human rights advocate who died tragically in a 1998 airplane crash, HIV-positive South African High Court Justice Edwin Cameron decried the "shocking and monstrous inequity" in treatment access between the developed and developing world, and South Africa's Treatment Action Campaign staged a well-publicized march on the conference.

SOUTH AFRICAN PRESIDENT Thabo Mbeki undoubtedly helped to boost media interest in the conference by questioning the link between HIV and AIDS, suggesting that AIDS symptoms were side effects of the antiretroviral drugs produced by Western pharmaceutical companies. His views were echoed by his Minister of Health, Manto Tshabalala-Msimang. The bizarre position taken by President Mbeki and his health minister prompted 5,000 scientists from around the world to publish "The Durban Declaration" in Nature on the eve of the conference, confirming the overwhelming scientific evidence about the aetiology of AIDS.

THE DURBAN CONFERENCE proved to be a unique platform to address both treatment inequity and AIDS denialism, and helped to galvanize political support and resources in the years to come; universal access to HIV prevention, treatment and care became the new target for the international community.

MOVING THE INTERNATIONAL AIDS Conference to a biannual schedule after the Yokohama conference in 1994 allowed the IAS to organize a second specialty conference, focused on basic science and clinical issues, including novel therapeutics, side effect profiles, simplified drug regimens, and drug resistance. The IAS Conference on HIV Pathogenesis and Treatment (later renamed the IAS Conference on Pathogenesis, Treatment and Prevention, to include the growing field of biomedical prevention research) was first held in 2001 and the series has proven to be a popular platform for presenting new research and discussing its implications for policy and practice.

WITH SCALE-UP CAME new challenges and new questions about the best approach to delivering HIV treatment, care and prevention interventions. This was the background against which the Sydney Declaration was issued by the organizers of IAS 2007 in The Lancet. The Sydney Declaration highlighted the need for operations research to guide scale-up efforts, calling for donors to allocate 10% of all HIV resources to research. The Sydney Declaration helped draw attention to an under-resourced but critical area of research; in March 2008, IAS, WHO, the World Bank and the Global Fund co-hosted a consultation to help identify research priorities and allocate roles and responsibilities in implementing the Sydney Declaration recommendations. The 2008 conference in Mexico City, the first to be held in Latin America, will expand its focus on the need to mobilize the HIV community to address health systems strengthening to achieve universal access to HIV prevention, treatment and care.

THE INTERNATIONAL AIDS Conference is one of very few international meetings in which programmatic and personal experience is presented alongside traditional scientific research; this blend of scientific research, community engagement and the participation of influential leaders involved in the global response has helped make it the world's largest regular forum on any health or development issue. As has been the case for the last 20 years, the future of the IAS will mirror the future of the epidemic, and the IAS will continue to leverage the enormous passion and collective wisdom of its members, staff and stakeholders in the fight against AIDS. ■


Lars Kallings, founder and first Secretary General of the IAS

Pilot programme for infant diagnosis of HIV using DNA PCR, Haiti. Photo: Nathaniel Segaren, Courtesy of Photoshare

The HIV/AIDS Epidemic in Latin America and the Caribbean

By Pedro Cahn

THE HIV/AIDS EPIDEMIC poses one of the most important challenges for the healthcare systems, citizens, researchers, and governments of Latin America and the Caribbean. At the same time, this region has offered some of the most creative and energetic responses to the epidemic.

OF ALL THE areas in the world, the Caribbean is the second most severely affected by HIV, with 1.2% of the population infected. In Latin America, the epidemic tends to be concentrated among specific populations. In this region, however, the subject of HIV/AIDS is often swept under the rug. To discuss HIV/AIDS is to give a name to issues that many people would prefer to avoid: generalized poverty, homophobia, gender inequality, lack of access to healthcare and educational services, immigration and emigration, the lack of leadership in some countries, the lack of research into patterns of transmission, the pressure from some churches not to promote the use of condoms, and laws that are inadequate in the context of the epidemic. These are only some of the factors that characterize this region and interfere with the possibility of responding effectively to HIV/AIDS.

FROM THE TIME when the epidemic first began, the prevalence of the illness and the populations vulnerable to it have varied. The manner in which the virus is transmitted, however, has remained the same: most cases continue to be transmitted sexually. In Latin America, the epidemic is seen fundamentally among members of vulnerable populations, such as sex workers, men who have sex with men, members of "trans" groups (i.e. transvestites, transsexuals, and transgendered individuals), and drug users.

AT THE SAME time, the feminization of the epidemic is also apparent in the region. This trend is a result of the vulnerability of the female population, in both biological and social terms. In 2001, 37% of the total number of adults living with HIV in the Caribbean were women. By 2007, this proportion had increased to 43%. In Latin America, 512,000 women were living with HIV in 2007, representing 32% of all cases.

IN THIS REGION, young people are a vulnerable population as well. A number of factors increased the vulnerability of members of this group, including increased inequality, marginalization, and the tendency to adopt risky behaviors, among other factors. In Brazil, for example, 41.1% of the sexually transmitted cases of HIV that were recorded in 2006 occurred among men between the ages of 13 and 24 years, who had sex with men. National surveys taken in the early 2000s indicated that 20% of young women in Nicaragua used condoms when having premarital sexual relations. The number was 21% in Bolivia, 20% in Peru, 32% in Colombia, and 31% in the Dominican Republic. Finally, estimates indicate that in the Caribbean, 1.6% of women and 0.7% of men between the ages of 15 and 24 were living with HIV in 2004. In Latin America, the numbers were 0.3% of women and 0.5% of men.

WITH REGARD TO children, estimates indicate that 39,000 children are living with HIV in Latin America, and 10,000 in the Caribbean. In 2007, there were 6,700 new infections among this population in Latin America, and 2,000 in the Caribbean.

MEANWHILE, AMONG LOW- to middle-income regions, Latin America and the Caribbean have the greatest access to antiretroviral therapy. It is estimated that 72% of those who need the treatment receive it; this figure represents 355,000 individuals. In no country are 100% of those who need treatment covered, however. More than 95% are covered in Costa Rica and Cuba. But the Dominican Republic and Haiti, the countries where the disease is most prevalent, only reach 37% and 39%, respectively. Bolivia is at the lower extreme, with a treatment access rate of 24%.

ALTHOUGH AN INCREASING number of countries in the region provide universal coverage to persons living with HIV, there is also a lack of access to healthcare in general. As a result, many individuals do not know their HIV status and, consequently, do not avail themselves of medical screenings and treatments, even when these are available. This is the case in Brazil and Argentina. Although universal access is guaranteed in these countries, it reaches only 85% and 79% of HIV patients, respectively.

FOR ALL OF these reasons, it is not possible to speak of one single epidemic in the region, since different contexts require specific approaches. In Latin America, the epidemic has been stable since 2003, with 0.5% of the population infected. There were 100,000 new infections in 2007, and 1.6 million persons are living with HIV. Approximately 58,000 individuals die as a result of AIDS, and it is estimated that in 2015 there will be 3 million individuals with HIV and 1.5 million deaths.

BRAZIL, MEXICO, ARGENTINA, and Colombia are the Latin American countries with the largest populations and, consequently, the highest numbers of cases. The virus is most prevalent, however, in the smallest countries, such as Honduras, Panama, El Salvador, or Guatemala, where about 1% of adults are infected. In Haiti, the Bahamas, Guyana, and Belize, the proportion is above 2%.

ABOUT ONE THIRD of the people with HIV in Latin America live in Brazil, where the number of HIV-positive individuals reached 620,000 in 2006. In the last five years, however, a downward trend in the number of new infections has been reported, with 32,000 new cases reported in 2006.

IN MEXICO, 0.3% of the population is HIV-positive, and almost 90% of the reported cases are the result of unprotected sex. Half of these cases are among men who had sex with men. Of the 182,000 HIV-positive individuals in the country, it is estimated that only one third are aware that they are infected. Sex is the most common means of transmitting HIV in Argentina as well. It has been estimated that 130,000 persons are living with HIV in that country, which indicates a prevalence of 0.6% among the adult population. It is estimated, however, that two thirds of those infected are unaware of their status.

IN URUGUAY, MORE than three fourths of all cases of AIDS have been reported in the capital, Montevideo, and the surrounding areas. Unprotected sex is the means of transmission in two thirds of the HIV cases that are reported; the majority of these cases involve heterosexual encounters. In Paraguay, too, the epidemic is primarily centered in the capital city, Asunción, and in areas bordering Argentina and Brazil. Chile, where the prevalence is 0.3%, shows the same tendency, with cases concentrated in urban areas.

IN THE ANDEAN region, men who have sex with men are a significant factor. In Bolivia, the prevalence of the virus is 0.1%, and it is concentrated in urban areas. In Ecuador, where the number of HIV cases has doubled since 2001, the prevalence is 0.3%, and more than two thirds of transmissions were caused by unprotected sex between men. In Colombia and Peru, the prevalence of the virus is 0.6%, and it is concentrated among the population of homosexual males as well. In some cities in Peru, however, such as Arequipa, Iquitos, Pucallpa and Sullana, the prevalence climbs to between 6% and 12%, and it reaches 23% in Lima. In Colombia, meanwhile, 83% of all AIDS cases are found among men who have sex with men.

IN CENTRAL AMERICA, the virus is spreading primarily among the most vulnerable groups, and it is concentrated in urban areas and along transport routes. In Belize, Costa Rica, El Salvador, Nicaragua, Panama, and Guatemala, there is a prevalence of 0.9% among men who have sex with men, and the rate is up to three times higher in the cities where the virus first occurred. Honduras, with a 1.5% prevalence, has one of the highest rates in the region. Some data, however, show that this figure is declining.

IN THE SUB-REGION of the Caribbean, the epidemic varies significantly by country and population. Of the 230,000 HIV-positive individuals in the Caribbean, 51% are adult women. Over the course of 2007, 11,000 persons died of causes related to AIDS; of this number, 1,500 were children. AIDS is the most common cause of death among adults aged 15 to 44 years.

MOST COUNTRIES IN the Caribbean have managed to stabilize the epidemic. National responses have been developed, including national commissions, legislation, programmes, services, and the active involvement of the public. At the same time, however, structural factors, such as poverty, unemployment, stigmatization, and gender discrimination and inequality hinder responses to the epidemic.

IN THIS SUB-REGION, HIV is primarily transmitted through sex. This is particularly the case among men who have sex with men; this population accounts for 12% of new infections. Unprotected sex between sex workers and their clients also constitutes a significant factor.

HAITI IS HOME to the highest number of HIV-infected individuals in the Caribbean, with a 2.2% prevalence. Among pregnant women who received care at pre-natal clinics, however, the prevalence dropped from 5.9% in 1996 to 3.1% in 2004. There is also a trend towards lower numbers in the capital, Port-au-Prince, and other cities, where the prevalence of HIV in women aged 14 to 44 years fell from 5.5% to 3% between 2000 and 2005.

IN THE DOMINICAN Republic, sex workers form one of the most vulnerable populations. In Guyana, which has a prevalence of 2.4%, HIV is transmitted primarily through unprotected sex. The most recent survey taken at pre-natal clinics in Guyana indicates a 1.6% prevalence of HIV among pregnant women; this figure is lower than the percentage observed in 2004.

CUBA REPRESENTS AN exceptional case, with the lowest prevalence in the region (0.1% among the adult population). In addition, its vertical prevention programme is one of the most effective in the world. Cuba also offers free, universal access to antiretroviral treatment, which has limited both the number of AIDS cases and the number of AIDS-related deaths.

IN CONCLUSION, THE stabilization of the epidemic in the region does not mean that infections have been halted, or that the number of deaths has been reduced. What it does mean is that prevalence figures are holding steady over time. In some Central American and Caribbean countries, however, those prevalence figures continue to be very high. This is the case in Barbados (1.5%), the Dominican Republic (1.0%) Jamaica (1.5%), the Bahamas (3.3%) and Trinidad and Tobago (2.6%).

CONSEQUENTLY, IT CONTINUES to be necessary to address vulnerability at the structural level, through sustained intervention that departs from predetermined formulas. In the words of Dr. Mirta Roses, Director of the Pan American Health Organization (PAHO), during her closing presentation at the 4th Latin American and Caribbean Forum on HIV/AIDS and STD: "The only way to stop and reverse the HIV epidemic is through a comprehensive response that achieves an appropriate balance among prevention, care and treatment. This must take place in a social atmosphere of respect, in which human rights are exercised, including the right to health, inclusion and zero tolerance of stigmatization and discrimination." ■

References:

· Az Prensa – Spain. Los jóvenes siguen sin utilizar protección en relaciones sexuales a pesar del peligro de contagio [Young People are Still Not Using Protection during Sexual Relations, in Spite of the Risk of Disease]. 31/03/2008.

· Barria / EFE. Lideres durante la IV Reunión de la Coalición de Primeras Damas de América Latina [Leaders during the 4th Meeting of the Coalition of First Ladies of Latin America]. 29/03/08

· Cohen. HIV/AIDS: Latin America and the Caribbean. Science. July 2006

· Comisión Caribeña de Salud y Desarrollo [Caribbean Health and Development Commission], 2005; Inciardi, Syvertsen and Surratt, 2005.

· El Mundo – Spain. Brasil lanza una campaña para atajar el SID entre jóvenes homosexuales [Brazil Launches Campaign to Halt AIDS among Young Homosexuals]. 10/04/2008

· Eugene Schiff, ¿Dónde están los medicamentos antirretrovirales en el Caribe? Una tragedia ignorada y sin sentido [Where are Anti-Retroviral Medications in the Caribbean? An Unheeded and Senseless Tragedy], March 2005 in http://aguabuena.org/articulos.html

· Fitzgerald, J., Gomez, B., An open competition model for regional price negotiations yields lowest ARV in the Americas, December 2003 in http://www.paho.org/English/AD/THS/EV/acceso_gen_priceneg.pdf

· Fundación Huésped. Actualizaciones en SIDA [Updates on AIDS]. Vol. 16, No. 59. March 2008.

· Fundación Huésped. Actualizaciones en SIDA [Updates on AIDS]. Vol. 16, No. 59. March 2008.

· Gupta et al., 2006; Ministry of Public Health and Social Services of the Dominican Republic, 2005b; PAHO, 2007; Gebre et al., 2006; Allen et al., 2006.

· InfoPAE. Aumentan los casos de VIH y SIDA en mujeres [HIV and AIDS Cases Increase Among Women]. 01/04/08.

· International Treatment Preparedness Coalition (ITPC), Missing the Target: A report on HIV/AIDS treatment access from the frontlines, November 2005, in http://www.aidstreatmentaccess.org/itpcfinal.pdf.

· International Treatment Preparedness Coalition (ITPC), Missing the Target: Improving AIDS Drug Access and Advancing Health Care for All. December 2007.

· Jong-Wook, L., Message from the Director-General, December 2005 in http://www.who.int/dg/lee/speeches/2005/worldaidsday2005b/en/index.html

· Kaiser Family Foundation. HIV/AIDS Policy Fact Sheet. The HIV/AIDS Epidemic in the Caribbean. November 2007.

· Laura Porras, Ante Fracaso de 3x5, ITPC presenta investigación y propuestas [In the Face of 3x5 Failure, ITPC Presents Research and Proposals], Agua Buena, 28 November 2005 in http://www.aguabuena.org/articulos/regional20051213.html.

· Ministry of Health of Jamaica, 2007; Ministry of Health of the Bahamas, 2006; PAHO and WHO, 2006; Ministry of Health of Trinidad and Tobago, 2007.

· Montano et al., 2005; Programa Nacional del sida del Uruguay [National AIDS Program of Uruguay], 2007; IDES et al., 2005.

· UNAIDS and the Global Coalition on Women and AIDS. Keeping the Promise: An Agenda for Action on Women and AIDS. 2006

· UNAIDS, WHO & PAHO. HIV and AIDS in the Americas. 2007 Report. The evolving epidemic, response and challenges ahead. September 2007.

· UNAIDS. Hoja Informativa 05-06. El Caribe [Informational Sheet 05-06. The Caribbean].

· UNAIDS/WHO, AIDS Epidemic Update, 2007.

· PAHO. 46o Consejo Directivo. El Acceso a la Atención para las personas que viven con el VIH o aquejadas de SIDA [46th Directive Council. Access to Care for Persons Living with HIV or Suffering from AIDS]. September 2005.

· Proceso – Mexico. CENSIDA [National Center for the Prevention and Control of HIV/AIDS]: Sólo la mitad de los seropositivos reciben atención médica gratuita [Only Half of HIV-Positive Individuals Receive Free Medical Care]. 02/04/2008.

· Roses, Dr. Mirta. closing presentation at the 4th Latin American and Caribbean Forum on HIV/AIDS and STD. "Latinoamérica y el Caribe: Unidos en la diversidad hacia el acceso universal" [Latin America and the Caribbean: United in Diversity, Towards Universal Access]. April 2007.

· Seoane Vázquez, E., Rodríguez-Monguío, R., Análisis del Impacto de las negociaciones de medicamentos en la región andina [Analysis of the Impact of Negotiations of Medications in the Andean Region], The Ohio State University, March 2005 in http://www.paho.org/Spanish/AD/FCH/AI/NegociacionPreciosVIH.pdf

· UNAIDS, 2006 Report on the Global AIDS epidemic.

· UNAIDS, 2006 Report on the Global AIDS epidemic. Annex 1. Country Profiles.

· UNAIDS. Inciting the World against AIDS. November 2007.


(c) Wien Tourismus/Gerhard Weinkim

VIENNA TO HOST AIDS 2010

Vienna, Austria has been chosen to host the XVIII International AIDS Conference (AIDS 2010), the largest international meeting on HIV, where every two years 25,000 participants representing all stakeholders in the global response to HIV meet to assess progress and identify future priorities.

AIDS 2010 IS organized by the International AIDS Society (IAS), in partnership with government, scientific and civil society partners in Austria and international partners from civil society and the United Nations. Based in Geneva, Switzerland, the IAS is the world's leading independent association of HIV professionals.

"THE INTERNATIONAL AIDS Society and its partners are extremely pleased to partner with the City of Vienna, the Government of Austria and local scientific and community leaders, who have a long history of leadership on HIV issues," said IAS President, Dr. Julio Montaner, Director of the BC Centre for Excellence in HIV/AIDS and International Conference Chair for AIDS 2010. "Because the 2010 conference will coincide with the deadline that world leaders set for the goal of providing universal access to HIV prevention, treatment, care and support, all eyes of the world will be upon Vienna."

"VIENNA HAS THROUGH history been seen as a crossroads between Western and Eastern Europe, and it will continue to serve that role as host of the conference," said Dr. Montaner. "The conference is an opportunity to look specifically at the challenges facing the emerging epidemics in Eastern Europe in the context of hardest hit regions around the world and the overall global response."

"THE INTERNATIONAL AIDS Conference is the most important gathering for the release and discussion of scientific, programmatic and policy developments in the global response to HIV/AIDS. As the largest and most diverse international gathering devoted to a global health issue, the conference brings together the movement of people responding to the HIV/AIDS epidemic to share their lessons and together stake out the road ahead. We look forward to welcoming delegates to Vienna," said Local Conference Chair, Brigitte Schmied of the Austrian AIDS Society.

AIDS 2010 WILL be held from 18 to 23 July 2010 at the Reed Messe Wien.

AIDS 2010 WILL be the eighteenth in this series of international AIDS conferences. In August 2008, it will be held in Mexico City, Mexico, and the previous meeting was held in Toronto, Canada in 2006. With more than 2,500 international journalists expected to attend, the conference is the single most widely covered health event in the world.

VIENNA WAS SELECTED to host AIDS 2010 following an evaluation of candidate cities by the IAS in consultation with its international partners. Candidate cities were evaluated by the IAS Governing Council according to three criteria: potential impact on the epidemic, sufficient infrastructure, and freedom of movement and travel for people living with HIV/AIDS. According to a policy of non-discrimination first adopted by the IAS Governing Council in 1992, the Society will not hold its conferences in countries that restrict short term entry of people living with HIV/AIDS, and/or require prospective HIV-positive visitors to declare their HIV status on visa application forms or other documentation required for entry into the country. ■

IAS Contributes to a Successful 2nd Eastern Europe and Central Asia AIDS Conference

THE INTERNATIONAL AIDS Society played a major role in the second Eastern Europe and Central Asia AIDS Conference in Moscow on 3-5 May 2008. The IAS was a co-organizer, alongside the Government of the Russian Federation, the Joint United Nations Programme on HIV and AIDS, and the Global Fund to Fight AIDS, Tuberculosis and Malaria. Craig McClure, the IAS Executive Director, was one of the four conference co-chairs.

WORKING WITH THE other stakeholders, the IAS helped to significantly raise the quality of the programme of the conference in a number of ways. First, the process for selection of the conference organizing and programme building committees was made more transparent and inclusive, allowing most-at-risk populations to be adequately represented. Second, it was agreed from the outset that all relevant issues and topics for the region would be addressed at the conference, including opioid substitution therapy, men who have sex with men, sex work, and women and HIV. To raise the quality of science, a proper abstract submission and selection process was put in place for the first time. The IAS supported the participation of Françoise Barrè-Sinoussi, co-discoverer of HIV, on the Conference Organizing Committee and of three plenary speakers as a way to bring international science to the region.

THE IAS WAS the main provider of technical assistance to AIDS InfoShare, the non-governmental organization assigned the role of Conference Secretariat. Advice covered: conference governance, programme building, logistics, fundraising, and communications. During the conference, Craig McClure co-chaired the opening session and a number of other conference sessions as well as giving a plenary speech. The IAS President, Dr. Pedro Cahn, gave a plenary presentation on state-of the-art antiretroviral therapy.

Nearly 80 HIV Physicians to Benefit from EACS Training in 2008

EVERY YEAR, THE European AIDS Clinical Society (EACS) offers training and education to HIV physicians from Western and Eastern Europe and from countries with limited resources. The EACS does this through two programmes: the Medical Exchange Programme and the Advanced HIV Course. This year, 19 physicians have been selected to the 2008 Medical Exchange Programme. Another 60 applicants have been accepted for the 6th Advanced HIV Course, which takes place on 3-5 September 2008 in Montpellier, France. Of the total, 44 applicants are from Europe, 28 from Africa, four from South America and three from Asia.

EACS ALSO ORGANIZES the European AIDS

Conference and publishes the EACS Treatment Guidelines. The next conference is scheduled for 11-14 November 2009 in Cologne, Germany.

FOR MORE INFORMATION on EACS and its activities, visit *www.eacs.eu*. ■

ASAP and 9th ICAAP Update

As the custodian of the International Congress on AIDS in Asia and the Pacific (ICAAP), the AIDS Society of Asia and the Pacific (ASAP) is working closely with the Local Organizing Committee of the 9th ICAAP to be held in Bali, Indonesia in August 2009.

FOR MORE THAN 20 years, countries around the world have faced the HIV and AIDS epidemic with only a fraction of the support that is needed. While best practices have been documented to help countries deal with their specific epidemics, the world continues to globalize and country borders become more porous. New practices need to be examined and creative interventions introduced to address the spread of the virus through a host of avenues, including mobility, migration and poverty. Attention to vulnerable groups, including sex workers, men who have sex with men, people who inject, and women, remains insufficient by many governments, especially when the real facts about sub-populations are hidden in generalizations in low-prevalence countries. The 9th ICAAP's overall theme, Empowering People; Strengthening Networks, will therefore provide delegates with opportunities to better challenge these barriers.

THE LOCAL ORGANIZING Committee of the 9th ICAAP believes in the importance of change when trying to find better ways of meeting the challenges faced by all of us. The theme therefore, highlights the importance of providing opportunities for change through the empowerment of people by inclusive and participative engagement across sectors in Asia and the Pacific.

THE FORMATIVE STAGES of the development of the 9th ICAAP are well underway. Both ASAP and the Local Organising Committee are pleased that the overall theme reflects the importance of building commitment across sectors and that synergy is being created between previous congresses and the 9th ICAAP.

FOR UPDATED INFORMATION about ASAP and the 9th ICAAP, please visit: *www.aidssocietyap.org and http://icaap9.aidsindonesia.or.id.* ■

Ninth International Congress on Drug Therapy in HIV, Glasgow, 9-13 November 2008

The International Congress on Drug Therapy in HIV Infection is recognized as a major HIV meeting. The congress aims to provide a wide-ranging and accessible programme focusing on developments and innovations in therapeutic strategies impacting on the management of HIV infection. Organisers expect up to 3,000 delegates will attend the congress.

A TOPICAL AND informative Scientific Programme has been structured, incorporating presentations by recognised experts from Europe, North and South America, Asia and Australia. The programme will feature 15 sessions, including keynote lectures and hot topics, and will involve more than 22 invited speakers.

TWO CASE STUDY sessions will be presented: one covering assessment of sick HIV-positive returning travellers or immigrants from tropical regions; and one focusing on clinical management of complex HIV/AIDS cases. A special plenary session has been co-organised with the International AIDS Society, during which key topics in relation to HIV treatment guidelines and antiretroviral drug use in developing countries will be addressed.

PROSPECTIVE DELEGATES ARE encouraged to register online before 20 October 2008 by visiting the congress website at *www.hiv9.com*. For further information, please contact the HIV9 Congress Secretariat by emailing *hiv9@kp360group.com*. ■

FORO 2009 to be Launched in Mexico

THE GROUP FOR Horizontal Technical Cooperation held an Extraordinary Assembly in Sao Paulo, Brazil on 8 May 2008 to discuss and agree on the next steps in the organization of the Fifth Latin American and Caribbean FORUM on HIV/AIDS and Sexually Transmitted Infections (FORO 2009). FORO 2009 will take place in Lima, Peru, in the first week of May 2009. The group is the organizer of FORO and is made up of representatives of governmental HIV/AIDS control and prevention programmes from 20 Latin America and Caribbean countries.

THE GROUP DISCUSSED a wide range of issues, including the conference theme and tracks, the launching of the conference and the importance of strengthening horizontal international cooperation within the region. It also covered sharing knowledge and lessons learned between governments, scientific groups, persons living with HIV and civil society in the Latin America and Caribbean region.

UNIVERSAL ACCESS FOR All with the Participation of the Community was proposed as the theme for FORO 2009.

THE PROPOSED CONFERENCE tracks are: Basic Science; Health Care Services; Prevention; Behavioural and Epidemiological themes; Social Response; and Policy and Political factors. Proposed cross-cutting themes are: good practice; evidence-based achievements of multi-sector work; social participation effects without losing the stewardship of the strategic alliances for improving universal access; horizontal technical cooperation projects – achievements, barriers and the future; application of scientific advances and new technologies on the operative ground; social inequality, stigma and discrimination as co-adjuvant factors in the expansion of the epidemic; planning, monitoring and assessment of activities and activism in Latin America – background, present and future.

THE OFFICIAL LAUNCH of FORO 2009 will take place during the XVII International AIDS Conference. ■

Letters to the Editor

LETTERS SHOULD BE e-mailed 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. ■

HIV-Related Travel Restrictions Satellite at EECAAC

The IAS' Policy and Advocacy Programme convened a satellite session on HIV-related travel, and entry and migration restrictions at the recent second Eastern Europe and Central Asia AIDS Conference (EECAAC), held on 3-5 May, in Moscow.

THE SATELLITE WAS co-chaired by Craig McClure, IAS Executive Director, and Roman Gailevich, Regional Programme Adviser of the Joint United Nations Programme on HIV/AIDS (UNAIDS). The purpose of the satellite session was to: increase attention to the issue of HIV-related travel, entry and migration restrictions in Eastern Europe and Central Asia; highlight their impacts on universal access to HIV prevention, care and treatment; share experiences of countries' efforts towards elimination of these restrictions; and spur greater commitment for longer-term action.

Key challenges and policy options discussed[1]:

WHILE THERE IS no process that is monitoring the status of HIV-related travel restrictions in Eastern Europe and Central Asia, 2007 reports suggest that people living with HIV are not barred from travelling for short-term stay, except in Armenia and Moldova[2]. However, long-term restrictions currently apply across Eastern Europe and Central Asia; many countries implement compulsory testing for HIV as a requirement for long-term stay, and in many cases, people face deportation when their HIV-positive status is discovered.

MARINA BRITVENKO EXPRESSED concern and frustration at the current HIV-related travel restrictions that impose limitations on realizing her dreams. People living with HIV do not have the right to travel for personal visits to the U.S. and other countries with a complete HIV entry ban.

IN 2006, THE Russian Federation received migrant labour from 138 countries. Central Asia, in particular Tajikistan, is a key source of labour migrants to Russia. The Federal Service of Migration of Russian Federation issued 2.1 million work permission certificates in 2007, mostly to men between the ages of 18 and 39. Eastern Europe, including Russia, Ukraine, Belarus and Baltic countries, is also a source of migrant labour, in particular to the European Union. It is expected that the flow of migrants from China will increase in the near future.

UNDP RESEARCH CONDUCTED in Russia shows that non-nationals made up less than 5% of the number of people who tested HIV positive in 2007. Numbers of HIV cases registered by the Federal Service on Consumer Rights Protection and Human Wellbeing of the Russian Federation between 1987 and 2007 among foreign citizens also remain very low. Long-term HIV-related entry and migration restrictions therefore do not have any significant impact on the course of the HIV epidemic in Russia.

LONG-TERM HIV-RELATED ENTRY and migration restrictions exacerbate the vulnerability faced by PLHIV, migrants and others seeking to move for work or study. Culturally and linguistically appropriate HIV prevention, treatment, care and support programmes are scarce. Further, labour migrants may be living in geographically-isolated areas, such as on construction, highway building and mining sites, with little access to health services. The Tajikistan case study, presented at the conference, highlighted lessons for wider application across the Eastern Europe and Central Asia region.

4. Community recommendations urged countries to:

A) RECOGNIZE THAT universal access is good for public health and is cost-effective: comprehensive and holistic HIV treatment approaches lower the morbidity and mortality associated with HIV/AIDS; transmission of HIV is less likely if all people in need of antiretroviral therapy are treated; people will uptake services and be more likely to test voluntarily for HIV if the process of establishing HIV status is linked to the provision of treatment, care and support upon a positive result, and not simply for epidemiological or migration procedures.

B) RECOGNIZE THE problem of inadequate access to healthcare services for migrants and migrant populations at the highest political levels given their role in the economies of the region and the commitments made in the United Nations General Assembly Special Session on HIV/AIDS Declaration of Commitment on HIV/AIDS (2001) and the 2006 Political Declaration[3].

C) ADOPT APPROACHES that are sensitive to culture, religion and language and address multi-sectoral needs, including sexual and reproductive health; promote regional best

Tajikistan

It is estimated that 635,000 migrants leave Tajikistan seeking employment every year, destined primarily for the Russian Federation. A 2006 study showed that: only 16.5% of the labour migrants have adequate knowledge on HIV transmission and prevention; 30% engage in risky sexual behaviour in the country of destination; and many face other challenges which increase their vulnerability, including separation from families, sexually transmitted infections (STIs), and irregular or undocumented status. In 2005, with funding from the Global Fund and in collaboration with the International Organization for Migration, UNDP and non-governmental organization partners, the Republic of Tajikistan developed a programme to respond to the HIV/AIDS prevention, care, treatment and support needs of labour migrants and their families. Information stands, kiosks and booths were installed at railway stations and airports. The programme included voluntary counselling and testing, STI treatment, condom distribution, capacity building and outreach to families.

The Tajikistan programme recognizes that it is necessary to develop regional inter-governmental cooperation, and establish partnership projects with AIDS service organizations in the countries of destination in order to ensure that migrants receive a continuum of comprehensive HIV services at all stages of the migration process: in the country of origin, in transit, and in the country of destination. It aims to conduct advocacy campaigns to promote access to, and prevent interruption of, antiretroviral therapy in the countries of destination. Additional advocacy is also needed to improve cooperation with the private sector, both in the country of origin and in the country of destination.

1 Copies of the PowerPoint presentations can be found on the IAS website: www.iasociety.org

2 This information is taken from the website of the European AIDS Treatment Group and is based on a survey which was originally done by the German AIDS Federation in 1999 and has been continually updated. The information has not been independently verified. See http://www.eatg.org/hivtravel/

practice; eliminate harmful practices, such as deportation connected with HIV status; redress the repression and criminalization of marginalized and stigmatized groups; and meaningfully involve migrants and migrant communities in HIV prevention, care and treatment services. ■

13th TB/HIV Core Group Meeting

THE 13TH MEETING of the Core Group of the TB/HIV Working Group of the Stop TB Partnership was held in New York, USA on 17-18 April 2008. It was co-hosted by Treatment Action Group and Consortium to Respond Effectively to the AIDS/TB Epidemic. The meeting reviewed global progress, challenges, constraints and regional responses in the implementation of collaborative TB/HIV activities, discussed key strategic issues in the global response to the dual TB and HIV epidemic, and formulated conclusions and recommendations to improve the quality of care provided to individuals co-infected with TB and HIV.

THE CORE GROUP noted the encouraging rate of increase in the implementation of collaborative TB/HIV activities globally, and particularly in sub-Saharan Africa. However, the overall coverage of the services, particularly of those interventions aimed at reducing the burden of TB among PLHIV, was badly insufficient and required urgent concerted action. Specific populations were also being targeted, for example, through the World Health Organization's (WHO's) development of TB/HIV guidelines for drug users, which will provide guidance for integrated TB and HIV prevention in those settings where drug use is fuelling the HIV epidemic.

THE CORE GROUP highlighted the importance of strong health systems for the delivery of collaborative TB/HIV activities, and emphasized the need for meaningful engagement of the TB/HIV efforts with the International Health Partnership. The IAS and other TB/HIV Core Group members will increase their engagement and promotion of TB/HIV goals in ongoing initiatives to strengthen the capacity of health systems that are crucial for the delivery of collaborative TB/HIV activities.

WHO'S HIV DEPARTMENT presented outcomes from the 3 Is meeting (Isoniazid preventive therapy, intensified case finding and TB infection control)[4], held on 2-4 April 2008 in Geneva, Switzerland. The Core Group recognized that the meeting was an important step to enhance the engagement of HIV service providers for the implementation of these crucial interventions. However, it expressed concern about the lack of representation of leading HIV treatment providers and opinion leaders. The engagement of leading HIV implementers was underlined as a critical step to enhance scale up of implementation of TB/HIV activities in affected countries and needs urgent attention.

ISONIAZID PREVENTIVE THERAPY (IPT): It was reported that the IPT Consensus Statement had undergone a full Working Group consultation process and was discussed at the IAS Governing Council retreat in November 2007. The Core Group agreed to the submission of the manuscript as an advocacy piece to a peer-reviewed journal for publication. The lack of a clear and explicit guide on the use of IPT was cited as a main bottleneck for the use of IPT in the South East Asia region, and a document that particularly targets TB and AIDS control managers was suggested. It was also noted that as many more people were living with latent TB infection in Asia, the use of IPT should be promoted, rather than fear of the emergence of drug resistance. In addition, it was noted that it was essential to promote research that assesses the efficacy of use of IPT in settings with high levels of multidrug resistant TB.

Infection Control:

THE CORE GROUP expressed concern about the slow response to TB infection control, including the response by WHO, that is leading to the loss of the sense of urgency that was built after the emergence of extensively drug resistant (XDR) TB. The Core Group endorsed and emphasized the proposal for urgent development of a 10-point guide for countries to address TB infection control, based on existing guidelines and recommendations.

THERE IS AN urgent need to develop tailored information about TB infection control, particularly for HIV stakeholders and service providers through simple messaging and information sharing strategies (e.g., posters). The importance of prioritizing health workers' safety as part of TB infection control was raised. Generating demand by community groups and grass root communities for TB infection control and related TB/HIV services was underlined. The IAS expressed commitment to raising the profile of TB infection control as a matter of urgency; and it will mainstream TB infection control into its health workforce-related activities, positioning these as an integral part of health system strengthening efforts. The IAS will also organize an informal meeting of HIV stakeholders around the implication of TB infection control for HIV care and treatment services.

RECOMMENDATIONS EMERGING FROM the meeting included that all members: advocate and actively support the engagement of community groups and civil society organizations in the TB/HIV response; support advocacy for a sustained increase in long-term funding and investment in TB/HIV research, highlighting the importance of addressing TB diagnostic needs of PLHIV; and continue to promote visibility of TB/HIV goals at key events, including the Implementers' Meeting and the International AIDS Conference.

KEY MESSAGES FOR Global TB/HIV Policy Advocacy Efforts from UNAIDS and Stop TB Partnership[5]:

EVERY THREE MINUTES, a person living with HIV dies of TB. Resources and bold leadership are needed at all levels – science, community and policy making – to dramatically reduce the annual number of deaths from TB among people living with HIV.

WITH THE EMERGENCE of drug-resistant strains of TB, which are particularly lethal in populations with high rates of HIV infection, TB/HIV has become a global security issue, requiring priority TB/HIV action in the context of Universal Access and in all national HIV action frameworks and strategies.

THE DRUGS, DIAGNOSTICS and vaccines currently available are not appropriate for people living with HIV TB co-infection. Acceleration of research and promotion of the development of new tools for prevention, diagnosis, and treatment of TB, particularly in the presence of co-infection, is urgently needed.

HIV AND TB are major threats to socio-economic development and realization of the right to health; a person-centred approach, focusing on "one life, two diseases", is needed; it is essential to ensure that PLHIV are able to attend health services without fear of contracting TB; and investments made in strengthening health systems could contribute to the achievement of Millennium Development Goals.

4 Additional information on the TB/HIV 3 Is strategy can be found on WHO's website: www.who.int

5 Additional information on global TB/HIV advocacy messages can be found on the Stop TB Partnership website: www.stoptb.org

2008 IAS Governing Council Election

Introducing the new President, President-Elect and Treasurer of the IAS: 2008-2010

IAS President
Julio SG Montaner
Canada

DR. JULIO MONTANER is originally from Buenos Aires, Argentina. He received his Medical degree with Honours from the University of Buenos Aires in 1979. In 1981, Dr. Montaner joined the University of British Columbia (UBC) at St Paul's Hospital (SPH), where he completed his training in Internal Medicine and Respiratory Medicine. While still in training, he led several clinical studies that demonstrated the role of adjunctive corticosteroids in PCP-related respiratory failure. In 1988, he became the Director of the AIDS Research Programme and the Immunodeficiency Clinic at SPH/UBC. Since then, he has focused his research on the development of antiretroviral therapies and management strategies. In the mid 1990s, he played a key role in establishing the efficacy of NNRTI-based highly active antiretroviral therapy (HAART). This was one of the pivotal contributions emerging from the IAS-sponsored Vancouver 1996 International AIDS Conference, of which he was a co-organizer. He is a Professor of Medicine at UBC and has held the Endowed Chair in AIDS Research at SPH/UBC since 1996. He is a founding Co-Director of the Canadian HIV Trials Network and the Director of the British Columbia Centre for Excellence in HIV/AIDS. Dr. Montaner has authored more than 350 scientific publications on HIV/AIDS. His current research interests include HAART as prevention, optimal use of HAART, salvage therapy and new antiretrovirals, as well as hard-to-reach populations and harm reduction. Dr. Montaner has been a member of the IAS since 1988 and an IAS Governing Council member in the USA and Canada Region since 2002. In 2006, he was elected President-Elect, to take office as President in August 2008. ■

ELLY KATABIRA, MBCHB, FRCP Edin., is an Associate Professor of Medicine and former Deputy Dean for Research at the Faculty of Medicine, Makerere University in Kampala, Uganda. He trained as a medical doctor at Makerere University and later as a physician, specializing in Neurology (Manchester UK, 1984). Since his return to Uganda in 1985, he has worked extensively in the field of care and support for PLHIV. He is the Clinical Advisor at the AIDS Clinic in Mulago Hospital and at the Infectious Diseases Institute of Makerere University Medical School in Uganda. In 1990, he was recognized as a World AIDS Foundation International Scholar. His strength is in the development of treatment and management guidelines for HIV/AIDS and he has written several publications and chapters in various books on this topic. His research interest includes clinical trials and operational research issues on various aspects of HIV/AIDS care and support delivery both within institutions and at community level. He has also undertaken several consultancies on HIV/AIDS care and support for UNAIDS and WHO, both for the headquarters in Geneva and for the African Regional Office, as well as for Family Health International. He is also Co-Founder of The AIDS Support Organization and has been its Medical Advisor since 1987. He is a founding member of the Academic Alliance of AIDS Care and Prevention in Africa and the author of more than 150 published scientific articles and abstracts. In June 2000, Dr. Katabira was elected as an IAS Governing Council member in the African Region and in December 2007, it was confirmed that he would become the next President-Elect of the IAS. During his time on the Governing Council, he has actively participated in a range of IAS activities, including co-chairing the IAS Industry Liaison Forum and serving as Co-Editor of *The Journal of the International AIDS Society* ■

IAS President-Elect
Elly T Katabira
Uganda

IAS Treasurer
Alan W Whiteside
South Africa

ALAN WHITESIDE IS a Professor at the University of KwaZulu-Natal in Durban, South Africa, where he is the Director of the Health and Economics and HIV/AIDS Research Division (HEARD), an organization he established in 1998. Prior to his position at HEARD, Prof. Whiteside was in the university's Economic Research Unit. Throughout his 21-year involvement with HIV/AIDS research, Prof. Whiteside has written extensively, dealing primarily with sub-Saharan Africa and has published a number of books on the topic. In 2000, he co-authored *AIDS: The Challenge for South Africa* with Clem Sunter, and in 2002, *AIDS in the Twenty-First Century: Disease and Globalisation* with Tony Barnett (a second edition was published in 2006). Most recently, he published *HIV/AIDS: A Very Short Introduction* with Oxford University Press (2008). He was a founding editor of AIDS Analysis Africa, and a Commissioner for the United Nations Commission on HIV/AIDS and Governance in Africa. Prof. Whiteside became a member of the IAS Governing Council in 2000 and was confirmed as the next IAS Treasurer in late 2007. ■

Newsletter design: www.sandstromdesign.se

ISBN number for August newsletter is 978-92-95069-03-9