Plenary: Dynamics of the Epidemic in Context
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FEMALE SPEAKER: Please welcome Terry McGovern, Senior Program Officer of the Ford Foundation where she works on gender rights and equality with a focus on human-rights related HIV/AIDS issues.

TERRY MCGOVERN: Paul Semugoma is a medical doctor trained in Tanzania and working in Uganda where he is involved in delivery of services for LGBTI in advocacy to address the gaps in HIV prevention and sexuality education and in education and building capacity for sexual minorities both nationally and regionally. Dr. Semugoma first became aware of the challenging gaps in HIV prevention among sexual minorities in Africa in 2004. He subsequently became involved in efforts to address these gaps and was immediately confronted by the stumbling blocks of ignorance and prejudice.

In 2009, he took part in the campaign to challenge the anti-homosexuality bill in Uganda with emphasis on the predicted effects on health and HIV prevention service delivery. He's currently a member of the steering committee of the Global Forum for HIV and MSM, a board member of African Men for Sexual Health and Rights and of AFYA Minority in East Africa. Welcome, doctor. [Applause]

DR. PAUL SEMUGOMA: Thank you very much. After that rousing introduction, I feel so unready to be here, but I am here. We've had a wonderful conference. We've been talking

about all the major advances which have been happening throughout the world concerning HIV. HIV is a major challenge, but we as the people of the world have been able to deal with it.

We are talking about turning the tide together for HIV, all of us together, also talking about specific populations. It is men who have sex with men that I'm concerned with. A brief overview of my talk, I'm going to talk about gay men and other MSM, the burden of HIV that they bear, about clinical care and HIV prevention, and then the barriers to progress because these are the most important things. We are able to turn the tide but there are barriers to progress with a few case studies including my country Uganda and then a call to action.

Men who have sex with men exist everywhere. It's kind of interesting to start like that. When we talk about men who have sex with men, actually I am also a man who have sex with men. [Applause] It's a major and important point to point out that men who have sex with men exist everywhere. If we say that they don't exist then we don't know how to deal with them, we don't know how to get to the challenges that we have in HIV prevention with them. Looking at this map, these are the latest statistics on HIV prevalence amongst men who have sex with men. It's a beautiful map. It shows the prevalence over all the world.

In the fourth decade of the HIV epidemic, pandemic, we do still have countries in the world which do not have HIV statistics for men who have sex with men. What is the problem there? There's a huge denial that they exist.

I want to tell you a story about the patient who changed my life. This was in 2004. I was by then a medical doctor. I had studied in two medical schools that is at Muhimbili Medical Center in the University of Dar es Salaam and had also studied at Makerere University. I had a bit of work of country, and then I'd gone back to Kampala, which is the capital city of Uganda to start work in private practice.

As I said, I'm a gay man. I had been dealing with HIV amongst Ugandans and I knew it was a disease that is spread by sex, but I had not been confronted by then by the fact that HIV is also spread by gay sex. I didn't have that link. I was faced by this guy. He was gay. I knew him. He had bisexual practices meaning he used to sleep with men and at a certain point in time he had slept with women. He had been recently diagnosed with HIV.

One of the things that he told me was one of my lovers must have slept with a woman. I was like you didn't sleep with a woman at this particular point, you must have got it from your lover. His point was since I've been seeing all these nice photos of men and women and the government telling us be careful, love carefully. These are the ones who spread HIV; it

is the women who give it to us. He also asked me a question, how do I protect my lovers? That was the question that changed my life. I knew at that particular moment that I didn't know how to protect him, how to give him the information, how to tell him to protect his lovers, and that was the changing point.

I then discovered that because I didn't know, I was ignorant. I was in sort of denial because I was a gay man and I am still a gay man. I just needed to know. I had access to the internet and I quickly educated myself, something which we all have to do. It is important that we leave from being just friendly to MSM, to men who have sex with men, to being competent in care.

This ignorance and denial it didn't happen just with me. It is also with everybody. Just a few months ago, about three months ago in [break in audio] Uganda the first LGBTI clinic was opened by one of the groups, one of the LGBTI groups. There are saying that, well we do not have a clinic. The doctors don't really know the problems that we have and we need a clinic. They got funding, very good, put the clinic in Kampala, very good, and then made sure that the government didn't know.

Then, what touched me was that three doctors were asked in Uganda what do you think about this? They are saying we do not discriminate because we are doctors, which is fantastic.

Then, they said we do not discriminate because we do not ask about sexual orientation. Now, if you do not ask about sexual orientation then that means that you are not aware that men who have sex with men actually come and sit with you in the consultation room and that men who have sex with men actually have a higher risk of HIV.

This ignorance is part of what is there. We have to ask ourselves the question. Are we going to an AIDS-free generation without including MSM? Actually the answer from the science that we have is that no, we are not going to do that.

Most of these figures I'm getting them from the pull out in the *Lancet* which all of you have in your bags. This is global prevalence of HIV in MSM compared with the regional adult prevalence in 2010. What I would like you see is that these are figures from all over the world. It is consistent. That pink bar is generally higher all over the world for MSM as compared to the general population. This is a matter of fact. This is something which is on and on and on even in the countries which do not have HIV figures for MSM. This is something which is ongoing. We cannot deny it.

This is another figure. It is about HIV prevalence among black MSM versus black population across the diaspora. What does it mean? We have HIV high amongst MSM, men who have sex with men, but we also have disparities in HIV prevalence in

care in how these populations actually do have contact with the rest of medical HIV prevention and care.

What does that mean? We have HIV prevalence disparities among black MSM versus the general population. In the US, it is 72 times more likely to be HIV positive when you're black MSM, in Canada it is 73 times, in the UK it is 111 times more likely. These disparities persist between black and white throughout the treatment cascade. When we are talking about HIV prevention and treatment we have people who have HIV. We have those who are diagnosed positive. We go on to the point of care where we are putting them on drugs and they have virus suppression. The fact is we still have difference even amongst MSM populations.

These problems persist. We have suboptimal care, which means that men who have sex with men are reticent to disclose their fears they have because of stigmatization. That's what was happening in Uganda. Healthcare providers are unaware of the diversity of MSM. One of my friends here in DC told me, oh yes I fell sick and I went to a clinic. The healthcare provider told me I'm going to take an HIV test.

That particular moment he was surrounded by workmates. You know what that means? I'm going to take an HIV test. He looks around and is like should I say no, should I say yes? I'm I being out-ed at gay man or not? Healthcare providers are unique gatekeepers, but when they do not know about MSM like

those in Uganda then they are really blind and they're not doing any HIV prevention.

A lot of studying has been done. We know the drivers of HIV transmission amongst MSM and the targets for prevention. I mean, these are things we know. We know that there's a high biological risk for anal sex. We know that there are things that can be done both as biomedical interventions like condoms and pre-exposure prophylaxis, behavior interventions, and also structural enablers. We know that a person who has a high viral load is going to transmit HIV very efficiently.

We know that if we give air of this that person going to be less infectious within the community, within the communities of MSM, and within the wider community. We all know that. We know that we can deal with high STI incidence. We know that we can deal with a lack of awareness of the HIV sero status. Those are things that we know. These are the interesting points that we have been learning about in this conference.

We also have the efficacy. We know that these things work. Okay. From individual level behavior change interventions to network level in behavior change interventions. We know that PrEP works. We know that condom distribution works and condoms work. We also know that ART for those who are positive works. Those are interesting, but how are we going to apply them? How

are we going to apply them especially to these pariah communities?

This is another map of interventions as they've been cited amongst MSM. What I would like you to note is not where all the spots are but where they are not. Remember that in Africa we have the highest burden of HIV. How many spots are there? Just one. What are the problems? Criminalization. I have heard this over and over again. You are dealing with a criminal population and the criminal population somehow seems to not be citizens, somehow seem not to fit to have intervention, somehow they just don't seem to deserve the attention that others get even in HIV prevention.

This is the relationship between criminalization and sex practices. Untargeted expenditure. This is for HIV programming. We saw that HIV burden is actually higher amongst MSM but what actually happens when the monies for HIV prevention go to the countries there's attenuation. Less and less gets to the MSM because of the stigma, because they are criminals.

Here is another study, HIV prevalence among black MSM versus the general population. These are [inaudible] compared to anti-homosexual criminalization policies in Africa and Caribbean. Actually, in the Caribbean countries it got the level of being significant. Figures are figures but we need

also to get right down to the nitty-gritty of what is happening because it is very hard to measure stigma.

This case study is of Senegal. Senegal is a country in West Africa has an epidemic which is concentrated amongst MSM. They actually were one of the first African countries to do an MSM-targeted HIV prevention effort. They did a study, which I was very happy to come across in 2004. They saw that they have a concentrated epidemic with HIV 20 times higher amongst the MSM than in the general population. They did comprehensive outreach in place for MSM.

In 2008, we had this ICASA, ICASA is the equivalent of AIDS meeting for Africa. During that ICASA, they actually came to tell the rest of the country about what was happening that they are doing some HIV prevention amongst the highest risk population in Senegal. After ICASA, nine outreach workers were arrested and prosecuted. They were released April 2009. They had been convicted of spreading homosexuality most likely. The issue was that happening almost destroyed the HIV outreach amongst the highest risk population in Senegal.

Now, let's talk about my country, Uganda. Uganda had a study done in 2008 on — a study dome in Kampala the HIV rate was almost 14-percent, but it's 13.7-percent amongst MSM in Kampala, compared to a rate of 4.4-percent amongst other men in Kampala, which actually means that this was a high-risk population. During the time of the study the Director General

of Uganda AIDS, the national program, said that for the first time he actually admitted that MSM exists in Uganda, which was a positive, but he said we are not going to deal with them.

Now, what happened is that some of us decided that no, this was a bit too much and we had the Implementers' Meeting happening in Uganda, and we decided to come and storm the meeting and held a five minute protest. What happened after that was that some of us were arrested and they continued to be prosecuted for demanding for HIV prevention program amongst MSM in Uganda, okay, for demanding for an HIV prevention program amongst a vulnerable population in Uganda, that's why there were prosecuted.

Now, this had an effect on the study which was happening in Kampala at that time. Those people were studying [inaudible] that MSM were not coming to the study, there were respondents who are not coming. There recruitment dipped, it recovered sometime later, but then dipped again, because Uganda unfortunately is a very highly homophobic country. They got about 300 respondents, which in six months was very few homosexuals, compared to Kenya, compared to Tanzania, compared to Zanzibar. In two months they'll get 500 people.

In the first study in Kenya they actually had to stop the study, because in Nairobi they were getting more than 500 gay people. Now, Uganda has definitely been one of the worst offenders in HIV prevention for MSM. We want to ban the

[inaudible] agencies which work for gay rights, that was about last month I think. And LGBT [inaudible] it needs to be shut. All this homophobia is actually happening when we have a study done with folks that we have a vulnerable population, which actually is responding to the homophobia in the country.

Okay, HIV prevalence amongst the MSM was related to [inaudible] homophobia. Now, we know a thing, we know one, we have MSM in every country in the world, okay, that's a matter of fact. There's no going around it. Even in countries where we deny it, we know there are gay people in that country. We know that MSM [applause] are at a high risk of HIV, that is a matter of fact.

We are not getting around it, okay, that is fact. We know that we have the tools to end HIV and yes, we can do it, but we cannot do it when we continue keeping our heads in the sand. We have to acknowledge that these groups are there, we have to acknowledge that we have the tools to deal with them, and we have to go ahead and bite the bullet and say, yes, we can do something about HIV prevention [applause].

What can we do? This is a call to action. For everyone one of us, for each and everyone in countries in Africa and outside Africa, because this is a problem not only in Africa. It is not a problem of Uganda, it is a problem of the whole world. We have to end invisibility in epidemiology. This is

the fourth decade since HIV started, HIV actually started amongst MSM.

The first reports were amongst MSM, let us stop making these populations invisible. They have to be visible. We have to know our epidemic and then go ahead and tackle on the epidemic. We have the tools, let's go ahead and tackle it. We have to end the invisibility, in service delivery and decision making.

We have to include these men. We have to get back to the basics, I mean these populations are not big, these populations are small. There's a concept for example in Uganda that tackling homosexuals as they call us is going to make homosexuality spread through the population, that is impossible, that is impossible, it is not a disease, it is not like HIV, which is actually going to spread without the population, because we are not dealing with it, okay [applause].

Back to the basics. Let's promote condoms and let's remember that amongst MSM, condoms go with lube, let's remember, and lube [applause]. It has to be lubrication. There has to be condom compatible lubricant, which means what the best lubricant? All silicon based lubricant, but we should not let these people use oil-based lubricants which destroy the condoms and make the condoms useless.

Bayer and others [inaudible] 134 million is needed for condoms and lubricants to avoid 25-percent of global MSM infections in the next 10 years, that is not expensive. When we get to the point of fact of saying that we can deal with this problem, then we know that it is not expensive. There are many things that we can do. There are inputs including the epidemiology, the HIV prevalence, the HIV incidence. We just started and we only know about incidence in only three countries.

Dealing with undiagnosed HIV positives, dealing with recent STIs, that is all part of epidemiology. Social setting, criminalization, access to condoms and condom compatible lubricant, availability of providers who treat MSM, and then the clinical factors, virus operation, treatment of diagnosed STIs, regular engagement in care, all these things can be done, okay? We've overcome the barriers to prevention. We expand access using evidence based studies. We coordinate [inaudible] plans and demand accountability targets on assessment of what works, all these things will lead us to the ending of the epidemic.

In conclusion, MSM are an important part of the HIV epidemic. We cannot achieve an AIDS free generation without including MSM this is just too important. We cannot achieve an AIDS free generation without including MSM. We need to address the structural challenges, we need to fight stigma, we need to

fight ignorance with data, we need to give information, and we need a major stakeholder effort for governments, researchers, providers, communities of MSM.

Now, I wanted to acknowledge the fact that a lot of people have helped me to prepare this speech, but I remembered that I can acknowledge also those people who have lost this fight, I mean who have been killed, the price of advocacy. Advocates are beaten, they are arrested, they are killed. I just wanted to remember these few, Ali Mombin [misspelled?] Camaroon, Steve Harve [misspelled?] in Jamaica, David Cartuin [misspelled?] in Uganda, Apelan Mapoplen [misspelled?] in South Africa [applause].

One of my most enduring memories of David Decatchu [misspelled?] is of him when we went into the Implementers' Meeting when he wanted to engage the speakers, and then running very fast on this big road with the police behind him, they wanted to arrest him, because we had ban stormed the Implementers' Meeting. Many stories are untold, unreported.

It is stuff to achieve comprehensive HIV prevention and treatment in this context, but it has been done, it has been done before, it is being done now, it is going to be done again. We have tried and they continue to try.

Last of all I want to acknowledge my partner. We took this photo in the [inaudible]. I love you [applause].

FEMALE SPEAKER: Please welcome Craig McClure, Chief of HIV/AIDS Program at UNICEF [applause].

CRAIG MCCLURE: Fantastic. Ending AIDS will require the scale up of what we know works. The basic programmatic activities of condom promotion and distribution, male circumcision, treatment, including what we've called up till now PMTCT to protect health, and to prevent transmission. Targeted approaches for key populations, including harm reduction for people who use drugs and behavior change, communication, and education that works.

The scale up and the impact of these basic activities cannot be optimized without laws, policies, and program that protect the rights and ensure the access and full and meaningful participation of sex workers [applause]. Women, men, transgender sex workers, girls, and boys, gay, straight, and bisexual, sex workers with disabilities, sex workers who use drugs, and sex workers living with HIV. It is an honor to introduce a woman who has devoted close to 30 years to this issue. Cheryl, it's a pleasure to see you here [applause].

Cheryl Overs founded a sex worker organization with pioneered harm reduction, rights advocacy, and peer education in Melbourne in the early 80s, when HIV was identified she served as advisor to the Global Program on AIDS, before establishing the Global Network of Sex Work Projects in 1992 [applause]. Since then she has worked in HIV policy and

programming for male, female, and transgender sex workers in more than 20 developing countries.

Cheryl is Senior Research Fellow at the Michael Kirby Centre for Public Health and Human Rights at Monash University in Melbourne, and a Visiting Fellow at the Institute of Development Studies UK. She's also a member of the Technical Advisory Group of the Global Commission on HIV and the Law. Her current work includes supervising an online resource center on sex work, a study of the impact of law on sex workers, and establishing a legal service for sex workers in Cambodia.

As well as academic publications, Cheryl has written several key resources on sex work and HIV, including Understanding Sex Work, Sex Work and the New Era of HIV Prevention and Care, and most recently, Only Rights Can Stop the Wrongs. Cheryl Overs, welcome [applause].

CHERYL OVERS: Good morning, everybody. I hope you're not bored at all with the tide [inaudible], yes, because you're going to get some more of it [laughter].

Just like in a real tide there are many waves that make up the metaphoric tide that we're here to talk about turning, and as my reduction from Craig explained, my place in the metaphor is on a beach, and these are some of the waves washing up where we sit on the beach, under the red umbrella of the sex workers right movement [applause].

I'm going to talk about why involving and empowering sex workers is crucial to turning that tide. The first thing to say is that the waves are interconnected, so there's no selecting which waves to turn back. The need for integrated approach that address human rights, and social and economic issues, as well as public health, has been stressed throughout the epidemic. And this is particularly important at AIDS 2002, which is the conference at the dawn of the new era of prevention, Justice Durban was the conference at the dawn of the new era of treatment.

The new era of treatment as prevention, antiretroviral based microbicides and pre-exposure prophylaxis has been rightly described by Michele Sidibe as game changing. And the optimism at this conference is palpable. Millie Katana has summed up that the world, especially the women folk are desperate for technology that will put the powers of preventing HIV in the hands of women, but alongside that hope is tension, between those who want to shift resources away from education and community responses, to biomedical approaches and those who don't.

The Robert Carr Doctrine warns that scientific advances will be wasted when people are denied access to services or they can't access them safely. Some of us are asking is there really a product or a medicine that can change the power of balance between sex workers and their clients. Will champions

of medical prevention being community mobilization, and social and educational planning, and policy advocacy to of failed as the *Lancet* editorialized last year.

The *Lancet's* made its position clear, and now there's talk about avoiding the dilemma by saying that we need to do both, and that sounds pretty good, but then others tell us that there's not money to do both. I don't know which of those is true, but what I do know is that around sex work, law reform and much better planning will be needed if these technologies are going to live up to their epidemic ending potential [applause].

The risk of sex workers of all genders will be enormous if condoms are replaced by partially effective HIV methods that don't protect against STIs or unwanted pregnancies. I mean it's good to talk about an extra tool in the prevention tool kit, but it doesn't all easily on sex workers ears that they're still going to have to get their clients to use condoms. Sex workers know their clients and they know that there will be increased demand for condomless sex. Clients are already talking on the internet how about the new HIV pill is going to liberate them from rubber.

Sex workers also understand that they work in an industry. Like all business market forces and workplace practices play a far greater role in determining what happens than the negotiation between individuals, and they also know

that just as it was for the old prevention methods the cost and the responsibility for the new methods will be on them, not on their clients. When peer educators hear about the new technologies they immediately realize that they're going to have to learn to share very new, and very complex information, including with clients, who have consistently proven to be one of the most difficult populations to convince throughout the epidemic, and I do mean convince there, they're not hard to reach. I'm sure I'm reaching hundreds in this very room right now [applause].

Everybody's concerned about cost. Even if HIV prevention is subsidized, the overall price of the tool kit that sex workers will need to manage their sexual and reproductive health will rise. Of course HIV testing is more important than ever, because ARVs is either as treatment or prevention can only be used by people who know their status. The sex workers taking the HIV test remains flawed, with the risk of violence, discrimination, lack of access to treatment, and importantly loss of lively hood.

Cost is a factor here too, because even if the testing is free, the bus to get to it probably isn't, and time away from work costs money. An instant HIV test might be seen as a solution by some, but on the spot testing in the street, or the brothel, or the police station raises predictable fritz to both public health and human rights.

Sex workers can't expect confidentiality of HIV test results still. HIV test results can and do lead to criminal prosecutions of sex workers in several states of the United States, and the misdemeanor of prostitution becomes a felony if the person selling sex is also living with HIV. Positive results are often shared with brothel, authorities, and even the public.

One particularly outrageous example is when authorities post photographs of HIV positive sex workers on the internet in some kind of misguided attempt at HIV prevention. In many place some sex workers are already subject to punishment if they don't submit to medical procedures, so it's not unreasonable that HIV testing and medical prevention could be thrust on sex workers in this way, or that health services could only be provided to sex workers who agree to the testing.

Now, I haven't raised these issues about new prevention technologies to suggest that they can't work for sex workers. I raised them to illustrate that they create challenges that can't be solved without strong inputs from sex worker advocates, and to underline the fact that the fewer rights sex workers have, the less chance we have of these new scientific developments being successful, as Peter Piot pointed out.

The epidemic is not driven by the lack of a pill or a gadget, the epidemic is driven by repression [applause], and this brings me to law and policy. Sex workers from Sweden to

Singapore to Swaziland all say that the greatest threat to their health and human rights is the law that makes it impossible to find safe places to work, and prevents them from having the in protections as other workers and other citizens.

Conference delegates will have by now seeing the red umbrellas waving, and heard sex workers demanding de-criminalization, highlighting violencing, and condemning the United States anti-prostitution pledge, but perhaps the greatest rage is against the distorted accounts of exploitation and human trafficking, that are used to justify increasingly repressive laws and violent raids [applause].

I'd like to show you what a so called rescue looks like from a mobile phone of a sex worker. [Video Played]

This illustrates what sex workers are talking about when they say save us from saviors [applause], and you know even without violent raids like that the criminal law shapes the sex industry. It creates workplaces that are so inherently dangerous that the workers in them can't be made safe by any pill, or any gadget, or any service. These are some imagines for me to leave that struck me as an unambiguous illustration of that.

No one could mistake this for a safe place to work in any sense, and the used condoms everywhere certainly doesn't mean that every act was risk free. Any HIV positive woman here

is probably amongst the least likely people in Europe to access HIV care, let alone any other sort of healthcare.

Look, these women shouldn't be there, that's clear to everybody, but everybody wants them taken somewhere different, a village, a university, a beauty parlor, a prison cell, or a place where sex can be sold legally, and no doubt the various women there would chose didn't options if they were ever given a choice, even the jail option might be chosen if anybody is being held against their will.

The point is that while migrant sex workers are deprived of rights and the law prohibits legal places to sell sex, these mattresses will stay in these bushes, and no amount of feel good stories about individual women being saved is going to change that, so while other moralize and theorize the only removal that's actually likely to happen here is police action that will send the workers fleeing, they'll be deported, and the whole thing will be banished to an even more dangerous place. We don't need a legal framework that aims to get prevention services to sex workers in dangerous places. We need a law that gets commercial sex out of dangerous places and into safe ones [applause].

For decades the sex workers rights movements been saying that the way to do that is to make sex work completely legal, and to govern it with the same nix of regulations,

labor, and criminal law that apply to other workers and other businesses.

Recently the Global Commission on HIV and the law agreed with this, they recommended to repeal the laws against consenting adult sex, to stop harassing sex workers, prohibit mandatory testing, and to look at taking complimentary legal measures to ensure safe conditions for sex worker, but you know what at the same time, it's inevitable that the word de-criminalization scares some governments, so we need strategies that don't set of moral panics.

We've heard many examples of this here, including prosecuting violence against sex workers, ending arbitrary detention, issuing sex workers national identity cards or passports, and stocking the condoms as evidence, ridiculousness. In the UK the government is backing an initiative that's called the Mugs Game Scheme that will distributes information about violent clients and other sex workers, and legal services and courts are playing a role too.

There have been some important court decisions that render sex workers eligible for services and legal protections. Smart action and policy like this is cost effective, especially where the decision is only to stop doing something, that's free. Conference speakers usually make a case that there constituency deserves a bigger slice of the resource pie, and that barely needs to be said for sex work, where clearly

allocation is dis-appropriately low. This painting by sex work is for the Global Fund carries an important message about better use of resources. Sex workers deliver value for money, and we created the slogan, sex work is part of the solution, to emphasis sex workers roll in the response.

Empowered sex worker communities have resisted not just risky sex, but violent police and thugs, loan sharks, child abusers, drug dealers, missionaries, traffickers, quacks, and everybody else who comes to take advantage of their lack of protection.

Individual sex workers have proven that they can be far more than underpaid peer educators and survey respondents. They can be policy makers, program managers, researchers, and they can operate credit cooperatives and conduct campaigns against violence, child abuse, and exploitation. Over the years we've developed a series of stories about these that you can see in the making sex work safe collection on the NSWP website, and this is one from the Dominican Republic. It better play this time. [Video played] [applause] Mundane organizations like it have been extremely successful.

In the sex workers rights movement we never had any doubt that the largest declines in HIV and STIs would be achieved by programs that fully involved sex workers and addressed clients. The Global Program on AIDS drew that conclusion in 1991 with the scant data available at the time,

and now extensive analysis of contemporary data reaches the same conclusion.

The folks from Johns Hopkins will be presenting on that this afternoon, I think. Never the less, clients continue to be largely ignored and almost all HIV funding is channeled through agencies who established the style, and the content, and the personnel of programs.

It's in this context that I want to recall the words of my friend and colleague, Elena Hanga, coordinator of RedTraSex, the Latin American Network of Sex Workers. At AIDS 2008 in Mexico, she challenges donors to resources and therefore power directly to sex workers. I conclude in her spirit with my list of targeted messages, beginning with those for donors and program planners.

We need more support for educational, social and structural programs now, now more than ever. If those resources are decreased, the new prevention technologies will fail and they may even cause harm. Stop wasting money on programs that sex workers are telling you don't work.

Far too much is spent on useless stuff; rehabilitation is one example, but there's plenty more and if you'd like to hear more about that speak to any of the sex workers here. To researchers and the organizations rolling out the new prevention technologies, you must engage with sex workers as advocates, not just to survey respondents. [Applause]. You

need to focus more on the challenges in the broader environment of sex work, not just getting the products to sex workers.

To the U.N. and to the international agencies, how many sex workers does your agency employ? How many have been on your board? If the answer, none, you need to change it. [Applause]. We hear a lot about evidence-based programming with HIV programming and anti-trafficking programming on facts. We need facts. Sex workers have those facts, not moralists and fanatics. [Applause].

Support meaningful participation. Sex workers need space to grow organically as a movement. It's great to be invited to your meetings and consultations, but not just if the participation is just tokenism that serves the interests of others. [Applause]. Sex workers need to occupy some uninvited spaces. We need tidy advocacy like this and like this woman speaking at a very high level meeting of the UN, we also we need messy activism and we need space for that. [Applause].

To everybody, stop the moralizing and the theorizing. Include sex workers in all communities. Sex workers are only people, as Craig said, they might be young, they might be old, they might be migrant, they might be indigenous, they might be religious or atheists, gay or straight. Some are dull, some are interesting, but they don't always want or need to be a separate community or group. Communities exist in real life,

not as epidemiological categories configured around HIV funding. So include sex workers in all communities.

Look, don't buy into this business about diverting sources from social and behavioral programs to medical prevention. They're talking code. [Applause]. To governments, perhaps the most important, make sex work legal, obviously; some countries have no excuse not to do that immediately. Criminalize real crime, not sex or HIV. [Applause]. Don't push medical procedures on sex workers, it violates human rights, costs more and creates gaps through which the most vulnerable fall.

To the United States government in particular, I'll just go through a couple there: repeal the PEPFAR anti-prostitution pledge, change your policy on trafficking, it currently misses the real abusers. It fails the genuinely help abused and it increases HIV.

Thirdly, thank you for correctly assessing me as a person worthy of entering the country, but no thanks for excluding my friends. Revise the immigration law to allow sex workers to enter the U.S. It's ridiculous that we're here talking about turning the tide together while sex workers and drug users are prohibited from the conference and are watching from Keeockokasha [misspelled?] in Kiev. This contravenes everything that has ever been said about HIV and human rights. Sorry, I'm done right now. One second longer.

Thanks to my fellow seafarers and lifesavers and in particular to the IAS staff who have been absolutely wonderful and particularly to Bebe Loff, my co-author, the first person whoever mentioned the idea of sex workers' rights to me when I was 18 years-old. Happy birthday too, Bebe! To the NSWP, there's the Network address, you can see it all there.

Finally, I just want to pay tribute to two great Americans, Norma Jean Almodovar, as a sex worker activist who was jailed in California after exposing police corruption, and Carol Lee, who's here in the audience, the woman who invented the term, 'sex worker', and in doing so, who illuminated the path to the solution. Sex work is work. Thank you very much. [Applause].

FEMALE SPEAKER: Please welcome Marine Buissonniere, the director of the Open Society Public Health Program.

MARINE BUISSONNIERE: Ladies and gentlemen, it is my great pleasure to introduce you, Ms. Debbie McMillan. I can definitively say that this conference would be greatly diminished without Debbie on this very stage. Debbie is passionate about her. She deeply cares about the issues that African American transgender face. As an employee of Transgender Health Empowerment, she works with people with high risk infections and STIs for the dual prevention plans, to counsel and connect them to care and social services.

Born and raised in Washington DC, educated in DC's public school and currently an undergraduate of the University of the District of Columbia, where she sits on the dean's list, Debbie speaks for the residents of the city. Not the politicians and lobbyists, the people at the frontline of the AIDS epidemics, those who suffer from criminalization, racism and poverty every day. As someone who once was in jail, Debbie speaks for incarcerated people all over the world. People are as much a part of the solution as all of us here.

As a former sex worker and drug user, Debbie speaks for the thousands of people who have been excluded from this conference by immigration laws barring sex workers and people who use drugs for eligibility to get US visas. In solidarity and if you have not done so, please don your crown and your green headbands.

In the response to HIV, we need more organization and people like Debbie, people that stand for human rights, to equality, to bodily integrity and to freedom from punishment for who they are. I hope that the sex workers and the people who use drugs who have been restricted from attending this conference, including those who run the Sex Worker Freedom Festival in Calcutta India, see Debbie on the stage, someone who is not on the outside looking in, but is right up here where she belongs. [Applause]. Please join me in welcoming Ms. Debbie McMillan.

DEBBIE MCMILLAN: Good morning and thank you all for being here. Before I give my presentation, I'd like to invite you to watch messages from my peers around the world. [Video. Applause].

Welcome to the United State. We've missed you for the last 22 years. I want to especially thank the IAS for giving me this opportunity to speak to you all. It's a privilege.

Who am I? Like most people, the sum of who I am is much more than my individual traits, however, there are facts that categorize as high risk in the HIV world. I am African American, I'm a transgender woman, I used to be a drug user, I used to be a sex worker, I used to be incarcerated. For 20 years, I lived a life that virtually guaranteed that I would contract HIV. That should mean that I was then or am now irrelevant. [Applause].

That would gravely underestimate me and there's an opportunity to address HIV. I'm here today because I represent people at the heart of the AIDS crisis, a small group with a big problem. If this is true, then it should be equally true that the solution lies with people like me. When people like me are included in the design and policy and programming, these programs are much more successful, they are much less so when we are not consulted.

While everyone in high risk populations that I represent are individuals with their own set of circumstances,

broaden the lines of my story are not uncommon. I went to the street alone at 14. It seemed the only place for someone like me. I became a commercial sex worker because I believed that was the only occupation for someone like me. I got high to dull the reality of the things I had to do to survive that life.

My addiction to drugs took me to places that I never want to go back to. Crack smokers, my drug of choice when I was using, are three times more likely to be infected than non-smokers. For many years, injecting drug use directly and indirectly account for more than one third of AIDS cases in the United States. Clean syringes are an essential competent to the prevention of HIV in injection drug users. Research consistently demonstrates the effectiveness of syringe exchange in preventing transmission. [Applause].

Syringe exchange programs are prohibited from receiving federal funds in the United States. In fact, Congress just last year re-established that funding ban. Chris Collins of the Foundation of AIDS Research calls that decision anti-science, anti-public health. [Applause].

I don't need research to know that this is true. I've seen it myself, both on the street and later when I worked with HIPS, an organization that provides syringes, clean syringes to other sex workers and other services. Drug use and sex work go together like power and money. You can have one without the

other, but it doesn't happen often and it didn't happen with me.

It's hard to get good data on the rate of HIV among sex workers, but I can tell you that out there, infection is considered inevitable. Having HIV sex workers further into the shadows, further into depression, despair and leads to more drug use. In this country, drug use and sex work are crimes themselves. No matter how risky life is on the outside, being in prison is worse. After one of many arrests for prostitution, I was sent to a men's prison. I was housed in the wing with murderers and rapists. I'm sure you can guess what happened. Nothing is gained by describing those details.

I could have gotten HIV anywhere, but I'm convinced I got it in prison. Americans are sent to prison every day just for using drugs. In fact, the United States incarcerates more of its citizens than any other country on the planet. This ensures that we get multiple public health problems instead of just one.

Instead of helping users identify and decrease risk behavior, the American legal punishes them in a way that significantly increase the chances of HIV infection. If you really look hard at drug addiction, you will see that it's just a symptom. For me, it was the stigma I experienced for most of my life as a transgendered woman. Data isn't uniformly for transgendered populations, so we don't know how many of us in

the United States are infected with HIV, what data there is, indicates high rates.

My mother, an IV drug user and a sex worker, left me with my grandmother. For some, my mother represents everything that's wrong with America, someone who could have risen above her circumstances, stayed in school, but chose a life of drugs and prostitution. For some, she represents the failure of society to take care of the most vulnerable among us. To me, my mother was the only person who ever completely accepted me as I am. [Applause].

I like my mother. My father disowned me when it became clear that my sexual identity was not what he thought it should be. On the street, I looked for acceptance, a family, a man who would give me what my father never did. At some point, my mother was infected with HIV, while she was still alive and living with my grandmother, she had one cup, one fork, one spoon, one plate.

When she used the bathroom, my grandmother followed behind her, bleaching everything she touched. During one of my incarcerations for solicitation, my mother died of complications of AIDS. I had to view my mother's body alone in shackles and handcuffs. Two months later, I was diagnosed with HIV. I was 20 years-old and I was convinced I was going to die.

So there I was, stigma on top of stigma. As a rule, medical personnel don't excel in bedside manner when it comes to transgender people. It's hard enough to face HIV. You want a doctor who understands that your entire life changes the instant you get that diagnosis, not someone who doesn't bother to look you in the eyes and see the very basics of who you are.

On the street, I lived a life of Debbie. I had a different name once, but that name has nothing to do with who I am today. [Applause]. To have a doctor consistently call me by my birth name feels like a punch in the stomach. It feels like one cup, one fork, one spoon, one plate.

When you're using drugs, there are high moments and low moments. In the high moments, you just want to keep getting high, in the low moments, you think about the things that drove you to use drugs and your self-esteem plummets. I broke free in a low moment when I thought I could actually envision living my life as a woman. The single wish to actually wish to actually be Debbie is what made me persevere. I got into the Bridge Back to Recovery Program which was specifically HIV positive LGBT people. The key to its success was they accepted me 100-percent.

Any inkling of a barrier, any whiff of an attitude would have given me the excuse that I needed, actually the excuse I was looking for to leave and go back to the street. For me to kick drugs, I needed to focus on that single goal

without the distraction of being HIV positive; without the distraction of being a sex worker and transgendered woman. When I had that space, I stopped using, then I got off the street.

I came to the organization Transgendered Health Empowerment, the only agency in the Washington, DC area that provides services specifically for transgendered people. Through them, I found supportive housing. Yes, I got a cosmetology license, but my heart is with my family that I found on the street. So I got a job with HIPS. Three years later, I started working in Transgendered Health Empowerment as a comprehensive risk counseling specialist. [Applause].

Our primary goal is to get the sex workers, drug users and transgendered women off the street, connected with social services, medical services and treatment. Now I'm Debbie in every sense of the word, but the Bridge Back program is no more. It died for lack of funding. The lesson that I want to impart today is that if you include people like me in your program design, you get solutions like Bridge Back, you get solutions that work.

No matter how well-meaning, a program that didn't truly understand where my head was when I walked in that door was never going to be successful. We need more programs like Bridge Back, not less. [Applause]. If you include people like me in your advocacy efforts, you get powerful proponents for

syringe exchange funding, changes to drug laws. This conference is the perfect venue to discuss what does and what doesn't work and why. I don't want to be on the outside looking in. I want to collaborate with all of you and my peers in Calcutta and Kiev [applause] because they can't be here.

As you know, the United States, while generous with HIV funding around the world, has policy that makes it extraordinarily difficult for current and former sex workers to enter into the country. If you honestly respond to questions on the application for a U.S. visa, someone who is engaged in either of these activities during the last 10 years will be denied entry. You can apply for a waiver for the cost of $500, but when you arrive, our system says you have confessed of moral in turpitude. You can be denied entry anyway. Your passport is then branded with this confession.

I asked applaud President Obama for lifting the ban for people living with HIV from entering the country and I'll tell him that if I get to meet him, however it will be far more productive for our government to eliminate policies that are more judgments and has nothing to do with public health. [Applause].

The U.S. entry ban says people who have a history of drug use or sex work are not actually included in this dialogue. This is a serious setback for the fight against AIDS. It would be better if this conference were located where

affected groups could participate. In fact, peer driven programs often prove to be most successful in combating this epidemic in both sex work and drug use. Over and over again, my peers and I have proven our value. [Applause].

Don't underestimate our knowledge or our potential for contribution, include us, let us help. If we are truly turning the tide together, than transgendered propel, sex workers, drug users, people like me, should be included and part of the solution. Again, thank you. [Applause].

FEMALE SPEAKER: Please welcome Julio Montaner, director of the British Columbia Center for Excellence in HIV/AIDS.

JULIO MONTANER: It is my pleasure and indeed an honor to welcome to the podium Gottfried Hirschall, who is the director of HIV/AIDS Department of the World Health Organization. In that role, he provides the leadership to a very important component of our strategy to turn the tide against HIV and AIDS.

Having been a proponent for aggressive [inaudible] antiviral therapy for a long time, I am reassured that our fight is going to be made a lot easier by having Gottfried's leadership at one of the most important places and providing us with the normative guidance that we need to move these issues forward. We're in very good hands. Thank you, Gottfried.

GOTTFRIED HIRSCHALL: It's not easy to follow Debbie. That video was fantastic. Thank you. [Applause]. What a testimony. Thank you, Julio, for the kind introduction and thanks for the organizers to having me here. It's a great opportunity. Good morning, colleagues and friends.

I think we all agree that we are at a defining moment. An overarching issue of this talk and indeed of this conference is how to use ARVs most strategically. Certainly with a view toward ending the epidemic. I would like to highlight three issues.

First, as we work towards our current goal of 50 million in 2015, can we reach this goal? I will argue that we can. My second question is whether it will be sufficient to achieve optimal treatment and prevention impact and whether we shouldn't think and plan now beyond the 50 million and I'm strongly convinced that this is the moment to do so. Finally if indeed we want to set the bar higher. How could that be done? What strategic choices can and need to be made and what opportunities exist to affect program reach?

Let me start with the tremendously good news of this conference. 800 million people had retained access to ART by the end of 2011. This is an increase of about 1.4 million or 20-percent in the last 12 months. Clearly despite economics and other challenges, we continue to reap the benefit of a decade of commitment, hard work, and resources. Let's remember

that just nine years in 2003, getting 3 million on treatment, a target of 3 by 5, seemed like a dream to many of us. We should really not underestimate the scale of the achievement to have reached 8 million people now. I strongly believe that we have sustained efforts at a somewhat enhanced pace of scale up in the next three years. We will achieve the target of 50 million ART in 2015. [Applause].

Why am I optimistic? For three reasons. First, we have impressive examples of successful countries that are showing what can be achieved. Second, we have unprecedented opportunities today and in the near future to expand program effectiveness and reach. Third, in 2011, spending in AIDs has not, as many have feared a year ago, decreased, but on the contrary has gone up by about 10-percent. As much fear as we are of course about the flat-lining of external resources, we have seen an encouraging trend on the increase of domestic spending in low and particularly middle income countries.

So let us look at what is possible in countries. I want to take a moment to highlight just three success stories. This slide shows the increase in ART coverage for those CD4 count below 350 between 2003 and 2011 in Cambodia, Malawi and South Africa. These are three different countries which face different challenges, have different academics and somewhat different health systems. Their responses however share a number of common traits.

In all three, we have seen exemplary commitment in political leadership, tailored and proactive approaches to testing and considerable innovation in service delivery. These are just three of the many countries that are showing us what can be done and how to do it effectively.

At the same time, there's wide variation and scale-up across countries, regions and populations. The persistently low coverage in Eastern Europe and Central Asia, shown in red, and North Africa and the Middle East, shown in purple, remains a great concern. By comparison, sub-Saharan Africa, shown in green, even with its high disease burden and health system constraints is making extraordinary progress, having now achieved 62-percent adult coverage. Disparities between populations still do exist. We've just heard three examples.

At 28-percent, coverage for children continues to lack well behind adults and while there may be reasons, there's absolutely no excuse for this. [Applause]. Key populations also have disproportionately low access. As one example, data from Europe and Central Asia consistently show injection drug users while account for two thirds of those living with HIV, still have low treatment coverage of less than 10-percent.

As we have just heard this morning from my speaker colleagues, other groups including MSM, transgendered person and sex workers, have similar to accessing appropriate services including ART. It is unacceptable as coverage expands overall

at global level, that these inequities are not being more aggressively addressed.

Our ultimate measure of success is of course impact. Here in yellow, we progress against scaling up trends in mortality and new infections, shown in green and red, respectively. Also, we have seen a decline in mortality. 1.7 million people still died in 2011 and the number of new infections has certainly decreased, yet it's still at 2.4 million in low and middle income countries. This begs the question, why do so many continue to die? Is it due to lack of access? Late diagnosis? Poor diagnosis of OIs such as TB and hepatitis? Late initiation of treatment or poor quality of services? The answer is probably all of the above.

A second question prompted by this graph is at what threshold of global treatment coverage will we see a more dramatic prevention impact? The answer is unclear, but it is evident that the current level of 54-percent is not enough. We also really do not know how many of these 8 million on treatment have in fact achieved viral suppression, but presumably it is only a fraction.

A major public health question at this point, how much greater could the impact on prevention be if ART were initiated earlier at higher CD4 threshold? For the first time, we have empirical evidence derived from a study in South Africa in a generalized epidemic and presented by Frank Pantani this year

at Croix. It shows the effect of ART scale up of individual risk, innovate of new infections. In essence, we see that forever 10 percentage point increase in coverage, there's a 17-eprcent decline in individual AIDS new infections.

This data offers real encouragement that on a population basis, the prevention benefit of ART can be and should be substantial. It is noteworthy that these effects were achieved on a CD4 threshold below 200 and again, the effect could arguably be greater with more people accessing ART earlier.

An important discourse at this conference focuses on the question whether the clinical and prevention benefits of early initiation of ART either at a CD 4 count above 350 or indeed regardless of CD4 count, outweigh the potential individual and public health risks. Clearly the balance of clinical evidence is tipping strongly towards early initiation. Late breaker sessions planned today and tomorrow for AIDS 052 will provide additional exciting results and I think we all shouldn't miss those sessions. The prevention benefits of course are well established and tip that balance even further.

Programmatically, we have more and better choices over the last years, we have seen substantial improvements in the potency and durability and tolerability of regimens in constrained settings. For the future, we will have a wider of range of regimen sequencing options. On the other hand, the

risk of resistance is sometimes used to argue against early initiation of ART and I want to spend a minute presenting new WHO data on drug assistance that has just been released at this conference in the first global drug assistance report.

A critical question is, should resistance concerns make us more cautious with regard to the scale up of ART? Will much increased use of ART actually lead to massive resistance as we have seen this in TB? From what we see now, it is very unlikely. This slide from the WHO service and transmitted drug assistance, shows that yes, there is a statistically significant association between ART coverage and the emerging of resistance. Transmitted assistance to non-nuclear size, which is low and middle income countries drives the emergence of drug assistance increased the need with increasing coverage, but it remained low. Less than 5-percent, even at the highest coverage levels observed.

Vigilance is of course in order to avoid increases in resistance levels, programs need to ensure the use of robust regimens and fix those combinations, achieve optimal adherence and retention, ensure regular drive and supplies and money to AIDS viral suppression.

Let’s review the issue of ART eligibility and evolving policies and aerials. This slide shows you five such scenarios. Starting on the left, in 2003, WHO recommended initiation in CD4 below 200. Scenario 1. In 2010, guidelines

shifted to initiation at CD4 cell count below 350, scenario 2. Current WHO guidance broadly corresponds with scenario 3, highlighted here in yellow, that is: a recommendation to initiative ART at a CD4 cell count below 350, plus considering ways to enhance the prevention benefit in certain populations, through treatment as prevention or TAPS.

Scenario 4 initial at a CD4 count 50-0, shown here in shaded yellow, is currently the subject of a systematic view of evidence by the WHO and the outcome of this review will inform the next generation of WHO guideline, supposedly released in early 2013.

Scenario 5, commonly referred to as the test and treat approach stipulates regularly testing and immediate offering of treatment for all at any CD4 level, in other words, shifting progressively One through to 5, means the number of people eligible people for ART would go up. Current estimates for eligibility are shown in the arrow at the top of the slide and over an inch from 11 million in scenario 1 to 32 million in scenario 5. That is treating all people living with HIV in low and middle income countries.

It is noteworthy that the transition between scenarios 2 and 3, by which I mean incrementally adding task for serodiscordant couples, pregnant women and key populations, would increase the current estimate of those in need from 15 million to around 23 million.

Clearly, offering ART to millions of people earlier will have cost implications. So is this the strategic investment? A number of models have assessed the cost effectiveness of the various expenses of the ART initiation scenarios. Overall the consensus of modeling analysis points to initiation of ART being cost effective, both in the short term and the longer term. Importantly, these models highlight the need for increased investment for treatment in the short term, in other words, front loading of resources in order to achieve immediately health and societal gains and of course, cost savings.

Here we turn to the question: is 15 million going to be enough? The answer is clearly no. It is obvious that evolving policies in areas already have and will further increase the number of persons eligible for ART well beyond 50 million. That is why we need to be working now to address the gaps, seize the programmatic opportunities and plan for future further scale up. WHO has promptly responded to new evidence and release a range of new guidance to countries in 2012? My dear colleague, Chewe Luo from UNICEF has actually already spoken to them yesterday.

In particular, WHO recommends recoments offering treatment as prevention for serodiscordant couples countries to providing early and lifelong ART for pregnant women and to

exploring the use of treatment as prevention in key populations.

In addition, WHO just released guidelines on pre-exposure prophylaxis or PrEP, with a recommendation to countries to carry out demonstration projects for PrEP prior to going to scale.

In early 2013, WHO will release new and colidasted guidelines of all aspects on ART use for treatment and prevention for all age groups and populations. This will include clinical recommendations on when to start, when to switch and how to monitor patients. The guidelines will make recommendations on selecting the most simple and effective regimens and also address treatment of co-morbidities of TB and hepatitis B and C.

They will include operational guidance paying particular attention to each such as diagnostics and delivery and program guidance and how to expand and scale up programs most equitably with full consideration of ethical and human rights concerns.

So what is happening in countries? What tare the policies applied in countries right now? Of 61 countries responding in a recent survey, about two thirds, 43 of them, were initiating treatment at CD4 cell count of below 350 and 12 in addition had a policy of offering ARVs early to the positive partner in a serodiscordant couple or to key populations.

The survey also showed that several countries are starting to offer ART at CD4 counts of 500 or below. In too many instances of course, there's a gap between policy and what is actually happening in implementation. While low and middle income countries have become more effective in enrolling people earlier, the reality is that virtually everyone starting ART countries in those countries does so still now at CD4 counts below 200. This makes it obvious that for many countries providing treatment to all individuals below 350 should be the top priority while at the same time looking at opportunities to enhance the prevention benefit through TAPS.

While this reality should not alter evidence based recommendations to move to higher CD4 thresholds, it does however point to the need to intensify efforts test and enroll people earlier. This slide also raise the question, how can the gap between policy and practice be bridged and how to address the reality that an increasing access to ART sooner rather than later?

Let us look at current program effectiveness and opportunities to improve it. WHO early warning indicators for drug assistance highlight a number as you see on this slide. Surveys for more than 2000 clinics from 50 countries show quite efficiencies across the board, notably in terms of retention and even more worryingly, more than 65-percent of the health

facility surveyed, the lower bar were able to ensure continuous drug supplies.

Enhancing program effectiveness requires understanding what is happening at test treat within cascade. The cascade shows demand question for testing and treatment to enrolling in treatment and ultimately showing that patients are retained and achieve viral suppression. As we have heard so many times this week already, analysis of the cascade shows significant linkages right along this continuum.

We know that regardless of epidemic health system or income level, virtually all countries are losing opportunities and that means people at every step along the cascade. In this group of six sub-Saharan African countries, only 25-percent of those tested went on to start ART. Data from the United States presented earlier this week show that despite high testing rates only 20-percent of individuals who are HIV positive achieve viral suppression.

This not only compromises treatment outcomes, but prevention benefits as well.

A key question every single country there is, how to prevent leakage at various points of the cascade? Clearly, there are a number of areas where we should focus our efforts. First, we must expand, simplify and also diversify our approaches to HIV testing. We need to offer concrete

interventions in the pre-ART window and eventually show them if not fully close it through earlier ART.

We have to provide simpler and better drugs for first and second line as well as diagnostic tests and monitoring tools at point of care and we need innovation service delivered to enhance adherence and retention.

Let me briefly look at some o those areas in bit more detail. First testing, currently more than 40-percent of people with HIV global know their status. For too long, lower uptake of testing has been a barrier to accessing ART. As a priority, clinical settings, we need to expand and Provider Initiated Testing and Counseling or PITC. This map shows that most countries in Africa at different times have now adopted policies at PITC. What seemed a novel and even controversial approach six years ago is now accepted according to a number of studies that I refer to in this slide. It is however an insufficient scale up between TB and anti-natal settings.

The stark reality is that many health facilities in generalized epidemics are still not routinely offering HIV testing and this obviously needs to change. Even if PITC were to be fully implemented, it would likely not be sufficient to achieve the reats of testing that we need to see. Community-based approaches better serve people, particularly those who would not access testing or facilities in general. A range of

approaches to community-based approaches is shown on this slide.

All of these are being implemented to different digress in different settings. What is critical is that countries should strategically select a mix of testing models based on the local epidemic with a view to dramatically improving equity of access and increasing demand of testing and treatment. One new and promising approach I want to highlight is self-testing.

A technology that allows someone to perform and test in the privacy of his own home. This is not without controversy but tests are becoming increasingly available and are being used. On the other hand, there are obviously challenges in terms of the need for confirmatory testing and potential risks if not linked to services. I believe it is an approach that we must definitely explore for further use with the right safeguards in place.

On the issue of testing overall, let me announce that today, WHO launches a key guidance document that addresses the teaching combinations of testing approaches in various types of epidemics. It also includes long awaited guidance and rapid test strategies and algorithms. Turning to drugs, in the context of the treatment 2.0 Initiative, WHO has convened global experts to define a number of important strategies that need to be followed if we are to achieve the most from antiretroviral medicines.

In the short term, we need to ensure that the best of the current first and second line drugs are available in once daily, heat stable fixed dose combinations and that drugs for children are more palatable. In the immediate term, we will be looking to add new drugs and to sequence the available classes in possibly different ways and in the longer term, we hoped that new therapeutic approaches now being studied such as induction of maintenance strategies will bear fruit.

One important goal to work towards in a public health approach is to have one regimen for children, adults and pregnant women. This would be a tremendous step forward in terms of programmatic simplification. This slide highlights the significant cost savings that can result from drug optimization shown in a recent landmark infectious disease paper by Crawford.

Take the example of Tenofovir, a very widely used drug, a combination of optimization strategies could lead to a price reduction of nearly 30-percent. The study describes other exciting opportunities to substantially reduce costs of other ARVs including PIs by one to two thirds. We are also at a very exciting moment in terms of point of care diagnostics. With relatively few advances made for the last decade, the market is now evolving rapidly and we are really on the verge of some major breakthroughs. Point of care CD4 tests are just

available, one pre-qualified by WHO and more products in the pipeline.

This year we should have for the first time a point of care to determine viral load and in 2013 for early diagnosis in infants. Point of care viral load tests at affordable prices will certainly be critically important to simply find patient monitoring and will likely replace CD4 test to determine treatment success and possibly treatment initiations.

This slide illustrates the challenge of retaining patients over the long term in a number of countries. There are obvious difference between settings. Data reported to WHO show that some countries are able to retain patients over five years while others lose up to 40-percent in the first two years. Clearly the situation can be minimized, but we need to learn more from those programs that are doing well.

Let me conclude. First, global progress on scale up of ART has been extraordinary. Positive experiences in many countries together with new opportunities to enhance program reach an effectiveness are reasons to be confident that the target of 50 million people can be reach by 2015. At the same time, it is of great concern that disparities and inequities persist between hundreds of regions and for key populations at greatest risk. Specific attention needs to focus n countries that are lagging behind on elimination barriers to access

including decriminalization and to addressing inequities which exist in low middle and high income countries.

The number of people eligible for ARTs are increasing in light of policies in area and evidence that favors early initiation. Countries face a number of strategic choices with regard to setting policy on ART eligibility and are already taking advantage of new opportunities in particular, of early initiation of ART and TAPS. ART scale-up will have to be combined with other interventions of known effectiveness, specially condom use, male circumcision and harm reduction for IV use.

Globally now this is the moment to think and plan beyond the 50 million target. That includes assessing the resources that will be needed to optimize the full range of benefits offered by ART, early ART in combination with other interventions. We can and we must do more and we can and must deliver ART and other services better; the need to provide ARVs to a larger number of people sooner rather than later calls for bold and forward looking policies, more effective and innovative approaches and a commitment to making the needed investments.

Specifically in the area of testing, new approaches must be explored and optimally involved in existing ones. These are exciting prospects for further simplification of drugs and diagnostics at the point of care and we see good

examples of innovation in service delivery and patient support including community-based responses, which are essential to ensure optimal adherence and ultimately viral suppression. In summary, if scaled up effectively and strategically, ARVs constitute a hugely powerful tool and will contribute significantly to us ending the epidemic.

Now is not the time to be timid. It is critical that our ambition and our commitment match the incredibly potential of this moment. Thanks to all my colleagues and collaborators of this presentation, from my own department and also colleagues from outside and I would like to specifically recognize Ian Grab who helped me tremendously preparing this presentation. Thank you very much.

[END RECORDING]