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## **XVII International AIDS Conference Official Press Conference August 6, 2008**

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**CRAIG MCCLURE:** Welcome back. Craig McClure again from the International AIDS Society, and welcome you to this morning's Plenary Press Conference. We had another very exciting Plenary today, three very dynamic presentations.

What I am going to do is introduce the three speakers from this morning, and then each of them will give couple of minutes, quick overview of their presentations. Then we will open it up for questions and answers. Now just so you are aware again, there are headphones at the door.

Elena Reynaga, one of our three presenters will be speaking in Spanish. You are free to ask your questions in Spanish or in English. But if you do not speak both languages it is always helpful to have one of these.

The three speakers this morning were Robert Siliciano, member of the Howard Hughes Medical Institute and Professor of Medicine in Molecular Biology and Genetics at Johns Hopkins University School of Medicine in the United States. His Plenary presentation was on HIV Persistence in Patients on Highly Active Antiretroviral Therapy Re-evaluating the Prospects for Eradication.

Our second speaker was Linda Richter, the Executive Director of Child, Youth, Family, and Social Development at the Human Sciences Research Council in South Africa. And Linda Richter's presentation was entitled, No Small Issue: Children and Families.

Our third presenter was Elena Reynaga. Elena is a female sex worker, born in San Pedro de Jujuy, Argentina. She is the Founder and Executive Secretary of the Argentine Association of Female Sex Workers. Its major achievements have been the elimination of police edicts which criminalize sex work and the establishment of a syndicate which gives females sex workers the status of workers. Her presentation was on sex workers.

I will turn to Bob Siliciano first of all.

**ROBERT SILICIANO, M.D., PH.D.:** Thanks Craig. So, my talk was on what we need to do to cure HIV infection. And because the drugs that have been developed over the last 15 or so years are very effective and can reduce the amount of virus in the blood to below the limit of the detection, there has been quite a bit of confusion about what the ultimate potential of these drugs is to cure people and how good they are actually working.

Because in fact, in all of this time nobody, not a single patient has been cured, and one of the most confusing aspects of this is that in people who are doing well on treatment there is a little bit of virus in the blood that is below the level of detection of the clinical assays, but can be detected with laboratory assays and this has led people to think that the drugs are not completely controlling the infection.

The main point of my talk was that new research suggests that in the optimal situation that is when people actually all the drugs as prescribed. The virus has been completely stopped from replicating, and the evidence is that if you add more drugs the amount of virus in the blood does not go down anymore.

And what is really happening is that the virus in the blood is coming from a long-term reservoir of cells that have been infected even before therapy began. And that is the reservoir that has to be eliminated before anybody can be cured.

But I think the good news is that the drugs are actually working a lot better than we thought in people who have access to the drugs and who take the drugs correctly. We really can stop the virus from replicating, from evolving and in principle patients who take the drugs and who do not have toxicity should be able to lead a normal life because we have stopped the virus from evolving.

To cure them we are going to have to find a way to target those reservoirs which is the main focus of our work, and I can talk about that in more detail if there is questions.

**CRAIG MCCLURE:** Thank you. I will turn now to Linda Richter.

**PROFESSOR LINDA RICHTER, PH.D:** Thank you very much. I think one of the distinguishing features of this conference is the much more measured approach and appreciation that we have

of the HIV/AIDS epidemic. We now know there is no magic vaccine around the corner, there is no magic microbicide. And we are really beginning to appreciate the very long-term generational impacts that this disease is having. We are into the third generation now, and people are saying we will go another 25 years, and perhaps another 25 after that to control.

I tried to make two major points with respect to that. Four points about, in what way we are failing children. Prevention, although we have effective methods are not reaching children. Treatment is lagging for children and I illustrated that in my talk.

Our concentration on orphans only, particularly when our definition of orphans means that of that group of children called orphans, 80-percent have a surviving parent, making it absolutely imperative that we reorient our response to protect vulnerable children, and that families are by and large affording this epidemic out of their own pockets and their own emotional and social reservoirs, and I made four recommendations.

Firstly, that we should begin to support families as an integral part of the response into the long-term multi generational impact that it is having on human societies. That we need to provide treatment, prevention and care through family centered services. That social protection at this point was a critical entry point for children, and by that I mean the package of services that protect people from becoming very

vulnerable under the circumstances of HIV, and lastly I spoke about income transfers.

And unfortunately, I did not time myself quite correctly because I had a point that I would like to reiterate now. I did say that HIV and AIDS was impoverishing families and impoverishing communities, and with time is impoverishing countries. And that in many high prevalent settings, poverty may well be the next barrier to any further scale up of HIV/AIDS treatment and prevention.

The inability of families to actually access any further provision of services without additional support and I think the income transfer argument really needs to be looked at very seriously, along a continuum from treatment allowances right through to full social security enablers like old aged pension and child support grants.

**CRAIG MCCLURE:** Thank you very much, Linda. Obviously a very active day out there and so we will speak close to the microphones as we can. I will turn now to Elena Reynaga.

**ELENA REYNAGA:** [Speaking Spanish].

**CRAIG MCCLURE:** Thank you very much.

I am going to take the prerogative of the Chair and ask one question to each participant before opening up. Bob, you basically presented in your talk that the drugs we currently have are doing an excellent job eliminating HIV in cells that are active. You spoke of the lung resting, latent cells that are

infected with HIV and the need to make those cells active and to find ways to make them active so the drugs can work.

Can you talk about the kind of approaches you are looking at and what is holding back the development of interventions to bring to life, if you like the latently infected cells?

**ROBERT SILICIANO, M.D., PH.D.:** Yes, well the approach that has been taken by many groups is to activate the T cell and when you do that because HIV's own activation is linked so closely to the activation of the T cell, then that is a way to reactive latent HIV.

But that is associated with a lot of toxicity with the attempts that have been tried because the immune system is really not designed to have all of the cells active at the same time. There is production of so much cytokines and inflammation and side effects that it is actually very dangerous for the patient.

So we need something selective that will only turn on the cells that have latent HIV, and right now it is not really clear how to do that. I think the thing that we can take some hope from is that we have developed better ways to study this.

In the past it has been very difficult to study these latently infected cells because they are present at a frequency of one in a million, and so it is almost impossible to do any mechanistic work.

Now it is possible to generate these cells, essentially in the laboratory in a very realistic way and the hope is that with that improved system and possibly using the classic approach that the pharmaceutical industry is taking involving screening of large libraries of drugs, we will uncover some unexpected approach that will allow us to do this.

**CRAIG MCCLURE:** Thank you Bob. Linda, I wonder if you have identified any examples, any countries that are implementing this comprehensive family centered approach to prevent and treat HIV in children and protect them. That you would advocate for scaling out, examples of good practice.

**PROFESSOR LINDA RICHTER, PH.D:** Right, there are many more than we think actually. Rwanda of course, is an extraordinary example of an integrated service in a comprehensive package protection for children.

Tanzania, Kenya has scaled up to 100,000 currently to be expanded to 300,000 families. Malawi is already reaching several hundred thousand of the 10-percent poorest families in these kinds of comprehensive approaches.

At the moment they are very much supported financially and with technical assistance from external agencies, but they have government participation. In fact, in 2006, the Southern African Government signed up to what is called the Livingston Accord, which was a commitment to social protection.

Budgets have been put to that. And in October 2008, they will meet again to further that agenda, and increasingly

the international agencies are coming behind this as a confluence of the interest of HIV/AIDS and development in the region, which are absolutely and extricably linked in this epidemic both in terms of transmission and mitigation.

**CRAIG MCCLURE:** Thank you. Elena, you gave an example in India where in Calcutta, where sex work was decriminalized. HIV infection, HIV prevalence dropped to very low levels and you compared it with another city in India, Mombi where sex work is not decriminalized and HIV prevalence was, I think 50-percent.

Do you have other examples or can you explain to us why you think that made such a difference?

**ELENA REYNAGA:** [Speaking Spanish].

**CRAIG MCCLURE:** Okay, I would like to open it up now. Please state your name and your media house before the question.

Here at the back, halfway. Yes, you, microphones. We have microphones. No, back, back, back, back, back, back, right there. Thank you.

**FEMALE SPEAKER:** [Speaking Spanish].

**CRAIG MCCLURE:** Just one question, sorry.

**FEMALE SPEAKER:** [Speaking Spanish].

**PROFESSOR LINDA RICHTER, PH.D:** Yes, thank you very much. One of the big arguments for income transfers and social protection systems directed to very vulnerable families is to

ensure more of the money that is being released in the HIV/AIDS epidemic to beneficiaries actually reaches them.

You would have all seen the report that 70-percent of PEPFAR funds are actually paid to international agencies. That is an incredibly inefficient way of moving money down to people who need it. It is very difficult to track that money and to see how each intermediary organization or consortium is using that money and how much eventually trickles down.

The income transfers are a very direct way of getting money to people who are vulnerable because it does not go through many translations. Money arrives in countries whether it is for education, for roads or whatever, it has to be translated. It translates many, many times if you provide food to the poorest families they often reconvert it into cash. So there are many ways in which money decreases in value if you do not provide it directly to families.

Now when we look at income transfer programs, I mean you have an exemplary one in Mexico, Opportunity Dardis [misspelled?], which is a experimentally well studied program with very good results showing the benefits to children's health, education, nutrition.

When we study those income transfer programs, we see that money when it reaches households is extremely well used, 80-percent of it buys food, other parts of that money goes to paying for education supplies for children. So we do know and have good evidence that families benefit very directly from

income transfers. We do not have a lot of evidence that families benefit from large amounts of money released into international organizations for programs.

**CRAIG MCCLURE:** Thank you. I will try to come back to you if we have time. Next question [Speaking Spanish], Larry.

**LARRY ALTMAN:** Larry Altman, *New York Times*. One, you are saying you are challenging current paradigms into how to improve the lives of children and you are talking about income transfer. But income transfers is a jargon phrase. Could you just spell out more directly what you mean by that and how you are challenging the-

**CRAIG MCCLURE:** Thank you. Back to you, Linda.

**PROFESSOR LINDA RICHTER, PH.D:** Thank you, Larry. Yes, I think there is a paradigm shift from provision of services to ensuring that families actually have the wherewithal to access those services. We cannot simply provide services if families lack the capacity to do that. And this is what is driving the income transfer movement.

Now income transfers, why I use that word, you know they have been used cash transfers, you have Opportunities New York, which is a very interesting program happening that is incentivizing the use of benefits for children.

These social protection programs, which is perhaps more accurate to speak about, can span a very wide range. Germany introduced them in the 1890s as really as insurance programs when people were injured on duty or injured at work. They were

then expanded into old age pensions. They can take many forms. They can take the forms of allowances, of subsidies, direct cash to households.

And I think every country has to look at its own situation and decide what sort of thing it wants to introduce. But treatment allowances, for example, it is almost becoming imperative that if people do not receive small amounts of money to benefit from ARV programs, they cannot keep up the adherence levels because it costs them to get to clinics to receive medication. It costs them to buy extra food to maintain the level of effectiveness of the drugs.

So, Larry, without committing oneself to a particular form of these transfers, it really is a very wide spectrum.

**CRAIG MCCLURE:** I will take a question here please.

**MALE SPEAKER:** [Speaking Spanish] And I would also like Mr. McClure to comment on that. Thank you.

**ELENA REYNAGA:** [Speaking Spanish].

**CRAIG MCCLURE:** There were different types of excitement, I think in the plenary hall itself, which seemed to me like it was packed with 7,000, 8,000 people, what I heard was an enormous roar of approval that finally after 25 years at the International Aids Conference a sex worker who had become a leader around the world around sex worker's issues was speaking about sex work rather than a researcher who had never done sex work or a policy analyst who had never done sex work.

So there was a roar of approval at the conference enabling a leader who herself is a sex worker to speak about what works to prevent HIV transmission among sex workers.

If you are referring to the little demonstration at the front with three women sex workers from Mexico, that was about their desire for a Mexican to speak about sex work issues. But we need to remember this is not a Mexican conference. It is an international conference that has many Mexicans speaking at it. So for me the most important thing was that roar approval for all of the organizers, including the IAS that we had put a sex worker on the stage to speak about sex work.

Can I take another question please? Anymore questions? Martin, and then we will go to you in the back. Okay, go ahead.

**FEMALE SPEAKER:** [Speaking Spanish].

**FEMALE SPEAKER:** [Speaking Spanish].

**CRAIG MCCLURE:** Thank you. Martin, do you have a microphone?

**MARTIN:** Is this on, yes. My question is to Dr. Siliciano. It is whether your research has revealed any new news on viral latent reservoirs of HIV in the genital tracks and any continued infectiousness despite undetectable viral load in patients in the blood? And whether this is then able to give a message that people can have sex safely without condoms? Do you understand what I am saying?

**ROBERT SILICIANO, MD, PH.D:** You are referring to people on treatment.

**MARTIN:** Yeah, but I mean you know have you revealed any new research about the latent reservoirs of HIV in the genital track through your research?

**ROBERT SILICIANO, MD, PH.D:** Not in our own research. I think there is a general feeling that lymphocytes, including these resting T-cells, that harbor latent HIV are widely distributed throughout the body are likely to be in every organ at some concentration.

And in terms of the issue of whether they could contribute to transmission in people on treatment, I mean the reality is that the lower the viral load the lower the likelihood of transmission. But because of these reservoirs even in a patient with suppression of viremia to load limit protection there is a possibility of transmission. That is certainly what we counsel our patients and I think that is the wise thing to say.

**CRAIG MCCLURE:** And just to follow up Dr. Siliciano, there was a report just before the conference in *The International Herald Tribune* that claimed quite wrongly, in my mind, that the HIV field does not care anymore about cures and eradication. And your talk clearly spoke to that issue and said to me that eradication is something we are all very concerned about and that that may in fact be possible.

**ROBERT SILICIANO, MD, PH.D:** Well, I think it is interesting that after all of the excitement following the introduction of HART, there was a great disappointment when reservoirs were identified that would prevent cure, even though the drugs reduced the amount of virus in the blood to undetectable levels.

And that almost led to a point where people were afraid to talk about it. And I think there still is a danger in talking about it and people thinking that it is going to be easy to do. So what I am trying to say is that we can break this down and do it in a step-wise fashion.

What is, I guess, impressive to me is that the first step, which is you have to stop the virus from replicating, that actually is done. Now it may be much harder to find these reservoirs and I think it is clearly like a vaccine it is something that we are obligated to try and work on and who knows how long it will take.

But the first step has actually been accomplished and that also has implications for everybody who has got HIV. It means that if those people have access to the drugs and if they take the drugs, they will not develop AIDS.

**CRAIG MCCLURE:** Fantastic. I think we can take another question, mike, sorry.

**DON MESSNER:** Don Messner [misspelled?], United Methodist Communications. I would like to speak to Dr. Richter. I appreciated your comment about income transfer for

nutrition and travel. It seems to me that nutrition and need for food is consistently overlooked in the matter of treatment. In India I was in centers in rural India where they get World Food Program foods but it is not the food that people like to eat.

And there needs to be money to help them fix it in a way. So the food goes to waste. In Malawi I have seen thousands and thousands of school children getting no food. What do you recommend and what positive examples? I mean the United States, the McGovern goal International Food Program was cut for school children at the very time we are talking about increasing nutritional health. So there is an enormous difference and your help is appreciated.

**PROFESSOR LINDA RICHTER, PH.D:** Nutrition remains an enormous problem in most poor countries where a third to a half of all children are stunted with long-term consequences for their development, for their schooling, for their employment. I mean we have recently published in *The Lancet* showing the income effects of early stunting and poverty.

There is no doubt, though, that what we are trying to achieve in the response to HIV is a balance between provision and demand. If our emphasis continues in what we are spending the money on, on provision without simultaneously increasing the capacity of families and individuals to respond, to get the provision, we are not going to get any further than we are. I

mean in some Southern African countries we are talking about perhaps reaching the plateau in how much provision can further.

There is a big debate going on now about food, the provision of food versus the provision of money, particularly with rising food prices, and the neglect of agriculture in many of the poor countries over the last decade. That assistance has both within country and from abroad has not supported the level of agricultural development we should have.

However, it seems where there are functioning markets, and some economists quip that a functioning market is where you can buy a Coke, where there are functioning markets you need to continue to give money rather than food. That families more efficiently use money to purchase the foods that they need, the foods that they like, the foods that can last and be preserved, and that in many cases where food is provided, it is inefficiently translated into money.

It is sold to near neighbors. The only difference is when food is given to schoolchildren. That seems to be a very efficient transfer and it does mitigate hunger, but it does not mitigate stunting. Stunting occurs in the first two years of life. That is nutrition in the home and that is where you have to ensure the families are being able to maintain their consumption levels, particularly for very young children.

**CRAIG MCCLURE:** Thank you very much. I am afraid that is all the time we have. You may want to speak to the

presenters individually, and can discuss with Karen if that is the case. Thank you very much and thank you to our presenters.

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