Forum on the 2010 International AIDS Conference
Kaiser Family Foundation
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[START VIDEO RECORDING]

MALE SPEAKER [Julio Montaner]: Today with the start of the 2010 AIDS Conference, we raise our voices louder and demand faster action from our political leaders. We can and we will overcome. Let Vienna be the beginning of a different new era. Thank you.

MALE SPEAKER [Michel Sidibe]: We cannot settle for a world where some people get treatment while others do not. Where some enjoy access to prevention while others are criminalized.

FEMALE SPEAKER [Annie Lennox]: Let us recommit this year, 2010, to doubling and strengthening our efforts of support and making sure that the message reaches the people who need to hear it.

MALE SPEAKER [Kgolema MotLanthe]: I'd argue that now is not the time to disinvest in health.

FEMALE SPEAKER [Quarraisha Abdool Karim]: It is indeed a great honor and privilege on behalf of the Caprisa 0014 with Salim and myself to present the data from the effectiveness and

safety of vaginal microbicide, one-percent Tenofovir gel for the prevention of HIV infection in women.

MALE SPEAKER [Salim Abdool Karim]: Tenofovir gel potentially adds the new approach to HIV prevention as the first that can be used and controlled by women. It can help empower women to take control of their own risk of HIV infection.

FEMALE SPEAKER [Everjoice Win]: It is important that we recognize and address the intersection of violence and HIV. These issues don't exist in silos. Just as loudly as we say violence is a cause of HIV, we must say that HIV is a cause of violence against women and girls.

MALE SPEAKER [Jeffrey Crowley]: So the vision for the national HIV/AIDS strategy is that the Untied States will become a place where new HIV infections are rare and when they do occur, every person will have unfettered access to high-quality life-extending care free from stigma and discrimination.

MALE SPEAKER [Aaron Motsoaledi]: I can stand before you here today to state categorically that in 2010, all of

South Africa is united behind our one goal on HIV prevention and treatment.

PRESIDENT BILL CLINTON: We cannot get to the end of this epidemic without both more money and real changes in the way we spend it.

MALE SPEAKER [Bill Gates]: So if we keep spending our resources in exactly the same way we do today, we'll fall further behind in our ability to treat everyone.

FEMALE SPEAKER [Rachel Arinii]: In order to realize right here right now for young people, we demand that you, you, and you to invest in young people leaderships.

FEMALE SPEAKER [Caitlin Chandler]: We need to break down the barriers between our movements and we need to unite different youth populations in building our response to HIV.

MALE SPEAKER [Elly Katabira]: I can't do it alone but with you, I'm sure we win. Please you are leaders. We are all leaders and we need to take action. Thank you very much.

PRESIDENT BARACK OBAMA: Ending this pandemic won't be easy and it won't happen overnight but thanks to you, we've come a long way. The United States is committed to continuing

that progress. Thank you for your hard work and dedication. I look forward to welcoming all of you to Washington, D.C. in July 2012.

JENNIFER KATES: Good morning everyone. My name is Jen Kates and on behalf of the Kaiser Family Foundation, I want to welcome you here and thank you for joining us. I also want to thank our co-hosts, CSIS, a longstanding partner of the Foundation and in particular, Steve Morrison who is the Director of the Global Health Policy Center at CSIS and Lisa Carty who's the deputy Director. What you just watched is a short collection of clips from the conference based on our web casting and the footage that we helped put together. As an attendee, I can actually say it really captures the feeling and the highlights and you can watch all of those on the Web. I want to take this opportunity to give a big shout out to our web casting team who web casts over, close to 60 sessions plus interviews and then Francis Yang in particular who came back from that experience and put this together very quickly when I asked him to put something together that captured the

conference. So thank you Francis. Thanks to Alicia Carbaugh and Kim Boortz on my team also for helping get this organized.

We're really glad you could come to the forum this morning. The purpose of the forum is to give those of us who were in D.C. and weren't able to go to the conference as well as many of us who did go to the conference but while you're there for anyone who's been, it's hard to take it all in, a chance to reflect on it, take away some big messages, and the challenges and opportunities and look ahead, particularly to D.C. 2012.

We've convened similar forums after each International AIDS Conference over the last several years with CSIS and they've been very helpful in thinking about where we go next. So we've invited a panel of experts to share their insights from Vienna and offer a look ahead to 2012 when the next International AIDS Conference will be here in D.C. I actually remember several years ago sitting in this room and saying it would be great to be able to bring the conference back and so here we are.

I'm going to briefly introduce the panelists and then we'll get started. First thank you very much. We're very glad to have Deborah von Zinkernagel, the principal Deputy Global AIDS Coordinator from the Office of the U.S. Global AIDS Coordinator, be with us to share the perspectives from OGAC and PEPFAR.

Next we have Jeff Crowley, the Director of the White House Office of National AIDS Policy and Senior Advisory on Disability Policy. We have Dr. Chris Beyrer who's Professor at Johns Hopkins Bloomberg School of Public Health and also on the International AIDS Society governing council and finally, Phil Wilson, the President and CEO of the Black AIDS Institute.

Before we turn to the panel for their comments, I'm going to provide a few framing thoughts and then we'll hear from Lisa Carty from CSIS, who will do the same. We'll go to the panel, hear from them, have some Q&A with you and then finally, Steve Morrison will provide some summary comments.

So in stepping back from Vienna, which was the 18th International AIDS Conference, I think it's important to put it in context particularly where it falls in time relative to the

last International AIDS Conference in Mexico City. Often in a two-year period, not that much changes but actually in this two-year period, a lot has changed.

At the time of Mexico City two years ago, this is before the world had sort of come to grips with the global economic crisis, PEPFAR had just been reauthorized a couple of weeks before, there was no national HIV/AIDS strategy, and we were in a different Administration in the United States.

In the two years since Mexico City, various big shifts have occurred. By October of 2008, just a couple months after the conference, there was a recognition of the global economic recession. By November, we had a new Administration in the United States. By May of 2009, we had the Global Health Initiative announced. Shortly, a few months after, the immigration and travel ban was lifted thus allowing the conference to come back. Beyond the U.S. sort of broader focus on global health at large with PEPFAR and AIDS being a part of it, many other donors are doing the same thing, the G8 and EU and in general, sort of taking a broader approach.

Now some would say this is building on the tremendous work successes of AIDS and the response to the global AIDS epidemic and to create a more integrated and sustainable response. Others would say it's moving away from AIDS and that's part of the tension. There's a lot of questions about commitments. Indeed as we might hear, one of the big tensions at this conference was around financing and funding and commitments. Clearly there's a need for more resources. The gap is clear but assessing the fair share, assessing where it needs to come from is a big challenge.

To help provide some background on this, I'm going to show you some new data that we released at the conference very briefly. It's in your packets and there's more of it on our website. It's from a report we do every year with UNAIDS where we go to donors and collect the latest data we can get from them on disbursements. We've been doing this for years and years and years.

For the first time, we found that there was essentially flat funding. So the first moment after the economic crisis, we found flat funding. Whether you look at commitments or

really when you look at disbursements, which is really what you want to focus on because that's the money that is actually going out, flat funding from donor governments.

When we looked beneath this, what we found is that the U.S. actually was one of the main donors that increased its funding both in terms of commitments and disbursements, which helped to offset decreases from several other donors including Canada, France, Germany, Ireland, Italy, and the Netherlands.

If you look at sort of the distribution of those resources in 2009, the U.S. was about 58-percent with the U.K., the next largest. This is the need estimate. This is UNAIDS need estimate of about $24 billion needed to fill the gap for all needs on HIV in low- and middle-income countries. You can see where the gap is, $7.7 billion.

Now one of the things that's always tricky with doing these analyses is how do you assess fair share. We look at it a couple of different ways. I showed you that one slide with 58-percent from the U.S. Another way to look at it is looking at the share of the GDP, the world GDP by each donor. You could see, for example, the U.S. is about 25-percent of the

world GDP and contributes about 27-percent of the resources for AIDS.

Another way to do that is to look at GDP per $1 million to sort of standardize it. So while clearly the U.S. is a much bigger economy, so how do we look at a standardized measure and here the U.S. is not at the top.

So these are really just to illustrate this is not an easy thing to assess. Clearly I think what I felt at the conference was that there's just a lot of worry and tension and it got directed in different places but ultimately the bottom line was that there's more that's needed and where it's going to come from and how and how quickly given the economic crisis and given some of the other pressures was a big topic of conversation.

Now I'm going to ask Lisa Carty to come up and provide some opening remarks as well and then we'll turn to our panel.

LISA CARTY: Good morning everyone and thanks very much Jen. Welcome also to our panelists and on behalf of CSIS. As Jen mentioned, CSIS and the Kaiser Family Foundation have had a longstanding collaboration in global health particularly with

the focus on HIV and we've done a number of these at IAS conference debriefs.

They've been tremendously valuable just speaking on behalf of CSIS and Steve as well, I can't tell you how much we do value our relationship with CSIS, with Kaiser and how much we've benefited from Jen's insights. So we're really very glad to be here this morning and co-hosting this discussion.

Before I turn to my very brief introductory remarks, I did want to tell you all about something that we'll be holding at CSIS tomorrow morning at 9:30. It's the inaugural session of a series of debates we're launching called Fault Lines in Global Health, which will look at some of the critical global health controversies.

Our opening debate tomorrow will be with Princeton Lyman from the Council on Foreign Relations who will argue that the U.S. commitment to universal AIDS treatment is unsustainable. Steve Morrison, from CSIS, and Todd Summers of the One Campaign will serve as respondents. So that's tomorrow morning at 9:30 at CSIS. There'll be a series of other debates

during the fall and they'll be posted on our website that we very much like to have as many of you as possible join us.

So turning to today's topic, Jen you're not the only one that gets to start the discussion with a visual aid, even though many in this audience have attended many IAS conferences. I did want to remind people of the shear magnitude and breadth of these meetings.

So I brought with me this morning a copy of the conference program. Those of you that were in Vienna will probably remember carrying this around. It weighs about a pound. There are 381 pages of scheduled events that conference participants can attend.

The conference abstract documents are about eight or nine inches thick. I don't even want to imagine what that must weigh but that's just all to say that I think we need to be very careful because for as many people as attended the conference and there were about 19,000, there's probably as many different opinions as to what was really important and what really matters as we look ahead.

So as Jen said, what we're trying to do this morning is to really raise the question: what happened in Vienna that's important for the U.S. to think about as it looks to the future of its HIV programs both domestic and international, and how should the U.S. start to think now about how to prepare for the conference in 2012.

So what I'd like to do is share with you this morning my own observations and key questions very briefly because we want to get quickly to our panelists and I only have four observations but they're really intended to help us think about kind of looking forward and what the important issues are to focus on that we're going to need to continue to pay attention to.

So first, speaker after speaker in Vienna talked about the need to recommit to the universal access goals in a way that would increase the effectiveness of prevention and treatment programs. Yet as Jen highlighted in her opening comments, the financial resources required to make that happen are becoming increasingly constricted and the outlook for rapid growth is modest.

So how can this very difficult reality be managed in a way that preserves the energy of the universal access movement, doesn't discourage the high expectations and concrete progress made in many countries but also recognizes that difficult choices need to be made.

These questions were really not fully and constructively explored in Vienna. However, the MDG Summit is fast approaching and it will provide yet another opportunity to articulate how we can continue to move towards universal access even in a resource-constrained environment. So my first question for further discussion is: what lessons from Vienna can we take to the MDG Summit to help ensure a greater unity of effort between progress on HIV goals but also progress on the other Millennium Development Goals?

My second point is directly related to my first. As resources become evermore constrained and by necessity, choices need to be made across interventions and between approaches, there's a real risk that the global leadership on HIV becomes evermore fragmented. It would be a tragedy to return to the old debates of prevention versus treatment or to the rivalries

that pit one organization against the other. It's short sided and counterproductive when the public conversation on HIV devolves into destructive rancor as sometimes happened in Vienna.

We need a new leadership consensus and coordination of effort across the major funders with affected countries and with civil society to help navigate this difficult period. We need to define the common challenges ahead and we need to lay out a constructive shared vision for moving forward. So my second question I'd like us to reflect a bit on is: what role can the U.S. play in forging this new consensus?

Third, this was supposed to be the conference that finally focused on the epidemic in Eastern Europe, the fastest growing epidemic in the world and the epidemic that is most heavily concentrated in high-risk populations. There was strong and compelling representation from civil society yet there was almost no high-level government presence and very little meaningful discussion of how to better reach and serve high-risk groups.

These Eastern European countries, many of which are no longer eligible for or will soon graduate from Global Fund support, are test cases for the challenge of implementing a country-owned approach when the countries in question are themselves in denial of the problem. so my third question: how do we manage that reality both in the Eastern European context but also elsewhere?

Finally by the end of the week in Vienna, I found myself asking, "what would happen if IAS gave a conference and the Americans didn't come?" I mean it's a moot point since the next conference is here but nevertheless it's a little interesting to think about. The answer, I believe, is really quite dismal.

It was striking to me that the lions' share of the financial, political, and scientific leadership in Vienna came from the United States. This is something that we should be very proud of and also something that we need to take great care to preserve but if these conferences are to continue to be successful that imbalance has to be corrected and steps need to

be taken to broaden high-level participation and ensure a civil climate for discussion.

I'd be happy to be corrected but I believe that in Vienna, we only had two African health ministers. There were no sitting African heads of state in attendance. There was very little political leadership from elsewhere around the world including from Europe. Reversing this trend will be a tremendous challenge going into the 2012 conference and one where the U.S. will need to lead aggressively in order to get others back to the table, which brings me to my final question.

What do we need to start doing now to ensure more active participation, leadership, and financial support from others, support and engagement that not is going to be important to the success of the conference in 2012 but also important to the success of everything that needs to happen quite urgently between now and then? So thanks very much and with those thoughts, I'll give the floor back to Jen and to the panel.

JENNIFER KATES: Thanks Lisa. I guess we're ready to hear from you now. We're going to start with Deborah.

DEBORAH VON ZINKERNAGEL: Great. Well thank you very much both to Kaiser Family Foundation, and CSIS for sponsoring this event. It's a pleasure to come and to share some reflections with you today. I think a number of you were at the IAS conference and probably got to more sessions than I was able to.

So there's a breadth of knowledge in the room about some of the studies that were reported on but there, amidst the real clear and compelling evidence of unmet need, there was a lot of positiveness coming out of the conference. I think that that's what we were somewhat heartened and encouraged by although it does highlight how far we have to go yet.

The WHO reported that 5.2 million people were accessing ART and that that was the largest increase in a single year's time. within the PEPFAR program, we have seen increases from 1.7 million to 2.5 in this past year. So roughly about 800,000 new individuals accessing ART. So it speaks to progress. It also speaks to the road that's yet ahead for us.

There was also news put out by UNAIDS on prevention showing some, that in a number of the hardest hit countries and

Sub-Saharan Africa, there were decreases in the 15-to-24-year-old age group, about 25-percent decrease in HIV infections over the last number of years. So how we attribute that, what's the benefit is that the prevention efforts that we're doing. It's hopeful trends. I think we still need to keep looking at the data and to keep intensifying all of our efforts on the prevention front.

I think prevention's a good place to start because that's where some of the most hopeful news came and as you mentioned in your opening, the Caprisa trial was really the highlight of the meeting where with the use of the Tenofovir vaginal gel, there was a decrease over a two-and-a-half year period of 39-percent decrease in new infections, transmissions, sexual transmission.

In a shorter timeframe of a one-year period, there was an even greater in women who were very adherent. There was a 54-percent decrease in new infections. That was extraordinary data and it was encouraging to see that it held up at some level over more than a year's timeframe.

So there's many issues yet to be resolved with that but it's a solid proof of concept. The data was strong also on the Tenofovir gel as a preventive measure for genital herpes, I think about a 51-percent reduction there. So in many ways, it was the standing ovation of the conference. When it was announced, everybody stood up and it was an exciting moment for that.

There was also a lot of attention given to male circumcision as an HIV prevention measure. There are about 55 presentations on that, different models of scaling that up. It clearly is something that people are really anxious to bring to scale in the most positive way. Many countries are moving in that direction. There are some where it's still a difficult issue. I think it is a country by country conversation around what the data shows and how to integrate that into sort of the existing society.

There was also a lot of attention given to the issues of combination prevention. So looking at different combinations of interventions, biomedical, behavioral, structural and trying to say what is the optimal combination

that actually pushes us farther down in terms of reducing infection rates. The call for strong science on that, implementation science, and rigorous study and it's something in the PEPFAR program.

We're really committed to taking a hard look at this both to narrowing down and really defining what are the high-impact interventions and then in what combination are they most appropriate in a tailored setting. So I think in the next year or two in the literature, I think there'll be a lot more emphasis on looking at combination prevention.

The issues about IDU injection drug use as a driver of an epidemic was tremendously important in this meeting. It can't underestimate sort of the compelling nature of the issues that were raised from the Eastern European countries particularly not that that's the only place but also in Southeast Asia. You've heard of the Vienna Declaration, which was a public call on many advocates' position to endorse more effective ways of reducing transmission and consequences of injection drug use.

We were fortunate to be able to, before getting to Vienna to put out the new PEPFAR guidance, which does allow as a combination prevention effort with other measures supporting the needle exchange programs and methadone programs as they're appropriate in the country setting. So we hope that this will be helpful and many of you have helped us to get there. So thank you.

I think the issue of treatment as prevention was also kind of another theme and that bridges into the treatment arena and does indeed once more time showed how these are not very different entities but one is linked with the other. So there was the data that was shown out of a study in Vancouver looking at sort of population-based decreases in HIV prevalence as treatment was scaled up in that area. I think there's a lot more work to be done on this but it's clearly, it's defining the delta but it's with us now.

There was also a discussion of the Treatment 2.0 concept, which is being advanced now. Basically it's simpler, more durable treatments with medications that have a lower resistance potential, need less clinical monitoring, lab

monitoring, looking at improving how we do counseling and testing and linkages to care and better utilization and mobilization of community systems of care.

The whole goal being we are never going to get as far as we need to go unless we're finding better and cheaper ways of sort of delivering the services that are so desperately needed. There is a lot of emphasis also on HIV/TB, which I know is really an important area both in terms of earlier diagnosis more effective integration of services. There was the Camilla study, which came out of Cambodia, which showed that not to delay ART for long after starting TB treatment but to start it early and to increase the effectiveness of sort of the patient outcomes on that.

The last thing I would think is sort of the context of sort of the general global response to global response and we spent a lot of time in the PEPFAR program working with the Global Fund and sort of looking at how it is we are going to go forward as a partner with the Global Fund at the country level and at the broader level to increase both the outputs of both of our programs in terms of effectiveness and efficiencies at

the country level. And it was reiterated in many sessions with Dr. Kazakstein that this was going to be an important new step for us going forward.

There was also recognition by South Africa of the importance of increasing country level investment in HIV. Dr. Motsoaledi cited that South Africa is now about $1 billion a year investing in HIV treatment and care and prevention. So it's an extraordinary effort being mounted there and the call was broad from all corridors that countries do need to, to the extent that they can, step up and sort of take the pieces of this response as possible.

There was a session on country ownership that PEPFAR was pleased to host and we thank the Kaiser Family Foundation for broadcasting that and the second one also on gender, which I think profiled two issues that were particularly wanted to bring focus on as part of the overall response. We had panelists from Botswana and Malawi providing the country level perspective on country ownership and I encourage you to see that if you have an interest in sort of hearing from different voices on this issue. So with that, I will—

JEFFREY CROWLEY: Good morning. My name is Jeff Crowley. I'm with the White House Office of National AIDS Policy and so two days before I left for Vienna, we had an event at the White House with Secretary Sebelius, Melanie Barnes who's the Director of the Domestic Policy Council and President's Domestic Policy Advisor. I should say that my office is part of the domestic policy council. Dr. Howard Koh, the Assistant Secretary for Health at HHS, and I released the national HIV/AIDS strategy for the United States.

This is something that the President committed to during the campaign and is something that as soon as I started the very beginning of his Administration, we've been working on since that time. I think it was an important milestone for our domestic epidemic. So we went to Vienna just having done that. That evening, the President hosted an even tat the White House for the AIDS community to honor the work and the contributions they made getting there but also it gave them a chance to talk about his personal commitment to ending the epidemic. So that was the backdrop of going to Vienna for us.

I'm not going to get into all the details about the strategy. I brought a copy but you can all get them from our website or AIDS.gov is probably an easy website to remember where you can get it. I encourage you to read it.

The President set three goals for the strategy: He said he wanted a strategy that would reduce HIV incidence, increase access to care and that's something we think of holistically improving health outcomes, and reducing HIV-related health disparities. And yet we said all along that we're building on success that we think that this isn't about reinventing our domestic response but it's about assessing and what are the small number of steps we need to take in addition to the things we're already doing. From my perspective, hopefully what you'll see when you read it is that it's really an honest discussion about where we are in the AIDS epidemic in this country and hopefully a fairly concise vision for what we need to do going forward.

So when we went to Vienna, we one are excited about hosting the conference in 2012 but really saw this as an opportunity to step up the engagement of the United States

government at this conference. I was there with Greg Millett who's my Senior Policy Advisor but also from the White House we had Dr. Zeke Emanuel who's a key policy leader on the Global Health Initiative.

We had Dr. Jack Stein with the Office of National Drug Control Policy. So just from the White House, we had a higher level of engagement than we probably had in the past but also across the United States government. We sent more people but also senior leadership and thought that was very important to show that we're committed to engaging both highlighting our challenges on the domestic epidemic but engaging globally.

We went there wanting to have a conversation with the global community about our domestic epidemic. We had a satellite session on July 18th. It was well attended. If I could say the one thing I feel badly about and some of this was the late breaking nature that we organized it, you probably had 150 or so people there.

When I took a show of hands. They're virtually all Americans, which was great but in the future, I would have loved to have a more robust dialogue with other people but it

was really a helpful discussion. I was able to provide an overview of what we're doing.

Dr. Koh, who will have a very significant role implementing the strategy, talked about some of the key steps we're taking. We had a panel with our federal partners so some of our key federal agencies were represented talking about their role and what they think the key things they need to be doing. Then we had a community panel, andI would say that hopefully what people have seen and this wasn't something that I just sat in a room and developed over these many months. We had a broad level of community engagement. I know there are many friends in this room but I should of course have to acknowledge Phill and the Black AIDS Institute. He's also part of the Coalition for National HIV/AIDS Strategy that were with us every step of the way.

He now, of course, serves on the Presidential Advisory Council on AIDS, which we said had as a major role in monitoring the implementation and ensuring success with the strategy. So we had a really good community discussion there.

Now the next steps are really all about implementation and people think I'm joking but in some respects, I feel good about the next steps because to some extent, up until now I felt like it was all on my shoulders.

Now we have a strategy. Now it's on everybody else running with that. I'm serious in that hopefully people look at this and say it's pretty. It has a nice cover but this could be lovely words on a paper unless other people do lots of things and make this strategy meaningful.

I think from a federal perspective, we're really committed to doing our part but it's not just on what we do. It's what other people do as well. When we released the strategy, we released a federal implementation plan identifying very specific action steps the federal government will take this year in calendar year 2010 and next year.

We've also committed to updating this annually but this is just really our initial commitment but when we release the strategy, we have the strategy, the implementation plan. the President also issued a Presidential memorandum on any identified lead agencies responsible for implementing the

strategy saying very clearly that all parts of the government have a role but identified lead agencies, HHS, HUD, Justice, Labor, Veteran's Affairs, and Social Security Administration, they have specific roles.

He identified a specific role for the Secretary of Health and Human Services and that's really been delegated, as I mentioned, Dr. Howard Koh to focus on coordination across the government not just within HHS. So whereas my office is the lead in policy setting for HIV policy, there's a lot of operational programmatic issues that I'm not best suited to deal with. So Dr. Koh is really going to focus on that.

So I think by doing all these things putting out our initial plan, this Presidential memorandum we can we show we're serious. I'd also say that in addition to the agencies that have a central role there are other parts of the government that have a role too. The Department of Defense has been asked to come up with a plan for how they're going to implement the strategy in the context of health care services provided to military.

Equal Employment Opportunity Commission has been asked to give us a report on steps that we can take to increase employment opportunities for people with HIV but also steps we can take to reduce employment-related discrimination. But the Secretary of State and an educated guess I'd say is probably been delegated to Ambassador Goosby,the President asked them to write us a report and really tell us the lessons that we can learn from a PEPFAR program and what things can we apply to our response to the domestic epidemic. So that's really what we're trying and these reports are all due within 150 days.

There's also ongoing responsibilities for the lead agencies but that's really what we're seeing as our federal commitment but we need state implementation plans. We need community implementation plans. Without getting into all the specifics, one of the key recommendations we had for reducing HIV incidence is that we need to recognize that unlike in Sub-Saharan Africa, we don't have a generalized epidemic. We have a concentrated epidemic. So we really need to focus our resources more intently on the communities at greatest risk.

We could talk about what that means as far as federal funding but that's not the end of the story. That's a lot of work to make just even achieving that is really meaningful. So we're looking to a lot of people to help us implement the strategies so again it's not just a lovely document but that it means something in a few years.

Now speaking about 2012, I would say that from the moment we began discussions about what do we need to host this, I think across the government and certainly across the White House, everybody in the IAS government saw this as an important opportunity and one that we embraced. At its core, we see it as a scientific conference and we think it's a great opportunity essentially to be in the backyard at the NIH, the world's premier biomedical research institute but also our response to HIV is not just about NIH. There's CDC. There's HRSA and FDA.

I mean I could go through the list but there's a lot of federal agencies and I think from our perspective, it's a huge opportunity not just to have a handful of key leaders from these agencies but really have a much broader participation of

our scientists and community partners and others to engage on this but we also think that there's an opportunity for the global community to come to the United States as well. In this country, we're not always good at acknowledging what we have to learn from other countries but I do think that we'll all benefit from a rich dialogue and it's time that it is in the United States again.

I would say that planning is already underway. IAS, they do this and they know how to do this but they had their initial conference coordinating committee meeting in Vienna. Greg Millet who's my Senior Policy Advisor's representing us on that planning committee, Dr. Jack Whitescarver who's the head of the Office of AIDS Research at NIH is also engaged but there's numerous civil society groups engaged including the Black AIDS Institute and others.

So I will say that being in Vienna, it was only my second international AIDS conference but now that I'm a U.S. government employee and watching this conference, it feels a little daunting to think about what we have to do between now and in July of 2012 but again I think it's a huge opportunity

for our country and I think that there'll be lots of opportunities to dialogue with you and IAS and others but I think we're committed to making the conference a huge success both for our global response but also for our domestic response as well. Thank you.

JENNIFER KATES: Thanks Jeff. Before we go to Chris, I just want to say in the past when we've done these, we've thought we wanted to find a way to bridge the global and the domestic and it's not always been so straightforward.

I think this was the first time that that bridge was a little more obvious and actually if people remember, part of the call for the national AIDS strategy was saying that the U.S. government and many other donors are asking countries where we were and have plans and have strategies yet we didn't have one here. So I think it brings it full circle and then having the conference back here. So thanks to both of you for representing both of those perspectives on the government. Chris?

CHRIS BEYRER: Well thanks very much Jen and also I want to thank Kaiser and CSIS for hosting this event. I

thought I would very briefly talk with you about some of the scientific highlights representing somewhat more the scientific clinical and public health research perspective and then talk a little bit more in detail the Vienna Declaration, which was both an International AIDS Society declaration but also of course the official conference declaration of Vienna and how it came about and what we hope it will mean.

I'll talk a little bit about the conference and why it was different from some in the past and then also talk a little bit from the IAS perspective about 2012.

So first of all, I have to say the theme of this conference, which hopefully everybody here has embraced and knows was, thank you, yes, so rights here right now and the conceptualization for Vienna was that we held this conference as close as we could get to Eastern Europe and Central Asia deliberately because of course those epidemics, as Lisa Carty so eloquently pointed out, are among the fastest growing and are among the most problematic in terms of public health responses, treatment access, HIV prevention, human rights protections, a wide array of challenges.

The theme of "Rights Here, Right Now" was an attempt also to bring the rights components and the civil justice, civil society components of that Eastern European epidemic into the scientific discussion. So we're trying to move out of the polarity of science versus human rights and really talk about how these perspectives are so profoundly interconnected. I think from that perspective, we have to say that Vienna was something of a landmark that there really was tremendous cross-talk, cross-engagement in scientific communities.

When I talk about the Caprisa study, I want to just flag for all of you that we really have to also think about the vaginal microbicides as women's empowerment. That is a profound aspect of this and obviously the gender inequities, the issues that drive the most severe epidemic for women in Sub-Saharan Africa are fundamentally related to the power dynamic to rights issues for women and this vaginal microbicide is actually a tool that has an important human rights component. That's the kind of thing I'm talking about in terms of the integration of scientific perspectives and rights' perspectives.

So a little bit about basic science, which is where we always begin. It's track A for a reason. One of the issues for us in terms of organizing these conferences is that we have been concerned for a number of years about the declining participation of basic science.

You will hear the mantra that you often hear from people in the scientific community is that they don't go to the International AIDS Conference because it isn't really a scientific conference anymore. We feel that the participation of the scientists is absolutely critical. It's also very good for them to hear all the other perspectives and to really understand where the global AIDS movement is going and needs to go.

So in an effort to address that, our President-elect Françoise Barré-Sinoussi, Nobel Prize winner and co-discoverer of HIV virus convened a two-day pre-meeting in advance of the main conference in Vienna on the issue of viral eradication and the issue of latency and reservoirs of HIV and I have to say that throughout the conference but also at that pre-conference,

it really was a tremendous success to bring those people back. It was a very well attended conference.

The scientists were very excited about it. Dr. Tony Fauci, of course, the director of NIAID has highlighted this particular component of the research effort as the way forward to something we actually honestly put aside for many years, which was the idea that we were going to cure HIV infection. But there really is dynamic interest in that area again and there really are some advances.

The second, of course, great struggle in HIV has been the HIV vaccine effort. We've had some very disappointing news for as many here will know, over many years, but one of the things that's really very exciting about Vienna is that the investment in basic science, in the return to sort of going back to the basics and really thinking about, for example, what neutralizing antibodies need to do or what they need to look like has actually started to bare some fruit. There is real enthusiasm again for an antibody-based approach or at least an antibody-based component in HIV vaccine research. A lot of that was presented in Vienna.

So we are, on some of the really core basic science questions, making headway. I would also say there were a couple of other critical advances. One is there's much more awareness now in understanding of the role of compartments in HIV and compartments like the vaginal floor or the vaginal compartment like lymph node, like reproductive tissue, like the gut as opposed to just HIV drugs in serum or in blood.

There's a lot of new agents out there and new interventions in the HIV lifecycle that are going to have more tissue-specific activity. Why does that matter? Well for example, the Caprisa study is about a vaginal microbicide. It was very carefully part of the counseling not to attempt to use this for anal-rectal intercourse and for anal-rectal use because its safety for that use has not been evaluated.

Nevertheless we need a rectal microbicide. Heterosexuals engage in anal sex and of course so do men who have sex with men, a critical component of so many epidemics. There are some new antiviral agents that have tremendous uptake in the gut that really appear to concentrate in gut mucosa and are really potentially going to be a way forward with that

problem. So the basic science arena is actually one of tremendous interest and as one of the commentators pointed out earlier that still is hugely a U.S. investment. We really are leading the investment in basic science.

A couple of other things that I would say that treatment as prevention research effort. There were a number of presentations on this. You heard about Julio Montaner's presentation, which is one of the first population-based studies looking at this issue. I think what Vienna will be remembered for and something of a landmark in addition to Caprisa, the other big landmark is going to be that the science has finally ended this divide in our thinking about treatment and prevention.

It is, however it all pans out, and there is a great deal of work to be done on this front, it nevertheless is increasingly the case that single agent antivirals like Tenofovir gel or the drugs that are to follow, the PREP data and the use of PREP that is beginning to emerge and it will be the exciting science for the next two years until D.C.

The profound impacts of treatment on couples, for example, all of those are making us understand that the role of antivirals in prevention is enormous and is really the frontier that we have to look at. There was a lot of exciting science on that front.

Let's turn then just briefly to a little more detail about Caprisa. Caprisa was a proof of concept trial. It was done very appropriately in the setting where you have to say the highest rates of HIV infection among women and girls are seen worldwide. KwaZulu-Natal really is ground zero.

If you look carefully at the incidence rates, so that's the rate of new infection in each arm of this trial, in the placebo arm, it was nine per 100 woman years. That is an unbelievably high rate of HIV infection. In the arm where women used Tenofovir, it was still five-percent. I mean if we had a five-percent sero-incidence in women here, we would be calling that an absolute public health emergency.

So the fact is that this was done appropriately and in the right population but that remains an incredibly hot epidemic and a five-percent sero incidence in women obviously

is totally unacceptable. So we have a long way to go on that front. Nevertheless scientific highlights of Caprisa, certainly one is safety. This was incredibly safe. That's extremely important because if people are going to use this in their ordinary daily lives who are not HIV-infected, it's got to have a very good safety profile.

There was virtually no or very, very little uptake in the general other body compartments. So it really stayed a microbicide. That is critical because we don't want to see this generating Tenofovir-resistant virus. There really is no evidence for that. That is very important as a finding. Additionally we learned a great deal about adherence. A vaginal microbicide that was used, this was a coitally dependent product and basically it's the regime that was suggested for women is before, after, twice in 24 hours. So BAT 24 that's the buzz word.

The critical piece there is that there was a clear dose response. So the most adherent women had the biggest impact and the least adherent women got the least impact. So this is going to be like condoms. It's a biomechanical barrier but

it's a behavior. It's a sexual behavior that has to happen around sexual activity, which for women in so many of these settings is not always under their control, is not always consensual and so forth. It remains an important challenge. For the future, we're looking at daily dosing.

There's a trial underway with the microbicide trial network of daily use. That is going to be a very important impact to understand versus the coitally dependent. Then of course there's the string of oral pre-exposure prophylaxis trials underway among men who have sex with men developing countries, in the U.S. and among injection drug users in Bangkok. So those are critical.

I have to say that in terms of the science for drug users, there was some very important findings and I'm not going to blow my own horn but just to say that we did a special issue of The Lancet for this conference. Many of you will remember that from Mexico City, there was a special theme issue on prevention.

For this one, The Lancet and to Richard Horton's great credit, the Editor-in-Chief, they wanted to focus on injection

drug use. So I guest-edited with a number of colleagues that special theme issue. We presented that in Vienna the same day as Tenofovir gel. So we didn't get the media bounce that we had hoped for.

Nevertheless all of you will now read it and we'll get picked up. But the critical thing there is that we had a very nice review by the Australian group led by Louisa Dagenhart, UNAIDS colleagues, looking at the impact of needle and syringe exchange, needle and syringe exchange and substitution therapy with methadone buprinorphine and both of those in combination with antiviral therapy access for injection drug users.

The bottom line is that triple therapy works. This is a new triple therapy and it works synergistically. What we found and what Dagenhart reported, unfortunately, is that needle and syringe exchange alone really can only reduce about 20-percent of HIV incident infections. You really need ARVs, substitution therapy, and antiviral therapy access. So that is a critical finding.

That leads us into the Vienna Declaration. Let me say I think we're now over 12,000 signatures. The Vienna

Declaration concept was really to say that the whole drug policy regime and the approaches based on punitive arrest and detention of the use of detention as drug treatment, which is so widespread and which is not evidence-based, and approaches that really violate the fundamental human rights, rights to health care, rights to a nondiscrimination in health care that are so widespread are aiding and abetting this epidemic and that it is time essentially to really look at the war on drugs, the impact of these policies and really ask the question are we making a difficult situation worst.

The Vienna Declaration calls on governments to look at policies of decriminalizing drug use, of approaching drug use really as a health issue, a public health concern in need of treatment and to move away from criminalization and punitive approaches. I have to say that we are really hoping that the Vienna Declaration can have some of the same impacts of the Durban Declaration had, which many of you may have been co-signatories to but this is a very challenging arena and the lack of participation particularly of the Russian, Central

Asian, Eastern European leadership on this issue, we think, is a real barrier.

I don't want to take too much time but I'll just say that in terms of what was one of the real highlights, what was different about Vienna 2012, one thing certainly is the return of U.S. science.

Many of you will know that over the last number of years, there have been real restrictions on the number of U.S. scientists who could participate in the international AIDS meetings really since the Bangkok meeting and it was a qualitative and quantitative difference to have U.S. scientific leadership back in the room leading sessions, organizing satellites. It really was tremendous. That is also an aspect of the return of basic science to the meeting, which we all think is really critical.

Finally in terms of 2012, you heard that the planning here is underway. I will tell you that as a governing council member and for those of you who are members of the International AIDS Society, thanks for your votes. I'm happy to represent you. It's an elected position but the way the

meeting is supposed to work is that it alternates between the developed and the developing countries.

So Vienna, Austria's not exactly a developing country. The next meeting is supposed to be in a developing country but we all felt that given the great likelihood that the visa ban, the visa immigration travel ban on HIV-positive people was going to be lifted that if it were and that opened the door for the meeting to come back to D.C. that it would be so important to do that, both to address the local epidemic here, the national epidemic in the United States, to bring the international meeting back to the U.S. but also really to acknowledge again what an advance that is on human rights.

We really have to thank this administration for doing that. It really is tremendous. There is huge good will out there for this return.

There is concern and trepidation about, from a number of groups, about whether or not people are going to be able to get here. That's always an issue in every country where we hold these meetings. When we talk about affected communities, it all sounds good, vulnerable populations, people are

concerned. When you start saying sex workers, drug users, they're people who have usually complex personal lives and arrest histories and it's challenging. We know that it's challenging. Their participation is critical. IAS is going to do everything we can to make sure that that participation remains real and vital and meaningful. Thanks.

JENNIFER KATES: Thanks Chris. You can see why we asked Chris, as the scientist, to talk about the science because he makes it accessible and I would actually, on bridging the science and the community, for those of you who haven't watched the Caprisa web cast, I highly recommend it because it's a great example of a very simple elegant presentation of very complicated information in a very nice way. Actually that's a good segway way to Phill who's going to talk about more of the community perspective I think.

PHILL WILSON: Well thank you Jen. I want to thank Kaiser and CSIS also for putting on this presentation and inviting me to participate. I've been asked to talk about the community perspective and some of you in the room have heard me speak before. So it'll be no secret what part of the community

that I'm going to focus on. I would say that the theme of Vienna was clearly a theme of promise.

I'm apt to make bold statements and I said it in Vienna and I'll say it now and this is my story, I'm going to stick to it and that is Vienna is the new Vancouver. So what do I mean by that?

Now as someone who's been living with HIV now for nearly 30 years, Vancouver was a turning point for those of us infected with HIV. I think for everyone in this room who's serious about attempting to get to a point, as Jeff talked about, in the national AIDS strategy, a world without AIDS or where HIV happens rarely, Vienna was very, very important. Vancouver was where we really talked about combination therapy, where we really talked about hitting the lifecycle of the virus at different points.

Now what's interesting is that we often work in silos and somehow lessons are not learned. When we've talked about ending the epidemic, fighting the epidemic, we still talk about it as if we're talking in the days of AZT. Now the truth of the matter is that what we learned in Vienna, what we should've

known all along is that prevention alone is not going to end the AIDS epidemic.

Treatment alone, we're not going to treat our way out of this epidemic. Research alone, even money alone, mobilization alone, none of those things as monotherapy is going to end the AIDS epidemic. What we need is combination therapy.

I think that that's what this conference was all about is about breaking those silos, us talking to each other. There are a number of presentations on the web cast that I would really encourage you to view.

Now two of them, the two Bills if you will, the Bill Gates presentation, the Bill Clinton presentation and both of them talk about really the story about the definition of insanity, you all know it that if you continue to do the same thing over and over again and expect a different outcome that's the definition of insanity. Quite frankly for 30 years, we've all been insane because we've been doing the same thing over and over again in some ways and expecting different outcomes.

So I think this conference, front and center, was a conversation about doing things differently and that was really, really important. Now I have a secret to kind of share with each and every one of you and that is that I really do know that Black people aren't the only people who get impacted by HIV. I know that that may come as a mystery to some but I know that but why is it that I am unapologetic in talking about focusing on Black people?

One of the things that the Black AIDS Institute does at these international conferences is that we report on the conference from a Black perspective. My closing op ed was that it's all about the Blacks and every turn at this conference, I appreciate that we are as close to Eastern Europe as we could be and we should be but even the messages from Eastern Europe, from my perspective, is all about the Blacks because if we want to talk about how we're going to be successful in Eastern Europe, where are the most important lessons? The lessons are the lessons that we learn in Southern Africa or across the African continent.

When we look at the turnaround that's happened in South Africa that's the kind of turnaround that we want to see in Eastern Europe. When we look at the Uganda experience or the Botswana experience where governments have said that we all have to come to the table. That's the kind of experience that we want to see in Eastern Europe as well.

For me, the conference in many ways is about context and it happened before we ever got to Vienna. Again following along with my themes, the first story of the conference, quite frankly, happened what a week-and-a-half before the conference even began, the curtain raiser was the antibody story and the fact that we now know that we have the building blocks for building toward a vaccine that is antibody-based.

We've been working on this for obviously since the very, very beginning but what's special about that? The fact that we've identified three antibodies that combined, give us 90-percent plus immunity against the virus.

So again, for me, that was the beginning of the story but again, it's from what lens? The message that I say to my audience is that the most powerful of those antibodies was

found in a Black man. That's an important part of the story not necessarily so important from the science but it is important if we're talking about ending the AIDS epidemic. So that was the first important story.

The second important story of the conference was the poverty story. AP broke it. AP got it wrong, for the record, when their headline was that it was poverty not race that drives the AIDS epidemic is an absurd construct and it speaks to kind of the opening comments around that we need to stop this either/or paradigm. It's not poverty or race. It's poverty and race. Race is often a driver of poverty. When we look at per capita who's poor in America today so to suggest that you can disengage poverty and race when it comes to HIV is an absurd construct to begin with. That, in my opinion, was the second important story of the conference.

The third important story for me of course is a story that I'm sorry I missed a step, the second important story was really the release of the national AIDS strategy. I believe probably every conversation that Jeff and I had from three

months leading up to the conferences that it has to be released before the conference.

It has to be released before the conference and I know you worked very, very hard on that. I want to publicly thank Jeff for making sure against, I'm sure, tremendous odds that the national HIV/AIDS strategy was out before we got to Vienna. That was really critically important.

I am proud of the AIDS strategy in many ways for what it is not. It also speaks to the notion of doing things differently. The easy thing for this national HIV strategy to have been would have been a laundry list. It would have been easy to try to make every single person who could potentially be angry, happy by checking the list, checking the list, checking the list.

Well we've done that. The CDC has done that. NIH has done that. HRSA's done that. Everybody has done that and one of the things that this is not, it is not a laundry list. That was critically important that this national HIV strategy, the President has said we need to focus.

Yes we have a concentrated epidemic in the U.S. but among those populations that are impacted, we have a generalized epidemic and particularly when you talk about Black communities, the epidemic and that's what the poverty story is about as well. We have a generalized epidemic within a larger concentrated epidemic.

The national AIDS strategy does a number of things in that it focuses on critical population. It focuses on African Americans in general. It focuses on men who have sex with men that's driven often by young, Black gay men. It focuses on people who live in the south, again a large percentage of those folks are Black as well. So from my perspective, regardless of how other folks spinning it, again this is my story, I'm sticking to it, the national HIV/AIDS strategy is about confronting the epidemic in Black America. So why is that important?

In an environment of limited resources, where we need to focus on is where we can break the back of the epidemic and where we can break the back of the epidemic large really is in Black communities and addressing that issue. In the interest

of time, I'll quickly go through the other major stories from a community perspective.

Everyone has talked about the microbicide story and why that's important. My spin on the microbicide story is really about that this is a study that was conceived in South Africa, it was designed in South Africa, it was executed in South Africa, it was one of the most elegant scientific presentations I've ever seen at one of these international AIDS conferences, and it was presented by South Africans.

So rarely do we lift up Thabo Mbeki but when Thabo Mbeki talked about an African solution, this is an African solution. We should be proud of that. We were proud of that and that's very, very exciting. We can go into prep. We can go into IDUs. We can go into the Black Diaspora, all community stories that are really, really important from the conference but I'll end on the issue around 2012.

As the conference comes to Washington, D.C., I would argue that quite frankly if you look at the numbers, in Mexico City, we released a report called "Left Behind" and it asked the question if Black America were a country unto itself, how

would that AIDS epidemic stack up to the AIDS epidemic in developing countries. The truth of the matter is that the AIDS epidemic in Black America is, in many ways, similar to the AIDS epidemic in developing countries.

So when the International AIDS Conference comes to Washington, D.C., if you look at the numbers, the international AIDS epidemic, in some ways, is coming to a developing country because when we talk about five-percent among women being outrageous and when there are populations in this city right here where we have a 10-percent HIV rate that's one of the main reasons why this conference needs to come here. That was maybe even the biggest overall story of the conference. There was excitement everywhere you turned around the AIDS epidemic coming to Washington, D.C.

So I think that there are a few things that we need to talk about as far as challenges moving forward. Number one, show me the money Jerry, show me the money. Whether we're talking about the national HIV/AIDS strategy and yes we can spend the money, we can redirect the resources we have better. But nevertheless we are still underinvesting in the AIDS

epidemic. When we talk about all of these advances, the challenges of scale-up and replicability are important issues that we need to address.

When we talk about the 2012 conference, we have an epidemic raging in this city. We have an election coming up in Washington, D.C., I'm an outsider so I'm not getting all the nuance but certainly as I read the Washington Post, I don't see any candidate talking about the HIV/AIDS epidemic in this city. That should be an issue that's front and center. In the past when we've had national debates, HIV has been on the agenda, issue would be on the agenda in this city for the upcoming election. I think there's a mayoral debate coming up a week from now.

Folks who are interested in HIV should be there. They should challenge the candidates. The next mayor of Washington, D.C. is going to be the presiding mayor over the International AIDS Conference here in 2012. So I will stop there.

JENNIFER KATES: Thanks PhilL. We have about 20 minutes for questions. So let's just get right to them. I have several but let's go to you. We'll take three at a time.

If they're directed at someone, please say who and say your name and organization.

BILLY PICK: I'm Billy Pick, USAID. Thanks to the entire panel who I've known for mostly a very long time. The question is to Chris because you were going to do the science. The actual scientific Caprisa was wonderful, absolutely stunning, great results except for the incidence in the control arm. Could you talk a little bit about the CDC late breaker and Tenofovir at MSM because actually I thought that microbicides are wonderful, a bit sticky, a bit messy applicators.

The Tenofovir study in MSM was only a safety study but I think if you look at the study, one of the things that came out even though it wasn't powered to detect a difference in incidence, was that there were three infections in the control arm, three infections in the delayed arm, and absolutely no infections. This goes to a larger question that I want you guys to think about is in a year or two, we'll have some data on Tenofovir or Truvada as prep. It's a pill, once-a-day. It's already out there. Everybody in the United States, just

about who has HIV, takes Truvada. So there's no supply chain issues with it.

Anybody could go to the pharmacy and get it. Are we ready, Chris, when the data comes out for people the next day not to go to their friends and say can you give me some Truvada, their HIV-positive friends, do we have that?

One of the jokes in Caprisa when we came out of the meeting was basically a bunch of HIV-positive people in Africa are now grinding up their ARVs, mixing it with KY and they're going into business.

JENNIFER KATES: Thanks Billy. I'm going to ask people to keep it a little shorter just so we can get two more questions now.

DAVID BRYDEN: Yes, David Bryden with the Infectious Disease Society of America. It's been a really fascinating panel so thank you. I just wanted to say I think the Administration really deserves to be greatly congratulated for its new guidance on injecting drug users, which is a tremendous development and also for taking a really strong action to address the treatment shortages in Uganda. I wonder if kind of

going looking at that issue of treatment if the representatives here could expand a bit on the importance of treatment as prevention.

The President seemed to counterpose treatment and prevention a little bit with his comments earlier this week. I understand from what Chris was saying that this is now an accepted scientific concept but I'm wondering if you could also respond to the critique from MSF about the Administration not moving faster on early treatment and with better regimens and the cost savings that would accrue if that were rolled out.

CHRISTINE CAMPBELL: Hi. My name is Christine Campbell. I'm from Housing Works. I just wanted to build on a little bit about what Dr. Beyrer and Phill was talking about in terms of combining research with community advocacy and activism. Now that we have this information on the importance of poverty and the role it plays in the epidemic, how do we actually incorporate this research into a lot of the community action and the policy that we need to move forward?

Right now a lot of our policy, including the national HIV/AIDS strategy, does not include a strong emphasis on the

environmental context, the structural interventions that need to be in place for us to actually move towards ending the epidemic especially in the areas of prevention and addressing health disparities. So how do we take this research that shows the importance of poverty and in that race but the importance of poverty and include that in the work we do around prevention and addressing health disparities?

JENNIFER KATES: So we have a question that was mainly for Chris, the first science question and then there was probably for Deborah on the treatment scale-up and earlier treatment, Jeff.

CHRIS BEYRER: So thanks Billy for that question. Yes, the CDC safety study results were presented on the last day of the conference as a late breaker because the data were really only available getting very close to the conference.

It was tremendous to have them because that really is some of the very first data we've had on PREP. So that's the pre-exposure prophylaxis concept. That is a daily oral dosing. There are now I guess all together something like five trials

of various approaches in different populations. This one was the CDC-funded study in gay men or men who sex with men.

The really good important news there is that the safety profile is tremendous and that's what you want to hear from a safety study. It is true that there was some early data on interventions on potential outcomes. It's always good to see that that is trending in the right direction. I think you really can't say more about that until you have the power basically to answer that question. That's a different design.

There is a large study underway that's funded jointly by the NIH and the Bill and Melinda Gates Foundation, the iPrEx trial that actually is powered to answer the efficacy question and it is in men who have sex with men. I think a really encouraging thing about that trial is that there are trial sites in Chiang Mai, in Northern Thailand with men who have sex with men, in South Africa. That's really the first intervention trial of its kind among men who have sex with men in an African population. So that's critically important also in South America. I think it's Peru and Brazil. So that will be really a more definitive answer about the efficacy issues.

The other question that Billy raised, which was sort of the secondary aspect of this: are we ready? Are we prepared to deal with PREP and with the PREP rollout? I have to say I think that this is one of those situations where the science is moving along. There's been a lot of expectation because of the biological plausibility that these approaches are going to have efficacy. How they get implemented if we are indeed going to implement them, we are totally not there.

I had just recently, we had a Gates-funded summit on prevention approaches for injection drug users. I brought this up and said so everybody, what are we going to do if the results of the Thai trial, again a CDC-funded study, several thousand injection drug users in Bangkok on PREP, show that this works for drug users? Are we going to add PREP to harm reduction?

Is it going to be in drug treatment programs? Is it going to be where you get your methadone, your epinorphin? How are we going to integrate this? Really we are in our infancy in thinking about this. That's a little scary because the results are all coming out in 2010, 2011, 2012. So anybody who

thought that the operational science issues were kind of over in HIV, wrong. I'll stop there.

JENNIFER KATES: Deb do you want to?

DEBORAH VON ZINKERNAGEL: Thank you, David, for your question around the sort of the relationship between treatment as prevention and I think the data, at this point, the data is quite clear. That is a continuum, the evidence of dropping viral load, very definitely reduces infectivity, the data's strongest and discordant couples where I believe it's over a 90-percent reduction in new transmission. So the use of antiretrovirals, as an effective prevention agent, I think that's been answered at this point. The challenges around that you've raised around earlier initiation of treatment are a more complex issue.

Clearly I think that the data's been gathered for a while that by averting a wise and advanced disease, you can have better treatment outcomes, less mortality. So many of the major guidelines at this point are reinforcing that. The difficulty that we have is in the programmatic level where

right now in the PEPFAR program, the average new person starting ART is coming in with a CD4 of around 138.

So we're still seeing late presentations, people not aware of their status coming in late for care and really an urgent need of ARVs. So where we are in terms of our ability to respond to this, we've placed a priority and encouraged all of our granteeing country teams to make sure at least we're getting the sickest individuals first into care and treatment.

Those that are most at-risk of losing life or severe morbidity, it's important to get them. We've also initiated, identified pregnant women as a key group that needs to access, you're going to prevent a new infection is clear. We have an opportunity. We need to do it. Also HIV/TB where the speed of sort of the progression of disease is also very clear.

So there's some populations where it just again the trend, opportunity for prevention or the trend towards mortality is so great that we need to look at the higher CD4 but again this is an issue that really needs to be decided at the country level with the country teamed with the host country government. This is a shared burden that the USG holds with

countries in terms of what their guidelines are, what do they think jointly we can sustain but it is, the data is there increasingly for supporting for treatment to the extent that we can extend it.

JENNIFER KATES: Really quickly on the last mic because I want to make sure we get to some more questions if either of you want.

PHILL WILSON: To respond to Christine's question because I think it's important on a number of fronts and that is the intersection between research and advocacy and mobilization. I think that you're right, the social determinants are absolutely important. One of the things that happened in Vienna was a screening of a documentary around the AIDS epidemic in Washington, D.C. called The Other City.

There's a person that is profiled in there who says that housing is my prevention. Housing is my treatment. How do you expect me to actually deal with my disease if I'm homeless and that is outrageous that I have to wait two years to get a housing voucher.

So the relationship between those social determinants and treatment and prevention are critically important. I think that, in some ways, the science actually has just caught up to the community in understanding treatment as prevention. I mean those of us who are living in the real world have known that for a long time. As we move forward, it is certainly scientifically proven what happens with discordant couples but also reducing the viral burden in a community level is critically important on the issue of science as treatment.

What I would say to your question, Christine, is that just like we've had to understand and to be more disciplined at how we look at the AIDS epidemic from a science lens, we need to do that from an advocacy lens as well. In 1984, 1985 maybe it was okay and definitely it was okay and necessary to use a sledge hammer that all we really needed, what we need to do is get people's attention. I think today we need to be more strategic. We need to be more precise.

We need to be more disciplined in our advocacy because I think in some ways, kind of dumbing down the advocacy message does harm and not good. So we need to be precise and

connecting the dots, which means we need to invest a lot more energy and time in building infrastructure and capacity and literacy in our advocacy efforts as well.

JENNIFER KATES: Three more questions and make them quick please.

JILL GAY: Quick question, Jill Gay, author of whatworksforwomen.rog, I'd like you to comment on the gender/women issues at the conference beyond the Caprisa trial particularly the intersection between reproductive rights and HIV treatment and care.

NANCY DONALDSON: I'm Nancy Donaldson, the Director of the ILO office in Washington, International Labor Organization and I was very struck by Lisa's remark that what are we going to do about buy-in from countries and how are we going to engage them. So I just want to ask from the U.S. perspective because now there's an opportunity to think about this to 2012, how are you going to engage U.S. constituencies and other governments and just from the ILO perspective, as I'm sure many people know, 183 countries are member countries.

Their labor and business constituents debated and adopted for the first time a labor recommendation about HIV/AIDS in the workplace in June. This recommendation is very broad. It applies to anybody from the armed services to seekers, to dependents, and it covers gender, sexual orientation. This has been adopted and recommended by countries.

So for the next year, we're challenged before our next conference in June to really come up with an implementation plan, which will include changing laws across the world and engaging the key sectors that involve employers and laborers. So I guess my question is how can we work together to strengthen country engagement and also engage U.S. constituencies, which is part of my job. I'd love to work with you on that on this.

JENNIFER KATES: One more question really quickly please.

PAUL CRIST: Hi, my name's Paul Crist and I work with AIDS Health Care Foundation. I'm based here in Washington, D.C. I was in sessions with pretty much all of you except

maybe you Phill in Vienna but this question is really for Deborah from OGAC.

My question is to what extent are we really prioritizing because the United States is contributing such a large percentage of the global response to HIV/AIDS, to what extent is the State Department and OGAC prioritizing getting England and Germany and some of the other countries that actually reduced their contributions to the Global Fund this year to get them to step up in a serious way?

My other question was about the patent pools with UNTAID and is OGAC working to help on that front because we need, as Phill says, we need the show me the money and we also need to find new ways to bring down the per patient annual cost of treatment and care.

JENNIFER KATES: I'm going to be more disciplined with our panel and ask you to respond really quickly because Steve was going to provide some summary comments and I think we can all stay up here afterwards to talk more with folks if we need to. Anyone want to take those?

DEBORAH VON ZINKERNAGEL: I'm happy to address your questions around the reproductive health rights and the close intersection with the epidemic. I didn't give due justice to that in sort of my opening remarks.

There was a real focus on the gender-related issues integrated both from prevention, gender-based violence, the tight linkage that we see in many areas between rates of gender-based violence in women and the explosion of an epidemic and what kind of strategies are available, what kind of policy changes are needed, how can we support both at a very community-based level but also at policy level, strategies that help us move in directions where there's greater protections and rights for women.

I don't have a particularly good answer to where are we on the reproductive health rights other than to say I'm very grateful that this has risen up much higher on the radar screen as a clear need and also I think in the larger Global Health Initiative that the U.S. is invested in now, looking at that intersection of reproductive rights, access to contraception, basic packages that can be looked at as a basic package of care

for any HIV-positive woman or any woman. So I think we're looking very closely at what that integration can be, how do we do it well and wisely but looking at the need very much.

I'm happy to touch a little bit quickly on the ILO, your question in terms of engaging. Business labor, all sectors, sort of and how do we increase perhaps participation, the new document by the ILO is indeed an extraordinary statement. It was presented at Geneva, also at the UN PCB meeting in June. I think we would like to figure out how to work with you around those issues. There's a huge need to bring in the workforce issues. There's a lot of new data sort of on productivity issues by having people receive care and treatment, the effect of that on the marketplace.

There's also a need to much more tightly, as we look at all the country ownership, country sustainability programs, we've got to integrate this not as an aid program by itself but very much within the country structures of private sector, workplace, etc. So it's a debate that I'm sure both Jeff and I would be glad to continue with you.

Your question on the G8 and how it is we can work with our partners, this is a tough one. I mean these are really hard years I think in a lot of the donor countries. We do know we have heard that the new government in the U.K. is intending to continue its contributions as much as possible. So it is a country by country discussion. Obviously those discussions do take place but I think our job is to keep doing as much as we can do and try and do it as well as possible.

JENNIFER KATES: In the interest of your time and our time, we're going to move to Steve Morrison who's going to provide some summary remarks but as I mentioned, we'll go down here while Steve talks and then some of us can stay around and continue but let's turn to Steve. You can sum this all up for us right Steve? Okay. Actually before Steve starts, can you join me in thanking everyone tremendously for their time [applause].

STEVE MORRISON: Thank you all. I'm substituting today very briefly for my colleagues, Katherine Bliss and Phil Nyberg, both of whom are in Vienna but both of whom had unforeseen personal emergencies that made it impossible for

them to be here today. I want to repeat a bit of what Lisa said in thanking our colleagues here at Kaiser, Jen Kates, Craig Palosky, Alicia Carbaugh, and of course the leadership, Drew Altman and Diane Rowland who've been fabulous partners and welcoming us all here today.

I also want to single out Ron MacInnis from IAS who has become a great friend and ally here and worked indefatigably in pulling this together. I think you deserve some special thanks. Our panelists, I think looking back, we started this effort with Kaiser, I think it was in '04 and it's been a very successful tradition and a very useful one in pulling people together and doing these reflections.

I think the quality and mix of the panelists today were just exceptional and I'm very grateful to you and congratulations also to the Administration for the things that we heard about: lifting the ban, the national strategy, the IDU guidance issuing, and also opening the doors to much fuller scientific engagement and also showing that the team that is guiding both the international and domestic response is very much in place. You cannot say that in several other foreign

assistance priority areas where there's been delays and there's been difficulties in sort of moving ahead. Here it really comes across that there is a very strong team that's in place that is doing its work.

I wanted to mention just one thing about Melanne Verveer will be speaking on September 7th, which is the day people come back from the holiday, Tuesday on September 7th from 10AM on, lead up to the MDG Summit with special focus on gender and please join us. That will be at CSIS. Some very quick comments.

We've got some work under way that Katherine was going to discuss today, Katherine Bliss, who's a historian and a Deputy Director with us. She's taken on a project of looking at, historically, at the evolution of the conferences and going back to the original one, interviewing many of the principals involved, trying to put a lens on the shifting balance of political leadership science focal areas, level of engagement, and impacts, and the question around impacts, and how do you begin to assess those. That work will come forward to many of you, will be asked to comment on draft, short draft paper as we move towards the end of the year. We'll surface that as a published document in the early part of next year.

The intention really is to try and capture the shifts that have happened and use that as a device among many devices of engaging an American public that will be shortly, in less than two years' time, seeing the return of this conference to American soil for the first time in 22 years and the return of this conference to American soil is going to come at a very crowded period. It's going to come in the midst of the G8 summit hosted by the United States, in all likelihood, a G20 summit, maybe not in the same timeline but it will be in an intense period of Presidential race and Congressional races.

I think it will be a period in which we will continue to struggle with the reality of historically high debts and deficits and pressures and unstill, very unresolved question around how to bring about economic recovery and rebalance budgets and remain committed to things like global HIV/AIDS and domestic HIV/AIDS demands and challenges there. We'll still be struggling with that reality.

I do think that we are in a difficult transition point. I do think we're at the front edge of a difficult transition point and that Vienna was really the first conference in this new era. It was the first conference that came after the September, if you use the Lehman Brothers collapse in mid-September of '08,

it was the first that had come forward when the reality of the global recession was upon us and the reality of much more challenged budget situations particularly among the major donor countries. It came shortly after the G8 summit in Muskoka, Canada, in which the Glen Eagles commitments were basically retired, in which it became clear that Canada, U.S., and U.K. were really the only three donors able to remain robust in the global health realm.

So we're in this transition in which the high growth decade of the previous decade has now moved into a period of greater uncertainty and stress and an enduring global recession, a shift of the G8, the emergence of a G20 with a very uncertain sort of focus on any of these issues and ourselves, we really haven't yet confronted fully the reality of our own debt and deficit problems. We are looking at the possibility of significant change of power relations between the executive and Congress in this next cycle. That all lies ahead of us.

I think we have to be very protective of the bipartisan consensus that's built up over the years to support U.S. leadership and U.S. leadership remains so fundamental. I think we have to be very protective of preserving fairness and balance and civility and discourse around what is happening particularly

as we move towards Washington. I think Washington, in the 2012 context, is a great opportunity to shape American opinion and global opinion. It's a great opportunity to reach other Americans outside of global health who matter to opinion and have them engaged in new and different ways.

I think that we've got time to think about this. We've got time to tap the advisory council and be creative but we need to really make sure that the debates that happen in Washington are forward looking, are constructive that they convey the magnitude of the U.S. achievement and the achievement of our partners and the contributions of others and that we make this a place where leaders, to get back to Lisa's point, there is a gap. There is a deficit of leadership at these summits. We saw that in spades in Vienna.

If we're going to correct that, we're going to have to guarantee that this is a comfortable and inviting place for leaders to put themselves forward because there are plenty of alternative venues for leaders to go and engage. This is one that is a profoundly important one but it's one where we have to ask ourselves why have leaders ceased to come? Why have they done that?

What are we going to do to make sure that this environment is one that draws them forward and makes the case that their presence is vital, their vision and views will be heard, and it will be a place of great discourse and fairness and balance in the view in the midst of a difficult context, in the midst of having to make adjustments in the vision and the timeline but keep a vision looking forward that's very constructive and the like. So I'll just close there. I want to thank again all of you for being here with us today and for our panelists and our sponsors. Thank you [applause].

[END RECORDING]