



Photo by David Lee Roberts Jr.

International Aids Conference Mexico City

Universal Action Now

August 3rd to 8th, 2008:

HIV is a virus not a crime

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Photo by Ecum. Advocacy Alliance

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Glossary:

AgA (Action against AIDS – German lobby and advocacy network), ART (anti-retroviral therapy), ARV (anti-retroviral drugs), EAA (Ecumenical Advocacy Alliance), IDU (intravenous drug users), MIC (middle income country), MSM (men who have sex with men), PLWH (people living with HIV), PMTCT (prevention of mother-to-child transmission), PEP (post-exposure prophylaxis), PrEP (pre-exposure prophylaxis), VCT (voluntary counselling and testing)

HIV is a virus not a crime

This slogan by Edwin Cameron reflects well the spirit of this conference which clearly put human rights at centre stage. It was the first conference in Latin America and attracted about 22 000 people (the 2nd largest IAC) with 6000 from Latin America- the highest Latino participation ever. Even before the conference started, the health and education ministers in Latin America met and decided to offer comprehensive sex education in schools. Also, Mexico took steps against homophobia and a march of about 3000 people who demonstrated against homophobia took place on the Saturday before the conference started. Mexico further wants to facilitate the import of ARVs at much lower prices, as the country needs to spend 90% of its Aids budget on drugs. The local media coverage of the conference was good and the kaisernetzwerk also filmed a lot of the sessions – Mexico really wanted to use the opportunity to reach its own people with HIV messages and education during the 5 days of the conference. It was important that this conference took place in Latin America.

Big issues at this conference were: human rights of PLWH and high-risk groups, gender and gender-based violence, combination prevention, marrying prevention with treatment and not seeing it as either/or. This conference had a much bigger focus on prevention than previous ones, as over the last year 1 million people were put on treatment and 2.7 million got newly infected, ie for every 2 people put on treatment, 5 became newly infected. Whilst a renewed focus on prevention is welcome, treatment also needs to be scaled up more quickly. At the present rate we will not have 10 million people on treatment by 2010, but only 4.6 million. At present we have managed to reach the target 3 million which was already set for the year 2005. It is clear that successful treatment (no detectable viral load) reduces the risk of transmission enormously so both prevention and treatment need to be scaled up in order to bring down the high numbers of new infections. At the same time a PLWH who is under successful treatment can easily add another 45 years to his or her life. At present about 40% of PLWH infect others unconsciously, so getting more people to know their status would certainly help. The highest risk of passing on the HIV infection is within the first 8 weeks of someone becoming infected him- or herself. The ill-conceived debate on whether we should focus on strengthening health systems first and then scaling up ART was also put to rest at this conference and ART seen as the catalyst for strengthening health systems.

Human Rights of Affected Groups

The rights of MSMs, IDUs, sex workers and the de-criminalization of high risk groups was demanded time and again. For the first time a sex-worker at the conference talked about her work and showed that the criminalization of sex work drives people underground with lack of health services and accessibility of condoms and therefore increases their risk and those of their clients. Also, in societies where MSMs or IDUs are heavily stigmatized or even

criminalized, the groups have little access to information and services and will not want to access these services for fear of stigmatization. An example was given of MSMs in Togo who thought that they were not at risk of HIV infection since they did not have heterosexual intercourse- it shows how messages do not reach groups which a Government or society does not want to acknowledge. About 70 countries still have travel restrictions for HIV+ people and the conference clearly demanded that they be removed. The US had removed the travel ban on HIV+ people a few days before the conference started.

In a number of countries transmitting HIV is criminalized. Justice Edwin Cameron, HIV+ High Court Judge in South Africa, showed that this criminalization has adverse effects particularly on women and leads to people not wanting to get tested. In Sierra Leone, for instance, the law says that an HIV positive person must not knowingly place another person at risk. This sounds well-intended for stopping the spread of HIV, but what does this do to a pregnant woman who finds out that she is HIV positive and is not in a position to introduce condoms into her relationship with her husband, has no access to PMTCT and might therefore pass the virus on to her baby? Will she be treated like a criminal and put into jail? In the USA a homeless man was arrested for spitting at a police officer. The man was HIV positive and was put into prison for 35 years. Since there is no way of transmitting HIV by spitting at someone, this shows clearly that the measures are unscientific, totally inappropriate and that the person is punished because he is HIV positive and it is assumed that he wants to infect others. Edwin Cameron gave 10 reasons why criminalization does not make sense in the area of transmission:

- It is ineffective and does not stop HIV
- It is a poor measure to protect those at risk
- The uninfected needs to be capacitated to negotiate safe sex
- It victimizes, oppresses and endangers women – particularly in Africa as 61 % of HIV positive people in Africa are women
- Criminalization is often unfairly and selectively applied and may be mainly targeted at MSMs, IDUs, sex workers
- It places blame on one person instead of putting responsibility on two (with regard to consensual sex)
- Many of these laws are poorly drafted and demand that the person informs the partner in advance. In advance of what - intimacy, kissing, cuddling, having intercourse?
- It increases stigma
- It is a disincentive for testing
- Assumes the worst about PLWH

He finished his speech by saying: ‘Let today be the start of a campaign against criminalization and let us fight against stigma and discrimination’ and received standing ovations.

Gender and Gender based violence

Many sessions – almost all of the sessions I attended – dealt in some form or other with the gender dimension of HIV and many addressed Gender-based violence. A third of all women experience being beaten, abused or raped once in their lifetime which clearly shows the extent of gender based violence worldwide. A presentation from Zimbabwe showed how rape is used to intimidate people who vote for the ‘wrong’ party. A presentation from the DRC showed that sexual violence is used as a war weapon and that most perpetrators are soldiers or armed persons and the victims range from 2 to 60 years. Statistics clearly show that apart from politically volatile situations, most women experience violence from their partners. Some, but still few, good examples were given of working with men, but at least the call to address men and not just women was made in many sessions. A project from South Africa showed that working with men can have impact. A 60 year old man who had taken part in a

gender and masculinity workshop called his sons together and told them that from now on things would change. Their mother could not be expected to do all the housework when she comes home from work at 6 pm, so he himself would help with doing the dishes and the sons would have to cook. A presentation from Sudan showed that working with the Sudan People's Liberation Army reduced the risk of infection for the soldiers and their families, but also for the communities surrounding the army camp.

Combination Prevention

85% of all transmission worldwide occur heterosexually, so the main focus of prevention is avoiding sexual transmission by employing a number of methods in combination –one of the keywords at this conference was: combination prevention. A *vaccine* is still far off but scientists can work with a lot of the data from the vaccine candidates which have failed. Also, the new approach is to collaborate with younger scientists who may have innovative ideas and to involve researchers from other fields as well. The situation for *microbicides* looks more promising. New candidates which will go into the trial phases soon are all based on ARVs and scientists are hopeful that a microbicide will become available in the next few years. Male circumcision was discussed at length. The 3 clinical trials clearly showed that *circumcision* reduces a man's risk to contracting the virus through heterosexual intercourse by 50-60%. Questions remain about the benefit to women and to MSMs – it is not believed that it will have any benefit for a better protection of MSMs; one assumes that women would indirectly benefit from the reduced infection rates of men, the Ugandan study showed the opposite, though. Further questions are asked about how to introduce circumcision in societies that have not practiced it so far. This question remained open. A good example of culturally appropriate adaptation was given from Western Kenya where initiation is modified to ensure safe practices and better education. The boys are circumcised in the community but by trained medical personnel. The month of initiation is used to educate the boys on sexual and reproductive health, on gender relations and on HIV. So the traditional ceremony is kept but initiation modified to include safe practices. It is believed that the most cost-effective way to introduce circumcision is before the age of 35, but there is also the fear that men who have been circumcised might think they are safe and not use condoms any longer, so circumcision where it is introduced or adapted would have to go hand in hand with proper HIV education. *MSM*: The fight against homophobia was another important theme. 7 out of 10 countries, which have a high-prevalence rate among MSMs criminalize homosexuality – worldwide the no. of countries which criminalize homosexuality comes to 86 (incl. half of the African countries). For the last UNGASS reporting, only 31 % of the country reports provided data on MSMs. Stigmatization of MSMs is a big factor in the further spread within this risk group. *PreP* and *PEP* are also discussed as prevention tools. PreP could be used for high risk groups or the HIV negative partner when a couple wants to have kids. PEP services only reach about 30% of those who need them, ie further scale-up is necessary. Male and female *condoms* have to become more widely available. Especially female condoms are often not available due to their high price and the fact that only 1 female condom is produced for 467 male condoms.

11 million people are *IDUs*. About 3.3 million of them are HIV+. More needle exchange and methadone programmes should be offered, yet many countries are going the other way and despite the proven benefit of having these programmes, many are shut down. Also the Drug Use UNGASS recommendations are contradictory to the AIDS UNGASS recommendations, so the UN would have to sort this out.

Youth

45% of all new infection occur in youth aged 15-24 years. A number of youth sat on panels and demanded time and again to be involved ('we want a place at the table') when

programmes are designed. A comprehensive sex education is needed and all studies show that rather than motivating youth to start their first sexual experience early, comprehensive knowledge leads to a later sexual debut. Abstinence only programmes do not work – this was again reiterated at this conference and youth also need to be equipped to be able to use condoms correctly and for young women to be able to negotiate for condom use.

Testing, Treatment and Care

Only about 20% of HIV+ people know their status, so more emphasis should be put on testing and on offering testing services in rural areas. One innovative approach which was presented at the conference is home-based testing. In Rwanda one organisation goes door-to-door to educate people about HIV and to see, if the family wants to be tested (for kids under 12, the parents have to consent). The method seems to be effective in getting more people tested, the challenges however are that complete privacy cannot be guaranteed –neighbours showing up, etc. Also, during the day it is often only the women and those children that do not go to school which are at home, so men and school-going children are not reached to the same extent. Another example from Asia changed the concept and now offers ‘edutainment’ in the evenings and provides VCT before or after film-screenings, drama performances, etc. Also, as far as home-based care goes, it is clear that education on treatment needs to be incorporated so that patients can be prepared and access treatment rather than just being cared for until they die. Also, good experience was made with people who come for repeat testing or couples who come for testing

The fact that 3 million PLWH are on ART now is a great improvement, however this is only 30% of those who need to be on treatment. In order to reach more people and scale up treatment, mobile services as well as task-shifting, ie letting clinical officers and nurses put people on treatment rather than doctors needs to be put into practice. The few studies that exist of task shifting have shown high levels of patient satisfaction – but it will also require doctors to supervise nurses and clinical officers and the latter will need to be trained on ART.

I did not attend the scientific sessions on treatment at this conference but what was said by the rapporteurs at the end of the conference does not seem to go much beyond what we heard in Berlin at the German HIV congress (cf. notes of German Aids Congress, March 2008)

TB and HIV

Only 1% of HIV+ people are screened for TB globally. Whilst the recommendation in the past was to treat people with TB first before starting ART, the present recommendation seems to be to treat both concurrently when people present late – despite the risk of IRIS. Late presenters with low CD4 counts cannot afford to wait until the immune system is further run down – this will reduce their chance of survival. The call for TB and HIV treatment to become integrated was also made time and again at the conference as was the call for better drugs and diagnostics. On the whole XDR and MDR TB could have played a bigger role at this conference, though – one of the criticisms by the rapporteurs at the end..

Children and PMTCT

33% of all HIV+ pregnant women have access to PMTCT worldwide. If exclusive breastfeeding for 6 months or formula feeding should be promoted did not seem to be determined conclusively by the studies presented. Data from Botswana where formula feeding is preferred seems to suggest that this reduces the infection rate further. However, other countries seem to lose a lot of babies due to diarrhoea and other diseases so that exclusive breastfeeding for 6 months seems to be the better option. Recommendations would probably have to depend on the specific country and personal situation.

How to tell children that they are HIV positive was another issue which was talked about. Many carers are hesitant to inform the kid of its HIV status, as they fear that the kid will be stigmatised by other kids and adults in the neighbourhood – at the same time as kids grow up they are often not prepared to keep on taking medicines when they ‘feel fine’. So, adherence and compliance often become a problem when not revealing the status to the kid – also when neighbours call by, the kid often receives the medicines rather late, as one does not want to show the medicines to the neighbours. 50% of HIV positive babies die within the first 2 years of life, so many demands were made for better diagnostics for kids, more clinicians to be trained on pediatric care and care-givers to be trained more thoroughly as well (studies showed that care-givers were often confused as to how often and what dosages to give to the kids) and more appropriate medication (more FDCs with newer drugs –most FDC for kids which Indian generic manufactures produced contain d4T) and better treatment and diagnostics for TB as well.

Talks with Pharmaceutical Industry

The EAA and AgA had talks with Tibotec, Abbott and Gilead. All three companies are not willing to withdraw their patent applications in India, though Tibotec and Gilead seem to be open towards patent pools. Tibotec seemed a lot more open than the 2 other firms – even for their relatively new drugs they have developed pediatric formulations for kids above the age of 4. (Since most of their drugs are used in salvage therapy, it may not be necessary to have them for very small kids at this stage, yet they are looking into crystal technology for the under 4s). With TMC 278 which is being tested in phase 3, pediatric trials are going on at the same time and Tibotec wants to make sure that its products can be used in developing countries and are safe, so half of the people enrolled are women of reproductive age and teenagers are enrolled as well. Tibotec is open to collaborating with others to make FDCs and sees the pressure from civil society as helpful in changing the scene and having more appropriate medication developed.

Abbott has managed to produce ritonavir in a heat stable tablet and wants to have it registered with the EU and FDA before the end of the year. Abbott said that information about registration of their drugs is on their website, said, we could not find it – they are willing to send it to us. The pediatric tablet is filed or registered (was not clear to me) in 90 countries now. Pediatric prices for all their HIV drugs are half of the adult price. On issue of diagnostics, Abbott wants to produce CD4 and VL tests and machines which are better adapted to the developing world (easy to use and less expensive). There is little chance at present of an infant alluvia- ‘We don’t know how to do it.’ (Dirk v. Eeden).

A study on Kaletra and Isentress which started in June 2008 might lead to a co-formulation, if shown as effective – but the outcomes would have to be awaited. Generally Abbott is of the opinion that whoever provides the active ingredient should come up with the FDC. In response to our postcard campaign, Abbott said that they have no official position yet on that and would have to go back to talk to their bosses. They emphasized that 5 generic firms are producing Kaletra already and that they do not enforce their patent on ritonavir in South Africa (5 year non-enforcement which started in 2005) and yet the South African generic firms have not produced a generic version of ritonavir yet. Ritonavir for boosting costs about 43\$, they could not give the price for ritonavir as a full dosage

Gilead: Pediatric Viread is in phase III – it is going to be for children aged 2-18 years old. They could not say anything about a formulation for kids under 2 – none of those present in the Gilead delegation could answer the question. The syrup had a very bad taste so that kids could not be convinced to take it more than once and Gilead for a long time did not manage to mask the taste. The new formulation which is being tested consists of encapsulated drugs which can be mixed with food.

HIV is their largest research and development area. Their new integrase inhibitor is in phase III and needs to be boosted with ritonavir. Their own booster is being developed and trials are going to start soon. A pediatric form would only be developed after the adult formulation has been approved. - Atripla is available in 34 countries now. Received a list of where Viread and Truvada are approved, filed or pending submission. Gilead does not comment on the Paul Hunt Guidelines.

Gilead as well as Abbott defended their tiered pricing and felt that MICs could pay a higher price. We argued that many MICs are putting a lot of people on treatment and a lot on second line and that the prices they are demanding are not sustainable for these governments. Unfortunately, Indian generic firms were not present at this conference so the envisaged talks with them to clarify a number of issues will have to take place later.

What issues did not get much coverage?

There was one poster discussion at lunchtime and one evening discussion on patents from the point of view of civil society organisations. Activists from Columbia, Thailand, China, India, South Africa, Thailand and Brazil reported about access to medicines and the steps they took (pre-grant opposition to patent applications in India, involvement of civil society in their Govt filing for a compulsory licence or with regard to national policies in the trade sector - I used both sessions to make our postcard campaign known to other activists. Our signature campaign as AgA was offered at the stalls of action medeor, the EAA and Deutsche Aidshilfe. However, since many participants did not understand English, it was sometimes difficult to explain our campaign to passers-by. Altogether we seem to have collected between 200 and 300 signatures at both conferences.

Since pricing of newer drugs was mentioned in a number of panel discussions, patents should get a much higher profile at the International Aids Conference. This was also mentioned by the rapporteur at the end of the conference. Already talked to Gottfried Mernyi to have this included in the 2010 agenda – this would definitely be an area where AgA could collaborate with our Austrian counterparts.

Whilst sexual transmission is the predominant mode of transmission and much focus should rightly be placed on seeing that prevention finally works with proven methods and approaches rather than people's ideological hobby-horses (PEPFAR was frequently accused at this conference of promoting and funding projects which will not lead us to make any inroads on successful prevention work), I nevertheless felt that other modes of transmission did not get their fair share at this conference. Whilst IDU was still a topic, the incidence of re-using syringes, not having blood screened before it is given to patients, midwives not having any protective gear and delivering one baby after the other is not so uncommon in many places. The only place where this was mentioned was in one session on HIV in conflict and post-conflict settings: 1.8 million PLWW are confronted with emergencies and the situation they find themselves in does not provide the care they need. Are these ill-equipped health and ante-natal centres or traditional birth attendants who have neither got access to equipment nor been properly trained on HIV really the exception to the rule??? Here as well as in the area of traditional healers re-using equipment like razor blades, we simply do not have any statistics and I would imagine that this is a source of infection for many people. Having more reliable data in this area and seeing what more could be done by the respective governments and civil society would be a step in the right direction. It might also help to de-stigmatize HIV and PWLH, as people would be aware that there are different ways of getting the virus rather than jumping to the conclusion that people got infected by having sex.

At the evaluation of the Ecumenical Pre-Conference we noted that there were no religious leaders on any of the big panels and that satellite sessions with religious leaders on the

Sunday before the conference starts would be marginalizing faith-based organisations further. More effort needs to be done to present the work of churches and faith based organisations at the next conference. The skill-building workshop on the cooperation between FBOs and secular organisations where I was asked to moderate one of the group sessions was very well attended which showed a keen interest in the subject.

Participation of the 12 sponsored African partner organisations – during the Pre- as well as towards the end of the main conference I met with our African partner organisations some of whom had already been actively involved in either the pre- or the main conference or both. They all felt they had benefited greatly from both conferences and will now brief their organisations at home and try to put new ideas into practice as well as network more closely with other organisations. A number of our partners were interested in extending their work with youth, involving more youth and doing more on nutrition and HIV. I have asked the partners to write up a few paragraphs in a month or two as to what they were able to put into practice concretely and what has changed for them as a result of attending the pre- and the main AIDS conference.

For further information on the main conference and the issues discussed, please consult the IAS website. The next IAC will be held in *Vienna* from *July 18-23, 2010*.

Stuttgart, August 12th, 2008

A. Berner-Rodoreda