How to Write a Prize-Winning Abstract (That Will Get You Accepted as a Speaker!)
Structure of an abstract:

Option 1

Abstracts presented under the first option should contain concise statements of:

Background: the study objectives, the hypothesis to be tested, or a description of the problem
- Why do we do our work?
- What is/are the specific problem(s) that motivated us?

Methods: method(s) used or approach taken
- Who did what, when, with how many, where?
- How did we do it?
- What was our methodology?
- How did we solve the problem (or try to solve it)?

Results: specific results in summarized form (with appropriate statistical analysis)
- When the experiment was completed, was the hypothesis proved or disproved?
- Summarize the key research results
- What challenges were there in this experiment?
- What happened?
- What did we learn?

Conclusions: description of the main outcome of the study
- What impact or implications does this have?
- What does it all mean for human beings/ for people in other regions/ countries/ cultures?
- What is transferable?
Activity 1: Now you try one… Please fill in an appropriate title for the following abstract

Title: ________________________________________________________________

____________________________________________________________________

Objectives: To propose a structured approach to consensual decision making on access to care, treatment and support by participants in clinical trials of HIV and other new vaccines.

Methods: Setting standards of care provided to participants in vaccine clinical trials has been the subject of long-standing debate. The central questions that arise are: Is there an obligation to provide care to trial participants? What is the source of the obligation? Who should benefit from care? What care and prevention should be offered and for how long? Who bears the responsibility of providing care, in what form and within what limits? In 2005-2006, recognizing the pressing need for practical guidance to researchers, research institutions and sponsors, national health authorities and communities hosting clinical vaccine trials, the World Health Organization Initiative on Vaccine Research (WHO/IVR) embarked on a series of regional consultations. These consultations mapped out current guidance and approaches applied in field situations; set out criteria for defining obligations and obstacles to providing care in the context of vaccine trials; and developed mechanisms and approaches conducive to the attainment of the highest possible synergy between scientific quality, outcome of research, and protection of trial participants.

Results: The series of consultations resulted in a guidance revolving around a concept of Good Research Governance. The guidance document, to be presented, proposes a pathway for consensual decision making on standards applicable to care and treatment in vaccine trials.

Conclusions: A structured approach involving investigators, sponsors, trial communities and other stakeholders in research should ensure that the needs and legitimate expectations of trial participants are appropriately met and obligations towards them delivered. This is a necessary, if not sufficient, condition for facilitating ethical research in the interest of public health. The experience acquired in actual field settings will be applied to the further elaboration of the guidance provided.

Abstract taken from IAS 2007 and can be found at:
Scoring criteria:

A. Clarity of purpose and objectives of the study
   − Are the objectives clear and well presented?

B. Appropriateness of the methodology and study design
   − Is the data analysis and interpretation appropriate?
   − Is the methodology used appropriate for the study?

C. Significance of the contribution
   − Are the conclusions clear and appropriate to the study?
   − Is the study innovative? Does it provide new insights?
   − Does the study help the advancement of the knowledge and development of the programme?

Scoring system:

<table>
<thead>
<tr>
<th>Score</th>
<th>Abstract quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>9-10</td>
<td>Very good – research and information is based on an original concept or furnish important or new results. You would strongly recommend this for an oral presentation.</td>
</tr>
<tr>
<td>7-8</td>
<td>Good – research and information is strong and relevant to the conference. This could be an oral but you would recommend this poster presentation.</td>
</tr>
<tr>
<td>5-6</td>
<td>Average – the abstract contains information from which colleagues with the same interest field can learn. This should be a poster.</td>
</tr>
<tr>
<td>3-4</td>
<td>Lower than average – redundant research/information, no substantial improvement of knowledge, poor information quality. This should probably be rejected.</td>
</tr>
<tr>
<td>1-2</td>
<td>Bad or incomplete – insufficient information quality, the abstract is formally incorrect, prescribed sections are missing. This should absolutely be rejected.</td>
</tr>
</tbody>
</table>

Based on the scores, each abstract is assigned a type of presentation:

- **Oral abstract presentation** ➔ Best
- **Poster discussion** ➔ Good
- **Poster exhibition** ➔ Average
- **None** ➔ Lower than average
Activity 2: Be a peer reviewer. Score each abstract according to the criteria and scoring system, and decide how it should be presented (if at all)

Biology and Pathogenesis of HIV

1. **Classical phenotype assays and sequencing analysis for determination of coreceptor tropism in Cuban HIV-1 strains**

   **Background:** Classical biological assays have been used to determine HIV coreceptor usage, the strains were classified into R5, X4 or R5/X4, which is closely related with the NSI or SI phenotype, as well as with the clinical evolution of the patients. Bioinformatics methods have identified amino acid changes in the HIV envelope, in particular, the V3 loop.

   **Methods:** This work shows the results of the characterization study performed to 11 strains from HIV-1 infected individuals, 5 of them from asymptomatic seropositives, and 6 from individuals with rapid progression to AIDS. It was compared the results of the phenotypic study performed by 2 classical biological assays, syncitium inducing capacity and coreceptor usage, along with the bioinformatics methods, 11/25 rule and PSSM.

   **Results:** All the strains (5) belonging to the asymptomatic seropositives were classified as R5/NSI by all the methods, while those from rapid progressors (6) were classified as SI by the 4 methods employed, and R5/X4 by the biological assays; nevertheless, when sequence analysis was done, 5 resulted pure X4 and only one was R5/X4. The mutational changes should have supported the growing of the pure X4 variants in individuals of the type of clinical evolution, but phenotypic transition, was not observed in vitro. These differences shown in the results given by the bioinformatics methods, and the phenotypic ones, could be explained by means of the theory of gradual processing of mutations, which precede the phenotypic change of the stains. Furthermore other authors have reported DNA sequences predictive of CXCR4 usage in blood without any detectable replication of pure X4 variants.

   **Conclusions:** It was valued, the predicting character of the bioinformatics methods, and its usefulness in therapeutic decision making, also, the necessity to continue studying the classical assays, to deepen in its clinical utility, and in the understanding of HIV/AIDS pathogenesis.


Score: 5

Session: 

Comments: 

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2. **Humoral immune responses have little effect on controlling viremia during SIVagm infection of African green monkeys**

**Background:** SIV-infected African nonhuman primates (NHPs) do not progress to AIDS despite active and persistent viral replication of the same magnitude or higher than in pathogenic infections. It has been suggested that higher viral loads (VLs) in chronic, natural SIV infections are due to lower anti-SIV antibody titers in SIV-infected African NHPs, which implies a role for antibodies in controlling VLs. We investigated the impact of antibody responses on SIVagm replication in African green monkeys (AGMs).

**Methods:** Ten AGMs were inoculated with 300 TCID50 of SIVagm.sab. Four AGMs received 50 mg/kg of Rituxan (anti-CD20 antibody, gift from Genentech) every 21 days, starting from day -7 post-infection. Remaining AGMs received only SIVagm.sab. VLs in plasma and tissues were determined by real-time PCR and in situ hybridization (ISH). Dynamics of the major lymphocyte subsets were measured in peripheral blood, lymph nodes (LNs) and intestine by flow-cytometry. T-cell immune activation, proliferation and apoptosis were investigated by flow-cytometry and immunohistochemistry. Differences in the emergence of anti-SIV antibodies were compared by serology.

**Results:** All Rituxan-treated AGMs successfully depleted CD20 cells in peripheral blood, LNs and intestine, as illustrated by the dynamics of CD20+ and CD79a+ cells. There was no significant difference in VLs between CD20-depleted AGMs and control monkeys: during acute infection peak VLs ranged 10^7-10^8 copies/ml; during chronic infection, set-point values ranged from 10^4 to 10^5 SIV RNA copies/ml. Levels of acute CD4 T-cell depletion in the intestine were similar in treated and non-treated animals. The production of anti-SIV antibodies and neutralizing antibodies was ablated in the CD20-depleted AGMs compared to the controls. CD20 depletion resulted in effacing the histological structure of the germinal centers in the LNs and Peyer’s patches.

**Conclusions:** Our study shows that humoral immune responses play no significant role in SIV viral replication control during acute and chronic SIVagm infection in the natural host.

Abstract taken from AIDS 2008 and can be found at: http://www.iasociety.org/Default.aspx?pageId=11&abstractId=200720812

**Score:**

**Session:**

**Comments:**
3. **Multi- and extensively-drug resistant tuberculosis infection control assessment in a resource-limited setting in rural South Africa**

**Background:** Recent reports of nosocomially-transmitted multi- and extensively drug-resistant tuberculosis (M/XDR-TB) in rural South Africa mandate attention to strengthening airborne infection control (IC). IC information, motivation and skills among hospital staff in such settings are not well known, yet critically important to inform IC interventions.

**Methods:** A baseline assessment to identify staff IC deficits by focus groups, confidential questionnaires, and direct observations performed during July-September 2007 in high-risk areas of a rural South African district hospital. Data organized into Administrative, Environmental, and Personal Behavioral realms and analyzed using Information-Motivation-Behavior (IMB) behavior change model.

**Results:** Administrative deficits included: lack of formal IC policy, poor patient TB screening process, inadequate separation of TB suspects, and inconsistent use of cough hygiene. Environmental weakness was inconsistent natural ventilation during winter months (compliance 35-100%). Personal Behavioral deficits included: inconsistent respirator use (compliance 0-98%), staff unaware of own HIV status (37.9%), staff discomfort transferring from high-risk areas if HIV-positive (13.7%) and seeking personal TB diagnosis if symptomatic (15.5%).

IMB model analysis of barriers indicated: high Information levels; low Motivation to follow unofficial/unwritten policies (53.8% cite as barrier to implementation) and distrust in occupational health services confidentiality (25.0%); Behavioral skill deficits included inability to deliver unsettling news/recommendations and effective IC instructions to patients (45.5% and 35.8%, respectively), and moderate staff respirator skills (16.9% do not know how to wear, 24.1% how to check seal).

**Conclusions:** Assessment of hospital staff IC Information, Motivation, and Behavioral skills provides useful baseline information regarding IC deficits and barriers to effective strategies. Staff Information levels are high, but Motivation and Behavioral skills need improvement. This assessment informs subsequent intervention, which includes: creation/implementation of an IC policy; focused staff training addressing identified deficits, and continual monitoring and evaluation aimed at reducing nosocomial M/XDR-TB transmission risk.

Abstract taken from AIDS 2008 and can be found at: http://www.iasociety.org/Default.aspx?pageId=11&abstractId=200717672

Score: ____________

Session: _______________________________________________________________________

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4. **A prospective, randomized, open label trial of efavirenz versus lopinavir/ritonavir based HAART among antiretroviral therapy naïve, HIV-infected individuals presenting for care with CD4 cell counts <200/mm3 in Mexico**

**Background:** Late presentation to care of HIV+ individuals is frequent, particularly in resource-limited settings. The relative efficacy of preferred PI or NNRTI first line HAART regimens has not been evaluated in this setting.

**Objective:** To compare the efficacy of efavirenz (EFV) vs lopinavir/ritonavir (LPV/r) based HAART among ART naïve, HIV+ individuals presenting for care with CD4 cell counts <200/mm3 in Mexico.

**Methods:** This is a prospective, randomized, open label, multi-center trial comparing EFV vs LPV/r plus AZT and 3TC (FDC) in HIV+ ART naïve individuals with CD4<200/mm3. The primary endpoint was the percentage of patients with plasma HIV-1-RNA (pVL) <50 copies/mL at 48 weeks (ITT analysis). Secondary endpoints included: the percentage of patients with <400 copies/mL at 48 weeks (ITT), and CD4 count change by treatment group. We also evaluated the percentage of patients with pVL <50 and <400 copies/mL using OT analyses.

**Results:** 189 patients (85% male) were randomized: 95 to EFV and 94 to LPV/r. Median baseline CD4 was 64 and 52 cells/mm3 respectively (p=NS). By ITT analysis, the proportion of patients with pVL <50 copies/mL at week 48 was 70% with EFV and 54% with LPV/r (p=0.0141). The ITT proportion of patients with pVL <400 copies/ml at week 48 was 73% with EFV and 65% with LPV/r (p=0.25). Mean CD4 cell count increase at 48 weeks was 156.9 in EFV and 166.9 in LPV/r. Premature discontinuation occurred in 27% and 34% in EFV and LPV/r (virological failure: 7 and 16, lost to follow-up:14 and 6, AE and death: 5 and 10). OT and ITT results were consistent overall. Mean change in Cholesterol and triglyceride levels were 53 and 84 mg/dl in EFV and 62.5 and 168.5 mg/dl in LPV/r (p=0.24 and p=0.0036).

**Conclusions:** In these very advanced HIV infected ARV naïve subjects EFV had superior virological efficacy than LPV/r.

Abstract taken from AIDS 2008 and can be found at: http://www.iasociety.org/Default.aspx?pageId=11&abstractId=200720914

**Score:**

**Session:**

**Comments:**
To strengthen the self-organization of female sex workers in Central America: a strategy to increase sustainability in HIV prevention

Issues: Self-organization of Female Sex Workers; self-esteem and training in rights as a strategy for sustainable HIV prevention; use of mass media to fight stigma linked to sex work

Description: Central America is the subregion where rights of sex workers are violated the most, and where there is less self-organization (RedTraSex, 2005). Given the close link between violation of human rights and difficulties preventing HIV, during 2006 and 2007 we trained 20 activists from six countries (Guatemala, El Salvador, Costa Rica, Honduras, Nicaragua and Dominican Republic) in issues of identity of sex worker, human rights, organization, HIV / AIDS, gender and violence. This was supported by UNFPA and UNAIDS.

We held conferences where we denounced the situation of vulnerability in the region. In this process, the leader from Guatemala showed up on TV in her country for the first time as a sex worker. We edited "Un movimiento de tacones altos", a manual developed by sex workers. During 2007 each country repeated the training using the manual, reaching 155 mates.

Lessons learned: Our self-organization is against the interests of pimps and police. In Nicaragua there were reprisals after the workshops. We’ve learned that we must organize ourselves carefully to preserve our integrity. This experience shows that self-organization and strengthening the sex worker’s identity as a worker’s identity is a sustainable strategy to prevent HIV. As another results of the program a new organization called “Girasoles” was created in Nicaragua, and Costa Rica joined RedTraSex. In addition, each organization was able to link up with the national program for HIV / AIDS of their countries.

Next steps: Continue strengthening Central America with emphasis on participation of Female Sex Workers in policy and decision-making arena, so that their voices are taken into account in defining policies on prevention of HIV.

Abstract taken from AIDS 2008 and can be found at: http://www.iasociety.org/Default.aspx?pageId=11&abstractId=200721406

Score: _____________________________

Session: ___________________________

Comments: ____________________________________________________________________
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6. Sexual risk behaviors and HIV infection among men who have sex with men who use the internet

**Background:** MSM is increasingly using the Internet to find sex partners. Yet the demographic characteristics of MSM who use the Internet (MSMUI), their risky sexual behaviors and prevalence of HIV and syphilis are not well studied.

**Methods:** Between June and August 2007, 429 MSMUI were recruited via the Internet from Beijing and Urumqi, China. Interview was conducted in a private room with a questionnaire administered face-to-face by a trained interviewer. Information collected included demographic characteristics, Internet use and sexual behaviors. Blood specimen was collected and tested for HIV and syphilis.

**Results:** The mean age of participants was 27 years. Nearly three quarters (72.7%) had an education of some college or more and 22.8% were students. Median number of lifetime male sexual partners was 10. Most identified as homosexual (70.9%) or bisexual (18.5%). Ninety-one percent were Han ethnic. Average age for first sex with man was 21 years. Proportions of condom use in the last oral sex, insertive anal sex and receptive anal sex with a male partner were 8.8%, 66.3% and 60.4%, respectively. Forty-one percent ever had sex with a female partner, and 42.1% of whom used condom in the last sex. Ninety-one percent ever had sex with a cyber friend. Most (390, 96.5%) participants supported online HIV/STI counseling. The prevalence of HIV, syphilis, and co-infection were 4.6%, 11.2%, and 1.6%, respectively. Factors associated with HIV infection were being 24 years old or younger (OR=2.934, 95% CI: 1.069-8.055), being syphilis positive (OR=4.814, 95% CI: 1.734-13.362) and having anal sex before knowing how to use the Internet (OR=3.225, 95% CI: 1.128-9.227).

**Conclusions:** MSMUI engages in high risky sexual behaviors for HIV infection and has a high prevalence of HIV infection. It is urgent to design and implement specific and effective intervention programs to target this special group of people. The Internet might be an effective platform.

Abstract taken from AIDS 2008 and can be found at: http://www.iasociety.org/Default.aspx?pageId=11&abstractId=200716223
7. **Improving living conditions of children aged between 6 and 15 years of age, affected by HIV/AIDS in Mtendere Township, Lusaka, Zambia**

**Issues:** HIV/AIDS has continued to ravage people in Mtendere resulting in high numbers of orphans and other vulnerable children. Children are faced with problems, which impact negatively on their lives. Although located in the capital, where most of the economic activities are taking place, poverty levels here are extremely high. Families live on less than a dollar a day and can hardly afford basic needs to send children to school. Some children end up on streets because they lack accommodation and support, some live in overcrowded accommodation with extended families mainly cases grandparents who are unemployed.

**Description:** BME Community Services (UK) in partnership with Lelemba Community Empowerment Project (Zambia) funded by the Big Lottery Fund- International Small Grant (UK), carried out research to assess the needs of the children of Mtendere. 40 respondents took part in the study divided into four categories. Group A had 10 school going pupils, B comprised of 10 children who were not in school and could not read or write, C had 10 adults including community leaders, while group D comprised 10 adults who cannot read or write.

**Lessons learned:** Poverty is still rife in Mtendere. Many people here have little or no knowledge of HIV/AIDS prevention. They are in great need of HIV/AIDS awareness and prevention training or information, sample size was small but very representative, so gave us a good picture of the need.

**Next steps:** To develop programmes that will help to create high level awareness of the dangers of HIV/AIDS aimed at ultimately reducing HIV new infections. To setup support systems offering the children and their guardians basic educational requirements and food to ensure more pupils attend school, ultimately reducing dropout rates in schools avoiding engaging in problems like crime, alcohol, drug abuse and prostitution all which can increase the risk of HIV infection.

Abstract taken from AIDS 2008 and can be found at:

**Score:** ____________________________

**Session:** ____________________________

**Comments:** ____________________________
8. **Measuring wellbeing in orphans and vulnerable children (OVC): the development of a standardized tool**

**Background:** A goal of vulnerable children programs is to improve wellbeing, which is often difficult to define and measure. Therefore programs commonly measure the type and quantity of services rendered. While necessary for routine monitoring, this practice is insufficient to assess outcome or impact on wellbeing. If reliable, valid and practical, measuring children’s perceived wellbeing could become a powerful outcome indicator of program achievement.

**Methods:** A literature review identified ten domains that contribute to wellbeing: nutrition/food security, shelter/environment, protection, family, health, spirituality, mental health, education, economics, and community cohesion. Following domain identification, over 100 self-reportable statements were developed, many adapted from validated tools. Forty expert judges ranked each statement for relevance as a proxy measure of wellbeing. 48 statements, each answerable using a 3-point Likert scale, were kept based on ≥70% agreement (S.D.£0.75) amongst judges. The tool was piloted in Haiti, Kenya, Rwanda, Tanzania and Zambia as part of an OVC mid-project evaluation.

**Results:** A total of 890 children aged 13-18 years participated in piloting the OVC wellbeing tool (OWT). Inter-item reliability analysis revealed Cronbach’s alpha of .70 across the 10 domains. Inter-item reliability within domains ranged from 0.238 (Economic Security) to 0.70 (Family Support). To assess concurrent validity, the tool was compared to the previously validated Children’s Hope Scale (Synder et al. 1997) showing strong correlation (Spearman’s rho=0.571, p<0.01). The larger project evaluation collected objective data to validate the self-reported domains within the OWT (e.g. poor nutrition domains in OWT significantly related to food insecurity in larger survey, p<.05).

**Conclusions:** The OWT is a practical self-reported measure of child wellbeing. This new tool, pilot tested in five countries, shows preliminary evidence of acceptable reliability and validity. To improve understanding of higher level outcomes of OVC programs further use/evaluation of the tool is encouraged.

Abstract taken from AIDS 2008 and can be found at: http://www.iasociety.org/Default.aspx?pageId=11&abstractId=200721040

**Score:**

**Session:**

**Comments:**
9. Discrimination at the workplace: winning the battles but losing the war?

Issues: Discrimination against PLHAs in employment settings (both public and private) continues to persist in spite of the constitutionally guaranteed fundamental right to equality (for public sector) and judicial pronouncements denouncing discrimination on account of HIV status.

Description: From 1998 to 2008, Lawyers Collective HIV/AIDS Unit has dealt with around 250 cases relating to employment, 40 of which have been litigated. Under the present legal framework, the burden of proof is on the employee to prove that s/he has been subjected to discrimination. It is exceedingly difficult for an employee to prove instances of discrimination due to lack of documentary evidence and non cooperation of fearful co-workers who refuse to testify. It is also difficult to seek redressal against certain incidents, which would amount to stigma and not discrimination. We have received favourable orders in certain cases directing employment or reinstatement or cessation of non-discriminatory practices. However, it has been observed that despite favourable orders, PLHAs continue to be subjected to discrimination, albeit in different forms like non payment of back wages, disqualification from benefits and time bound promotions and other incidents of stigma by superiors and co-workers.

Lessons learned: The experience shows that while there is an undisputed need for an anti-discrimination law that is applicable against the public and private sectors, the law should shift the burden of proof to the employer and oblige the employer to create a non-prejudicial working environment. This would serve as a disincentive to employers to discriminate against PLHAs and thereby guarantee economic sustenance to the affected worker.

Next steps: A specific law guaranteeing an enforceable right against non-discrimination on the basis of HIV status is required to effectively deal with discrimination in the employment setting. This has to be complemented by sustained advocacy efforts in collaboration with all stakeholders to eliminate stigma and discrimination.

Abstract taken from AIDS 2008 and can be found at:
10. **Impact of a community-led HIV prevention model on local policy area: lessons learned from rural Zambia, Keembe ADP**

**Background:** Experience from successful national responses to HIV & AIDS elsewhere shows that multi-sectoral, participatory and rights-based approaches can and result in lower HIV infection rates and less suffering among those affected by the epidemic. Many organizations have established HIV prevention Programmes but community coverage is still low and there is a great need for sustainable community-based models.

**Methods:** Baseline findings from an ongoing longitudinal operations research study identified some cultural practices that facilitated the spread of HIV and AIDS in Keembe including:
- Putting of naked little girls and/boys on the laps of an equally naked surviving spouse as a way of cleansing.
- Practice of incest to get rich
- Parents building separate huts for their girls when they come of age.
- Practice of incest to get rich
- Grand parents giving sex boosting medicine to boys to prove their manhood
- Some religious groupings allow ascension in their church hierarchy when one has more than one wife. Through continued community empowerment, the root cause of such dangerous practices was identified resulting in strategic training for headmen responsible for enacting and revoking laws in their respective chiefdoms.

**Results:** Today the Zambian government is allowing traditional leaders to participate and contribute in policy dialogue through the house of chiefs. However, these leaders require empowerment to identify and dialogue on local policy issues that impinge on HIV prevention for them to make informed contribution to HIV related policy formulation. Community dialogue and enactment of local by-laws and policies addressing cultural drivers of the epidemic will produce sustainable social change.

**Conclusions:** Train all the remaining traditional leaders and continue to support their joint dialogue on policy and other actions required to address the cultural drivers of the HIV epidemic. Conduct an end line survey to assess the impact of interventions.

Abstract taken from AIDS 2008 and can be found at: http://www.iasociety.org/Default.aspx?pageId=11&abstractId=200719412

**Score:**

**Session:**

**Comments:**
Example of an abstract submitted for mentoring:

**Abstract**

**Under Option II, Category C-54 Prevention program for general population**

“Be Bold Campaign” reduces stigma and increases tests and service uptake

**Background**

Andhra-Pradesh state, India has HIV prevalence of 1.4% (0.5 million people). Despite high awareness, prevalence was rising.

“Be-Bold” Campaign, launched on 1st December, 2006, aimed to translate awareness into action/behavioral-change; reduce stigma; improve health service uptake by infected people; mainstream fight against HIV/AIDS by making it a people’s movement.

General messages in the campaign exhorted people to talk about AIDS, get tested etc and targeted messages exhorted families to accept HIV+ve members, doctors to treat HIV+ve patients, teachers to teach infected/affected children; youth to say no to negative peer pressures.

**Be-Bold was the message; HIV tests the medium.** More tests identified more HIV+ves; got them early treatment and prevented inadvertent spreading by them; normalized the tests, thereby reducing stigma; gave better estimate of disease load for planning and resource allocation.

**Issues/Methods**

To improve access, HIV-testing-centers were increased from 286 to 677. Required staff recruited, trained and positioned with kits. To pre-screen people taking tests, a self-assessment questionnaire on risk-behaviors/symptoms was published in newspapers and distributed in villages. Popular leaders were got tested to inspire common people.

To treat those tested positive, capacity building of doctors was undertaken. These HIV+ve-people friendly doctors were formed into “Bold Doctors clubs”. More Care centers started. ART centers were increased from 3 to 24.

**Impact:**

15,32,952 tests were done in 12 months against 13,31,952 in SIX years from 2000.

Patients on ART increased from 5280, in October, 2006 to 25,021 in December, 2007.

Condom usage increased, new infections declined, HIV-TB cross referrals increased. “0/7-initiative” under the campaign led to significant increase in identification and institutional delivery of +ve pregnant mothers; nevirapine administration to them and their babies. The get-together on 7th December, 2007 saw 8000 PLHAs boldly converging at Hyderabad “to increase their life span”.

**Lessons-Learnt:**

HIV tests and access to health services help in reducing Stigma. Stigma- reduction curtails spread of HIV.
Example of the same abstract after it has been mentored:

Abstract

**Under Option II, Category C-54 Prevention program for general population**

“Be Bold Campaign” reduces stigma and increases tests and service uptake

**Background:**
Anchura-Pradesh (AP) state, India has HIV prevalence of 1.4%. Despite high awareness, prevalence was rising. The AP State AIDS Control Society (APSACS) launched the “Be-Bold” Campaign, launched on December 1, 2006 to translate awareness into action/behavioral change, reduce stigma, improve health service uptake by infected people, and mainstream fight against HIV/AIDS by making it a people’s movement.

Be Bold was the message; HIV tests the medium. More tests identified more HIV+; got them early treatment and prevented inadvertent spreading by them; normalized the tests, thereby reducing stigma; gave better estimate of disease load for planning and resource allocation.

**Issue/Methods:**
To improve access, HIV-testing centers were increased from 286 to 671. Required staff were recruited, trained and positioned (where?) with HIV test kits. To pre-screen people taking tests, a self-assessment questionnaire on risk-behaviors/symptoms was published in newspapers and distributed in villages. Popular leaders got tested to inspire common people. To treat those testing positive, capacity building of doctors was undertaken. These HIV+—people friendly doctors were formed into “Bold Doctors clubs”. More Care centers started. ART centers were increased from 3 to 24.

**Impact:**
15,31,952 tests were done in 12 months in 2006 compared to 13,31,952 in six years between 2000-2006. Patients on ART increased from 5280 in October 2006 to 25,021 in December 2007. Condom usage increased, new infections declined, HIV-1B cross referrals increased. “07-initiative” under the campaign led to the significant increase in identification and institutional delivery of HIV+ pregnant women, and to the receipt of perinatal nevirapine. The get-together on December 7, 2007 saw 8000 PLHAs boldly converge at Hyderabad to increase their life span.

**Lessons Learned:**
HIV tests and access to health services help in reducing stigma. Stigma—reduction curtails spread of HIV.
Steps for submitting an abstract to the Abstract Mentor Programme:

1. Go to http://www.ias2009.org/profile. Select the link that says ‘Click here to sign in to the Profile.’

2. Sign in if you have a profile from a previous conference. If not, create a new profile by entering your e-mail address.
3. Fill out the rest of your details in the following form and submit.

4. Before you submit your draft abstract we encourage you to use the self-help tools to improve it as much as you can on your own. These can be accessed by following the link http://www.ias2009.org/mentor or by clicking on the self-help tools link on the overview page of the profile.
5. On the overview page, select the link that says ‘Click here to have a mentor review your draft abstract’.

6. Choose the track and category that best applies to your abstract and type your text into the appropriate spaces. To submit, click on the ‘send to mentor’ button.
7. Once you have submitted the form a thank you screen will come up.
8. You will also receive an e-mail confirming your submission.

9. Within a few weeks you will receive an answer e-mail with a mentor’s feedback.
The four tracks for IAS 2009 abstract submission:

**Track A: Basic Sciences**
- Basic Retrovirology
- Immunology of HIV Infection
- Pathogenesis (HIV and SIV)
- Intracellular Restriction of HIV and SIV Replication
- Viral Diversity and Bioinformatics
- AIDS Vaccines (Basic and animal studies)
- Drug Development
- Mechanisms of HIV Transmission and Impact of Co-infection

**Track B: Clinical Sciences**
- Course of Infection and Disease
- Field Based Trials of Diagnosis and Monitoring Tools
- HIV-Associated Diseases
- Antiretroviral Therapies (strategic categories apply to resource rich and constrained settings)
- Children and Adolescents-specific Issues
- Complications of Therapy and Adherence
- Other Therapies

**Track C: Biomedical Prevention**
- Prevention of Mother-to-Child Transmission
- Microbicide Research
- Preventive Vaccine Clinical Trials
- ART for Prevention
- Other Biomedical Prevention Interventions
- Cross-Cutting Issues in Biomedical Prevention

**Track D: Operations Research**
- Intervention Studies
- Human Resources, Infrastructure and Health Care Strengthening
- Economic Evaluations and Financing
- Impact and Integration of Programmes
- Strengthening the Implementation and Use of Operational Research
Activity 3: Match the abstract to the track. Please assign each abstract an appropriate track from the conference's four tracks

1. Track: ________________________________

Prevalence of HIV and risky behaviors among injecting drug users of a prison in Tehran

Objectives: The objectives of the study were to determine the prevalence of HIV and risky behaviors among injecting drug users (IDUs) of a prison in Tehran.

Methods: This cross-sectional survey is the first phase of a cohort study to determine HIV incidence in IDU prisoners. Two groups of IDUs were included: 369 who had newly entered the prison and 371 others who had been staying in the prison for at least one week. Prisoners with evidence of drug injection were recruited to the study if they signed the written informed consent. After a counseling, they were interviewed and they submitted two blood samples for HIV Ab (ELISA and Western blot).

Results: Among 369 new entrants, 81 (22.0%) were HIV positive. Sixty nine (18.7%) of this group didn’t have any imprisonment history; 4 (6%) of whom were HIV positive. About one fifth of this group shared injection equipment in the last drug injection, one third of them had ever injected inside prison and 6% of the subjects started to inject inside the prison. In the group of 371 past residents of the prison; 89 (24.0%) were HIV positive. About 43% shared their injection equipment in the last drug injection, above half of the subjects had ever injected inside prison and 21% of them started to inject inside the prison. Logistic regression analysis showed that younger age at first drug injection, lower education level, duration of drug injection, duration of imprisonment, frequent sharing of injection equipment, drug injection inside prison and tattooing outside prison were associated with HIV infection.

Conclusions: We observed a high prevalence of HIV and risky behaviors among IDUs in the studied prison. This emphasizes the necessity of sustainable harm reduction programs. To protect general population from this epidemic, special programs should be targeted to the sexual partners of this high risk group.

Abstract taken from IAS 2007 and can be found at: http://www.iasociety.org/Default.aspx?pageId=11&abstractId=200704241
Regulatory T cells in infant macaques suppress anti-SIV responses among CD4+ T cells

**Objectives:** The impact of regulatory T cells (T-regs) on the course of HIV and SIV disease remains unclear. We found that infant macaque blood and tissue samples contain more regulatory T cells than adult samples and that these infant T-regs exhibit greater in vitro suppressive activity. We tested the impact of regulatory T cells on antiviral T cell responses by using infant and adult macaques as models of infected patients with high and low regulatory T cell numbers, respectively.

**Methods:** We followed immune responses and the course of SIV disease in infant macaques, containing an average of 10% T-regs among CD4+ cells, and adult macaques, containing on average only 4% T-regs. SIV-specific T cell responses were tested in the presence and absence of CD25+ T-regs. By comparing anti-SIV immune responses among infants, harboring many T-regs, and adults, harboring few T-regs, we sought to understand the importance of regulatory T cell numbers for anti-SIV responses.

**Results:** Infant macaques mounted only transient CD8+ T cell responses to SIV during the first two weeks of infection, while adult macaques maintained CD8+ T cell responses throughout infection. Depletion assays showed, however, that infant SIV-specific CD8+ T cells were not directly inhibited by T-regs. Infant SIV-specific CD4+ T cells expressing IL-2 and IFN-gamma, however, were directly inhibited by T-regs throughout infection and were detectable only after depletion of CD25+ cells. SIV-specific CD4+ T cells were consistently detected in adults, whether in the presence or absence of T-regs.

**Conclusions:** The presence of larger numbers of regulatory T cells among infant macaques is associated with active suppression of CD4+ T cells throughout infection and early failure of SIV-specific CD8+ T cell responses. Our findings implicate T-regs as potentially important direct antagonists of multifunctional CD4+ T cell responses and indirect antagonists of antiviral CD8+ T cell responses.

Abstract taken from IAS 2007 and can be found at: http://www.iasociety.org/Default.aspx?pageId=11&abstractId=200705188
Validating clinical and immunological definitions of antiretroviral treatment failure in Malawi

Objectives: Malawi has scaled up a large national ART program using first line therapy (D4T/3TC/NVP). Patients who have been adherent on treatment for at least 6 months and present with a new WHO stage 4 condition (clinical failure) or a > 30% decline from peak CD4 count (immunological failure) are described as having failed ART in the Malawi National ART guidelines. Second line treatment (AZT/3TC/tenofovir/lopinavir/ritonavir) is limited to the Lighthouse Clinic in Lilongwe and the Queen Elizabeth Central Hospital ART Clinic in Blantyre. We evaluated the current national definition of treatment failure in Malawi.

Methods: Patients meeting the Malawi national ART definition for treatment failure from December 2005 to January 2007 were evaluated. Blood was drawn for HIVRNA. Treatment failure was confirmed if HIV-RNA was > 400 copies/ml.

Results: 129 patients were identified as failures (93% Immunological, 7% Clinical) by the national definition. Mean age was 40 years, 52% were female, mean CD4 was 181 cells/ml and mean duration on therapy was 27 months. Seventy-one patients (55%) were confirmed to have virological failure (Clinical 57% and Immunological 48%). Confirmed virological failures were on ART longer (31 months vs. 23 months, p=0.0064) and had lower CD4 counts (111 cells vs. 249 cells, p<0.0001). On multivariate analysis, confirmed failure was associated with ART >3 years (OR= 5.84 [1.75-19.5]) and CD4 <200 cells/ml (OR 7.78 [2.49-24.2]). Active Tuberculosis and chemotherapy for Kaposi’s Sarcoma were identified as reasons for CD4 decline with HIVRNA<400 copies and misclassification of immunological failure.

Conclusions: Both immunological and clinical failure definitions misidentify patients as failures in approximately 50% of cases. Although ART failure definitions may be improved by including the duration of ART and the absolute CD4 count at the time of suspected failure, directed confirmatory HIVRNA testing can prevent misclassification of failure in resource poor settings.

Abstract taken from IAS 2007 and can be found at: