

International AIDS Society – Industry Liaison Forum
HELPING DEFINE A RESEARCH AGENDA FOR WOMEN IN
EASTERN EUROPE & CENTRAL ASIA

2nd Eastern European and Central Asian AIDS Conference
Moscow, Russian Federation

5 May 2008

MEETING REPORT

Executive Summary

The ILF session at the 2nd Eastern European and Central Asian AIDS Conference was the beginning of a new phase for the ILF - the inauguration of regional ILF meetings that focus more on the front lines of resource limited countries in order to learn about the regional necessities first hand as well as extend global knowledge gained to those interested in working on access, prevention, treatment and care.

In Moscow, the meeting objectives were to:

- Give an update on HIV epidemiology in the region.
- Break down the data by sex and specific subpopulations where possible.
- Begin to develop priorities for research, building on industry investment for areas for future study that inform HIV treatment for women.
- Highlight current and future clinical research relating to women in the region, defining appropriate study goals.
- Offer directions for the future.

Because so little research has been done up to this point in Eastern Europe and Central Asia, ILF hopes to take this opportunity to launch the development and support of an investigator-led research agenda supported by industry. The first step in achieving this is the announcement of a Regional Reference Group that, by using the information shared at the ILF satellite as well as at EECAAC as a whole, will be able to prioritise research priorities as well as outline the barriers. ILF made inroads into the regional pharmaceutical representatives, non-governmental organizations from many countries, and got a good attendance by researchers to the event.

Eastern Europe / Central Asia conclusions:

- Public HIV education programs (i.e., transmission and prevention) are limited. A large percentage of HIV+ women are between 20 and 29 years. Education programs for all populations in particular in young women as well as girls in higher education are urgently needed.
- Barriers to prevention, diagnosis, treatment and care need to be identified and dismantled, for example STI clinic availability. Some of these barriers can be lowered through operational research (service hours, etc).
- Regionally, approximately 10% of HIV+ people are on treatment. There is an urgent need to scale up the access to treatment to the whole affected population.

- The power balance in society is not equal. Examples like adultery, partner violence, limited access of women to condoms (male or female), need to be highlighted, understood, and addressed by society in order to make prevention programmes function better.
- Many women, whether commercial sex workers, intravenous drug users or partners of said, are marginalized. They need to be included in outreach and education efforts.
- There is very little organized network research happening now. ILF will aim for better networking with its current membership as well as getting newly-interested investigators and other stakeholders involved from EE / CA.
- Epidemiology is quite advanced in Eastern Europe and Central Asia. ILF can use its experience to make the epidemiological work in the region even more flawless, by fomenting a better understanding of women and why they are involved in the epidemic, whether it be as partners of primary infected people, or due to their being IDUs or commercial sex workers. A better understanding of who is being counted is urgently needed, including drug use and gender.
- The quality and accessibility of Voluntary Counseling and Testing (VCT) is very good. All nations in the region need to subscribe to universal testing, and offer prevention and treatment programs to all women at antenatal centers.
- Pregnant women are not offered a complete health program. Pregnant women need to be offered a total clinical program (regular CD4 testing and HAART where appropriate, including adherence measures) during pregnancy to take care of their own health as well as that of their infants. Prevention and reproductive health need to be available for pregnant women at risk, including peer counseling, evaluation programs and removal of barriers that prevent women from using Antenatal Clinics (ANC) are needed.
- Penal care support is limited. Drastically needed are prevention, care and treatment for prisoners and post-incarceration follow up.

Evidence shows the efficacy of substitution therapy, including for pregnant women. Substitution therapy needs to be recognized and implemented everywhere, including peer counseling and removal of all barriers.

Pedro Cahn – What is ILF?

Pedro Cahn opened the meeting with an introduction to the Industry Liaison Forum.

He spoke about the mission of the Industry Liaison Forum (ILF), which is to accelerate scientifically promising, ethical HIV research in resource-limited countries with a particular focus on the role and responsibilities of industry as sponsors and supporters of research. He mentioned ILF's place within IAS' Strategic Framework, the planning document for 2005 - 2009. The ILF is composed of Pharmaceutical Industry representatives, NGOs, investigators, members of academia, research institutions, policy makers and funders, all working toward helping make each other stronger through working on research together.

He mentioned two previous themes of the ILF as examples of how ILF has worked: post-trial access to medications and Pre-Exposure Prophylaxis. The ILF's basic commitments are to create opportunities for researchers to coordinate with partners to advance HIV research in resource-constrained settings and to build consensus for best practices models as well as guidance for safeguarding the rights of research participants including getting local communities involved in trial design and conduct. Research and human rights are important aspects of ILF that help guide us. The commitment is to expand the membership base and to involve more researchers and community from these areas, with the contribution of independent organisations like UNAIDS, regulatory authorities and various philanthropic organizations.

Why women in 2008? Women are biologically and socially more vulnerable and they continue to be among the fastest growing HIV populations, often reported simply as 'heterosexual' (i.e., underreported). Women are underrepresented in clinical trials; one rarely sees more than 20 - 25% women in clinical trials. Yet drugs tested in men are approved for use of women as well, sometimes with inadequate evidence.

Cahn reminded the audience to contact ILF if anyone is interested in finding out more about ILF, and its current work, or getting involved at a regional level in ILF. He emphasized the goal of setting up a Regional Reference Group of researchers, community and pharma as an EE / CA branch of ILF.

Women and HIV in Eastern Europe and Central Asia, a regional overview of recent Trends and Challenges By Anja Nitzsche-Bell

Data accuracy and reliability in the region

In Eastern Europe and Central Asia, there is only scant information on gender in national and regional reports, which makes it difficult to measure trends accurately. Factors that heighten the risk (of transmission, progression, etc, for different subpopulations) remain hidden and progress in adopting safer behaviours and reduced vulnerability is hard to verify. Women and girls are often more vulnerable. Most reports are not able to break down the data by sex. In many instances, the quality and reliability of the data is quite poor, due to small sample sizes and selection biases. Most surveys are on clients who access services and data is extrapolated from that; when those services are not 'normalised' (how do people access services?) it is hard to confidently extrapolate to the larger population. Even less information is available on societal barriers in order to put it all into context (Who is being served? Who is not being served? What are the barriers?). In official national policy reports, gender is rarely mentioned; it is hard to institute effective targeted programs when national policy reports are so bare.

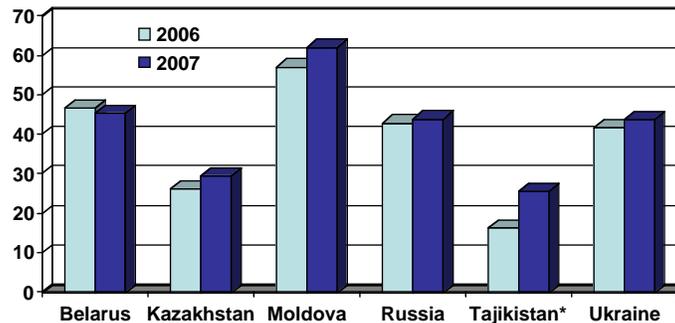
Recent epidemiological data

The HIV epidemic is expanding in Eastern Europe and Central Asia. There were approximately 150,000 new cases in the region in 2007. Russia and Ukraine officially have nearly 90% of the new cases reported in this region. Ukraine's prevalence is the highest at 1.6%. In Russia, the huge outbreaks in drug users in the '90s are seen less these days, and the epidemic seems to be expanding at a slower rate. Cases are on the rise in Azerbaijan, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Tajikistan and Uzbekistan. These countries have their prevalence concentrated in IDUs, sex workers and their sexual partners, and less so in MSM, although the low prevalence reported in the latter group may be related to our limited knowledge about them, and may be underreported.

Generally, countries are reporting varying levels of HIV prevalence among most-at-risk populations, including in MSM where it is measured and reported.

Nearly 62% of reported cases with established transmission routes are linked to intravenous drug use while 37% is reportedly due to unprotected heterosexual sex, which is continuing to rise, and varies from 34% (Russia) to 66% (Belarus) of newly reported cases in 2007. As heterosexual transmission increases, this directly reflects on the number of women detected – 40% regionally in 2007, thus the 'feminisation' of the epidemic. The number of women affected is increasing in all countries, passing the 40% mark in countries with more mature epidemics, getting closer and closer to 50% (see slide).

Percentage of women among newly registered HIV cases (UNGASS 2008)



Nitzsche-Bell commented on the terms 'generalisation' and 'feminisation', both frequently heard when discussing recent trends of the epidemic in the region. While there is a clear increase in sexual transmission, there are a lot of potential fallacies in the reported data, as mentioned earlier. Policy changes on testing IDUs have changed, so less IDUs are being tested than in the past. Women are potentially a higher percentage of IDUs than previously thought, and the overall quality of reporting of transmission routes remains poor. As testing of pregnant women is almost universal in the region, there is a clear detection bias towards HIV infection in women. Official statistics are probably a result of a combination of all of these reasons, and the official descriptive categories do not give a clear indication of the overlap of categories. A recent study conducted in Russia shows that out of those

pregnant HIV-positive women newly reported in 2006 and listed as having been infected via 'unprotected heterosexual contact', 35% had a drug using history and another 50% were partners of a current or former drug user. Therefore, we need to be cautious when describing the epidemic in the region as potentially 'feminised' and/or 'generalised'.

Access to knowledge, prevention and treatment services between men and women is similar, but in some countries, HIV misconceptions (transmission routes, etc) reach 75%. Condom use is reported about the same between men and women, and remains relatively low, although varying by country.

We lack public knowledge on drug use and gender. Substance abuse in women is estimated to be between 20% and 40% in the region. Young men and women begin drug use early and at the same rates. Women are engaged in sex work in order to buy drugs, thus their prevention needs are broader. Men use needle exchange services more than women do, and at those services women are at the end of the line. When needles are shared, women often use the needle last.

VCT programmes & results

Women are being tested more during pregnancy. In 2005, 75% of pregnant women in 7 countries were counseled on PMTCT and received an HIV test, up from 66% in 2004. Many countries have introduced national protocols and policies. Access to VCT is highest in the hardest hit countries.

Women test more than men, probably related to testing availability in ANC programmes in Moldova, the Russian Federation and Ukraine. There is a consistently high PMTCT coverage in the region, approaching 90%.

Women represent a reasonable percentage of everyone on antiretroviral treatment (HAART) throughout the region, reflecting the infection rates, although the actual numbers of people on treatment are small.

Urgent actions on gender equity that need to be taken

- Collect and regularly report gender-specific data on access to prevention, treatment and care
- Complement this with operational research to enhance an understanding of why certain interventions may be failing
- Better determine the identity of high risk groups and prioritise prevention services (commonly overlooked risk groups where gender plays a role: partners of risk group members, i.e., IDUs, prisoners, MSM, migrants)
- Scale-up and improve quality and accessibility of VCT, prevention and treatment programs
- Increase efforts to reach marginalized women

Research priorities

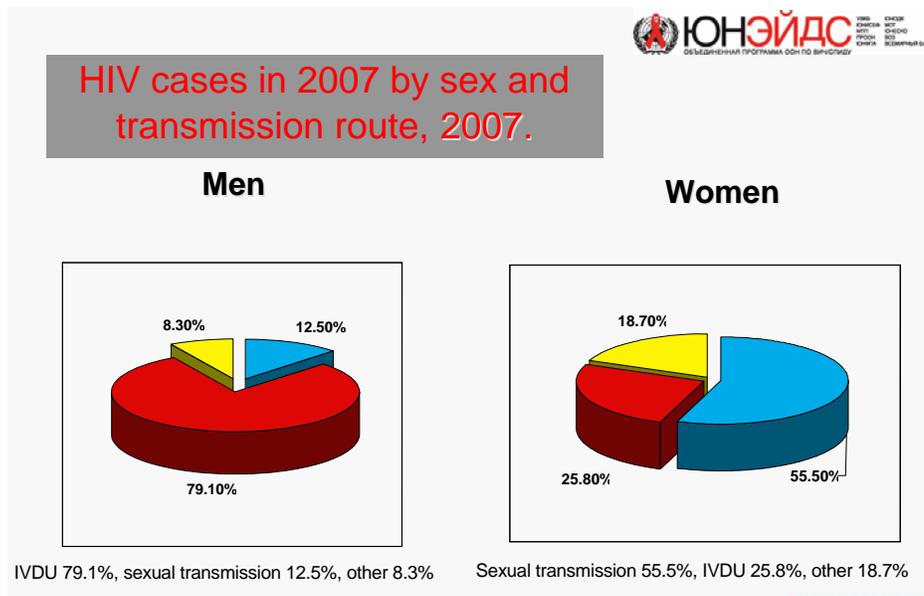
- Vaccine development is important in Russia, it should meet international standards and get more involved with international partners
- Microbicides and other prevention technologies
- Diagnostic technologies
- Therapy (coverage, affordability, safety and efficacy in women vs the general

population)

- Quality of care and treatment for women and their children
- Drug resistance – especially related to MDR and XDR TB
- PrEP and PEP, i.e., for victims of sexual assault
- TB/HIV co-infection
- HBV, HCV co-infection with HIV
- Sperm-washing – more and more women with HIV positive partners are deciding to get pregnant
- Male circumcision and HIV prevention and its impact on women

The HIV epidemic and women in Central Asia By Irina Savtchenko

Irina Savtchenko used Kazakhstan as an example for Central Asia that includes Kyrgyzstan, Uzbekistan, Turkmenistan and Kazakhstan. UNAIDS conducts no research, therefore reports from the Kazakhstan Republic AIDS Centre, along with public polls and sociological surveys were used for the presentation. In new cases year on year, AIDS started to accelerate in 2004, reaching 1979 cases of HIV in 2007. Prevalence data based on sentinel gathering is highest among IDUs at 3.9%. The second highest risk group is sex workers where prevalence reaches 2.3%. This group is followed by MSM, prisoners, patients at STI clinics, and pregnant women. The total, by national estimates, is that 13,500 – 15,000 people are living with HIV in Kazakhstan.



Comparing 2007 to 2006, we see a growing number of new cases in pregnant women; 152 HIV-positive children were born in 2007. In 2007, approximately 29% of the HIV-positive population were women. As far as transmission routes, 79% of men acquire HIV through drug use and 12.5% contract it via heterosexual intercourse. In women, it is 55% heterosexual transmission and 25% due to drug use (see slide). Data on HIV, HCV and syphilis in female sex workers certify high risk

behaviour and huge potential for HIV to spread. Some estimates put the sex worker population at 20,000 total, with a reported prevalence of 2.3%. In those who do not inject drugs, 26% have syphilis, 17.3% HCV. In sex workers who use drugs, the HIV rate is 5.6%, syphilis 67.5%, hepatitis C 35%. Of sex workers, 58% know about HIV infection (transmission routes, etc). Untreated gynaecological problems and STIs make this group very vulnerable for HIV infection.

The national HIV program in Kazakhstan for 2006 – 2010 emphasizes the prevention of vertical transmission, and it provides some measures to make counseling and testing more accessible. It also includes methods to prevent opportunistic infections, i.e., prophylaxis, as well as care to newborns.

There is clearly a higher vulnerability of women to HIV infection. Adultery by the husband is not rejected in society. Violence to women is common. Condoms can generally be initiated only by men. Women do not always have access to well-paid work.

In conclusion, the number of women living with HIV is increasing; HIV-positive women constitute roughly one third of the total HIV-positive population and the number is on the rise. More than half of women are infected through heterosexual route; the second most common route of transmission is through injecting drugs. Infected children need more attention; PMTCT is guaranteed on paper but that is not sufficient, as access to PMTCT is 60%. Sex worker access to gynaecological and STI treatment is insufficient.

Access to VCT and PMTCT in Eastern Europe / Central Asia By Ruslan Malyuta

Malyuta started with the epidemiologic trends of women in Europe. In Eastern Europe, you can see a virtual explosion of transmission in comparison to Western and Central Europe: the number of HIV infections reached nearly 25,000 cases in 2006. The majority of HIV infected women in Eastern Europe are seen in Ukraine, slightly less in the Russian Federation.

The Dublin Declaration of 2004 set as a goal the virtual elimination of HIV in newborns through mother-to-child transmission by 2010, defined as getting the mother-to-child transmission down to 2%. The key intervention is to ensure free and universal access of pregnant women for HIV testing during the antenatal period.

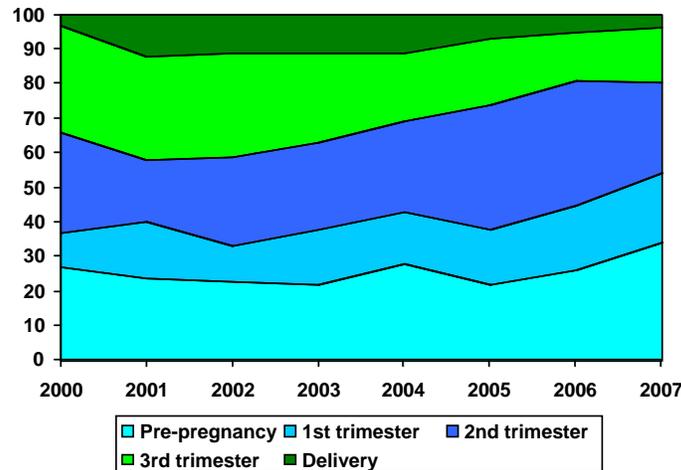
National policies on HIV testing during pregnancy vary - many countries pursue a universal testing approach (opt-in or opt-out), although the reality is that de facto mandatory testing is still in use. The overall coverage with HIV testing in the region among pregnant women is above 70%, while the most affected countries like Russia have reached up to 90% coverage.

There are gaps in monitoring PMTCT programs in the region. Very few research studies focus on prevention of mother-to-child transmission despite the fact that they could potentially provide valuable evidence and a better understanding on how to design, manage and deliver a comprehensive response to prevent new HIV cases among infants.

As one example, Malyuta looked at Ukraine. A large cohort study as part of the continent-wide European Collaborative Study has been implemented here since 2000 and enrolled more than 3,500 HIV positive pregnant women and their children. The data collected in this cohort study combined with national data sources provide an opportunity to extrapolate to the entire population of HIV-positive women in the Ukraine. National data shows, for example, that before the year 2000 there was a

low percentage of coverage of HIV testing for pregnant women (less than 50%), yet by 2005 full coverage was reached. Data from that cohort study indicates that half of HIV-positive pregnant women were infected via IDU directly or indirectly (as a sexual partner of an IDU). At the same time, 49% of women didn't report any risk factor that led to their HIV infection (see slide).

Trends in timing of diagnosis, 2000-2007



Source: European Collaborative Study, 2007

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Along with prevention measures, it is important that HIV infections are detected as early as possible, to find out whether seroconversion happens before pregnancy or during. Late diagnoses have gone down over time, from 35% to 25% in the 3rd trimester or at/after delivery. IDUs are more likely to be diagnosed late. Women are getting longer-term prophylaxis (one week prior to birth) with AZT; shorter-term prophylaxis (at birth) has gone down – thus, prophylaxis is evolving. The women themselves are being treated, not only the newborns, so their own health as well as their infants health can be better preserved.

Services need to be continued and expanded. CD4 tests in HIV positive pregnant women are monitored more than once, from as low as 5% in some rural clinical sites in Ukraine to more than 80% in Kiev. There are fewer than five medical centers that can provide monitoring of CD4 cell counts in most countries of Eastern Europe. In Ukraine with 3,500 HIV+ women giving birth annually, only seven centers can provide CD4 cell count monitoring. In contrast, in Turkey, with only five HIV transmission occurred during delivery in 2007, where the number of CD4 monitoring-equipped centers is 25, reflecting disparities within countries in the region.

In closing, Malyuta believes that the goals of the Dublin Agreement are attainable. But important work needs to be continued:

- A revision of testing policies is needed. All countries need to move toward universal testing and exclude mandatory testing.
- The quality of PMTCT interventions needs to be improved - prophylaxis needs to

be reinforced during pregnancy within a total health program for mother and child, regardless of the health status, which has shown to be the most promising and efficacious program, that also includes a complete health program with regular evaluation of CD4s for the pregnant women, and adherence programs.

- Hard to reach women (IDUs, etc) need to be able to fit in - substitution therapy for pregnant IDUs is Standard of Care in many countries.
- Peer counseling and evaluation and removal of barriers that prevent women from using antenatal centers need to be instituted.

Eastern Europe needs to follow the example set by the rest of Europe, as well as the recommendations of UN.

A focus on Ukraine; Epidemiology, access and challenges

By Alla Shcherbinskaya

The first cases of HIV/AIDS were detected in Ukraine 20 years ago, and HIV prevalence today is at 178 per 100,000 persons. That means that 122,674 people have contracted HIV since the beginning of epidemic, and of those 22,000 have been diagnosed with AIDS. There have been about 12,000 AIDS related deaths. There were 17,687 new cases of HIV in 2007, 1,500 more than in 2006. The rate of newly diagnosed HIV/AIDS cases is 38 per 100,000. There were 3,430 newborns born to HIV-positive mothers. There were 2,500 deaths of AIDS, including 23 children in 2007. The annual number of AIDS cases and AIDS deaths is increasing rapidly in Ukraine since 2000.

In 2004, Ukraine started administering antiretroviral drugs. By the end of 2007 we have reached the level of 7,657 patients on antiretroviral treatment including 905 children under 15 years old.

The highest HIV prevalence is observed in the Central Ukraine. The epidemic is slowly moving from the south-east regions to the north-west part of the country.

The proportion of women in a total number of annually registered HIV/AIDS cases is increasing year by year. In 2007, 43.8% of all new cases were women. The most vulnerable age group is 20-29. More than 20% of HIV infected women are IDUs, and a substantial part of the women are sexual partners of injecting drug users.

Deaths are considerable among women. Estimates of potential deaths by 2014 among men range from 112,000 – 165,000 and among women from 98,500 - 134,000.

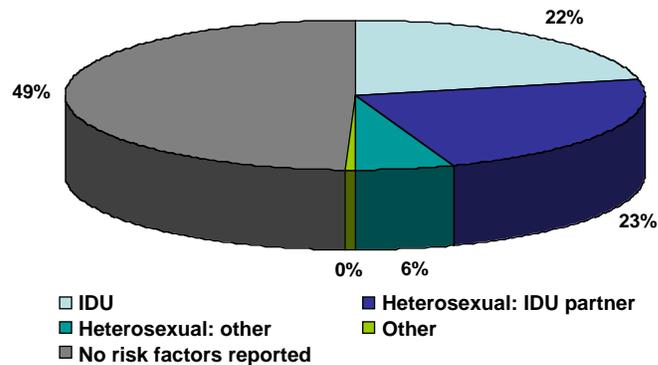
The modes of HIV transmission among women is also changing. In 1996 unsafe drug injection dominated and over time, starting in 1998 - 1999, an increasing proportion of women have contracted HIV through sex, with a proportional reduction in IVDU transmission. There is still a small proportion of women (less than 5%) who do not indicate the cause of the infection. At the same time almost 50% of HIV infected women were unable to determine risk factors that led to acquisition of HIV (see table below).

In 2007 4,330 HIV-positive pregnant women were registered in Ukraine. Pre- and post-test counseling is provided at all health clinics. 92% of pregnant women were tested for HIV in 2007. The HIV transmission rate from HIV-positive mothers to their children was 7% in 2006. Following the Global Fund guidelines, all mothers have access to milk formula (to avoid HIV transmission via breastfeeding).

Prophylaxis treatment starting at week 28 was given to 91% of the HIV+ women. The 9% of women who did not take prophylaxis at week 28 were active IDUs without

a prior medical observation at the antenatal clinic or at home and they only found out about their HIV status after delivery. They are marginalized and we need to make better inroads to getting to these women and preserving their health, along with that of their babies.

Maternal mode of acquisition of HIV in Ukraine, 2000-2007



Source: European Collaborative Study, 2007

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Pregnant women are the healthiest layer of society. The social support system is working for pregnant women. Over the last 4 years, the HIV rate in pregnant women has stabilized at 0.33-0.34%.

Access to ARV treatment is equal for men and women. In Ukraine 7,657 people are on HAART and 46% of those are women, about 3,500 of the total.

The social support system is also functioning in the penal care system. These programs are similar in terms of getting access to everyone who needs it.

We are working on development of two new national programmes: insuring access to HIV diagnosis and treatment and HIV prevention and strengthening reproductive health among women, a program that insures the health of women and mothers.

Access to VCT and HIV medical care is a challenge in rural and district areas where residents have to go to the regional capitals. Home care is available in rural settings but on a limited scale. Social care is also a challenge in rural areas, although there are some NGOs involved in these activities.

The new 2009 - 2013 national program anticipates implementation of HIV prevention treatment for all pregnant women with availability of triple-therapy regimens.

The final thing to be mentioned is the shortage of education programs for young girls as well as girls in high education schools.

**Roundtable with representatives of industry and civil society
Moderated by Pedro Cahn and Shirin Heidari**

While everyone on the panel expressed a desire to work on the issues outlined in all of the presentations and to better represent women wherever possible, there is not much going on at the present time in terms of research projects or clinical trials in Eastern Europe and Central Asia. Women's needs are currently not addressed (by industry nor other research entities) in research projects or programmes within the region. Clinical trials, drug development, treatment programmes and regulatory issues urgently need development.

The key challenges and gaps in these projects are outlined above, but the industry and the community did express great commitment to address the challenges. A desire for partnerships was expressed between industry and community along with independent investigators and governments and external funders to address clinical research questions, including design and endpoints that can also best inform the treatment of women living with HIV in Eastern Europe and Central Asia.

Jennifer Watt, director of international access operations for Gilead, mentioned that Gilead does not have offices or operations in Eastern Europe and Central Asia. Their top priority in the region is access to TDF-based products and they are collaborating with local partners to make their products available more quickly. They have filed for registration in 11 countries in the region. They are currently compiling the registration packet for Russia. Access is obviously a concern - when clinical studies are completed there needs to be continuity of care. In Gilead's TDF pivotal study 903, there was a good number of women – 26%. Some of the interesting findings included that women have a slightly higher CD4 response and a lower lipid increase. They are collaborating with Tibotec in the region and support the efforts of EuroSIDA. Tenofovir gel is also playing an important role in prevention studies, having been out-licensed to the International Partnership for Microbicides and Conrad and is in several Phase II/III microbicide studies, focusing primarily on women. In addition, there are various ongoing pre-exposure studies with TDF (Viread) and TDF/FTC (Truvada) that have included women, with two studies focusing on only women. Several studies on prevention of mother-to-child transmission are also ongoing, looking at the role of TDF or TDF/FTC in preventing HIV transmission from mother to child.

Regarding treatment access and the challenges to conducting clinical research, Watt reminded us that the local governments' demands limit quick implementation, i.e., where foreign language packaging is restricted, and if a product is approved by Food and Drug Administration (FDA) it is not always sufficient, and approval by each country's regulatory authorities is required in most East European and Central Asian countries.

Sergei Smirnov from Boehringer Ingelheim added that vertical transmission programmes need to be not just composed of one drug or programme but a combination (NVP + CBV or NVP + TVD, etc), and triple therapy should be available for the mothers and the infants as needed, and that over the short term, efforts in this area need to be coordinated. Companies need to work together – one company cannot do it all.

As far as getting women into trials, Maarit Kokki representing Tibotec added that that is one of the issues Tibotec is trying to address. Tibotec does not know enough of the epidemic and the patients in the region to gain access to those patients. Partnerships and collaboration at all levels are urgently needed, among the industry and also with governments and investigative networks. Programmes should be in the hands of

national coordinating boards.

Regarding filling the research gaps for women, Watt reminded us that it has to be a priority for industry to reflect the epidemic and this requires a major collaborative approach with NGOs, and having the patient voice in clinical studies from the beginning is paramount to better reflect real life needs, including women and other specific populations. Smirnov concurred, saying that BI has large education programmes in the region and they want to work closer with NGOs.

Closing remarks

By Pedro Cahn

Closing the meeting, Pedro Cahn remarked that this was a good start on a new process, of opening up, including learning from and giving back to investigation on a regional level. He asked everyone present to please join the ILF regional reference group, and contacting ILF to provide input and feedback to the future activities of ILF.

The next ILF meeting will be organized at the XVII International AIDS Conference (AIDS 2008), to be held in México City, México from 3-8 August 2008.



International AIDS Society – Industry Liaison Forum

**HELPING THE PHARMACEUTICAL INDUSTRY SUPPORT A
RESEARCH AGENDA FOR WOMEN**

Congress Hall 2, World Trade Center, Moscow, Russian Federation
Monday 5 May 2008, 13.00 – 14.30

AGENDA

13.00-13.15	Welcome and Opening remarks Introduction to Industry Liaison Forum	Pedro Cahn, IAS President and ILF Chair
13.15-13.30	Epidemiologic Update on demographics on women in Eastern Europe	Anja Nitzsche-Bell UNAIDS, Moscow
13.30-13.40	Epidemiologic Update and women's access to treatment and main challenges – Examples from Central Asian countries	Irina Savtchenko UNAIDS, Kazakhstan
13.40-13.50	VCT and PMTCT in Eastern Europe / Central Asia	Ruslan Malyuta, UNICEF, Geneva
13.50-14.00	Epidemiologic Update and women's access to treatment and key challenges - Examples from Eastern European countries	Alla M. Shcherbinskaya Director - Ukrainian AIDS Centre
14.00-14.20	Round Table discussion - Research projects and programme activities in the region - key challenges in addressing women <i>Participants: Jenifer Watt, Gilead, Sergei Smirnov, Boehringer Ingelheim, Maarit Kokki, Tibotec, Anna Dovbakh, International AIDS Alliance, Ukraine</i>	Moderated by Konstantine Lezhentsev (Regrets)
14.20-14.30	Concluding remarks	Pedro Cahn