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ANTHONY HARRIES: My name is Tony Harries and I work for the International Union against Tuberculosis and lung disease, also I have a position at the London School of Hygiene and Tropical Medicine. I spent 25 years of my professional life living and working in Africa dealing predominately with HIV/AIDS and Tuberculosis.

JUDITH CURRIER: My name is Judith Currier and I'm from the University of California in Los Angeles where I'm a professor of medicine and Division Chief for infectious diseases and I work on HIV treatments and I'm also a clinical caring for people with HIV and my plenary was on the Intersection of HIV Aging and Non-communicable Diseases.

YOGAN PILLAY: Good morning everyone, I'm Yogan Pillay from South Africa I'm the Deputy Director General responsible in the national department for HIV, T.B., maternal and child health, non-communicable diseases as well as a few other things. My topic was Optimization and Integration with specific focus on efficiency and effectiveness of HIV programming, thank you.

ANTHONY HARRIES: So maybe we'll go around again, so my plenary this morning was on HIV and Tuberculosis on Turning the Tide and I expanded that title to talk about reducing death. The reason for that is that if you look at the global figures in 2010, those are the latest figures we have we had 1.1

million people globally with HIV associated Tuberculosis of whom 350,000 died.

Now given that Tuberculosis is a curable, treatable condition and HIV/AIDS is in fact a treatable condition this is totally unacceptable that we have such high mortality and if we look on the HIV/AIDS side Tuberculosis is responsible for 25-percent of deaths that occur in people living with HIV/AIDS.

So this morning I spent the time really looking at how can turn the tide, how we can reduce these deaths and very simply I think if we can, in the high burden areas of the world, that's essentially Sub-Saharan Africa, if we can get people with HIV onto antiretroviral therapy earlier than we are doing and if we can add [inaudible] and preventive therapy to antiretroviral treatment I think we have a really good chance of trying to reduce their risk of getting Tuberculosis in the first place.

So I think prevention is always much better than cure. I think if you don't prevent Tuberculosis we've got to find Tuberculosis, our standard techniques of doing this are a bit old-fashioned, we use spits and smear and x-ray, they've been around for decades in fact but we do have some new technology that is available.

One of them being the Xpert MTB/RIF machine that I talked about this morning. Now this is very good but it's costly, we haven't yet been able to decentralize this down to

the peripheral levels of health care and Yogan this morning altered us to the fact that there is actually a shortage of cartridges which you need for this machine to make it work. So it's a bit worrying, we have new technology, it's been promoted, it's obviously very good and we're beginning to run into challenges with logistics and consumables.

Anyway, these are things we have to deal with. I think this an advance, if we can pick up Tuberculosis earlier, treat it, then we can certainly save lives. I think I'll stop there and hand over to Judith.

JUDITH CURRIER: Do you want to take questions or just move on? So I talked about the fact that as we've gotten more successful in treating HIV the people are living longer and here in the U.S. it's estimated that by 2020, 50-percent of people with HIV will be over the age of 50. So that creates I think, some new challenges for us.

I also talked about the fact that non-communicable diseases, and these are—the term NCD is used and you've probably seen it around the conference this time. So these are conditions that are not transmissible between people and include cardiovascular disease, cancer, diabetes and chronic respiratory disease. Also diseases like renal disease, neurologic disease, mental health disorders and gastrointestinal disease.

Many studies have now shown that when we effectively treat HIV over the long-term and as people with HIV, they may be at increased risk for some of the chronic conditions. We saw data at the conference to highlight the fact that people with HIV on long-term treatment may have one or more chronic conditions and compared to people of the same age who are HIV negative.

So I discussed some of the theories and work that's going on to understand what might be causing this, I highlighted I think very importantly that NCD's are a growing problem in low and middle income countries and that we'll begin to see these diseases emerging with long-term treatment in those settings and that we need to identify interventions to reduce the risk of these diseases.

For many of these non-communicable diseases we have effective prevention interventions and these include very scalable things like smoking cessation, exercise and improved diet. I think that our first approach needs to be to emphasis the need for healthy lifestyle for people with HIV to ensure that they get the best long-term benefit from our treatment.

I also highlighted that we need to continue to invest in studying the differences between treatment regimens and their impact on NCD's and we need to continue to look for newer, even more safe drugs because until there is a cure, we'll be treating people for many years to come.

YOGAN PILLAY: My presentation, one of the first things I did was to try and locate Washington D.C. with respect to the 19th IAS Conference against the Toronto Conference. Where South Africa was much maligned because the focus then was not as much on antiretroviral treatment but on nutrition, and for those that remember Toronto you would know what I'm talking about. But I went on to highlight some of the successes in South Africa and the successes must be understood in the context of a middle income country with significant inequities between rich and poor.

But we've nonetheless made fairly significant gains over the last few years. In the last 20 months we have 20 million people so that's roughly a million people a month and that's juxtapose against on average we used to test about two million people a year so it's a significant increase in the number of people we've tested.

Cumulatively from 2004 we now have 1.7 million of the eight million people in the world that are on treatment, 1.7 million are in South Africa. Our maternal to child transmission rates have reduced very dramatically in the last years; in 2008 it was 8-percent, in 2010 it was 3.5-percent and in 2011, in figures we've just released it's 2.7-percent.

So what does that translate to? That translates to if you do nothing with respect to the prevalence rate in South Africa and the transmission rates in South Africa in 2004, we

would typically have had 70,000 infants born HIV positive each year.

At the moment it's under 10,000, it's about 8,000 patients so there's a big difference between 2004 and 2011 with respect to reduction in vertical transmission. As you know, medical male circumcision has shown to be highly efficacious and from May last year to May this year we have circumcised half a million men in South Africa.

So we're doing all the right things, we think we're getting them at the right scale, the key of course, it to meet our next set of targets. In 2016 we should have about three million patients on treatment with respect to current eligibility criteria. Of course if we go to test and treat, we should have almost six million patients in treatment so the question is; how in the current economic environment with the resources that currently have will we be able to reach that target? The only to do is to squeeze additional efficiencies out of the system and that's basically what my presentation was about.

I agreed with everything my co-presenters said with respect to both T.B. and HIV integration and the integration of HIV with non-communicable diseases because there's really no doubt that unless we have a wholly integrated service delivery platform we will be caught short as we go along. Thank you very much.

CHRISTINA BACHMANN: Hello Christina Bachmann Deutschland Village International Broadcasting. I have a question for all of you; this is today, Friday the end of the conference, if you could please tell us what do you in your field for your country take home from this conference? Thank you.

ANTHONY HARRIES: Thank you very much. I think it's been a very positive conference, I don't come to many World AIDS Conferences, the first one I ever went to was in fact, in Yogan's country in Durbin in the year 2000 and that to me was a milestone in turning around the HIV/AIDS epidemic on the African Continent. We came away—I was working in Malawi at the time and I remember coming away with a really exciting feeling that we can do something about treating the thousands of patients we were seeing with HIV/AIDS in Sub-Saharan Africa.

This conference, I also come away with an exciting feel that if we can use antiretroviral treatment earlier for treatment and prevention, we can do a lot to try and turn around this epidemic. Obviously my field is HIV and Tuberculosis and I explained this morning of the plenary but I think if we can start antiretroviral treatment much earlier we have a very good chance of reduction Tuberculosis which is of course, a big killer in Sub-Saharan Africa.

So I've really enjoyed the conference, I come away with a very positive feeling but this is if you like, sort of

another milestone and providing we can get on and get our guidelines sorted quickly, we can move. And as Yogan said we can sort out these service delivery issues, I think we can begin to turn this epidemic around and begin to think actually of perhaps ending this epidemic. So very good, I leave with a positive feeling.

JUDITH CURRIER: I share the enthusiasm about the meeting, I think having the conference in the United States was really important and I think it gave an opportunity to see the U.S. commitment to the global response to HIV. I think that we're beginning to see the fruits of our labors in terms of research and understanding how to deploy our resources to get the most for the money. I think there's a real sense of integration going on throughout the field, we heard about integration of health systems, integrating treatment and prevention and integration of ART for benefits beyond just the clinical benefits to the individual.

So I'm really excited about the renewed enthusiasm and the U.S. commitment to the HIV epidemic and it's also been wonderful to see so many young people at the conference kind of taking up the AIDS Movement and getting involved. I think that ensures that we'll continued success in the years ahead.

YOGAN PILLAY: I share the optimism of my co-presenters. The science is moving so fast and I'm a program manager I'm not a researcher, the researches are sitting to my

right. I wish they would slow down a little bit, my major concern when I go back home is what do I do with all of these things? How do I implement them? Because if you don't implement them they're not as useful as we'd like to think of them. So the key question for me when I go back home is; how do I rally my troops and how do I get all get all the good since that was presented at this conference implemented?

Of course the flip side of that is that this conference has given us renewed hope that we are on the right track, that what we are doing is correct and we are now seeing the evidence and the evidence is best shown by people living longer. But of course that comes as the reminder does, that comes with the set of others things that we need to think about in terms of chronic diseases.

How do we ensure that we keep people alive, not just from HIV but from other diseases but also keep them well and healthy so that they can lead productive lives and not get hit by some other disease, especially chronic diseases? So that's a concern that as people live longer, we would need to ensure that our health delivery system is geared up to take care of people who live to 80, 90 years old. Especially in Sub-Saharan Africa where non-communicable diseases is now a growing problem.

The other big thing I think that comes out of the conference, I was telling my colleagues that I summarized the

plenary session on Monday in one word and that is adherence. We don't get viral suppression if we don't get adherence so you can put any number of patients that you on treatment but if you don't get them to adhere for long periods of time, you won't get viral suppression.

And you won't get the desired benefit either at the individual level or at the population level so either treatment as prevention or for the individual's own sake. With respect to adherence, if we don't work closely and I'm taking for myself now as somebody who works in the health department, if we don't work closely with civil society and communities and the rest of it, we will not get good adherence which is a prerequisite for a good program. Thank you.

MALE SPEAKER: I'd like to follow up on the question of optimism. On the one hand, those of us that have been here through the conference have heard endless fascinating detail about the scientific breakthroughs, the advances in treatment, the way that targeted groups have really taken up this issue.

But on the other hand, all of those advances and exploiting all of those advances require a great deal more money than is currently being spent. And all of this happens against the backdrop for the very time in probably 15, 16, 17 years, international support for HIV and AIDS programs particularly in Sub-Saharan Africa have gone down and frankly

the prognosis for restoring those funding cuts particularly in the United States being the largest funder is not good.

So in the absence of solving that problem, in the absence of continuing significant increases in financial resources coming internationally, in the case of South Africa I think a lot of the progress that's been made in the past few years is because the Zulu Administration has put a great deal more money into the programming in fact. Everyone talks about doing more with less and squeezing the system to get rid of the inefficiencies, but how many inefficiencies are there, how much can you squeeze and aren't we collectively in great danger of squandering the scientific and social opportunities that this conference has highlighted?

YOGAN PILLAY: That's a great question. There's no doubt that we need more money, that's a given and some countries need it more than others. Malawi for example, will not be able to ante up, the government won't be able to ante up if donors pull out and Tony can speak much more about Malawi because he knows it first-hand.

South Africa is in a slightly better position because it's a middle income country. And we have taken and my government has taken the position that certainly on the treatment side, we would have to ensure that we are able to treat the patients that we need to treat back home. So while we would like the PEPFAR funding in particular to stay at

current levels, it's unlikely to stay at current levels over the next five years.

We are in discussions with the PEPFAR team both in South Africa and in the U.S. about how to transition some of the PEPFAR activities to government and that's a discussion that we've held during this week and we have in the weeks to come as well.

The key thing is to figure out what are the comparative advantages of development of aid and what should countries put in? Now the African Union Meeting last week, which I quoted in my input this morning suggested that there is also a requirement for African governments to increase domestic funding.

As you know many African countries are now finding oil and oil can be a good thing or a bad thing and we need to figure how the additional revenues from oil in many of the African countries can be directed towards social investment about health, education and the like. So I think there is an obligation on African countries in particular to raise additional domestic funding where they can but I do agree that we need to better define what fair share means and how do we operationalize global solidarity even in the context of an economic meltdown?

ANTHONY HARRIES: Again, great question. I remember very well back in 2004 when we were starting to scale up

antiretroviral treatments in Malawi and we were supported by the Global Fund, people on the ground, in the field, in the community saying well this costs money, will the international community continue to give us money in Malawi as we scale out more and more people onto treatment?

I think our answer at that time was if we do a good job, if we can show that in fact our treatment is being used efficiently and is saving lives, I can't see that the international community can run away from this.

There's a sort of moral imperative if you like, globally to try and help and I think eight years later we all know about the global economic downturn but the morale imperative is still there. We have an exciting sort of scientific time where we can think; listen, we can if we use our tools much more strategically we can do a lot better.

And I think as Yogan said, I think really what the internationally community needs to do is to think where are those countries that really need external aid? Malawi is going to be one of them, Malawi can tap a little bit into its domestic resources but those domestic resources are very, very thin and they're stretched too far and I don't think Malawi has oil yet. May find it in Lake Malawi, but it doesn't.

So I think one is going to perhaps need to do some painful prioritization and say well maybe South Africa, maybe some of the external aid could be cut back a bit, Yogan you may

not like me saying that but I mean shifted to countries where the need is in fact greater. So I think there's going to have to be discussion, debate on this and I think Yogan showed very nicely this morning that we have got to be more efficient.

I again go back to the early years of ART scale up where I think we perhaps weren't as efficient as we could have been, I think we learned to be efficient and we deliver treatment very cheaply now. I think we've got to look at these things.

But I still remain optimistic, I think if you have a vision and a vision is we're going to end this epidemic, we can do it through the science and the implementation. I sort of feel it's difficult to run away and say well we can't find the money.

JUDITH CURRIER: I would just add that one thing that made me more optimistic was going to the session where several U.S. Congressmen spoke about their involvement in PEPFAR and really strong bipartisan support for the program from people who really have taken the time to look at what it means and what it's been able to deliver. And that gives me hope that maybe they can convince some of their colleagues about the importance of this as funding allocations are made. The money is there, it's just how we choose to prioritize what we spend it on.

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