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CRAIG MCCLURE: Good morning everyone, and welcome to the press conference following the first days plenary session this morning. I have a number of the plenary speakers from this morning who participated in a panel discussion on the current state of the epidemic world wide.

The first speaker will be Geoff. I am just going to introduce all the speakers and then each of them will give a very brief synopsis of their discussion/presentation this morning, and then we will open it up for discussion.

The three speakers that we have this morning are Geoffrey Garnett, Professor of Microparasite Epidemiology at Imperial College, London and Chair of the UNAIDS reference group on estimates, models and projections.

Miss Elizabeth Fadul, from the Dominican Network for Youth Rights and Global Youth Partners, a HIV Youth Leader.

And thirdly, Dr. Alex Coutinho, who is Executive Director of the Infectious Diseases Institute at Makerere University in Kampala, Uganda.

So I would like to turn to Geoff first.

GEOFFREY GARNETT, PH.D.: -presentation, what I was trying to do was explore some of the different patterns of the HIV epidemic that we have seen across the world, in particular, focusing on the declines and prevalence in some of the generalized HIV epidemics and whether those declines in

prevalence can be attributed to the natural cause of the HIV epidemic as it saturates those with high risks, or whether we see volitional, large-scale changes in behavior.

We are using mathematical models to simulate the epidemic. We can distinguish between real declines in incidence and risk and just the natural course of the epidemic, and there are a number of examples now emerging of where we have seen success at the international level. Ideally, we would want to analyze incidence, but the problem with measuring incidence is one, we do not have a valid tool, and two, incidences is an order of magnitude lower than prevalence, so we would need to change our surveillance methods.

I then went on to talk about combining interventions and how we should not concentrate on one single change. There is a natural synergy by combining interventions that reduces the incidence of infections and then talk about the relationship between drivers, social/economic structural variables that change peoples risk behavior that leads to HIV incidents and the methods we can use to look at those theoretical models to relate the drivers to HIV incidence.
Thank you.

CRAIG MCCLURE: Thank you Geoff. I would like to turn now to Elizabeth Fadul.

ELIZABETH FADUL: Thanks Craig. My presentation mainly focused on the state of the epidemic and the response in regards to young people.

Today, the epidemic looks increasingly young, significantly female and unjustly marginalized with over 40-percent of our new infections of HIV among young people from 15 to 24 years. It clearly shows that the epidemic has shown a lack of involvement and lack of acknowledgement of our rights and realities in the national and international responses.

Representation focused on a call to action, to leadership at all levels, to recognize the rights and realities, and move from putting just responding to putting out fires to focus on a substantial long-term and short-term response that can adopt the following principals.

That assures the international dialogs become in-country actions and governments are held accountable for the investments made, and the commitments held. The implementation of evidence based and sexual reproductive health education and information and services; services that do not discriminate us and that are safe and trustworthy.

The prevention intervention focused on young people living with HIV and AIDS. That meaningful involvement of us and young people in greatest context of risk are prioritized and vital. That we celebrate our diversity of gender, culture, sexual orientation in our programs and policies targeting us.

That the provision of support and harm reduction services is prioritized and that we complete the cycle of response by enforcing policies that address and mainstream our rights into poverty reduction, employment and education. Thank you.

CRAIG MCCLURE: Thank you Elizabeth. I turn now to Alex Coutinho.

ALEX COUTINHO, M.D., M.P.H.: Thank you. My talk was about the state of the epidemic and the response, with particular reference to the universal access targets. As I said, my tag line was the promises of universal access, the progress to date, and the problems.

I think the highlights of the progress is that 3 x 5 was at last met. Three million people are on anti-retroviral therapy, the majority in Africa. There have also been significant gains in services for women and children. We have now 33-percent of HIV positive women who are pregnant getting PMT services [misspelled?] up from a low of 10-percent in 2002.

We also have 200,000 HIV infected children on anti-retroviral therapy. Some of the challenges though are that particularly in Sub-Saharan Africa; there are many marginalized communities that are not getting services, particularly HIV prevention services. Those communities include men who have sex with men, injection drug users, sex workers, migrant workers, and others. Unless we address these marginalized communities, we will never really be ahead of this epidemic.

I think some of the comments I made is that very few of the countries are actually going to achieve the target of universal access by 2010, but that in itself should not discourage us. I think by setting targets it makes us aspire to try to reach them, and when we do that, we generally perform better than if we had not set targets to reach. Thank you.

CRAIG MCCLURE: Thank you Alex. I am going to open up for questions, but just before I do, just to remind you that headphones are available. We have English to Spanish and Spanish to English interpretations. So if you would like to ask a question in either English or Spanish, we all have headphones up here, and they are available to you back there. If you could just state your name and media house before you ask your question.

JOHN HABLONCE: Radio One, John Hablonce [misspelled?] question to Alex Coutinho. You mentioned the rise from 14-percent to 33-percent for mothers. This is a short intervention I understand. Doesn't that lead to more AIDS orphans instead of helping—the question is, doesn't that lead to more AIDS orphans than what you would have mothers actually dying? Which is, of course, a hell of a dilemma? You look as if you do not understand my question?

ALEX COUTINHO, M.D., M.P.H.: I am understanding it. I am just trying to think of the implications of that question. I need to be sure that I have got you right. We had a

situation—let me talk historically—we had a situation previously where prevention of mother-to-child transmission services were not there. What often happened is that the mothers themselves died, but often the babies were infected also died.

If you have a service that is keeping the babies alive, but is not keeping the mothers alive, then you might end up with a situation where you have more AIDS orphans. Prevention of mother-to-child transmission has four pillars to it and one of those pillars is to keep the mother alive as well. I did point out however, that at the present moment, only 12-percent who are HIV positive are also getting access to life-saving treatment, and that figure needs to go up. The aim of the good program is to keep the babies alive and uninfected, and keep the mothers alive.

TREVOR CULLEN: Trevor Cullen [misspelled?], *Australian Journalist Review*, question for Geoffrey Garnett, could you say now that the epidemic has peaked, or if not, when do you think it will?

GEOFFREY GARNETT, PH.D.: So I think over time, the epidemic incidence rose, then declined and it seems to be, across the globe, it is a fairly stable level. Although, in some places there are increases that are too big. In other cases, there have been decline. So I think you can say that so far, we have had a peak in the HIV epidemic. It is very

difficult to predict long-term what might happen. So we are seeing really worrying trends in developed countries amongst MSM where in the U.K, now we have more new case of HIV infections in MSM than we used to have in the mid 1980's. So we are seeing new waves of the epidemic that may grow over a different time scale from the rapid, early epidemic we have seen. So there is no room for complacency, but we have seen in a lot of places a peak in prevalence, followed by the mortality kick in.

CRAIG MCCLURE: Can I just add to the question for you all? I think a lot of people are interpreting this notion of the epidemic peaking—people often think oh, if it is peaked it will then fall down. I wonder if you can comment on that misconception.

GEOFFREY GARNETT, PH.D.: Yes, definitely. So what has happened is that at the moment globally, the deaths are being balanced by new infections and we are getting a fairly stable prevalence of HIV. That means that there are over two million new HIV infections each year. So although prevalence has come down, we expect it to go to a new stable level, with far too many new infections each year. Even in the places like Uganda and Zimbabwe, where we have seen dramatic changes in behavior and big reductions in prevalence, we still need much bigger changes to get all the way down to the source of incidences that would be acceptable.

ALEX COUTINHO, M.D., M.P.H.: The other factor to add to that is that if an HIV prevalence peaks, and stays at that peak, over a period of 10 to 20 years, the population growth in our countries will mean that the actual numbers may double in 20 years, even though the epidemic appears to have peaked and stayed at a particular platform of say 7-percent.

CRAIG MCCLURE: Thanks Alex. Another question?

FEMALE SPEAKER: [Speaking Spanish]

GEOFFREY GARNETT, PH.D.: Okay, so I think there may have been a slight mis-translation. What I meant was that the HIV prevalence increases, it peaks—if the newly sexually active individuals entering the population have a similar risk, you expect for the epidemic to stabilize. If there is a high prevalence, if there is reduced risk, you expect the prevalence to decline. It then goes to what we call an endemic, steady state. A stable prevalence and that stable prevalence is when each case of the infection is causing one more new infection. So that is the situation I think we have in a lot of countries in Sub-Saharan Africa at the moment, where we have one new infection of an 11 year period, causing another new infection and the epidemic staying at a steady level. Have I explained that okay?

CRAIG MCCLURE: Alex?

ALEX COUTINHO, M.D., M.P.H.: I think if I add comments in terms of what happens at a practical level, is that the risk

you take in having one episode of unprotected sex, there is tremendously, in a population where the HIV prevalence is 1-percent, compared to a population where the HIV prevalence is 23-percent. So if you live in Botswana, or South Africa, or Swaziland, and you are having unprotected sex, or you intend to have sex, you have to take far more precautions. There is less room for error so to speak because the background HIV prevalence is so much higher than in other countries where it is only 1-percent. Where it is 1-percent, you may or may not get infected, but you may get away with a lot of risks, whereas you may not get away with it in a country like Swaziland.

FRED SHEIK, FRTV: This question is for Geoffrey. Since your information is based upon the epi-data, and it comes slowly, is there any efforts being made to increase the speed at which you can get that data so we can spot and respond to trends more quickly?

GEOFFREY GARNETT, PH.D.: So over time, surveillance from the antenatal clinics and national surveys have increased in number and improved in quality and hopefully, the time limits of the dates will improve as well, although it does need analyzing and unite the governments to actually look at the data.

So we are seeing an improvement in the timeliness of the data, we are also trying to develop methods that can detect

a change faster, so we are only looking back three or four years, instead of looking back ten years.

Ideally, I would like to be able to say incidence has increased or decreased over the last year. It is just that we have not got the tools to do that at the moment. I think in the U.S., they have been using tests for recent infection, in a very controlled environment where they have calibrated the tests for the United States of America. So maybe for the United States, they can actually look at current patterns of incidence. In the rest of the world, those laboratory based tests have not been adequately calibrated and validated, and so far, when we have looked at them, have given spurious results.

CRAIG MCCLURE: Another question, yes?

SHANNON PETAPIECE: Shannon Petapiece [misspelled?], Bloomberg News. My question is about preventing mother-to-child transmission. I would be interested in hearing each one of your take on how good of a job we are doing, and if there is a few key things we could do to really make a significant impact, that are not being done now?

ALEX COUTINHO, M.D., M.P.H.: As I said, when you add up all the data globally, we have made tremendous improvement from where we were. PM TCT [misspelled?] had a very low priority. We are now at 33-percent, however, that is the science we are using in terms often of single dose Nevirapine to both mother and child is not the best regimen for preventing

mother-to-child. The best regimens are going to be more complicated and will require much better and functioning health systems.

I always say that the litmus test of a functioning health system is how good your prevention of mother-to-child program is. Because it is really one of those programs that does need a really good functioning health system.

There are four pillars to a PMCT program, the first pillar is to keep mothers HIV negative, because HIV negative mothers will get HIV negative babies. So, the whole prevention/interventions that keep mothers and fathers negative are very important.

The second is to actually prevent the transmission of infection from the mother to the baby through anti-retroviral therapy. The third is to then keep the baby negative through breast feeding approaches. And the fourth is to keep the mother alive through care, because many of the mothers may have CD4 counts that are higher than 250, but also through anti-retroviral therapy when that is needed.

So you have to measure the whole spectrum of these interventions to see how effective you are. And as we heard from ex President Festus Mogai, I think Botswana is an example of a country that has brought down transmission rates to about four percent, and most of the other countries are still in catch-up mode.

MALE SPEAKER: You mentioned the 12-percent of the mothers, were you talking about people who were above the 250? Or under the 250? Are we talking patients? Or are we talking—?

ALEX COUTINHO, M.D., M.P.H.: No, I think I was talking about those who get care and treatment. Care and/or treatment, 12-percent actually enter a care and treatment. Not just treatment, because they would need things like co-trimoxazole and other interventions.

CRAIG MCCLURE: This is a question from the chair, one of our other speakers this morning, Heime Supolvita [misspelled?], from the Bill and Melinda Gates Foundation, talked about the combined impact of combination approaches to prevention, just as we use different drugs combined for treatment, he was discussing combined interventions for prevention, including behavioral interventions, biomedical interventions, like circumcision, anti-retrovirals themselves and structural interventions and the need to measure strategically the impact of combining all or some of those, or the negative impact, I wonder if any of you would like to comment on that?

MALE SPEAKER: So maybe I could try? In terms of the anti-retroviral treatment that is being rolled out at the moment, there is no doubt if we cannot prevent the new infections from happening, then we are going to have to keep increasing the number of people on treatment.

The anti-retroviral treatments themselves have a direct benefit reducing viral loads and probably reducing transmission from those on treatments. Most of the transmission occurs in those people who do not know that they are infected, and well before treatment would be indicated clinically. We need a big improvement of finding those individuals who are HIV infected, and having prevention for positives.

At the same time, there are more negatives in any one population than there are positives, and we need to change bad behaviors as well. It is only through combining our bio-medical, our behavioral, our social, our structural that I believe that we can move to a position where the epidemic is under control. I think if we focus on just one aspect of HIV epidemic, and believe in the magic bullet, we are always going to fail. We do need to combine our prevention and our treatment approaches.

One of the arguments of the neat scale of treatments is that it would facilitate prevention and we must not ignore that facilitation of prevention.

CRAIG MCCLURE: Elizabeth, just to follow up to that, as you mentioned, young people are disproportionately vulnerable, and particularly young people in marginalized communities whether they are in concentrated epidemics, whether they are men who have sex with men, or sex workers or drug

users. What are your thoughts about this combined approach to prevention?

ELIZABETH FADUL: Yeah, well I think a lot of it depends on how we reflect, how the information is getting and how we are drafting it. Are the prevention efforts that we are implementing, does it promote a behavior change among our targeted populations, and what strategies could we use to promote a behavior change? Because if we take for example, the adequate information I have and put it against my risk perception, normally there is a big difference. So what are those prevention strategies that we need to do that make me have a higher risk perception of contracting HIV and AIDS and that all depends on that we cannot simply say if, well, if HIV is transmitted through heterosexual transmission, it is transmission also through blood transfusion, through injected drug use. We also have to adapt it to the population that we are saying it to.

We cannot simply put the information out there and just put the statistic there. It is kind of like if we are doing a marketing campaign for a product, we adapt it to the public; we adapt it to who we want to change their perception. And I think that is one of the main things we have to do, and as Geoff said, it also has to combine with the treatment, the care and has to be an integral approach that does not just focus on one component, but actually focus on all of the person and

actually focuses on how that person can become empowered with the information of HIV and AIDS.

CRAIG MCCLURE: Another question? In the front?

ADMESO SIMWAY: Admeso Simay [Misspelled?], Independent Matters In Kampala, Uganda. There is a spinning that some people do not have the virus anymore because of the ARVs. They are mistaking the ARVs to be a cure, and they are not scared, so there is a lot of complacency. What do you say about that?

ALEX COUTINHO, M.D., M.P.H.: I think a lot of people did not feel the virus even before anti-retroviral therapy. I think research plainly shows a disinhibition despite adequate knowledge. Translating knowledge into behavior has always been a challenge for social scientists. If we could get it right, we could really control this epidemic.

I think the availability of anti-retroviral therapy might have changed some perceptions about HIV not being a killer disease, in to a chronic, manageable disease. We know this has happened in many countries around the world, and I think current efforts are to insure that HIV positive people speak out, particularly those in treatment, so that people know that on the one hand, yes, it is a chronic, manageable condition, but if people had the choice of whether to be HIV positive or HIV negative, I would think most people would vote to be HIV negative, and so the media plays an important role in de-mystifying some of these perceptions among the young and

not-so-young people about whether they can take more risks in an ART era.

CRAIG MCCLURE: Elizabeth, what do you think about what young people think about anti-retroviral drugs and whether that discourages them from worrying about AIDS or worrying about getting infected with HIV?

ELIZABETH FADUL: Well, I think that the fact that you have anti-retroviral therapy means that for young people, that many young people that are infected at an early age, that we can have a productive life that can insert into the labor force and economic force and it does not mean that we have to lower our risk perception, because of getting infected with HIV.

Anti-retroviral therapy is applied to persons already living with HIV and I think that it depends on how we put the information out there, and how we actually implement our programs. It is for example, like if some people say that if you promote safe sex among young people they will have sex, and you should promote abstinence. It is the same thing. If you promote safe sex and give the adequate information, then you will actually have more of a risk perception and lower incidence rates.

CRAIG MCCLURE: Thanks. Question from the front?

PHYLISS CARTIEZ: Hello I am Phyliss Cartiez

[misspelled?], journalist from *The Sentinel* in Zimbabwe. My question is directed to Elizabeth Fadul. Earlier on, you

referred to HIV. The young people and women increasingly becoming the new face of HIV. Maybe you could give me your thoughts on new strategies that could be employed to remove that? Thank you.

ELIZABETH FADUL: The first strategy is mainly participation of young women into the design of those programs. The second one is that we actually address the gender, oppression and violence among women and those social norms and cultural norms that are in our societies, we must implement—and I know there are women activists all around the world have been doing a great job on this, but we implement a behavior change among those authorities, among those government officials that actually implement those policies that discriminate us. I think another key barrier, well like I said, information is key and we must have that available and we must take a role and we must lead the response to HIV and AIDS.

CRAIG MCCLURE: It sounds like you and UNAIDS and others talked recently about the notion of knowing your epidemic. That each epidemic is different in different countries, different cultures and it sounds like you are saying that young people in a particular epidemic need to be part of deciding what interventions will work for them. Is that?

ELIZABETH FADUL: Yes, definitely, how can you have an intervention that addresses me if you do not know my realities. For example, we have the statistics. We have the trends of the

epidemic, but if we are talking about a response, how can you respond to my life, to my experiences if you do not know what I am thinking, if you do not know what is happening.

So by the rate that we are involved and we participate and that we took help in the development of strategies, these programs can actually have a real and impacting result on the diminishing of the prevalence of the epidemic of AIDS.

CRAIG MCCLURE: I can take one more question. Here please.

KARKRAE SHORONDO: My name is Karkrae Shorondo [misspelled?], I work with *The Daily Monitor* in Uganda. My question goes to Dr. Coutinho. You say that most of the countries are not going to achieve the 2010 targets. Is Uganda one of them? And if so, why do you think we are going to fail to achieve these targets?

ALEX COUTINHO, M.D., M.P.H.: Uganda is not going to reach 2010, the universal access 2010. They may be—see, universal access has many sub targets on treatment, on prevention, and it will not reach most of them. Possibly it might reach treatment, it depends on the scale-up and there are several reasons around that. Some of them are leadership. I think for Uganda, there has been to some extent around HIV prevention, we have allowed others to take the leadership that we once had in HIV prevention, because the newer leaders are

promoting combination prevention, and we are not promoting it as much as we did in earlier days.

There are also result constraints, there are health system issues, so it is a whole complex set of reasons that varies from country to country, but Uganda will not reach universal access targets by 2010.

CRAIG MCCLURE: Well, on that gloomy note, I would like to thank the presenters and thank all of you. Thank you.

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