Regional Session: Connecting the Dots: HIV and AIDS in the Context of the Black Diaspora
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DAVID ERNESTO MUNAR: Good afternoon. My name is Daniel Ernesto Munar and I am President of the AIDS Foundation of Chicago. I'm very proud to co-moderate the session today. Welcome to the regional session on the U.S. and Canada. Our distinguished presenters and panelists will discuss the epidemiological trends in our region, talk about the national goals and disparities and efforts needed to make progress against the HIV/AIDS region.

MONA LOUFTY: Good afternoon. My name is Dr. Mona Loufty. I'm an infectious disease specialist with the Women's College Research Institute in Toronto. I will be co-moderating today's session with David. We are honored today to have our governments' most senior health officials with us to give welcoming remarks. As a proud Canadian woman, it is my pleasure to introduce the Canadian Minister of Health: Leona Aglukkaq. Minister Aglukkaq was first elected to the House of Commons in October, 2008 where she became the first Inuk to be sworn into the Federal Cabinet serving as Minister of Health in every Cabinet since.

Prior to federal politics Ms. Aglukkaq served in the Nunavummiut Legislative Assembly as the member of Legislative Assembly for Nattilik. Ms. Aglukkaq has always fought hard for Inuit issues that she was raised to believe in; which now

includes HIV. I present the Honorable Minister, Ms. Aglukkaq. [Applause].

LEONA AGLUKKAQ: Thank you. [Inaudible]. It's an honor to be here to be co-hosting this session with my good friend Secretary Sebelius, Secretary of Health and Human Services of the United States. I would also like to thank my Canadian colleagues for joining me today at this session. I think many of the achievements we have accomplished in addressing HIV and AIDS in Canada are due in large part to the remarkable dedication and support of Canadians who have demonstrated to this cause over the last few years.

Again, I also want to take an opportunity to congratulate the indigenous aboriginal working group on HIV and AIDS for a historic moment yesterday to be full participants of this international conference for the very first time in 30 years. [Applause]. As a Canadian Health Minister, I am proud to have pushed for the cause so that we are full participants as aboriginal people in this forum.

Because of the significant hardship this epidemic has caused in developing countries, in situations in North America, it's not often in the spotlight. It's good to have a session where we look at how the epidemic is evolving on both sides of the 49th Parallel and to assess where we stand. When HIV first emerged in North America 30 years ago, no treatment was

available and many people who were infected in the early years of the epidemic died. Since the introduction of the anti-viral therapy in the 1990s, HIV has become, for many, a serious but manageable chronic condition.

At the same time, our surveillance data tells us that despite ongoing investments in HIV prevention, new HIV infection continues to occur. Rates are not declining, and in both Canada and the United States there is still a high rate of new infections within certain groups such as gay men and other men who have sex with men and people who inject drugs.

So despite our investments in the general well being of our populations, preventing HIV transmission remains an urgent public health priority. To make meaningful progress we will have to find ways to refocus our prevention programs to make them more effective. Especially for those who are most at risk.

The political declaration that both Canada and the United States joined last year at the U.N. high level meeting recognized, by consensus, that the epidemic affects every country differently. That is certainly true for our two countries. While we have a great deal in common, the composition of our countries is very different and so too is the epidemic.

Nonetheless, Canada and the United States have a lot to learn from each other's successes and challenges. By comparing our approaches, I hope that we can help each other become more effective at preventing new infections and addressing the treatment and the care and the support needs of those living with HIV and AIDS.

It also provides us with an opportunity to look at ways that our two countries can continue our long standing history of collaboration and to address HIV and AIDS in North America. Canada's federal initiative to address HIV and AIDS guides the funding of research projects, supporting community groups which help us reach those who are most at risk, and monitors HIV and AIDS through a national surveillance system.

We have programs designed for key populations such as the streets involved youth, women and gay men. We are working to address the social issues including accessible housing, income security, addictions and mental health that contribute to vulnerability for infectious disease. Canada demonstrates response to the epidemic, and our responses as a member of the global community are equally important.

We have helped to strengthen the health care system in developing countries and have played a lead role in mobilizing international action to support maternal, new born and child's health. We have also started dialogs on emerging issues

related to HIV and AIDS. Our annual policy dialogs have brought together international experts from governments, the academia and civil society to discuss a range of areas that impact HIV prevention, treatment, care and support.

At the latest dialog in January of this year, we partnered with the United States to host a dialog on HIV/AIDS and mental health. This was a successful event that resulted in yesterday's satellite session addressing mental disorder, the missing link to HIV prevention, treatment, care and support.

Canada will continue supporting cutting edge research including the search for an effective vaccine. We are also continuing to partner with civil society and invest considerable resources to building community capacity to respond to HIV and AIDS.

We hope that we can accomplish even more in the next decade than we have in the last three decades so that we can increase the likelihood have having an AIDS free generation in foreseeable future. An important part of that work starts right here with a hard look at what is happening in our regions with Canada and the United States. I am pleased to be a part of that this afternoon. [Inaudible]. Thank you. [Applause].

DAVID ERNESTO MUNAR: Thank you. Thank you. Thank you protestors, committee members, thank you Minister. I'd like to

move on with our program. Now it's my pleasure to introduce U.S. Secretary of Health and Human Services, Kathleen Sebelius. In 2011 *Forbes Magazine* named Secretary Sebelius the 13th most powerful woman in the world.

Before her Cabinet appointment in 2009 she served as Governor of Kansas – beginning in 2003 where she was named one of America's top five governors by *Time Magazine*. She served as a Kansas insurance commissioner and was a member of the Kansas House of Representatives before her election as governor. As a person living with HIV, thank you, Secretary Sebelius for all of your leadership on HIV/AIDS. We really appreciate it. Please join me in welcoming Secretary Kathleen Sebelius. [Applause].

KATHLEEN SEBELIUS: Good afternoon, everyone and thank you for joining Leona and me for this important dialog on U.S./Canadian work on HIV and AIDS. I want to thank David and Mona for not only your efforts to moderate today, but your leadership around this critical health issue. We do have a lot to learn from each other.

Over the last three years it's been my great privilege to work with Minister Aglukkaq on some of the most urgent health challenges affecting both of our countries, from H1N1 which we dealt with at the very beginning of our relationship to the avian flu to chronic diseases. It is great to be here

to discuss one of the biggest health challenges facing both Canada and the United States, and one in which we have a lot to learn and work on together.

We both have seen a lot of progress in the fight against HIV and AIDS, but we know there's a lot more work to be done. In particular, both in the United States and Canada, we continue to see high infection rates among certain groups. In the United States we're even seeing rates rise among certain populations including young gay and bi-sexual men. Now that's just unacceptable here in 2012.

In the United States we finally did what we've asked other countries to do for years when we support them through our PEPFAR program, and that's develop a comprehensive national strategy. We finally did that under the Obama administration, and the national strategy is really guided by a couple of key principles.

First, we recognize the need to fill the key gaps at every point along what we call the treatment cascade. For example, we know it's not enough to simply make testing and treatment available and tell people just go find it and go get it. If it was, we wouldn't have currently approximately 200,000 people living with AIDS in the United States who don't know their status; they haven't been tested. Another 200,000 who know their status but haven't been linked effectively to

care, and almost 250,000 on top of that who aren't in continuous care.

When we are in a country where we estimate 1.1 million people living with HIV/AIDS, that's 59-percent of folks in that treatment cascade somewhere along the way falling through the cracks. We know we can do better; we know we must do better. We're trying to support programs that build strong linkages at every step along the way from testing to care to treatment.

I recently visited an organization that does just that right here in D.C. called the Community Education Group. They're getting some pretty impressive results. Instead of just testing folks and handing a referral slip for care, they actually set up care appointments that day, or at the very latest the following day.

They then take the patient to the appointment. Not just the first appointment, but the first five, and if, indeed, those patients stop going at some point along the way, they have an alert system and they go back and try to convince those patients to once again connect with care.

Nationally our rate of care continuation is about 77-percent. Here at the Community Education Group, they're up above 95-percent. So we know that they're strategies that really can do better. [Applause]. A second principle we're following is to take proven approaches to the communities that

actually have been the hardest hit. Already we've made some key changes in how we distribute funds to health departments for prevention, moving to a new formula that reflects the needs of today.

We're building on programs where we've already seen progress. For example, we've worked over many years with America's tribal nations to address HIV/AIDS disproportionate impact among American Indians and Alaska Natives. Due to health disparities, not only are tribal people more likely to be HIV positive than others, but they also, alarmingly, have the shortest survival after diagnosis of any racial or ethnic group. To combat those alarming trends, we work closely with tribal leaders and health providers to increase screening. Over the last years HIV screening rates have more than tripled in tribal communities.

Over the last five years the pre-natal HIV screening rate has risen from 65-percent to 80-percent across the entire breadth of the Indian Health Service. But this effort reaches beyond screening with more than 100 projects taking place around Indian country from tele-health initiatives to clinical training to more precise data collection. Our goal is to identify the most effective programs and to bring them to the communities with the greatest need.

A third priority has been to support and expand public/private collaboration. I was able to speak to the opening session on Sunday, and I announced a number of new public/private partnerships.

They include one where we've come together with the eight largest AIDS drug companies to create a single application form for AIDS medications offered through their patient assistance programs and that's a big step forward. [Applause]. Now that application – a single form – will make it far easier for patients and their doctors to get life saving drugs. All eight companies have agreed to use the form and begin accepting it starting September 1st of this year. So we hope this model will create a foundation for even more partnerships to come.

There's a fourth principle that we don't always talk about, but it's just as important, and that's finding new ways for America and Canada to work together. The United States and Canada, as the Minister has already said, are not the same, but we have a lot in common.

There's so much we can learn from one another whether it's sharing the latest scientific research or the best educational approach for reaching our underserved communities. We're used to reaching out to each other during sporadic pandemics and other times of crisis, but the strong

collaboration and health cooperation between our nations shouldn't end there. That's why at sessions like this, and I know you're going to hear from some panel members that follow us, we can bring our brightest minds together and that's what's so important about gatherings like this.

In order to actually achieve the goal of an AIDS free generation, there are still big challenges on the horizon for both of our countries. We are far more likely to find the solutions that we need if we go forward together arm in arm. So thank you for being here today and thank you for what you all are doing. [Applause].

MONA LOUFTY: Our deepest thank you to both officials for their opening remarks. Because of official business, our distinguished guests cannot stay for the remainder of the session, but we thank them for helping set the stage and for their time and commitment. If I can request for our speakers and panelists to join David and I on stage. While they are doing that, it is now my pleasure to introduce Dr. Kevin Fenton who serves as the Director of the National Center for HIV and AIDS, Viral Hepatitis, Sexually Transmitted Diseases and TB Prevention at the United States Center for Disease Control and Prevention. I very much appreciate the activism as expected at the International AIDS Conference. Dr. Fenton. [Applause].

DR. KEVIN FENTON: Thank you very much. Good afternoon everyone, distinguished guests and colleagues, friends. I've been asked to provide a brief overview of the status of the HIV epidemic in the United States. Before doing so I think its worth while revisiting the vision of the U.S. National HIV/AIDS strategy which really sets a very bold goal for us to envision change in our response to the HIV epidemic in the United States.

In this vision we see the United States as a place where new infections are rare and all Americans, regardless of their status in life, will have unfettered access to high quality, life extending care free from stigma and discrimination.

In my presentation today I'm going to be reflecting on where we are today in our response to this epidemic and ways in which we need to be moving forward to meet this vision for an AIDS free generation in the United States. I'll begin by reflecting on the current epidemiological profile, looking at burden and trajectory of disease.

I'll be also focusing a bit on geographic [inaudible] and concentration of the HIV epidemic in the United States. I'll briefly reflect on some of the social and structural drivers of the epidemic in the U.S. before looking at ways in

which we at CDC and partners across the federal government are working to enhance HIV prevention.

This first slide really shows a panoramic view of the HIV/AIDS epidemic in the United States, really looking at the prevalence and incidents of HIV over the past 30 years. As many of you are aware, the United States has a fairly severe and pervasive HIV epidemic compared to other western industrialized countries. There are more than 1.1 million Americans who are currently living with HIV.

Each year approximately 50,000 Americans become newly affected with HIV, and 19,000 individuals die as a result of HIV or AIDS. Consequently, we continue to add approximately 30,000 infections to the prevalent diagnosed and un-diagnosed pool of people living with HIV each year. Consequently, HIV prevalence has increased in the United States by eight percent between 2006 and 2009.

The growing prevalence in the presence of stable HIV incidents - which has been stable for the past decade – suggests that the HIV transmission rate is actually declining in the U.S., and it has indeed declined by nine percent between 2006 and 2009.

Another way of looking at the prevalence of disease in the United States is looking at the estimated number of adults and adolescents living with both diagnosed and un-diagnosed HIV

between 1985 and 2008. This slide is really here just to demonstrate a tremendous prevention success that we've had in the U.S. which is the gradual and sustained decreases in the proportion of people living with HIV who are un-diagnosed.

From a high in excess of 80-percent being un-diagnosed in the early 1980s to the current level today which is just above 20-percent of HIV affected individuals who are unaware of their HIV status. We are making progress, but we must do more and we must do more, faster.

Focusing on HIV incidents, we have been seeing stable HIV incidents in the U.S. over the past decade. However, this stable incidents really hides tremendous variation or [inaudible] trends across the transmission risk groups. For example, among injecting drug users we've seen tremendous declines in HIV incidents over the past two decades. From its peak in the late 1980s we've seen nearly an 80-percent reduction in new HIV infections among injecting drug users. Among heterosexuals, from a peak in the late 1990s, we are seeing declines in HIV incidents among heterosexuals, although the rates of declines are not as dramatic as what we've seen for injecting drug users.

In contrast, illustrated in the blue line in this chart, among gay and bi-sexual men from a nadir, or the lowest point of HIV incidents in the early 1990s, we've been seeing

year on year increases in HIV incidents among men who have sex with men. More recently, the increases in HIV incidents in young men who have sex with men in the United States has been predominately by increases among young black and Hispanic men who have sex with men.

The burden of this new HIV infection can be further explored by looking at the distribution by both gender as well as race, ethnicity in the U.S. Here we see the tremendous variations across the racial and ethnic groups by gender in terms of new HIV infections which are occurring in the U.S. In 2009 the rate of new HIV infections for black men was six times as high as that for white men, and 2.5 times higher than that for Latino men or black women in the United States.

In 2009 women and new infections in women accounted for about 23-percent of all new HIV infections which occurred in the United States. The severe burden of disease among black women is indeed highlighted in this chart where the rates among black women are 15 times that of white women and over three times that of Hispanic and Latino women. Consequently, these high rates of HIV infection continue to drive diagnostic burden and pressure within African American community so that today one in sixteen black men and one in thirty-two black women in the United States will be diagnosed with HIV.

Further exploration of the epidemic burden is illustrated here by looking at the burden of disease among the most affected communities and populations. You can see to the left hand side of the chart that the three most affected groups in terms of the burden of disease among transmission categories are, in fact, men who have sex with men.

In the United States MSM account for approximately two-percent of the population, but 64-percent of new HIV infections. Black men who have sex with men account for 73-percent of HIV infections which occur among black men in the United States and approximately 38-percent of HIV infections which occur among all men who have sex with men.

Similar concentration of the disease among Latino men who have sex with men is also illustrated in this chart where 81-percent of new HIV infections which occur among Latino men occur in Latino men who have sex with men. Latino MSM account for about 20-percent of all HIV infections occurring in gay men.

The final slide that I'm going to show, which really illustrates the disproportionate disease burden, will be looking specifically at what's happening among men who have sex with men in the United States. Here we're looking at the distribution both by race as well as through the racial age group categories in the United States.

HIV incidents and new infections in the U.S. really are occurring among people. Thirty-nine percent or 19,000 of the new infections each year occur in Americans age 13 to 29 years. Young men who have sex with men account for about 27-percent of new HIV infections in the U.S. and 69-percent of new HIV infections among persons age 13 to 29.

Of note in this slide are the very different patterns of the distribution of new HIV infections by age group categories between black men who have sex with men, Hispanic MSM and white men. For white men we see nearly equal proportions or distributions of new infections occurring if you're age 13 to 29, 13 to 39 or 40 to 49, but for black or Hispanic men you can see the disproportionate burden of new HIV infections which occur specifically among young men who have sex with men.

Now I'm going to move to look at aspects of the epidemic related to geographic distribution and concentration. First, just to look at the distribution of reported AIDS cases in the United States. By region, the number of people diagnosed with AIDS is, in fact, highest in the south followed by the northeast, the west and the Midwest. Once adjusted for population size, we see that AIDS diagnoses rates in the United States are highest in the northeast followed by the south, the west and the Midwest.

We can further look at the geographic concentration of the epidemic by looking at the distribution by states in the U.S. and we see tremendous concentrations. Four states in the U.S. account for an estimated 50-percent of persons living with a diagnosis of HIV infection by the end of 2009. The four, unsurprisingly, are New York, California, Florida and Texas.

Ten states account for an estimated 73-percent of persons living with a diagnosis of HIV. This has tremendous implications for the ways in which we resource our prevention response in the United States. We work with specific states to scale up effective policies and we address some of the structural issues in these states where HIV is concentrated.

Again, we can drill a bit deeper to look at further concentration of the disease among metropolitan areas in the United States. The majority of individuals living with diagnosed HIV or AIDS actually reside in areas in the United States with an excess of 500,000 inhabitants.

Among MSAs, in the 50 states and D.C. the top metropolitan statistical areas accounted for - the top ten MSAs – accounted for an estimated 55-percent of persons living with a diagnosis of HIV. Again, unsurprisingly, some of the cities which are hardest hit include New York, Miami, Los Angeles, Chicago, Atlanta – my hometown – San Francisco, Houston, Philadelphia, Dallas and Baltimore.

In the chart presented in a slide, we also see adjustments by population to illustrate the distribution of the rates of diagnoses of HIV infection by the MSA or Metropolitan Statistical Area of residence in 2010. Again, you can see the concentration of disease among urban centers, especially in the East, the Southeast and on the West Coast of the United States.

Finally, as we reflect on geographic concentration of the disease, it is well known that in our inner cities within the United States we have, in many areas, hyper-endemic levels of HIV infection including here in Washington D.C. where the prevalence is estimated to approximately 2.7-percent of residents. What we see when we drill deeper into cities are the hyper-concentration of prevalent as well as incident HIV infections, especially in areas which have high populations of individuals or communities at risk, or high concentrations of urban poor or urban homeless populations.

In the third and final and ultimate section of the presentation, I'm going to quickly reflect on some of the social and structural drivers of the epidemic in the United States. Many of you in the room are familiar with the WHO model for social determinates of health which argues that to understand the distribution of health and well being in any given population, there is a dynamic interaction between the quality and access to health care services, individual level

determinants including behaviors, risk factors and the individuals' position in the social hierarchy, as well as a range of social and structural drivers.

If we are going to be thinking about the social determinants of health for HIV, we need to amend this model because we are dealing with a highly stigmatized infectious disease and factors, such as the background prevalence of the disease, the quality of the sexual mixing patterns and networks, the correctional system in the United States and factors such as racism, sexism, trans and homophobia and other types of discrimination need to be added to this model.

We know that nearly a quarter of Americans and Latino families live in poverty in the United States; compared to approximately 10-percent of white families. We also know that there are substantial differences in the United States in access to health insurance coverage by race ethnicity as illustrated in this slide.

CDC studies have actually demonstrated that HIV diagnoses rates actually increase as income inequality and the proportion of unmarried individuals within a jurisdiction increase. Further studies done by CDC in more than 21 jurisdictions across the country looking at high poverty urban areas found a prevalence of about 2.1-percent of HIV among heterosexuals.

In this study, poverty was the most important determinant of being HIV infected among inner city heterosexuals, and this study found absolutely little or no differences in HIV prevalence by race ethnicity in urban poor areas within the United States.

Inner city HIV prevalence was also associated with homelessness, unemployment and lower educational attainment. So as we're thinking about our response to the epidemic, certainly in the United States, we need to have a balance portfolio of both individual, social, structural, family as well as policy interventions to respond.

Health system factors are also important for the United States. Here I just wanted to illustrate the fact that 45-percent of Americans have ever been tested for HIV, and approximately 10-percent report being tested in the last year. There are tremendous variations by gender, by age and by race ethnicity in the United States, but late HIV testing remains a problem with 37-percent of new diagnoses – individuals newly diagnosed with HIV – developing AIDS within a year of diagnosis.

Late diagnosis in the United States is particularly problematic among older adults, male injecting drug users, Hispanic and Latinos and persons of multiple races. Many of you have already seen this cascade which really illustrates the

prevention, treatment and care cascade in the United States. I won't dwell on this for this presentation, but suffice to say we know that only 28-percent of all HIV infected persons in the United States have a suppressed viral load. We know that we are losing HIV infected individuals as they are linked to care or as we attempt to keep them and maintain them in care. This will be a key element of strengthening our response to the epidemic in the U.S.

In the final section of my presentation, I really just wanted to think about where we need to go to achieve the results and the vision of the national strategy. The strategy articulates three clear goals for us to achieve in the United States. CDC, as the nation's public health agency, is perfectly aligned with achieving the goals of the strategy either through focusing on domestic HIV prevention or efforts to link and partner with other agencies to improve care, to monitor health disparities and develop programs or to scale efforts with other federal agencies and to measure progress on the strategy.

To implement the strategy, we have conceptualized a new strategic approach to prevention in the United States called high impact prevention. This combines the best of implementation science with an expanding prevention tool kit to ensure that we're selecting the right interventions for right

populations, targeting the interventions and scaling them for impact. So in the United States we're having new conversations about the effectiveness and cost effectiveness of interventions, the way we cover and target our interventions, the way we prioritize interventions and the way we bring them to scale for population impact.

Part of this focus means that rather than funding and allowing for the support from multiple interventions, we are prioritizing interventions that can be scaled for maximum impact. These include HIV testing, prevention with HIV positives, condom distribution and structural and policy initiatives.

To summarize, in the United States we have a severe and pervasive HIV epidemic and more Americans are living with HIV in an environment where we have stable HIV incidents, declining mortality and declining transmission rates. As you've seen today, the HIV epidemic in the United States is both demographically and geographically concentrated at a time when one in five persons living with HIV are unaware of their HIV status, and less then a third are engaged in care and maximally benefiting from effective anti-retroviral treatments.

As we work towards achieving an AIDS free generation in the United States, future success will critically depend on our ability to implement and bring to scale what we know works for

those who are at risk while expanding the knowledge base for more effective implementation. I'd like to thank colleagues from CDC who assisted with this presentation. Thank you. [Applause].

DR. MONA LOUFTY: Thank you Dr. Fenton. Our next presenter will give the Canadian perspective, and that's Dr. Howard Njoo. Dr. Njoo is a Director-General at the Public Health Agency of Canada, and is the lead for the Canadian government's Federal Initiatives Against HIV and AIDS as well as the Canadian HIV vaccine initiative, a joint effort between the government of Canada and the Bill and Melina Gates Foundation. It gives me great pleasure to welcome Dr. Njoo. [Applause].

HOWARD NJOO: Good afternoon, everyone. It certainly is a pleasure for me to be here to give the overview of the state of the HIV epidemic in Canada. What I hope to do in the next 15 minutes or less is give a little bit of an overview of Canada in general and then talk about the epidemiology of HIV in Canada, the drivers of new HIV infections, the government of Canada's domestic response to HIV and finally, some concluding remarks.

In terms of the overview of Canada, the first thing I'd like to do is show you a map of Canada; really to draw your attention to two specific aspects: the demography and also our

political system, which in turn will inform, I think, what I'm going to make in later points about the epidemiology in Canada as well as how the federal government addresses HIV and AIDS. As you can see from the map here, Canada's a large country. It's the second largest country in the world after Russia.

From the Pacific Ocean to the Atlantic we span six times zones. Our home is close to 10 million square kilometers, and you can see its also northern country where about 40-percent of our country is north of 60; north of 60 degrees latitude.

What's also interesting though, is the make up of Canada's population. Almost one-fifth or 20-percent of the Canadian population is foreign born and four percent is Aboriginal. What's really interesting is how the population is distributed in a very thin strip along the U.S. border. Fully 90-percent of Canadians live within 100 miles of the U.S. border. I think, in part, because we do like and get along with our American neighbors, and partly, I think, because of the weather where we try to be as south as possible [laughter].

What's also interesting is that 75-percent or three-quarters of the Canadian population lives in three provinces: British Columbia on the Pacific coast, and in eastern Canada Ontario and Quebec. The reason being in large part because the three largest cities in Canada – Vancouver in British Columbia,

Toronto in Ontario and Montreal in Quebec – also account for a large part of the Canadian population.

It's also where the migrants, both internally in Canada and also from externally tend to congregate, and so that's something we need to keep in mind. The other interesting thing about Canada is that only about 0.3-percent of the population does live in the north in the Territories.

In terms of the political system, what I will say is that according to our constitution, the primary responsibility for the delivery of health care services falls to provinces and territories. The federal government, in terms of delivery of health care services, is restricted to a few federal populations.

For example, Canadian forces and inmates in federal correctional facilities and First Nation peoples on a Reserve. However, when it comes to public health, that's seen as more of a shared responsibility. Particularly when it relates to, for example, infectious disease outbreaks that span multiple jurisdictions. In that regard, as you can see here from this organizational structure, the Public Health Agency of Canada plays a lead role in terms of the federal focal point.

This is the mandate of a center for which I work, and I'd like to make two specific points. You can see at the bottom the diseases for which my center is responsible for, and

you can see HIV/AIDS, TB, sexually transmitted infections and so on.

What I will focus on is that for HIV/AIDS, as mentioned earlier, we are the focal point for the Federal Initiative to Address HIV/AIDS in Canada as well as the Canadian HIV Vaccine Initiative, which is an important collaboration with the Bill and Melinda Gates Foundation in terms of Canadian engagement at the global level in terms of developing an HIV vaccine.

With respect to our mandate, the part that would certainly recognize, and therefore it is in our mandate, is that we do have a focus on what we call key populations at risk. Recognizing that there are certain populations who are particularly vulnerable and certainly disproportionately impacted by the diseases we deal with.

In terms of the HIV epidemiology in Canada, this chart here shows the estimated HIV prevalence in Canada over time; from 1975 to 2008. The first case of HIV infection in Canada was in 1982, and you can see over time, how that prevalence has increased.

There was obviously the increase in the early days, and then a slight dip in the 1990s which we think was attributable to mortality and the pre-anti-retroviral age as well as early prevention programming. You can see later on, up to the present date, that prevalence has increased which we think is

mostly a good news story. Certainly with the advent of anti-retrovirals people are living longer, but we also recognize that there's still ongoing transmission. Over all, Canada is considered what we call a low prevalence country. Our prevalence in Canada right now is about 0.2-percent, which is about 65,000 people.

Looking at estimated new HIV infections per year in Canada by exposure category, you can see that in the early days predominant to category, was men who had sex with men, which had an overwhelmed proportion, but over time that's decreased. So that's a bit of a good news story.

Unfortunately, you can see there's a bit of an increase in recent years which in part, we think, is attributable to the fact that younger generations of gay men and men who have sex with men are now considering HIV to bit a bit of a chronic condition. They don't view it in the same way as older generations, where in the early days certainly HIV/AIDS was a uniformly fatal condition.

The other interesting part is that in terms of injection drug users, there was a peak in 1987 to '90, but since then it's declined and more or less has remained fairly stable over the past few years. What is of note is the category of heterosexual contact. That category, unfortunately, has increased in terms of both infections and in

the proportion. Just looking at 2008, the proportion of new infections due to men with sex with men is about 44-percent, it's about 36-percent for heterosexual contact and about 16-percent for injection drug use.

This one is a very simple graph looking at the male-female breakdown. Females in Canada make slightly over 50-percent of the population, and you can see that the overwhelming proportion of new infections is still among males at about 74-percent. In terms of incidents by ethnicity and country of birth, this slide is meant to highlight that there are two populations which are still at disproportionate risk for HIV infection in Canada.

Aboriginal peoples, where the risk is about 3.6 times higher than the general Canadian population and people who come from HIV endemic countries, where it's about eight and a half times. Another way of looking at it is if you look at population distribution. Aboriginals make up about four percent of the Canadian population, but about twelve and a half percent of all new infections; for people born in HIV endemic countries, they make up about 2.2-percent of the Canadian population, but about 16-percent of all new cases.

This slide shows the distribution over time by province. It's interesting to note that in 2000 it's exactly what you would've expected. As I mentioned earlier, because of

the three most populous provinces in the urban centers as well as, you can see, Alberta and Manitoba which also have large urban centers as well, that the rates are higher than in the rest of the country, so that's should be expected. However, what's certainly interesting and somewhat disconcerting is that in 2010 the province Saskatchewan, in essence, had quite an HIV outbreak and had quite high rates.

Certainly, a lot of people are involved, including ourselves at the federal level, giving support to our provincial colleagues to determine the cause and hopefully do the right interventions to address the issue. At this point, it appears to be concentrated among Aboriginal peoples and also people who use injection drugs. That's certainly something we hope to address in the coming weeks and months.

Finally, in summary in terms of the epidemiology, we recognize increased prevalence due to, in large part we think, effective treatment and ongoing transmission, unfortunately. The prevalence is concentrated among certain key populations, but the patterns of infection have shifted. Particularly the category for heterosexual contact. Unfortunately, new infections are not declining, so that's certainly something we need to keep addressing.

What are the key drivers? Well, in Canada, because we do have a concentrated epidemic, we recognize there are certain

key populations we need to focus on. Under the Federal Initiative, you can see here on the left side of the screen the eight key populations we focused on. We also recognize that in terms of risk behaviors the two on the right – unprotected sex and the sharing of drug use equipment – account for essentially 100-percent of all new infections in Canada with unprotected sex accounting for about 80-percent.

We recognize also, as well in Canada, the determinants of health certainly have an impact on a wide range of diseases, and HIV is no exception. So I'm just listing a few here which I think are of particular relevance to HIV vulnerability, being stigma and discrimination which we know certainly increases vulnerability to HIV. Mental health, as well, we recognize to be an important issue which is, in turn, affected by stigma and discrimination and, in turn, can also affect the likelihood of engaging in risk behaviors.

Health care; well, in Canada we're rightly proud of our universal health care system, but we recognize that in terms of what we call the delivery of knowledgeable and culturally competent care, the lack of it in various parts of the country will affect access to prevention, diagnosis and care. So that's something we need to keep addressing. On the positive side, certainly we recognize that social support, in terms of

networks and connection with family and friends and communities, while in a positive way also affect vulnerability.

Coming to the Government of Canada's domestic response to HIV, as I mentioned earlier, provinces and territories have the primary responsibility for delivery of health care and public health services. The federal government does play several key roles in addition to health care delivery for specific populations.

Certainly we do national, what we call routine surveillance, where we collect the data from the provincial colleagues, in a sense to paint a pan-Canadian picture, but we also engage in what we call enhanced surveillance; specific surveillance initiatives directed at key populations such as injection drug users and people who come from endemic countries and Aboriginals.

We also are involved in what we call the development – we call public health guidance. Technical documents which are aimed at frontline professionals – health care professionals – in order to improve practice. We also support community programs on a project basis. We recognize that the community plays a large part in enhancing their capacity to address HIV, so we support various projects at the community level as well as partnerships.

We have partnerships, obviously, with our provincial and territorial colleagues, but also we recognize it's important to have partnerships with civil society and, as well, with bilateral relationships. For example, we have a very good ongoing relationship with the CDC, but also multi-laterally with organizations such as UNAIDS.

Research is a big part of what we do in Canada, as well, in terms of funding through the Canadian Institutes of Health Research. Our laboratory in Winnipeg, as part of the Public Health Agency of Canada, also provides important reference services and quality assurance programs across the country.

Looking at how we deal with Canada in the Canada Comprehensive Prevention Approach, I think it was very encouraging to see that our approach is really not much different from what's happening in the United States and elsewhere. We certainly see that it's very important too to include all aspects, to have all the tools in the toolbox so to speak.

When I heard Secretary of State Clinton refer to combination prevention, we recognize in Canada we have a similar approach. Condom use, access to testing, care and treatment, treatment as prevention, all those things, vaccine research, are all part of the toolbox and they all have to be

equally considered in terms of a comprehensive approach. Really in Canada, I think we need to keep moving along. As new developments come along in terms of scientific research findings, we need to make sure that we also take them into account as we move forward.

Finally, in conclusion, HIV we recognize continues to be a significant public health issue in Canada and we have some notable successes. For example in Canada because of the universal healthcare system, it's very rare. Essentially, anyone in Canada who gets diagnosed with HIV does have access to essential care and treatment.

Certainly, issue such as mother to child transmission is not really a big problem in Canada. However, we recognize there're ongoing challenges. Probably about one-quarter of people with HIV infection in Canada are unaware of their status and that's a concern that we reckon is still the issue of ongoing transmission, as well as the fact of challenges for certain populations in terms of adherence to treatment regimens.

In terms of the way forward, you can see right here, we need to keep using science as a strong basis in terms of how we inform our program and policy. The other key part that we're also doing in Canada, which I see is also happening around the word, is how we're having more of an integrated approach.

Instead of HIV/AIDS, sort of continue to be the silo, we recognize we need an integrated approach to all the sexually transmitted and blood-borne infections, as well as other co-morbidities such as TB, as well as chronic conditions, such as mental health.

Final point in Canada, we're always about collaboration, and so, we recognize that the collaborative approach between governments across sectors and with affected population, civil society is the key to success. Thank you very much. [Applause]

DANIEL ERNESTO MUNAR: Thank you, Dr. Njoo. Now, to broaden our discussion about the most relevant issues and policies in our respective countries, we're going to turn the discussion to our distinguished panel. They're going to make brief remarks and help us illuminate what are some of the key issues to pay attention to in response to the epidemiological presentations we just heard.

In the interest of time, I'm actually going to allow our panelists to introduce themselves in their brief three to five-minute responses. Then we're going to take a few questions. Maria, why don't you kick us off, and then we'll go straight down the panel.

MARIA MEJIA: Hello, everyone. My name is Maria Mejia. I'm an international media activist. I have also been living

with HIV for 23 years. I was infected as a teen at the age of 16. I've made it my life mission to educate young people and old in different ways to prevent the virus by showing my face and telling my story.

I use social media, YouTube, Twitter; I blog. I put my face out there, especially for the Latin American community. We do not like to show our faces and that is, basically, what I do. I am the tool of education. I go to schools, universities, everywhere that I can be heard. I believe that that is the most effective way to prevent HIV/AIDS by sharing our stories with people that are living with HIV/AIDS. [Applause]

RANDY JACKSON: I'm Randy Jackson. I'm a Ph.D. candidate at McMaster University in the School of Social Work. Thank you. I guess I want to begin by acknowledging how I struggled with what to bring here this afternoon. I mean, how could I possibly add to what hasn't already been said in the literature by my colleagues in this afternoon's panel, the very strong voices; voices that shake the epidemic or responds to the epidemic and say how aboriginal or indigenous people in Canada are overrepresented. In my struggle to decide how to respond, I managed to find some room to breathe.

The weekend before coming to Washington, I traveled to my home community to attend an annual powwow and to meet other aboriginal people to sing and dance and socialize and to honor

our culture and I had the most amazing experience when I was there. During one of the dances, the man's traditional fancy dance, a single lone man danced backwards.

Now, if you were to ask a few aboriginal people what this means, the man dancing backwards, you'd probably hear what I heard. Someone might say to you that he was contrary or two-spirit and others might add that he was providing comic relief for what was otherwise a very intense highly public competition. Still others might say he was dancing backwards to protect the circle of life or that he did that to honor the warriors who were returning home from battle.

The truth is perhaps it really doesn't matter why he danced backwards, but what feels right, what resonates with me, what is my truth and my essence. He danced backwards to remind me of the value and the importance of thinking about things a little bit differently, of the need to craft responses in different or contrary ways. He danced backwards in other words as a way of providing me some medicine.

My comments are not really meant to diminish, I think, what is some really valuable and good work that is occurring in Canada, but one of the things that I find most difficult about what I heard this afternoon and I'm going to quote O'Neal, Reading and Leader is that stories we heard this afternoon quite possibly provide us with portraits of aboriginal sickness

and misery that act as powerful social instruments for the construction of aboriginal identity. "Epidemiological knowledge constructs an understanding of aboriginal society that reinforces unequal power relationships." In other words, an image of a sick and disorganized community that can later be used to justify continuing paradigms of paternalism and dependency.

I've been involved in community organizing for almost 18 years now and I've seen plenty of leaders who do their work with an open heart, a compassionate spirit, and a clean mind. I've seen and heard even when they don’t speak it how they dance backwards saying not on my watch, they honored and tend to relationships, and they foster a sense of connection that supports and values the whole person.

I've witnessed this medicine in action healing people traumatized by racism, paternalism, and colonialism including the hurts that I've also experienced. It's likely no surprise to anybody in this room that it's an incredibly challenging and difficult work that we do.

Take for example, the writing of Wade Davis who once said that "Western knowledge is simply one model of reality, the consequences of one's set of intellectual and spiritual choices that one cultural group made, however successfully, many generations ago."

I think part of the success of the Canadian Aboriginal AIDS movement in Canada has had despite some increasing rates of infection is that our relationship has modeled another possibility. One that values, draws on, and filters the information we heard this afternoon through an indigenous lens. I've witnessed and danced backwards and they've envisioned a different possibility, a different way about thinking about HIV, and a different way of talking about responding to and interacting with people at risk, affected by, and living with HIV. They've created a range of services that successfully incorporate our ancient tribal wisdoms into their HIV intervention programs.

I'm a proud HIV-positive Chippewa Ojibwa man who has played my part in this movement and it has not always been easy particularly in today's political climate. Cognitive imperialism continues in a vertical ordering of reality or knowledge continues in the west. Take for example, recent health funding cuts to a range of aboriginal health organizations in Canada.

Despite promises of major investments in aboriginal health at the program service delivery level, many observers believe that what is actually happening is the creation of a major void, one that seeks to undermine the bringing together of first nation's Inuit and Métis perspectives on social

determinants of health that present a unified statement that continues to recognize the value of sustaining growth of the unique and multiple indigenous protest to health.

Now, I'm going to end here by asking one very simple question to everybody here this afternoon. Am I the only one who sees the man dancing backwards? Thank you very much. [Applause]

GRANT COLFAX: Good afternoon, everybody. I'm Grant Colfax. I'm Director of the Office of National AIDS Policy here in D.C. I just want to say I'm delighted to be here. I really have enjoyed the speakers so far. I think this is really the legacy of the HIV movement of community, people coming together from every level of government, from every level of community across the world to really make a difference and realize the dream of an AIDS-free generation. I just want to express my gratitude for being here today.

In terms of the perspective that I would like to share, it's from the office of National Aids Policy which is charged by President Obama to implement the National HIV/AIDS Strategy. Dr. Fenton covered the strategy to some degree in his talks from the CDC's perspective and just to acknowledge the CDC's leadership and really looking at the evidence and aligning resources where they really need to be. Dr. Fenton talked about

the fact that in the United States HIV is a concentrated epidemic.

Until the strategy was released a couple of years ago in the United States, we really had a scattershot approach to how we were addressing HIV. Many people were doing very good things both at the federal level or the state level and the community level, but there was really no common forum, no common blueprint for moving forward.

When President Obama came into office, he made a priority the construction of a comprehensive National HIV/AIDS Strategy and it really talks about the importance of—the key questions are how many lives are we saving and how many HIV infections are we preventing.

This is really around maintaining a scientific approach to the epidemic, a shared responsibility to moving forward, and making sure that we're following the science, really following the science and making sure that we're held accountable to what we do. This is a really exciting time in the United States and I think the Secretary mentioned this earlier, but we are continuing to implement the Affordable Care Act.

This is transformative in terms of its effect on the healthcare of Americans. We haven't had social legislation like this passed for over 40 years. This is really how we're going to move forward and achieve–made part of how we're going to

achieve the goals of the strategy which will embark to reduce HIV infections, improve health outcomes for people living with HIV, and address the very profound HIV related disparities that Kevin talked about in particularly among gay men, especially among young black gay men, and among women among women of color who account for 75-percent of infections among women of color.

The Affordable Care Act has already extended HIV testing to millions of Americans—HIV testing benefits to millions of Americans and its implementation is forward and extends coverage to 30 million Americans and that includes tens of thousands of people living with HIV.

Tens of thousands of people living with HIV in this country will be able to gain coverage and it also prevents some of the worst abuses of the insurance industry in terms of denying coverage based on preexisting conditions. [Applause] That's a critical piece. As a recent provider myself I had many conversations with people who are at high risk for HIV, but didn’t want to get tested because they were concerned they didn’t have coverage. They were concerned if an HIV-positive test went into the record, as many of you know, then they would be concerned about the potential for future insurance status.

Increased health care coverage is necessary, but it's not sufficient for reaching health equity in addressing the

health disparities that we continue to see again as Dr. Fenton described so eloquently in his presentation.

The questions now as we move forward is how do we actually get real about this and how do we implement what we're doing? Using the research is critically important, but as many of you know randomized controlled trials really occur in pristine environments.

Now, the question is how do we take the evidence that is so critically important there and really apply it and be flexible? It's really needing to meet any needs. In the way the epidemic is concentrated in certain communities in the United States, it's very clear I think that we can't use a cookie cutter approach. How do we maintain the principles and look towards the goals of the strategy, but maintain enough flexibility so that we can apply the principles of the strategy in response to local community needs.

I think the third piece of that is how do we measure our outcomes? We have a lot of data collection at the federal level. We have a lot of data collection at the state/local level and some of those data are not necessarily the most salient or the key pieces.

Remember the two questions are, how many HIV infections are we preventing and how many lives have we saved? Really as we look at the cascade of treatment that Dr. Fenton showed, we

really need to focus on those areas as we move forward. How are we actually improving the testing rates, the engagement, the retention and care, and the suppression of viral load?

Finally, I just want to add that going more upstream to the social determinants of health which is so critical, which really brings us all together addressing stigma and discrimination, addressing high unemployment rates, addressing educational levels.

These are particularly the social determinants of health that track along the disparities that we see in young men including young black gay men. I just want to pause, and again, acknowledge transformative moments that have occurred recently when the President expressed his support for marriage equality and just think about what that does for a young gay man living with HIV and what that means [applause] for his self-esteem, for his being able to see what the future really holds. We know that these pieces are vital to improving health and wellness among people living with HIV and at risk for HIV.

I just want to thank you all for being here today. I'm really excited to continue the work with many of you here in this room and recognize the vision of an AIDS-free generation. [Applause]

RAINER ENGELHARDT: I'm Rainer Engelhardt. I'm the Assistant Deputy Minister in Canada for the Public Health Agency. My

responsibilities are really entirely in the Infectious Disease and Control area for Canada's population at large. HIV is a very big part of what we're engaged in.

Maybe just a couple of comments in response to the presentations made by both Kevin and Howard. Dr. Njoo indicated that in Canada, the incidence overall of HIV is roughly about 0.2-percent. The estimated number is 65,000 individuals. Given the population of Canada of 36 million, that is a roughly 0.2-percent which puts Canada when you look globally into a position where it could be—I won't say complacent, but it could say, okay that's pretty darn good.

But that would really be inconsistent with what is the general orientation, I think, of Canadian's all together, which is a lifestyle that's based on equity, equality and that's really enshrined in the charter for rights and freedoms under the Canadian constitution and that really pervades the thinking in Canada all together. When Dr. Njoo talks about the fight or the response to HIV, it is predominantly targeting the populations that are most at risk, and that's where the issues are within Canada.

We've been of course engaged in the response to HIV, the fight against HIV and AIDS for many years now. That has been predominantly under this framework of the Federal Initiative where much work has been done especially on the scientific side, also in supporting communities that are affected by HIV and AIDS. Lots of advances have happened, as we know, including the new findings and

the promising—very promising findings in treatment as prevention, as well as some advances being made in vaccines and microbicides and so forth. That all sounds very good, and yet, we see the same thing even in a country with overall a relatively lower than global proportion of HIV and AIDS-burdened individuals we are not able to bring the situation under control.

That has led to sort of a rethinking in Canada about what sort of approach we need to use. This may be not politically speaking at all because I'm not a politician anyhow, but generally speaking, the older approach has been top-down, looking at HIV from a clinical perspective, from the scientific perspective, from a population perspective saying this is what we should be doing in order to solve it at the population level.

Increasingly now, we are taking a different approach and looking at the problem if you like bottom-up in the sense of really being engaged and increasingly engaged with the sector, with the communities, with the at-risk populations and really adapting their learnings into trying to solve the problem. I'm not saying that we have any particular solutions as yet, but it is really we think a better way of addressing the problem.

In part, this was sort of exemplified by the participation of our Canadian aboriginals with global aboriginals here at this conference. It's just an example that interest I'm talking about is not limited to the aboriginal peoples. With a little bit more

elaboration that means and you said it just now that the determinants of health have to be factored in to almost quantitative sense, addressed very, very specifically in order to get us into a decreasing incidence rather than a flat of incidence of HIV and AIDS in the country.

That's where we are putting increasingly our effort, recognizing that there is a close, close linkage to stigma issues. Close, close linkage—I can't list them all and won't list them all here—to co-infections and co-morbidities and predisposition towards tuberculosis and so forth.

More recently we're making efforts and very concerted efforts in integrating the mental health issues in the response to HIV, whether it's a contributory or a result of the infection. [Applause]

Those are all representative of a much more holistic approach that we need to use and we are now using in our country. Also, I guess, given—maybe that's what we're saying—that given the restraints that we are under in Canada like every country in the world fiscally and we formulate a direction that everybody's following of decreasing federal budgets including budgets available for all areas by a pretty high percentage in the next three years.

I can tell you that the funding for HIV and AIDS has at least remained steady. In fact, we've increased the—specific to aboriginal populations for the aboriginal health component increased

that slightly by $25 million. That one is actually interesting because they're specifically to engage the aboriginal communities and individuals in the social and biological research that has them engaged in trying to solve the problem of HIV and other health problems. It's a new era of thinking and I'm very much in support of it and I hope that it will yield the results that we hope to achieve. [Applause]

ADAORA ADIMORA: Good afternoon. I'm Ada Adimora. I am an infectious disease physician and faculty member at the University of North Carolina at Chapel Hill. I do HIV epidemiology research with the focus mainly on African-Americans, but on other people as well. I have the perspective of a clinician.

I've been taking care of people with HIV infection for years, decades in fact; also, the perspective of a researcher, but also the perspective of a Black woman living in the United States. From my vantage point, in fact, the science is on track with respect to HIV infection and the Public Health Agenda thanks to the development of a National AIDS Strategy and to the efforts of public health officials, the Public Health Agenda is also on track.

The fact of the matter is we really haven't done well in the United States. I don't want to be Debbie Downer, but we really haven't. The problem is that we have failed to implement a lot of what we already know how to do and what is very obvious that we should have been doing. We, basically, haven't fully implemented what

we know how to do. We haven't brought it up to anywhere near bringing it up to scale. It's not for lack of commitment on the part of scientists or clinicians or other researchers or public health officials or activists or patients themselves.

From my perspective, it's because of lack of political will on the part [applause] of a substantial proportion of the American people and substantial proportion of politicians and resultant deficiencies in resources and funding. [Applause] The problem is this is not a failure of any one public health administration. It's not even a problem that is restricted to HIV. We see this for a ton of health problems in the United States. [Applause]

A real issue is that, I think, all of us who are in HIV research and care, we are very good at preaching to our own choir. We talk very well to each other, [applause] but I don't think that we've done an optimal job of communicating the rationale, the importance or the urgency of what we need to do to the general public.

There is a real problem with the American public because I know the people from other countries look at us like we're crazy. How is it–thank God the Affordable Care Act has passed, but it had to go to the Supreme Court and it's still under siege. Depending upon the results of the election or the multiple elections in the fall, large parts of it could actually conceivably change.

There is something very wrong here. We need to—I think the next front here for us as scientists, as public health people, as

activists needs to be figure out how to convince the American public, the voters, and therefore, also the politicians to do what we need to do to implement all the things that we've been talking about, that Grant Colfax and Kevin Fenton were talking about.

How do we do that? I think the things that we need to convey to them are number one, that we are all—no matter what you feel about Black people, gay people, whatever kind of people that you have a problem with, we are all connected. [Applause]

We are all connected and whatever happens to one group of people is going to affect the rest of us some way, whether it's directly or indirectly through our health or the health of our children or economically. Number two, that it is in fact cost effective since money is the final argument. In this case it is a good argument, but it is cost effective for us to do what needs to be done in terms of HIV prevention and care and implementing the National AIDS Strategy. I guess I'll stop there. [Applause]

DANIEL ERNESTO MUNAR: Thank you. Thank you panelists and thank you Dr. Adimora for your remarks. I want to pick up on the arguments that you laid out, Dr. Adimora. We're going to tease out a few of these issues time permitting. Before as we were preparing for this session, we were having this discussion about how do we engender support in the American public for responses to health, to HIV when the epidemic continues to disproportionately affect minority groups, in many cases stigmatizing populations? It's such a challenge that

we're facing and probably our colleagues to the north are facing it as well.

I want to actually direct this question to Maria, and actually, as an aside I was really excited this morning to see Linda Scruggs speak in the plenary, probably the first time an openly HIV-positive African-American woman from the United States spoke in the U.S. conference. I will say this is probably a historic moment as well because we have, I think, probably the only session that I know of where there's an openly HIV-positive Latina on the panel, and two Latinos, and actually, two Columbian-Americans living with HIV.

MARIA MEJIA: Right.

DANIEL ERNESTO MUNAR: I guess my question to you, Maria, is the Latino community where there is so much silence about HIV and so much ignorance–and I just came back from a session at Una Visión where there're still deep misconceptions about who's affected by HIV and how it's transmitted. In your work as an activist—and really for anyone on the panel after Maria—how do we start to break that sense of silence around HIV and get more people outside of these walls to pay attention and to have the accurate information?

MARIA MEJIA: As you said, the Latino community is like—I describe it as they're, 'don't ask, don't tell.' They are very conservative when it comes to sex and things that are taboo. They want to keep it within the family. They self-stigmatize themselves. That's why I said I have to show my face. I cannot hide anymore.

I have to show people that this can happen to anyone. It can happen from a baby to an 80-year-old woman. As I said before, the most effective way at least for me—let's say as a tester, when I go and test and I even approach a Hispanic male or female, they sometimes get very upset at me because of the myths about the stereotypes that you have to be a gay man or a prostitute or an I.V. drug user. I told them, no. This can happen to anyone.

HIV/AIDS does not have a face and you should get tested for yourself and for maybe preventing your wife getting infected or the new generation. The key, I always tell everyone is in education, but the reality is, when I go to schools especially like the high target Latino and African-American communities and I speak to teenagers; that's where I really start to speak, they don't respect the virus. I tell them it's not a death sentence anymore, but it is a life sentence. The key is education and showing our faces, not to hide anymore behind the shame and the stigma.

DANIEL ERNESTO MUNAR: You agree with Phil Wilson's call on Monday that people with HIV to the extent possible should come out about their status on having the HIV?

MARIA MEJIA: They need to come out of the HIV closet, correct.

DANIEL ERNESTO MUNAR: Other responses to how we break that ceiling of silence?

MONA LOUTFY: Okay, thank you. I'll take the second question, and maybe it will be directed at Dr. Njoo, and maybe also Rainer. Dr. Njoo you talked about the universal healthcare system in Canada. I had the opportunity in March to go out to Saskatchewan myself. I heard about what was happening in Saskatchewan and I said I have to get out there myself and see what's happening. I went to Saskatoon and to Prince Albert; and as a Canadian, I was shocked.

I couldn't believe the segregation. I couldn't believe the racism. Being Canadian, being brought up with anti-racist values, I was shocked there. I went to the Westside Clinic which is relative small, the little clinic in Prince Albert. If we're going to do something in Saskatchewan, really we need clinics like the Westside Clinic that are 10 times the size of the Westside Clinic.

We need outreach and really we don't have universal healthcare because in the population [applause] that I saw there, they're fearful of the medical system. They don't trust the medical system. If a pregnant woman goes to the medical system, she fears that her child is going to be taken away by the Child Protection Agency. Why would she go?

In Saskatchewan there were seven babies born HIV-positive because they either sero-converted in pregnancy or they show up late. What are we going to do about that? Also, we knew this was coming. The numbers were shown from 2006 that this was coming. What are we

going to do about Saskatchewan and Manitoba and the Prairies?

[Applause]

RAINER ENGELHARDT: Thank you, Mona. You point out a significant problem. There is no doubt. Certainly, there is a universal healthcare system in Canada, right? It exists and exists for every person living in Canada that is there by definition. The access to it, how it's utilized, and how comfortable people feel, how fearless they feel in order to access that, that's where the problem lies. The way to address that and I think it's a challenge to all of us, but we need to assist.

I mean, if we're to show leadership federally, it is really creating that transparency, creating that awareness of HIV. Even the question—this conference, for example, that's showing major breakthroughs in that we're able to bring a chronic disease under control that is seen by the general population still as being sort of perfidious, right?

It's our responsibility to relate that to the general population at large, to not have them fearful of HIV, not to create that stigma—maybe to remove that stigma that is there. That's the challenge we have. That's just as important as working ahead on a vaccine or working ahead on tasks all that is just part of the same scene. You're pointing out the problem that there is. There's no doubt about that, but it's more the Federal Government as well in Canada or the National Government in the U.S.

For us, Canada, we're a federated state. There is a, for Canada, unique system of how we actually have healthcare carried out and paid for. Now, the healthcare transfer payments, they go to the provinces.

The provinces look after the delivery of healthcare and it isn't delivered in a uniform fashion all over amongst the provinces and territories or even within the province and territory so that there is a disconnect that has to be remedied. At the same time, I must say that our provinces progressively are becoming more and more engaged in the response to HIV and AIDS and even Saskatchewan that the issue here identifying from a provincial government perspective is recognized, but it's more than that.

It's not just two tiers of government. It's down to the municipal healthcare level, how we manage in particular the aboriginal populations, and in this case, the Saskatchewan who live both on reserve and off reserve. Those that are off reserve—Canada has this reserve system still—that are off reserve, they don't get captured as well. Some of our statistics get really skewed. It is an issue that we are recognizing what needs to be done and it's up to us now to make it happen to address it.

DANIEL ERNESTO MUNAR: Dr. Njoo?

HOWARD NJOO: Really not much more to add to what Dr. Engelhardt has said except what I said in my presentation. We recognize and we're very mindful at the federal level of the

responsibility of provinces and territories to deliver healthcare services, and certainly, we're there and support, recognizing that for the average Canadian they don't really care. They want access to good healthcare, and also, to good public health services and for them it doesn't really matter if it's federal or provincial and territorial. In a sense, between the two governments, the federal and provincial and territorial, it's up to us to get our act together and to work in a collaborative fashion to address this. [Applause]

DANIEL ERNESTO MUNAR: Thank you. It doesn't bode well for our U.S. contacts in the balance of state and federal challenges hearing from our Canadian friends. We have many people in line for questions. We're going to take as many as people. We're going to be over time. If our panelists are willing to stick around a little bit, we'll keep going. We'd ask that you keep your questions as short as possible and directing to one member of the panel. We'll start at this mic.

REY CANDELARIA: Thank you very much, panel. My name is Rey Candelaria and I'm the director for the South Suburban Clinics of Cook County in Illinois, part of David Munar's home territory. I wanted to thank the panel first for your insights. As my colleague David knows, we've implemented almost all of the components, but one of the things I think that I did not hear mentioned and I wanted to hear just some ideas about is this idea of lack of transportation

infrastructure. We're so close to Chicago that we can see the trains go by, but we don't have trains.

We don't have buses that are effectively transporting people to where they need to go. We are close to spending about 10-percent of our budget on transportation just getting the patients to clinic and back from clinic to groups, the things that they really need to really be retained in care. These are some of the things that we're facing and I'd like to hear from the panel about this idea of transportation infrastructure and how it's critical to getting people to the doctor and making sure they stay in care.

DANIEL ERNESTO MUNAR: Ada?

ADAORA ADIMORA: I'll be very quick. I was only going to just add to that that it's a huge problem in the rural south [applause] where there are often only a few centers that have HIV expertise. I have clinic patients who routinely—I have quite a few—who routinely travel an hour and a half, two hours in one direction to see me and we absolutely see a fall-off in clinic attendance when the gas prices go up. I mean, there is absolutely no question that there is a fall-off. It's a huge, huge problem.

GRANT COLFAX: Just to follow up on what Ada was saying. Again, I've experienced the same thing in my clinic where people do not show up for appointments often because of transportation issues. I think that I would just congratulate your agency for really making sure that people do get to their appointments and what they need. I

think that it is really part as we move forward with the implementation of the strategy and I said earlier that healthcare coverage is necessary, but not sufficient.

What are some of the models that we need to do to address these larger structural issues that are keeping people from getting there? We're looking at some innovations, the Minority AIDS Initiative, for instance, just recently released an RFA that's going to provide $44 million to communities largely in the south and to address some of the issues you're talking about.

How do we make sure people are able to link with testing? How are they able to engage in care? Certainly, we're hopeful that some of the demonstration projects that will come in will attempt to address some of these transportation issues that you're talking about.

REY CANDELARIA: If I could just briefly follow up–

RANIER ENGELHARDT: I could add to that. I know you're absolutely right with transportation, but just imagine that transportation issue when you're dealing with a remote population. The distance from Resolute Bay to the nearest hospital or a significant hospital is 3,000 kilometers or if you live in Cambridge Bay, any number of the northern settlements. Alaska's the same.

To get to–it doesn't have to be a hospital care, even ordinary care. The distances really do matter and that is one of the

social problems that is very difficult to address, but has to be addressed.

REY CANDELARIA: I just wanted to follow. One of the things that we're trying to explore is the old idea of 'what is old is new again' and that is bringing the clinician to the patient. I think that's going to be one of the things that we're really going to look at.

MONA LOUTFY: Okay, great. Thank you. We're going to try to get as many questions. The mic over here.

CLARE HACKSEL: Hi, my name is Clare Hacksel. I'm from Vancouver, Canada. My question's for Dr. Njoo. You identified in your presentation that injection drug users are a population at risk. We also know in Vancouver, Canada that supervised injection is the leading way to prevent HIV transmission among injection drug users along with supervised injection, needle exchange, but the conservative government who appointed you, I understand, is very opposed to harm reduction, and certainly, supervised injection.

As far as I'm aware, no one including the Minister has ever come to see the injection facility in Vancouver. We've set up a demonstration model of it here in D.C. because this is a conference. It's for knowledge exchange and we want to spread the concept of supervised injection all around the conference and anyone interested in preventing HIV transmission.

I'd like to know on the record when you plan on coming to visit our mock demonstration. I'd be happy to stay late. I'm sure the other researchers would be happy to stay late. We'd just like to know when you plan on coming and seeing Canada's leading way to prevent HIV transmission among populations at risk. [Applause]

HOWARD NJOO: Okay, thank you very much for your question. Just to let you know that I wasn't appointed. I'm actually a public health infectious disease physician, and so, in terms of practicing my specialty which is community public health, I chose to work with the federal government. That's just one point. In terms of visit to Vancouver and Insite and so on, I have done so in terms of my professional, sort of—

CLARE HACKSEL: But I mean in your position as a representative of the Canadian government which you are here at this conference and on this panel.

HOWARD NJOO: Since I work for the government of Canada what I will say is that we recognize in terms of how we deal with HIV in Canada, you need all the tools in the toolbox. Everything from prevention in terms of preventing people from getting infection in the first place, to those who happen to be on drugs and we want to get them to rehabilitation services; all that's important.

Other things that you mentioned such as harm reduction, certainly from a scientific point of view, I recognize are valid tools in the tool box. Certainly, we're looking always at the

scientific evidence in terms of then forming the recommendations and advise we give to our Minister.

CLARE HACKSEL: Are you planning on coming and visiting our demonstration site as a representative of Canada?

HOWARD NJOO: Demonstration? Which, I'm not sure–

CLARE HACKSEL: It's in the Global Village right below us where we're standing right now.

HOWARD NJOO: Sure, yes. Not a problem. [Applause]

MONA LOUTFY: Yes, I'll bring Dr. Njoo.

CLARE HACKSEL: That's wonderful, thank you.

HOWARD NJOO: Yes. [Applause]

DANIEL ERNESTO MUNAR: We're interested in hearing from everyone who's standing up right now. What we're going to do is take the three at the back and then to the panel. Then we'll get three and three. We'll do three more rounds. If we could get this mic and that mic, and then we'll respond. Go ahead, sir.

LOUIS LETELLIER: Good afternoon. My name is Louis Letellier. I'm from Montréal, Canada, the French part of Canada that was not mentioned earlier. Canada's a big country, but there is a province which speaks French only or almost. We do have problems in Canada as well. Something is wrong because for the last four years at least more than ever, we had to go to court.

I'm a lawyer by the way and I am founding member of CACTUS Montréal who is known to be the first needle exchange program in

North America, so 23 years of harm reduction success. Over the last for years more than ever we had to go to court to make sure that people living with AIDS or people at risk, their rights are respected. This is not normal. It's a loss of time, loss of energy and money.

Our Minister as you see—it's hard to be a minister especially the Minister of Health these days in Canada— but the minister gave us a very positive picture of what is going on in the AIDS issues. Fortunately, our two representatives give another view as well in the problems that we have to face in the next few years.

The picture of the minister could have been a little bit darker. She didn't mention that a couple of months ago many Canadian organizations across the border were cut from their national federal funding; some as much as 70-percent which is a dramatic cut and this is something that doesn't help the fight against AIDS.

DANIEL ERNESTO MUNAR: Please wrap up so we can get to the other people standing.

LOUIS LETELLIER: Yes, I will. This is a shame that the Minister couldn't stay at least to answer a few questions. I have a question for Dr. Njoo. In one of your slide—I'm sorry but I have to ask you this question. You mentioned some key populations, but among those key population I.D. use were not mentioned. Was it an unfortunate mistake or was it done on purpose?

DANIEL ERNESTO MUNAR: We're going to take three questions at a time. Maam, if you can just mention your question —

HOWARD NJOO: I did mention people who use drugs as one of the–

MONA LOUTFY: With what—it was up there.

HOWARD NJOO: It was up there.

MONA LOUTFY: Yes.

ELIZABETH BENSON: Hi, my name is Elizabeth Benson. I work as a mental service provider, otherwise known as a support worker for Healing Our Spirit in Vancouver, British Columbia, Canada. One of the things that I wanted to say was stigma and discrimination doesn't belong to me. It belongs to you. It's your responsibility to understand who I am, where I'm at as an aboriginal woman living with HIV and AIDS.

That's your own responsibility, not mine but as for our part you mentioned something about mental health and providing services. I really encourage you to focus on that part because there is a reason why there's alcoholism and injection drug users anywhere in Canada. They are self-medicating for some reason. As an addiction worker, I really encourage you to call those people to your table.

No one's ever asked me whether I had successful cases when I've been working as a support worker for 17 years with people, aboriginal people living with HIV and AIDS, especially the ones that

are suffering the most are the two spirits. We really need programs for them in Vancouver. They are the most at high risk for HIV.

DANIEL ERNESTO MUNAR: Thank you, ma'am.

ELIZABETH BENSON: Especially when they move to the cities, they are at risk and that's all I have to say.

DANIEL ERNESTO MUNAR: Thank you.

ELIZABETH BENSON: I'd encourage you to focus on that.

[Applause]

THOMPSON NTUBA: I am Dr. Thompson. I am an international speaker and consultant in Recovery Mission and we focus on addictions, AIDS, and abuse cases. Recently, we noticed that there is a movement that is actively in place in the world that is called Denialism Movement powered by conspiracy theories with fingers pointed at the United States and Canada by extension.

I think that there are very famous scientists also in this country who are associated with HIV/AIDS work who are working for this movement behind to get themselves enriched. Since we are focusing our attention and emphasis has been placed on prevention today and we are today about primary, secondary and tertiary prevention, we seem to be very silent in the scientific community in our counter to this movement.

I want you policymakers, leaders of government, and the scientific community and faculties to throw light to some of the

people who are here on what has been done or what has anticipatedly been put in place to counter that Denialism Movement. Thank you.

DANIEL ERNESTO MUNAR: Maria?

MARIA MEJIA: Actually, I have a huge problem with their denialist dissidents and one of the major groups is Rethink AIDS and they're worldwide. They're targeting Africa, Latin American countries and they're in the U.S.A. I'm in a constant war with them because they are manipulating people that are newly diagnosed and vulnerable.

They even have me on a waiting list to die because they have managed to make some people believe that we are being poisoned, that HIV does not exist. They're pretty much saying that I'm going to die because of my HIV medications. They even have the funds to have the House of Numbers which is a very well-known documentary and it was even going to be shown in a university here in the United States, which is incredible to me in Florida, and believe it or not, they have a lot of power.

They're all over the media and at least us as activists, we are constantly being attacked. I'm sorry for these words I'm going to use, but they call me a 'Pharma whore.' They also say that I am an actress, that I'm not even positive. It's a constant battle with them and a lot of people are dying because of them. This is something very valid and I hope that everyone knows that this is really serious and it's a big movement.

MONA LOUTFY: Thank you for raising that point. Unfortunately, we've been told by our technical staff that there is a session in here at 6:30. Is that correct? You're nodding your heads and David gave me the hard task to do this.

DANIEL ERNESTO MUNAR: I opened.

MONA LOUTFY: To say that we're going to have to—I'm very sorry for the people standing with questions—if you want to come up here and ask our panelists. The technical support has to get the room ready for the next session. We'd like to thank our speakers and our panelists for a very exciting session. Thank you and thank you, David. [Applause]

[END RECORDING]