Plenary: Ending the Epidemic: Turning the Tide Together
XIX International AIDS Conference
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FEMALE SPEAKER 1: Ladies and gentlemen, we ask that you please take your seats. If you have your mobile phones, please make sure they are on silent. We are about to get started. Thank you. Introducing the noble laureate, Dr. Francois Mauriac and incoming IAS president.

FEMALE SPEAKER 2: Ladies and gentlemen, as you know, my country, France, has been eagerly involved in the fight against HIV/AIDS since the very first beginning of the epidemic. Remains will remain committed as you will hear it now. Ladies and gentlemen, I have the honor and the great pleasure of announce the president of the French Republic, Mr. Francois Hollande. That is fine.

FRANCOIS HOLLANDE: Madame, monsieurs [French Spoken].

FEMALE SPEAKER 1: Now we are happy to introduce the award presentation of the IAS Night of Fellowship, Dr. Elly Katabira and Dr. Jacques Normand.

ELLY KATABIRA, MD: Good morning and welcome for our day one preliminaries. Drug use and the global issue that brings with it greatly risk of HIV infection. The total of about 120 countries have reported the cases of HIV among people who injected drugs. Overall, growth in the numbers of HIV infection have slowed down in most of the regions of the world. One exception of this trend however is the continued growth in numbers of HIV infection linked to injecting drug use,

especially in the Eastern Europe and Central Asia where HIV link prevalence among people who inject drugs is higher than 40-percent in some countries.

Primary reduction services still need to be scaled up to reach everyone at risk. Use of other substances such as alcohol, cocaine and methamphetamine is also associated with increased risk of HIV behaviors. Considering the high prevalence of HIV in people using drugs and other substances, there is an urgent need to study the impact of HIV, of these substances and the progression of HIV and infections as well as the interactions with the antiretroviral drugs.

JACQUES NORMAND, MD: Good morning, my name is Jacques Normand. I am the director of the AIDS research program at the National Institute of Drug Abuse. This initiative was started about four years ago and we intend to continue pursuing it. The intent of it is to try to bring young investigators and established investigators to try to bring more attention to the intersection of drug abuse and HIV/AIDS. The stipend consists basically of $75,000 for post-doctorate for 18 months and the same amount of stipend for more senior individual for 8 months. There is no restriction in terms of whether or not the fellow as to the identify mentor in the United States or anywhere else. You could find mentors in any institution across the world and it is open to all international applicants, both senior and junior investigators.

ELLY KATABIRA, MD: Now we would like to introduce the recipient of this fellowships. We will start with Makhbatsho Bakhromov from Tajikistan for the project Temporary Labor Migration, Substance Abuse and HIV Risk among Tajik Male Migrants in Moscow under the guidance of the mentor, Judith Levy. Salequl Islam, from Bangladesh for the project Mechanisms and Implications of Injection and Inflammation Among HIV/HCV-coinfected Drug Users in the ALIVE Study under the guidance of Gregory Kirk.

Georgios Nikolopoulo from Greece for the project Developing Measures to Study How Macro-level Economic and Social Changes May Have Affected HIV Risk in the Population Risk in Injecting Drug Users under the guidance of the mentor Samuel Friedman.

Mehrak Paydar from the Republic of Iran for the project Neuroprotective Effects of Estrogen/Soy Isoflavones Against the Development of HIV-induced Neurodegeneration in Awake, Freely Moving Rats through Moderation in Dopamine Transmission System. He is under the guidance of mentor Rosemarie Booze and unfortunately he is not with us because he was denied an entry visa into the U.S.

The last one is Seyed Ramin Radfar from the Islamic Republic of Iran for project Prevalence of ATS Use Among Those Who Are Under MMT/BMT and Its Effects on HIV risk-related

Behaviors in Isfahan, Iran and he is under the guidance of mentor Richard Rawson.

JACQUES NORMAND, MD: In closing, I would like to take the occasion to remind everyone that the program will be opening sometime in early December and typically the closing date for applications are late January, early February, so all the information will be posted on the IAS webpage. I would like to also thank Sharon Inerwick [misspelled?] from IAS that have made this year the most successful year for the applications. We have received a large number and we were very, very satisfied with the quality of the applicants. Thanks a lot.

FEMALE SPEAKER 1: Introducing Kevin Moody; CEO of the Global Network for People Living with HIV and Red Ribbon working group member.

KEVIN MOODY: Good morning everyone and welcome. It is my pleasure today to introduce the Red Ribbon award, the world's leading award for outstanding community-based organizations active in the AIDS response. The award recognizes and inspires exceptional Reponses to AIDS at the community level. Community involvement is key in the AIDS response and these organizations are the ones that are closest to the people. We need to listen to them and follow their leadership. In recognition of the importance of the Red Ribbon award, the organizers of the International AIDS Conference have gratuitously given the Red Ribbon Award a special session

during the conference to highlight the Red Ribbon Award Winners for 2012. This will be on Wednesday, the 25th of July from 1:00 to 2:00. The speakers for the session will be Michel Sidibe, crowned Princess Mette Marit of Norway, Alam Suki [misspelled?], Jim MacDonald, U.S. Congressman and Marisol Touraine, French Minister of Health. Also important is that you should know about the community dialogue space.

In the global village, delegates are warmly welcomed to visit their community dialogue space, meet the Red Ribbon award winners, to learn about their experiences and to attend the community dialogue space sessions.

Now this is a distinct pleasure for me to be able to introduce the Red Ribbon award winners for 2012. I am going to ask them to stand one by one and ask you to please hold your applause until the end. In the category of prevention among by people who use drugs, Afraye Sabz Association, Iran and Espolea, Mexico. In the category stopping new HIV infections in children, keeping mothers alive, women's health, Giramatsiko Post Test Club, Uganda, Global Youth Coalition Against AIDS, Egypt. In the category advocacy and human rights, Initiative Group Patients In Control, Russian Federation. Please stand, thank you. And the Delhi Network of Positive People in India. In the category of treatment, care and support, we have the Kenya Hospices and Palliative Care Association in Kenya and we have the Positive Women's Network in Sri Lanka. And last but

not least, in the category of prevention of sexual transmission, we have The Help in Myanmar and we have the Foundation SEROvie in Haiti. I would ask you all to stand up please. Stand up. Round of applause.

FEMALE SPEAKER 1: To introduce our first plenary speaker, please welcome Professor Francois Barre-Sinoussi, director of the Regulation of Retroviral Infections Unit at the Pasteur Institute in Paris and Nobel Prize Laureate for medicine.

FRANCOIS BARRE-SINOUSSI, MD: Thank you. Ladies and gentlemen, Americans, dear colleagues and delegates, it is a real privilege and honor to introduce the first speaker of the very first plenary session of the AIDS 2012 Conference back in Washington, D.C. after 25 years. Only one person could give this very first talk. A person who is a real vision of science and what science can do for public health. There is a reason why I am really delighted to introduce this person, Tony Fauci. Tony is the director of the National of Institute Allergy and Infectious Disease at the NIH since 1984. He has overseen an extensive research, portfolio they voted to preventing diagnosing and treating infectious and immuno-infectious disease. Dr. Fauci is also chief of the NIAID laboratory of Immunoregulation where he has made numerous important discoveries related to HIV/AIDS and he is one of the most sited scientists in the field. He is the author, editor of more than

1,200 scientific publications including several major textbooks. Dr. Fauci has received numerous awards for his scientific teachings including the National Medal of Science, the Mary Woodward Lasker Award for Public Service and the Presidential Medal of Freedom. Ladies and gentlemen, I am pleased to call Tony.

ANTHONY FAUCI, MD: Thank you very, Francoise, for that kind introduction. Madame Chairperson, ladies and gentlemen, I want to thank the organizers for giving me the opportunity to kick off the scientific component of this international symposium and take the theme that was developed last night with great enthusiasm and to discuss with you over my time allotment why we now have the scientific basis to be able to even consider the feasibility and the reality of an HIV/AIDS free generation.

I want to start first by a little background. I love maps. I love the deep blue of the oceans, the refreshing of green of the plains and the awesome mountains, but when we now look at maps, many of us over the past couple of decades, they have taken on a different complexion, the dreaded differential shadings indicating prevalence in different regions of the world with now 34 million people living with HIV/AIDS. If you look in the upper left-hand corner of the slide, you see the United States where we have 1.1 million people living with HIV and focus it a little bit and you see Washington, D.C. Now

there are a couple of issues about Washington. Now we welcome you here, but it was 25 years ago that the International AIDS Conference was in Washington. I have had the privilege and opportunity to participate in every one of the 19 conferences of the International AIDs Society, but I want to play a little bit moment with you with Washington when you talk about what we share globally. Like I said, I like maps. This is a Google map of Washington, D.C. This is where you are sitting, again the dreaded shadings, because in Washington, D.C. we have a prevalence that in many respects equals some of the PEPFAR nations. As Michel said last night, it is the best of times and the worst of times. The worst of times is the prevalence. The hope for the best of times, as you heard from the mayor last night, Washington, DC has implemented an aggressive and innovative program that can serve as an impact and I will get back to that in a moment.

Let us get to the gist of what I want to develop with you over the next several minutes. We want to get to the end of AIDS. That will only occur with some fundamental foundations and these foundations are the basic and the clinical research which will give us the tools which will ultimately lead to interventions and then ultimately these will need to be implemented together with studies about how best to implement them. So let me briefly go through each of these with you.

The basic and the clinical research: we have had a stunning amount of advances in the arena of basic and clinical science, which are delineated on this slide. I do not have time to go through each and every one of them with you, but there are some that stand out. Some as breakthroughs such as the initial identification of the virus by Francois Barre-Sinoussi and her colleagues at the Pasteur. The demonstration that it is the ideological agent by Gallo and his colleagues. The intensive incremental, if that was a breakthrough, the incremental science each year learning more and more about the HIV virus itself as well as the pathogenic mechanisms. Now this is a confusing slide because I put on one slide of about 30 years of incremental research and what we know now a lot about this virus: the primary infection, the establishment of infection in lymphoid tissue, massive virenia, seating of organs, immune activation, partial, but never completely immunological control, accelerated virus replication and in the absence of destruction of the immune system. Very important in that process of incremental scientific knowledge is understanding the early events of HIV particularly at the mucosal surface where there is vulnerability of the host and vulnerability of the virus and understanding that interdigitation is extraordinarily important in insight into both transmission and vaccine development. Probably the most important in the understanding the HIV replication cycle from

the binding fusion insertion of its RNA, reverse transcription, integration and then viral budding because each of that year after year has given us targets of vulnerability on the part of the virus and it is that kind of basic science that brings us to the next step and that is the step of interventions, predominantly in the arena of treatment and prevention.

Let us start with treatment. I dug this photo out of the archives, a picture of me and some of my fellows and students in the very early 1980s when we were frustrated clinically, but beginning to made headways scientifically. I refer to these as the dark years of my medical career, but what kept us, myself and my colleagues not only here but throughout the country and the world going forward even though we were much in the dark was realizing what people were going through in the community as eloquently stated by Cleve Jones in some of the films that you see about what was going on in the Castro in San Francisco by Larry Kramer and his play The Normal Heart describing what was going on in Greenwich Village. But things began to happen. The science led to interventions and if you look at the evolution of treatment strategies the first drug in 1987, AZT, a glimmer of hope, virus goes down, very little does not stay down, resistance occurs. Years go by, two drugs, virus goes down further for a little bit longer but not enough. Then the transforming meeting in Vancouver in 1996 with a three-drug therapy, brings down the virus to below detectable levels stays

there potentially indefinitely and we have a new dawn of therapeutics with HIV/AIDS that have transformed the lives of individuals. We have now up to 30 HIV/anti-HIV drugs approved by the FDA. Multiple classes used in combinations that have completely transformed things, but we can't stop there because there are still those that are not responding to these drugs and we still need long acting drugs particularly with regard to adherence.

The results have been spectacular. I am going to pick out a couple of examples. If you look, and this is a study from Holland. I told you back in the dark years of my experience, the median survival of my patients was 6 to 8 months, 60-percent dead in 6 to 8 months. Now if a person walks into our clinic at the NIH or any other place that has availability of treatment, is young, 25, and recently infected, you put them on combination therapy and you could look them in the eye and tell them it is likely that if they adhere to that regimen, that they will live an additional 50 years. This is not only confined just to the developed world because we know now in countries for example, the cohort analysis in Uganda, that the same similar results with normal life expectancy, That is the good news.

But then there is challenges. This is a very scary slide because if you look at the United States of the 1.1 million people inf*ected,* 20-percent do not know they're

infected. 62-percent are linked to care. 41-percent are retained in care.

Only 36-percent are on antivirals and 28-percent are suppressing their viral loads. We must do better than that. We have the tools and as I will get to in a moment, we need to implement that. It can be all around. We can take examples from the developing world, but what we need to do is that we need and are doing it having a care continuum that is seeking out, testing, linking to care, treating when eligible and making sure they adhere.

And in fact getting back to the District of Columbia, there is a study going on now with six cities, two of which are implement cities, the South Bronx, and Washington D.C. where we are starting to see that this can actually occur if you put the effort and I am sure you'll hear more about that later from Martha L. Sauder [misspelled?] and her colleagues. It does not only happen in the developed world and That is what people keep saying, is this really going to be able to be done? Well take a look at what's going on in Rwanda where you have a community based program where the two year retention of treatment was 92-percent with 98-percent tested at two years had suppressed viral load. Similar results in Botswana. Extending the intervention, what about prevention?

Combination HIV prevention, the message for this is prevention is not unique dimensional. And we all know that.

There is a combination That is comprehensive on the lower level of these building blocks are interventions that are not necessarily biologically driven. We were implementing them before we even knew there was a virus, what the virus was. But then as the years went by, science led us some examples briefly, prevention of mother to child transmission, the breakthrough study of 076 indicating that by treating the mother, you can actually decrease dramatically. Now we treat mother's for their disease and then secondarily together with mother's help, the baby is born uninfected and can be breastfed.

In the United States, this has transformed what you see now on these red bars the estimated number of HIV infected infants, but in fact, remember what Mayor Grey said last night, in this city, with high prevalence, there has not been a child born with HIV infected since 2009 in a city with high prevalence.

That is the good news that 600,000 pediatrics were averted by prophylactics. But we still have a challenge. There are 330,000 new infections in 2011 alone. What about male circumcision? This is a stunningly successful intervention. The initial trials in South Africa, Kenya and Uganda showed efficacy that in the confines of a trial, it works. The real question is, will it work in the field? And as a matter of fact, uniquely this is one of the few prevention interventions

that actually gets better with time because the initial result was 55 to 60-percent.

If you go to the Rakai District in Uganda, five years out, the effectiveness in the community is 73-percent. Topical microbicides. Good news and challenging news because of mixed results. The caprices study improved the concept. You can have the women mandated intervention by a gel that has Tenofovir when you adhere to it. This study and the prep study has then soberly told us something.

Biological interventions work, but they do not work if you do not adhere, which tells us why we have to marry biological with behavioral. There is no doubt about that. We know that from the Voy study, which was discontinued due to futility, hopefully we'll get the answer from the Facts study. Getting back to the long acting orals, the same thing has to do with the microbicides and we are very pleased that the approach of now monthly use in two studies were started this year, the Aspire study and the Ring study which will hopefully bring a greater degree of adherence to show that efficacy will bring a greater degree of adherence. Pre-exposure prophylactics again mixed results.

The breakthrough study with the Iprexin, the recent approval of the FDA with Truvada, both higher risk men who have sex with men and heterosexual either discordant couples are

heterosexuals at risk, but there are some studies that show it does not work.

It does not work almost certainly with some biological effect, perhaps with concentration of drug, but importantly adherence again hammering home to us the concept that biological efficacy will not be effective without adherence. Probably the most game changing advance over the last couple of years with treatment as prevention with the now very famous HPTN052 trial which reduced by 96-percent the likelihood that someone will transmit to their uninfected partner if you treat early.

A great argument for getting people on treatment. Now before I go onto the implementation, I just want to mention that I am telling you a lot of good news about science, but we still have challenges. We have challenges in the arena of vaccination and we have challenges in the arena of cure.

What about the development of a vaccine? If we were able to plug in a vaccine block, we would surely have a very robust combination prevention package, even if it wasn't a perfect vaccine, even if it wasn't 90-percent or 80-percent, we could do it. Let us take a look where we have been with that. You are all familiar with the RV144 trial. It is a humbling trial because it showed a modest degree of efficacy, but when you mine down and try and figure out the potential carlets, we

find out that it is non-neurtraili9zing, non-CD8 regulated, response against a variable region of the envelope.

Something that the classic paradigm would not have predicted. But the neutralizing antibody approach is also very important, in fact, naturally induce neutralizing antibody, as few as they are, as ineffective as they are and as late as they are, are giving us scientific clues to identify neutralizing epitomes on the envelope, which will do two things, and you are going to see parallel research going on.

You are going to see structure based immune design for a vaccine at the same time, the provision passively of neutralizing antibodies, either by transfer or by gene-based vectors. We need to show if neutralizing antibodies actually do protect, otherwise a vaccine could be moot.

What about a cure? Francoise and her colleagues a couple of days ago sponsored and extraordinary symposium about approaches to an HIV cure. Two general types, either eradication purging it, which would be very difficult, or perhaps what I have called years ago, a functional cure. Mainly encasing HIV immunity or modifying the host cells to be resistant. I want to make sure, I know people in this room understand, but others do not; this is not an implementable intervention, this is way upstream on the fundamental basic discovery level, so that you can put an end to the HIV pandemic, which, as Mark said last night, is an epidemiological

phenomena without curing anybody and you can cure a few people, without putting an end to the HIV pandemic.

Let us go onto implementation. We have been able to implement from what we have discussed over the last day or so, the extraordinary effect of the PEPFAR program, the Global Fund, philanthropies such as the Billimon, the Gates Foundation, Metsanfranteya, the Clinton Foundation, but importantly, recently, the assumption by host countries of their own responsibility, and this has really been very important, so I wanted to take a look at this, just a couple of minutes of this. What happens when you take an efficacious clinical trial based scientific observation and you try to scale it up regionally or locally to see if it becomes effective.

There are many examples, I am just going to give you a few. What about the positive impact of scaling up any retrovirals in Botswana? Take a look at the red dots, which is the percentage of mothers who are actually being treated. Take a look at the diminishing blue bars, the number and percentage of children who are born with HIV. It works. What about the fact that if you treat people, do you really save their lives? We now have 8 million people receiving antiretrovirals in low- and middle-income countries, which in fact 840,000 in AIDS-related deaths have been averted in 2011 alone. Ask the question, what about the positive impact of therapy on the HIV

incidents? You go to a place where you have 30-percent in Kwazulu-Natal and another section where there is 10-percent coverage. There is a 38-percent lower risk of acquiring HIV in those high coverage areas. Treatment as prevention works in the field if you implement it. We know that scientifically.

What about the impact of voluntary male circumcision? Again, if you look at the study in the Rakai district, if you take non-Muslim populations who generally do not get circumcised, if you increase the circumcision by 35-percent by 2011, you have a 42-percent decrease in acquisition of infection.

What about co-morbidities? ART and TB, very nefarious marriage between those two diseases. But look at what ART is doing for TB, it reduces incidences the best way to prevent TB is by treating the HIV. It decreases it by 67-percent. It halves the recurrent rate and it reduces mortality by up to 90-plus-percent. Now you are going to hear a lot about models, important models, models can be complex and confusing depending upon what the assumptions are. You could model scale up of ART, microbicides, PMCC, male circumcision and you could even stick a vaccine in there. Rather than go through the complexities of the models, I want to talk to you just for a minute about a very uncomplicated aspirational model.

We know now that the incidence is going down from 2.7 to 2.5, so the slope is going down. Notice in the lower right,

I do not have the date there, because we can't talk about a date, but for sure, the decline is not steep enough. So when you talk about scaling up the things that Eric Goosby and others have been talking about, this is what we hope for.

That we will see a major deflection of that curve and if we are fortunate enough to add a vaccine to that, this is what we hope to see. No promises, no dates, but we know it can happen. So if you go back to what I have been saying about the science today, in July, of 2012, the statement that we do not have the scientific basis to implement is no longer valid, we do, That is the point.

The critical question is what's going to happen because this will not happen spontaneously. What it will require are the things that Secretary Clinton spoke about when she introduced the possibility in November of 2011 at the NIH of an AIDS free generation a lot of people, a lot of countries, a lot of regions have a lot to do, from country ownership, capacity building, health systems strengthening, increased commitment by current partners involving new partners, coordination, get rid of what does not work, concentrate on what does work and remove the legal and political and stigma barriers. Only then will this occur. So let's get back to this dreaded map.

I mentioned in the beginning of my talk, I had had the opportunity at every one of the 19 meetings. This is the map that I led off this meeting for. What I hope for over the

coming meetings of the International AIDS Society is to be able to show a map that goes like this, and this, and this until finally we can say, that we are the generation that opened the door through our scientific endeavors and our implementation to an AIDS free generation. Thank you.

FEMALE SPEAKER 1: Introducing our second speaker, please welcome Ebony Johnson, CEO of a A Drop of Prevention and the Athena Network.

EBONY JOHNSON: Good morning, first as a woman from the United States, I am so please to welcome you back and to thank and congratulate the exceptional bold leadership of President Obama for lifting the travel ban. But as a black woman, residing in Washington, D.C., we face the highest rates of HIV and we are black women at the center of vulnerability. It is a pleasure to welcome you back to be your voice and for this to be a call of action.

It is my pleasure to introduce from the U.S., Phill Wilson. Phill Wilson is the president and CEO of the Black AIDS Institute. The black AIDS Institute is the only national HIV/AIDS think tank in the United States focused exclusively on ending the AIDS pandemic in black communities by engaging and mobilizing individuals and efforts to confront HIV by interpreting public and private sector policies, conducting trainings, providing technical assistance and disseminating HIV and AIDs-related advocacy. From a uniquely and unapologetically

black perspective. Wilson previously served as the AIDS coordinator for the city of Los Angeles as the director of policy and planning for Project Los Angeles, as co-chair for the Los Angeles Health Commission and as an appointee to Hersik for the Advisory Committee.

Wilson has been involved in a myriad of agencies from their inception across the United States. They include the National Black Lesbian and Gay Leadership forum, the National Taskforce on AIDS, the Chris Brownlie Hospice, the AIDS Healthcare Foundation, the National Minority AIDS Council, the Los Angeles County Gay Men of Color Consort ion, the Gay Coalition and Mr. Wilson has also worked very extensively across eastern and western Europe, in sub-Saharan Africa, India and Mexico.

In 2001, Phill Wilson was named as the leadership for change in the world recipient. In 2004, he received the Discovery Health Channel Medal of Honor. He has also been named as the 2005 Black History Makers in the Making by Black Entertainment Television. Mr. Wilson is a prolific writer, who has published several articles and newspaper writings. Please welcome him to the stage. Thank you.

PHILL WILSON: I am both honored and humbled to have been asked by the conference organizers to share my thoughts with you this morning. But I am also a little intimidated to have to follow Dr. Tony Fauci, one of the greatest heroes in

this movement and I am more than a little nervous to stand between and one of the highlights of this conference, Secretary of State, Hillary Clinton.

I am thinking something about a rock and a hard place right now, but on behalf of the estimated 1.1 million Americans living with HIV and the tens of thousands of doctors, nurses, researchers, advocates, counselors, activists and volunteers who serve them who work every day to end the AIDS epidemic in this country, welcome back to our house.

22 years is a long time and we missed you. And welcome to the first International AIDS Conference where we know that we can end AIDS. 31 years after this disease was discovered right here in this country, we finally have the right combination in this country to stop this epidemic. No, we do not have a cure or vaccine yet, but David only had a slingshot and he felled Goliath. Our tools are not perfect but they are good enough to get the job done if, and this is a big if, if we use them efficiently, effectively, expeditiously and compassionately. And That is what I want to talk to you about this morning.

I am an openly gay man who has been living with HIV for 32 years. Treatment may be prevention, but I am proof that treatment is treatment when half of the people living with HIV in this country are black and over 60-percent are men who have

sex with men, I understand why the organizers of this meeting would invite someone like me to give this talk.

You see, I am a three. I am black, I am gay, I am HIV-positive and according to AARP, I can clip off the senior box as well. But it is not lost on me all the things I am not. I am not a woman, a straight man, or a transgendered person. I am not an Asian Pacific Islander, Latino, Native American, White or an immigrant. I do not speak Spanish or Creole or Vietnamese. I am not an injecting drug user, sex worker, homeless or the victim of domestic violence. I do not live in the rural South and I have never even been to Anchorage or Bismarck. But I know this, I know that we will not end the AIDS epidemic in this country unless all of those voices are included. All of what I am and am not must be a part of the conversation.

The United States spans nine time zones. It has a population of over 300 million people speaking 311 languages and 14 million American households, English is not the primary language. You might think the United States has it easy and in some ways we do. We have great universities that generate superb science.

We have an entrepreneurial and a can-do spirit. And we are wealthy. But even so, many of our residents live in debilitating poverty. We have unacceptable homelessness, addiction and mental health illness. We have large numbers of

people who suffer from other diseases such as Hepatitis B and C and are marginalized and stigmatized. We not only have the largest epidemic in the developing world, we have one of the most complicated epidemics in the entire world. We face gigantic challenges, challenges that demands we rely on lessons learned in many other countries, lessons learned by you in this room and challenges that offer the possibility for learning that in turn can be applied all over the globe.

Approximately 50,000 people get infected each year in the United States. That is a dramatic decrease from where we were in the mid-80s, but our prevention efforts have been stalled for at least the last 15 years.

Demographically our epidemic is 75-percent male and 25-percent female. Estimated HIV prevalence among transgendered persons range from 14-percent to 69-percent. Our epidemic is 43-percent black, 44-percent white, 19-percent Latino, 1-percent Asian Pacific Islander and less than 1-percent Native American and Hawaiian. 44-percent of the epidemic lives in 12 cities, but new HIV infections are rapidly rising in rural communities, especially the South.

The U.S. epidemic is primarily a concentrated epidemic. But in certain populations, we have generalized epidemics. For example with a background HIV prevalence of almost 8-percent, and 835 new HIV infections in 2010, the AIDS epidemic in Washington, D.C. right here is a generalized one. And it is one

that is worse than the AIDS epidemic in Port-au-Prince, Haiti. Black men, who have sex with men are engulfed raging generalized epidemic, according to a new report released by the Black Gay Men's Advocacy Coalition, the Black Gay Research Group and the Black Gay Institute, black MSM are at a an elevated risk of HIV infection regardless of age. The odds that a black MSM will become infected increases from 1 in 4, 1 in 4 at age 25 to 59.3-percent chance by the time he reaches 40 years-old.

Now think about that for a minute. By the time a black gay man reaches 40 years-old, nearly 60-percent of them, 6 out of 10 will be HIV-positive. The AIDS epidemic in America is a tale of Two Cities. That seems to be a theme for this week. It is defiantly the best of times and the worst of times. We have a system that can work very well for some of us. But for many of us, the system is terribly, terribly broken.

The other day, I was talking to my friend, David Munar, the president and CEO of the AIDS Foundation of Chicago about his friend Luis. A Mexican immigrant who lived the last nine years of his life in the United States. He worked 6 and sometimes 7 days a week as a busboy and dishwasher at two restaurants. He paid taxes and otherwise obeyed the law. He was privately jovial, silly and loved to dress in drag. Do not we all?

His health declined rapidly and tragically in 1995, at the age of 25, Luis died from AIDS-related complications. His friends pulled together the resources to bury him, but what followed next shocked everyone who knew him. His name was not Luis. That was an alias he assumed for work papers, social security and Medicaid. He lived the secretive life of all. In fact, his sister who traveled from Mexico to come collect his remains learned only after his death that her brother was gay and had AIDS. Luis's deception helped him access meds and healthcare that he otherwise could not afford, but it denied him a chance to live and die with dignity.

Lawrence Stahlworth is in the audience today. He was 17 years-old when he found out that he was HIV-positive. If only took one mistake for the virus to become a personal reality for him. Lawrence's father, once he found out that his son has HIV, reacted by going into the bathroom and closing the door. Lawrence eventually got linked to care, found a job working in HIV. Unfortunately his job didn't offer health insurance and did not pay enough for Lawrence for his own treatment, so he was forced to choose between working or staying on medication. What kind of choice is that? Luis and Lawrence are not isolated examples.

This next model first described by Dr. Edward Gardner at the University of Colorado estimates how many people with HIV in the U.S. are engaged in the various steps and the

continuum of care from diagnosis to viral suppression. There are three things in this slide that strike me most. First, about 80-percent of HIV positive people in the United States know their status. Now we can do better, but That is not too bad.

Second, once we get people on antiretrovirals, around 71-percent get to suppression, again, we can do better. But the real problem is in this middle section here. We do a terrible job of moving people from testing to being on antiretrovirals. Between testing positive and going on antiretrovirals, we lose 54-percent of people with HIV. Remember these are people for whom we have some kind of contact. Bottom-line, in the richest nation on the planet, barely a quarter of the people with HIV are in fully effective treatment. More than 70-percent are either not on treatment at all or on sabbatanal [misspelled?] treatment. That is bad for them and it is bad for everyone else because when they are not on treatment, they are much, much more likely to spread the virus.

We, you and I, the people in this room, the people in the global. Village, the people doing work every day who couldn’t afford to come to this conference have to change that. Luckily there are people in program who are showing us how. Right here in this city, the community education group, a small not-for-profit organization that serves predominantly black neighborhoods offers HIV tests and a whole lot more. Of the

people who test, who turn out to be positive, 95-percent, 95-percent are linked, re-linked or confirmed to be receiving HIV care and treatment services. Rather than giving individuals a paper referral, CG provides its clients an immediate personal escort and if needed, financial incentives to go to medical providers. CG uses new technology to conduct risk assessments and enroll community members in DC's Free Asserns program and/or Medicaid. They also provide patient follow-up, such as text message reminders and indications of when they have medical appointments. Something else happened here in Washington DC.

There is huge help for people who have HIV. It is called the Affordable Care Act, better known as Obama Care. Because of this law, no insurance company can deny you coverage because you have a preexisting condition, jack up your rates or drop you because you get sick because your care costs too much. For people with HIV and AIDS, these provisions are absolutely life-saving.

Leadership matters. Two years ago, President Obama released a first ever comprehensive HIV/AIDS strategy in the United States. According to the vision of the strategy, the United States would become a place where new HIV infections are rare and when they do occur, every person regardless of AIDS, gender, race, ethnicity, sexual orientation, gender identity, or socioeconomic circumstance will have unfettered access to

high quality, life-extending care, free from stigma and discrimination.

Together we can manifest that vision if we do the following things: first, we must fully implement the Affordability Care Act; this will deliver health coverage to more than 30 million people who are currently uninsured. Single childless adults who are typically not eligible for Medicaid, a critical failure in an epidemic concentrated among low income gay men, but under the Affordable Care Act, everyone will have the means to pay for life saving treatment. This most important piece of legislation over the last 40 years has generated a lot of opposition and misinformation. AIDS advocates must be at the forefront of opposing any efforts, any efforts opposed to rollback reform on the Affordability Care Act.

We need to ensure that the mandatory benefits packages include an annual physical for everyone, an HIV test at physical, including at least two annual HIV tests for high risk individuals, twice a year viral load test for people living with HIV and comprehensive coverage of ARVs, both for treatment and prevention.

Second, everyone living with HIV must come out. We all must come out. Living openly and proudly with HIV, not only confronts HIV stigma, but it also helps build demand for essential services. Openly HIV positive people serve as living, compelling reminders of the importance of knowing one’s HIV

status and that it also communicates that it is possible to live a full, healthy life with HIV and That is important. When you come out about your HIV status, you not only say, you save your life, but you save other lives as well. My family is here in this room this morning. My brother, my dad, and my mom. When I was 24, I gave my mother a book called Loving Someone Gay and she said to me why do you give me this book? I do not love anyone gay. Yes, you do I said. You love me. And I was right. I am alive today because I have the love and support of family and friends, but they could not support me if I denied them a chance to truly know me, not just some one dimensional avatar of me, but all of me. Despite the quilt being on the Mall this week, which is really about our death, the stories of our lives are largely untold and unnoticed. We want our families to love us and to support us, but they cannot love us if they do not' know us and they can't know us if we continue to hide from them.

Now, I am not naïve. I know it is too dangerous for some of us to come out right now, but some of us can, and if we do, others will be able to join us later.

Third, we need to put as much emphasis on building demand on treatment as insuring access. Our healthcare system has long been a source of shame. The United States is the only industrialized country that has not guaranteed health coverage for its citizens, but through a combination of programs such as

Medicaid and the Ryan White Care Act, we have actually built a robust system of care for people living with HIV. Yet only about one and four people with HIV in our country are now receiving the care they need and deserve. If we demand it, they will have to build it. Health services are not meaningful unless they are actually used. Too many people are intimidated by the medical system.

Too many still believe that a positive HIV test is a death sentence. And too many people believe that HIV treatment requires a fistful of pills everyday with horrible side effects. We need a massive investment in community education and HIV science treatment literacy. We need an army of peer patient navigators that lead individuals to deliver the care they need.

Four, we need to integrate the biomedical and the behavioral in our prevention and treatment efforts. Some people in the AIDS field continue to resist the so-called medicalization of AIDS while others promote these new biomedical tools as a panacea. Neither perspective is correct. These new biomedical strategies, the treatment as prevention, prep and the others still to be developed are more powerful than anything we have ever had in our toolkit before. But to work, these powerful biomedical tools will need to connect with actually people.

Those who deliver them and those who use them. Our biomedical interventions won't be effective if people are frustrated by the complexity of the medical delivery service system. And they simply give up, if they do not understand the important of adherence to the prescribed regimens or if their providers are judgmental or display that they do not understand what our lives are like, over the course of this epidemic, we have learned a lot about how to influence human behavior. And we need to apply these lessons as we have put our new biomedical tools into practice.

The crucial point here is that it is not an either/or, but a both/and. The biomedical only works when education counseling, behavioral change, adherence and support are all there. The whole history of the epidemic has shown us that while education and social behavior interventions are necessary, they're absolutely not sufficient. IF they were, the epidemic would be over already. It is the addition of biomedical interventions that can lead us to the promise of ending AIDS. We must turn this tide together.

Finally, the fifth thing we need to do is that AIDS organizations need to retool themselves to rapidly evolving AIDS landscape. Communities will always remain central to our ability to end AIDS. But most of our community based organizations have focused their expertise on behavioral interventions only.

Few have meaningful scientific expertise and fewer still actually deliver healthcare services. With biomedical tools rapidly becoming a critical part of our AIDS response and with Affordable Care Act poised to dramatically alter the terrain for health and social services, many AIDS organizations risk becoming wholly irrelevant.

Fortunately some visionary organizations have already begin to retool. Harlem United for example has actively worked to adapt to the dynamic environment readying itself for state Medicaid reform and shifts in the Nations' healthcare system. It began as a small organization, but today, it is a federally qualified health center with 3,000 patient. Harlem United connects the dot between medical care and social services.

Eric De La Torre is also here this morning. He is a health educator and youth advocate for Vienna Star, a unique peer-based social service organization serving locations in Los Angeles. They serve them by building an infrastructure that connects prevention and treatment and science with advocacy. Harlem United CEG and Vienna Star are three examples of what effective AIDS service organizations must look like if we are going to end the AIDS epidemic.

I have a recurring dream in which a little boy asks a wise old woman, what did you do when millions of people were dying from AIDS? I always wake up before the wise old woman has a chance to answer. I am afraid I wake up because I am afraid

of the answer. I am afraid the answer will be, not enough. I work for a tiny organization and for all I know, we may close our doors next week, but this week, this week with our 30 black treatment advocates and our black scientists, no, this week with our journalists, we are going to squeeze every drop out of information out of this meeting that we can.

My worst nightmare is that we will squander this historic opportunity. And this is what I know. The day will come when this epidemic will be over and when it does, it is important for them to know that we were not all monsters, that we were not all cowards, that some of us, some of us dared to care in the face of it. Some of us, some of us darted to fight because of it and some of us, some of us dared to love in spite of it because it is in the caring and the fighting and the loving that we live forever. This is our time, this is our deciding moment together we are greater than AIDS.

FEMALE SPEAKER 1: Ladies and gentlemen, our next speaker will be on shortly. Please stand by. Please welcome Michel Sidibe, executive director of UNAIDS.

MICHEL SIDIBE: Friends, when we gather at the opening ceremony, I challenge you all to dream big dreams, to be born, to think of opportunity we have to end this epidemic. To be able to say, ten or twenty years from now that our generation took us over the finish line. Our generation made the decision to finally end AIDS, what a legacy for all of us. This morning,

I am honored to be given the honor to introduce a great leader who already is turning our aspiration into reality. She is part of America's dream team for HIV. President Obama, Secretary Clinton, Secretary Sebelius and my brother, friend Ambassador Goosby. Secretary Clinton is a person of vision, courage and intellect.

Here on the wall her leadership has touched so many people, from people in Island communities to heads of state. She was the first global leader to use foreign policy as a tool to promote global health. For example, appointing America's first ambassador at large for global women's issue. She was the first global leader to speak out about the tragic physical and economic impact of violence against women. And last November, she was the first global leader to call for an AIDS free generation.

She challenges us all to imagine a world where all babies are born free from HIV. Where everyone in need has access to treatment, where the rights of rights of women and girls are protected and promoted. Where shared responsibility with a global solidarity, where all people but especially those most affected by the epidemic have no fear or stigma of discrimination. She understands that if we turn the tide of HIV now, it will produce benefits of health and development around the world. History will remember her not only as one of the

world's more inspiring leaders, but also one of its most effective and committed visionaries for change.

At the moment when she has so many urgent demands from Syria to Afghanistan to the Human Red Cancer, her presence here is a powerful testimony of her heat and sensitivity and despite her global. Somehow she has always found time to be a caring mother of her impressive daughter, it is my tremendous pleasure and honor to introduce a true champion of the AIDS movement, the Secretary of State of United States of American, Hillary Rodham Clinton.

HILLARY RODHAM CLINTON: Good morning, good morning, now what would an AIDs conference be without a little protesting? We understand that. Part of the reason we have come as far as we have is because so many people all over the world have not been satisfied that we have done enough., And I am here to set a goal for a generation that is free of AIDS.

But first, let me say five words we have not been able to say for too long. Welcome to the United States. It was in 1990, in San Francisco, Dr. Eric Goosby, who is now our global AIDS ambassador, ran a triage center there for all the HIV-positive people who became sick during the conference. They set up IV drug drips to rehydrate patients. They gave antibiotics to people with AIDS-related pneumonia. Many had to be hospitalized and a few died. Even at a time when the world's

response to the epidemic was sorely lacking there were places and people of caring where people with AIDS found support.

Tragically, there was so little that could be done medically, and thankfully, that has changed. Caring brought action and action has made an impact. The ability to prevent and treat and the disease has advanced beyond what many might have reasonably hoped 22 years ago. Yes, AIDS is still incurable, but it no longer has to be a death sentence. That is a tribute to the work of countless people around the world many of whom are here at this conference. Others who are no longer with us but whose contributions live on.

For decades, the United States has played a key role. Starting in the 1990s under the Clinton Administration, we began slowly to make HIV treatment drugs more affordable. We began to face the epidemic in our own country. Then, in 2003 President Bush launched PEPFAR with strong bipartisan support from Congress, and this country began treating millions of people. Today, under President Obama, we are building on this legacy. PEPFAR is shifting out of emergency mode and starting to build sustainable health systems that will help us finally win this fight and deliver an AIDS-free generation. It is hard to overstate how sweeping or how crucial this change is.

When President Obama took office we knew that if we were going to win the fight against AIDS we could not keep treating it as an emergency. We had to fundamentally change the

way and our global partners did business. We have engaged diplomatically with ministers of finance and health but also with presidents and prime ministers to listen and learn about their priorities and needs in order to chart the best way forward together.

Now, I will admit that has required difficult conversations about issues that some leaders do not want to face, like government corruption and the procurement and delivery of drugs, or dealing with injecting drug users. It has been an essential part of helping more countries manage more of their own response to the epidemic.

We have also focused on supporting high-impact interventions, making tough decisions driven by science about we will and will not fund. We are delivering more results for the American taxpayer's dollar by taking simple steps, switching to generic drugs which saved more than $380 million in 2010 alone.

Crucially, we have vastly improved our coordination with the Global Fund. Where we used to work independently of each other, we now sit down together to decide, for example, which of us will fund AIDS treatment somewhere and which of us will fund the delivery of that treatment. That is a new way of working together for both of us, but I think it holds great results for all of us.

Now, all of these strategic shifts have required a lot of heavy lifting. It only matters in the end if it means we are saving more lives and we are. Since 2009, we have more than doubled the number of people who get treatment that keeps them alive. We are also reaching far more people with prevention, testing, and counseling. I want publicly to thank, first and foremost, Dr. Eric Goosby who has been on the frontlines of all this work since the 1980s in San Francisco.

He is somewhere in this vast hall, cringing with embarrassment but more than anyone else he had a vision for what PEPFAR needed to become, and the tenacity to keep working to make it happen. I want to thank his extraordinary partners here in this administration, Dr. Tom Frieden at the Centers for Disease Control and Dr. Rajiv Shah at USAID.

Now, with the progress we are making together, we can look ahead to a historic goal, creating an AIDS-free generation. This is part of President Obama's call to make fighting global HIV/AIDS at home and abroad a priority for this administration.

In July 2010, he launched the first comprehensive National HIV/AIDS Strategy which has reinvigorated the domestic response to the epidemic, especially important here in Washington D.C., which needs more attention, more resources, and smarter strategies to deal with the epidemic in our nation's capital. Last November at the National Institutes of

Health with my friend Dr. Tony Fauci there, I spoke in depth about the goal of an AIDS-free generation and laid some of the ways we are advancing it through PEPFAR, USAID, and the CDC. On World AIDS Day, President Obama announced an ambitious commitment for the United States to reach six million people globally with life-saving treatment.

Now, since that time, I have heard a few voices from people raising questions about America's commitment to an AIDS-free generation, wondering whether we are really serious about achieving it. I am here today to make it absolutely clear. United States is committed and will remain committed to achieving an AIDS-free generation. We will not back off, we will not back down, we will fight for the resources necessary to achieve this historic milestone.

I know that many of you share my passion about achieving this goal. In fact, one could say I am preaching to the choir. Right now, I think we need a little preaching to choir and we need the choir and the congregation to keep singing, lifting up their voices, and spreading the message to everyone who is still standing outside. While I want to reaffirm my government's commitment, I am also here to boost yours. This is a fight we can win. We have already come so far, too far to stop now.

I want describe some of the progress we have made toward that goal and some of the work that lies ahead. Let me

begin by defining what we mean by an AIDS-free generation. It is time when first of all virtually no child anywhere will be born with the virus.

Secondly, as children and teenagers become adults they will be at significantly lower risk of ever becoming infected than they would be today, no matter where they are living. Third, if someone does acquire HIV they will have access to treatment that helps prevent them from developing AIDS and passing the virus onto others. Yes, HIV may be with us into the future until we finally achieve a cure, a vaccine; but the disease that HIV causes need not be with us.

As of last fall, every agency in the United States government involved in this effort is working together to get us on that path to an AIDS-free generation. We are focusing on what we call combination-prevention. Our strategy includes condoms, counseling and testing, and places special emphasis on three other interventions; treatment as prevention, voluntary medical male circumcision, and stopping the transmission of HIV from mothers to children.

Since November, we have elevated combination-prevention in all our HIV/AIDS work including right here in Washington which still has the highest HIV rate of any large city in our country. Globally, we have supported our partner countries shifting their investments toward the specific mix of prevention tools that will have the greatest impact for their

people. For example, Haiti is scaling up its efforts to prevent mother-to-child transmission including full treatment for mothers with HIV which will in turn, of course, prevent new infections. For the first time, the Haitian ministry of Health is committing its own funding to provide anti-retroviral treatment.

We are also making notable progress on the three pillars of our combination-prevention strategy. On treatment as prevention, the United States has added funding for nearly 600,000 more people since September, which means we are reaching nearly 4.5 million people now and closing in on our national goal of 6 million by the end of next year. That is our contribution to the global effort to reach universal coverage.

On male circumcision, we have supported more than 400,000 procedures since last December alone. I am pleased to announce that PEPFAR will provide an additional $40 million dollars to support South Africa's plans to provide voluntary medical circumcisions for almost a half a million of boys and men in the coming year.

You know, and we want the world to know that this procedure reduces the risk of female-to-male transmission by more than 60-percent, and for the rest of the man's life. The impact can be phenomenal. In Kenya and Tanzania, mothers ask for circumcision campaigns during school vacation so their teenage sons can participate.

In Zimbabwe, some male lawmakers wanted to show their constituents how safe and virtually painless the procedure is so they went to a mobile clinic and got circumcised. That is the kind of leadership we welcome. We are also seeing the development of new tools that would allow people to perform the procedure with less training and equipment that they need today without compromising safety. When such a device is approved by the World Health Organization, PEPFAR is ready to support it right away.

On mother-to-child transmission, we are committed to eliminating it by 2015 getting the number to zero. Over the years, we have invested more than $1 billion for this effort. In the first half of this fiscal year, we reached more than 370,000 women globally and we are on track to hit PEPFAR's target of reaching an additional 1.5 million women by next year.

We are also setting out to overcome one of the biggest hurdles in getting to zero. When women are identified as HIV positive and eligible for treatment, they are often referred to another clinic, one that may be too far away for them to reach. As a result, too many women never start treatment. Today, I am announcing that the United States will invest an additional $80 million dollars to fill this gap.

These funds will support innovative approaches to ensure that HIV-positive pregnant women get the treatment they

need to protect themselves, their babies, and their partners. Let there be no mistake, the United States is accelerating its work on all three of these fronts in the effort to create an AIDS-free generation.

Look at how all these elements come together to make a historic impact. In Zambia, we are supporting the government as they step up their efforts to prevent mother-to-child transmission. Between 2009 and 2011, the number of new infections went down by more than half and we are just getting started. Together we are going to keep up our momentum on mother-to-child transmission. In addition, we will help many more Zambians get on treatment and support a massive scale-up of male circumcision as well; two steps that, according to our models, will drive down the number of new sexually transmitted infections there by more than 25-percent over the next five years.

As the number of new infections in Zambia goes down, it will be possible to treat more people than are becoming infected each year. We will for the first time get ahead of the pandemic there. Eventually, an AIDS-free generation of Zambians will be in sight. Think of the lives we will touch in Zambia alone, all the mothers and fathers and children who will never have their lives ripped apart by this disease. Now, multiply that across the many other countries we are working with. In

fact, if you are not getting excited about this, please raise your hand and I will send somebody to check your pulse.

I know that creating an AIDS-free generation takes more than the right tools as important as they are. Ultimately, it is about people; the people who have the most to contribute to this goal and the most to gain from it. That means embracing the essential role that communities play, especially people living with HIV and the critical work of faith-based organizations. We need to make sure we are looking out for orphans and vulnerable children who are too often still overlooked on this epidemic. It will be no surprise to you to hear me say I want to highlight the particular role that women play.

In Sub-Saharan Africa today, women account for 60-percent of those living with HIV. Women want to protect themselves from HIV and they want access to adequate healthcare. We need to answer their call. PEPFAR is part of our comprehensive effort to meet the health needs of women and girls working across United States government and with our partners on HIV, maternal and child health, and reproductive health including voluntary family planning and our newly launched Child Survival Call to Action. Every woman should be able to decide when and whether to have children. This is true whether she is HIV positive or not.

I agree with the strong message that came out of the London Summit on Family Planning earlier this month, there should be no controversy about this, none at all. Across all of our health and development work, the United States is emphasizing gender equality because women need and deserve a voice in the decisions that affect their lives.

We are working to prevent and respond to gender-based violence which puts women at higher risk for contracting the virus and because women need more ways to protect themselves from HIV infection, last year we invested more than $90 million in research on microbicides. All these efforts will help close the health gap between women and men and lead to healthier families, communities, and nations as well.

If we are going to create an AIDS-free generation we also must address the needs of the people who are at the highest risk of contracting HIV. One recent study of female sex workers and those trafficked into prostitution in low and middle income countries found that on average 12-percent of them were HIV positive, far above the rates for women at large.

People who use injecting drugs account for about one-third of all the people who acquire HIV outside of Sub-Saharan Africa. In low and middle income countries, studies suggest that HIV prevalence among men who have sex with male partners could be up to 19 times higher than among the general population. Now, over the years, I have seen and experienced

how difficult it can be to talk about a disease that is transmitted the way that AIDS is. If we are going to beat AIDS we cannot afford to avoid sensitive conversations and we cannot fail to reach the people who are at the highest risk.

Unfortunately, today very few countries monitor the quality of services delivered to these high-risk key populations. Few are still rigorously assessed whether the services provided actually prevent transmission or do anything to ensure that HIV-positive people in these groups get the care and treatment they need. Even worse, some take actions that rather than discouraging risky behavior actually drives more people into the shadows where the epidemic is that much harder to fight.

The consequences are devastating for the people themselves and for the fight against HIV, because when key groups are marginalized the virus spreads rapidly within those groups and then also into the lower-risk general population. We are seeing this happen right now in Eastern Europe and Southeast Asia. Humans might discriminate but viruses do not. There is an old saying that goes why rob banks-because that is where the money is. If we want to save more lives we need to go where the virus is and get there as quickly as possible.

That means science should guide our efforts. Today, I am announcing three new efforts by the United States government to reach key populations. We will invest $15 million in

implementation research to identify the specific interventions that are most effective for each key population. We are also launching a $20 million challenge fund that will support country-lead plans to expand services for key populations. Finally, through the Robert Carr Civil Society Network Fund, we will invest $2 million to bolster the efforts of civil society groups to reach key populations.

Americans are rightly proud of the leading role that our country plays in the fight against HIV/AIDS. The world has learned a great deal through PEPFAR about what works and why. We have also learned a great deal about the needs that are not being met and how everyone can must work together to meet those needs.

For our part, PEPFAR will remain at the center of America's commitment to an AIDS-free generation. I have asked ambassador, Dr. Goosby to take the lead on developing and sharing our blueprint of the goals and objectives for the next phase of our effort and to release this blueprint by World AIDS Day this year. We want the next Congress, the next Secretary of State, and all of our partners here at home and around the world to have a clear picture of everything we have learned and a road map that shows what we will contribute to achieving an AIDS-free generation.

Reaching this goal is a shared responsibility. It beings with what we all do to help break the chain of mother-

to-child transmission, and this takes leadership at every level from investing in healthcare workers to removing the registrations fees that discourage women from seeking care. We need community and family leaders from grandmothers to religious leaders to encourage women to get tested and to demand treatment if they need it.

We also have a shared responsibility to support multilateral institutions like the Global Fund. In recent months as the United States has stepped up our commitment so have Saudi Arabia, Japan, Germany, the Gates foundation and others. I encourage other donors especially in emerging economies to increase their contributions to this essential organization.

Then finally, we all have a shared responsibility to get serious about promoting country ownership. The end state where a nation's efforts are lead, implemented, and eventually paid for by its government, its communities, its civil society, its private sector. I spoke earlier about how the United States is supporting country ownership. Well, we also look to our partner countries and donors to do their part. They can follow the example of the last few years in South Africa, Namibia, Botswana, India, and other countries who are able to provide more and better care for their own people because they are committing more of their own resources to HIV/AIDS.

Partner countries also need to take steps like fighting corruption and making sure their systems for approving drugs are as efficient as possible.

I began today by recalling the last time this conference was held here in the United States. I want to close by recalling another symbol of our cause, the AIDS memorial quilt. For a quarter century this quilt has been a source of solace and comfort for people around the world, a visible way to honor and remember, to mourn husbands and wives, brothers and sisters, sons and daughters, partners and friends. Some of you have seen the parts of the quilt that are on view in Washington this week.

I well remember the moment in 1996 when Bill and I went to the National Mall to see the quilt for ourselves. I had sent word ahead that I wanted to know where the names of friends I had lost were placed so that I could be sure to find them. When we saw how enormous the quilt was, cover acres of ground stretching from the Capitol Building to the Washington Monument; it was devastating.

In the months and years that followed, the quilt kept growing. In fact, back in 1996 was the last time it could be displayed all at once because it just got too big; too many people kept dying.

We are all here today because we want to bring about that moment when we stopped adding names and we can come to a

gathering like this one and not talk about the fight against AIDS, but instead commemorate the birth of a generation that is free of AIDS. That moment is still in the distance, but we know what road we need to take. We are closer to that destination than we have ever been, and as we continue on this journey together, we should be encouraged and inspired by the knowledge of how far we have already come.

Today and throughout this week, let us restore our own faith and renew our own purpose so we may together reach that goal of an AIDS-free generation and truly honor all of those who have been lost. Thank you all very much.

FEMALE SPEAKER 1: Ladies and gentlemen, please remain seated and standby while we reset the stage for the next presenter. Our next speaker will begin her speech shortly.

Please welcome Dr. Margaret Chan; Director General of the World Health Organization.

MARGARET CHAN, MD: Good morning, good morning, good morning to all of you. Ladies and gentlemen, the next presentation is titled, Turning the Tide in Affected Countries: Leadership, Accountability and Targets. It is, indeed, my please to introduce Sheila Tlou who is the Director of the UNAIDS Regional Support Team for Eastern and Southern Africa and the U.N. Eminent Person for Women, Girls, and HIV/AID in Southern Africa.

She has been involved in the response to HIV/AIDS from the start of the epidemic in Botswana. As a former member of Parliament and Minister of Health in Botswana, she met a successful national HIV and AIDS prevention, treatment, care, and support program. As chairperson of the Southern African Development Community, or SADC, and African Union Ministers of Health in 2005 and 2006, she provided leadership in adopting the SADC Malaria Eradication Program, the SADC HIV/AIDS Pan of Action, and the Maputo Plan of Action on Sexual and Reproductive Health and Rights.

She founded the Botswana chapter of the Society of Women and AIDS in Africa and represented Eastern and Southern African on the Board of the Global Fund. Dr. Tlou is a former Professor of Nursing at the University of Botswana and a former Director of the WHO Collaborating Centre for Nursing and Midwifery Development in Primary Health Care for Anglophone Africa; we are very proud of you Sheila.

Sheila has received several awards including the Botswana Presidential Order of Honor, the Florence Nightingale Award from the International Red Cross Society, and the Trailblazer Woman Leading Change Award from the World YWCA.

Ladies and gentlemen, please join me in welcoming Sheila Tlou to the stage.

SHEILA TLOU: Thank you very much, Margaret. Ladies and gentlemen, after all that—and I know already that time is up, I

will try to be as brief as possible. I do have to say that I am so happy to be back here in Washington D.C. I used to go to school here at the Catholic University of America and it is where I was taught the basic principles of public health that were applicable then as they still are now. It is here, too, that I was taught Catholicism but who became a Catholic who practices evidence-based Catholicism, so we will talk about that.

I want to recognize the people who went before me. After that performance, what more do you want? Nothing. However, being an actor, I know that there is something that did not happen yesterday. As an African, I have missed it and I know as black people; black people that are here missed it last night, we just did not have enough singing. So for my brother, if you will sing and then after I will say saw a prayer; a brief prayer that will take just a minute and then I will go on.

God of our weary years, God of our silent tears, thou who has brought us thus far on the way, thou who has by thy might led us into the light, keep us forever on the path we pray.

With that, let me use a little slide. I want us to recognize our ministers who are here. The ministers from Eastern and Southern Africa, the ministers from south Sub-Saharan African who are here, as well as the Deputy President of the Republic of South Africa. This shows [inaudible]

commitment and we are very proud of you because only when you are here can you be able to interact and really know where the epidemic is going and, therefore, we do not have to do a lot of advocates [inaudible].

This slide number goes at the back, but I have addressed conferences before. The nicest I ever addressed was the ECASA [misspelled?] in Kenya, where I simply told the people this is just—I left the professor at the hotel. What is before you is a village woman. That way I was able to go anywhere I wanted. Why, because I was a civil society person.

On that point, I want to salute all of the members of civil society who are here. I was born and bred in civil society and I am saying to keep on because we are not there yet so keep on. Indeed, this presentation, which I will have to go through very quickly because, in any event, I am [inaudible] and Hillary Clinton, and the other speakers are really put in a lot on our table. These are the people who donate—who contributed.

I was very excited getting this invitation that I sent it to everybody include Facebook and asked what I should do, and all my 5,000 Facebook friends contributed members of—I mean, everybody. I could write a book, so I am just waiting for Peter [inaudible] to teach me how to write one. [Inaudible].

I want to recognize to two new kids on the block, the [inaudible] Africa, which is uniformed, and the president is

right here, Dr. [inaudible] from Zimbabwe. This is an organization made up of members of Parliament, ministers, and all those top women on the continent who are now going to work with the African Union, our president, to ensure advocacy and to ensure that everything that is talked about here—that country ownership, shared responsibility, mutual accountability is actually realized. We see them as a very powerful organization. Of course, the Pan African Positive Women's Coalition, an affiliate of ICW, which is to be launched here, which [inaudible] the size, the problems, and the needs of the African woman and be able to work with the African Union commission to calculate the needs of HIV positive women in the continent of Africa. That map has already been shown. I will not go into it. It does show how affected we are.

However, I must also say that map also shows that people are alive. It could be a actually a little quieter, meaning that the people have died. People are alive and they are on ARVs and we want them to die of old age, just like everybody else. We have done a lot. We have done a lot in Africa, and I am not going to go through all the things, but will simply say that in less than a decade, HIV treatment has actually increased more than 100-fold.

Yes, the orphans and vulnerable children are now receiving basic education, health, and social protection. We

have partnerships, but more than all, Africa is owning the epidemic.

Actually ownership is not a new concept. I still remember 1996, the Vancouver where it was said hope, but in Africa that is probably was not hope with the crisis it was. When the price is sort of reduced, the scientists were saying uh-uh, it would never be done in such limited settings, they do not have the same [inaudible] or the facilities and all of that.

I regret to say that in 1998, after the ADT-076 [misspelled?] study, we talked to our president Muhi [misspelled?] who is here with the champions for an HIV-free generation, and he said that it was just one study done in Thailand and it told him that it has been found to reduce mother-to-child transmission. He said if it can save our children then we will also do that. That was bold leadership because at that time, his counterparts were still wondering whether HIV even caused AIDS. Here was a man who was saying we are running out and in 1999 Botswana started the rollout of services to prevent mother-to-child transmission; the first country to do that.

When I became Minister of Health in 2004, my predecessor had already rolled out enough that mother-to-child transmission was in doubt, but between 2004—because now we are really able to roll out to the rural areas, we have brought

down mother-to-child transmission from around 35-percent all the way to less than 5% within four years showing that, yes, it can be done in Africa. As [inaudible] once said, yes we can; and we were able to show that yes, we can.

The same thing happened with ARVs drawn out by 1996 had rolled out to more than 8-percent of the population and the [inaudible] guidelines. That brought about [inaudible] in Africa where people who—and of course, they were the partners, they were the partners. I must say that even before PAPFAM arrived, partners such as Botswana have a partnership where they [inaudible] and the drug companies, [inaudible] where all there so by the time PAPFAM came, country ownership was ours and we are able to say we are moving from here to there.

Even when they said they do not support condoms, we said fine, we took the money and took it to the Minister of Education then took our own money and bought condoms. It was a simple as that, so we have been able to come far.

Africa has been able to come very far, but we have challenges. The challenges have been very well calculated. We still have punitive loss; gender inequality and gender-based violence that we have to deal with. Because in the ultimate, science and behavior, yes, but we need an environment that supports that positive behavior and we still have to calculate that.

However, there was much realization last year when our leaders got together in 2011 at the United Nations General Assembly High Level Meeting on AIDS. The global community was there including all the global leaders and there were 3 problems: security council resolution, the global plan of elimination of new youth actions among children, and keeping their mothers alive. I like that part, and of course, the political [inaudible] on HIV and AIDS, which came out with 10 targets. These are the commandments for an HIV-free generation. These are the commandments for getting to 0. It is as simple as that.

One—and I am sure you can read them, but I am not going to go through them because I take it as [inaudible] we already know them. Anyone who raises their hand I am going to say, like Hillary Clinton, let us check [inaudible]. However, I am going to highlight some of them.

Eliminating new infections among children; of the 330,000 babies, 300,000 are in Sub-Saharan Africa and in 22 countries. Those are the countries that we want to work with to ensure 90-percent coverage but not including [inaudible].

Last year our civil society was very clear; saying no to single-dose nevirapine, and I am pleased to tell you that a lot of countries are moving toward Option B, but are now actually considering B plus because Malawi has already rolled out Option B plus, meaning that women are accessing ARVs

throughout their lives. They can breast feed, they can live longer, and it is great. They have they human right to be alive, so we are hoping that we will work with the [inaudible] community because in the ultimate, we do need to have maternal mortality.

Having this is a good objective and goal, but left to some of us then we would be saying eliminate maternal mortality because in the ultimate, we know there is a lot that we can do to prevent it; so we have maternal mortality [inaudible] work with countries who do that and to say that Option B plus is the way to go, and no country or no woman should settle for less. It is a simple as that.

In our debate—I have heard two things already. I am talking all over the place. One of the things was about the costs, and in for me, I said that if men where the ones getting pregnant would we be the one adding up all the costs of option B plus? I do not think so. We would not be wondering, and it is in the same manner.

That is because as women we are saying that women have the right to be alive, it is a right. They have the right to nurture their children, to bring them up [inaudible] so well articulated yesterday. Let us forge ahead, civil society, advocate for Option B plus. We will be right there.

Here we are. Are we close to getting there? If you look at that dot, you will see that, yes, we have considered

[inaudible] ownership and shared responsibility [inaudible]. We will reach that zero mark.

What about for reaching 15,000,000 people with ART? 8 million and 6 million in Sub-Saharan Africa which is a 22-percent increase. The most dramatic progress was in South Africa, Zimbabwe, and Kenya; countries in Sub-Saharan Africa, but we know, of course, that Botswana and [inaudible] have long achieved universal coverage. It is already showing that treatment is prevention in that it has actually resulted in reductions in new HIV infections.

Yes, if you look at those graphs, AIDS-related deaths versus those put on ARV's, those graphs are going to cross but we think with enough effort then we will get to that point.

Here is the problematic one; reducing sexual transmission of HIV by 50%. We are still having people infected. Granted, less than what use to happen, but infections have declined.

These declines have been, especially, among young adults, but at this juncture I want to say that we can do more if we can have new access and comprehensive sexuality education; that is the way to go. Young people have the right to decide when, how, and with whom to have sex and we are depriving them of that. Now we have young people who are pioneers, who are champions, who are really saying that they are going to [inaudible] and claim our rights. As adults who

are here, it is high time we accept that young people are not the leaders of tomorrow, they are the leaders of now.

Where are we? We are not on line to achieve this. I really do not think so, but young-considered efforts, maybe, in 2050 we will be able to assess where we are and to say that we are nearly there, and we want to be there but we have to remember that as much as we are saying treatment is prevention, we cannot treat ourselves out of the epidemic. Here we are. That line is where we are completely parallel to that dot, but we will bend it. Let us show together we bend it a little bit and we will get there.

Priority actions; we have already talked about that. Know your epidemic, know your response studies. [Inaudible] working with countries on these studies.

There is something about evidence that hits you right in the face. You cannot ignore it. Any one leader who says that they do not have homosexuality, then we will simply say that here is the prevalence among men who have sex with men, here is the prevalence among sex workers, you cannot dispute those facts.

We really need now to scale up. We need investment framework and to use it as a tool to scale up all those services, but not only that. To ensure that in this scale-up we have other aspects. For example, critical enablers which provide access to housing, access to education, zero tolerance

for gender-based violence, gender equality, and things like that. We need a lot of work on this one, but we have to ensure the investment framework is really looks at what is working and scale it up; and let us reduce what does not seem to be working. With the little money we have, we can begin to do that.

Now is a component of combination prevention. We have had [inaudible]. I am really glad of the registration by the FDA of Truvada. My appeal is simply to say that it was tested in population in our region. Therefore, populations in our region should be some of the best to benefit from that. It has to be labeled as one of those guinea pig things, so we need that kind of advocacy and we are hoping we will soon be seeing Truvada on our medicine stands.

To end AIDS we need a bold leadership that, like I just said before, yes, a political leadership that I am describing [inaudible]. Before when I used to talk as the Minister of Health, they would say using we are scaling up because Botswana has resources, and I would say to them, no Botswana does not have any more resources than any other African continent. We have political commitment, prudent spending, good governments, and zero tolerance for corruption. I said those four ingredients are the one that are making us follow him.

This year, it was said by our ministers of health and finance—at that meeting I could have kissed them because they

now, for the first time, need good government and zero tolerance for corruption and the will be able to ensure that resources are going to where they are most needed. That is really great. We need leadership that can tackle the taboo topics on sexuality and shy away from phrases such as [inaudible]. It is very interesting. I do not have a problem with the word, [inaudible], but I get instead all the wrong places when you are using that for young people that you know are actually using contraception or anybody else who wants to just enjoy sex. We should have access to sexual and reproductive health commodities, period, for the complete enjoyment of sex.

I am a middle-aged woman. I have long had my children [inaudible], but I have the right to safe sex when, how, and anytime I want. [Interposing] does not make any sense to me.

So, let us talk about sex and sexuality ,and know that it is a God-given thing and we cannot shy away from it. We need leaders like that and we still do not want them yet, but we will cultivate them. They are coming up in Africa. Who are they?

The Global Commission on HIV did say that. They said countries should end false laws against all forms of child sexual abuse and child sexual exploitation, but should the differentiation between discriminating people, because what some African leaders right now are saying is that we do not

want men to have sex with men because they are luring our children into being homosexuals. We are saying no, a pedophile is a pedophile, amen. Whether he is a heterosexual or a homosexual, they should be punished. Sexual consent between adults should not be punished, so we should differentiate between the two, and I am glad the Global Commission on HIV and the Law has really come up with that. Of course, all countries really have to play their part, but most important, we are still encouraging our nations to really have sustainability for the AIDS response at country level [inaudible] of 15%, but not only that innovation that says when to tap resources such as all those that we have mentioned. [Inaudible], mobile phones, and Zimbabwe is [inaudible] which is very exemplary, has now been adopted by a lot of countries.

To end AIDS, we need mutual accountability. We need to define minimal standard-of-AIDS care, and we need to be able to monitor how resources are used both by the governments, by the partners, and the civil society, so we need transparency and we need literacy by all state borders. There is nothing quite as offensive as an advocate who does not know. You mention to somebody about the Maputo Plan of Action, and they do not know it, yet they are advocating for sexual and reproductive health say this, that is our Bible. If you do not know that, do you know ICPD? No you wouldn't. So, you should now, at least, the basic instruments for advocating with, we need that.

To end AIDS, we need innovations and sponsoring research. On that point, I want to commend South Africa. South Africa is leading on home-grown research that is done at home by home researchers and we need that kind of thing in Africa. Our leaders need to sponsor that. Yes, we can partner, but we need to be able to do that.

A vaccine; we have already talked about how the quest must be a global effort. We need to improve even our messaging. Let me tell you how I was able to get people to use the female condom, or at least to get our MPs to take it. After I launched it as the Minster of Health, they didn't want me to even bring the boxes to Parliament because they said it was hallowed ground and those things shouldn't be there. So, I said to them, let me tell you something; for women who have never had an orgasm, well they use this condom, they see God. Members of Parliament came and everyone went to their own box and said okay. When I went to show our constituents, I do not know they were used, but at least they were taken, and That is good, so any kind of mixed messaging. The message is simple, only shared responsibility and [inaudible] among all sections of society can end AIDS.

Our own executive director—I am just about to finish—our own executive director has been a real champion in revitalizing Africa at continental level. We have all these bodies, most of them are new. We have a U.N. envoy on AIDS in

Africa, a daughter of Africa, and we also have for the first time, and African Union chair who is a woman, and do not tell Africa.

So, hey, things that have been happening in Africa, watch this face because one day you may be seeing Sheila Tlou, President of the Republic of Botswana that would be so great.

This is the roadmap that our leaders have agreed on and it actually is show how and when to make sure to use those three pillars to drive country ownership, financial responsibility as well as that group of solidarity, but for the three diseases of AIDS, TB, and malaria.

I won't go too much into them because people are already going in, but certain responsibility and [inaudible] simply is saying, and people have already been saying it, that the development or model of donor and recipient is changing. We need to identify our own evidence-based informed policies, find out how to solve them, put funds in there, and then get the partners so that they come in as partners.

At the same time, we need more funding. No country can do this alone. We are not saying that countries should now be left on their own, no, and I am glad of what Hillary Clinton just promised us—the country of [inaudible] has always been the one who has stood by the developing countries, and now we have more partners, so this should really be done.

So with all of that, let me just end by saying that South Africa remains the center of the epidemic. Our civil society is very dedicated to the ten [inaudible] and should receive the proportional focus and resources. With all of this, we achieve our vision of zero new infections, zero discrimination, and zero AIDS-related deaths.

Thank you very much.

FEMALE SPEAKER 1: Ladies and gentlemen, please remain seated for the next session. There are volunteers passing out question cards. If you are here to see the session that starts at 11 o'clock, there are volunteers passing out question cards. We will have about a 5-minute change for seats and table set-up.

[END RECORDING]