Opening Session
Kaiser Family Foundation
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[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

[START RECORDING]

MALE SPEAKER 1: Please welcome them to the stage. [Applause].

MALE SPEAKER 2: Community based organizations are central to the global AIDS response, often displaying courage and resilience in addressing the challenges presented by the epidemic. These organizations are best placed to know the exact needs of their communities and are in the best position to know how to address those needs. They teach us how to respond to a global epidemic one community at a time.

[Inaudible] is a partnership initiative of the United Nations Development Program and the entire UNAIDS family that honors and celebrates 25 community based organizations implementing successful and sustainable programs that reduce the spread and impact of AIDS and is presented every two years at International AIDS Conference.

This year UNDP received 720 nominations from all over the world and through an independent and civil society lead process these 25 winners were selected to represent outstanding leadership in the following categories, ensure that people living with HIV receive treatment, support HIV prevention, treatment and care programs for people who use drugs, remove punitive policies and laws stigma and discrimination that block effective aids responses and marginalize key populations, stop violence against women and girls and reduce gender inequality,

enhance social support for those infected with HIV including orphans and vulnerable children.

Now, let's welcome the 25 winners of the 2010 Red Ribbon Award. [Applause]. The Albanian Association of People Living with HIV provides treatment, care and support for people living with HIV focusing specifically on children. Through lobbying and advocacy the organization has created a national human rights framework that now allows children living with HIV to go to school. [Applause].

Asociación Comité Contra El Sida Cabañas, CoCoSI, in El Salvador is a leader in fighting for the rights for women living with HIV. CoCoSi works to provide services and educate the community on reproductive health and rights and violence against women and girls. [Applause].

Asociación de Mujeres Meretrices de la Argentina, AMMAR, Argentina, is a network of 15,000 sex workers which has successfully advocated for the adoption of municipal codes and police orders that now protect and promote the rights of sex workers in the country. [Applause].

Association Pénitentiaire Africaine, Burkina Faso, [applause] advocates for the rights of prisoners by educating prison staff, providing legal assistance to inmates and offering support services for vulnerable populations in prisons.

The Center for Domestic Violence Prevention in Uganda focuses on the rights of women and girls and works to prevent domestic violence and HIV. Using workshops and media campaigns, they challenge gender norms and unequal gender relations. Their advocacy was instrumental in passing the new domestic violence bill in the country. [Applause].

Chrysalide, Mauritius, operates a center for women living with HIV and women who use drugs and their children. Chrysalide not only suppers and educates women, but also offers programs that empowers women to become community leaders themselves. [Applause].

Colectivo SerGay de Aguascalientes, Mexico, works with men who have sex with men and transgender groups to expose human rights violations towards sexual minorities and marginalized groups. They run a weekly radio program and host the community center that is a safe space for young gay men to interact and receive medical and other support. [Applause].

Elan d'Amour, Ivory Coast, works in hospitals and other healthcare facilities training staff to reduce stigma and discrimination in the health sector and eliminate barriers to treatment access. They also provide inside education, treatment and counseling services. [Applause]. Thank you.

The International Treatment Preparedness Coalition, Russia, mobilizes and trains people living with HIV to advocate for an inclusion in local, regional and international decision-

making mechanisms and facilitates important information exchange distributing treatment information through its web and media campaign in the whole Eastern Europe. [Applause].

Nikat Women's Association from Ethiopia is the first community based association in Addis Ababa, Ethiopia that is devoted to improving the living conditions of poor women and commercial sex workers, thereby fighting poverty and protecting the right to health. Unfortunately, they're not here with us tonight, but they deserve a clap anyway. [Applause].

Novices Aids Intervention and Rehabilitation Network in Thailand is an organization of Buddhist monks who have been trained as HIV peer educators breaking the stigma associated with HIV and becoming a model for other novice monks and monastic schools in Thailand. [Applause].

The Penitentiary Initiative in Ukraine works in six prisons to provide treatment and support services for over 2,500 inmates. In particular, the organization works with prison inmates who use drugs and with men who have sex with men setting up support groups and training prison staff. [Applause].

Physicians for Social Justice, Nigeria, has trained family caregivers to conduct home visits to support people living with HIV and in particular women, thereby challenging existing gender and cultural stereo types. [Applause].

Positive Voice, Nepal, is an organization of drug users and former drug users who successful lobbied for access to harm reduction services and anti-retroviral treatment for people who use drugs in Nepal. [Applause].

Positive Women's Network, South Africa, created a safe space for women with HIV, comprehensively addressing their needs and forming a powerful group that educates the wider community about HIV and AIDS. [Applause].

Pride Community Health Organization, Zambia, operates a safe haven for people living with HIV, particularly orphans, vulnerable children, youth, women and people living with disabilities, providing them with HIV and tuberculosis care and support through homecare based visits. [Applause].

Productive Organization for Women in Action, POWA, Belize, uses a mobile information booth featuring live music and dancing to attract a wide range of community members and educate them about HIV, gender-based violence, condom use and HIV testing and referral services. [Applause].

SPIN Plus, Tajikistan, provides an innovative and peer-based services to drug users and people living with HIV in the country. SPIN Plus's members were the first to public announce their HIV positive status and to lobby to make available anti-retroviral treatments to people who use drugs. [Applause].

The Substance Abuse and Research Center, SARC-AMAN, Palestine, is the first organization in Gaza to tackle issues

of drug use and HIV including stigma and discrimination. Facilitated by a team of former drug users and current drug users, they tackled stigma and discrimination and they have built a center for building awareness among people who inject drugs, high school and university students and they provide services in refugee camps in the Gaza Strip. [Applause].

Svitanok Club, Ukraine, has created and is managed by people living with HIV and people who use drugs. They provide comprehensive support services to a broad range of vulnerable groups including women, men who have sex with men, prisoners, drug users and sex workers. Svitanok has become a catalyst in the creation of other organizations serving these populations in the country. [Applause].

The Initiative for Equal Rights, Nigeria, works to break the silence around issues of sexual minorities in the country. They have formed partnerships with human rights lawyers to increase legal advocacy and form partnerships with civil society and the government to increase HIV programming for men who have sex with men. [Applause].

The Youth Volunteer Group, Thailand, works with some of the most marginalized children educating them about HIV and reducing stigma and the barrier to care. Responding to the needs of children and young people living with HIV, they build their self-esteem and empower them to communicate their needs. [Applause].

Timur Islamov Charitable Foundation, Russia, has built strong relationships with local authorities and public health centers and through these relationships has become a primary driver of advancing HIV testing, referrals and support programs for drug users in the country. [Applause].

Finally, Widows, Orphans and People Living with HIV/AIDS in Sudan is a community based organization of people living with HIV that works to increase access to anti-retroviral treatment by forming partnerships with hospitals, facilitating referrals for treatment and developing a home based care system in the region. [Applause].

Thank you so much and let's celebrate the 25 Red Ribbon Award winners for this year. [Applause].

MALE SPEAKER 2: We welcome again to the stage the Schoen-brunn Palace Orchestra.

[Audio Played]

[Video Played]

MALE SPEAKER 2: Ladies and gentlemen, attention. Please take your seats for special message, the United Nations Secretary General Ban Ki-moon.

BAN KI-MOON: Ladies and gentlemen, I send my very best wishes to the International AIDS Conference. Let me pay tribute in particular to those among you who are living with HIV. Your courage has given strength to people around the world. You have helped people suffering as a result of stigma

and discrimination to emerge from the shadows and to seek not only treatment, but their fundamental human rights.

We have made significant progress in the global response. New infections have declined. Access to treatment has expanded. Decades old travel restrictions are being lifted, but too many obstacles remain. Some governments are cutting back on their response to AIDS. This should be a cause for great concern to us all. We must ensure that our recent gains are not reversed. We must raise additional resources for other areas that have been neglected for far too long, maternal health in particular.

We must also recognize the intrinsic links between AIDS and our work to achieve the millennium development goals especially women's and children health. The MDGs are indivisible and should never be pitted against each other. So let us say again no more HIV infections. No more discrimination. No more AIDS related death. Health and development for all.

As this conference proclaims, right here, right now. This is a bold vision. To realize it, universal access must remain our beacon, access to life saving drugs, access to HIV prevention, treatment, care and support.

Next year marks a milestone, 10 years since the UN decoration of commitment, 5 years since our political decoration. It will also be a year in which the general

assembly convenes for a crucially important meeting aimed at strengthening the global response further still. I look forward to your contributions. I look forward to walking with you to conquer this disease once and for all. Thank you. [Applause].

MALE SPEAKER 2: Ladies and gentlemen, the conference chair and local court chair Dr. Julio Montaner and Brigitte Schmied.

JULIO MONTANER: You alright?

BRIGITTE SCHMIED: Yeah.

JULIO MONTANER: Before we start, let's make one thing clear for everybody. There should be no retreat fundage, we fully agree.

BRIGITTE SCHMIED: We agree. [Interposing]. Ladies and gentleman, distinguished guests, a very warm welcome to Vienna. [Speaking in a foreign language]. I would like to thank the Vienna city government and the federal minister of health. Thank you as well Ati Falvine [misspelled?] and many other local organizations for their contributions and support during the organization of AIDS 2010.

Thank you very much to all sponsors and donors. For example, [inaudible], MSD, Tibotech [misspelled?] [inaudible] Healthcare. Finally, I would like to thank you, Julio, as well as the International AIDS Society and its international partners for choosing Vienna to host AIDS 2010.

Vienna was chosen to host the conference because our city is a crossroads between east and west. Eastern Europe and Central Asia is the region with the fastest growing epidemic worldwide and just a few hundred kilometers away east of Austria a very different epidemic from what you will find here you find there.

In contrast to universal X's in Austria in the neighboring region of Eastern Europe and Central Asia just 23-percent of people who are in need have access to anti-retroviral treatment. Globally in 2008, more than 10 million people living with HIV were still in need of treatment in a figure that has grown substantially since then.

In Austria and other parts of the world, HIV is a chronic disease, but in many others people are turned away from clinic and denied life saving treatment due to shortages. In those same areas including the most heavily and affected region of Southern Africa, funding shortfalls will result in rationed care and the agonizing choice of who is allowed to live and who will die. We must not let that happen. [Applause].

AIDS was never just about science. It has always been about social justice as well and that is part why the AIDS 2010 team theme of right here, right now emphasizes the role of human rights in the scale up of HIV programs, including the right to live a life free of stigma and discrimination. Right here, right now also emphasizes the right to healthcare

including access to all scientifically proven HIV prevention interventions such as opioid substitution therapy and needle and syringe programs.

To this end, I urge all of each to add your voice to the growing call for the reform of illicit drug policies by signing the Vienna Declaration. Treatment not prosecution is demanded. [Applause].

Over the past seven years in particular, we have demonstrated that effective treatment can be brought to scale and in doing so we have learned that HIV treatment significantly reduces the risk of transmission.

With regard to prevention, we know that a combination of behavioral and biomedical strategies is most effective and that these strategies must be reinforced with structural interventions that create an enabling legal, social and political environment. Repealing loss that criminalize homosexuality and addiction and empowering and educating especially young women and girls are important examples. [Applause].

Recent progress in scaling up HIV prevention treatment, care and support has been remarkable. In the past five years alone, the ability of individual treatment in low and middle income countries has increased tenfold to five million people. Just 10 years after term we have shown the skeptics that

universal access is achievable. That is the goal that we can and we must reach.

AIDS 2010 participants have come to Vienna from more than 185 countries, something that would not have been possible 100 years ago. As our world becomes smaller, let us try to remember that the goal of universal access to treatment, prevention, care and support as well as global health is ultimately about communities, about families and about individuals each with his or her own story.

It's the mother who must leave her newborn in hospital because she has no capacity to care for her child due to the lack of social support. It's the person who injects drugs and is terrorized or even beaten while trying picking up clean needles and syringe to protect himself and his partner from infection. Tragically, it's the child that's suffering from AIDS because his parents deny the existence of HIV.

In our shrinking world, the goal of universal access and global health can no longer be viewed as a story about others. These are our stories. Universal access is our responsibility and holding ourselves and our political leaders accountable is our continued challenge. Let us meet these challenges with [inaudible] in the days and months ahead. Thank you. [Applause].

JULIO MONTANER: Thank you. We also agree sex work is work and it should be decriminalized. [Applause]. Thank you

Brigitte for your kind remarks and for looking after the formalities. I would like to briefly share with you some of my most pressing concerns as we gather in Vienna at this very important 18th International AIDS Conference.

Dear friends, we find the global AIDS response at a crossroads. In 2005, aglíningals [misspelled?] and the G8 has set the 2010 target for universal access. These represent a bold and visionary objective. In short order, it led to the establishment of one of the most successful ever multilateral and bilateral efforts including the Global Fund, PEPFAR and other such initiatives.

We went from almost nobody in HAART in 2005 to five million plus today. This unprecedented role of success proved many, many skeptics wrong. Having said that, I cannot hide my profound disappointed and deep frustration with a recently confounded G8 and G20 meetings in anywhere else but Canada. [Applause].

By failing to take full responsibility for the universal access pledge and more importantly for failing to articulate the next steps to meet not just the six MDG, but also all of them because without universal access there shall be no MDG's by 2015.

We have heard excuses related to the fiscal crisis, but we were failing behind way before the fiscal crisis ever became a problem. If lagging countries like my own, Canada, would

have matched the American contribution to the fight of HIV on a GDP basis we would be seeing a vastly different picture today.

Let me remind you, over the last year the same leaders had absolutely no problem finding money on a moment's notice to bail out their corporate friends the greedy Wall Street bunkers [applause] and yet when it comes to global health the purse is always empty. If 410 billion euro appear from nowhere when the Greek economy falter earlier this year, but when it comes to universal access we simply are choosing to ignore it that is not acceptable. [Applause].

Quite simply, it is a matter of priorities. The G8's priorities have to change. Our number one goal here today and for the rest of the week is to send a very clear, evidence based message to the G8, why they should do so and why they should do so now. [Applause].

So what is the evidence? As I recently learned from an old Chinese proverb, I would like to tell you today don't let those that say that it cannot be or will not be done, stop those of us that are doing it and we have no intention to stop. We will continue doing it. [Applause].

Over the last five years, the science has improved and enhanced dramatically in supporting the value, the multiple layer of value of the universal access pledge. Recently, the World Health Organization has put forward new guidelines calling for better HAART regiments and early initiation of

therapy, a higher CD4 count of 350. Some argue that that was a problem. We argue that is part of the solution and we congratulate the WHO for that. [Applause].

In addition, in the last several years several groups, including our own, have generated a compelling body of evidence demonstrating that HAART is not only highly effective at preventing HIV related mobility and mortality, but it also dramatically decreases HIV transmission from all routes. This has now been widely accepted as the way to eliminate vertical transmission of HIV and WHO and UNAIDS have called for the global elimination of vertical transmission as a result and this should be done urgently. [Applause].

More recently, a study funded by the AIDS Foundation in seven African countries published the Lancet last month showed a great than 90-percent, 9-0, 90-perecnt reduction on HIV transmission when the effected index member of a [inaudible] was treated with anti-retroviral therapy.

Work from Vancouver has added to these when we showed in a recent number of the lancet earlier today that by treating more we prevent more. In fact, even among IDU's we saw a 50-percent reduction, 50-percent, 50-percent of HIV new diagnosis as a result of increased coverage with HAART.

As my friend, past president of the IES, Pedro Cahn said at the last [inaudible] in Cape Town, it is no more treatment and prevention, it is treatment is prevention.

[Applause]. This new understanding represents a true great changer. This has been now acknowledged by multiple parties. It's time to move on it and it's time to move it now.

I was actually very pleased when France's first lady Ms. Carla Bruni-Sarkozy said, "We have a historic opportunity. In a few years, we can control AIDS. We can eradicate it from the surface of the planet." She added in the daily liberation when writing these notes she said, "Treating everyone means halting the transmission of the virus."

In other words, stopping the epidemic. She said, "Solutions can be imagined for today and tomorrow." But she cautioned, "We must act very quickly. She requested that an international tax be considered to raise the much needed financial support, whereby full behind those comments and I remind you the next G8 will be on Sarkozy's land and we expect he will follow his wife's words. [Applause].

Consensus has arrived. Treatment and prevention are one thing and they are the way forward. Universal access is the way forward. As it was announced earlier today by my good friend and colleague Michel Sidibé, the Secretary Director of UNAIDS, Treatment 2.0 represented the single most important thing coming out of this meeting. It is the most effective way forward to deliver on the universal access pledge. Let's rally behind Michel and be sure that Treatment 2.0 is indeed a reality. [Applause].

The theme of AIDS 2010, right here, right now, was chosen to emphasize the critical and fundamental connection between human rights and HIV. There can be no end to the pandemic if we don't secure full protection of human rights for those that are vulnerable or living with HIV.

Stigma and discrimination, persecution, prosecution and criminalization in the various forms concerning infected, affected and at risk populations are major obstacles to controlling HIV in the world today as we speak. These are huge barriers to HIV testing, care and support and dramatically increase the risk of HIV transmission.

As we move to enhance efficiencies and get better bang for our buck, we must recognize that full protection of human rights represents a fundamental first step to achieve this goal. We waste too much money looking for people that the police is chasing on the other hand.

Stigma and discrimination result in misguided polices and misallocated resources as many governments are averse to implementing scientifically sound programs for key at risk groups, including people who use drugs, sex trade workers and men who have sex with men. Gender discrimination contributes to the heightened vulnerability of HIV among women and girls.

For all of these reasons, I urge you to join former presidents, noble lariats and the scientific community as well as myself and the full 10,003 people that have signed already

the Vienna Declaration which hopefully will motivate people to move away from the war on drugs into an evidence based approach with our policy. [Applause].

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

MALE SPEAKER 2: We now present Mr. Vladimir Zhovtayak and Ms. Sasha Volgina who will speak on human rights in Eastern Europe and Central Asia. [Applause].

SASHA VOLGINA: First of all, no retreat, fund AIDS. [Applause]. We're dying less, but we're dying faster.

VLADIMIR ZHOVTAYAK: [Speaking in a foreign language].

SASHA VOLGINA: Three hundred million people live in our region. The region of Eastern Europe and Central Asia includes 18 countries and we have the world's fastest rate of epidemic growth.

VLADIMIR ZHOVTAYAK: [Speaking in a foreign language].

SASHA VOLGINA: Now, 100,000 people receive higher retreatment in our region, but our epidemic is growing fasters and sill 300,000 people are in need of treatment now.

VLADIMIR ZHOVTAYAK: [Speaking in a foreign language].

SASHA VOLGINA: We are very different. Our region is so big that when we visit our colleagues, we fly from Catholic Cathedral of Lithuania to the Islamic mosques is Uzbekistan,

from highest mountains of Ira [misspelled?] to the cold, grey waters of Baltic in St. Petersburg.

VLADIMIR ZHOVTAYAK: [Speaking in a foreign language].

SASHA VOLGINA: We are 18 different countries, but we are united by our history and we're united by joint prejudice, wars and successes. It's a first fly to space by Eureka [misspelled?]. It's periodic table of chemical elements by [inaudible]. It's first research of immune system by [inaudible].

VLADIMIR ZHOVTAYAK: [Speaking in a foreign language].

SASHA VOLGINA: Our region gave the world [inaudible].

VLADIMIR ZHOVTAYAK: [Speaking in a foreign language].

SASHA VOLGINA: Immigrations, escape from prejudice of 20th century inspired the sympathy and personal commitment of many people whose roots are in our region. Michelle Kazurchkin [misspelled?] born in Russian family who has done more for us than any of our own politicians. David Barr [misspelled?], the living legend of [inaudible] who today with us is calling governments to keep their promises. Jay Dobkin who's our doctor who personally brought medicines to us when we were dying.

VLADIMIR ZHOVTAYAK: [Speaking in a foreign language].

SASHA VOLGINA: We are building independent countries. We are teaching our children to speak in our national languages. We're teaching them to love the culture of their

motherland, although we have common history. Our generation grew up in one country. Our generation suffered most from its breakup, civil wars and crisis.

VLADIMIR ZHOVTAYAK: [Speaking in a foreign language].

SASHA VOLGINA: Also, we are united by the world's fastest rate of HIV epidemic.

VLADIMIR ZHOVTAYAK: [Speaking in a foreign language].

SASHA VOLGINA: Everyday 500 of our friends, loved ones, our children are infected with HIV in our region.

VLADIMIR ZHOVTAYAK: [Speaking in a foreign language].

SASHA VOLGINA: We're dying less, but we're dying faster. Each second an HIV person in our region is dying from tuberculosis. Hepatitis C is threatening the lives of millions of HIV positive people. We're dying because we don't have access to drug dependent treatment. We're dying because of double stigma and discrimination, for HIV positive drug users, for sex workers, for men having sex with men, for lots of us. [Applause].

VLADIMIR ZHOVTAYAK: [Speaking in a foreign language].

SASHA VOLGINA: Our rights are violated and we are dying from IV shortages like it happens in Russia, from the closing of substitution treatment sites like it happened in Uzbekistan. We are dying from repressive drug policies. When every fourth person living with HIV in our region is in prison,

we are dying from the corruption in governmental procurement of IRBs. When mothers have to give their pills to their children.

VLADIMIR ZHOVTAYAK: [Speaking in a foreign language].

SASHA VOLGINA: That's why we, people living with HIV, we call upon leaders of our countries to upset the HIV epidemic under their personal control. We call upon presidents and prime ministers to recognize HIV as a threat to national security.

VLADIMIR ZHOVTAYAK: [Speaking in a foreign language].

SASHA VOLGINA: Now, we call upon global community to support us with sustainable funding to save lives of million people in our region.

VLADIMIR ZHOVTAYAK: [Speaking in a foreign language].

SASHA VOLGINA: And that will be time when we'll stop dying. That will be time for us to live.

VLADIMIR ZHOVTAYAK: [Speaking in a foreign language].

SASHA VOLGINA: Our task, the task of people living with HIV is to build a future where it will be no place for corruption, for stigma, for discrimination, for enslavement of one human being by the other.

VLADIMIR ZHOVTAYAK: [Speaking in a foreign language].

SASHA VOLGINA: As HIV activists [inaudible] and then afterward kick the shit of this disease and we are going to be alive [applause] to kick the shit out of the system, so that

this never happens again and that's them, and we will still stay alive. Thank you. [Applause].

MALE SPEAKER 2: Dr. Yves Souteyrand will now deliver the first plenary presentation on the state of the epidemic.

YVES SOUTEYRAND: Good evening, friends. I want first to thank the organizer for inviting me to be here today. It's a great privilege to be present on the global AIDS epidemic and on the links between human rights and the response to AIDS.

This code for M3SN [misspelled?] we now have the number price in economics help to contextualize the presentation. To understand the problem with clarity is already half way to our solving it. In nuance the effectiveness of social interventions, contributes greatly to resonation, fatalism and callousness.

It is true of the global epidemic of AIDS today as it has been a major human disaster in the past. The AIDS epidemic is a story of a global public health crisis with the ability to know your epidemic and to use that knowledge to form the AIDS response is strongly dependent on protecting human rights.

First, I will review progress made in conquering the epidemic due to increased global financing and action. However, doing more of the same will not take the global AIDS response to the next level. Over the last 15 years, our knowledge of HIV has improved dramatically, but progress in human rights has not.

I opt to show that without urgent action in human rights, we will not achieve the results necessary to halt and reverse the epidemic. The slide summarizes the evolution of the epidemic over the last years. At the end of 2008 as you can see looking at the gray bars on the slide, 33.4 million people were living with HIV including 2.1 children under 15.

These represent the global prevalence in the adult population of 0.8-percent. This figured picked in the early 2000, but the global number of people living with HIV continues to increase due to global population growth, high incidents and reduce mortality among people with HIV.

The annual number of new HIV infection, which is in red on the slide, 1896 and gradually decline since then. In 2008, there were 2.7 new infections including 430,000 children, one quarter less than at the peak. In 2008, two million people died of HIV/AIDS as you can see following the yellow line the graph, including 280,000 children.

Due to the scale up of anti-retroviral therapy, mortality has decreased since 2004 when the annual number of AIDS related deaths peaked at 2.2 million. HIV continued to be the number one killer globally for women of reproductive AIDS and one of the largest single causes of mortality worldwide.

This is a global snapshot of the epidemic. Despite what is shown in new infections, everyday an estimated 7,400 people are infected with HIV, including 1,200 children. Five

thousand people die of HIV/AIDS and about approximately 3,000 more are placed on anti-retroviral therapy. The epidemic continues to outpace efforts to contain it.

Low and middle income countries especially those in Sub-Saharan in Africa are disproportionally affected by the burden of the epidemic. Compare with 2001, when the [inaudible] Declaration was launched the decrease of new infections is, of course, positive news, but it is far from what is needed to consider the epidemic under control.

The HIV epidemic remains a major obstacle to the achievement of health related Millennium Development Goals including MDG-4 on child mortality and MDG-5 on maternial mortality and it is also a major obstacle to the control of TB epidemic.

Increasing AIDS financing of the load, the rapid scale up of HIV interventions yet as I seen the impact of prevention intervention is complex. Part of the decreases in incidents can be attributed to the natural evolution of the epidemic, the fact that individuals with highest risk behaviors are affected rapidly, incidents will naturally fall after the epidemic has moved through this population. However, recent evidence confirmed that prevention impact and probation level.

The systematic analysis of countries which generize [misspelled?] epidemic would be presented during the conference. It demonstrates that both HIV prevalence among

young people and at risk sexual behaviors have declined in most countries between 2000 and 2008 including 10 countries reporting prevalence declines of more than 25-percent.

The recent mortality [misspelled?] studies has also estimated that in an area of Zimbabwe prevention interventions have been responsible for avert between 460,000 and 860,000 infections from 1999 to 2004 due to reductions in risk behavior. [Applause].

UNAIDS recently estimated the impact of anti-retroviral to prevent vertical transmission and the number of infections averted in infants. The slide estimates that in total 200,000 HIV infections among children were averted globally in the past 12 years due to these interventions. As access to anti-retroviral prophylaxes for pregnant and breastfeeding women expands, that figure will continue to increase.

More than five million people are currently on the anti-retroviral therapy in low and middle income countries. We're starting to get good estimates in different countries on the impact of HAART and reducing death at the population level. The table on this slide is based on repeated population survey in South Africa.

It shows that sense to HAART approximately 440,000 South Africans remain alive. Additional HIV prevalence is good news when it reflects longer life for people with HIV.

This slide refers to speak of this conference as Julio has already addressed. The impact of HAART in reducing HIV incident, it brings to mind a number of recent studies including a trial among several [inaudible] capitals in Africa and recent ecology coastal cities [inaudible] in San Francisco and Vancouver.

Additional research is needed to confirm the long-term impact of art on population level incidents, but evidence to date suggests expanded access to HAART would have a significant impact on the epidemic and is a powerful new argument to increase these AIDS investments.

The theme of the conference, right here, right now speaks to both a necessity and urgency for human rights to play a central role in the response to the epidemic. As we have just seen, we have made encouraging progress in different domains, but we cannot [inaudible] that much of our accomplishments have been reached working with populations that are relatively easy to access with HIV services.

Reducing new infections is proven to be more difficult to achieve among vulnerable and most at risk population where often among the most marginalized, stigmatized and discriminated against.

I will turn now to show how the lack of human rights protections are compromising the response and limiting the progress to halt and reverse the epidemic. The framework

developed by the WHO commission on social determinant of health is helpful in outlining the factors affecting health statutes and access to health services. It helps to locate human rights violations or protections as part of the social determinant of health.

And two determinants in this framework, particularly important in the context of the AIDS epidemic. First, governments and policy that violate and protect human rights of population. For example, those criminalizing sex work which contribute to vulnerability of sex workers to HIV infection, to violence and often reduced access to health services.

Second, social and cultural norms and values such as gender and equity,which makes many women and girls more vulnerable to HIV infections. [Applause].

HIV and human rights are intimately linked in four ways. First, human rights violations are a buyout to knowing your epidemic. Second, analytical [inaudible] exacerbates human rights abuses. Third, human rights abuses contribute to HIV transmission and the expansion of the epidemic. Fourth, failing to act on the epidemiological evidence or worse using the [inaudible] as a rational for criminalizing behaviors will send human rights challenges faced by vulnerable and most at risk populations.

This map depicts results from a recent study of the quality of national HIV Serbian [misspelled?] systems. Granted

they have improved considerably since the start of the epidemic, however as we can see in yellow and red on the map many countries especially those with low level epidemics and those with epidemics concentrated among most at risk populations have weak Serbian systems.

Most concerning even in countries with strong system marked in green on the map, epidemiological information on most at risk population is often scarce or of poor quality. This problem is further compounded by the absence of strong health information and vital registration systems.

The reality is that human rights abuses and violations continue to undermine the collection, analyzes and news of good epidemiological data. It is hard to conduct surveys among population when their behaviors are criminalized or denied by public officials and when participation in research could endanger their lives.

Analytical [inaudible] can further exacerbate stigma and discrimination faced by individuals, moreover unless surveillance activity can ensure the privacy and confidentiality of health information, it is likely to certainly discourage personal disclosure about risks and behaviors, thus compromising the quality of the data obtained. Addressing this issue requires close collaboration with communities in the collection and analysis of data.

At last, as stressed in the quote on these slides, critical also is a moral requirement to ensure responsiveness to epidemiological evidence. There are still too many discrepancies between AP evidence and problematic focus. Convincing evidence on links between human rights, the HIV epidemic, and the response to AIDS is available.

There are many examples from different populations, including women, children, sex workers, prisoners, and transgender communities, all of which face unique vulnerabilities that increase the risk of HIV infections. Time permits me to focus on only a few, so I will look at migrants, men who have sex with men, and people who inject drugs.

Epidemic among migrants provide a convincing example of the complex link between human rights, epidemiology, and the response. Data presented here demonstrates the scope of the epidemic among migrant population in France, my country if you have not understood, Spain, and the Netherlands.

In these three countries, between one-third and three-quarters of the epidemic is among people from other countries of origin; mostly from Sub-Saharan Africa for France and the Netherlands, and from Latin America for Spain. The recent report from the European CDC outlines tensions between immigration and security policies on one hand, and health policies on the other.

These tensions undermine access to HIV prevention, testing and counseling, treatment and care, especially for undocumented migrants. Migration policies focus on protecting borders and deporting illegal immigrants.

In the current context of economic crisis, there is a risk that collecting and disseminating such information on the epidemic among migrants could increase stigma and discrimination faced by these communities. However, ignoring the epidemiological evidence amongst this population also prevents opportunities to develop urgently needed health interventions. The slide illustrates results of the UNAIDS modes of transmission model, developed in Sub-Saharan Africa in 2008 and 2009.

Also the majority of infection due to single or multiple partner heterosexual transmission, most of this population contribute almost 23-percent of new infections in West Africa. MSM represent around 10-percent of new infections in Côte d'Ivoire, Ghana, Kenya, Nigeria, and Senegal. IDUs represent around the same proportion in Nigeria.

After many years of steady declines, the past several years have seen gradual increases in new infections among MSM in many high-income countries, but the situation for MSM in low and middle income countries is even more concerning as shown in the last week paper by Behrher [misspelled?] based on 50 countries. A peer reports indicate HIV prevalence even in

settings where rate of HIV infection in other population is decreasing.

Globally, the risk of HIV infection is almost 20 times greater for MSM populations compared to general population. The Behrher paper on the slide found strikingly high level of prevalence among MSM in Botswana, Malawi and Namibia, up to 36-percent of all HIV prevalence among MSM over 30 years of age.

In the same study, provides evidence of the high prevalence of human rights abuses, with more than 40-percent of MSM reporting at least one human right abuse, such as being blackmailed or denied health services.

MSM face formidable human rights challenges, and some of the poorest intervention coverage of most at-risk population. Homosexuality is criminalized in 80 countries around the world, with penalties ranging from significant prisons to death sentences.

Human rights abuses and intense homophobia correlate with poor access to prevention interventions and high HIV prevalence. This slide illustrates the link between criminalization of homosexuality and high HIV prevalence among MSM in different Caribbean countries.

Responses to AIDS in most African countries has not adapted to evidence of significant HIV prevalence among MSM, and few programs provide HIV services to this population. In some countries, new legislation or expansion of existing anti-

homosexuality laws have been proposed or implemented, including criminalization of organization advocating for gay rights. The case of MSM highlights how law enforcement, combined with social norms that include homophobia are compromising both knowledge of the epidemic and an effective and comprehensive response.

As with MSMs, the response to epidemic among people who inject drugs is too frequently not aligned with the burden of the epidemic. Some of the lowest coverage of evidence-based intervention such as opiate substitution therapy, and needle and syringe exchange programs is among countries that have significant IDU epidemics, including several countries in Eastern Europe and Central Asia.

IDUs face a double legal challenge: first, those that limit access to relevant evidence-based intervention, and second, drug control laws, part of the global war against drugs that criminalize drug use. This law often results in police violence and in some cases, encompass confinement in drug detention centers. Human right abuses are commonplace; individuals are denied access to basic health services.

This slide is part of the study by Strudies [misspelled?] that provides an innovative analysis of the potential link between inaction and structural factors, and the epidemic among IDUs. The study applied to Ukraine, where there is impact of a human rights intervention.

In this case, we do show police violence again IDUs in reducing HIV incidents. A significant proportion of IDUs report being beaten by police.

This can have an indirect effect on HIV risk by discouraging IDUs away from harm reduction settings. These actions can increase the likelihood of injecting with contaminated equipment. [Inaudible] of the study made the assumption that eliminating police beatings would remove the excess in risk behavior across the population. In Ukraine, the model applied to the three cities with the highest HIV prevalence among IDUs in the country suggests the decrease of the incidents by as high as 19-percent.

To end this presentation, I will focus on Ukraine's AIDS response, for it shows both the progress that we have made, and the challenge that lie ahead. The Ukrainian experience reflects how to effectively address each of the full links between epidemiology and human rights. Ukraine improved knowledge of its epidemic with a comprehensive surveillance plan, involvement of the health sector, NGOs and IDU communities has been key to ensuring good epidemiological data.

The country responded to the AP information by scaling up evidence-based prevention and treatment, interventions for people who use drugs, including since 2004 opiate substitution therapy. After 10 years of consistent growth, the number of

officially reported new cases of HIV has been decreasing among IDUs slowly but steadily.

Even more encouraging, as shown on the slide, is that these decreases have more than doubled among IDUs with a recent history of drug injections. Collaboration among the health sector, low enforcement against the IDU communities and NGO has been critical to success to date.

However, only certified portion of IDUs have access to this service and these programs are not available in prisons. Ukraine's long-term success should build on these good initial results by strengthening human rights protections and expanding evidence-based interventions for IDU and other affected populations.

Let me turn now to my conclusions. First, we have now more and better data than ever. Still, we must redouble our efforts to improve AIDS information and vital registration system, for they remain a major bottleneck for data generation and policy development.

Second, after 30 years, human rights abuses continue to blind our knowledge of the epidemic, to contribute to its expansion and to challenge our ability to respond.

Third, concerted efforts and expanded access to HIV services are having impact on the epidemic, decreasing new infection and death. But it is just a start, and our challenge now is to expand the response in all kinds of epidemics to

reach those groups that are most marginalized, such as injecting drug users, migrants, sex workers, transgender, young women, men who have sex with men, prisoners.

Fourth, we must acknowledge that human rights violations are not the only contributor to an expanding epidemic, and that human rights protection alone will not end AIDS. But it is also true that universal access to prevention and treatment cannot be achieved without universal access to human rights. Human rights promotion is an essential component of a comprehensive public health response to AIDS, without which this crisis will not be controlled.

I would like to end my presentation with the words of Jonathan Mann. Very early in the epidemic, he outlined how human rights principles should provide a foundation for an effective public health response to the AIDS epidemic.

He said, "Health and human rights are two entirely complementary ways of speaking about and working to ameliorate human suffering in all its form." Twelve years after his tragic death, his visionary approach has proven to be essential in articulating a response to the epidemic.

In 2006, at the United Nations high level meeting on AIDS, heads of all member states reaffirmed that the full realization of all human rights and fundamental freedoms for all is an essential element in the global response to the HIV/AIDS epidemic. We must together ensure that this visionary

commitment of our political leaders be translated from rhetoric to reality.

Let me acknowledge also who contributed to this presentation: [Speaking foreign language], my colleagues from WHO and UNAIDS who have supported this development, and many other colleagues, scientific and friends who have helped me, whatever their contribution, to articulate it. I thank you very much for your attention. [Applause]

MALE SPEAKER 2: Ladies and gentlemen, Mr. Alois Stöger, Austrian Minister of Health. [Applause]

ALOIS STÖGER: [Speaking in Austrian].

FEMALE SPEAKER 2: Federal President Fisher, dear colleagues, Your Excellencies, ladies and gentlemen. It is a great honor for me to welcome all of you today here in Vienna to this very important international AIDS conference.

Following the model of the conference being "Right Here, Right Now." Thirty years ago, Austria had its first cases of a disease the likes of which no one had ever seen. Today, we know what those cases were. It was HIV and AIDS. Back then, HIV and AIDS was a deadly disease, non-treatable and non-curable.

Back then, we hardly had any information on the nature of the disease and no prospect whatsoever for developing an effective therapy or an effective vaccine. Under those conditions, our only option was to verify and substantiate what

we already knew, and pass this knowledge on to the public in campaigns that were as broad-based as possible.

For us, it's been very important endeavor to inform people about how they can keep from becoming infected. The Austrian health policy very quickly was able to drive back the transmission via blood products or hospital stays were potential sources of transmission. Austria quickly put health policies in place to alleviate this problem.

So of course, another task of government policy is to protect people with HIV/AIDS from discrimination. Austria responded early on by adapting pertinent provisions of law. These new regulations set up standards for the safety of blood products, and ensure free access to testing and treatment.

Anyone infected with HIV or sick with AIDS can rely on the Austrian health system. Medical treatment is state of the art and paid for by a public health insurance system based on solidarity. Austria always considered education and prevention efforts extremely important.

The only way citizens can prevent possible infection is if they receive correct and accurate information. AIDS relief organizations do important work in this regard. For instance, the AIDS team in Austria stages workshops in schools nationwide, informing young people about the risks associated with HIV/AIDS and reducing their fear of contact with those suffering from HIV and AIDS.

In addition to this educational work, Austria launched needle exchange programs for drug addicts and drastically reduced the rate of infection from dirty needles. Another very important step was the introduction of nationwide substitution programs to assist drug addicts.

Much has also been done in Austria for people with HIV and AIDS. The new therapies available since 1997 sharply reduced the number of cases of individuals developing AIDS and dying from AIDS. I would like to emphasize again that in Austria, the government pays for all forms of therapy. Austrian health policy has accomplished a great deal. Medically speaking, people with HIV and AIDS are given everything of benefit to them.

Considerable progress has also been made in fighting discrimination against people with HIV/AIDS, and it was the constant involvement of the NGOs that contributed to bringing about progress in this respect. However, I would also like to once again stress that we by no means can rest on our laurels. We must continue to fight discrimination against people with HIV/AIDS. It's there for sure that we still need to do a lot of work in this area.

As a representative of the country hosting this conference, I hope we can share our successful experience, and I encourage all neighboring countries, to the extent they haven't done yet, to lay down a solid legal foundation for

implementing a comprehensive program to fight HIV and AIDS. Thank you very much for your attention and your commitment. [applause]

MALE SPEAKER 2: Please welcome Mr. John Dalli, the European Commissioner for Health and Consumer Policy. [applause]

JOHN DALLI: Ladies and gentlemen, I am extremely delighted to have the honor of participating in this important conference, which the European Commission is very pleased to support. HIV and AIDS have now been wreaking havoc on people and communities across the world for more than a quarter of a century. More than two million people still die of AIDS each year, and almost three million people become newly infected.

One percent of these new infections occurred in the European Union. That might sound like a relative success; however, even our relative affluent society is suffering from an increase in infections.

One of our main objectives is to strengthen cooperation between the European Union and our neighboring countries to tackle the HIV epidemic. And in a broader context, we express our disappointment at the fact that the millennium goal of universal access to HIV prevention, treatment and care by 2010 has not been met.

We must step up efforts to fight this chronic situation. The new member states have recently reaffirmed

their determination to support the achievement of the millennium development goals. This resolve recognizes the need for all partners to demonstrate firm political commitment to implement policy changes and to take concrete action.

I believe health is a universal right, and so is access to HIV treatment; sadly, a right that is still denied to millions of people. HIV treatment is not a luxury; it is a matter of life and death. And this is why it must be [applause] and it must become universally available. This will pay dividends not just for people, but for society as a whole. The EU was among the first contributors to the Global Fund to fight AIDS, tuberculosis, and malaria, to which the European Commission alone has pledged more than €1 billion.

We sincerely hope that big donors, wealthy countries, and other organizations will contribute. Contributing is not just a question of donations. It is a question of strengthening country ownership and aid effectiveness to long-term and predictable financing. We will continue to keep AIDS high on the agenda of our dialogue with partner countries and civil society.

"Right Here, Right Now," the rallying call of this conference, is certainly well chosen. The time has come to turn well-meaning goals into tangible successes. We need to improve access to information, to prevention, to treatment, to

care, and to support, and stigmatization and discrimination must be the focus of greater attention.

Some might think it is easy for a European to say this. But as we made clear in our European AIDS strategy, even here in Europe, we need to improve leadership, and to empower civil society. We need greater efficiency of prevention and anti-discrimination measures. And finally, we need equal access to treatment and care.

Let me highlight the situation in the European Union. There are major inequalities in treatment coverage across Europe from eight to 100 percent of those who need it. Costs for treatment differ enormously between EU countries, with stocks of medication sometimes running out.

Between 15 to 38-percent of people living with HIV in European Union do not know they have HIV, and many people do not have any access and easy access to a testing center. Some countries proved comprehensive harm reduction measures, while other do not.

Ladies and gentlemen, we must put an end to this epidemic. We must stop HIV's path of destruction. Politicians, policymakers, international organizations, businesses, celebrities, health professional, citizens, we all have a role to play; to support the AIDS community and to do everything in our power to fight AIDS, and this is why we are here today.

I am confident that a clear vision will emerge from this conference on how our goals and targets can be reached for the benefit of those millions of people living with HIV/AIDS. Thank you very much. [applause]

MALE SPEAKER 2: Dr. Sharon Lewin will now deliver the second plenary presentation on the State of the Epidemic.

SHARON LEWIN: Thank you. Good evening ladies and gentlemen. I would like to thank the conference organizers for the great honor in being invited to give this talk, but more importantly, I'd like to thank the conference organizers, the International AIDS Society, and particularly Francois Barris [misspelled?] for their leadership in the quest to find a cure for HIV, and giving this issue such great prominence at this meeting. [Applause]

Universal access to anti-retroviral therapy remains and undeniable human right that we must support; but ultimately, we must find a cure.

The International AIDS Conference in Vancouver in 1996 marked the beginning of the great success story of HAART. We've seen mortality from AIDS plummet, treatment has become simpler and less toxic, and over 5 million people in low and middle income countries are now receiving HAART.

But despite these major successes, and in the absence of an effective vaccine, I argue that the need for a cure is even more urgent now in 2010 than ever before.

Over the next 25 minutes, I hope to convince you why we need a cure for HIV; to explain what the current barriers to cure are; what type of cure is achievable; and finally, what strategies for cure currently look promising in the laboratory and may be close to testing in patients.

So why do we need a cure for HIV? Well despite the major successes of HAART, full life expectancy is not restored. This data comes from the Danish HIV Cohort Study, and shows the probability of survival for 4,000 individuals with HIV, compared to close to 400,000 negative controls.

The probability of survival of population controls is shown in black; the probability of survival pre-HAART in blue; HAART in the late '90s in orange; and HAART from 2000 to 2005 in red. What's striking from this graph is a substantial increase in survival following the introduction of HAART.

However, even with availability of HAART in the early 2000's, life expectancy remains significantly less than population controls. In fact, the chance of a person with HIV reaching the age of 70 is 50-percent of that of a population control. And this is in Denmark, a country with one of the best health care systems in the world. I don't think this is acceptable.

Significant morbidity still persists on HAART; there's a complex interaction between toxicity of the drugs, persistent HIV and inflammation, and aging, and we're seeing increasing

levels of cardiovascular disease, metabolic disorders, neurocognitive abnormalities, liver and renal disease, bone disorders, malignancy and frailty. This significant morbidity I don't think is acceptable.

And finally, an issue that we've heard a lot about this evening, long-term HAART for everyone, is presenting a major challenge. For every two people starting HAART, there are five new infections. We need to start HAART earlier from the current recommendation of 200 to now 350, and there's an urgent need to increase coverage from the current levels of only 40-percent.

This data shows the total projected annual AIDS resource requirements in lower-middle income countries if we currently continue what we're doing. Starting HIV treatment at CD4 counts of 200, and only achieving 40-percent HAART coverage. The estimated costs by 2031 approach $25 billion.

If we increased HAART coverages, we should to over 80-percent. This figure reaches almost $35 billion, and to put that into context, AIDS treatment costs alone will account for almost half the U.S. foreign aid budget for 2016.

We must develop interventions that will make sure that everyone will have universal and lifetime access to heart and in the absence of an effective vaccine, we must seriously pursue the possibility of cure.

So what are the current barriers to curing HIV? This is not going to be easy. As many of you know, when antiretroviral therapy started, virolo [misspelled?] rapidly reduces to undectable levels of less than 50 copies per mil. And is recovery of the immune system and CD4 cells return to normal in most individuals.

However, if the patient has been on treatment on two years or 15 years, whether they've been on three drugs or six drugs, if they started treatment as soon as they were infected or started with an established infection, as soon as treatment stopped, the virus rapidly rebounds.

So, of course, the big question is where is the virus sitting while the patient has a viral load of less than 50 copies per mil. Over 10 years ago, several groups, including that of Tony Fauci, Bob Siliciano, and Doug Richmond identified the persistence of virus in long-lived cells, which one can measure by looking at HIV DNA.

And this always remains detectable in a patient on treatment. More recently, Sara Palmer and John Coffin have developed far better essays that measure viral load down to one copy per mil, and they've clearly demonstrated that in nearly all patients, there is persistent low level viremia of around three copies per mil.

In other words, there's no such thing as an undetectable viral load. The virus persists and the major

question is what's contributing to this low level viremia? What's contributing to the persistent DNA and do we ever have a chance of eliminating it? And I think it's currently accepted that there are three major barriers to cure.

There's a lot of debate about which might be more important, but I think all of them are contributing to persistent viral replications or persistent viremia patient on treatment. And they include latently infected t-cells, residual viral replication, and anatomical reservoirs.

Lately, infected T-Cells represent the biggest challenge for us in ever finding a cure for HIV. I'd like to spend a few minutes explaining exactly what we mean by latency. So, HIV infects CD4 t-cells, but it largely infects activated CD4 t-cells. Most of our T-cells are resting and when they contact foreign antigen, become activated.

In activated CD4 t-cells, the virus easily enters, replicates, and can produce stored verions and ultimately the activated infected cell dies. When a patient goes on antiretroviral therapy, subsequent rounds of replication are blocked. But in a resting CD4 t-cell, HIV enters, integrates into the host genome and can just sit there for the life span of the cell.

It is as if HIV has gone to sleep in that cell and can wake up at any time. The origin of these latently infected cells was originally thought to be from an activated infected

cell reverting to a resting state. But more recently, several groups have shown that you can cause direct infection of resting t-cells that largely occurs in tissue.

These latently infected t-cells are extremely long-lived and therefore represent a major barrier to cure. So, latently infected t-cells can intimately reduce virus into the circulation and intimately become activated and produce virus. But this virus doesn't go on to infect new t-cells, but it is a constant source of low-level viremia.

We now know that the latent pool of the number of cells that can be latently infected is far greater than originally thought. The original descriptions identify latency in one particular subset of t-cells called central memory t-cells. But over the last one to two years, we've identified that latency can exist in a range of individual t-cells, including transitional memory t-cells, naïve t-cells, and most important, multiprotein progenitor cells or stem cells.

And together this constitutes a latent reservoir. More importantly, recently we've learned from work from Nicolas Chomont and Rafik Sekaly that these latently infected cells can also proliferate. So this presents a very daunting challenge. The number in cells in which latency can be established and the fact that latency might in fact be perpetuated by t-cell proliferation.

The alternative explanation for persistent virus is that there's ongoing virus replication in activated t-cells. In other words, HAART is effective, perhaps 99.9-percent effective, but not 100-percent effective. And finally, we know that HIV can hide in anatomical reservoirs such as the brain, the gastrointestinal tract, and the genital tract.

And in these sites, latently infected cells can persist activated, replicating cells can exist, as well as long-lived infected cells such as dendritic cells, macrophages, and astrocytes. These sites also have unique barriers to entry of antiretroviral therapy, which limits penetration of drugs.

We know that anatomical sites represent a significant viral reservoir on HAART. This data count builds on earlier observations from T Wok Chau [misspelled?] and comes from Joseph Kwong's lab and looks at the number of infected cells in the gut in all levels, duodenum, internal ilium, right colon or rectum, compared to what one sees in the blood.

And in patients on antiviral treatment with undetectable viral load or a viral load less than 50 copies is almost has almost as much as 10 times as much virus sitting in the gastrointestinal tract compared to what we can find in blood.

Given these significant barriers to cure, what type of cure might ultimately be achievable? The field is currently thinking about two strategies for cure. Traditional cure or

what I would call an infectious diseases model of cure, where one treats the pathogen and it disappears all together. Perhaps a lofty goal in the management of HIV, but this would require elimination of all HIV infected cells. Patients would have to have an RNA less than 1 copy per mil. And this is now commonly referred to as sterilizing cure.

The alternative approach would be to aim for remission or what one might consider a cancer model, where an individual would have long-term health in the absence of treatment, perhaps low level viremia at less than 50 copies per mil. And this is commonly referred to as a functional cure.

And there is evidence of both sterilizing cure and functional cure that we need to learn from in designing new strategies for cure. Last year there was a spectacular case report of a German patient who has received a bone marrow transplantation who was a donor who was resistant to HIV. The donor carried a mutation in the CCR5 gene, the major co-receptor for HIV.

The patient was transplanted because of a diagnosis of leukemia. And subsequently went off treatment and multiple biopsies of the gastrointestinal tract, analysis of the CSF, and analysis of blood HIV RNA shows no detectable virus.

Of course, a strategy of using transplantation with a CCR5 mutant is certainly not really realistic, but we have to know why this patient eliminated HIV. This patient tells us

that latently infected cells can be eliminated. That anatomical reservoirs can decay and that complete viral suppression without HAART is possible. But we need to know why this happened in this patient. Was it conditioning treatment the patient received for his AML or his leukemia diagnosis? Was it the transplantation from a resistant source?

Elite controllers are another group that will teach us a lot about trying to achieve functional cure. Elite controllers represent a unique group of patients who are able to achieve a consistent HIV RNA less than 50 copies per mil in the absence of treatment. There's been many, many studies on these interesting patients from many laboratories and consistently these studies show that a very good immune response is critical in achieving an elite control.

However, I think it's important to recognize the long-term effects of low-level viremia. In a percentage of these patients, CD4 t-cells are eventually lost. There is ongoing virus replication and evolution and immune activation is also increased in these patients.

So given the multiple barriers to cure, the potential targets of sterilizing or functional cure, what potential strategies might we explore in the future? These strategies include optimizing antiretroviral therapy through either intensification or early treatment, eliminating latently

infected cells, and perhaps in the future making cells resistant to HIV.

There have been a number of studies that have looked to the effective treatment intensification on residual virus. They've included adding additional agents such as T20 or Lopinavir, Atazanavir, or Raltegravir to an already suppressive regiment. And disappointingly, we find that this persistent low-level viremia continues in all of these studies and persistent HIV DNA does not change.

However, one study has shared a very important lesson with us. This is a study that comes from Spain and included 69 patients who were randomized to continue antiretroviral therapy or have the addition of Raltegravir, a very potent integrase inhibitor to their regimen. Raltegrevir has the unique effect of blocking integration into the host genome, and when integration doesn't happen, a byproduct of the virus is produced, something called 2-LTR circles.

So if 2-LTR circles increase, this is evidence that there is residual viral replication. And this study nicely showed in a third of patients, there was a very significant increase in a number of 2-LTR circles at two weeks, confirming that patients still have residual viral replication.

Of course, this strategy didn't actually impact on the residual virus there, but it tells us that if we're ever to use

any strategies that promote viral replication, we must combine this with intensification.

Early treatment may be a potential strategy to reduce or even control the viral reservoirs. This data comes from a large cohort in France, Laurent Ocalu [misspelled?] and Christine Rousseau who studied the size of the reservoir by measuring HIV DNA in patients with chronic infection, shown in red, and acute infections shown in blue after the initiations of treatment.

And you can see the very marked, decrease in size in the number of infected cells in patients who initiate treatment early. So again, if we're ever going to achieve a cure by reducing the size of that reservoir to potentially a manageable size or eliminating it all together, early initiation of treatment may be a cornerstone of this approach.

But the biggest challenge that stays with us is a strategy to eliminate latently infected t-cells. And there are a number of potential strategies to do this. The major principle is that perhaps we could turn a latently infected cell into an activated cell. In other words, turning on t-cell activation. The activated cell would produce virus, subsequent rounds of infection would be blocked by antiretroviral therapy, and the latently infected cell would die.

And we already have some potential strategies that do this very effectively in the laboratory. IL7 is one of those

compounds that can very potently activate latently activated cells, and we know IL7 is safe in patients who have HIV, there were two studies completed last year showing that IL7 is well tolerated and particularly induces CD4 recovery.

Alternative compounds such as Prostratin have not yet trialed in humans, also has a similar effect of promoting t-cell activation and eliminating latency. An alternative approach is a far more targeted approach and that is just to turn HIV genes on.

In a latently infected cell, the HIV gene is silent and turned off. And there are many compounds around now that can stimulate or turn genes on, and specifically HIV genes. And these compounds include a group of drugs called histone deacetylase inhibitors, many of which are in advanced clinical development for the treatment of cancer.

One of these drugs, Vorinostat or called SAHA is already licensed for t-cell lymphoma, is well tolerated in humans and has a very potent activity in promoting HIV or turning HIV genes on. Other drugs such as methylation inhibitors have a similar effect, and probably the most potent effect is combination therapy.

And this is suggesting that to perhaps eliminate these latently infected cells, we will need to use a similar approach to what's used in cancer, multiple simultaneous strategies. I think it's important to remind you though that latently

infected cells are rare. On average they occur in one in a million, or one in a 100,000 cells. So any strategies that are not HIV specific are the ones I've mentioned or have potentially have effects on uninfected cells and this needs to be monitored carefully.

So potential future approaches that are currently being investigated include making cells resistant to HIV using gene therapy and ultimately allowing for cessation of HAART. Some approaches have included reducing expression of the chemokine receptor CCR5, or blocking or inhibiting HIV replication.

And in the last month, there is a report in science translational medicine of four patients with HIV and AIDS associated lymphoma who received a transplant with these particular gene products as part of the transplant. So it is a proof of principle that these gene products can be introduced and they actually persisted in patients in follow up of two years.

Definitely a strategy for the future, a high-tech strategy which would ultimately need to be simplified, but important to demonstrate whether this may be possible in ultimately curing HIV.

So we know a lot about the barriers to cure, we know a lot about potential ways we could address it. There's still lots that we need to do. We need far better in vitro in animal

models to better understand how latency is establish, how its maintained, and how it can be reversed.

We need far better sensitive, non-invasive ways to quantify reservoirs in viva. We need a lot of drug development so that we can increase the specificity of current strategies we have that will just target latently infected cells, not an easy task.

And we need to determine what role the immune system plays in clearing or establishing latency in reservoirs. However, there's much that we can already do now. I want to emphasize that universal access to HAART still remains a major cornerstone of managing patients with HIV and will always be a major cornerstone in any strategy that we develop for cure.

There's an urgent need for clinical trials. We have compounds that look very promising in a laboratory, such as Vorinostat and IL7 and almost certainly these should be tested in combination with intensification and in patients who have received early treatment. And the long-term combination approach is going to be likely.

We need far better community engagement in this process, the science is certainly complicated and the interventions will be challenging in patients who are already enjoy very good quality of live on antiretroviral therapy.

And ultimately, we need to think carefully about what the end points of these clinical trials will be. Can we just

assume efficacy by measuring residual viral replication or is the ultimate test to look at cessation of treatment with its inherent associated toxicities?

We need far better consortium of research networks, similar to what's already established in vaccine research. Not only amongst HIV researches, but laterally amongst different disciplines.

And finally, in order to achieve any of this, we need to prioritize funding to find a cure. Over the last six months, we've seen some tremendous innovation in funding research towards a cure. The American Foundation for AIDS Research or AMFAR have been a real leader in this area, recently funding a collaborative network of researchers.

And NIH just in the last two weeks announced a very innovative approach, the Martin Delaney Collaboratory, a generous fund to look at public-private partnerships to develop strategies for cure.

And the strategic plan of the office of AIDS research for 2011, identifying reservoirs, understanding latency, strategies for cure, are all identified as top priorities. However, we need significant amounts of funding to complete this work.

So the International AIDS Conference in Vienna will unfortunately not the conference that announces the cure for HIV. But we hope this meeting will mark the beginning of a

future where we seriously prioritize finding a cure. We should not and cannot continue to accept that HIV is a long-term chronic illness that commits patients to life-long treatment and associated toxicities. We should not and cannot accept that life-long treatment may not be available to all who need it.

A cure will still need a great scientific advance, but we will not achieve a cure with science alone. We need scientists, clinicians, infected communities, farmers, politicians, and government to embrace the challenge. And I put to you that our goals for the future must include HIV prevention, treatment, care, and cure. Thanks very much. [Applause]

I'd just like to acknowledge a number of people that assisted me with the talk, which is a limit right there but a number of PhD students and Post Ops in my laboratory. Thank you. Colleagues, collaborators, and mentors, many of who have provided data for the talk of figures or just very helpful advice in preparing the presentation.

And I'd also like to thank the funding bodies who contributed to supporting my own work on latency and reservoirs, past and present, AMFAR, the National Health and Medical Research Council of Australia, and the Alford Foundation. Thank you very much. [Applause]

MALE SPEAKER 2: Ladies and gentlemen, Ms. Rachel Arinii. [Applause]

RACHEL ARINII: Good evening Vienna. Good thanks to all the attendees, my colleagues and my friends. My name is Rachel. I am 21 years old. I carry the voice of the young people at this conference and beyond. [Applause]

I come from Indonesia, the largest, mostly in population in the world. I come from a fundamentally strict religious background and I understand what it means to be a young woman in today's world. I have friends who have been raped, married off at young age, trafficked, and infected by HIV. Some of these things happened to me and now I support it to demand justice.

Now I am aware that the young people have fights and that we are diverse. Today, we celebrate our diversity. Like many other young people, I live in an era where we are supposed to benefit from universal access and I see the action agenda, but suddenly young people's lives still remain challenged by poverty, inequality, and violence.

Young people account for around 40-percent of new infections, but we don't account for 40-percent of budgets and programs. [Applause] The theme of this conference is right here, right now. Tonight, my peers and I urge you to become a focus for young people.

We want to highlight three critical areas for young people. The first is that we need to fully acknowledge and protect the human rights of young people. It is sexy to say that you work with young people, but we know the truth, it is still hard to acknowledge, accept, and celebrate that the young people are entitled to all human rights, including accepting our diversity and understanding in the complexity of our identity.

For example, our human rights cannot be fully protected if young people who use drugs cannot get clean needles. Young people living with HIV cannot choose the school they want to attend or a job they want to apply just because a blood test is required. Our human rights cannot be fully enjoyed if young sex worker cannot access health services.

Our human rights cannot be fully enjoyed if the girls and young women are not able to access legal and safe abortions services and female condoms. We long for comprehensive sexual and reproductive healthcare services.

Identity is complex. Young people are more dangerous and number in epidemiology. We need a floor leveling. We must respect the diversity of the young people. We must eliminate policies that discriminate against us. We demand more inclusive and progressive agendas that protect sexual rights and sexual diversity.

The second area is access to information and services. When I was 15, my teacher together asked for a special meeting. A male guest in doctor's coat accompanied by our emom [misspelled?] told us that the condom company was only a propaganda to make people lose faith in God and they're asking to see nurse.

No girls could ask questions because they say only boys were at risk. This is my sexual advocations. Yet, I was refused by the clinics when I went for HIV testing, they said I am too young and I'm not married and not to mention our struggle to access therapy. But I know that I'm also too young to die of AIDS.

I realize that sometimes what is written on paper, even international agreements can be useless. We have to do better than this. We call on decision makes to provide a evident based, comprehensive sexual education for young people, both in and out of school.

They should recognize the rights of young people to enjoy their sexual at the safe and pleasurable place, free from coercion, discriminations, and violence. We call on decision makers to provide comprehensive, youth-friendly HIV care, services, and support that actually can be accessed by young people.

Those services should be delivered by trained health providers who respect the diversity and rights and

confidentiality of young people. To achieve this, we must eliminate legal barriers, such as age, parental, and spousal consent.

The third area is sustaining young people leadership. Young people involvement is critical. We believe we are capable of reversing the impact of HIV epidemics and the new AIDS die supporting this. More and more youth leaders and activists have taken steps to build their own responses. They have established their owned networks, called for a strong leadership, mobilized resources, and promoted many youth based organizations.

We are already out there, we just need to be recognized, respected, and supported. Most youth-led networds and initiatives are informal and run by volunteers, but we are flexible. Here call creative and open to collaborate. Sadly, we almost always have no funding for operational costs.

As with any HIV programs, we have to acknowledge that one size doesn't fit for all. But today's architecture often only recognize one size fits all. I want to accord the concern, broken promise kills. We should put health resources as country priorities. We call for a more sustainable findings for programs and treatment, which includes core funding for initiatives and network.

All of these three areas cannot be achieved without meaningful youth participations. We call for meaningful

involvement of young people in the development of programs, by yet policy, but especially, we want a seat at a table to make a decision, a seat at the table to make a decision and not making cookies and coffee. [Applause]

In order to realize right here, right now for young people, we demand that you, you, and you to invest in young people's leaderships, especially the leadership of the young women and girls. We hope the new youth entity for women breeds a formal platform for young women and girls to meaningful participate at every level.

We need international approaches that foster transparencies, accountabilities, and support of our networks. We need a mentorship and also a partnership, not just a jargon. My peers and I will not only be the leaders of tomorrow, we are the leaders for today. We intend to work together for right here, right now for all.

And now I have to challenge you. I have to challenge you to follow up all the commitment in this conference to make this conference not to become just another conference, to translate from paper to people, and now make it happen. [Applause] And with women rights for upcoming activity. [Applause]

MALE SPEAKER 2: The Executive Director of the United Nations Joint Program on HIV/AIDS, Mr. Michel Sidibe.

MICHEL SIDIBE: As I said in Washington, this is women deliver. Women deliver. Good evening. Ladies and gentlemen, it is my honor to address you for the first time as the Head of UNAIDS. Thank you. Thank you. Thank you for your tireless work.

Like me, you are here because you believe that we can end this epidemic, because you wake up every day ready to continue fighting for a world without AIDS. On behalf of the UN Secretary General, Ban Ki-Moon and the 10 UNAIDS [inaudible] I thank the city of Vienna, the Austrian government, and the International AIDS Society.

From Vancouver in 1996 to Vienna, we have achieved great things together. The conspiracy of silence has been broken. Five million people are alive because of treatment. Infection rates have dropped 17-percent since 2001. We have seen unprecedented activism and of the full engagement of people living with HIV. But I am scared by what I see today.

Prevention models are coming up short. Some governments are cracking down on the medical groups, treatment is not sustainable. Costs are rising. Countries like Brazil are seeing treatment costs the full circle from I to U, to I again.

Meanwhile, 10 million people are waiting for any treatment at all. You're afraid for their future, for their lives, and are trying to not to lose hope. In Vienna, we are

at a defining moment. Millions more will die if we keep offering only a double mix and coordinated and underfunded and underutilized services.

For the first time in a decade, an investment has not grown. The hopes of millions were put on hold when the G8 abandoned any referrals to finish our commitment they made in [inaudible].

I'm not just addressing donor countries, developing countries, developing countries need to keep their commitment too. The 15-percent promise made in Abuja must not be buried. It is about sharing the responsibility. We have to go on. The financial crises should not be an excuse to flight line or scale back.

In fact, it is an opportunity for new sources of funding like a levy on international transaction, a levy or tax. Now it is the time to face up to our responsibilities, to show integrity to keep our commitments, to demonstrate that we can build a society where we will democratize problem solving and be more number like 80. We need to listen to those affected by epidemic or natural disaster.

It is time to support communities to lead and own the response. We cannot settle for a world where some people get treatment while others do not, when some enjoy access to prevention, when orders are criminalized for who they are and

who they love; where some are offered hope, while the hope of others is crushed.

Our vision must be uncompromising. We want nothing less than zero new HIV infections, zero discrimination, zero AIDS related deaths. [Applause] We have a plan.

Four pillars that are fundamental to achieve this vision. A prevention revolution, new models for treatment, full equality for women and girl [applause] ending discrimination.

First, I have called for a prevention revolution. A global, political, and social movement. One rooted in human rights and gender equality. We found a vaccine or a cure for AIDS pandemic will become unmanageable unless we drastically and quickly reduce the transmission rate.

In 2008, 1.4 million more people were newly infected than started treatment. This projector must be broken, or the world will need to find the resources to treat two million more people very year, every day, for the rest of their lives.

Better prevention in itself will break the trajectory of this epidemic. We have evidence of the impact of competent partnerships and will value of innovation like male circumcision. Now we have to put this evidence to work.

I share Anthony Fauci's optimism that ongoing high-risk, high-impact is finally going to put all of us out of work. Perhaps my group decides on using RV to prevent

transmission are not the show stoppers on their own, but all take their place in our arsenal of combination prevention.

Young people are leading this prevention revolution. HIV prevalence dropped among the youth in 15 of the highest burden countries. We need to continue to empower them. We have a sexual integration that builds life skills. Their energy and the bold ideas inspire me in Vienna. I have taken to heart their slogan, now make it happen. Now, make it happen.

Treatment 2.0, the next generation of treatment is the seven pillars. Treatment is alright, treatment is a smart investment. That reduces HIV transmission, TB, and maternal and child deaths.

Thanks to the support of British Columbia Premier Campbell and the dedication of Julio Montaner. The world now knows that treatment for prevention is a reality that works for the three p's. It works for the patient, it works for the people, and it works for the pockets.

Treatment 2.0 radically simplifies treatment approaches to maximize the number of people who can benefit. This will save more money. But in the end, we will only be measured by the number of lives we save.

Treatment 2.0 calls for bold new partnerships with the pharmaceutical industry and to expect the full us of this to vastly scale up access. I believe so strongly in Treatment 2.0

that I am putting my authority as the Head of UNAIDS behind it. We have a joint leadership of Margaret Chan, WHO and UNAIDS will direct country level representative to sit down with their national partners to explain the meaning and importance of 2.0.

We will ask our global partners, PEPFAR, the Global Fund, UNITED, the Clinton and Gate Foundation, President Mojai [misspelled?], HIV Champions and order to work with Aides of State, Ministers of Finance, Minister of Health, and civil society to take up the banner of Treatment 2.0.

As the third pillar, we must end discrimination. Instead of universal access, the people who suffer most face universal obstacles. No one should endure discrimination, not man who have sex with men, not the transgender people, not the sex workers, not people who injected drugs, not prisoner, not especially people living with HIV.

Eastern Europe has some of the highest concentrations of HIV among people who injected drugs. This epidemic is inflamed by a stigma and punitive laws and won't stop burning until our reduction and drug participation programs are scaled-up.

The U.S. government took a steadied step this week. We have announcement that PEPFAR will now support needle change and substance abuse therapy. [Applause] Laws must work for all of the reliable people, not against them, and injustice to one is an injustice to all.

The fourth pillar is gender equality. The research of Russian has highlighted how so many profile AIDS responses focus on men. Even though most new infections in high prevalence areas are among women, meanwhile society turns a blind eye to the gender violence that makes women and girls more vulnerable.

Gender equality must become part of our DNA. We men must have better tools to protect themselves from HIV like microbicides and female condoms. [Applause] They must have the rights, the skills, and the power to negotiate their own sexuality. And they must feel safe from violence.

The research shows that traditional HIV intervention don't work when intimate partner violence is present. UNAIDS, will ransack every strategy to find what will. Integration is the only way forward. AIDS response should be the bridge draining of this movement, maternal and child health, sexual and reproductive health, women's rights, and even the fight against women concept.

We must move past the dangerous mission that impurities steal from each other. On the contrary, when we take AIDS out of isolation, AIDS and others health movements strengthen each other. They strengthen health systems and they transform communities from passive beneficiaries to actors of change.

On this road to zero we cannot turn back or turn our backs on the people and problems in our path. Ten million

still need treatment. For every two people starting treatment, five more are newly infected. More than 80 countries have homophobic laws and still babies are being born infected and are dying before their second birthday.

An AIDS free generation is so close at hand. We cannot stumble. There is more at stake here than newborn's life, it is their mother's life also. We must never lose sight that woman will give birth must also survive. [Applause]

Eventual elimination of mother to child transmission by 2015 is a sacrosanct. My friends, there is so much hope on the horizon. The more leadership of South Africa giving AIDS historic attention, the timely move by China to lift HIV travel and restriction, treatment and prevention, a possible breakthrough on vaccines, young people taking action, and bringing their prevalence rate down.

And every day scientists edge closer to a cure. You just have the last presentation. This idea that we should cut back or slow down now is ridiculous. [Applause] The zero hour approaches. And when I think of that day, I imagine living out the words of Ted Kennedy.

There were hard hours on our journey and often we sail against the wind, but always we kept our rudder through. And there were so many of you who stayed the course and share our hope, you gave your help, but even more, you gave your hearts. My fellow activists keep giving your hearts. Thank you.

[Applause] I want you to join me also to wish happy birthday to my hero, Mandela Mandibar, Happy Birthday Mandela. [Applause]

MALE SPEAKER 2: Ms. Paula Akugizibwe will now deliver the third presentation on the state of epidemic.

PAULA AKUGIZIBWE: Good evening. [Applause] Thank you.

[Audio played]

PAULA AKUGIZIBWE: I want to start off by emphasizing that the message that opened the conference this evening is possibly the most important message that you will hear over the next few days, regardless of what specific issues we are addressing. We need to see accountability, broken promises killed in regards to funding, to quality of evidence based interventions, we need to keep the promises that we have made and we need to keep funding universal access. [Applause]

Ten years ago, the German declaration at the AIDS Conference in South Africa ended with the statement that by working together, we have the power to reverse the tide of this epidemic. Science will one day triumph over AIDS, just as it did over small pox.

Curving the spread of HIV, HIV will be the first step, and until then, reason, solidarity, political will, and courage

must be our partners. So here we are 10 years later, the year that we're supposed to be celebrating universal access.

But I still have to stage die-ins after the national AIDS conference to draw attention to the fact that already, despite the fact that we're less than halfway to realizing this triumph over AIDS, the political world, the courage, the solidarity that we had thought would be necessary and had fought to see through to the end have already began to wane.

So here we have about 20, 25,000 participants from about 100 countries around the world. And if we make a conservative estimate of about $2,000 per participant including travel accommodation, registration, and so on, which we can all agree is a very conservative estimate, and work out the total of this costs, it's 20-percent of the total of money that was given by the Global Fund in 2009 to the Southern African region for all three diseases in seven countries in Southern Africa. [Applause]

Not just that, but as has been stated in all of the Austrian Government sites, 2010 is also of great important to Vienna as a conference center. The current prognosis for the conference to contribute a total of $45 million Euro to Austria's gross domestic product. What's the moral of the story? We'll come back to that later.

Let's start off by establishing the common ground that we all have here this evening. We're all here because we have

a shared vision, namely gathered around related goal six, which is to curve the spread of HIV, TB, and other infectious diseases and to realizing universal access, although the precise definition of that may be debatable and needs to be clarified, but it is to realize universal access to HIV prevention treatment and care for all of those who need it.

This is not an unattainable goal, as has been said by Ban-Ki-Moon in this year's development goal report. Yes, we can achieve this goal. He says the world possesses the resources and the knowledge to ensure that even the poorest countries and others held back by disease, geographic isolation or civil strife can be empowered to achieve the MDGs.

So even in the worst circumstances that one could imagine these goals, are attainable. So what' going wrong? Development and implementation of successful interventions requires the resources and knowledge that I referred to in the statement. But additionally, especially when it comes to the context of HIV and human right, go out to HIV, the make or break at the end of the day is not just about collective knowledge and collective resources.

The make or break ultimately comes down to individual level decisions. The decision to use a condom when having sex, the decision to get tested, the decision to initiate treatment and to adhere to it. The decision to travel 200 km or however

far it is to get to the nearest facility where you can your CD4 monitored.

These are all the decisions that make or break the HIV epidemic on a daily basis. But it's important for us to realize that because of the context, the social and legal, cultural economic context within which these intervensions are being implemented, often these decisions are not just a matter of one person involved, because we're dealing with human beings.

And ultimately the HIV response is not about microbes, it's about humans who live in human realities. And these realities come with social dimensions, cultural, economic, and political dimensions, and ultimately because of failing to address this, we have put people within a limited frame work that chooses for them what decisions they can make, what access to services they can have and yet at the same time, we claim to be committed to universal access.

And so we walk into the International AIDS conference because too long we have seen a false divide between human rights and science. We've seen allegations that human rights holds back progress and scientific innovations, but at the end of the day, we're all working towards the same thing, we know what we want to achieve.

So the question that we all need to agree on now is how do we get there? If science is the engine of the human rights

response, then the endgine of the HIV response, then Human rights are the vehicle that take us forward. Resources are the fuel and the accountability is the driver. And we need all of these together in order for us to make progress.

If anyone is missing, then we're going nowhere. And so here we are in 2010, a critical year and you are making or breaking. As you can see from the new stories over the past few months, many of the challenges that we are facing in 2010 with making the best possible se of the tools that we already have are not already fundamentally scientific challenges.

Yes, absolutely, we need more research and all like to see the day when there's a cure for HIV or a vaccine for HIV, but right now with what we do have, we could be doing a lot more. And the reason why we're not doing as much as we could, fundamentally, politically, or social, economic, or cultural problems.

So today, I'm going to speak about how human rights have shaped the state of the epidemic. And I'll speak in three main areas. First the ability to reach and engage people where they are. Secondly, our ability to nurture and sustain a sense of shared responsibility for the HIV response, and thirdly, accountability, both in regards in funding as well as the implementation of evidence based approaches.

Let's start at the foundation, the right to health. I wanted to ask by show of hands how many people sitting here in

the room today believe that health is a human right. It seems like just about everyone does. And yet if you look at the policies, the constitutions of many of the governments around the world, they do not reflect this belief.

It's interesting to note that the global HIV response was originally written in a recognition to health. It was unprecedented in the history of public health for so many governments and people around the world to mobilize, billions of dollars in terms of lateral initiatives such as the global fund, to respond to a global disease. And this happened because millions of people around the world mobilized around the right to health and how it related to the right to life.

But unfortunately, this has not happened so much at the national level, and because of the absence of legally enforceable revisions of the national level, our ability to sustain this energy is flimsy and it is not predictable.

Last year the World Ranking UNAIDS did a survey to see which of the countries believed that the HIV response would be under threat in the coming year because of economic crisis. And they found that national recognition of the Right to Health was one of the key three predictors of sustainability for HIV treatment programs at a time of economic crisis.

So, lack of recognition of the Right to Health doesn't only create an unpredictability in our response. But, it also creates hierarchies of axes where governments can decide based

on their own subjective political whim who is more entitled to the right to health and thus, who is more entitled to the right to move and through this we end up seeing groups of people who are most needing of particular interventions but are systematically excluded from receiving them.

If we talk about universal access it has to be universal. And, we'll never manage to get anywhere the indications we're trying to reach as long as we have specific people being left out in a systematic way.

So, let's look at ways, in which, human rights have worked for us. Access to essential medicines trips flexibilities. The whole rationale behind this was that people's rights, human rights, the right to people who need access to medicines need to be prioritized over the profit rights of pharmaceutical companies. And, as a result, we've seeing remarkable gains in reductions in ARV prices over the past ten years.

We do see almost a hundred fold in some cases. Meaning that many people who would never had access to life-saving medicine were able to afford it. But, because of lack of this principle at the national level, lack of an understanding of the importance to ensure the rights to health and access to health services, we're seeing that many of these gains are threatened at the regional international level. Some examples

being some of the intellectual property of Neimans [misspelled?].

Economic partisan agreements that are being set up with European Union and other countries. I was interested to hear the European Commissioner for Health saying that HIV treatment was being universally available and accessible because we're seeing concerns in the past year with this very treatment being confiscated and held here in this very continent. One that's on its way to meet people who need it in order to stay alive. [Applause] It doesn't seem to be much consistency in that.

Within countries that need access to medicines, as well, we've seen challenges with regional laws, such as the anti-counterfeit bill in Kenya that threatened access to generic medicines, which in itself is not a bad law, but somehow, intentionally, otherwise groups generics medicines as part of counterfeit medicine.

And, my best threat accessing feature. People living with HIV have taken the government to court based on the human right to health and the human right to life. And, so far the rulings in favor and we call in the Kenyan government to ensure that when the final decision is handed down it is not for delay the right to people living with HIV to access generic medicines. [Applause]

Same contrast to seeing rights in action and the positive impact that we've had a result, we also have many more

examples of rights inaction and the devastating impact that this has. And one of the most talked examples is that of prisons. In most cases in the world if you are sentenced to spend time in prison today, you're also sentenced to disease.

A sentence to HIV and TB and very little chance of actually seeing testing treatment and care. And one has to wonder how prison is being subjected to a series of human rights violations expected to be rehabilitated within these systems. We see gross lack of HIV, TB prevention, testing and treatment measures in prisons.

Lack of condoms, although we know it is a reality that sex happens in prisons and that it happens because many cases it happens because other rights are being violated. Because there's overcrowding, because people don't have access to food or water and as a result they have to have sex as a transactional way of getting access to these essential things that they need to stay alive.

It's been estimated that 27-percent of the U.S. inmates experience sexual violence and across the wall, we see that the challenges faced by prisons overlap with other rights challenges and they each have a response such as injecting drug use.

On HIV, UNAIDS and UNODC [misspelled?] say that we haven't sufficient knowledge but what we do know is alarming. And rates in prisons could be up fifty times general population

rates. TB incidence could be 10 to 100 times the general population. Every year, 30 million people go through the prison system and at any given time these only several million people who are actually in prison.

So, all of the rest of these people are coming through the system where they are exposed to these high risks and then coming back into the communities, which is why prisons have often been described as epidemiological pans or reservoirs of disease.

It is a human rights violation but from a public health perspective it's also completely irrational. We also see challenges with migrants and I asked a few activists from the Southern African region. If they had one story and one message that they would like to send to this National AIDS Conference what would it be?

This story came from Botswana of a man called Isaac whose been in a long-term relationship with this Zimbabewean woman who was unable to access PMTCT because she is not a citizen of Botswana.

As a result, when they had their son, Othelea [misspelled?] in 2007, he was born with HIV in a country that has one of the most advanced HIV treatment programs on the African continent. He did not inherent Botswana citizenship for whatever reason and therefore, he, himself was unable to access ART.

When he fell sick, Isaac could not watch his only son die and he started sharing his ARVs with his child. Eventually, the child died and Isaac has now developed drug resistant HIV.

And, Cindy says the last time we spoke to Isaac he said I can't believe my own government that I voted into power that's cremated my own flesh and blood. How much could it have cost to save my child's life? What could have become of my child's life?

She goes on to say that as long as African governments fail to make their goodwill commitments and as long as donors continue to scale back on their commitments to funding universal access, organizations such as hers, Bonella in Botswana [misspelled?] will not be able to challenge these discriminations because ultimately it comes down to priorities with our national resource allocation.

So, systematic marginalization precludes universal access. As long as we have elation of rights that are entrenched in punitive laws, we'll have access virus for key populations.

And, you can see here that many countries around the world reportedly do have laws that precludes access for drug users, for men having sex with men, for sex workers and even this reporting, you can see, is not quite up to scratch because if you look at the African region, we know that many more

countries have laws that prohibit same-sex relationships and now effected in this graph.

And while we welcome the increase recognition of the need for interventions for these groups, such as the establishment of a global fund and reserve around ten for most adverse populations, we also need to recognize that this is not just the part of public health approach Avilelei , that the risk in prevalence that these groups face are not inevitable but that the results of political, social, cultural frameworks. And, until we can address these from a human rights based perspective a public health interventions will have limited reach.

The fundamental principle of rights is that of equality and this includes equal protection of the right to have regardless of subjective opinions on morality. And this is not just the human rights angle but it is also supported by public health rationale. As we can see here drug users, MSM and sex workers contribute a large part of the prevalence in many regions of the world.

Next, talk about drug use in Eastern Europe. We've all heard about the Vienna Declaration in the previous speakers which opens with the statement that the criminalization of illicit drug users is fueling the HIV epidemic. And has now resulted in overwhelmingly negative health and social consequences. A full policy orientation is needed.

We have the fasted growing epidemic in the world here, 66 prevalent increased over the past few years and we have a huge amount of incidence being related to drug use. And yet, drug users often don't receive prevention intervention such as clean needles. And not only that, but they are least likely to access ART.

Although, there's no evidence to support the prejudiced assumption that are acting [inaudible] resistance because of the fact that they won't adhere to treatment. Research has shown that this is not the case.

So, the rights-based approach calls for harm reduction which includes needle exchange, as well as, opiate substitution programs. Scientifically, it's very sound. This graph shows that we can reduce incidence by 50-percent if we scaled up old period programs by 50-percent but politically, unfortunately, we find that it is too unpalatable.

Let's talk about Human Rights and LGBTI. At least six countries around the world criminalize same sex relationships. And this is not just a matter of law and policy, as many people tend to think. It's actually an epidemic of societal homophobia based on pseudo-religious and cultural arguments and I won't get into those now.

You're welcome to visit the ARASA toll if you'd like to know more about how attempting to respond to this. But, ultimately these arguments though are designed to explain why

people ongoing engaging consensual same-sex relationships should not have the equal rights that the rest of us enjoy.

Has dramatic indications, first before the ability to engage in healthy relationships for the experiences of homophobia and the way that this impacts the sexual relationships. Sexual violences, we've heard of correctional rape being implemented in some countries but people who are in same-sex relationships are raped as a way of attempting to desensitize them to these practices. It makes no sense in the spread HIV.

And, finally, decreased access to HIV services because of the stigma that they face. As a result, we see prevalence levels are much higher among social minorities. Particularly in the MSM sub-Saharan African region. But, in many other groups there is very little known about transmission because these groups are not prioritized.

Here's another story of someone from Kallaroo, and who was arrested and spent a year in prison because the law prohibits same-sex relationships where HIV prevention and treatment are not readily available. Ten days after his release from prison and he died of AIDS related complications and the message from Chief Willy [misspelled?] from the International Gay and Lesbian Human Rights Commission is that homophobics stigma and denial have pushed the issue of same-sex HIV transmission firmly into the closet.

The needs of African same-sex practicing people are off the map that governments and civil society have drawn to guide national and regional HIV strategies. Political and colorful resistance technology, African homosexualities and the resulting invisibilization of same-sex practicing people are contributing to wide spread human rights abusers and increasing vulnerability to HIV.

Let's talk about sex workers which we've heard very little about so far. UNAIDS has said the rights based approach calls for recognition of agency over ones body and choices. And this includes the choice of work because sex-work is work. It's just that the work it involves is sex, much like some marriages some might say without the paperwork. [Laughter]

So, there's no logical reason why we should criminalize against this particular group apart from our own prejudice notions of what morality is. Criminalization renders sex workers vulnerable to violence, it compromises their ability to negotiate companies, and it ostracizes them from access to health and justice.

And, as a result, prevalence rates are about 75-percent in some populations because of this criminalization and despite the fact that they have such high prevalence rates, sex work and HIV receives less than 1-percent of the global resources. There is no rationality in this.

In countries that have taken the courageous steps, such as New Zealand, after criminalizating sex what the impacts have been astonishing. Both with regards to increased condom use as well as the perception of the right to refuse sex which in many countries the sex work is criminalized, is not a right that's recognized. And, finally it expands opportunities for sex workers to consider other professions if they should choose to do so in the future because it doesn't come with a criminal record.

Human rights in gender, we've heard a lot about, so, I want to talk about this at length. But, we need to emphasize the challenges we see with HIV among women and especially sub-Saharan African region but we need many other regions across the world need to be placed within the broader context of structural inequalities of sexual violence, economic dependency and an equal access to medicine.

And HIV response cannot divorce itself from these realities and not cannot it continue if it only pays them lip service. As has been said in the MDG report, gender equality and the impartment of woman are the heart of the MDGs and are preconditions for overcoming poverty, hunger and disease.

But progress has been sluggish on all fronts from education to access to political decision-making. As we can see by this diagram, showing how many woman are in positions of decision-making power in countries around the world.

We also need to recognize that this course in gender creates cultural tensions and that we need to find ways of engagement that are not didactic but actually creates safe spaces for people to talk.

And additionally, the divisionism that we see now as part of the backlash in HIV funding which states that we need to take money away from HIV in order to focus on maternal health and a child health is really a forced dichotomy and a very dangerous one.

Because maternal mortality in many regions in the world could be significantly reduced by ensuring that universal coverage of HIV services available to all woman. But, unfortunately, this is not the case. PMTCT has scaled up at a very slow rate, particularly in the African region but in many other regions as well. Reproductive rights were under threat in the early days of HIV epidemic but continue to be under threat.

And initially, the pretext though was given for this was that these were risk of vertical transmission. PMTCT has result this dilemma but there's been a delay in scaling it up and as a result we still see that 1,200 children are born with HIV daily that access to maternal health and entinatal care remains very low. And we continue to see social stigmatization of pregnant woman living with HIV which in itself presents a deterrent to access.

Recently in the media we're seeing that even where there is considerable scale up of PMTCT the extreme med is to curtail the reproductive rights such as forced sterilization of woman who reports to hospitals needing care and in order for them to receive the care are forced to consent to sterilization to prevent them from having children in future because they are living with HIV. How do we expect people to be drawn to services when this subtle stigma that we are offering them in return?

Ending with [inaudible] transmission. The course of approach is have a place. I would just like to emphasize here that getting people to test, getting pregnant woman to test for HIV which sometimes they have chosen to do a mandatory fashion is only the first step of a multiple step journey. And that if you ostracize and antagonize people at this step, we break down the system every other point of the way. As this systematic review showed, the main reasons for people not engaging with PMTCT right through to this conclusion of poor understanding, patient denial, and fewer stigma.

We cannot adopt public health approaches that ignore these realities and Jonathon Mann, the former head of HIV of the WHO spoke with the prophetic insight when he said in 1987 that the epidemic of stigma discrimination and denial is essential to the global AIDS challenge as the disease itself. We need to start learning these lessons.

We cannot control HIV TB through coercive approaches, we cannot force people to get tested for public health rationale because ultimately this pushes people away from the services to which we are attempting to draw them.

But, unfortunately, the examples in the region Lesotho, Swaziland, and South Africa and although the evidence has suggested that this happens in the context of universal testing campaigns often because health care workers don't receive adequate training and sensitization leaves no rationality in forcibly entering people into a program when at the end-of-the-day they're not going to be able to see through the life-long commitment that one needs to enjoy the positive benefits of HIV services because of the fact that their rights have been violated. [Applause]

Criminalization is becoming more popular in countries around the world. [Inaudible] is meant to encourage disclosure, it’s meant to protect woman, but often, it has the opposite effect. It reinforces stigma, it particularly affects woman because they themselves are often at risk because they cannot negotiate safe-sex because of fear of violence or they cannot disclose the HIV stages because of fear of violence.

So, the very objectives the way using to defend the stance often have the precise opposite outcome when you look at what happens in reality. Criminal law, as was said a couple of years ago, cannot draw reasonable and forceable lines between

criminal and non-criminal behavior. Nor can it protect individuals of society from HIV transmission. In the protection of woman it is a poor substitute for policies that go to the roots of subordination and gender-based violence.

The use of criminal law to address HIV is inappropriate, except in rare cases. And, similarly, the use of criminal law to control TB is inappropriate. And this is something that has been recognized by the WHO in the most recent guidelines.

We know that TB HIV are essentially called epidemics, particularly, in Southern Africa which is where I am based. And we started to see governments attempting to clamp down on transmission of TB by forcibly assumating people in facilities.

In some parts of the world, like Ukraine, a lot of TB patients, not as drug resistant TB patients are kept in isolation facilities. Many models around the world have shown that community-based care has preferable outcomes.

Not only from human rights but also from a public health perspective and yet we still practicing mandatory isolation regardless of intrastructural capacity, which is a lot more costly than treating people in the communities in the homes in a manner that respects their rights. There is no rationality in this and there's no rationality in a continued refusal of many national HIV programs.

To address the socio-economic context in which HIV interventions are being implemented. Why is it that the systematic review shows two years after initiation of people in NRT in sub-Sahara and Africa? We have an average of 60-percent retention in NRV programs.

Simply getting people services is one thing but in order to retain them within these services we need to make sure that we address the challenges that they face such as food insecurity, distance to health care facilities, stigma and discrimination, these are things that come up repeatedly but still somehow have not found their way to the center of the way in which we design our responses.

In thought, we are hearing a lot about bold and radical new strategies. We are entering brave new world of treatment 2.0. Many have a need by medical approaches said yes, are welcoming and necessary but the question from the human rights perspective is what is happened to the same old problems that we have been facing.

How can we focus on bold new interventions before we have addressed a lot of these very fundamental social economic and political challenges that have really been the fundamental shortcomings and the response to HIV. This is a staggering and a costly rationality and would do well to heed the words of Marcos Espinal who said earlier this year that TB is not a medical problem.

It's a development issue, it's an economic problem, and it's a human rights situation. The same thing could apply to HIV.

And in closing, I just want to bring us back to our original, to where we started on the issue of funding and rationalities and rights. I'm not an economist, so I borrowed — time's up. Okay. Excuse me, I'm just going to be a few more minutes.

I think it is very important this message gets emphasized. We are making decisions to cut back on funding that is now is going to violate people's rights, people's access to health but ultimately going to be very foolish economic decisions, as is evidence by the statements from African heads of state and from the World Bank.

The global economic crisis is not the thing that is threatening the fight against AIDS, it's a global priorities crisis that is threatening the fight against all MDGs. [Applause] The issue is one that HIV is overfunded, the issue is that health is underfunded and it's underfunded because we do not prioritize it. Because we would rather prioritize competing political interests.

And these are some of the things that we seem to have a lot of funding for, political luxury vehicles, for military expenditure, for politician's pay, for World Cup Stadiums and

when it comes to health we have to beg for one's till. There's very little rationality in that. [Applause]

In closing, I want us to just consider this situation, where you have a government that instructs implementing countries that they should not enlong people on HIV lifesaving treatment unless other people have died to create gaps in programs for them.

You have a government that's just a few weeks before they host International AIDS Conference ripe for the global fund to say that health is not a thematic priority of the Austrian development Corporation and therefore they cannot make any contributions to the global fund over the next few years, although, they will be making 45 Million Euro from this conference.

You have a government that has tolling billions of dollars from health donors and are yet to pay half of this money back and then you have activists who visit the World Economic Forum to deliver the mirandum emphasizing that health is wealth.

You have the Iranian doctors who have medical integrity, the courage and the humanity to provide treatment to people in a country that's stigmatizes HIV at the highest levels. And the question that I ask you as intelligent, rationale and humane human beings which I seen that all of us in this room are, is who are the criminals in this context?

I'll give you a clue, it's those ones circled in red. And the point of this, the moral of this story is that something is going very wrong in accountability, in the way that we approach the HIV response and we need to start looking as we call for more funding, we need to start looking what we do much more quickly.

We need to remember that the theme of this conference human rights is not just about having all these rights face interventions but ultimately that the human rights based approach calls on all of us as human beings to accept our own individual sense of responsibility. Not as bureaucrats, not as commissions, not as researchers, as humans.

And, therefore, whatever we discuss over the next few days cannot end here. We each have an individual responsibility to take it back through where we came from and if you all believe in the rights you have is a human right then we need to go back to our countries and we need to make sure that the resources, types of interventions that are implemented over the next few years recognize this right. Apologies of going over time. Thank you. [Applause]

MALE SPEAKER 2: Annie Lennox, singer songwriter and long-time activist founder of the Sing Campaign and International UNAIDS Ambassador. [Applause]

ANNIE LENNOX: Good evening everybody. It is absolutely wonderful to be here, along with my fellow

activists, friends, campaigners. It's an honor and a privilege to be able to address you here the 18th Global AIDS Conference.

And, I've been campaigning on the issue of HIV and AIDS since 2003 when I was invited to take part in the launch of Nelson Mandela's 46664 HIV/AIDS Campaign. In a concert that was held in Cape Town in South Africa. And really my life changed from that point on.

We were invited, that is the artists, to join with Nelson Mandela, the following day on Robben Island, the place where Mandela had been incarcerated for so many years. He stood in the former prison exercise yard of the prison and addressed the World's press.

Describing the HIV/AIDS pandemic as a genocide that was affecting woman and children at an insurmountable rate. This word 'genocide' shook me for various reasons. One of them being this, this was Nelson Mandela, one of the most revered and respected individuals on the planet, describing the HIV/AIDS pandemic as a genocide and I thought, I haven't heard that before.

Who's listening, who's responding, we are the people here tonight who have responded and who are continuing to respond and I took a pledge in that moment when I understood that I would respond. That I would become a campaigner because of my gender, initially, because I am a woman and women are

being affected as such a tremendous rate, the face of AIDS has changed dramatically since the 80s.

I have had the privilege of great medical care, all the things that we are talking about human rights earlier. We in the west, we live in a bubble of human rights, actually. We are used to human rights, but when I look at my gender in other countries, in developing countries, in places like sub-Sahara in Africa, where is the protection of my gender's human rights. [Applause]

And how could it be, that the rainbow nation in South Africa, the country that had given us so much hope. Hope over despair, despair at partite. How could it be, that on a daily basis, for over a decade, almost a thousand people dying. Mother's leaving millions of orphaned children behind. How could that be? Are we not enraged? Do they not have the right to life?

I joined Treatment Action Campaign, I became a very active campaigner, I spoke up and continue to speak up about the issue that profoundly affects me and I look on this issue of HIV and AIDS very much in parallel with the anti-partite movement.

I was hugely inspired today to witness the Deputy President of South Africa standing on the stage alongside the Director of UNAIDS Michel Sidibe. That was a historical moment and one that we must not forget. It signifies a huge change in

the sense of the commitment of the South African government once-and-for-all to roll up its sleeves and to acknowledge the pandemic and to commit to making significant change and we must celebrate that. [Applause]

We must celebrate that, we must see it as a positive step, we must support the South African government in all its attempts, it's a huge challenge, but we must see this as a light, as beacon of hope over despair just in the same way that Nelson Mandela and the anti-partite movement and the ANC and all the people that fought against the partite are a very special symbol of hope over despair.

Let us recommit this year, in 2010 to doubling and strengthening our efforts of support and making sure that the message reaches the people who need to hear it, the governments, government leaders, civil society, all the people that can make the difference and the difference can be made. And I'm going to illustrate that with you now.

I want to share a story of a little girl, her name is Avilelei [misspelled?]. Avilelei's story travels with me wherever I go and I campaign all over the world. This is a photograph of Avilelei, a little girl who was born HIV positive. Avilelei's mother died of AIDS.

This child in this photograph is weighing less than a one-year-old baby. Avilelei in this photograph is struggling to survive. She has full-blown AIDS and pneumonia. Avilelei

represents millions of children in Sub-Saharan Africa and in other parts of the world and in this instance, Avilelei had access to good medical care and nutrition.

Five months after this photograph was taken, we went back to the eastern Cape where she was living and I want to share the photograph of her transformation with you now. [Applause]

Isn't that inspiring? Doesn't that make you feel that every single moment that you have spent campaigning and working on behalf of people who are struggling with this issue, doesn't it make it seem worthwhile? Don't you think her life is worth saving. [Applause]

Everywhere I go I wear my HIV positive t-shirt. It is my tool so that when people take my photograph, it's not just a picture of Annie Lennox. It's a picture of a woman standing in solidarity with every single person in the world who is suffering with this virus. It should not be stigmatized. It must come out of the closet and be normalized. That is the message. [Applause]

There should be no more shame at HIV. So let's not wait for another 10 years. Let's not wait for five years. Let's not even wait for one more day. Let's commit here and now, here in Vienna, let's recommit to all the work that we have done and we will continue to do until we see universal

access. It is achievable, it can be done. Thank you.

[Applause]

MALE SPEAKER 2: His Excellency, Doctor Kgalema Motlanthe, Deputy President of South Africa. [Applause]

DEPUTY PRESIDENT KGALEMA MOTLANTHE: Good evening and thank you program director, his Excellency, President of the Federal Republic of Austria, Heinz Fischer and Mrs. Fischer, Conference President Mr. Julio Montaner, Executive Director of UNAIDS Mr. Michel Sidibé and Mrs. Sidibé, Honorable Ministers and Deputy Ministers present, Excellencies, Ambassadors present, distinguished delegates, on behalf of the people of South Africa, I thank the organizers of this 18th International AIDS Conference for inviting me to this important gather.

I also wish to express sincere appreciation to the government and people of Austria for hosting this magnanimous event in this cultural hub and beautiful city of Vienna which offers an abundance of history and inspiration. I thank our host for the hospitality given to our delegation since our arrival here yesterday.

A week ago an audience of over 1 billion people witnessed the dramatic conclusion to the FIFA World Cup. I'm sure all would agree that in the main this World Cup provided pulsating excitement and memorable moments that will live on in football history.

On behalf of the people of South Africa and indeed the African continent I wish to express our gratitude to all the 31 countries represented by their teams in the FIFA World Cup Finals.

I want to believe this sporting tournament has provided all of us with lessons we can apply in our collective approach to deal with the HIV and AIDS pandemic. One of those lessons is the importance of teamwork even in the battle against HIV and AIDS.

Another lesson is the setting of targets, milestones, roles and responsibilities in order to achieve those goals. Support from local and international stakeholders has also proven to be priceless in supplementing our efforts. The FIFA World Cup has emphasized the lasting importance of interdependence and cooperation with all stakeholders, domestic and international.

Ladies and gentleman, the timeliness of our participation at this conference is important since we are here to learn, share experience and compare notes in response to the common challenge. Our objectives and messages have been consistent.

Firstly, our government is unambiguous regarding the importance and efficacy of antiretroviral treatment. We are taking all steps to ensure the availability and accessibility of treatment for the needy. Working with our social partners,

we have striven to ensure that our response to the pandemic is evidence-based, properly resourced and effective. Allow me to share with you how South Africa is organizing that wide of response.

Our medium-term strategic framework builds upon the successes of the first 15 years of our democracy and draws from the lessons identified in the government's 15-year review and issues that arose in our scenario planning process. The scenario planning process identified a number of macro-social dynamics and trends that could present themselves in the long term.

It posited that a number of new opportunities as well as some serious new risks could arise in the context of possible scenarios. This scenario planning process resonates with a similar project conducted by the UNAIDS titled *AIDS In Africa: Three Scenarios to 2015.*

The UNAIDS document juxtaposes some of the issues raised in our own scenarios against the challenges posed by responding to the combined pandemics of HIV and AIDS and tuberculosis. The scenarios throw into sharp perspective the tough choices and difficult decisions governments face in identifying priorities and tackling the challenges of poverty and underdevelopment in a background of unprecedented demand on health systems.

There is a message emanating from the council of the champions for HIV-free Generation, chaired by former president Festus Mogae of Botswana who's present here this evening, has managed to draw attention to the following: To share experiences and encourage leadership to renew and revitalize the response to the HIV pandemic, highlight prevention of HIV as priority number one, and endorse a policy on medical male circumcision and infant circumcision as a matter of urgency.

In South Africa and indeed in most countries in Africa, the champions have initiated a discourse on the role of traditional leaders in educating communities about responsible sexual behavior. We are acting on the belief that every instrument available in society must be used to address the HIV and AIDS pandemic.

In our country, we have deliberately embarked on a substantial HIV testing and counseling campaign. The aim is to allow the majority of our population to know their HIV status and thereafter act accordingly and where necessary to access the expanded treatment and support services that are provided.

In addition to testing for HIV, people will also be able to receive other essential services such as screening for among others, tuberculosis, blood pressure, sugar diabetes, and cholesterol levels. In effect, these diseases require a coordinated response.

Working with the South African National AIDS Council which includes, amongst others, social partners, people living with HIV and AIDS, traditional leaders, performing artists, medical practitioners, researchers and scientists, women, children and youth, we are all working in unison under the theme *I Am Responsible, We Are Responsible, South Africa Is Taking Responsibility.*

Program director over the past — [Applause] — over the past few years we have made progress in many key aspects of our collective national response. The prevention of mother-to-child transmission program has seen dramatic improvement. Antiretroviral treatment is provided to well over 80 percent of diagnosed mothers and in some of our priority districts we're succeeding to reduce mother-to-child transmission to below 6 percent.

Therefore, we continue to make the investments necessary and are working hard to ensure that they're proportionate to the response that is required even in the face of declining revenues.

The global AIDS reports show how much this investment has made in realizing the right to health. We cannot let up now and allow recession to take precedence over the right to health and the principals enshrined in the universal declaration of human rights. [Applause]

Dear delegates, we must also strengthen our collective response by ensuring that aid for AIDS does not result in the creation of parallel policy, parallel governance, and procurement systems in the recipient countries. Rather, we should allow for country-led interventions that strengthen capacity in the respective countries.

We need renewed commitment for consistent, sustained and predictable financing mechanisms. I would argue that now is not the time to disinvest in health. We are pleased, therefore, that the global fund has invested close to 10.5 trillion U.S. dollars into the response thus far.

We must all stay on cost. Most importantly, we need to be drawing lessons from responses to other diseases. One key lesson is that our response needs to be united, coordinated, and comprehensive.

The UNAIDS Three Ones principle should remain in force and I'll also argue that a broader development framework that brings together the MDGs, the universal access framework, the Andas report [misspelled?], and all other pertinent national reports is the obvious outcome to make this harmonization effective.

The creation of a single, unified framework that enables a broad reporting focus on the spectrum of economic, government, social, sociopolitical and health issues will enable comprehensive planning and budgeting and will also allow

us to apply a holistic and comprehensive analysis to key issues that need our attention.

I'm convinced that we are all moving in the right direction but the next step for us to overcome this pandemic will require harmonization and collaboration across our national responses.

We have demonstrated that working together in partnerships across all sectors of society we can achieve much to ensure all of our people have access to good quality health care. In conclusion, on behalf of the people and the government of South Africa, I reiterate South Africa's and indeed Africa's determination to realize an HIV and AIDS free generation. Ten years ago at the 13th International AIDS Conference in Durban our former president, Nelson Mandela, etched us to always act in solidarity with others.

And he said, I quote, "We want to move away from rhetoric to practical action. We need African resolve to fight this war. Partnership with international community is vital. A constant theme in all our messages has been that in this interdependent and globalized world, we have indeed again become the keepers of our brother and sister.

That cannot be more graphically the case than in the common fight against HIV and AIDS." I thank you very much for your attention. [Applause]

MALE SPEAKER 2: His Excellency, Doctor Heinz Fischer, President of Austria. [Applause]

PRESIDENT HEINZ FISCHER: Honorable, wise South Africa, Excellences, distinguished delegates, ladies and gentlemen; our opening meeting for the 18th International AIDS Conference is coming to its end now. It was a very, very remarkable opening meeting in my opinion.

Every speaker, and there were quite a number of speakers, was full of engagement, full of determination, presenting facts and figures and arguments and portraying a picture of a problem with a worldwide huge dimension.

And I really, for a few remarks, will put aside my manuscript avoiding the danger to repeat one or another effecting idea and just say that if the further conference tomorrow, day after tomorrow, until the end of the week, is as intensive and inspiring and energetic as this meeting, there's a real chance that those are right who so optimistically said we will be able, united, to reach main goals on this issue and we do not wait 10 years and not five years as Mrs. Lennox said, but will start tomorrow.

We have the very best arguments on our side and I don't say on your side, I say on our side. It was impressive how it was described and I knew it from documents and figures but now it was presented so lively how big the burden is just in particularly for women and how children are suffering and not

one or 10 or 100, but hundreds of thousands and even more altogether.

It was impressive to listen to the young woman representation their opinion of young people and seeing the combination of self-confidence and suffering and solidarity and optimism. I can only congratulate you to your approach – [Applause] – and to this determination.

It is also impressive to realize and to understand the geographic aspect; that this AIDS and HIV is not distributed in an equal pattern all over our pattern, that some special regions and parts of our world who are suffering most and that those regions where people have much, much less chances and much less access to the possibilities which exist already today and which help those in the advanced regions and in the richer parts of our world.

And finally I want to mention that another aspect that gives hope is the progress in science and the progress in the field of medicine and that every year and maybe even every month, new steps are possible for treatment of this terrible illness and for methods that give not only hope but really change the life of those who are affected and those who are suffering under this illness. So I think this was a very remarkable gathering with contributions from all sides.

By the way, even a rather balanced distribution between male and female speakers, different regions, different sciences

and approaches and I thank you very much that you have invited me, given the opportunity to listen and to think about the arguments.

And so much thanks was expressed this evening already on the one or the other address but I want to express also heartfelt thanks to those who have organized this meeting, who have undertaken so much efforts and done so much work.

And if one of the speakers has said he hopes that Vienna starts a new period or new approach, new progress; I very, very much hope he is right and then to the next conference in two years, if I'm right, in the United States, there will be the possibility to report a lot and positive developments that have started in the coming days during your meeting. All the best, thank you very much. [Applause]

MALE SPEAKER 3: Conference organizers would like to acknowledge the support of the following sponsors: Abbott Biology, Boehringer Ingelheim, Bristol-Myers-Squib, Juilliard, MSD, Tibotec, Vive Healthcare. Conference organizers would like also to acknowledge the support of the following cooperating governments: The City of Vienna, the Austrian Federal Health Ministry.

The organizers would also like to acknowledge the support of the following cooperating institutions: UNAIDS; The Global Fund to Fight AIDS, Tuberculosis, and Malaria; World

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The government of France ANRS, the government of Canada, the government of the United Kingdom, the European Commission, Ford Foundation, the Government of the Netherlands, the Government of Norway, the Bill and Melinda Gates Foundation, Centers for Disease Control, the OPEC Fund For International Development, Positive Action.

Thank you for attending the operating session of AIDS 2010.

[END RECORDING]