

AIDS 2006—XVI: Reflections

It was a privilege to be able to attend the IAC. It is an event that I have wanted to attend for many years but was unable to because of the location and expense of the conference.

I had the honor of bringing a piece of Guelph to the conference for the world to see. I had the opportunity to co-present an information session in the Canadian exhibit space with Martine Stomp the HIV clinic nurse at the Masai Centre. We were able to highlight an example of a community-based project where an AIDS Service Organization and an HIV Clinic come together to provide HIV care, treatment and support.

I also heard many stories of stigma and discrimination around the globe. I attended a workshop on the impact of mandatory HIV testing on refugees and migrant workers. For migrant workers who travel to other countries for seasonal work it is a very prestigious job. It gives them an opportunity to earn money to send back home to their families.

The following are a couple of examples of the impact mandatory HIV testing has on refugee and migrant workers. In some countries in Africa, HIV positive pregnant women are held in refugee camps and after giving birth they are told to breastfeed their children for up to 6 months. The mother often continues this practice much longer because of the lack of food in these camps.

In Beijing, Migrant workers are tested upon entry into the country. If they receive a positive test result they will be removed from the country within 24 hours, often being handcuffed.

After people have been diagnosed HIV+, often their families and communities find out and the person is disowned and thrown to the side. Living in total isolation with no family supports.

I struggle with these concepts, trying to put myself in their shoes. My family has been a key support for me throughout my years of living with HIV. I could not see how this level of stigma and discrimination still exists. Later that day an older woman stopped me on the street to ask me what the name badge was that I was wearing around my neck. She said that she has seen a lot of people wearing the same thing for the last week. I was excited to tell her about the conference. I was stunned by her response. She said, "Oh that's a waste of time and money. You should just let those people die." As an AIDS activist for 16 years I was stunned into silence. I had just witnessed the stigma and discrimination I have heard so much about.

Tom Hammond



ACG staff blocking traffic at an intersection on Young Street to protest the Federal Government's plan to cut funding to Insite, Vancouver's Safe Injection Site.

Anonymous HIV testing now offered weekly.

Tuesday afternoons at the ACG office from 1:30 to 3:30 p.m.

- HIV Testing
- Hepatitis B and C Testing
- Hepatitis B Immunization
- Hepatitis A immunization for MSM and IDU

All services are free and confidential. No Health Card or appointment is required.

For more information on the clinic or other Harm Reduction Services provided please call our office.

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Opening Doors Regional Conference

November 7th & 8th—Hamilton

A forum for people living With HIV/AIDS, their friends, families, partners and health care providers.

Age of Consent (July 2006)

Adopted by the Canadian AIDS Society's Board of Directors, July, 2006.

Currently, the Government of Canada is exploring increasing the legal age of consent for sexual activity from 14 to 16 years of age. The Canadian AIDS Society does not support this action.

The Canadian AIDS Society is concerned that increasing the age of consent could result in young people being more secretive about their sexual practices and not seeking out the information they need. This will place youth at an increased risk of contracting HIV and other sexually transmitted infections.

Furthermore, the proposed amendments to the age of consent do not address an existing law prohibiting anal intercourse for individuals under the age of 18. Age of consent should be universal and not discriminate by type of sexual activity.

The Criminal Code of Canada already protects people under the age of 18 from sexual relationships that happen under circumstances of exploitation, pornography, prostitution or in relationships of trust, authority or dependency.

Passed by Parliament in July 2005, Bill C-2 created new protections for

youth under 18 years of age against exploitative sexual activity. Bill C-2 takes into account the nature and circumstance of the relationship, including the age of the young person, the difference in age between the youth and the other person, how the relationship evolved, and the degree of control or influence exercised over a youth under 18.

The average age of first sexual intercourse is 14.1 years for boys and 14.5 years for girls as reported in the *Canadian Youth, Sexual Health and HIV/AIDS Study (2003)* by the Canadian Council of Ministers of Education. In 2000, 29% of all positive HIV tests in Canada were reported by youth ages 15-29. Young people between the ages of 15 and 19 already have the highest rate of sexually transmitted infections in Canada.



The Canadian AIDS Society believes that the Canadian government should be focusing their

efforts on promoting consistent, comprehensive HIV/AIDS and sexual health education across Canada. The best way to protect and support youth is to

ensure that education and services are available to inform them about their rights and options, and the risks and benefits of engaging in sexual activity. Educating youth to make informed choices that are right for them is better addressed through parental guidance and comprehensive sexual health education than by using the Criminal Code.

AIDS Awareness Week—Nov. 27th to Dec. 1st. 2nd Annual AIDS Symposium November 27th / Dec. 1st Vigil

Please check our website at www.acg.guelph.org for more information on these two events as well as others for the week.

Support Services Event Listings

Please contact Tom at 763-2255 ext. 28 for more information

We are pleased to announce that
Massage Therapy
is now available at ACG.

Beginning Tues. Oct. 31st, with
Wesley Bowers, a Registered
Massage Therapist.

Appointments: the last Tues-
day at the end of every month
at 1:30, 2:30 and 3:30pm.

www.norfolkwellness.com

Naturopathic Clinic
Every Wed.—4pm–8pm
With Dr. Heidi McGill

Services Include

Naturopathic Consultation
Nutritional Counselling
Acupuncture
Folic Acid Supplements
Vitamin B12 Shots

An appointment is required.

Movie Night
with Homemade Chili
Nov. 16th—6pm



**Holiday
Drop-In**
Wed. Dec. 13, 1:30-4



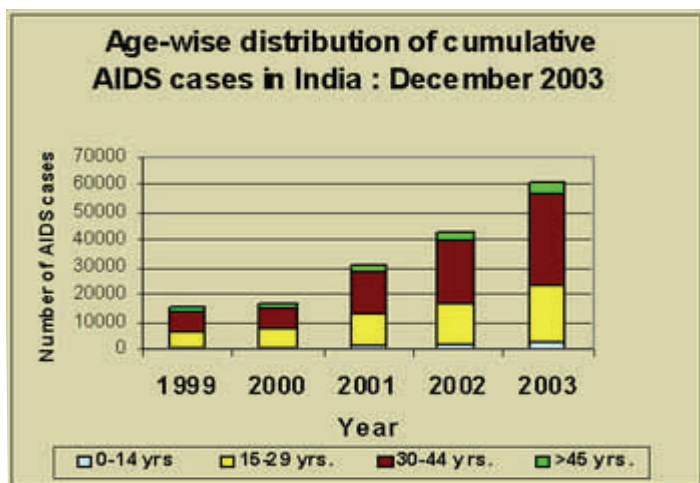
HIV infection in India

A brief idea about the HIV pandemic in the country

by Rohit Sarkar

The first case of HIV infections in India was reported in Chennai, Tamilnadu in 1986, and since then the number of infections has increased drastically -- in 2006 the total number of HIV infections is 5.7 million. Although the number of infections is quite alarming rate of the HIV prevalence in India is less than 1% because of the extremely high population (1.1 billion in 2006), despite the fact that eight states have reached high prevalence (> 1 %): Andhra Pradesh, Goa, Karnataka, Maharashtra, Manipur, Mizoram, Nagaland, and Tamilnadu.

The occurrence of the infection is different in various part of the country because of societal and cultural diversity. Most infections in India occur by sexual transmission (approximately 86%) and the rest are from blood transfusions, mother-to-child-transmission and injecting drug use (particularly in North Eastern states and some metropolitan cities). Young people in India are among those at high-risk of contracting HIV. Over 35% of all reported HIV-infections in India occur among young people in the age group of 15 to 24 years.



Although HIV/AIDS is still largely concentrated in at-risk populations, including sex workers, injecting drug users, truck drivers and men who have sex with men, the surveillance data suggest that the epidemic is moving beyond these groups in some regions and into the general population. It is also moving from urban to rural districts. In order to counter the spread of HIV/AIDS, many governments, voluntary, private and bilateral / multilateral agencies have initiated HIV/AIDS program in various parts of India.

Stigma and discrimination attached to the infection

In India the social reactions to people with AIDS have been overwhelmingly negative. For example, in one study 36% of people felt it

would be better if infected people killed themselves, and the same percentage believed that infected people deserved their fate. Also, 34% said they would not associate with people with AIDS, and one fifth stated that AIDS was a punishment from God.

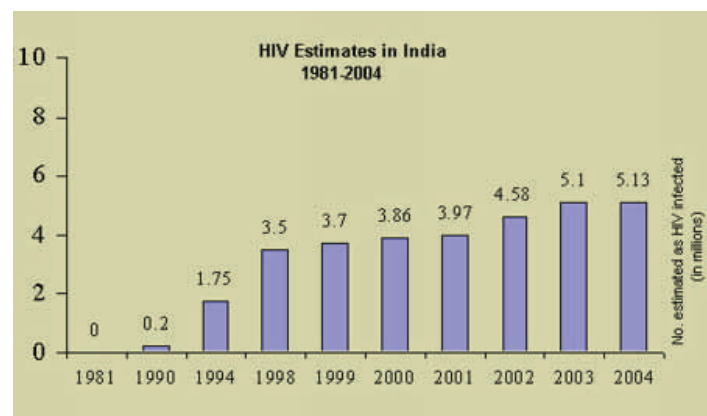
Stigma and discrimination is one of the reasons that work as barriers to address the infection and initiative to control it. For a long time most of the people were reluctant to receive any information regarding HIV as it deals with issues related to sexual health and a common believe is that it could only happen to those whose lifestyles are considered "perverted" and "sinful". As a result of this HIV positive people often are isolated from the community and their family members also face discrimination.

Prevention efforts

In 1987 the government of India launched its first "National AIDS Control Program" (NACP I) worth US \$84 million; this program has since been extended up to 31st March, 1999. After NACP I another national AIDS control program was initiated (NACP 2) which cost \$250 million and formally ends on March 31, 2006. The programs had various components to slow down the spread of HIV/AIDS infection through creation of awareness targeting behavioral change. In 2007 India is going to begin the third AIDS control program, this program could cost \$ 2.5 billion, The five-year program (NACP-III) will focus on getting accurate data on HIV prevalence in the provinces of UP, Bihar, MP, Rajasthan and Orissa it would also expand government funded centres offering free testing, counseling and treatment.

Besides the government many voluntary, private and bilateral / multilateral agencies have initiated HIV/AIDS program in various parts of India to counter and control HIV/AIDS.

• Rohit Sarkar is a placement with ACG from Canada World Youth.



Information sources and references

1. Avert Society (www.avertsociety.org)
2. National AIDS Control Organization, India (www.nacoonline.org)
3. Solidarity and Action Against The HIV Infection in India (www.saathii.org)
4. UNAIDS India (www.unaids.org.in)
5. West Bengal State AIDS Prevention & Control Society

Male Circumcision

—Cutting Edge News—

As you might have heard, there was a lot of talk of **circumcision** at this year's International AIDS Conference held in Toronto. For a number of years, there has been discussion about the possible effectiveness of **male circumcision** as a prevention method against the contraction of HIV. Here is a brief breakdown of some of the news.

Here's What We Know So Far

Late last year (2005), research results for a study conducted in South Africa were published and discussed at the International AIDS Society (IAS) Conference on HIV Pathogenesis and Treatment in Brazil. The South African study involved more than 3,000 HIV-negative, previously uncircumcised men aged 18 to 24 living in the South African township of Soweto. At the beginning of the study, half of the men were circumcised and the other half served as a control group, remaining uncircumcised. The results showed that for every 10 uncircumcised men who contracted HIV, about three circumcised men contracted the virus. The study ended early when it became clear that **circumcision** significantly reduced HIV transmission and that it was unethical to proceed without offering the option to all **males** in the study.(1)

There are two similar studies currently taking place in other areas of Africa, one in Kenya and another in Uganda. The results from both of these studies are expected to be similar to those of the South African study and are due to be released in mid-2007.

A recent study from Yale University estimates that increasing adult **male circumcision** rates in Soweto by 10 percent each year for five years could save 32,000 lives over 20 years. If adult **circumcision** rates were doubled to 20 percent, 52,000 lives could be saved over 20 years.(2)

Biology

Foreskin contains large concentrations of the types of cells that HIV targets - a finding that helps explain why uncircumcised men may be more prone to HIV infection than circumcised men. In addition, the foreskin may provide an environment for survival of bacteria and viruses, and may be susceptible to tears, scratches and abrasions, suggesting that the presence of foreskin may increase the likelihood of contracting HIV.(3) **Circumcision** is also associated with a decreased risk of other STIs, which may also decrease the overall risk of contracting HIV.(4)

Other Issues of Concern

There was considerable discussion and debate at the International AIDS Conference regarding the finding of the South African study. Many researchers and advocates encouraged the implementation of wide **circumcision** programs in countries with high rates of HIV/AIDS.

There were also several voices expressing concern around being too hasty in the implementation of these programs without due acknowledgment of several relevant issues, such as cultural implications and

training of medical staff to perform **circumcisions**. There is also, at this point, a lack of research indicating the effects of **male circumcision** on the likelihood of transmission from **male** to female partners in the case of penile-vaginal intercourse, and on the receptive **male** partner in the case of penile-anal intercourse.

Future Directions

Many researchers at the International AIDS Conference stated that **circumcision** should be widely adopted as an HIV prevention method in developing countries.

The World Health Organization (WHO) and UNAIDS have "refused to endorse" **circumcision** until the Kenya and Uganda studies produce successful results. If the results of the Kenyan and Ugandan studies are positive, organizations such as UNAIDS and WHO will issue statements advising communities of their points of view.

Is This News Relevant in Canada?

Until such time as there is a 100% effective vaccine preventing the contraction of HIV, the Canadian AIDS Society (CAS) will continue to emphasize the role of risk reduction and the realities of human nature when it comes to sexual, and other, behaviours.

Regardless of the potential protective factors relating to **circumcision** and HIV, all benefits would be lost if circumcised men gain a false sense of security and stop using condoms and/or stop practicing other means of safer sex.

Effective HIV prevention requires that a latex condom be used properly whether someone has a foreskin or not.

For further information about the continuum of risk reduction and sexual and drug using behaviours, please refer to *HIV Transmission: Guidelines for Assessing Risk*, which is available on our website at www.cdnaids.ca.

1 Bertran A., Taljaard D., Lagarde E., Sobngwi-Tambekou J., & Rémi Sitta AP. (2005). Randomized, Controlled Intervention Trial of **Male Circumcision** for Reduction of HIV Infection Risk: The ANRS 1265 Trial. *PLoS Medicine*, 2(11), <http://medicine.plosjournals.org/>.
2 Mesesan K., Owens D.K. & Paltiel A.D. (2006, August). *The potential benefits of expanded male circumcision programs in Africa: predicting the population-level impact on heterosexual HIV transmission in Soweto*. Oral abstract session presented at the XVI International AIDS Conference, Toronto, ON.
3 Canadian AIDS Society. (2004). *HIV Transmission: Guidelines for Assessing Risk*, 5th edition. Ottawa, ON.
4 Frascino, R.J. (2006). *Forum on Safe Sex and HIV Prevention: Circumcision*. www.thebody.com/Forums/AIDS/SafeSex/Current/O177936.html

Microbicide Research:

Scientific Progress in a Promising New HIV Prevention Technology

• *International Partnership for Microbicides*

Microbicides, substances that can be applied vaginally to prevent HIV transmission during sexual intercourse, are urgently needed to help stem the HIV/AIDS epidemic. Currently women are being disproportionately affected by HIV, accounting for an increasing percentage of new infections and bearing the brunt of emotional and physical toll as caregivers. Most disturbingly, young women, especially those who are married, are being infected at astonishingly high levels. Twenty-five percent of women in South Africa is infected with HIV by the time they are 22 years old. Studies from Kenya, and Zambia show that adolescents who are married are contracting HIV at a faster rate than sexually active unmarried teens. And, unfortunately, parts of Asia are not far behind. The rate of HIV infection is also increasing in women in Latin America, the Caribbean, and North America and Europe. So for women in many parts of the world, being poor, young and married are the most significant risk factors for acquiring HIV infection.

Microbicides can function through variety of different mechanisms. One approach is to preserve the low pH of the normal vaginal environment, thereby enhancing the effect of hydrogen-peroxide-producing lactobacilli that require acidic conditions to thrive. Some products may indirectly protect against HIV infection by killing other sexually transmitted organisms that cause ulcers and lesions that result in higher susceptibility to HIV. Some products formulated as gels or emulsions may have an indirect effect on HIV by lubricating the vaginal surface so that there are fewer abrasions during sex.

The most direct approach is to kill or inactivate HIV itself before it ever reaches its target cells. Some substances, called membrane disruptive agents, are thought to kill or inhibit HIV in the vaginal lumen. Other microbicides are designed to interfere with the ability of the virus to attach to its target cell. Some of these entry inhibitors are polyanions, which are large molecules that non-specifically block HIV-binding. Others are designed to specifically interact with HIV receptors, such as CD4 and CDR5, on the target cell surface. And a third class of microbicides works inside the target cell to block reverse transcriptase, an enzyme necessary for virus replication. These latter approaches, nucleotide reverse transcriptase inhibitors (NRTIs) and non-nucleoside reverse transcriptase inhibitors (NNRTIs), are currently important components of highly active antiretroviral treatment regimens. A fourth approach is the inhibition of the uptake of HIV by immune cells that carry the virus away into lymph nodes.

The drug development pathway for microbicides follows a well-defined course to determine safety and efficacy. Products should have good activity against circulating strains of HIV and low in-vitro cytotoxicity. This is particularly important to ensure that the vaginal and cervical surfaces are not disrupted even if the virus is. Studies progress from the simplest rapid assays in cell lines with laboratory-adapted HIV to tests for safety and efficacy using clinically relevant strains in explanted tissue models. It is important that these products do not disturb normal vaginal epithelium or hydrogen-peroxide-producing lactobacilli. In addition, microbicides should not cause significant inflammation, because inflammatory chemicals, cytokines, recruit additional immune target cells into the area and may enhance HIV replication.

Drug delivery is a crucial component of a microbicide product, which can be formulated as gels, creams, or emulsions that are delivered by an applicator. Microbicides may also be contained within a sponge, suppository, or this film that can be inserted by fingers. Vaginal rings that can be kept in place for as long as 90 days are also being developed. Depending upon the mechanism of action of the microbicide, specific formulations can keep the active ingredient in the vaginal lumen, on the surface of the epithelium, or within the tissue.

Formulations can also be designed to fit within a desired application schedule. For example, some gels or creams can deliver drug over a 24-hour period. Some microbicides can be put inside intravaginal rings that may deliver products over a period of a month or more. Formulations can also be designed to have anti-inflammatory properties, be lubricating or drying, act as spermicides, and possibly have activity against other sexually transmitted infections. Selection of the appropriate formulation to maximize the activity of each active ingredient is also made with cost, stability, and manufacturing ease in mind. Of equal importance is how the product looks, feels, smells, tastes, since highly effective microbicide that no one likes to use will not prevent any infections.

Over the last ten years there has been an increase in the number of products entering preclinical and clinical development. This year there are ten microbicides under active development for HIV in preclinical tests and sixteen in clinical trials, six of which are in or moving into efficacy studies later this year. Two of the latter include C31G (or Savvy), a membrane disruptive agent and Carra-gaurd, a non-specific inhibitor of viral entry, with

several more close behind. Results from these clinical trails and others to start later on this year will be important for the field.

Recently, there has been a shift towards the development of products that are specifically targeted at HIV attachment, entry, and replication. Over the last ten years, the science of HIV has advanced significantly and microbicide development is taking advantage of the progress in HIV therapeutics to develop more potentially potent products. The majority of the microbicides in preclinical and safety studies now represents the new generation of active agents. And as highly active antiretroviral therapy, newer microbicides will contain combinations of drugs with different mechanisms of action.

Two years ago, the International Partnership for Microbicides (IPM) was established to help accelerate the development of safe, effective, and accessible microbicides for women in resource-poor settings. Along with many other individuals and organizations that have been working for many years the IPM is seizing upon several areas where opportunities exist to rapidly move the field forward. First is the selection and funding of the most promising candidates so that they can move through the product development pathway as rapidly as possible. While not cutting corners on safety or efficacy, speed is of the utmost importance since infections cannot be prevented when candidates languish at any stage of development. If a candidate successfully passes a certain test, it needs to move rapidly on to the next. If it does not look promising, development should cease, resources conserved and other candidates moved ahead.

There is obviously a great deal to be done and many challenges to address before a safe and effective microbicide is widely available. One of these challenges is resources. There has been virtually no private sector investment in microbicide development. To date, a relatively small number of 'far-sighted' governments and foundations has supported the microbicide field. However, the science is there, the technology is there, and, most of all, the passion and dedication of those in the field is palpable. And failure is not an option. With leadership, sufficient financial resources, collaborative efforts and product development expertise, women in developing countries should have access to safe and effective microbicides within the next five to ten years.

Zeda Rosenberg, Chief Executive Officer of The International Partnership for Microbicides.

United Way Agency Awareness Day



Staff and volunteers pose for a photo during the United Way's Annual Fundraising Campaign. Pictured from left to right are: B.J. Caldwell, Marcey Gray-Joefeld, Kim Paton, Brian Warrington, Steven Pierce, and Rohit Sarkar.



Yes!

I want to help the AIDS Committee of Guelph and Wellington County. Here is my contribution of:

- \$15
- \$20
- \$25
- \$50
- \$75
- \$100
- Other
- \$_____

Please charge my:

- Visa MasterCard
- American Express

Card Number: _____

Expiry Date: _____

Signature: _____

Please make cheques payable to the AIDS Committee of Guelph.

Please mail to :

ACG
409 Woolwich St., 2nd Fl.
Guelph, ON N1H 3X2
Thank-you.

Community Workshops

HIV in Canada: An Update

Monday, October 23, 2006
5:30 – 7:00 pm

Hepatitis C 101

Thursday, November 2, 2006
5:30 – 7:00 pm

HIV/AIDS 101

Wednesday, November 8, 2006
5:30 – 7:00 pm

HIV Stigma and Discrimination

Monday, November 20, 2006
5:30 – 7:00 pm

Space is limited! Please RSVP to B.J. Caldwell, education@acg.guelph.org or 519-763-2255 ext 35. For volunteers please also confirm to Kim at volunteer@acg.guelph.org (ext. 28). Deadline for all workshops is 12:00 noon the day before.

Please send us your e-mail address.

Help save the environment and our postage budget. If you would like to receive this newsletter electronically please send your e-mail address to: volunteer@acg.guelph.org. Thank-you.



Queen Lizzie with a AIDS 2006 Participant



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www.acg.guelph.org

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