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CONF - 6/98
12th World AIDS Conf.

12th World AIDS Conference

Sunday 28 June

Daily Report from Constellation - *Tony Murdoch*

Attended morning rapporteur session and concluding plenary of Satellite session of International Symposium on HIV Prevention
at Noga Hilton Hotel

Key points from **Ronald Valdiserri** ,
Deputy Director, National Center for HIV, STD & TB Prevention

Principles for effective and sustainable interventions

⇒ consider context, behavior, practice & attitudes
⇒ require partnerships
⇒ support with technical assistance & evaluation
⇒ provide combination therapies

Key points from **Flavia Schlegel**, Head Federal AIDS Unit, Switzerland

Successful strategies that address social policy and legislative barriers to implementation and sustainability of HIV prevention

⇒ activism
⇒ pragmatism
⇒ networking
⇒ inclusiveness
⇒ comprehensiveness
⇒ AND a good dose of political commitment

Judith Auerbach, White House Office of Science and OAR

Current research on HIV prevention...

Her position speaks for the NIH and the US position...no need to elaborate

There are many challenges - one of the keys to success is to get program and policy implementation to follow on from research.....

How to get funds for studies that may criticize the very policies of the donors?

Comment: An excellent overview from an acknowledged expert.
A bit too fast for the interpreters and a bit "jargony" for non-native English speakers!

Comments from **Dr David Satcher**, US Surgeon General

General impression
He came across to this first time listener as authoritative, personable, warm and communicative....obviously has a good contact with media...interview opportunities to be sought out.

The press conference held at the end of the Symposium will be reported on in a separate document - distributed on Monday 29 June.

TENTATIVE PLAN FOR MONDAY 29 JUNE

Attend daily press conferences at 11.00 and 15.00 hours

In addition,

09.0 - 10.30	Plenary session on Prevention
09.30 - 11.00	Press conference, International Forum for Accessible science
11.0 - 12.30	Youth Prevention Programs (Chair Dr David Satcher)
15.0 - 17.00	Politics behind AIDS policies

If there are any other sessions you wish us to attend, please let us know
contact Tony on 079 200 8917

FAMILY HEALTH INTERNATIONAL

FOR RELEASE 28 June 1998

For more information
contact Mary O'Grady
at 079 206 3752 (cell)

Politics, Lack of Funding are Main Barriers to Global HIV/AIDS Prevention

GENEVA—Lack of political will and financial support continue to jeopardize global efforts to slow the spread of HIV/AIDS, the head of an international HIV/AIDS prevention project told participants in a satellite meeting of the XIIth International AIDS Conference.

"Throughout the world, millions of people are dying of a preventable disease because of apathy, denial and misguided public policy," said Dr. Peter Lamptey, director of the IMPACT (Implementing AIDS Care and Prevention) Project. "Political and business leaders must have the courage and the foresight to provide adequate funding for HIV/AIDS prevention and to support enlightened policies."

Speaking during the closing session of the 2nd International HIV Prevention Symposium on 28 June, Dr. Lamptey cited several examples of policies that hamper global prevention efforts, including prohibitions against public funding of needle exchange programs and restrictions on sex education for youth.

Policymakers have rejected proven prevention methods and failed to fund others at the levels needed to have an impact on the pandemic, Dr. Lamptey charged. Funding for prevention and care has not kept pace with the epidemic, and in some cases it has actually declined as the number of people affected by HIV/AIDS has increased.

Funding for research has also suffered. "Despite President Clinton's recent call for a vaccine within ten years," Dr. Lamptey said, "there have been no new pharmaceutical companies or biotechnology firms in vaccine development, and several existing HIV vaccine programs have been scaled back or canceled."

Noting that a safe and effective vaccine is at least five to ten years away and that it may not be affordable or completely effective in developing countries, where most HIV infections occur, Dr. Lamptey stressed the importance of the HIV/AIDS prevention efforts discussed at

-more-

FHi

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the symposium. This satellite meeting brought together 400 HIV prevention experts and people living with HIV/AIDS to discuss effective interventions, successful strategies for addressing social and political barriers to prevention, and current research.

After summarizing the key findings of the participants, Dr. Lamptey concluded with a call for greater public and private support for HIV/AIDS prevention, care and research. "We need a safe, effective vaccine and we need prevention methods that women can control, but most of all we need sufficient resources and supportive policies," he said.

IMPACT is sponsored by the United States Agency for International Development and implemented by Family Health International, a nongovernmental organization dedicated to improving the health of women and children and to preventing the spread of HIV/AIDS and other sexually transmitted diseases. The project's partners include: the Institute for Tropical Medicine in Antwerp, Belgium, and Management Sciences for Health, Population Services International, The Program for Appropriate Technology in Health and the University of North Carolina at Chapel Hill in the United States.

#

International Symposium on HIV Prevention 98

PRESS RELEASE

Saturday, June 27, to
Sunday, June 28, 1998
Geneva/Switzerland

Prevention is needed now more than ever

International Symposium on HIV Prevention showed that a combination of prevention measures is the key to successful HIV prevention

Official Satellite
Meeting of the

12th World AIDS
Conference
June 28–July 3, 1998
Geneva, Switzerland

Geneva, 28.6.98. Worldwide 16 000 people are newly infected with HIV every day. During the last two decades prevention programs all over the world have proved to be effective in reducing the number of new infections. But several surveys on preventive behaviour indicate that people are becoming less aware of the risks of HIV transmission.

«The danger today is that the merits of prevention get forgotten and efforts slacken in view of recent findings, progress in therapies and an impatient tendency to expect and often demand instant solutions», said Thomas Zeltner, Director of the Swiss Federal Office of Public Health at the 2nd International Symposium on HIV Prevention in Geneva. On June 27 and June 28, about 500 participants from more than 50 countries attended the Symposium which is an official satellite meeting of the 12th World AIDS Conference taking place in Geneva.

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Reduced risk perception on HIV transmission

Highly active antiretroviral therapy may be both an opportunity and a threat for HIV prevention, experts stated at the Symposium. Although it is likely that reducing viral load may reduce rates of HIV transmission, it is erroneous to consider this «cure« for HIV. Studies in both general population and in homo- and bisxual male populations suggest that some may be reducing safer sex practices in light of these medical advances.

«We must recognize that medical advances do not negate the need to prevent the disease», US SurgeonGeneral David Satcher said at the Symposium, «in fact, the availability of newer and better treatments often increases the need for prevention. How well we continue our work to develop integrated approaches to prevention and treatment may well define the future course of the HIV pandemic.»

Individual persuasion and societal enablement needed

There is no 'magic bullet' for prevention which could stop HIV from spreading throughout the world. The experts at the Symposium agreed that the success of prevention efforts are linked to well designed prevention programs that use a comprehensive and multilevel approach. In much the same way that HIV

Saturday, June 27, to
Sunday, June 28, 1998
Geneva/Switzerland

infection is best treated with multiple drugs in combination, so too should optimal HIV prevention efforts include multiple prevention strategies in «combination». For example access to sterile injection equipment and ready access to drug treatment are both essential for ending the epidemic among injecting drug users.

The Symposium made it clear that prevention programs are a valuable investment in human resources and community development. For example, efforts to empower women as an HIV prevention strategy can also result in other social and economic benefits for women. These social changes are required for sustainable HIV prevention. As Peter Piot, Director of the Joint United Nations Programm on HIV/AIDS (UNAIDS) stated at the Symposium: «If we wish to have a serious impact on the epidemic it is necessary to have both individual persuasion and societal enablement.»

The Symposium was organised by the Swiss AIDS Federation (AIDS-Hilfe Schweiz) in collaboration with the Swiss Federal Office of Public Health, the Joint United Nations Programme on HIV/AIDS (UNAIDS), the US National Institutes of Health (NIH), the US Centers for Disease Control and Prevention (CDC), the Canadian Public Health Association (CPHA), Health Canada, Family Health International (FHI), and the US Agency for International Development (USAID).

The Symposium provided an international forum to profile best practices, including models of successful HIV/AIDS prevention programs and policies, and to strengthen the importance of prevention in the global fight against HIV and AIDS. The third International Symposium on HIV Prevention will be held in Durban, South Africa, in 2000, as a satellite meeting to the 13th World AIDS Conference.

For further information contact Mathis Brauchbar, Cell Fone: +41 79 407 93 62

Official Satellite
Meeting of the

12th World AIDS
Conference
June 28–July 3, 1998
Geneva, Switzerland

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CURRENT CONCEPTS OF HIV PATHOGENESIS IN WOMEN

Saturday, June 27, 1998
8:45 to 4:30 pm

Thirteen speakers from the USA, Italy, France and UK presented information on their studies involving HIV in women. Attendance was light, averaging approximately thirty people. The presentations were followed by a few minutes for questions and answers, most of which involved comments from attendees.

One concern expressed at the session is the high infection rate among 15 to 24 year olds. One of five people living with AIDS were infected as teenagers.

The presenters were surprised and pleased when an attendee reported that a French study had achieved a 1% mother-to-child transmission rate by placing the mother alone on AZT (not the infant) and performing a C-section. This transmission rate is significantly lower than rates resulting from the 0176 protocol. The study will be presented as a poster and will be published in JAMA next week.

The first evidence is becoming available to suggest that virus is being produced in the vaginal environment. Vaccine development strategies will need to take into account possible differences between vaginal and blood isolates.

An emerging issue for domestic and eventually international studies is the ethics of conducting trials with women on therapy versus women who refuse therapy. It is clear that antiretroviral therapies are important for well-being and quality of life. Will research institutes continue to be able to fund studies involving women who refuse treatment? Can researchers be certain that such study participants are truly giving informed consent?

Dan Harrington
Constellation

Organon Teknika is pleased to sponsor a Satellite Symposium to the 12th World AIDS Conference in Geneva, Switzerland.

Current Concepts of HIV Pathogenesis in Women

12th World AIDS Conference Geneva June 28–July 3 1998

Saturday, June 27, 1998
8:45 am to 4:30 pm
Palexpo, Session Hall VII

This conference promises to be an exciting and informative prelude to the week's activities. Researchers and physicians from around the world will come together to present up-to-date information on their studies involving HIV in women. The one-day program will be hosted by NIAID. Scheduled presentations include:

8:45 am	**Opening Remarks**	Dr. Harold Burger, Albany, NY, USA Dr. Alan Landay, Chicago, IL, USA
9:00 am	**Epidemiology of HIV in Women**	Dr. Paola Miotti, Bethesda, MD, USA
9:30 am	**Clinical Issues in HIV-Infected Women**	Dr. Kathryn Anastos, New York, NY, USA
10:00 am	**Vaginal Ecology**	Dr. Penelope Hitchcock, Bethesda, MD, USA
10:30 am	Break	
10:45 am	**Pathogenesis of HIV Vertical Transmission**	Dr. Gabriella Scarlatti, Milan, Italy
11:15 am	**Mucosal Compartments and Plasma Viral Load**	Dr. James Bremer, Chicago, IL, USA
11:45 am	**Viral Diversity in the Genital Tract**	Dr. Harold Burger, Albany, NY, USA
12:15 pm	Lunch	
1:45 pm	**Molecular Determinants of HIV Disease Progression in Drug-Using Women**	Dr. Barbara Weiser, Albany, NY, USA
2:15 pm	**Immunopathogenesis in Mucosal Compartments in Women**	Dr. Alan Landay, Chicago, IL, USA
2:45 pm	**Correlates of Immune Protection in Women**	Dr. Sarah Rowland-Jones, Oxford, UK
3:15 pm	Break	
3:30 pm	**Reproductive and Hormonal Issues in Women with HIV**	Dr. Laurent Mandelbrot, Paris, France
4:00 pm	**Malignancies in HIV-Infected Women**	Dr. Alexandra Levine, Los Angeles, CA, USA

Organon Teknika will publish a compilation of all abstracts presented at this symposium. If you would like to receive a copy of this publication, *A Collection of Abstracts,* please fax your request to Organon Teknika at 1-919-620-2520.

ORGANON TEKNIKA

NIAID

12th World AIDS Conference

Saturday 27 June

Daily Report from Constellation - *Tony Murdoch*

Attended morning session of Satellite session
International Symposium on HIV Prevention
at Noga Hilton Hotel

Attendance about 250 - excellent program

Of note during the first plenary was address by Peter Piot, Executive Director UNAIDS (full text attached)

Some key points:

The cultural or socio-political context in which the prevention is desired must be matched with the technical or medical approaches.
If there is to be a serious impact on the epidemic, it is necessary to have both individual persuasion and societal enablement. Developing programs and interventions which pay attention to one of these factors but not to the other is simply not enough.

Programs for prevention should be multi-sectoral and multi-levelled, must be driven by a high degree of political commitment because HIV has no respect for the careful division of responsibilities which one can find between government departments.
It is not enough to provide facts about HIV/AIDS it is essential to promote a sense of social solidarity and greater acceptance of people living with HIV/AIDS. Similarly, people with HIV/AIDS must be allowed to be seen as part of the solution to the epidemic. This is how fears can be allayed and the levels of discrimination and stigmatisation reduced.

Mention was made of encouraging developments in technology: microbicides, the female condom, access to clean needles and syringes, therapies to reduce mother to child transmission.

Piot concludes with his fear of the consequences if HIV & AIDS lose their topicality and are no longer a priority for multilateral funding agencies. After more than 15 years of work, there is still little that is known about the best ways of creating political commitment and regenerating the flagging enthusiasm of donors, investors and national authorities.

12th World AIDS Conference

Saturday 27 June

Daily Report from Constellation - *Tony Murdoch*

Items picked up from the press room
These items are brought to your notice just to ensure there are no gaps in your coverage of relevant matters during the conference

from International AIDS Vaccine Initiative
NEW PLAN TO SPEED AIDS VACCINE DEVELOPMENT RELEASED

from National AIDS Fund (USA)
NATIONAL AIDS FUND AWARDS SCHOLARSHIPS TO LEADING COMMUNITY AIDS ADVOCATES FOR WORLD AIDS CONFERENCE IN GENEVA

from international AIDS Society (USA)
INTERNATIONAL AIDS SOCIETY - USA RELEASES RECOMMENDATIONS FOR ANTIRETROVIRAL THERAPY AND RESISTANCE TESTING

Current State of HIV Prevention - Advances and Challenges
Address to the '98 International Symposium on HIV Prevention, Geneva.
Peter Piot, Executive Director UNAIDS

Ladies and gentlemen, friends and colleagues, it is a pleasure to be here today to the opening plenary at the 1998 International Symposium on HIV Prevention. For UNAIDS, as one of the cosponsors and organisers of this event, it has been a truly enjoyable experience to put the programme together. I take this opportunity to thank our partners in this effort. I would also like to thank everyone for coming here today to participate in what I am sure will be important discussions in the run up to the Geneva World AIDS Conference.

The XIth International Conference on AIDS in Vancouver will stick in many people's minds because of 'good news' it brought about treatments. But it should also be remembered for the optimism expressed about HIV prevention. A special Satellite Symposium on this topic concluded not only that HIV prevention works and can be cost effective investment, but also that well designed programmes can reduce the impact of the epidemic by fostering social solidarity. However, in my Preface to the report produced following the meeting I warned that while we had turned a corner in knowing which prevention approaches to use, we were nowhere near the end of the road.

GLOBAL CONTEXT

Since the start of the global pandemic, an estimated 11.7 million people have died from HIV-related disease and another 30.6 million are presently living with HIV. Of these, about a third are young people aged between 10-24, and of the 16,000 new infections that take place every day, an estimated 7,000 are among members of this same age group. While there is encouraging evidence that the epidemic may be stabilising in resource rich countries such as Norway, Great Britain, Australia and Switzerland, elsewhere new infections continue to occur at an increasing rate. For example, new epidemics are taking off among injecting drug users in the Ukraine, Russia and the countries of Eastern Europe, and among the population more generally in Myanmar, Vietnam and China.

Not all that long ago, a distinction was drawn between developed and developing countries in relation to the control of HIV and AIDS. Some pessimists said that the resource poor environments of the South would never be able to control the epidemic, whereas the richer countries of the North could do so. But preventing HIV is not simply a matter of resources as recent surveillance data makes clear. Only a few weeks ago, the US Centers for Disease Control acknowledged that in the richest country in the world, HIV continues to spread throughout the population essentially unabated especially, among minority populations, whereas there is now clear evidence from Uganda, Senegal, Tanzania and Thailand that significant headway can be made in resource poor environments. So what is it that makes for success, and why do some countries fail to achieve their goals? The answer lies in implementing the right combination of interventions and policy initiatives at the correct time.

EVIDENCE OF SUCCESS IN HIV PREVENTION

There is not enough time to discuss in detail what counts as success in HIV prevention, but I would like to take the opportunity to argue for a properly ***inclusive*** approach. In contrast to those who value only the findings from experimental studies — randomised controlled trials for example — I prefer to adopt a more expansive definition of what works and what does not. At

UNAIDS, we believe that a range of different kinds of information can provide evidence of prevention success. Some of this information may come from comparative studies of intervention effectiveness, but other valuable evidence derives from efforts to evaluate complex programmes of intervention in the pursuit of predetermined objectives. While this latter approach may be methodologically 'messier', it may be a more realistic way of proceeding since we know that complex and multi-levelled programmes of intervention — not social 'magic bullets' — are most likely to work.

Another kind of evidence of course comes from intuition and moments of insight such as those which led gay men in New York and other major cities of the world to promote condom use for anal sex before a virus had even been identified, and those which led the leaders of organisations as diverse as *Coletivo Sol* in Mexico, *TASO* in Uganda and *Aides* in France to argue that it is solidarity and community participation (rather than coercion and control) which work in controlling the epidemic. You will see, therefore, that in the remainder of my talk this morning I will draw upon a range of sources of evidence when talking about what works in HIV prevention, and what does not

PREREQUISITES FOR SUCCESS

Ask perhaps the majority of people what they consider crucial to the success of HIV prevention and they will say knowledge about HIV and transmission. This common-sense view dominated thinking throughout the first decade of the epidemic and continues to hold sway in some quarters. But beyond knowledge, we acknowledge now that people need the skills to negotiate for safer sex and safer injecting practices, and the attitudes and support which makes behaviour change seem worthwhile.

Developing the skills which can be used to be assertive about ones sexual needs, particularly if you are a woman or a younger person, requires social encouragement and practice. Sadly, there are few formal environments in which skills such as these can be acquired, particularly by young people, which is one of the reasons why UNICEF and other agencies are now promoting a life skills approach to education about sex and personal relationships in schools.

Attitudes are notoriously difficult to change. Let me mention one important target group: If only there were a quick fix, policy makers could be instantly persuaded to make the right decisions, and communities and individuals would offer support and understanding, instead of discrimination and denial. Successful approaches to attitude change include efforts to shift perceived social norms, around safer sex for example, and social marketing campaigns which have aimed to increase the desirability of prevention technologies such as condoms.

There are encouraging results from recent studies of the effects of voluntary counselling and testing in Kenya, Tanzania and Trinidad which indicate that VCT produces greater reductions in unprotected sexual intercourse, particularly with non-primary partners, and among couples who had been tested and counselled together. The kinds of VCT approaches that are likely to be most successful are those which aim to enhance understanding, foster positive attitudes to risk reduction, and provide women and men with the skills to negotiate safer sex.

However, work on knowledge, skills and attitudes alone is insufficient to bring about desired changes in behaviour. What good is it is to a woman in Indonesia, for example, to know how HIV is transmitted when she has no choice but to have sex with a husband she knows to be unfaithful to her? And what good is this knowledge to a young women or man selling sex in Thailand in order to support their family back home, who knows they can earn considerably

more from selling unprotected sex than if they have sex with a condom? Both find themselves in circumstances not of their own choosing, and both have heightened vulnerability to HIV and other STDs.

It is therefore vital to take account of more pervasive environmental and societal factors. The Ottawa Charter for Health Promotion was one of the first internationally endorsed documents to recognise the importance of supportive environments for health, and has guided good practice in health promotion ever since. Societal factors such as power relationships and social inequalities render some groups more systematically vulnerable to STDs and HIV. These include gender relations, relations between groups from different social classes or backgrounds, relationships between minority and majority ethnic groups, relations between young and old, and the relations between the different groups involved in wars and civil conflict. Environmental factors are also important. It is well known, for example, that efforts to promote safer injecting will fail if clean needles and syringes are not locally available; and it is also known that introducing formal rules to make sex work in brothels safer can have a dramatic effect on the transmission of HIV and other STDs. There are good reasons to believe that efforts to promote human rights including freedom from exploitation, freedom from sexual violence and freedom from discrimination and stigmatization, are likely to have beneficial effects.

If there is one key message therefore that we should take from this work it is that both individual ***persuasion*** and societal ***enablement*** are necessary if we wish to have a serious impact on the epidemic. Developing programmes and interventions which pay attention to one of these factors but not the other is simply not enough.

SOME KEY PRINCIPLES

But where should we begin, and how should we focus our efforts? Internationally, a number of key principles are clear. It is vital that there is political commitment for prevention efforts. Without this stretching from community to the highest level, our efforts are unlikely to succeed. Programmes also need to promote greater openness about HIV and AIDS, making it possible for people to talk about the epidemic so as to dissipate fear and prejudice. Beyond this, we need systems to identify where people are infected and why, and to shed light on the factors which make some groups and communities more vulnerable than others.

Effective programmes involve focussing our action on where the epidemic is, and not where it might be imagined to be. Multiple and complimentary interventions of known effectiveness are needed, as is a steadily expanding response. It is important to enhance awareness among the population as a whole. But such work should encompass more than the provision of facts about HIV and AIDS, and should have a specific component to promote social solidarity and greater acceptance of people with HIV and AIDS.

Programmes and interventions need to be multi-sectoral and multi-levelled, and need to address both prevention and care. This is important because HIV has no respect for where the responsibilities of one government department end and the next begin. Joint action is needed by the public, private and voluntary sectors, both to prevent new infections and to provide support to people already living with HIV disease.

Experience all over the world demonstrates the importance of involving people with HIV and AIDS in programme development and implementation. This enhances community participation in prevention, but also minimises the potentially negative effects of the epidemic. Research shows that when a supposed threat is 'invisible' and 'unpredictable', public anxieties are

greatest. Providing ways for people with HIV and AIDS to be visible, and to show themselves to be part of the solution to the epidemic, is therefore essential. Only this way can unrealistic fears be allayed, and will efforts to reduce levels of discrimination and stigmatisation succeed.

Finally, we need to build societal resistance to the epidemic by addressing inequalities of gender, wealth, education and development. These make some groups systematically more vulnerable than others. Reducing societal vulnerability requires political commitment at the highest level in every country. While this may be difficult to achieve, it is well worth the effort since the likely spin off for other health issues and problems, as well as social development, is likely to be substantial.

THE PROMISE OF TECHNOLOGY

When the epidemics of HIV and AIDS first began, there were few means other than behaviour change and the male condom by which people could protect themselves and their partners against infection. As time has passed, technology has advanced and the female condom now offers a new prevention possibility for some. Earlier this year, representatives from fifteen countries in Eastern and Southern Africa came together in Pretoria to discuss how best to include the female condom within condom programming more generally. The response was overwhelmingly enthusiastic indicating the potential value of this new technology as another means of preventing HIV transmission.

Efforts to develop a microbicide for vaginal and/or rectal use have been stepped up in recent years. It is heartening to note that between 1994 and 1996 the number of products in pre-clinical evaluation rose from 12 to 20, and the number of products in clinical development increased from 9 to 13. Four new microbicides have now made their way through safety trials in humans, and all four are likely to be available for large-scale efficacy testing within two years.

Much of the push to develop and promote the female condom and microbicides has come from women anxious to see new female-controlled options to prevent infection. But in relation to the use of the male condom, there is encouraging news as well. Recent surveys of condom use among men in Zimbabwe and Uganda, for example, show that condom use with non regular partners is increasingly rapidly. In Kampala, Uganda 46% of men recently interviewed reported using a condom in their last non regular sexual encounter, and 31% reported always using condoms with 'casual' partners.

Technology in the form of access to clean needles and syringes also has an important role to play in the prevention of HIV transmission among injecting drug users. Efforts need to be made to build upon the success of harm reduction programmes in the richer countries by expanding this work into environments where resources are less easily available.

In relation to the mother to child transmission of HIV, major advances have been made. In industrialised countries, the antiretroviral drug zidovudine is known to be effective in reducing mother to child transmission by about two-thirds in the absence of breast feeding. A more recent trial completed in Thailand in early 1998 using a shortened regimen cut the rate of mother to child transmission during childbirth by half, at less than a tenth of the cost of the longer course. While many difficulties remain to be overcome — including issues relating the cost and availability of drugs, the availability of information and counselling services, and efficacy of ZDV treatment among women who breast feed — health authorities in developing countries should start planning for the introduction of mother to child transmission prevention procedures.

UNICEF, WHO and the UNAIDS Secretariat are now collaborating to start up pilote programmes in more than 10 countries this year.

Finally, there is now evidence to suggest that the administration of ZDV or: after percutaneous exposure to HIV, can significantly reduce the risk of infection. While ZDV treatment is the only regimen for which efficacy data exist, double and triple antiretroviral therapy is now being used as a preventive measure in some countries. Such interventions may increase antiretroviral activity and deal with HIV strains which are possibly resistant to ZDV. Currently, there is much debate about the use of antiretroviral drugs as means of prevention following sexual exposure to HIV. While this form of treatment has become common practice in some hospitals in Europe and the US, there is as yet no reliable data to indicate whether this kind of intervention can prevent sexually transmitted infections.

TREATMENT EFFECTIVENESS AND HIV PREVENTION

It is in relation to the impact of new treatments on viral load and infectivity that some of the greatest challenges for prevention lie. Together with the Center for AIDS Prevention Studies at the University of California San Francisco, UNAIDS hosted a major meeting on this subject only a few months ago. Among the issues discussed was the possibility that premature talk of there being a 'cure' for AIDS might encourage some people not to practice safer sex and safer drug use. While there is currently little other than anecdotal data to support such a view, evidence from a number of studies of changing attitudes towards HIV and AIDS suggest that people are now more optimistic about there being an effective treatment for AIDS, which may have implications for short and longer term behaviour change.

In countries such as Australia where the epidemic of HIV and AIDS have been confined to relatively discrete population groups, and where there is good epidemiological and behavioural monitoring, recent research suggests there has been an increase in unprotected sex among homosexually active men. Importantly, this increase has ***not*** been followed by an increase in seroconversions which raises some interesting questions about the effectiveness of safer sex strategies widely promoted in that country such as 'negotiated safety'. It also encourages further research to examine whether highly active antiretroviral therapy has the capacity to reduce levels of infectivity particularly at the population level.

The challenges for work in environments where counselling and testing are not widely available, and where highly active antiretroviral therapy is not likely to be available in the foreseeable future, are enormous. They are made even more so by sensational reporting in the international news media which suggests that every advance in treatment is one step closer to a 'cure'. It remains vitally important to impress upon people that prevention should remain a number one priority in work against AIDS, and that this means continuing to practice safer sex and safer injecting drug use.

SOME OUTSTANDING ISSUES

This important satellite meeting in Geneva provides an important opportunity for sustained discussion and debate. Because of this, and by way of conclusion, I want to highlight some issues which are central to the success of future prevention efforts.

It should be clear from what I have said that political will and commitment remain central to the success of any expanded response to the epidemic. This is especially true when HIV and AIDS are in danger of losing their topicality and becoming less of a priority for bilateral and

multilateral funding agencies. Curiously, after a decade and a half's work, we still know little about the best ways of creating political commitment and regenerating the flagging enthusiasm of donors, investors and national authorities. If there is one kind of research which could have dramatic benefit, it is enquiry into the beliefs and motivations of governments, politicians and policy makers for whom HIV and AIDS are important concerns. Parallel studies looking at the processes which lead to inaction, denial and discrimination are also needed.

Earlier this year, UNAIDS published a document entitled *Expanding the Global Response to HIV/AIDS through Focussed Action*. In it, we argued for a two pronged expansion of the global response. First, there needs to be an improvement in the quality, scope and coverage of continuing, prevention, support, care and impact alleviation. Second, there needs to be new action directed at the societal factors which enhance people's vulnerability to HIV and AIDS. Efforts to reduce individual and person risk must now been combined with actions to reduce vulnerability through changes in law and policy, and through longer processes of cultural, structural and environmental change. Political commitment to the achievement of these twin goals is essential.

As many of you will know, UNAIDS, its co-sponsors and partners have recently chosen to focus the 1988 World AIDS Campaign on Young People. Too often in the past, young people have been characterised either as wilful hedonists or the innocent victims of circumstances not of their own making. Indeed, these two stereotypes continue to dominate most of the published reports on HIV and AIDS. But it is time to take stock — to give young people back their sensibility and their agency, and to institute programmes and activities which see youth as part of the ***solution*** to the epidemic as well as a group made vulnerable by it. This means involving young people more actively in the design of programmes, it means listening carefully to what they have to say, and it involves recognising young people's sexuality and their right to enjoy sex (as well as to refuse it). This is precisely what we intend to do over the coming months, and UNAIDS will be interested to hear your suggestions about the kinds of projects and activities most needed.

Finally, I want to offer a challenge relating to the way in which we think about, and work with, people with HIV and AIDS. Since its inception, UNAIDS has argued that the interests, actions and concerns of people living with HIV and AIDS are central to prevention success. Recent treatment advance raises new opportunities to work together in a greater sense of partnership. A longer and better quality of life brings with it the possibility of contributing more to the struggle against AIDS, and while not everyone living with HIV disease will wish to contribute in this way. substantial numbers do. How can we therefore as international agencies, donors and investors in health, workers in government and non-governmental organisations, families, friends and lovers make our work more genuinely inclusive? How can we continue to support those who are denied access to the means to protect themselves and partners against infection? And how can we foster in the second decade of the epidemic the kinds of solidarity which too often eluded us in the first? These are but a few of the questions which must concern us all over the next two days during this important Satellite Symposium. Thank you.

3,484 words

EMBARGOED: For release on Sunday, June 28, 1998 at 15:00 CET (13:00 GMT; 9:00 EDT)

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NEW PLAN TO SPEED AIDS VACCINE DEVELOPMENT RELEASED

IAVI Wins New Financial Commitments from Bill and Melinda Gates, UK Government, and World Bank; Implementation of "Scientific Blueprint" To Begin Immediately

GENEVA, Switzerland, June 28, 1998 - The International AIDS Vaccine Initiative (IAVI) unveiled a new global scientific strategy to accelerate AIDS vaccine development, and said that it will begin work on the plan with existing resources and newly announced grants from the William H. Gates Foundation, the World Bank and the Government of the United Kingdom.

IAVI's *Scientific Blueprint for AIDS Vaccine Development* was released by the two-year old non-profit scientific and educational organization on the opening day of the 12th International Conference on AIDS. The report synthesizes months of consultations with scientific, industrial, political and community leaders in developing and industrialized countries, and includes an analysis of ongoing AIDS vaccine research and development efforts. (For the complete text of the Scientific Blueprint, visit www.iavi.org)

"The World Is Not On Track"

"The world is not on track to meet the goal of a safe and effective AIDS vaccine in the next decade," said Dr. Margaret Johnston, IAVI's Vice President for Scientific Affairs. "This program will not only put us back on track; it will put us on a fast track."

- More -

interest in this critical area. The Scientific Blueprint details a bold and necessary global program to achieve success in the shortest time possible," Piot added.

New Grants from Bill and Melinda Gates and UK Government

Dr. Berkley also announced a number of new financial commitments to IAVI that will allow it to begin immediately implementing the Scientific Blueprint. These contributions include a US$1.5 million grant from the William H. Gates Foundation, the charitable foundation established by Microsoft founder Bill Gates, and £200,000 from the United Kingdom's Department for International Development (DIFD). Berkley also said that the Levi Strauss Foundation had recently become IAVI's first significant corporate funder.

IAVI also receives ongoing support from the Rockefeller Foundation, the Starr Foundation, the Alfred P. Sloan Foundation, the Until There's A Cure Foundation, the World Bank, UNAIDS, Glaxo-Wellcome's Positive Action Program, Fondation Marcel Merieux, and the U.K.'s National AIDS Trust.

"The grants from the Gates Foundation, the UK government, and Levi Strauss represent IAVI's first significant commitments from a private individual, a government, and a corporation, respectively," Dr. Berkley said. "We salute them for their leadership."

Berkley added, "We're gratified that forward-thinking people like Bill and Melinda Gates were willing to invest in IAVI's scientific program."

Bill and Melinda Gates: "End AIDS For All Time"

"Melinda and I are committed to building a future in which AIDS is part of the past. As parents, and as believers in science and technology, we make this gift with the hope that a safe, accessible vaccine can be developed to end AIDS for all time," said Bill Gates, the founder of Microsoft and the trustee of the William H. Gates Foundation. "This will require a sustained global effort and creative thinking from organizations at all levels. We hope our commitment to IAVI will inspire others to join this worthy cause."

The UK Government said it was making its grant to signal support for a companion IAVI proposal, a plan to create International AIDS Vaccine Purchase and Development Funds. These funds would speed the development of AIDS vaccines and help ensure their distribution in poorer countries.

"The United Kingdom's Department for International Development (DFID) wish, through their contribution of £200,000 to IAVI, to signal their strong support for IAVI's international advocacy work to establish Vaccine Purchase and Development funds," a spokesperson for DFID said. "DFID recognizes that an International Vaccine Purchase Fund can help to ensure that an effective vaccine, once developed, can be made widely available and should benefit the poorest nations and the poorest sections of society."

For more information, or for a complete version of the Blueprint, visit IAVI's web site at www.iavi.org

The William H. Gates Foundation, based in Seattle, Wash., was created in 1994 by Bill and Melinda Gates to support initiatives in areas that are of particular concern to them. Those broad fields include support for institutions of higher learning, local capital campaigns, access to technology, and world health and population. In addition, the Gates' have also established the Gates Library Foundation, chartered to provide computer and Internet access to patrons at public libraries in low income communities across the U.S. and Canada.

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Note to Reporters, Assignment Editors, and Producers:

IAVI's press conference to release the Scientific Blueprint will be held on Sunday, 28 June 1998, from 15:00 to 16:00, in the Geneva II Room of the Swissair Building, directly adjacent to the Palexpo. Refreshments will be served.

- End -

NEWS RELEASE

FOR IMMEDIATE RELEASE

Contact: (In U.S.) Edie Clark, 202-408-4848, X243
(In Geneva as of 6/27) John Lloyd, 011-41-22-731-6250

NATIONAL AIDS FUND AWARDS SCHOLARSHIPS TO LEADING COMMUNITY AIDS ADVOCATES FOR WORLD AIDS CONFERENCE IN GENEVA

WASHINGTON, DC — June 9, 1998 — Fifteen leading AIDS advocates from communities nationwide will join 12,000 other international participants at the 12th World AIDS Conference, June 28-July 3, in Geneva, Switzerland. They are the finalists in the National AIDS Fund's 1998 Community Advocates Scholarship Program, which attracted more than 360 applicants.

A coalition of six pharmaceutical companies contributed $46,000 for the conference scholarships this year. The scholarships were awarded to people actively involved in community-based HIV/AIDS organizations, with preference for those without the resources to attend a conference of this scope. The scholarships ranged from $1,750 without living expenses to $3,500 with all expenses included.

"We applaud these 15 leaders who have consistently applied remarkable innovation and energy to combat HIV/AIDS in their communities," said B.J. Stiles, president and CEO of the National AIDS Fund. "We are confident that their participation in this major meeting will expand and strengthen their work."

Like those living with HIV/AIDS, the scholarship recipients are diverse, coming from different cultures, regions, educational backgrounds and relationships to the epidemic. For example, 12 of the women and men are HIV+; 10 are minorities; and they work in rural as well as urban and suburban communities. Their common goal is to end the HIV/AIDS epidemic while serving those currently affected.

(MORE)

National AIDS Fund Awards Scholarships— Add One

The recipients, their community organizations and locations are:
Patrick Bernsen, St. Louis Ryan White Planning Council, St. Louis, MO.
Judith Billings, President's Advisory Committee on HIV/AIDS, Puyallup, WA.
Michael Braddon, ARIS (AIDS Resources, Information & Services), Belmont, CA.
Tommy Chesbro, Indian Health Care Resource Center of Tulsa, Inc., Tulsa, OK.
Stuart Flavell, Greater Hartford AIDS Fund, Hartford, CT
Pam Harjo, Hunter Health Clinic, Inc., Wichita, KS.
Kent Lebstock, American Indian Community House HIV/AIDS Project, Albuquerque, NM.
Rodney Lofton, Metro Teen AIDS, Washington, DC.
Marva Miller, AIDS Council of Greater Kansas City, KS, Kansas City, MO.
Kim Nichols, African Services Committee, Inc., New York, NY.
Joyce Smith-Ezell, AIDS Taskforce of Greater Cleveland, Cleveland, OH.
Dr. Anibal Sosa, Latino Health Institute, Inc., Jamaica Plain, MA.
Dora-Louise Summers, Caribbean Women's Health Association and Bedford Stuyvesant/Crown Heights HIV Care Network, Brooklyn, NY.
Dr. Octavio J. Vallejo, University of California at Los Angeles Center for Health Promotion and Disease Prevention, Los Angeles, CA.
Kimberly Wheat, Open Door Community Services, Inc., Muncie, IN.

The contributors to the Fund's 1998 World AIDS Conference scholarship program are: The Merck Company Foundation; Glaxo Wellcome; Pfizer Inc.; Roche Laboratories Inc.; Agouron Pharmaceuticals, Inc.; and Gilead Sciences. The award recipients were selected by the program's review committee, which comprised 10 representatives from the nation's major HIV/AIDS organizations and institutions. The selection criteria included local AIDS advocacy leadership, a local letter of support, compelling narrative information, and a description of the ways the recipient would disseminate information from the conference.

After the conference, each scholarship recipient will submit a report to the National AIDS Fund to share with the six funders. They will describe how their educational experience will benefit their communities as they continue their advocacy as educators and service providers.

The National AIDS Fund's Community Advocates Scholarship Program was established in 1996 to help representatives of community-based HIV/AIDS organizations participate in professional and scientific meetings. The Fund provided scholarships to the Conference on Retroviruses and Opportunistic Infections in both 1997 and 1998. In 1996 the Fund awarded 19 scholarships for the 11th International Conference on AIDS in Vancouver, British Columbia, and another 19 for the 36th Interscience Conference on Antimicrobial Agents and Chemotherapy (ICAAC) conference in New Orleans. This program also will offer scholarships to the 1998 ICAAC conference in San Diego this September.

(MORE)

National AIDS Fund Awards Scholarships— Add Two

The 12th World AIDS Conference will highlight the latest scientific advances and focus international attention on bridging the gap in treatment possibilities between the established market economies in the North and the resource-poor countries of the South. The conference seeks to make advances in understanding, prevention and treatment relevant to the vast majority of people living with HIV. For the first time, the program for the World AIDS Conference is available on the Conference web site: www.aids98.ch.

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The National AIDS Fund is the leading business and pioneering philanthropic response to the HIV/AIDS epidemic. Based in Washington, DC, the Fund represents more than 1,500 companies, foundations, community groups and citizens whose contributions have generated more than $70 million over the past decade to combat the AIDS epidemic in communities across the country. The Fund provides national grants to 32 "Community Partners" in 25 states. Partners match the grants with their own fundraising and make grants to community organizations that provide prevention, education, care and services. In 1997, the Fund and its Partners awarded grants totaling over $10 million to more than 450 community groups. The Fund is also a strategic resource for key information and services on HIV/AIDS, and a pioneer in stimulating positive, practical responses from business and labor, both domestically and globally.

Quotes From the Recipients of Scholarships to the 12th World AIDS Conference
National AIDS Fund Community Advocates Scholarship Program

"The most important thing, in my mind, is encouraging others to find their voice and speak. Especially as an African American woman living with AIDS, in a city where there's so much silence among African Americans, this is important." — Joyce Smith-Ezell

"Participation in the international conference will deepen my understanding and knowledge of HIV/AIDS and improve my skills and expertise in teaching adherence techniques, early intervention strategy and behavioral change options to others in Missouri." — Patrick Bernsen

"For Native American AIDS activists in the 20th Century, it is our intent to ensure that we do not now suffer from an information immunity. We are, all of us, working to communicate the issues to our elders and leaders who set the tone for our struggle against any oppression, physical or political. We are working to combat issues of isolation and ignorance in our urban, rural and reservation communities." — Kent Lebsock

"I will honor the responsibility to glean as much HIV/AIDS information to benefit the populations of Wichita and Kansas as is possible."— Pam Harjo

"This is a dynamic epidemic that demands a dynamic response. I want to continue to urge that we bring new thinking to our work to end AIDS."— Stuart Flavell

International AIDS Society-USA

Presidio of San Francisco, 1001 B O'Reilly Avenue, Box 29916, San Francisco, CA 94129-0916
Telephone : (415) 561-6720 Facsimile : (415) 561-6740

*****FOR YOUR INFORMATION*****

International AIDS Society–USA Releases Recommendations for Antiretroviral Therapy and Resistance Testing

Media contacts: International AIDS Society–USA
Dr. Charles Carpenter, Dr. Martin Hirsch, or the International AIDS Society–USA can be reached at NGO Exhibition Hall 4, Booth 11.

GENEVA, SWITZERLAND - (June 27, 1998) — *The International AIDS Society–USA is releasing two reports: recommendations for antiretroviral therapy and for HIV drug resistance testing in HIV-infected patients. The continued support for potent antiretroviral therapy, the use of viral load assays of increased sensitivity, and the appearance of long-term adverse effects are issues discussed by the Antiretroviral Therapy Panel. The Resistance Testing Panel describes that HIV genotype assessment and phenotypic drug susceptibility testing have potential clinical application (eg, in choosing a drug regimen), and that more data are needed to define the precise role of these tools. Epidemiologic surveillance studies are also needed to track drug resistance in certain populations.*

The International AIDS Society–USA Antiretroviral Therapy Panel will have its updated recommendations published on July 1 in the *Journal of the American Medical Association*. The paper, *Antiretroviral Therapy for HIV Infection in 1998: Updated Recommendations of the International AIDS Society–USA Panel*, continues to support the use of potent antiretroviral therapy. Since the last report of the panel in 1997, choices for initial regimens have expanded, with a variety of combination regimens showing initial potency. In addition, more-sensitive viral load assays are very useful for monitoring patients taking antiretroviral drugs. However, the panel notes that more data are needed for defining when treatment is failing and determining the best alternate regimen should the initial treatment fail. The paper discusses the importance of the emerging long-term adverse effects of potent therapy.

The international panel was chaired by Charles C. J. Carpenter, MD, of Brown University School of Medicine. Commenting on the recent decline in HIV morbidity and mortality, Dr. Carpenter says, "I think that we can improve on [these declines] but we don't want to lose sight of the fact that things are improving. We can now treat HIV more effectively for longer periods of time because we have more new drugs and more new drug combinations."

A separate panel convened by the International AIDS Society–USA released the *Antiretroviral Drug Resistance Testing in HIV Infection of Adults: Implications for Clinical Management* paper last week. That panel's report was published in the *Journal of the American Medical Association* on June 24, 1998. The panel concluded that at this time plasma HIV RNA level and CD4+ cell count should be the primary

guide for initial antiretroviral therapy and for changes in therapy. Genotypic and phenotypic resistance testing may prove useful in individual patient management.

The panel noted that current assays are not yet standardized or validated. It also emphasized that while drug resistance is a possible cause of treatment failure, adherence, drug potency, and pharmacokinetic issues should also be considered.

The international panel was chaired by Martin S. Hirsch, MD, of Harvard Medical School. "It is clear that viral resistance...is an important reason why drug treatment fails some patients," says Dr. Hirsch. "While there is not yet enough data available to recommend which of the available tests is best in particular situations, we do believe that resistance information may be useful in guiding treatment, particularly in areas where resistant strains are prevalent."

The International AIDS Society–USA

The International AIDS Society–USA is a not-for-profit educational organization in the United States. Its mission is to improve the treatment, care, and quality of life of persons with HIV/AIDS through balanced, relevant, innovative, and state-of-the-art education and information for physicians who care for people with HIV disease. One of the organization's ongoing activities involves sponsorship of expert panels to address areas in HIV management in which there is controversy or confusion. Paul A. Volberding, MD, Chair of the Board of Directors of the International AIDS Society–USA, and Director of the AIDS Program at San Francisco General Hospital says, "The IAS–USA is committed to addressing challenging and continuously-emerging issues in HIV management in an effort to improve clinical outcome. The model we use, in which recommendations are developed through consensus of an expert panel, has helped us confront these issues effectively. The recommendations of the Antiretroviral Therapy Panel are a good example of how this model allows us to rapidly disseminate current information."

The International AIDS Society–USA also sponsors continuing medical education (CME) courses that cover recent advances in antiretroviral therapy, management of complications of HIV disease, HIV disease pathogenesis, resistance to antiretroviral drugs, and new drugs and regimens. *Improving the Management of HIV Disease*, the publication of the International AIDS Society–USA, is released 4 or 5 times per year. Each issue summarizes several of the key lectures given in the courses or reviews information presented at recent research conferences.

Panel Members

The members of the **Antiretroviral Therapy Panel** are Charles C. J. Carpenter, MD; Margaret A. Fischl, MD; Scott M. Hammer, MD; Martin S. Hirsch, MD; David A. Katzenstein, MD; Julio S. G. Montaner, MD; Douglas D. Richman, MD; Michael S. Saag, MD; Robert T. Schooley, MD; Melanie A. Thompson, MD; Stefano Vella, MD; Paul A. Volberding, MD; and Patrick G. Yeni, MD.

The members of the **Resistance Testing Panel** are Martin S. Hirsch, MD; Douglas D. Richman, MD; Françoise Brun-Vézinet, MD; Bonaventura Clotet, MD, PhD; Brian Conway, MD; Richard T. D'Aquila, MD; Lisa M. Demeter, MD; Scott M. Hammer, MD; Victoria A. Johnson, MD; Daniel R. Kuritzkes, MD; Clive Loveday, MD, PhD; John W. Mellors, MD; and Stefano Vella, MD.

The volunteer members of the **International AIDS Society–USA Board of Directors** are Paul A. Volberding, MD; Constance A. Benson, MD; Peter C. Cassat, JD; Margaret A. Fischl, MD; Harold A. Kessler, MD; Douglas D. Richman, MD; Michael S. Saag, MD; and Robert T. Schooley, MD.

Please visit the International AIDS Society–USA at NGO Exhibition Hall 4, Booth 11, for general questions about the organization, to obtain copies of the above-mentioned papers, to be put on the International AIDS Society–USA mailing list, or to obtain a question card for the panel of the International AIDS Society-USA symposium. The symposium, Antiretroviral Therapy and HIV Drug Resistance Testing in 1998: Issues and Applications, will take place on Wednesday, July 1, 1998, 15:00 - 17:15 at Satellite Hall 2000, B38.

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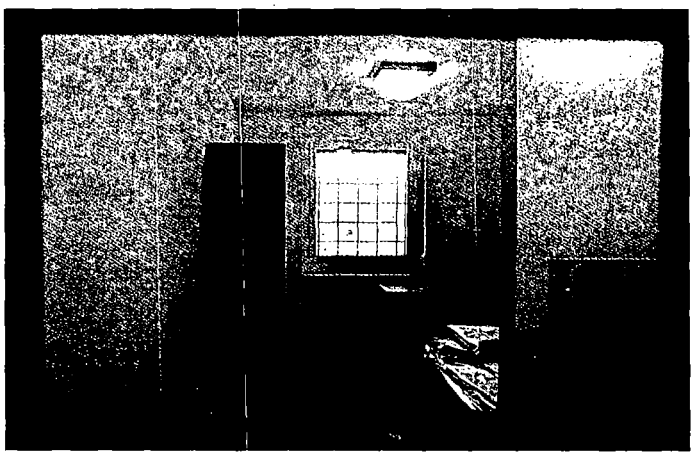
PRISON SETTINGS.

12th World AIDS Conference 1998 Geneva

The Swiss HIV/AIDS Prevention Program



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A CONDOM A DAY KEEPS THE DOCTOR AWAY

The Swiss Aids Prevention Campaign 1998

STOP AIDS

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12th World AIDS Conference Geneva June 28–July 3 1998

Abstract Option 1: [X] Abstract Option 2: [ ]

Location of research or project (country): THAILAND

Community organisation: [ ]

Track Categories: Indicate two choices for track/category codes (e.g. A5, D12)

Choice 1 Track/Category: B 3 Choice 2 Track/Category: C 3

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Serial No.

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1 (Author(s) title)

Clinical and Immunologic Spectrum of Disease Among 2261 HIV-1-Infected Patients at a Hospital in Bangkok

2 (Abstract text)

Background: The clinical spectrum of HIV infection, effect of opportunistic infections (OIs), and differences in pathogenesis associated with HIV-1 subtypes have been incompletely defined in Asia. Such information is critical in improving the lives of HIV-infected persons in Asia through preventive, therapeutic, and eventual vaccine interventions. We describe the clinical and immunologic presentations, including differences by subtype, of HIV-1-seropositive patients on their first admission to a hospital in Bangkok.
Methods: From 11/93 through 6/96, inpatients (≥14 years) at an infectious disease hospital received HIV counseling and testing. Demographic, clinical, and laboratory data were collected by enhanced surveillance.
Results: Of 10,876 admitted patients, 2261 (20.8%) were found to be HIV-positive. Of these, 1926 (85.2%) were male, 1942 (85.9%) were infected sexually or by non-drug-related means, 319 (14.1%) were injecting drug users (IDUs), and 1491 (65.9%) had AIDS. The most common AIDS-defining conditions were extrapulmonary cryptococcosis (EPC) (40.0%), tuberculosis (TB) (39.0%), and wasting syndrome (WS) (8.5%). IDUs were more likely ($p<0.05$) to have TB and WS but less likely ($p<0.05$) to have EPC and Pneumocystis carinii pneumonia. Lymphocyte counts were measured in 2047 (90.5%) patients; 81.8% had ≤1500 lymphocytes/μL. HIV-1 subtype was determined for 2116 (93.6%) patients; 86.5% had subtype E, and 13.5% had B. Among sexually infected patients, 1734 (95.3%) had subtype E, and 86 (4.7%) had B. Among IDUs, 199 (67.2%) had subtype B, and 97 (32.8%) had E. We compared patients with subtype B and those with E for differences in principal OIs, lymphocyte count, and, when available, CD4 counts by using multivariate analysis controlled for sex and age, for all patients and for IDUs only. The only difference between subtypes was that E was more associated with EPC (odds ratio=2.5; 95% confidence interval, 1.40-4.43).

Conclusion: In the HIV-infected Bangkok population studied, the frequencies of OIs for IDUs and non-IDUs differed. However, contrary to preliminary results, HIV-1 subtypes B and E seem to be associated with similar degrees of immune suppression and, with one exception, with similar OI patterns.

(Conclusion(s) (max 5 lines))

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I certify that I am complying to the Rule of Two in submitting a maximum of two abstracts
Presenting author's signature: Paul N. Amornkul

The presenting author will be 35 years of age or less on February 2, 1998 and wishes to be considered for a Young Investigator Award:
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Abstract Option 1 [X] Abstract Option 2 [ ]

Location of research or project (country): Community organisation [ ]

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Track Categories: Indicate two choices for track/category codes (e.g. A5, D12)

Choice 1: Track/Category D 0 1 Choice 2: Track/Category D 0 6

Serial No.

HIV Risk Through Drug Use and Sexual Behavior in the U.S. Population

Objectives: To measure the size of the 1996 US population at increased risk for HIV infection through specific sexual and drug risk behaviors.

Methods: Questions on sexual risk behaviors related to HIV were added to the 1996 National Household Survey of Drug Abuse (NHSDA), an annual household-based probability sample of the U.S. population. The sexual behavior questions were completed by 12,381 respondents age 18-59. Combined with drug use information on the survey, these data allow for a comprehensive estimate of HIV risk behaviors in the general U.S. population.

Results: 2.8% of respondents (95% C.I., 2.5-3.4%) reported some degree of increased risk through sexual behavior (in the past year: 6 or more partners, sex with an HIV-infected person, sex in exchange for money or drugs, male same sex partner). 2.4% (1.9-2.8%) reported drug risk (defined here as lifetime history of injection, past year use of crack or exchange of sex for drugs). By our definition 4.7% of adults (4.1-5.3%) had increased risk for HIV infection, representing 6.5 million persons (5.6-7.5 million). Persons reporting drug use risk were much more likely than others to be at risk through sexual behavior, but were not more likely to use condoms.

Conclusions: These estimates of the number of persons at risk for HIV in 1996 support the need for strengthening primary prevention programs. Increasing condom use among drug users should be an important goal for programs. Monitoring behavior through surveys of general and high risk populations is essential for designing and evaluating prevention programs.

Name and full address of contact author

A N D E R S O N J O H N E

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Presenting author's signature John E Anderson

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Abstract Option 1 [X] Abstract Option 2 [ ]

Location of research or project (country) Community organisation [ ]

T U R K E Y

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Choice 1: Track/Category D 3 7 Choice 2: Track/Category D 1 4 Serial No.

Human dignity promotion and civil society building as interventions to prevent STD/AIDS: examples from Turkey

Background: Vulnerability to STDs and AIDS is relatively higher in societies marked by: 1) a history of colonial rule or presence of a strong centralized state, with the accompanying lack of development of civil society; 2) a breakdown of the educational, political and health infrastructures following the end of colonial rule or strong centralized state; 3) increased economic inequality (sometimes resulting from large scale rapid economic development) coupled with low levels of human development; and 4) social interactions organized by power-obedience-guidance-protection rather than respect for human dignity-individual rights-self regulation. Moreover, in collectivistic societies where behavior is controlled more by group surveillance than by individual choice, marginalized activities and groups, e.g., groups vulnerable to STD/HIV spread cannot be reached through regular channels of social control. Interventions focusing on human dignity promotion, social capital enhancement, and civil society building may be particularly well accepted and effective in such societies. We assessed the societal and historical context in Turkey, identified interventions which fit the above definition and assessed their acceptability and potential impact.

Methods: Review of historical, political, sociological, and social psychological literature on Turkish society; inventory of STD/AIDS prevention interventions; in depth interviews with personnel working on intervention projects, and project participants.

Results: Three intervention projects; one focused on commercial sex workers, one focused on unionized industrial workers, and one focused on pharmacists were identified as fitting our description. None of the projects self-identified as promoting human dignity, enhancing social capital or building civil society. All three projects were highly acceptable to their target populations as reflected in participation and continuation rates. All three projects were effective in establishing dialogue on issues of human dignity, right to health, and STD/AIDS prevention, and in creating a clear demand for their continuation in a self-sustaining manner. Moreover, these projects created large scale discussions on issues of human rights, right to health, rights of marginalized populations and duties of health providers in the society at large through extensive media coverage.

Conclusions: In societies with inadequate social capital, little attention to human dignity, and insufficient presence of civil society, interventions which address these issues may play an important role in enhancing STD/AIDS prevention.

Name and full address of contact author

A R A L S E V G I O .

C E N T E R S F O R D I S E A S E C O N T R O L

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Choice 1: Track/Category D5

Choice 2: Track/Category C53

Serial No.

1 **Evaluation results from the *Safer Choices* project: A multi-faceted HIV prevention intervention program for high school students.**

2 **Objectives:** To evaluate the impact of a school-based HIV/STD infection and pregnancy prevention program on students knowledge, attitudes, and behavior.

Methods: A 2-year intervention consisting of five integrated components (school organization, curriculum and staff development, peer resources and school environment, parent education, school-community linkages) was evaluated using a randomized control trial involving 20 schools in California and Texas (USA); 3,869 ninth grade cohort students were tracked for 30 months. Multilevel (students within schools) statistical analyses were used.

Results: The program reduced the reported number of acts of unprotected intercourse among students in the cohort at the 6 MO. follow-up (p=0.03) and the 30 MO. follow-up (p=0.05) and showed a marginal effect on reducing the number of partners with whom students had unprotected sex (p=0.07) with this effect dissipating over time. The program increased the use of effective HIV prevention methods at last intercourse at all three time points (p=0.04 at 6 MO., p=0.06 at 18 MO., and p=0.04 at 30-MO.). The program also increased the use of pregnancy prevention methods at last intercourse (p=0.04 at 6 MO., 0.04 at 18 MO., and 0.06 at 30 MO.). No group differences were found in sexual initiation, condom use at first intercourse, or frequency of sexual intercourse. Across the 30 months, the study showed statistically significant gains favoring the intervention group among the majority of psychosocial variables, especially knowledge and other theoretical variables related to condom use.

3 **Conclusions:** The results of this evaluation provide evidence that carefully conceived school-based HIV/AIDS education programs can produce the knowledge, skills, and confidence required to reduce HIV-risk behavior among teenagers.

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(Double Trouble)^2 : HIV/TB Profiles from the U.S. and the U.K. derived from multiple surveillance systems

Objectives: to use data from multiple surveillance systems in two industrialized countries, the United Kingdom (U.K.) and the United States (U.S.) to examine the interaction between HIV and Tuberculosis (TB).
Methods: 1993-96 data from the national US TB surveillance system and 1993-95 data from the UK TB laboratory reporting system were used to compare HIV-seropositive TB cases with other TB cases. Crude TB rates for the HIV-seropositive populations were calculated. National AIDS data were used to compare individuals diagnosed with TB to those diagnosed with other conditions.
Results: TB/AIDS cases were 15% of U.S. TB cases, but only 4% of culture positive U.K. TB cases . TB accounted for 5% of U.S. and 4% of U.K. AIDS diagnoses. The U.S. TB annual case rate among people with HIV infection was approximately 333/100,000 (42 times that of the general population); in the U.K. the rate was 640/100,000 (116 times that of the general population). A significantly higher proportion of U.K. TB/AIDS cases (49%) were foreign-born than in the TB/non-AIDS group (21%); in the U.S. the situation was reversed (15% vs 33%). In the U.K., White individuals were predominant in both groups whereas in the U.S. there were three times as many Black than White individuals in the TB/AIDS group but nearly equal numbers in the TB/non-AIDS groups. In both countries, Asian individuals were significantly under-represented in the TB/AIDS group compared to the TB/non-AIDS group. Among AIDS/TB cases, there were a significantly higher proportion of Injecting Drug Users (IDU) and a lower proportion of men who have sex with men (MSM) compared to the non-TB group, whereas in the UK the AIDS/TB had a significantly higher percent of heterosexual cases and a lower proportion of MSM
Conclusions:. In both countries, the risk of TB is high among HIV-seropositive individuals, but the demographic picture of TB/AIDS in the U.S. is strongly affected by the higher risk of both diseases in the indigenous Black population. In the U.K., HIV is much less prevalent than in the U.S., and the largest indigenous minority (Indian subcontinent descent), have a high risk of TB but a low risk of HIV. The U.K. TB/AIDS picture is more strongly affected by immigration from countries with a high risk of both diseases, where heterosexual exposure is important.

DIANE BENNETT NCHSTP DTBE SEB

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Track Categories: Indicate two choices for track/category codes (e.g. A5, D12)

Choice 1: Track/Category C 2 9 Choice 2: Track/Category C 2 7 Serial No.

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Consistency of Condom Use for Disease Prevention among Unmarried Sexually Active Women - Data from a National (U.S.) Survey of Reproductive Age Women

Background. Although condoms are an effective barrier method (if used properly) for preventing transmission of sexually transmitted diseases, the proportion of sexually active women and their sex partners who use condoms consistently for disease prevention is not known. Objectives. The objectives of this study are: (1) to update national U.S. estimates of condom use for disease prevention; (2) to characterize consistent condom us for disease prevention. Data and Methods. The 1995 National Survey of Family Growth, a nationally representative survey of reproductive age women, was used. Data on 3,696 unmarried women, who were sexually active in the 12 months before their interview were analyzed. Methods designed for complex samples were used for making weighted statistical estimates. Results. 31.8% (95%, CI, 30.6% to 33,7%) (an estimated 19 million) of women from ages 14-to-44 were unmarried and sexually active in the 12 months before the interview. Of these women 11.4% (10.1% to 12.7%) reported never using condoms; 24.7% (23.0% to 26.4%) had ever used condoms for birth control only; 5.8% (4.9% to 6.7%) for disease prevention only; and 57.9% (56.0% to 59.8%) for both disease prevention and contraception. 19.8%(18.4% to 21.4%) of sexually active unmarried women reported always using condoms for disease prevention in the past 12 months before their interview. Younger, black women, who had more than 2 sex partners in the past year, never been pregnant, and were not currently using an oral contraceptive were more likely to always use a condom for disease prevention.

Conclusion. Although a very large percentage of sexually active women report using condoms for disease prevention and/or contraception, a relatively low proportion of women actually use condoms consistently. Prevention programs should continue to focus on the large population of sexually active women, promoting condom use for HIV/STD prevention regardless of contraceptive status.

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Enhanced production of monocyte-derived suppressive factors by HIV exposed, uninfected (EU) individuals.

Background: The mechanisms by which highly HIV-exposed individuals remain uninfected are largely unknown and may involve the production of soluble factors capable of suppressing post-integrated HIV replication.

Design: Cross-sectional, controlled study

Methods: Peripheral blood mononuclear cells (PBMCs) from 8 highly HIV-exposed, uninfected (EU) female sex workers (FSWs), 9 HIV-positive FSWs, and 9 HIV-negative, low-risk individuals in northern Thailand were separated into CD4+, CD8+, CD14+, and CD19+ cellular fractions by positive selection. PHA-stimulated culture supernatants were collected every 24 h and analyzed for their ability to suppress the activation of post-integrated HIV replication using chronically infected cell lines of myeloid (OM-10.1) and T-cell (ACH-2) lineages.

Results: Supernatants derived from the culture of EU PBMCs demonstrated a marked capability to suppress HIV replication in the chronically infected myeloid cell bioassay. Although individual variation was evident, overall EU cultures produced higher levels of suppressive factors than did HIV-negative control cultures (mean % inhibition = 49% vs. 14%, respectively; P = 0.003). Production of suppressive factors was similar for EU cultures and HIV-positive cultures. The majority of suppressive activity was attributable to monocyte-derived (CD14+) factors and was maximally produced 48 h after in vitro stimulation. Little or no suppression was evident in CD8-derived supernatants, even in a bioassay with chronically infected T-cells.

Conclusions: Monocyte-derived factors that suppress post-integrated HIV expression could represent a new class of soluble regulators. Enhanced production of these factors by EU individuals may be a consequence of chronic immune stimulation. Although the production of soluble factors capable of suppressing HIV replication cannot fully explain the mechanism of protection from infection, when combined with other local and systemic viral specific and nonspecific responses, an ability to abort HIV infection may result.

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Choice 1: Track/Category D7 Choice 2: Track/Category D1 Serial No.

Age of Initiation of Sexual Intercourse Among High School Students in the United States

Background: Many HIV prevention programs for adolescents focus on delay of first intercourse as a primary goal. Adolescents who initiate intercourse at early ages have been shown to have greater HIV risk throughout adolescence and early adulthood. Understanding current patterns of initiation can help inform appropriate interventions. The objective of this study was to examine the age and rates of initiation of sexual intercourse from 1991 through 1997 among high school students ages 14 to 17 in the United States.
Methods: Self-report data on age at first sexual intercourse were collected from approximately 65,000 adolescents as part of four nationally representative Youth Risk Behavior Surveys conducted between 1991 and 1997. Based on these data, life-table analysis was used to examine age and rates of initiation of sexual intercourse.
Results: The median age of first sexual intercourse was 16.4 years. Approximately 5% of students initiated intercourse by age 12, 10% initiated by age 13, 17% by age 14, 28% by age 15, 43% by age 16, and 59% by age 17. Among sexually experienced youth, adolescents who were early initiators (age 13 or younger) compared to adolescents who were later initiators (age 16 or older) were less likely to use a condom at last intercourse (50% vs. 60%) and more likely to have multiple sexual partners in the past three months (47% vs. 11%). On average, male students initiated intercourse earlier than females and black students initiated earlier than white or Hispanic students. The median and pattern of initiation were stable across the seven year period.
Conclusion: Over the past few decades we have seen progressively earlier ages of first intercourse. Recently, age at first intercourse appears to have stabilized. Age of initiation may be further increased through appropriately timed interventions. Because more than a quarter of adolescents initiate intercourse by age 15, interventions designed to delay initiation need to begin prior to this time.

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Serial No.

Local HIV-1 Expression in the Female Genital Tract Following Treatment of Cervical Intraepithelial Neoplasia

Objectives: We have previously shown that, after treatment of cervical intraepithelial neoplasia (CIN), HIV-1 RNA levels increase 1.0-3.6 logs in vaginal secretions, while plasma levels remain relatively constant. The objective of this study is to determine if the source of the increased HIV-1 RNA in vaginal secretions following treatment of CIN is blood or local expression.

Methods: Plasma and vaginal lavage samples were obtained from four women during an exam 2 weeks after treatment of CIN. The C2-V3 region of gp120 in HIV-1 was analyzed by direct cycle sequencing of DNA, which was amplified from reverse-transcribed RNA. Phylogenetic analysis was performed with a neighbor-joining tree, using 100 bootstrap replications. To estimate the proportion of viral load in vaginal lavages that was derived from HIV-1 RNA in blood, the amount of blood in vaginal lavages was measured, using a quantitative assay for hemoglobin.

Results: The nucleotide differences between plasma and vaginal HIV-1 from the four women were 0.9%, 1.7%, 5.8%, and 6.0% with predicted amino acid differences of 0.2%, 0.8%, 11.2%, and 14.8%, respectively. These differences indicate that two of the four women had a major species of HIV-1 in vaginal lavage that was significantly different from the major species in plasma. External contamination was excluded by phylogenetic analysis, which showed a >99 bootstrap value between plasma and vaginal HIV-1 of each woman. Less than 0.1% of vaginal HIV-1 was derived from contaminating blood, and thus, blood could not account for the close similarity of major species in two of the women.

Conclusion: These results show that HIV in vaginal secretions can be derived from local expression, and locally expressed HIV can have significant genotypic differences from plasma virus. These findings may have important implications for the development of vaccines to prevent heterosexual and perinatal HIV transmission.

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Cytomegalovirus and herpes simplex virus are not associated with acute pelvic inflammatory disease in HIV-infected women.

Background: Symptomatic pelvic inflammatory disease (PID) in HIV-infected women may be caused by organisms thought to be nonpathogenic in immunocompetent women, including the sexually transmitted viruses cytomegalovirus (CMV) and herpes simplex virus (HSV). Recent U.S. studies suggest that CMV may be a causative agent of PID.

Methods: We analyzed HIV-infected and uninfected patients diagnosed with PID using standard clinical criteria and HIV-infected women with cervical dysplasia who did not meet clinical criteria for PID. Endocervical swabs and transcervical endometrial biopsy specimens were cultured for HSV and CMV using standard methods.

Results: HIV-infected women with PID were more likely than uninfected women to have CMV recovered from the endocervix (10/36 [28%] vs. 18/144 [13%], $p < .05$) and endometrium (7/25 [28%] vs. 2/107 [2%], $p < .05$). However, in all but one CMV-infected patient, bacteria considered possible causative agents of PID were recovered. Recovery of endocervical and endometrial HSV did not differ by serostatus and probable bacterial pathogens were recovered in all HSV-infected patients. Among the HIV-infected women without PID, only one (1/14) had endometrial CMV recovered and no endocervical CMV (0/7), endocervical HSV (0/7), or endometrial HSV (0/14) were recovered.

Conclusion: CMV and HSV do not appear to be important causative agents of PID in the absence of bacterial infection. The reason for higher rates of recovery of endometrial CMV in HIV-infected women is not clear but may reflect reactivation of latent CMV by inflammatory cells that infiltrate endocervical and endometrial tissue during bacterial infection.

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Acute pelvic inflammatory disease associated with genital mycoplasma and streptococci species is more common in HIV-infected women.

Background: In theory, symptomatic pelvic inflammatory disease (PID) in HIV-infected women may be caused by organisms thought to be nonpathogenic in immunocompetent women.
Methods: We analyzed recovery of bacteria from endocervical swabs and endometrial biopsies collected from HIV-infected and uninfected women diagnosed with PID using standard clinical criteria and HIV-infected women with cervical dysplasia who did not meet criteria for PID. Specimens were tested for N. gonorrhoeae (NG) and facultative bacteria by culture and for C. trachomatis (CT), mycoplasmas, and ureaplasmas by culture and PCR.
Results: HIV-infected women with PID were more likely than uninfected women to have recovery of endometrial genital mycoplasmas (i.e., M. hominis, M. genitalium, or M. fermentans: 14/28 [50.0%) vs. 24/108 [22.2%], p <.05) and streptococci species (13/38 [34.2%] vs. 23/138 [16.7%], p<.05), despite somewhat greater use of broad-spectrum antibiotics shortly before enrollment by HIV-infected women (40.9% vs. 27.2%, p=.08). Among the HIV-infected and uninfected women in whom endocervical or endometrial NG or CT were not recovered, endometrial mycoplasma (50% vs. 14%, p<.05) and streptococci (38% vs. 18%, p<.05) species were more commonly recovered in HIV-infected women. No endometrial streptococci (0/14) or genital mycoplasma species (0/7) were recovered from HIV-infected women without PID. Recovery of other bacteria did not differ significantly by HIV serostatus.
Conclusion: Past studies indicate that genital mycoplasmas and streptococci may be ubiquitous in sexually active, immunocompetent women, but nevertheless may cause PID. In our study, genital mycoplasmas and streptococci recovery was more common in HIV-infected women with PID than uninfected women (especially among women lacking NG and CT), and genital mycoplasmas and streptococci were not found in HIV-infected women without PID. This suggests that these organisms play a more important role in PID pathogenesis in HIV-infected women. However, CDC-recommended antibiotics for PID provide adequate mycoplasma and streptococci coverage and should be generally effective in HIV-infected women.

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Serial No.

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Meta-Analysis of Sexual Risk Reduction Studies among Men Who Have Sex with Men

Background: The United States Centers for Disease Control and Prevention has initiated a system to identify and characterize behavioral interventions to reduce HIV transmission. In this presentation we synthesize results of research studies that evaluate interventions for men who have sex with men (MSM), and report a meta-analysis based on standardized program effect sizes.

Methods: We performed a comprehensive search for published and unpublished reports of HIV intervention studies, 1988 to present, and applied systematic criteria to select studies that measured HIV sexual risk behavior outcomes among MSM. Studies that assigned participants to intervention and comparison groups without apparent bias were eligible. We extracted data on sexual risk behavior, and used meta-analysis to compute a weighted average (WA) effect size and 95% confidence interval (CI) for the selected studies.

Results: We have obtained 53 reports of HIV behavioral interventions for MSM; of these, 43 measured sexual risk outcomes, including only 14 studies that assigned intervention groups without bias. Of the 14 studies, 8 reported outcome data necessary to determine intervention effect sizes; all reported some measure of unprotected sex. Among the 8 studies, 4 interventions were delivered through small groups featuring education, development of skills and social support. Two studies tested community-level interventions featuring peer outreach and media campaigns, 1 evaluated individual HIV counseling with optional antibody testing, and 1 featured analysis of self-justifications after sexual risk. Of the 8 studies, 4 were published after 1994. All 8 studies included more than 50 participants; 4 had >200 participants. The summary effect (WA=0.16) was positive and statistically significant (95% CI, 0.06 to 0.26), indicating that intervention groups reported less risk behavior than comparison groups.

Conclusions: Meta-analysis of rigorously evaluated interventions for MSM reveals a statistically significant reduction in unprotected sex. This weighted average effect corresponds to an 8% reduction in HIV sexual risk behavior, and was statistically similar among the 8 eligible studies. The risk for this population, however, has not been eliminated. Further research is needed to determine how various study characteristics contribute to the effects of these prevention approaches, and to develop and test new strategies that may yield greater potency.

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J o h n s o n W a y n e D

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Choice 1 Track/Category: D 5 0

Choice 2 Track/Category: D 0 2

Serial No.

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Room for Improvement: Informing and evaluating prevention communication programs for adolescents through phone surveys

Objectives: Many young people around the world have been exposed to HIV prevention messages via entertainment media and other channels. The kinds of knowledge, attitude, and behavior gains that prevention communication programs can achieve may have been achieved already. In addition, the source of a prevention message may not be noted, making a new prevention communication program difficult to evaluate. This study sought to quantify pre-program levels of HIV message exposure, to determine whether new message sources can be distinguished from usual sources, and to assess room for improvement in the kinds of determinants of risk behavior upon which prevention communication programs are likely to have an impact.
Design: Random sample phone survey.
Methods: In 1997 in 3 US sites (Sacramento, CA; Phoenix, AZ; and Northern VA), anonymous interviews were conducted with 663 adolescents ages 15-19 who lived in zip codes with high rates of teen STDs and pregnancy. Exposure to HIV prevention messages, false recognition of information about the Prevention Marketing Initiative (PMI) program, levels of hypothesized determinants of risk behavior, and frequency of condom use were examined. Twenty one per cent of parents of underage teens refused to allow their teens to participate, and 7% of teens who either had parental consent or were legal adults (at least 18 years old) refused to participate.
Results: Although 73%-79% reported having heard HIV messages on the radio or TV within the last 30 days, only 0%-1% said they heard about the not-yet-launched PMI Demonstration Project (a coalition-based social marketing effort that planned to employ media channels) through radio or TV. Respondents agreed with certain condom attitudes (e.g., the view that a condom is necessary even if you know the person), perceived a risk of infection, and felt able to negotiate condom use in over 90% of the cases. Participants reported that condoms had been used at last sex with main partners by 2/3 of the respondents who were sexually active, but only 34%-49% thought that most or all of their friends used condoms regularly, and only 36%-51% thought their friends considered condom use very important. While more than 90% of the sexually active respondents said it was easy or very easy to get condoms, only 1/4-1/3 of them took a condom with them the last time they left the house.
Conclusions: In 3 sites across the U.S., most teens hear media messages about HIV often but almost all teens can distinguish between usual and new message sources. Some determinants of risk behavior appear to be at or near ceiling. However, there appears to be room for improvement in others such as (1) how normative condom use is perceived to be, and (b) antecedent behaviors (e.g., condom carrying). These below-ceiling variables correlated with condom use at last sex and are potentially subject to influence by communication campaigns.

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12th World AIDS Conference Geneva June 28–July 3 1998

Abstract Option 1 ☐ Abstract Option 2 ☒

Location of research or project (country): Community organisation ☐

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Track Categories: Indicate two choices for track/category codes (e.g. A5, D12)

Choice 1: Track/Category C 4 2 Choice 2: Track/Category C 6 2

Serial No.

How local organizations tailor previously evaluated workshops for teens

Issue: Community-based organizations often tailor previously evaluated preventive interventions to update them and make them more suitable for specific local populations. In fact, social marketing recommends tailoring as part of its consumer orientation. Tailoring may enhance program acceptability and/or effectiveness, but deviating from standard approaches could reduce intervention effectiveness.

Project: In the Prevention Marketing Initiative (PMI) Demonstration Project, a 5-site social marketing effort for U.S. adolescents, local community coalitions identified skills-building workshops as promising interventions. Four workshop curricula with scientifically credible evidence of behavior change were provided to sites by the project funder, the Centers for Disease Control and Prevention. Sites were cautioned about making revisions, and possible revisions were ranked from least likely to reduce the effectiveness of the original program (e.g., changing character names in role plays to ethnically appropriate names) to most likely to compromise effectiveness (e.g., cutting whole sessions). The goal of the cautions was to preserve the integrity of the theory-based interventions.

Results: In all 5 sites, the same model curriculum was chosen as a basis for the PMI workshops. Four of the sites revised it, and the 5th site plans to do so. Revisions in all categories (least to most likely to threaten intervention effectiveness) were made. Names and text were made relevant to Latina/Latino and gay youth. Information on STDs and teen pregnancy was added. Details about the microbiology of HIV in the "knowledge" section were replaced by the statement that combination therapies are not a cure for AIDS. Abstinence examples and the notion of self-reward were included in negotiation exercises. Sessions were made more interactive, and videotapes with actors sharing racial/ethnic characteristics with local target audiences were substituted for recommended videotapes.

Lessons Learned: Despite being cautioned about revising tested model programs, local prevention service providers do revise standard approaches, often dramatically. Across PMI sites, independent decisions about revisions were similar, sugggesting that the decisions had been well-based. However, outcome evaluations of the revised curricula are now needed and are underway. Prevention technology transfer efforts should expect and take into account the kinds, extent and impact of typical modifications.

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K e n n e d y M a y

C D C

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USA

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Oral Sex and Barrier Use Among HIV Infected and At Risk Uninfected Women Reporting Recent Sexual Contact with a Woman

Objectives: To characterize homosexual behavior, barrier use, and female partners among HIV infected and at risk uninfected women reporting recent sexual contact with a woman.

Methods: HIV infected women (n=871) and at risk uninfected women (n=439) participating in a multi-center longitudinal study completed interviews that included information on sexual behavior and partner characteristics. The current data are taken from baseline and six follow up interviews.

Results: The sample was 59% African American, 16% Hispanic and 25% white. Nearly three quarters (72%) had annual household incomes below $12,000. Of the 871 HIV-infected women, 29% reported ever having had sex with a woman; 67 (8%) reported female sexual contact at some point during the study period. Of the 439 uninfected women, 35% reported ever having had sex with a woman, with 62 (14%) reporting female sexual contact during the study period. 66% (44) of infected women and 58% (36) of uninfected women with recent female contact reported having a main female partner. The majority of both infected (91%) and uninfected (94%) women reported engaging in oral sex with their main partners. HIV infected women were more likely to report using barriers (dental dam/latex protection) during oral sex than uninfected women ($p<0.05$), with 18% of HIV infected women and no uninfected women reporting consistent barrier use. Of the 33 HIV infected women reporting inconsistent barrier use, 32 reported that their main partner knew they were HIV infected. Additionally, 35% of the HIV infected and 18% of the uninfected women reported that their main female partner was HIV infected. Barrier use was not related to partner serostatus for either the HIV infected or uninfected women.

Conclusions: Among HIV-infected and at risk uninfected women with same-sex contact, unprotected oral sex is common, frequently occurring within serodiscordant couples. However, use of barriers during oral sex was unrelated to partner serostatus. Guidelines addressing oral sex and HIV risk should be developed for women who have sex with women and prevention programs addressing the needs of women who have sex with women are needed.

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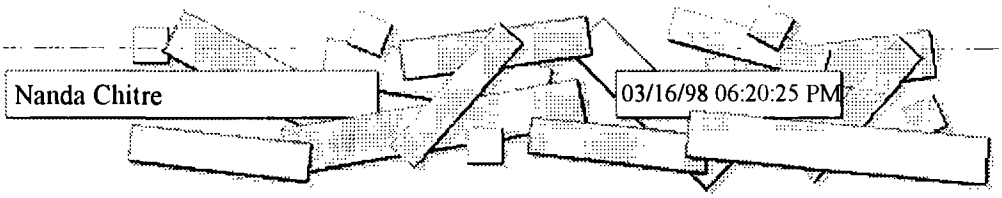

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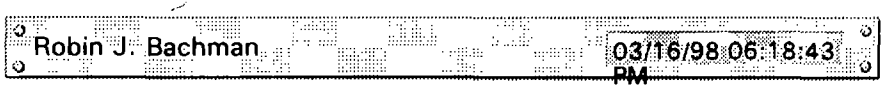

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This HHS fact sheet has FY99 numbers in it too. [http://www.hhs.gov/news/press/1998.html]
HHS also posted a few other related sheets.

Date: Thursday, March 12, 1998
FACT SHEET
Contact: HHS Press Office (202) 690-6343

CLINTON ADMINISTRATION RECORD ON HIV/AIDS

Overview: An estimated 650,000 to 900,000 Americans are believed to be living with HIV, the virus that causes AIDS. Since the AIDS epidemic began in 1981, more than 600,000 Americans have been diagnosed with AIDS and more than 370,000 men, women, and children have lost their lives to this disease.

The Clinton Administration has responded aggressively to the significant threat posed by HIV/AIDS with increased attention to research, prevention, and treatment. Overall funding for AIDS-related programs has increased by 86 percent under the Clinton Administration, with funding for AIDS care under the HHS Health Resources and Services Administration-administered Ryan White CARE Act increasing by 230 percent and assistance for the purchase of AIDS drugs increasing by 449 percent. For FY 1998, HHS' budget includes $6.8 billion for HIV/AIDS funding. This includes over $1 billion for Ryan White activities -- $154 million more than in 1997; $634 million for CDC's HIV prevention activities -- $17.5 million more than in 1997, and $1.6 billion to continue research efforts in HIV infection and AIDS supported by NIH -- $106 more than FY 1997. The President's FY 1999 budget includes $7.4 billion in HIV/AIDS funding, an increase of 9 percent over FY 1998.

At the same time, the Administration has sharpened the focus of its AIDS programs, establishing a new Office of National AIDS Policy at the White House. The Administration also convened the first-ever White House Conference on HIV and AIDS in December 1995, and released the first National AIDS Strategy in December 1996. In addition, in May 1997, President Clinton announced a comprehensive AIDS vaccine research initiative designed to lead to the development of an AIDS vaccine within the next 10 years.

Today, HIV prevention and education efforts are making real inroads, new drugs are providing vast improvements in the treatment of HIV and AIDS, and new treatment guidelines released by HHS are giving health professionals much needed guidance and helping to standardize care of individuals with HIV and AIDS. As a result of these improvements, CDC reported that in 1996, for the first time in the history of the AIDS epidemic, the number of Americans diagnosed with AIDS declined, falling by 6 percent for Americans over 12 between 1995 and 1996. In addition, CDC has reported that HIV/AIDS mortality declined 26 percent between 1995 and 1996, falling from the leading cause of death among 25-44 year olds to the second leading cause of death in that age group. The CDC has also reported a slowing in the epidemic overall, and a 43 percent decline in perinatally (mother-to-baby) acquired AIDS cases between 1992 and 1996.

Data from the first half of 1997 indicate that these trends are continuing. According to the CDC, AIDS deaths in the first half of 1997 dropped 44 percent compared to the same period in 1996. The number of new AIDS cases dropped 12 percent during this period. This marks the second straight year of declines in AIDS deaths.

HHS Spending on HIV/AIDS

Under the Clinton Administration, discretionary spending for AIDS research, prevention, and treatment has increased dramatically. These increases include:

	FY93	FY98	FY93-98 Change	FY 1999 Request
Research	$1.3 billion	$1.8 billion	+41%	$1.9 billion
Prevention	$398 million	$541 million	+36%	$544 million
Treatment	$397 million	$1.2 billion	+203%	$1.4 billion

Altogether, discretionary AIDS-related spending by HHS in FY 1998 will total $3.5 billion, up from $2.1 billion in FY 1993. An additional $3.3 billion, excluding the effect of protease inhibitors on AIDS expenditures, is expected to be expended in FY 1998 for AIDS care under Medicare and Medicaid, up from $1.6 billion in FY 1993. It is estimated that more than 50 percent of Americans living with AIDS rely on Medicaid for their health care coverage.

ADMINISTRATION INITIATIVES ON HIV/AIDS

Under President Clinton, a wide array of initiatives have been undertaken including:

AIDS Policy. The President created the Office of National AIDS Policy within the White House to advise him on AIDS policy issues and coordinate interdepartmental activities.

AIDS Conference. On December 6, 1995, the President convened the first White House Conference on HIV and AIDS, bringing together more than 300 experts, activists, and citizens from 37 states, the District of Columbia, and Puerto Rico for a full day of discussions of key issues.

AIDS Vaccine Initiative. On May 18, 1997, President Clinton challenged the nation to commit itself to the goal of developing an AIDS vaccine within the next ten years. The President also announced a number of important initiatives to help fulfill this commitment, including high-level international collaboration, a dedicated research center for AIDS vaccine research at NIH, and outreach to scientists, pharmaceutical companies, and patient advocates to maximize the involvement of both private and public sectors in the development of an AIDS vaccine.

AIDS Strategy. On December 17, 1996, the Clinton Administration released the first National AIDS Strategy, establishing goals for the nation and opportunities for immediate progress.

Advisory Council. The President created the Presidential Advisory Council on HIV and AIDS to provide him and his Administration with expert outside advice on the ways in which the Federal government should respond to the HIV/AIDS epidemic.

Disability Eligibility. The Social Security Administration published revised regulations expanding the list of health manifestations that will be considered in determining eligibility due to HIV/AIDS for Social Security and Supplemental Security Income disability benefits.

Drug Approval. Since 1993, the FDA has approved 10 AIDS drugs and 20 drugs for AIDS-related conditions, and accelerated approval to record times. Included in those approvals are a new class of drugs known as protease inhibitors, which show tremendous promise in the treatment of HIV disease. In March 1997, the FDA approved the first protease inhibitor with labeling for use in children.

Housing. The Department of Housing and Urban Development has established the National Office of HIV/AIDS Housing to assist people with HIV/AIDS to pay for housing. Funding for the Housing Opportunities for People with AIDS program has increased by 96 percent. HUD and HHS have launched collaborative efforts to combine housing assistance and medical and social services for people living with HIV/AIDS.

Mental Health. The Substance Abuse and Mental Health Administration awarded the first Federal grants to develop mental health services for persons living with HIV/AIDS and their families and partners.

Perinatal Transmission. Following the release of research findings from an NIH-sponsored AIDS clinical trial that indicated that use of AZT by HIV-infected pregnant women dramatically reduced the rate of HIV transmission from mother to infant, the U.S. Public Health Service issued guidelines recommending routine counseling and voluntary HIV testing for all pregnant women; and for those found to be HIV infected, the use of AZT during pregnancy. In treatment guidelines for use of antiretroviral drugs, HHS expanded the recommendation to include other pharmaceuticals, including protease inhibitors, as appropriate.

Prevention. The Centers for Disease Control and Prevention (CDC) launched a nationwide HIV prevention community planning process that gives local communities more authority over the shape and direction of AIDS prevention efforts, ensuring that programs are directed at those at greatest risk in each community. The CDC conducts prevention research and provides prevention science to communities and state and local health and education departments nationwide to ensure that prevention efforts are based on sound behavioral and biomedical science.

Research. In one of his first acts in office, President Clinton signed the National Institutes of Health Revitalization Act of 1993, placing full responsibility for planning, budgeting, and evaluation of the AIDS research program at NIH in the Office of AIDS Research. The President requested and received the first federal plan for biomedical research on AIDS.

Ryan White CARE Act. Funding for the CARE Act, administered by the HHS Health Resources and Services Administration (HRSA), has increased by 199 percent. On May 20, 1996, President Clinton signed a five-year reauthorization of this program, continuing the program until the year 2001. President Clinton's FY 1999 request for Ryan White activities totals $1.3 billion, an increase of 14 percent over FY 1998. In addition, funding for AIDS drug assistance has increased by 449 percent under the Clinton Administration. President Clinton's FY 1999 request totals $385.5 million for the AIDS Drug Assistance Program, a 35 percent increase over FY 1998.

Treatment Guidelines. HHS released draft guidelines for treating HIV-infected adults, adolescents, children, and infants with antiretroviral drugs. The guidelines, developed by panels of AIDS clinicians and researchers, reflect the current state of knowledge about HIV disease and antiretroviral drugs, and will help standardize and improve the quality of care for HIV-infected persons in the United States.

Water Safety. The CDC and the Environmental Protection Agency issued guidelines recommending steps to purify drinking water to protect vulnerable populations against Cryptosporidium, which can be fatal to those with compromised immune systems.

Youth. The Office of National AIDS Policy issued a report to the President on the continued threat of HIV for adolescents. The report noted that an average of at least one American under age 22 becomes infected with HIV every hour of every day and recommended steps to increase youth involvement in AIDS prevention, care, and research efforts.

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PROJET RETRO-CI
CHU de Treichville

Projet RETRO-CI Abstracts submitted to the 12th World AIDS Conference - Geneva June 28 - July 3, 1998

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HIV-1 plasma viral load and CD4 counts in surviving and non-surviving HIV-infected tuberculosis patients, Abidjan, Côte d'Ivoire.

Objective: To determine whether HIV-1 viral load and CD4 count measured at onset of tuberculosis (TB) therapy are associated with survival among HIV infected TB patients in Abidjan, Côte d'Ivoire.

Methods: As part of an ongoing cotrimoxazole prophylaxis trial in HIV-infected patients with pulmonary TB, plasma specimens obtained at the onset of TB therapy were selected from 64 patients known to have died and 78 surviving patients who were followed-up at least as long as the non-survivors. Lymphocyte subtyping was performed by standard flow cytometry and HIV-1 RNA plasma viral load was quantified by the modified HIV-1 Amplicor Monitor assay (Roche Diagnostics). Differences in mean CD4 count and mean $\log_{10}$ HIV-1 RNA viral load were compared by Student's t-test and the strength of association was assessed by the odds ratio (OR) and 95% confidence intervals (CI).

Results: The mean age of patients (35 years) and the proportion of males (61% vs 63%) was similar among survivors and non-survivors. The mean follow-up interval for non-survivors was 7 months (range 1-20) and for survivors was 8 months (1-21). In the combined groups, lower CD4 count and higher HIV viral load were correlated (correlation coefficient = -0.34, $p<0.001$). Mean CD4 count and mean $\log_{10}$ HIV-1 viral load at enrollment were 161 cells/μl (range 3-903) and 4.80 $\log_{10}$ copies/ml (2.60-6.50) for non-survivors and 391 cells/μl (51-979) and 4.51 $\log_{10}$ copies/ml (2.35-6.10) for survivors ($p<0.05$). When stratified by CD4 count, the mean $\log_{10}$ HIV-1 viral load in survivors vs non-survivors were no longer significantly different: 4.93 vs 4.89 for CD4 < 200 ($p=0.8$); 4.55 vs 4.66 for CD4 200-500 ($p=0.7$); and 4.11 vs 4.06 for CD4 >500 ($p=0.9$). In a multivariate analysis, non-survivors were significantly more likely than survivors to have a CD4 count < 200 (OR 7.5, CI 3.4-16.7) but not more likely to have a plasma HIV viral load > 4.0 $\log_{10}$ (10,000) copies/ml (OR1.3, CI 0.5-3.6).

Conclusion: In this population of HIV-infected TB patients, non-survivors had a higher viral load and lower CD4 count than survivors; however of the two parameters, only advanced immunosuppression (CD4 count <200 cells/μl) was significantly associated with death.

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Projet RETRO-CI Abstracts submitted to the 12th World AIDS Conference - Geneva June 28 - July 3, 1998

HIV-1 plasma viral load in tuberculosis patients with single HIV-1 and dual HIV-1/HIV-2 infections, Abidjan, Côte d'Ivoire

Objective: To compare HIV-1 plasma viral load in tuberculosis (TB) patients with PCR-confirmed HIV-1/HIV-2 dual infections with those who are HIV-1 seropositive.

Methods: Among HIV-infected TB patients enrolled in an ongoing cotrimoxazole chemoprophylaxis trial, CD4-count-matched blood samples obtained at onset of TB therapy from HIV-1 seroreactive (Sero-1) and HIV-1/2 dually reactive (Sero-D) patients were selected. For a subset of patients (10 Sero-1, 10 Sero-D), 12 months post-onset TB therapy specimens were also available. HIV seroreactivity was determined by a combination of monospecific peptide enzyme immunoassays. In Sero-D samples, HIV-infection status was determined by PCR using HIV-1 protease and HIV-2 LTR and protease genes primers. Plasma viral load was measured by the Amplicor Monitor Assay (Roche).

Results: The mean age (37 vs. 34 years) and percent of males (60 vs 62) was not significantly different in the 41 Sero-D and 45 Sero-1 patients. Among patients with Sero-D samples, HIV-1 and HIV-2 PCR were both positive in 26 (58%) samples (Sero-D/PCR-D), HIV-1 alone in 14 (Sero-D/PCR-1) and HIV-2 alone in one sample (Sero-D/PCR-2). Mean $\log_{10}$ HIV-1 viral load were similar for Sero-D/PCR-D (4.70 $\log_{10}$ copies/ml; range: 2.69-5.8), Sero-1 (4.62 $\log_{10}$ copies/ml; range:2.35-6.43) and Sero-D/PCR-1 (4.49 $\log_{10}$ copies/ml; range: 2.51-5.63); (all $p>0.05$). The mean change in viral load between onset of TB therapy and 12 months post-onset of therapy was similar for the 7 Sero-D/PCR-D, three Sero-D/PCR-1, and 10 Sero-1 patients with available samples ($\log_{10}$ HIV viral load 0.57, 0.67, and 0.34 copies/ml respectively).

Conclusions: Based on PCR results, the majority of HIV-1/HIV-2 seroreactive TB patients are HIV-1/HIV-2 dually infected. Patients with HIV-1/HIV-2 dual infection do not have a higher HIV-1 viral load or greater increase in viral load during follow-up as compared with HIV-1 seropositive patients suggesting that dual infection does not accelerate the natural history of HIV disease in these patients.

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Where do female sex workers go for sexual health care ? A study from Abidjan, Côte d'Ivoire

Objective. To obtain baseline data on the type of services female sex workers (FSW) prefer for the treatment of sexually transmitted diseases (STD) and contraceptive supplies, and the reasons for their preferences. These data will be used for improving health services for FSW.
Methods. A structured questionnaire on health needs and care seeking behaviour was prepared, based on information obtained from focus group discussions with FSW. This questionnaire was administered to a representative sample of 500 FSW, randlomly selected from the estimated 5000 FSW in Abidjan.
Results. Thirty percent of the women acknowledged that they ever had a STD. Of these, 30% first attended a public health service for the last episode of STD, 30% sought care in the private sector (clinic or pharmacy), 12% went to a specialized clinic for FSW and 21% bought drugs on the market. The majority of women were satisfied with the services they obtained. The main reason for this satisfaction was the perceived efficacy of the treatment. The specialized clinic was also appreciated because it is free of charge and the reception is friendly, but was still unknown by 46% of the population. Health care seeking behaviour for malaria showed a similar pattern.
Sixty-seven percent of women used a contraceptive method, among whom 90% used a modern contraceptive. Hormonal contraception or IUD were used by 19% of women, condoms by 71%. Hormonal contraceptives were mostly obtained from the pharmacy (47%) and family planning centre (24%). The majority of women (73%) bought condoms from shops. Forty-six percent of women reported a history of unwanted pregnancy, of whom 80% had an abortion.
Conclusion. Most FSW go to the public or private sector both for STD and other diseases. Despite relatively high satisfaction rates, there is a need to strengthen the quality of these structures. As expected, contraceptives were obtained through other channels. High rates of unwanted pregnancies indicate that contraceptive services should be improved. Integration of contraceptive services into curative services seems a logical step towards the provision of comprehensive health services for FSW in Abidjan.

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Prevalence of HIV and syphilis infections among pregnant women attending urban antenatal clinics in Côte d'Ivoire, 1997

Objective: To assess the prevalence of HIV and syphilis infections among pregnant women attending antenatal clinics in the ten largest cities of Côte d'Ivoire.

Methods: In 1997, as part of a nationwide HIV serosurveillance program, anonymous unlinked HIV testing was carried out in the capital cities of all ten regions of Côte d'Ivoire. Demographic data and aliquots of sera collected for syphilis testing were obtained from approximatively 300 consecutive first-time clinic attenders. Sera were tested for syphilis antibodies on-site, and after the women had received their syphilis result, anonymous unlinked serum samples were sent to a central laboratory and were screened for HIV antibodies by two mixed enzyme immunoassays (EIA); reactive samples were confirmed and serotyped by a combination of monospecific EIAs or Western blot. Serum samples were retested for syphilis antibodies by TPHA and RPR.

Results: 3043 women were tested for HIV antibodies and syphilis results were available for 1635 women. 82% of these women were born in Côte d'Ivoire and their median age was 24 years (range 13 - 57). 87% of women were living in stable partnerships and 66% had no formal education. Median gestational age was five months. Prevalence of HIV infection was 9.0% (7.8% HIV-1; 0.8% HIV-2; 0.4% dually reactive) and ranged from 5.9% to 13.3% by city. Prevalence of syphilis infection was 1.3% and ranged from 0.0% to 2.4%. In multivariate analysis, factors associated with HIV infection were: birth in Côte d'Ivoire (odds ratio [OR] 1.6; 95% confidence interval [CI] 1.04-2.4), age group 20-29 years (OR 2; CI 1.4-2.7), single marital status (OR 2.2; CI 1.5-3) and first trimester of pregnancy (OR 1.6; CI 1.1-2.3). Syphilis infection was not associated with HIV infection (OR 1.0; CI 0.1-4.2).

Conclusion: An HIV and syphilis sentinel surveillance program based in public antenatal clinics is feasible in Côte d'Ivoire. Prevalence of HIV infection among pregnant women varies by geographic region and is greater than 5% throughout the country, while prevalence of syphilis is less than 2.5%. Annual serosurveys in this population will enable the Ivorian Ministry of Health to monitor both national HIV and syphilis trends and the efficacy of HIV and STD prevention programs.

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Case-control study of cervical cancer and HIV infection in Abidjan, Côte d'Ivoire.

Objectives: To evaluate the association between HIV infection and cervical cancer and to compare characteristics of HIV-infected and uninfected women with cervical cancer in Abidjan, Côte d'Ivoire.

Methods: Since April 1997, women presenting with cervical lesions at the Gynecology and Oncology Services of two University Hospitals in Abidjan, Côte d'Ivoire are screened for enrollment into an ongoing case-control study. For consenting women, demographic and clinical information is obtained, HIV serology, lymphocyte phenotyping, and a cervical biopsy is performed. Women with histologically confirmed cervical cancer are retained as cases. For each woman with cervical cancer, four age-matched (within 5 years) controls are randomly selected from among women presenting at gynecology outpatient clinics who have a normal cervical cytologic examination.

Results: To date, 30 women with cervical cancer have been enrolled of whom 5 (17%) were HIV-seropositive (four HIV-1 and one HIV-2). Of the 120 controls, 14 (12%) were HIV-seropositive (ten HIV-1, two HIV-2, and two HIV-1/2 dually reactive). Excluding the HIV-2 and dually reactive women from the analysis, among women >40 years old, 0/21 with cervical cancer and 6/85 (7%) controls were HIV-1-seropositive (p=0.5); however, among women aged <40 years, 4/8 (50%) with cervical cancer and 4/31(13%) controls were HIV-1 seropositive (OR= 6.8 95% CI= 0.9-56.6; p=0.04). HIV-1-seropositive women with cervical cancer had a mean CD4 count of 400 cells/µl, and they were significantly younger than HIV-negative women with cervical cancer (mean age= 32 vs. 47 years, p= .02). Despite their younger age, (80%) of HIV-1-positive women had clinical stage III or IV cervical cancer compared with 76% of HIV-negative women.

Conclusions: These preliminary results suggest that in women aged less than 40 years cervical cancer appears to be associated with HIV-1 infection. Given the advanced stage of disease for most women with cervical cancer, and the HIV prevalence rate of 14% in sexually active women in Abidjan, routine cervical cancer screening should be considered as a public health priority for all women in Abidjan.

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Clinical manifestations of advanced HIV disease using hospital surveillance, clinical and autopsy data in Abidjan, Côte d'Ivoire

Objective: To describe the clinical manifestations of HIV-1 and HIV-2 infections among hospitalized patients in Abidjan, Côte d'Ivoire, and to compare the spectrum of severe HIV-related disease by HIV serostatus, gender, and age group.

Methods: We analyzed data that had been collected via three independent mechanisms among HIV-infected adults at the two principal university hospitals of Abidjan between 1991 and 1996: 1) AIDS case surveillance data collected on 2,234 patients from 3/94 to 12/96; 2) clinical studies of 349 patients admitted to the Infectious Diseases and Pulmonary Medicine Services during two 3-month periods from 3/95 to 3/96; and 3) an autopsy study conducted on 261 adults dying on various services in 1991-1992.

Results: In the surveillance database, in which clinical diagnoses were largely made based on history and physical examinations upon admission to hospital, the wasting syndrome (66%), tuberculosis (15%), esophageal candidiasis (13%), and pneumonia (11%) were the most common AIDS-defining diagnoses. In the clinical and autopsy studies that included more thorough laboratory-based evaluations, the most frequent diagnoses were tuberculosis (29% and 37%, respectively), septicemia (18% and 16%), meningitis (10% and 12%), pneumonia (6% and 29%), and cerebral toxoplasmosis (6% and 18%). Strikingly few differences in the spectrum of disease were found by HIV serostatus, gender, or age group.

Conclusions: These data provide a comprehensive overview of the spectrum of severe HIV-1- and HIV-2-related disease in West Africa. Although the wasting syndrome is the most clinically apparent manifestation of severe HIV disease, more thorough evaluations demonstrate that bacterial infections, tuberculosis and toxoplasmosis are the most important causes of HIV-related morbidity and mortality in this setting. Lastly, the spectrum of HIV-related disease does not appear to differ appreciably in various subpopulations.

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Presence of anti-HIV antibodies in cervicovaginal fluid of HIV-seronegative female sex workers in Abidjan, Côte d'Ivoire.

Objective: To identify the presence of acquired cervicovaginal mucosal HIV antibodies among HIV-seronegative female sex workers (FSW) in Abidjan.

Methods: As part of a larger intervention study, FSW were interviewed and screened for HIV and other sexually-transmitted diseases at a confidential clinic in Abidjan. HIV serostatus was determined using an algorithm including ELISA, a synthetic peptide line immuno-assay (LIA) and Western blot. Specific syphilitic antibodies were detected by TPHA. A cervicovaginal lavage (CVL) was collected in 10 ml PBS. Among HIV-seronegative FSW, anti-HIVgp160 antibodies were measured by indirect ELISA and the presence of sperm was assessed by prostatic acid phosphatase and prostatic soluble antigen tests on the supernatant of the CVL.

Results: Between April 1994 and November 1995, 421 (39%) of 1078 FSW were HIV seronegative and a CVL was obtained from 342 women. Of these, 317 CVLs were negative for anti-HIV antibodies (Ab-), 15 were positive for anti-HIV antibodies and positive for markers of sperm, indicating that the antibodies could have been in the sperm, and 10 were positive for anti-HIV antibodies and negative for markers of sperm (Ab+Sp-). Of these 10 women two had IgA only, two IgA+IgG, one IgA+IgM and five IgA+IgG+IgM antibodies. The median duration of sex work was two years for the 10 Ab+Sp- women and two years for the 317 Ab- women (p=NS). 100% condom use was reported by two of the 10 Ab+Sp- women and by 16% of the Ab- women (p=NS). None of the 10 Ab+Sp- and 20% of the Ab- had a positive TPHA result (p=0.1).

Conclusion: A small proportion of HIV-seronegative FSW have anti-HIV antibodies in the genital tract. The presence of these antibodies does not seem related to sexual exposure. Prospective studies are required to determine whether cervicovaginal anti-HIV antibodies can confer protection against HIV infection.

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Projet RETRO-CI Abstracts submitted to the 12th World AIDS Conference - Geneva June 28 - July 3, 1998

Immune activation markers and chemokine receptor 5 (CCR5) genotype in highly exposed but persistently seronegative female sex workers in Abidjan, Côte d'Ivoire

Objective: To study immunologic parameters and the presence of CCR5 receptor gene mutations in highly exposed but persistently seronegative (HEPS) female sex workers (FSW) in Abidjan, Côte d'Ivoire.

Methods: Between October 1996 and June 1997, 58 HIV-negative FSW attending a confidential STD/HIV clinic were selected based on their duration of prostitution: those with <6 months of prostitution were classified as a low exposure group (LEG, n=22) and those with >36 months of prostitution were classified as HEPS (n=36). Lymphocyte enumeration of CD_8-CD_{38}, CD_8-HLA-Dr, and CD_4-CD_{25} cell activation markers and HIV-replication suppressor marker CD_8-CD_{28} were carried out by standard flow cytometry on freshly obtained EDTA blood. The serum activation markers IL2R and ß2 microglobulin were tested by commercial ELISA assays (Quantikine R & D Systems). Chemokine receptor 5 (CCR5) genotyping was done on whole blood samples by DNA sequencing.

Results: HEPS were older than the LEG women (31 years vs. 23 years, $p<0.01$) and were less likely to report 100% condom use (6% vs. 26%, $p=0.01$). The percentage of the following markers was similar in HEPS compared with LEG women: % CD_8-CD_{38} (80.8 vs. 81.6, $p=0.7$), % CD_8-HL- Dr (47.7 vs. 46.3, $p=0.7$), % CD_4-CD_{25} (53 vs. 50.3, $p=0.5$), CD_8-CD_{28} (66.1 vs. 66.9, $p=0.8$). The level of IL2R cytokine was not significantly different between the two groups ($p=0.9$), but ß2 microglobulin levels were significantly higher in HEPS than in LEG women (mean ± SD, 2.72 ± 0.87 vs 1.84 ± 0.63, $p< 0.01$). No CCR5 receptor gene mutations were found among the 22 HEPS samples tested.

Conclusions: ß2 microglobulin levels were significantly higher in HEPS than LEG women indicating higher lymphocyte activation, perhaps through repeat antigen exposure as a result of longer duration of prositution. Other cellular and serum immune activation markers in HEPS and LEG were similar. Immune and/or genetic parameters other than those studied may play a role in HIV resistance in this population.

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Estimating the effect of treating sexually transmitted diseases (STDs) on HIV transmission.

Author(s): Rothenberg, Richard; Wasserheit, Judith N.; St. Louis, Michael E.; National HIV/STD Interactions Study Group.

Objective: To assess the potential impact on HIV transmission of treating STDs in the group of STD-clinic attendees who are coinfected with HIV.

Design: Retrospective chart review of data from 4,455 HIV-positive persons who attended eight STD clinics in the United States (Birmingham AL, Chicago IL, Colorado Springs CO, Denver CO, Los Angeles CA, Miami FL, New Orleans LA, New York NY).

Methods: Descriptive clinic data provided estimates of the range of coinfection with STDs and HIV. The attributable risk statistic was used to assess the maximal achievable decrease in HIV transmission. A multiple regression assessed the impact of sex, ethnicity, sexual preference, and age on the maximum achievable decrease for Genital Ulcer Disease (GUD), Nonulcerative STD (NUD), and any STD.

Results: In the group of 4,455 HIV-positive persons studied, the prevalence of GUD varied by clinic from 4.9% to 45.0%; of NUD, from 8.0% to 61.0%; and of any STD, from 13.9% to 65.9%. Depending on STD prevalence among HIV+ persons in these clinic settings, the maximum potential decrease in HIV transmission (assuming no other behavior change) ranged from 9.2% to 53.7% (GUD), from 15.8% to 51.1% (NUD), and from 20.4% to 64.2% (any STD). Using transmission probabilities of 0.001(♀ to ♂), 0.002 (♂ to♀) and 0.01 (♂ to ♂), if each HIV+ person in this group had a single new uninfected sexual contact, there would be 27 new cases of HIV in the absence of STD treatment, and 15 new cases if STD treatment were given, a reduction of 44%. Sexual preference and demographic factors did not significantly influence the maximal achievable impact.

Conclusions: In this special group of HIV+ persons who seek STD care, treatment of their STD may have an important impact on transmission of HIV to their uninfected partners. Further assessment is required to determine the impact of intensive STD casefinding and treatment among HIV+ persons, some proportion of whom continue to practice risky behaviors.

Protease Inhibitors are Associated with Declining AIDS Deaths in New York City (NYC)

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Background: In NYC, the number of HIV/AIDS deaths dropped 30% between 1995 and 1996. We evaluated the association between combination antiretroviral therapy with protease inhibitors (CPI) and mortality among AIDS patients.

Methods: In this population-based case-control study, a random sample was selected from the NYC HIV/AIDS reporting system (HARS). Cases (n=150) and controls (n=150), between the ages of 25 and 59, were diagnosed with AIDS in NYC during 1994-1996 and proportionately sampled by year of AIDS diagnosis. Women were oversampled (F:M=1:2). Cases were those who died of AIDS-related causes in 1996. Controls were not known to have died by the end of 1996. Data were obtained for 1995-1996 from HARS, death certificates, CD4 lab reporting system, and medical charts. Univariate and multivariate logistic regression analyses were used to identify independent predictors of dying from AIDS.

Results: Data are complete on 121 cases and 123 controls (total=244). Cases and controls were similar in age (mean, 40 vs. 39 yrs), sex (68% vs. 66% male); proportion of Black or Hispanic (81% vs. 85%), of injecting drug users (54% vs. 51%), and of uninsured (13% vs. 13%). Median CD4 count at AIDS diagnosis was 30/μL for cases and 106/μL for controls ($p<0.001$). In 1996, 12% of cases and 29% of controls were on CPI (Crude OR=2.9, 95%CI=1.4-6.1; Mantel-Haenszel OR=2.7, 95%CI=1.3-5.0 stratified by CD4 count). A logistic model was used to assess gender, age, race, health insurance, HIV risk, year of AIDS diagnosis, CD4, and antiretroviral therapy. Independent predictors for dying from AIDS were: non-use of CPI (adjusted OR=3.1, 95%CI=1.2-8.0), and low CD4 count (adjusted OR= 1.7 for every 50 cell decrease, 95%CI =1.3-2.0).

Conclusions: This population-based study suggests that AIDS death is strongly associated with not using protease inhibitor containing combination antiretroviral therapy. This association supports the likelihood that the decline in NYC AIDS deaths in 1996 resulted at least in part from increased use of combination antiretroviral therapy with protease inhibitors.

Social Science Framework for Microbicide Research

Issues: There are numerous studies exploring alternatives to the male condom for prevention of sexually transmitted HIV infection. Microbicides as such an option are being studied in a variety of clinical trials internationally. However, behavioral and social science issues have not been consistently incorporated into the conduct of the trials.

Project: A meeting of experts was convened in 1997 to identify social science and acceptability issues that should be addressed within the context of clinical trials and research that is parallel and complementary to those trials.

Results:A new conceptual framework for the integration of biomedical and social science research in the development, testing and introduction of topical microbicides was developed. Guidance for incorporating social science research in three critical areas of microbicide research was outlined:1) Basic research addressing crosscutting issues from related areas, such as product acceptability, should be incorporated; 2)Within the context of clinical trials, social science research should be carried out prior to each phase and during post-approval community studies; 3) Parallel research, occurring at the same time and/or in conjunction with clinical trials, should involve populations that are not usually included in clinical trials.

Lessons Learned: Addressing individual, social, and contextual issues throughout the research process may enhance ultimate utilization of such products in the prevention of sexually transmitted HIV infection. This framework combines traditional epidemiologic clinical trials methods and social science perspectives.

authors: Sussman, L. (USAID): Scarlett,M. I. (CDC): Bentley, M. (Hopkins) and Heise, L. (HDPP)

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HIV prevention indicators provide evidence of successes and failures of HIV prevention in San Francisco, California.

Objective: To examine the effectiveness of HIV prevention efforts by identifying and evaluating key indicators of HIV prevention using local data from various realms including: biological, behavioral, social and service areas.
Methods: Biological, behavioral, service, and socio-political level indicators are selected based on considerations of how prevention efforts have been targeted, specific objectives, data availability, reliability, validity and ease of assessment. Data were collected from local sources including, the San Francisco Department of Public Health (SFDPH) Division of STD Control, Division of Community Substance Abuse Services (CSAS), ongoing studies of at risk populations, outreach groups, and service providers.
Results: The table presents selected prevention indicators (PI) from four realms: biological (Bio), behavioral (Beh), service (Ser), and socio-political (S-P) among men, women, men who have sex with men (MSM), injection drug users (ISU).

Realm	Indicator	Population	1994	1996	% change
Bio	Syphilis (early) cases	Men age 15-24	8	2	75 % ↓
Bio	Chlamydia cases	Women age 15-24	1091	893	18 % ↓
Bio	Syphilis (early) cases	Women age 15- 24	7	2	71 % ↓
Bio	Rectal gonorrhea (GC) cases	Men age ≥ 15	73	134	84 % ↑
Beh	Unprotected anal sex w/ ≥2 partners	MSM (% reporting)	48%	60%	25 % ↑
Beh	Condom use always (anal sex)	MSM (% reporting)	70%	66%	6 % ↓
Ser	No. needles disbursed at NEP/month	IDU	125,027	157,138	26 % ↑
Ser	Persons receiving drug treatment	IDU	13,969	13,134	6 % ↓
S-P	Clean needle distribution	IDU	Public Health exemption: 1988		
S-P	Sodomy laws	MSM	Repealed in 1976		
S-P	Anti-discrimination based on sexual orientation		Legislation enacted 1991		
S-P	Domestic partnership recognition for same-sex couples		Legislation enacted 1990		

Conclusions: Indicators in San Francisco show decreases in STD in the general population yet disturbing increases in risk behaviors and rectal GC among MSM. Socio-political PI attest to a positive environment for marginalized populations at risk for HIV, which may facilitate prevention efforts. Service PI are more difficult to evaluate. Biological, behavioral, socio-political, and service level PI help build a more comprehensive view of the results of prevention, allowing more timely responses to trends than afforded by HIV or AIDS surveillance.

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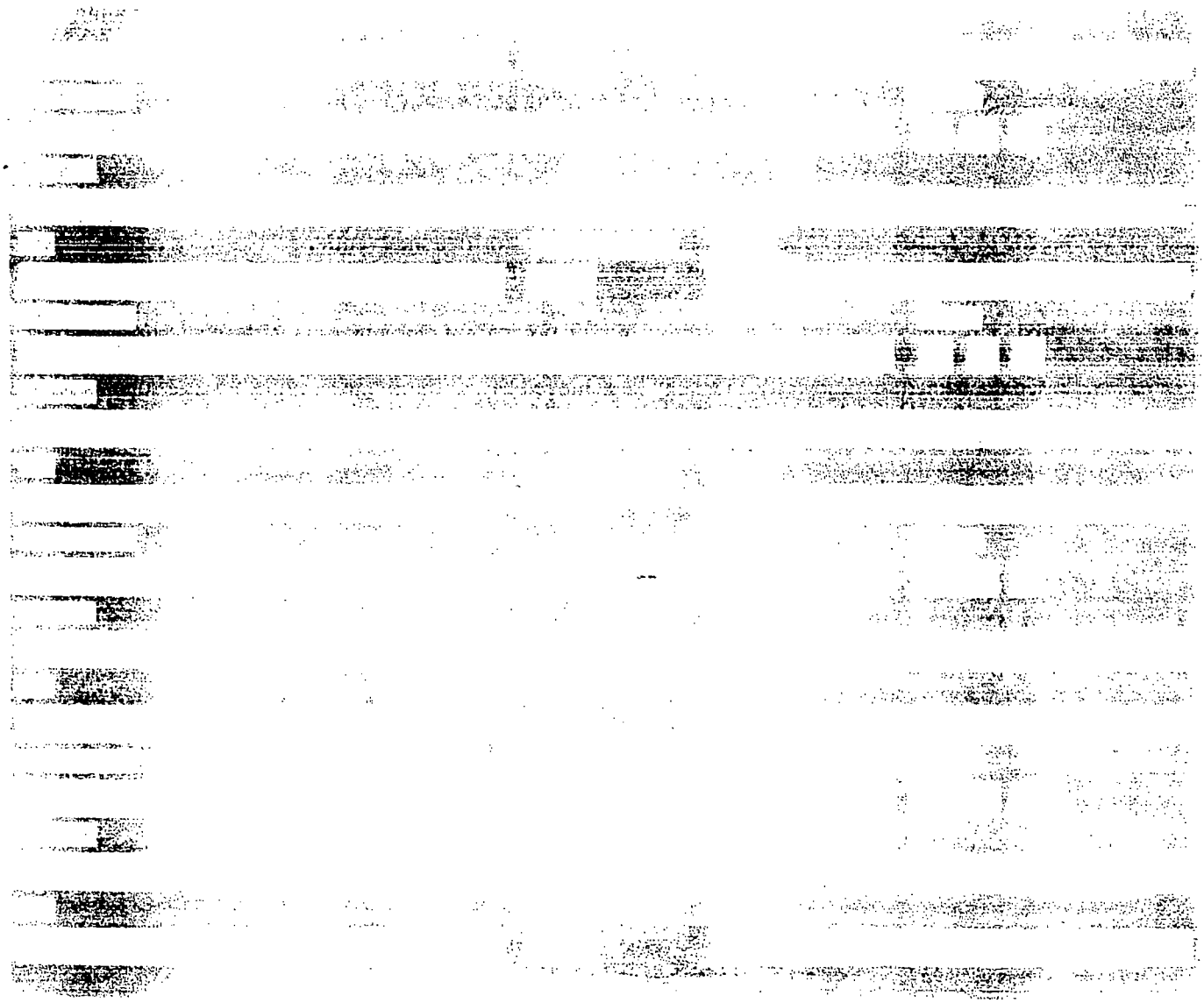

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Trends in the use of epidemiologic data in HIV prevention community planning in the United States, 1994 through 1997

Issues: Since 1994, 65 State, local, and U.S. territorial health departments that receive HIV prevention funds from the Centers for Disease Control and Prevention have been required to develop an evidence-based comprehensive HIV prevention plan in collaboration with local community planning groups (CPGs). An epidemiologic (epi) profile is an essential component of the prevention plan.

Project: To characterize trends in the development and use of epi profiles in the planning process, we analyzed data from: reports by multidisciplinary teams conducting an external review of applications and plans submitted to CDC each year, surveys of epidemiologist reviewers, and in-depth reviews of a stratified-random sample of epi profiles.

Results: Although epi data were included with the prevention plans in the first year of community planning (1994), most CPGs did not appear to use them for decision making. These findings prompted publication of guidelines for developing an epi profile; provision of epi technical assistance (TA) in the analysis, interpretation, and understanding of data; and encouragement of ongoing participation of local epidemiologists in the community planning process. Although epidemiologist reviewers noted that the quality of epi profiles submitted with most of the prevention plans in the second and third years (1995 and 1996) was much improved, links between the epi profile and needs assessment, priority setting, and prevention planning were not clearly defined. For example, in 1996, CPGs from only 5 of 13 (38%) project areas sampled for in-depth review clearly used the epi profile to identify target populations and select and prioritize interventions. The most recent review of prevention plans (1997), however, found that 48 of 59 (81%) plans were based on an epi profile.

Lessons Learned: The quality and use of epi profiles in HIV prevention planning have improved substantially with increases in epidemiologist participation, TA provision, and CPG competency in understanding data. The goal of data-based decision making by all CPGs may be achieved by continuing to provide TA and support epidemiologist participation in planning, and strengthening the emphasis on linking data from the epi profile with subsequent steps in the HIV prevention planning process.

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Man-to-Man: Sexual Health Seminar--Evaluation of an Innovative HIV Prevention Program for Men Who Have Sex with Men

Objectives: HIV prevention interventions aimed at men who have sex with men (MSM) often focus on immediate sexual behavior change without addressing how change will be maintained. The "Man-to-Man: Sexual Health Seminar" attempts to affect long-term risk reduction through a developmental model that addresses sexual attitudes and comprehensive sexual health. These educational seminars were designed to reduce internalized homophobia and sexual risk behaviors, such as unprotected anal intercourse, and to increase overall sexual health.
Design: Prospective, randomized controlled trial with 3- and 12-month follow-ups.
Methods: In 1997-98, 450 MSM volunteers for the sexual health seminar offered by the University of Minnesota's Program in Human Sexuality, were randomly assigned to either the 2-day seminar or a 3-hour AIDS education video. Baseline, immediate posttest, 3- and 12- month follow-up surveys were used to assess sexual attitudes (e.g. internalized homophobia) and risk behaviors (e.g. unprotected anal intercourse). Response rate at 3-month assessments was 86%.
Results: Preliminary results at 3 months show internalized homophobia decreased significantly among the 2-day seminar participants compared with the controls ($t=-2.09$, $p<.05$). Unprotected anal intercourse with multiple partners showed a 5% decrease among seminar attendees compared with a 1% increase among controls (chi square=1.23, n.s.).
Conclusion: A developmental, comprehensive sexual health approach to HIV prevention can reduce some of the covariates of risky sexual behavior, specifically internalized homophobia, shown elsewhere to be associated with unprotected anal intercourse. Although 3-month follow-up showed modest decreasing trends in immediate risk behavior, the 1-year assessment should provide information about the effect on long-term behavior.

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