

Official Press Conference: Meet Today's Plenary Speakers XVI International AIDS Conference August 14, 2006

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CRAIG McCLURE: Good morning everyone, my name is Craig McClure, and I'm the Executive Director of the International AIDS Society. I'd like to welcome you to the post plenary press conference this morning, our first day of plenary presentations. This morning I am really pleased to have with me the four speakers from this morning's plenary along with Dr. Nils Daulaire who Co-Chaired the Jonathan Mann Memorial Lecture presented by Anand Grover. The theme of today's plenary was Taking Stock: Current Changes in the Global Response. This session provided an opportunity to explore some of the major challenges we face in responding to the epidemic, and to propose strategies and approaches that will better prepare us to meet those challenges. We will begin with brief remarks from each of the plenary speakers and then open the floor to questions from all of you.

So without further adieu I would like to introduce first of all Dr. Julie Overbaugh who is a member and Associate Program Head at the Fred Hutchinson Cancer Research Center in Seattle. Her talk focused on host and viral factors influencing susceptibility to HIV infection, Julie.

JULIE OVERBAUGH, PhD: Good morning. This morning I covered in a broad swatch the -can you hear, oh you can't hear- This morning I covered in a broad overview some of the host and viral factors that at an individual level contribute to

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susceptibility to HIV infection. I highlighted some of the viral factors that have been recently discovered such as the fact that the virus is heavily glycosylated, which means it has just sugars sitting on the outside of it that seem to be imparting some difference in transmissibility. I also talked about host factors. Some recent discoveries of a couple of host factors by other lab groups called APOBEC3G and Trim5alpha that are host cell proteins that normally can block HIV infection, so I think they're important because they're giving us a way to mimic those kinds of strategies in the laboratory. Then I talked about whether preexisting infection by HIV renders somebody less susceptible to re-infection by HIV, that is super infection, and I showed data that suggests that super infection might be more common than we had previously appreciated.

CRAIG McCLURE: Thank you, Julie. Our second speaker was Dr. Chris Beyrer who is the Associate Professor in the Department Epidemiology and International Health at Johns Hopkins. He is also Director of Johns Hopkins Fogarty AIDS International Training and Research Program. Dr. Beyrer examined risk context of emerging and sustained epidemics in Eurasia and Southern Africa among IDU and MSM, Chris.

CHRIS BEYRER, MD, MPH: Thanks very much. My focus today was to try and talk about individual level risks for HIV acquisition and transmission, and the social and structural risks that, the context in which those individual risks occur;

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and to do that by looking at the very diverse epidemiology of HIV to focus on those areas in the global pandemic and those groups in the global pandemic where HIV spread is ongoing or accelerating. The three areas that I focused on are the IDU driven epidemics in Eastern Europe, Central Asia, and the former Soviet Union where epidemics have really been driven by a increasing and widespread heroin availability, largely because of tremendous increases in production in heroin in Afghanistan, a lack of basic prevention services, evidence based prevention for IDU, and harsh and punitive policy environments. The second epidemic that I focused on was among men who have sex with men where we see ongoing spread in first world settings, particularly in the Unites States, but also emerging epidemics in developing countries among MSM against backgrounds of low population prevalence, and we see that on four continents; and then the policy environments that really matter there are for stigma and discrimination and again a lack of basic prevention services for MSM, less than 10-percent globally having access to effective targeted prevention. Finally, I talked about the Southern African epidemic which is much more severe than the rest of Africa and appears to be continuing to expand, while there is evidence from East, West, and the horn of Africa that the HIV epidemic is actually slowing in those areas, but it is not in the South. We looked at factors associated with that ongoing spread and it appears

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that labor migration plays important roles, gender dynamics, sexual violence, intimate partner violence, concurrency of sexual relationships, and probably some biological factors like low rates of male circumcision, high rates of herpes simplex-2 virus, and low condom use.

CRAIG McCLURE: Thanks, Chris. I would like to introduce now Dr. Nils Daulaire, President and CEO of the Global Health Council. He is here today to present the Jonathan Mann award for Global Health and Human Rights which is bestowed annually by the Global Health Council to a leading practitioner in Health and Human Rights.

NILS DAULAIRE: Jonathan Mann was a campaigner for health and human rights; he died in a plane crash in 1998, but this is now the fourth time that a noted human rights and health campaigner has been invited to present the Jonathan Mann Memorial Lecture. What was striking about Jonathan and the legacy that he left behind, and which is reflected in both of the succeeding speakers, is that he made concrete the linkages between good health and the recognition of human rights, and particularly in the arena of AIDS, he laid out the reality that AIDS could not exist in a world in which human rights are truly respected, and that in fact the abrogation of those rights provide the prime pathway for the progression and spread of HIV/AIDS.

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ANAND GROVER: I had the privilege of doing the Jonathan Mann lecture because a lot of our work in India is shaped by his understanding of the link between vulnerabilities in HIV; and I spoke about four issues, one is the understanding of illness, it's not a standard category like whether you are ill or not ill, it's continuing. The second thing I spoke about was the whole notion which is now gaining ground, though today the W.H.O. and UNAIDS have issued a statement revising their guidelines on what is known as opt-out routine testing, and I argued that opt-out routine testing which is based on the Botswana model is a flawed strategy. The third thing that I spoke about was vulnerabilities, though Jonathan Mann had recognized this, all the views, my particular view is that the specific linkages between what are known as the specific vulnerable communities like men having sex with men, injecting drug users, and sex workers is fairly well recognized, but the traditionally marginalized sections like the race, migration of minorities, or cost minorities, or women, there is not much emphasis on that in terms of theory and practical application. The fourth thing that I talked about was the fact that there is a very strong pressure from the U.S. Drug Multi-National corporation lobbies, and the United States Government through the United States Trade Representative to roll back trips and have loss, which will actually impede the delivery of

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affordable medicines to HIV-positive people in the world, and particularly in the developing world.

CRAIG McCLURE: Thank you, Anand. Our fourth speaker this morning is Louise Binder. Louise is one of the strongest advocates, HIV advocates and activists in Canada and in the world. She is Chair of the Canadian Treatment Action Council, Vice-Chair of Voices of Positive Women, and Co-Chair of the Canadian Federal Ministerial Council on HIV and AIDS. Louise gave the plenary talk this morning on Women, Girls, and HIV. Louise.

LOUISE BINDER: Thank you. I just want to give a little context which I didn't do in my speech and that's to say that I am a woman who has been living with HIV for, well has been diagnosed for 14 years, and probably has been infected for about 18, so I've learned a lot from my own life experience that I certainly used in my presentation. In addition, I've become quite a strong advocate for women's issues both nationally and some international work as well, and I do a lot of work doing systemic access to treatment issues with government, so to make sure that people get the treatments that they need. So I kind of started from that experience, and what that experience has taught me over these 14 years is that it's power that drives this epidemic, and where power resides, we don't see this epidemic, but where power recedes it proliferates and thrives very well, and it's thriving very well

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right now in the, sort of, non-power group of women, transgender, transsexuals, non-whites, aboriginals, indigenous people, prisoners, illicit substance users, poor people, and people outside the main stream, and so the infection rates mirror those populations.

While women certainly have also a slight biological disadvantage, it is far more outweighed by the fact that we have a profound gender inequality and profound socioeconomic inequality which is really driving this epidemic. I talked about the ways that women are not given the kinds of empowerment tools to protect themselves including being sold into slavery, working in the sex trade, being abandoned by their families, being unpaid caregivers for everyone, and certainly many of these women are in fact not women yet but young girls, which is really tragic.

I also talked about the fact that within the context of this profound devastation women have been real success stories in terms of being leaders in our communities, and leading some very interesting HIV projects, and I gave examples of three that I thought were quite different, each one from another, and also quite compelling. One is the work that was done to get microbicides onto the research agenda, one is the work that has been done in Rwanda with rape survivors and survivors of the genocide there, and getting them economically viable and actually back into the mainstream; and the third was from

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Limpopo in the northern part of South Africa where a microfinance program matched with educational tools have actually reduced partner violence by 55-percent over the two years of the study that was done there, and has actually made quite profound changes in the way that society is run, so proving that in fact one can change culture if one leads the way properly.

I talked about that, and then I talked about the need for national health HIV/AIDS strategies that are comprehensive within the context of national reproductive health and rights strategies which are comprehensive within the context of development strategies that make sure that women are educated, have rights to property, have rights to inheritance, and are actually able to manage and be self-empowered so that we have to stop siloing all of these things, they have to be worked on together integrally and inter-sectorally, and in that way we have the opportunity to help women.

We have to drop a lot of the really bad policies that exist like the policy of ABCs which does not serve women well, the policy of attaching conditions such as abstinence until marriage to money that's being given to women's health and reproductive work because these are actually killing women; and we also have got to stop the practice of giving HIV, of (A) mandatory testing for HIV-positive pregnant women and (B) giving those women substandard treatment for their own HIV

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while they are pregnant which is monotherapy, so that's killing them and ultimately the orphans as well. Those are some of the areas that I covered in my talk.

CRAIG McCLURE: Thank you. Okay we'll start to take questions now and please stand up, wait for the microphone, for the translators, and state your name and your affiliation.

MALE SPEAKER: This is for Dr. Overbaugh. You discussed super infection and I'm with a New York City Spanish language newspaper, and in New York we had a controversy concerning super infection, and everybody pretty much pooh-poohed the Commissioner's alarm which came from Marty Markowitz and Dr. David Ho, you're saying, you said this morning that indeed super infection is real, it has been found in a small cohort in Africa, you tracked it in Africa I believe, and what is the risk, two questions, what is the future risk of super infection meaning the consequences of super infection? Secondly, should this change our prevention recommendations because right now zero sorting is very common, people having sex with people with HIV, people with HIV having sex with people with HIV, is zero sorting something that we shouldn't promote?

JULIE OVERBAUGH, PhD: Let me start by making sure I'm clear on the case you talked about in New York City. The case that I was aware of that caused a lot of press was not a case of super infection; it was a case of infection with what was considered to be a particularly virulent strain. Is that the

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case you're talking about? Okay, so what I'm referring to is a case in which a person is infected with one virus, continues to be exposed perhaps through zero sorting, and then becomes infected by a second partner, so I want to be clear that those are two different things and I agree that probably this issue of whether there was a particularly worrisome strain circulating was a little bit overblown from my perception. I think that the studies that we've done in Africa, some of which are not yet published and studies from the UCSD cohort and a number of other cohorts are suggesting that super infection, that is re-infection by a second partner is occurring more than we had originally expected. Ours is the biggest study that I am aware of to date, so we are still talking about only looking at 57 women in eight cases. I don't think we know yet whether the risk of super infection is nearly as high as first infection, but the data are starting to suggest that that's an issue. So the second point regarding the zero sorting and what should be advised for people who choose that option, I think again we don't have enough numbers to know the risk, and we don't know as I tried to highlight in one comment in my talk, we don't know whether getting re-infected makes the person progress more rapidly to disease; but I will tell you that the three cases from the UCSD cohort suggested that that's true, so at the moment there is a hint that getting re-infected could be worse for prognosis, in those three cases there was differences in

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drug susceptibilities of the strain which is of concern. At the moment I would say that we don't have enough data, we need more data, but I would be a little cautious in terms of the risk that people might have for getting re-infected and what it means for them personally.

CRAIG McCLURE: Thank you. The second question AFP I think, and then, okay, you're afterwards, go ahead, go ahead.

JOANNE OMANG: I'm Joanne Omang with *Ms. Magazine*, and *Ms. Magazine* in the PLANetWIRE, and I would like to ask about the controversy at the moment involving whether the focus on women that's much part of this conference is appropriate given the discussion, also there's a controversy over that saying that instead we should focus on sex workers, MSMs, and others who have more of a direct and larger impact as individuals. I would like to address this to Mr. Beyrer and Mr. Grover please.

CRAIG McCLURE: So the question is whether to focus on women per say, or in particular communities most at risk including sex workers, MSM, yes. So let's start with Chris.

CHRIS BEYRER, MD, MPH: I think one way to sort of frame this is to say that prevention, and now just speaking specifically about prevention, really needs to be fit and targeted to the epidemic that you're addressing. One of the things that I try to highlight is the increasing diversity, sort of multiple epidemiologies of HIV, so I think, and for example, many of the Central Asian states, these are highly

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concentrated newly emerging epidemics in IDU who are overwhelmingly young men. Now that is the target group for that stage of infection that is very appropriate for targeting preventive interventions. What we've seen unfortunately is that it's very hard for governments and policy makers to spend precious dollars on people they consider not deserving, so those populations get very underserved, and that unfortunately appears to be one of the key drivers of those epidemics. Now in contrast when you have a generalized epidemic that's primarily heterosexual in nature, like most of Sub-Saharan Africa and particularly Southern Sub-Saharan Africa, it's very clear first of all that women and girls are at enormous risk, and that prevention really has to deal with gender issues, it's a gendered issue, gender issues include men and their sexual behaviors and their gender attitudes toward women, and behaviors, concurrency, multiple partners, and an array of risks. So I think that the answer in a sense is both are true, you need targeted interventions that are appropriately fit to emerging epidemics, and you have got to deal with the incredible burden of HIV for women in Africa with a strong orientation toward gender, and I think that that was made clear actually by both of the other speakers.

ANAND GROVER: I come from India and this is a classical situation being, which actually raises a lot of issues in terms of either concentrating your resources in one community or the

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other. The way that epidemiologist have looked at the infection from the sex workers to the male clients to their wives or partners is what we are looking at. I think yesterday, I don't know if you were at the opening session, but Melinda Gates made a very important point saying that you can't exclude either of them and actually they are related, and moreover I think the traditionally marginalized groups like in the United States or in North Canada, the racial minorities or the ethnic minorities, have been ignored in the epidemic because it is very easy to make connections between certain types of sexual activity and HIV transmission. I think the epidemic has gone beyond that, it's not only concentrated in small groups like that, in India certainly it is now in the mainstream, you have to have strategies for both of them, they are different strategies, and most of all the strategies, whether it's sex workers or say housewives, require the government's, especially in the developing countries, to address the issue of this empowerment which is what Louise talked about, you know, and those are the key strategies, and only if you do that will you be able to empower women so that they can protect themselves.

CRAIG McCLURE: Okay, we will take the next question, Richard I think.

RICHARD INGHAM: Thank you very much, Richard Ingham from the French News Agency. A question for Dr. Overbaugh, if I could ask you to be low brow for a minute and for someone like

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me who, you know, when it comes to molecular biology / biology I fell pretty much at the first hurdle, but from what I understand from your very interesting presentation this morning, that there are prospective Achilles heels in the virus, and I was wondering if you could just talk this through to us in a very basic manor as to what you're looking for and how this could be potentially useful?

JULIE OVERBAUGH, PhD: So one of the aspects of the virus that I mentioned the different transmitted strains are these sugars, and the sugars essentially shield the virus protein and block other molecules, proteins getting at the virus. I think one area of interest is to see if we can find antibodies, so immune factors that would bind specifically and get access to those particular viruses perhaps by sort of getting through that sugar coat. I think those are the kinds of things that we and others are thinking about, but we're also thinking that if you have a vaccine that you are screening, or you have a microbicide that you are screening, then if you really want to know if they are going to block transmitted viruses you need to have a panel of these viruses to work with. In the field historically people have just pulled the virus off the shelf, whatever is there, it's a virus; and so I've been advocating for the past few years that we really need to target those kinds of viruses, so I think that's another important part of those findings.

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CRAIG McCLURE: Great, next question; the woman in the middle.

MARGE BERER: Thank you, Marge Berer from the journal Reproductive Health Matters. My question is to Chris Beyrer, we share a surname except for your "Y" but I don't know why exactly. I was, although the epidemic in Sub-Saharan Africa is overwhelmingly in women under the age of 30, much greater, it seemed to me that, I was wondering why you didn't also present figures for the over 30 age group where the epidemic, where more men, not necessarily overall, but certainly the proportion of men to women infected, is quite different, and I'm very concerned as a women's activist that while women were invisible seven or eight or ten years ago in this epidemic, the men are starting to become invisible, and both of them are important, and so if we are going to concentrate on infection only in women, we are going to start leaving men out, and men are vectors also if you like, men are as involved in this epidemic as women, so I wondered why you didn't present those figures.

CHRIS BEYRER, MD, MPH: Thanks for your question, and in fact that slide was about one-third, we actually had the full age distribution, and I really just didn't go through all of the ranges other than the interest of time. I think the point that I was trying to make there was about this early gender difference, particularly in young women and girls, but it is absolutely the case that men start to catch up, and although it

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becomes harder to look at prevalence, this is a little complicated because people who are infected early don't necessarily live, of course still, into their thirties and forties, so when men are getting infected at older ages, there tend to be more of them also in the older age groups as opposed to women, and that is going to increase as long as there still is not good ARV access. Africa is still under, and that was data on Africans, South Africans who of course are the least served by ARV, but it is absolutely the case that men are critical drivers in this, and the point that I showed in the data about labor migration patterns in particular, that appears to be very central to why sexual risks are so much higher, both for men and for women in that context.

CRAIG McCLURE: I'll take the next question, the woman in the back.

MICHELLE REED: Thank you, Michelle Reed[misspelled?] from George House Trust in Manchester England. I think this question is for Louise. Louise I absolutely agreed with everything that you said. I was at the Thailand Conference two years ago where both Koffi Anan the Prime Minister of Thailand, Nelson Mandela, and lots of people focused on the needs to empower women and young girls in the fight against this global epidemic. The focus there was on leadership and I wonder whether, I absolutely agree with the fact that you said that power drives this epidemic, and I think part of the power is

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with global leadership. I wonder whether you would comment on whether you've seen anything in the past two years on a global leadership level that gets us anywhere closer to empowering young women and girls, and particularly whether or not there is anything that has addressed the fact that men and boys also need to be educated if we're actually going to move from the position that we're in now to the position that we need to be in order to put women in the driver's seat of this, preventing this epidemic.

LOUISE BINDER: Certainly from a sort of project by project analysis I would say that yes there has been quite a bit of movement in all of the projects and programs that I discussed. The natural kind of corollary of what happened with those women in the microfinance situations, and in the sort of taking charge of the violence situations, was they were able to speak much more freely with their children about HIV and also with men. So sort of on an individual micro level, I think those programs are making a difference, unfortunately as I said in my presentation, it needs to get up to the macro level if we're going to get seriously making a difference fast enough, well we are already too late to be fast enough, but you know to slow it down. I've seen a few things that were encouraging, I did find the language in the U.N. General Assembly's Special Session, the last one, encouraging as it related to women, and it was fairly comprehensive. I also found, I read the -oh,

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where did they- it's an African document, I want to say AGUBA but I think that's the wrong name-

MALE SPEAKER: ABUJA document

LOUISE BINDER: ABUJA, thank you, document which had some very specific targets set in the areas of prevention and treatment and so on, and I think that's very important if we don't start setting targets and we don't start creating accountability mechanisms than we're really never going to know if we're getting anywhere. So I think there is some movement in that area, I think the support that finally we're getting for some of the women's research areas is very exciting as well, but it's very slow.

CRAIG McCLURE: I think we have time for one more question, possibly one more, but let's stick to one for now, Martin.

MARTIN: I'm Martin [inaudible] Positive Nation Magazine in the U.K. and my question is also about prevention for Louise Binder. With the growing population of HIV-positive people around the world struggling to live with the virus, and prevention campaigns mainly aimed at the HIV negative population, somebody has to catch the virus and somebody else has got to pass it on. Why is there so little prevention work done with HIV-positive people themselves, and what can we do to rectify this?

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CHRIS BEYRER, MD, MPH: Do you want to go first or do you want me to?

LOUISE BINDER: It doesn't matter, I, you look confident.

CHRIS BEYRER, MD, MPH: Maybe I'll start.

LOUISE BINDER: Go ahead.

CHRIS BEYRER, MD, MPH: Okay, so I think that's obviously a fundamental question. When I talked about, for example, the lack of prevention services for injection drug users, those absolutely are for uninfected people and for IDU who already have HIV infection, so one of the great things about needle and syringe exchange is that it has been seen as an access point into counseling, treatment, and ARV access. Secondly the same is true for substitution therapy, methadone maintenance therapy, which is probably the other best validated approach to HIV prevention, as an HIV prevention tool in injection drug use populations. That to is very much blind to HIV status, methadone is safe for people with HIV, and actually substitution therapy has been seen as being key for helping people with a history of injection drug use deal with ARVs and sort of get that stabilization that substitution therapy can provide. In the MSM arena this is clearly critical, and again the kinds of things that are out there in terms of HIV prevention services, the point that I made about the sort of social and structural barriers for MSM in developing countries

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have everything to do with the stigma and social isolation of MSM in those populations, and I think that is one of those situations where HIV adds more of a stigma burden, but the stigma of being a man who has sex with other men in a number of countries is a profound barrier to access to prevention. Clearly in those countries, more than half of Africa where it's illegal, it also remains criminalized so it's sort of a structural barrier to accessing services, the one African study that I cited which is a Waday study from Senegal, HIV rates are 22-percent in MSM in that study, and there was no surveillance for MSM in the country, and sex between men is illegal so it was very difficult to actually do that study and even find out what was going on in that population, so I think the point is well taken for those groups. In the African context it's clear that, you know, the sort of artificial separation of prevention services by status is not going to work, and we are clearly going to need prevention in the ARV roll out arena, those two things are very synergistic and probably the key place that they meet is where you have quality counseling and prevention services in diagnostics, that is critical the PCT.

LOUISE BINDER: Well it's a very complex question that you're asking, not a simple answer. I will speak a bit about women and then about men. Certainly one of the biggest problems for HIV infected women in prevention, as I mentioned, is the ability to actual the power to be able to be involved in a

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negotiation there, but even if they can female condoms are very inaccessible and exceedingly expensive even if you can get them, so that makes that not a good option for HIV-positive women, that's very unfortunate because I think they would be used much more by HIV-positive women if we could somehow get them to them at a price they can afford. Something good that is happening is that I'm involved in a group of HIV-positive international women who are working with the microbicide researchers, and we are starting to have discussions about what are the questions that we need to start asking about microbicides and their use by HIV-positive people, both men and women, so that's an encouraging kind of note.

Now my understanding, which is not broad, about condoms is, I mean we obviously have all of the problems of donors in the north who are putting conditions on the use of those in the south which I think is, well you've heard what I think if you heard my plenary, and in addition my understanding is that condoms are also very inaccessible. There are never enough of them to go around in those countries anyhow, and one of the problems that we have in the north is that people have, we are not really continuing appropriately to target our prevention and education to each of the populations of HIV-infected people to whom we ought to be, and you can't just educate once and go away, you have new generation after new generation, so it's very complicated. One good thing that we've done in Canada on

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the harm reduction side is that we have allowed a supervised injection facility which I think has been a tremendous success, but our Prime Minister must, by September 12th, make a decision about whether to renew the certificate for that facility, and I think that if I were a betting person I would be betting against it. I do not think he's going to do that, and that's a tragedy.

I think it's a very complex question, certainly we need to decriminalize the sex trade as well, I mean that's very important and we need to do that also.

CRAIG McCLURE: Okay, I would like to thank you all. I would like to thank our speakers from this morning, and I look forward to seeing you after tomorrow's plenary presentation.

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