IAS 2013
7th IAS CONFERENCE ON HIV PATHOGENESIS, TREATMENT AND PREVENTION
30 June - 03 July 2013 - Kuala Lumpur, Malaysia

Opening Session of IAS 2013

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Distinguished guests, Ladies and Gentlemen

I am very pleased to welcome all of you to Kuala Lumpur, to this 7th IAS Conference on Pathogenesis, Treatment and Prevention.

Many of you have made very long journeys to be with us for the next four days as we deliberate and debate the latest in HIV science and research.

In many ways for many of us in this room it has been a very long personal journey in our involvement with the HIV epidemic – whether it is as scientists, clinicians, programme implementers or indeed a Person Living with HIV. Much has evolved from the time when I first learnt about AIDS in my immunology class in medical school back in Melbourne in the early 80s. Who would ever imagine that I would one day be standing at this podium welcoming all of you with the person

who would then go on to discover the cause of AIDS, that in turn led to the development of diagnostic tools, treatment and the search for a vaccine and eventual cure.

Today that disease which gripped the world in the 80s as a disease with a certain death sentence has been turned into a chronic disease for those fortunate enough to be able to receive antiretroviral medications. From the development of HAART in the late 90s to ACTG 076 to more recent developments in the use of ARVs such as Treatment as Prevention and PrEP, from the knowledge that clean needles and condoms work (which we have known for decades) we know that we have the knowledge and the tools to turn the tide on the epidemic.

Malaysia was selected to host this Conference, the first in Asia and the first for a Muslim country in part because of its brave decision to adopt harm education to stem the raging epidemic amongst IDUs in 2005 against much public opposition. We now know that that decision to adopt this evidence-based approach is now paying off. Far fewer people who inject drugs are becoming infected and data to be presented here by colleagues from CERiA will show that this program has not only saved lives, but saved the government millions of ringgit.

Early adoption of the PMTCT program in Malaysia also meant that very few children have been born with HIV in this country. However, whilst we recognize these tremendous successes, we also know that there is still much work to be done. Whilst we have long had the science to prevent mother-to-child transmission, only around 30 per cent of pregnant women are offered an HIV test in East, South and South-East Asia. It is also deeply concerning that across the three same regions only around 16 per cent of HIV-infected pregnant women receive antiretrovirals to prevent mother-to-child transmission of HIV.

Scaling up of harm reduction programmes continue to be hampered by policies and laws that continue to criminalise drug use. Some 48% of the 37000 prisoners in Malaysia are in prison mostly for minor offences related to drug use; approximately 5% of them living with HIV with poor access to ARVs. Co-infection with tuberculosis not only threatens the individual but also the prison guards and the community

at large. I believe that Malaysia is not alone in this with many if not most countries in the region adopting a zero tolerance policy. Around the world, and particularly in Asia, clean needles and methadone alone are not going to be enough to achieve the global target of reducing HIV infection amongst PWID by 50 per cent by 2015. A serious review of the social and structural determinants as well as the laws and policies that impede our progress in HIV prevention amongst PWID must therefore be undertaken.

Reflecting back on this personal journey through the HIV/AIDS epidemic it would seem that advocating for and implementing harm reduction programs targeted at PWID here in Malaysia was a walk in the park compared to addressing HIV prevention for other key affected populations in Malaysia such as Men Who have Sex with men (MSM), sex workers and transgender people. Cultural and religious sensitivities and taboos continue to hamper our ability to implement what science has proven.

Yet at the same time our experience of the past 10 or years should be the basis by which we move forward to tackling the new challenges of reaching out to these groups.
We were able to make inroads with PWID because we finally had the epidemiology telling us that our local epidemic was at the time largely being driven injecting drug use. So it is now that we must look to strengthening the epidemiology that informs us better on the other key affected groups.

We were able to make inroads with PWID and get them on treatment precisely because had at our disposal highly antiretroviral drugs, one of the greatest scientific advances in the past few decades. So it is now that we now have the knowledge that early diagnosis and treatment is also prevention- a development that should be uppermost in in our strategies for reaching out to key affected people.

Lastly, I want to end my address by touching on the non scientific. We were able to make inroads with PWID because we also had a government willing to make a brave decision to tackle the epidemic head on, a decision, let´s be frank, that at the time was controversial and unpopular in some sectors in Malaysia. So it is now that we will need that same kind of political courage to turn around the changing

nature of the epidemic our country is currently facing. And we need that same political will to happen throughout our region.

Enjoy the conference and enjoy KL!
Thank you.