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AIDS 2014: What Happened and What's Next?
Kaiser Family Foundation
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JEN KATES, PHD: Good afternoon everyone. Welcome to the Kaiser Family Foundation and to our joint event with the Center for Strategic and International Studies to look at the outcomes of AIDS 2014 which is the 20th International AIDS Conference which wrapped up in Melbourne a couple of weeks ago. We have three distinguished guests with us today who I will introduce in a moment to discuss this as well, and also a very large audience. Thank you.

I first want to acknowledge and thank CSIS and Steve Morrison specifically for this ongoing collaboration. We have come together, our organizations, for five conferences, of the major conferences, afterwards to do this kind of gathering with the D.C. community to really take stock of the conference and try to understand what we learned from it, what it means for going forward. Thank you so much for doing this.

Second, given the large audience that signed up for this and that is as actually here, I'm just curious how many people in this room went to the conference this year? Raise your hand. Okay, so most of you did not. Understandably, it was far away. This is good. This is why we are trying to do this so we could bring you together.

Then, on a more serious note, I just want to say a few words about the tragedy that befell all of us as we set out to get to the conference and that's the crash of Malaysian

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Airlines MH17 on July 17th, literally the day that most of us were traveling to Melbourne. I can't speak to how it felt here on this side of the world but I can say that it can't be separated from the experience and the meaning of the conference itself. All of us collectively lost six incredible people who devoted their lives to fighting AIDS en route to do this very work and I actually want to name them all. They were Joep Lange who is the co-director of the HIV Netherlands Australia Research Collaboration, the science director at the Amsterdam Institute for Global Health and Development and former president of the International AIDS Society; Jacqueline van Tongeren who is also at the Amsterdam Institute for Global Health and Development; Pim de Kuijer who is at AIDS Fund Stop AIDS Now; Martine de Schutter who is also at AIDS Fund Stop AIDS Now; Lucie van Mens who is at the Female Health Company; and Glenn Thomas of the World Health Organization.

This experience shaped the beginning of the conference which was somber and serious and full of a lot of shock and some pain. It also reminded all of us something really important about our community and the response to HIV and that is the community, the community of scientists, of activists, of advocates, of patients, of politicians many times embodied in the same person. Just to remember these individuals, I'd like to quote a friend of mine who worked very closely with Joep and Jacqueline, Dr. Cate Hankins, who's also at the Amsterdam

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Institute for Global Health and Development. This is a reminder of who they were and what this means for our community and also frankly to recognize the act of violence that occurred that took them. These are Cate's words. They were a tribute that she just gave a few days ago about Joep and Jacqueline in particular as she said, "It is incomprehensible that people who worked so hard to save the lives of others should be shot down and be collateral damage in someone else's war. Each of us needs to reflect on how to celebrate their memories by taking forward their visions. This world is a better place for them having walked among us. Let this be said of each of us too."

With that, I want to just say a few more words about the conference itself, which was anticipated to be smaller than prior conferences because of where it was and it was in terms of the attendance and not expected to necessarily have scientific breakthroughs. It didn't, but nevertheless, it had an incredible richness that I'm not sure was felt here and an incredible depth in what was presented in the coming together of lots of communities in terms of highlighting what I think many of us feel is an emerging global consensus on where we need to go from here that's not always been present and emphasizing the importance of focusing on key populations, those who are marginalized, men who have sex with men and transgender individuals, sex workers, injecting drug users, and addressing and confronting stigma and discrimination in all

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their forms around the world, the emphasis on the need to scale up treatment and what we know now about treatment and how effective it is, but also the power of prevention again, and some exciting new information about PrEP which I'm sure we'll talk about among other things.

For now, I'd leave it at that. I'd like to ask our three panelists to come up. I'm very pleased that we're joined today by Ambassador Deborah Birx, the Ambassador-at-Large and Coordinator of the U.S. Global AIDS Program; Dr. Chris Beyrer, Professor at Johns Hopkins and also the new incoming President of the International AIDS Society which is the steward of the International AIDS Conference; and Dr. Steve Morrison, Senior Vice President and Director of Global Health Policy Center at CSIS. Please come and join me. You are there. Chris is here. That's my most important job today.

As with usual in our events, I'll ask a few questions of our panelists and we'll pretty quickly get to your questions and I hope this is a dialogue especially for those who weren't there who want to get a sense of how things really played out because we know that the media itself didn't cover the conference extensively. That's been a trend that we've seen for a long time and so bringing that information here is really a critical task that we want to help with. My first question, it's going to be the same question for each of you but I'll start with Ambassador Birx, is just to get a sense of your main

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impressions and takeaways from this year's conference. What were some of the big themes that came out and the ones that you hope to continue as we carry forward this work?

DEBORAH L. BIRX, MD: Great, thank you and thank you for having me here again today and thank you for all your information that you put on the Kaiser website about HIV/AIDS. Every question that I had from every African press over the last four days, they all reference the site—

JEN KATES, PHD: That's good to know.

DEBORAH L. BIRX, MD: —and how much they utilize the site. AIDS 2014 — I think when you start out with that level of heartbreak, it really required all of us to be very introspective the entire week because many of us came from that time when there were so many unexpected deaths among our friends for an unknown reason back in the early '80s. It was I think tough to have that reflection at the beginning and in sort of but then every time I was in a plenary or every time I heard something, I was able to — you're able to think about the history of HIV/AIDS and where we are. To me, it was historic content of our 30 years together and where we've been and where we've been together.

What started out as heartbreak I think came forward as very much as hope when UNAIDS reached — released its global report called the Gap Report. Hopefully, you all have seen it. It's really a return to fundamental data reporting from UNAIDS

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with clear analysis that we can all understand at the first time we look at the graphic without a lot of subtext. You only have to look at the pictures and you'll really – which I really appreciate – and you'll really get a sense of where we are around the globe. Then, I think to me the last thing was renewed commitment and the sharing of that shared experience at the beginning of the week. Really, when things happen and when advocates and activists spoke, there was a true resignation – resonating theme through all of us. When they were talking about they want to be undetectable and it's important to be undetectable and have viral load assessable, we all agree with that and it's so important so I think there was consensus.

I will leave with my final impression. Probably the biggest impact on me personally was a session done with individuals who have lived with HIV/AIDS for more than 20 years. It was really – I had somehow in my years of travel lost track of how those days felt and how sick those patients were. Hearing them relive the number of days they spent in the clinics, they spent in the hospitals throughout their 20s, throughout their 30s, throughout their 40s. They were unable to work, they were unable to access effective treatment, we had monotherapy and then bi-therapy and fortunately most of them or all of them in that room made it to combination and HAART, but hearing their life experiences and what an impact this is having when they're in their 60s and 70s and having lost their

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most productive work years reminded me why the United States turned to the huge epidemic in Sub-Saharan Africa and said we can't stand by this. We're losing all of the 25- to 45-year olds. We experienced that and hearing their stories and really understanding that their life journey has had a tremendous impact and we all need to resonate with that and understand that and understand that we have a lot of patients now who lived successfully with HIV but don't really have the wherewithal to retire successfully. It really renewed my commitment to really understand all of the stages of the life experience from prevention of mother-to-child transmission all the way I've been to our decades that we are – not you, me – are approaching rapidly and understanding and being able to understand people's life experience and respond to them.

JEN KATES, PHD: Thanks. Chris, I actually want to just thank you too because this is I think your third of these that you've done with us.

CHRIS BEYRER, MD, MPH: Yes. We were reflecting on.

JEN KATES, PHD: Yes. We'll bring in – just put on your calendar for two years as well so we'll come back.

CHRIS BEYRER, MD, MPH: Well, two years from now, we'll be talking about the Durban conference.

JEN KATES, PHD: Yes.

CHRIS BEYRER, MD, MPH: We might want to come back to that at the end. I would just add to Jen and Debbi's

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reflections that, of course, the MH17 tragedy changed all of our experiences. Obviously, it had a huge impact on the conference. To me, the word that summarized the response of our community by about mid-week we heard it repeatedly was unity, that this really powerfully brought people together. I think this will be remembered certainly as one of the conferences, if not the conference, where the divides that we sometimes see between researchers, providers, community, politicians really truly got resolved in some profound ways. There really was a unanimity of purpose and engagement which we all know we're going to need for the next phases of the response.

I would say that big picture messages that came out of the conference were certainly and Debbi's talks, Mark Dybul's plenary, a number of other presentations, the UNAIDS data. There is a consistent theme of using the resources we have strategically, more strategically, focusing on a better targeting of the response, focusing on the people. UNAIDS report actually shows that about 50 percent of new infections going forward are predicted to be in key populations. That's an incredibly important thing because there are relatively small proportions of our communities but bearing disproportionate burdens and excluded from services and that is a combination we have to change. We really have to work on that.

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That refinement of the response I think was really a theme that emerged. If I might, if now is the right moment, just go through a couple of the highlights from each of the tracks. Of course, we have five tracks known at the conferences. While there wasn't I would say any one or two single big studies, there were a number of advances in each of the tracks that I think are really important. Particularly since so many of you weren't able to attend, hopefully, this will be your 10- or 12-minute trip through the science and I will just highlight, and certainly the Kaiser site is a great place to go, AIDS 2014 is as well, but there are a couple of key talks.

For example, with track A which is our basic science where there is a lot of focus on cure obviously, the big news in advance of the course was unfortunately the breakthrough after 27 months of functional remission of the Mississippi child who is now 4 years old and doing well on therapy but unfortunately was not able to stay off any viral therapy. The big focus, of course, is on cure and vaccines and the cure plenary on the opening day by Dr. Jintanat Ananworanich is a masterful summary of that Science. It's clear. She managed to do both things, not dumb it down and also really keep us all apprised of the science. You might want to listen to that.

The big news from the focus on cure is the concept of kick and kill which is basically that you try and get HIV out

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of whatever latent reservoirs it's hiding in and then use either immune therapies or gene therapies or perhaps other drug therapies to try and then go after that reactivation virus. There's quite a lot of data and information on that and there are a couple of early studies that suggest that this may be a way forward.

There's clearly a consensus emerging that the best thing from a cure perspective and probably also from a clinical perspective for individual people with HIV and almost certainly from a prevention perspective is earlier is better. Early initiation of therapy is better and the people who are likely to be the most likely to benefit from cure strategies however they emerge are the people who are started on immediate HAART or very near to immediate HAART. That, of course, includes this large pool of children worldwide who have been started shortly after birth in places where that has been the policy. That is going to be a very important area.

Track B which is the clinical track, the good news there is that the number is very depending on what timeframe you're cutting it up but basically 13 million people worldwide are on antiviral therapy at this moment. With the new WHO guidelines, of course, another equal to that number or very close to it are now eligible for therapy at 500 CD4s or above. There is an enormous still untreated population out there but more people were started in the last several years really than

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at any other time and the response a lot of that, of course, is due to PEPFAR and the Global Fund but also to country ownership and that whole effort.

In terms of treatment areas that emerged, there was a big focus on tuberculosis. Diane Havlir's plenary on TB is a great summary and had some very important findings. There are some new combination therapies in TB/HIV coinfection that really looked quite promising. There's an emerging area related to clinical care and smoking and particularly with thinking about chronic obstructive pulmonary disease, COPD, as a smoker's condition but now also probably as a next frontier as a comorbidity in HIV. There's a lot of action on that front.

Then, probably track C as Jen alluded to which is epidemiology and prevention was the area where there was the most action because there have been the most new studies and trials out so a couple of things to highlight there. First of all, the new WHO guidelines on prevention, treatment and care for key affected populations were released just before the conference and then we had sessions on them. I showed full disclosure saying that I co-chaired that guideline process with Adeeba Kamarulzaman as the dean of the medical school at University of Malaya in Kuala Lumpur, a fantastic scientist. Those guidelines really made one of the strong recommendations based on the quality of evidence. It was for consideration of

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the use of pre-exposure prophylaxis so that is PrEP for men who have sex with men as an additional prevention option. Some of you will have seen that this got very misconstrued in the media, some very inflammatory headlines. WHO says all gay men should be on PrEP. Nobody said that. Please do read the guidelines there; I think they are a real advance. In addition to the recommendation for MSM, there's also an important recommendation for community distribution of naloxone to reduce overdose deaths which have actually in countries where there is good coverage of ARVs, overdose death has begun to replace HIV as the leading cause of death in people who inject opiates so a very important change.

There was also good news on PrEP among men who have sex with men and transgender women who have sex with men, which was the results released at the conference of iPrEx -- IPrEx was the clinical trial many will remember came out in 2011. Bob Grant was the lead investigator but this is the open-label extension. This is really the question of the effectiveness of PrEP when it's not a placebo-controlled randomized trial, when people know what they're taking and they can choose to take it or not. The good news is that the effectiveness was actually a little higher than in the trial, about 50percent overall, but looking at blood levels and at people who actually took the drug, it turns out first of all that the efficacy was 100percent as measured in people who actually took it every

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day. It really works if you take it, but it was just as good at six times a week, five times a week, and four times a week. While that is a difficult message to put out there and we're not backing away from daily PrEP at this point because we don't have the data to do that, adherence doesn't have to be perfect for the drug to work. That is a real advance.

The other thing that really emerged from that study which I think is very important is that people had a good sense of their own risk. Taking the drug daily was much more common among people who actually had high-risk exposures and less common among men and transgender women who didn't. That isn't surprising. People are smart and they know what kind of behaviors they're engaging in but nevertheless important.

The other thing I think that's critical is there's been all kinds of concern about risk compensation so you know if people are on this drug, they will use condoms less, the same concern raised by the way in using treatment as prevention in discordant couples. Lots of science around this. It turns out it's a theoretical, not a real world concern. Condom use is better in couples who are one of whom is being treated and who are using treatment as prevention for prevention. There was great data on that from Zambia and in iPrEx OLE, no evidence of behavioral disinhibition. There wasn't great condom use to start but it didn't decline.

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There also was encouraging news on voluntary male medical circumcision and the most important data there are the first real empirical findings from the French group that did the first trial of the benefits for HIV prevention for women of male circumcision and lower rates of HIV and also of syphilis in women whose partners were circumcised. That is data we've been waiting for and it really is very encouraging.

I would say on track D which is our human rights policy and law, there was an enormous amount of work. Michael Kirby, a distinguished Australian jurist, had led us off with that theme. There were a number of presentations on human rights policy and the law and also some empirical data from special issue of the *Lancet*. The *Lancet* special issues have now been happening regularly with these conferences. This one was on HIV and sex work and sex workers. I would encourage you all to read it. I also edited that so full disclosure but it's a wonderful group of young investigators who led those papers, really excited about the science but there's strong human rights evidence there for, for example, the potential benefits of reducing police violence on HIV incidence, its modeled outcome and also on decriminalization as an HIV prevention approach.

Finally, in track E which is the implementation science track, it actually now has the largest number of abstract submissions of any tracks. For those of you who work for

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implementers out there, you are an enormous sector in this field and doing lots and lots of work. There was great science, some very encouraging outcomes, also one or two warnings, and I would just highlight a couple of things. One was good news that earlier disclosure to adolescents turns out to really improve their adherence on therapy. That's an important finding because the cohort of kids who were born with HIV is now in adolescence and young adults, and happily in Africa, many of those kids are surviving but earlier disclosure to them matters. A challenging issue with Plan B which is putting all pregnant women living with HIV on therapy which looks like their retention and care is not as good as we'd hoped postpartum so they'd do great through the pregnancy and delivery and then they're falling off and that's going to be an important implementation, science challenge ahead particularly around breastfeeding.

I would say that finally from track E, the other thing that really emerged was how much more granular and granular is a big word at this conference. We're getting about the data, strategic use of data, Debbi alluded to this, and the importance of really targeting resources to where the virus is, where people need treatment, where transmission is ongoing given what the global funding climate looks like and given the fact that we are beginning now to really bear down on this epidemic. Thank you.

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JEN KATES, PHD: I have to thank you because I was at many of those sessions and I've read so much that's come out of the conference but that was the best summary of everything that happened. You got the best summary right here. Steve?

STEPHEN MORRISON, PHD: Thanks Jen and thanks to Kaiser and to Craig for hosting us and for this partnership. Congratulations, Chris, for your ascent into being the president for this next two years and working with Olive Shisana moving towards Durban and that's very exciting and we'll talk a bit about that.

I too was really struck by the convergence of opinion just in sitting and listening to Deborah Birx, to Salim Karim, to Mark Dybul, to Tony Fauci, to Michel Sidibé. The degree to which there is a very mature and advanced consensus around what needs to happen is remarkable. This is not a community beset by deep controversy and division.

CHRIS BEYRER, MD, MPH: Yes.

STEPHEN MORRISON, PHD: I was at times a little irritated that there was not more debate but this was really a sign of success I think and there was embedded within that was a palpable realism and focus upon results and implementation. There was a spirit of constructive forward-looking progress to this and a sense of advancement and a sense of realism that all came together around those five or six key things that need to happen and I didn't fully appreciate the degree to which that

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convergence had happened. It's a real testimony, the maturity of this, the leadership and the continuity of leadership when you look at the people that were up and eloquently making the case and you realized how long they've been in leadership positions in pushing this forward. It's a very unusual enterprise I think that we have.

I'm going to say just a few words about the implications of the MH17 because I think this was truly extraordinary and I'll explain a bit about that, a bit more. We've heard some about this but I think we need to tease out a little bit of the implications from it.

First of all, we've never had a conference in which a geopolitical global crisis sucked the conference in and sucked the host country in. Australia suffered the loss of 28 citizens and seven - and eight - permanent residents. 18 citizens from Victoria state died. This became a geostrategic top priority, pressing urgent matter for the Australian government as it did become a pressing and urgent human matter for the organizers of the International AIDS Conference. There was no accepting - there was no escaping the reality that this was going to become a dominant factor going through the week and beyond, so thinking about what that means in the immediate and longer term I think is important.

One is the MH tragedy will become a signature frame for thinking about this, I think in the future as we talk about

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this conference. Secondly is it triggered a massive spike of media coverage, and bear in mind, going off to Melbourne was to pushing the AIDS conference off into the periphery and lowering the numbers and lowering the media presence. In a world in which the global media is shrinking in terms of its willingness to deploy to these kinds of conferences, the media presence was a lot lighter certainly than it was two years ago but that tragedy spiked the media coverage in a period, but the storyline was not the substance of the conference. The storyline was the human tragedy and the impact there and what that meant. Far less was their coverage around - as there has been in the past - of the sort of programmatic developments that Chris and Deborah have summarized.

I do agree that the immediate impact was a slightly disorientating and dulling effect upon the population for the first couple of days. There was a somberness that hung over the opening ceremony, the delegates themselves individually, and the early panels and events. But what was interesting was that there was a rebound effect that began soon thereafter in which you saw a community that had an unusual resilience to it and it had an unusual capacity to absorb and process this tragedy and some of that has to do with the historical legacy of HIV/AIDS. It has to do with this is a community that is familiar with loss. It's familiar with irrational violence and

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cruelty. It has the 1998 precedent of Jonathan Mann and his wife dying on an aircraft.

There was a reconciliation of a kind that began to happen slowly and move people out of this dull and disoriented initial reaction. Then, I think one of the key moments, and I'd like to hear from Jen, Deb and Chris on this, I thought the key turning point was President Clinton on Wednesday, midday, and this was not a conference that attracted a lot of big celebrities. It attracted Bob Geldof as a faux celebrity but it only really attracted one global personality and that was Bill Clinton.

Clinton came in and the media attention intensified again and he really was quite deft I thought at lifting the spirits in the conference and defining the moment and he was particularly, I thought, humble and eloquent in the way he went about doing that. He talked about MH17 emanating from the dark spirits, dark forces of our interdependence. He reminded every one of the 2,000 people there in the room not to weaken their resolve in the face of this. He supported the Dutch and the Australian and the American positions that there was no excuse, that this was a crime and there was no excuse. Then, he segued to talking about the vital point of appealing to the assembled community that it had an obligation to honor the service and lives of those who were lost and the children that were lost. He said we have to remind people that people we lost on that

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airplane gave their lives to the proposition that our common humanity matters a hell of a lot more than our interests and differences. This was a kind of engagement and speech that was quite historic I thought and quite unusual and obviously driven by this tragedy.

Two other points about the impact. One is the Australian government. The Australian government was an exceptional host. They were gracious. They were well prepared. They were generous. They were cordial. It was very well organized on their side but this was a national tragedy for them. I think it completely consumed this government and in a way stole any serious high-level engagement away from it because they were then absorbed in the Security Council, they were absorbed in getting the forensics teams into the crash site, and they were rallying and mourning and grieving their own population. During the conference on Thursday in the early afternoon, 1,200 opinion leaders from Australia gathered at St. Paul's Cathedral, which was just across the river from the conference center. That was an important thing to remind ourselves that in the midst of this conference was this other larger drama that was unfolding.

The last thing I'll say, which Chris can add more element to, which has to do with Putin's actions vis-à-vis HIV/AIDS. This MH17 tragedy aggravated and it further worsened what was already a trend line in which Putin's seizure of

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Crimea, the confrontations over Ukraine and the battles to regain dominant shares over Central Asia and the Baltics and elsewhere, which has grave public health implications, was driven into the next stage. We need to think about that. We need to think about that. I'm not sure that there's any near-term solutions to this but it was another one of those dark and somewhat implicit implications for this terrible tragedy.

Thank you.

JEN KATES, PHD: Thanks. I actually want to pick up on one thing you said and then come to a couple of you as well around some of the turning points. I agree that speech that President Clinton made was quite extraordinary and I'm not sure everyone - it got the attention it needed given how extraordinary it was. The other thing I wanted to say is that the IAS itself in the way the IAS responded, was also pretty phenomenal because there had been a few calls for should we go on with the conference and the IAS came out immediately and said we are going on, that we have to go on. That really I think just gave a lot of energy to people that people needed and the way you adjusted to the opening ceremony to address it was just, I mean, very admirable so thank you for that.

There's a lot to pick up on and I'm just going to go to a couple of places. I don't know, Chris, if you want to say anything in reaction to some of the pieces that Steve mentioned

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on the conference or one thing that would be great to hear a little a bit about too is the Melbourne Declaration—

CHRIS BEYRER, MD, MPH: Yes.

JEN KATES, PHD: —so maybe those things and then we'll come back to you, Debbi.

CHRIS BEYRER, MD, MPH: Well, maybe just start with the Melbourne Declaration. One of the core ideas that we had for Australia is countries now 30 years and more into the epidemic, each have their own story and their own national response and what's happening. Part of the story with Australia is very early implementation of evidence-based prevention, very early engagement with communities, one of the first countries to really seriously take needle-and-syringe exchange to scale with the big injection drug use problem, and really heading HIV off at the pass in some ways and still having an admirably low rate of infection although ticking up in young gay men, as is happening virtually everywhere. This was always going to be part of the story, that Australia is a place to talk about key affected populations. We're in the Asia-Pacific Region where that is the principal driver of most of the epidemics and not so much the key affected populations but the poor public health policies and programs around them and the restrictive environments. That certainly is the case with Central Asia and the increasing Russian influence on public health programming in that region. We focused on the Melbourne Declaration to say

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basically nondiscrimination is totally unacceptable at this point and that if we cannot do a better job of delivering safe and effective programming with dignity and human rights for everybody who needs it, we're not going to be able to succeed in the HIV response.

The Melbourne Declaration became all too real and alive during this conference I have to say. Vis-à-vis the issue with the Russians, we wanted very much to try and have the Russians engage in this conference and to have the Central Asian governments engage as well as in the Asia-Pacific. We try really an outreach there - organized a special session on the region, which we invited Russian participation in. They agreed. The head of their Federal AIDS Program was the person they put forward. 10 days before the conference, that person pulled out and said sorry, we're not coming. The Russian government is not participating. We invited them then to put in a report. They didn't do it. And on the day of that session which was on the Thursday, they sent a letter to the International AIDS Society and also to all the media, protesting the Russian exclusion from participation in the conference. So very unhelpful to say the least and put us in a very challenging position. We tried to respond with the evidence. We laid out what actually had transpired, but as Steve said, I mean what is really distressing about this is first of all that their own public health programs have

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markedly deteriorated. The quality of the data and evidence is such at this point that I really don't think that anyone knows what is happening with new HIV infections in that enormous country honestly.

In addition to that, they are also aggressively promoting these policies and practices, blocking harm reduction, pressing hard on anti-homosexuality legislation in their region of influence. The best example of that, and I'll stop after this, is the occupation of Crimea as you may know. They announced the cessation of the methadone program - Ukraine has methadone substitution therapy - on the first day of their occupation of Crimea. That gives you a feel for where this sits in their priorities. You occupy somebody else's country, there's a long list of things you need to do, and most people would not put methadone on the day one list, but nevertheless. So we really do have an enormous challenge ahead.

JEN KATES, PHD: Thanks. Debbi, just to come back to you and then we'll open it up unless Steve wants to say another comment. Two other things that have come up, one is around this that I think we all felt around the global consensus about where we need to go. Whether it was the geographic focus, the goals, how we get there, how we use existing resources. I was just wondering how you, PEPFAR specifically, put itself into that dialogue and relates to that dialogue. Then, just a follow-up would be related to the African Summit just so we get

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that out because that just is wrapping up and I know it consumed all of your time until probably right before you arrived here so what's your readout on that for us.

DEBORAH L. BIRX, MD: Well, this particular meeting, the IAS was really helpful for me personally because it was the intersection of the new Gap Report really illustrating where we have done well and really recognizing that but also recognizing where we haven't done well and then immediately be able to go look at the posters and the plenaries and see whose got something that we can bring back to PEPFAR and try to implement in those areas. We looked through everything. Where do we still have gaps? TB/HIV—we have patients coming in and getting DOT therapy, being diagnosed with HIV, and not getting HIV treatment. We have a gap there and we have to figure that out. That one should be pretty simple because we already see the patients and we're paying for them to come to the DOTS Clinics so we need to really redouble that effort and really use, again, data for decision making and understand that situation.

The other big gap that was clear is pediatric treatment and so we really tried to respond to that immediately. We sat down with Pete McDermott. He shares my and everybody else's global concern of the children and the children not accessing treatment. Only about a third of the children who should be on treatment are on treatment. This is country by country even in countries that have been enormously accessible in getting

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adults on treatment - where you have adult rates on treatment of 80-, 90-percent and children of 30.

CIFF has joined forces with us and we have had the big announcement at the African Summit yesterday. I think it's really an exciting time, not only because what it stands for with PEPFAR but it recognizes that PEPFAR and the European community are working together on these issues. I think we haven't really had that kind of alliance with Europe during this time, and they feel very strongly about the Global Fund. We do too. We're the largest contributor but having that technical dialogue really helps us to have that broader dialogue so we're very excited about that and that's a gap I think we can all address.

I think the bubble diagram in the Gap Report over the continents was very important to make it very clear that the vulnerable population in sub-Saharan Africa is young women; 7,000 young women infected every week. If you add all the other bubbles of all the other vulnerable populations, they fit within the women's circle completely. That size of that group that is vulnerable and at risk.

If you walk around to the posters, a lot of people have ideas but none of them have been taken to scale. And young women like young men have their own agenda and their own endeavors and their own belief systems that we have to really discuss with young women. It takes us back to we have to

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understand what's driving young women's decision making. Do they have enough knowledge? Do they feel empowered? Are they making correct decisions for them and do they have all the information to make their own decisions and are we giving it to them and are we giving them the correct services in a friendly way where an adolescent feels like they can access a clinic and get advice without somebody going, why are you here? You mean you're having sex? We know that happens.

CHRIS BEYRER, MD, MPH: Yes.

DEBORAH L. BIRX, MD: It happened in our household so I think it's happening in others. They are all past that now. They're 27 and 31 but it was a vulnerable and difficult time.

CHRIS BEYRER, MD, MPH: Yes.

DEBORAH L. BIRX, MD: I think I recognize it as a mom. I think all of us struggle with this and we struggle to figure out the best way to resonate with young women and we have to figure that out. I think it was a great time to really look where we still need to do better and then see if that can connect with science that gives us a roadmap.

We're excited about those pieces coming together and we're excited about the opportunity to translate gaps immediately into response. But we want your ideas. We've put all of our data up on the website. You can go to it. Go to pepfar.gov. Go to data and results. You'll see all of our budgets, all of our results by country, all of our investment

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strategies by country, and send information back to us and say, well I'm there, I'm there. I've looked at this and this doesn't make sense. Nothing – you can't – don't try to hold back. We want to really hear where you think we could do a better job and we're committed to putting additional data as we receive it. We're going down to the site level and site level quality data so that you can really look at our performance and tell us how to do a better job because we're all in this together. It's a global pandemic. We're there together.

I just want to leave with one last thing because you didn't mention it and I'm sure it's on everybody's mind, Ebola. It's a very big contrast in how the United States has worked effectively in partnership with countries, because the last five or six Ebola outbreaks, you haven't even heard about. You haven't heard about them because scientists and clinicians in those countries had the immediate infrastructure, a laboratory infrastructure, the knowledge base. When those patients came in, they were immediately isolated, the laboratories immediately diagnosed them, so there was one case in Uganda or five cases in DRC, another one or two cases in Uganda. I think all of us should feel guilty in a way that Sierra Leone and Liberia and Guinea did not have the resources to really identify those cases in the laboratory. I think it speaks to the PEPFAR infrastructure and the laboratories that have been built have been really critical to the health system. And

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sometimes we ignore the laboratory and we shouldn't because it's absolutely critical.

I'm just going to - one more gap: long-acting PrEP-

CHRIS BEYRER, MD, MPH: Yeah.

DEBORAH L. BIRX, MD: -would be amazing because we have vulnerable young women who may not have the ability to take a pill everyday, regularly. I see a lot of birth control pills on my counters where there are still pills, and they're not all pushed out so it worries me. Yes, it worries me. PrEP is important and I think long-acting treatment options - so that people get monthly injections - long-acting PrEP could be a bridge for young women and vulnerable young women. And I think good-tasting pediatric formulations. I don't understand this frankly. We made Dimetapp taste good. We have gummy vitamins and we can't figure out how to make pediatric treatments taste good. A mother cannot hold their child down every day to give him a dose of medicine. It's horrifying. If your child is already sick and you're trying to do this, it's horrifying. We do have some still technical gaps that we need help for in a global way so if you're working in any of those areas, please work harder. Please work harder.

JEN KATES, PHD: I actually have one other thing that hasn't come up that was talked about at the conference which is the question of resources going forward and where they're going to come from. Part of it, there is a big emphasis on using the

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existing pool of funding that we have and using it wisely, which is incumbent upon everybody but also going forward, we know there are still these gaps and needs. We released a report showing that donor government commitments for HIV are actually going down so that was an issue but there are other sectors that can help. That is something we can get into if it comes up.

Steve, I'll just turn to you to see if you want to add anything else before we open it up.

STEPHEN MORRISON, PHD: Okay, just a couple of quick points. The Melbourne Declaration - Michael Kirby, the Australian jurist, came across just remarkably eloquent and powerful at multiple points from the beginning. Then there was a session on criminalization. That was a very dramatic session. The US Ambassador, John Berry, showed up at that and kicked that session off. In his presentation, it turned the view back upon the United States in terms of the body of law at the state, federal, or local level that impedes a sensible rational approach on reaching certain populations that need to be reached. It was a very, I thought, a very refreshing self-critical way, and it opened the discussion quite nicely. And Michael Kirby came in and joined it as well. That was quite amazing.

It was less clear to me what was supposed to be done. I mean, it was less clear to me after all of the

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pronouncements. I mean, the Melbourne Declaration was great, the criminalization session was great, the appeals that were made, Kirby's opening address on opening night, but it hasn't yet gelled into a fairly clear set of priority actions that are supposed to happen to address this surge of homophobia and a proliferation of bad laws that we confront. I'll put that out.

Another problem area that emerged was the fact that there were no serious high-level Asian leaders that showed up. The President of Fiji showed up, which was nice of him to do and that was great. There were ministers there, but there was not a surge of – there was not evidence of a broad-gauged, high-level political interest from the Asia-Pacific region, and I was disappointed to see that. The World Bank had a test run, a study of the financing across the Asia-Pacific, a paper that will be published that David Wilson is working on. It shows that in this case, the response is overwhelmingly dependent upon government commitments but is very flat and very deficient, so that's something.

On Myanmar, we did a session that Chris was very instrumental in helping us organize, a regional session which the deputy minister from Myanmar came and presented. This was a bit of a debut. I think that the government of Myanmar had overcome its sense of embarrassment or discomfort at talking publicly about its programs. It came forward in a very candid, comprehensive, honest and forthright way, and that was so

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refreshing to see, and the response was great. I mean you had dozens of Myanmar folks come and those from the region and you had the Indonesians and Thai experts join in that effort as well. I was really delighted to see that. Thank you.

JEN KATES, PHD: Okay. Let's open it up to questions or thoughts. We'll take three at a time. Just introduce yourself. There's mics I think on both sides. I will try to facilitate this by- anybody have anyone? This is not a shy group. Okay, you have somebody over there, over here and over here. Just say who you are.

SUZANNE LECLERC-MADLALA: Hello. I'm Suzanne Leclerc-Madlala from USAID. My question is for Dr. Morrison. You mentioned that there was like near consensus at the conference on the five or six things that need to be done to turn the tide of HIV. I'm wondering if you could just review those quickly.

JEN KATES, PHD: Okay, thanks. Next question.

MARY LYN FIELD-NGUER: Mary Lyn Field-Nguer from Creative Associates International. I had the same question for Stephen. I think consensus at an AIDS conference is a little frightening, and I wondered what you wanted to see more debate about. But I also wondered what is the explanatory dialogue going on about low treatment for pediatrics. I worked as a pediatric AIDS adviser to a child health project from 2005 to 2008 and I never thought it was the lack of reagents or formulations. Mothers in communities did not know anything

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about what could be done for their children, and the stigma around the discussion of parents being positive were much more the barriers. What will be the response of CIFF, what kind of interventions are being looked for is the question I have.

JEN KATES, PHD: Last question for this round.

EDWARD GREENE: My name is Edward Greene, and I'm the UN Secretary-General Special Envoy for HIV/AIDS in the Caribbean. I happened to be at the conference, and I share the sentiments of the head table, and in fact, I want to congratulate you for making the content, the context so vivid for the audience. I, however, want to add a more optimistic takeaway. For me, when I reflect on the conference, there was a takeaway which was a resolve to end HIV/AIDS in brackets by 2030, and I believe that this is a momentous opportunity for health and development. One reason is that I think it was embellished by the UNAIDS executive director, the 90:90:90. Now, I want to ask the panel are you as optimistic about that 90:90:90?

Secondly, an implication as we go forward, where it is we position AIDS in the post-2015 agenda, and one of the takeaways and one of the results I believe from the conference is ensuring that AIDS is positioned in the post-2015 agenda. I think we were all clear on that, but less clear was whether or not we embrace it within the conversion of health, and that's what I was not sure about and I think that we have to discuss

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that strategy as we move towards the UN General Assembly in September and beyond.

JEN KATES, PHD: Thank you. We had a couple – a few questions here. One on this consensus and what it was about specifically, another one around pediatric – lack of or low access and what's going on there, and this last one around – thank you very much – were we as optimistic and some of the really hard questions I think about post-2015 agenda, 90:90:90 – are we really going to get there. Do you want to start?

STEPHEN MORRISON, PHD: Sure. We've heard from Deborah in particular about the fundamentals of the consensus. I would say they are really about making a full use of an expanding and very promising set of prevention tools including treatment to prevent and PrEP, that there is a sense that in the last several years there's been dramatic improvement and expansion of tools and those become central in moving forward, a sense of the need to systemically re-tool approaches from the general to more targeted investments at local and sub-regional areas where the epidemic is most intense and that includes geographic as well as targeted populations. Dramatically, the need – the imperative to improve the use of empirical data to guide investments and track and prove impacts that will guide our future investments. The shared common view around girls, particularly rural girls in Southern Africa. Obviously key populations as high priorities.

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I would also put as the broad frame of this a shared optimism, a pragmatic approach, a forward-looking approach, a data-driven approach, and I was being only facetious really in saying I was – it bothered me there was not a more active debate. There will be more active debates but I found this broad consensus quite reassuring frankly.

The last thing on this is the whole question around criminalization, surge of homophobia, proliferation of bad laws. I mean that was a prominent portion of all argumentation across the board. I think those are the major elements.

JEN KATES, PHD: Okay. You want to pick up on that too.

DEBORAH L. BIRX, MD: I want to come back to the community piece because it not only relates to the children. It relates to all of the mothers and fathers in these difficult countries being further stigmatized, being afraid that they'll be – when the perception is that HIV/AIDS is only in the vulnerable populations, then it becomes finger pointing. We had it in the US. We have to make sure that our responses are comprehensive and comprehensive at the community level, so that the community understands that there is a compassion that needs to go with public health. I mean, we talked about a lot of technical details, but there has to be a sense that all of us are vulnerable and all of us need access to services and no one should be stigmatized.

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What has happened in Uganda, what has happened in Nigeria, what's happened at - isolated cases in Tanzania and Kenya, the DRC - very difficult and will only drive people away from services, because no one wants to feel like their life is in danger while you're seeking life-saving services, and people believe their lives are in danger. And they are, they are in danger, and so this has to be addressed. And so it's a matter of criminalization, but it's a matter of the community accepting that criminalization and actually even turning each other in, so we can't - and we need to work in that more comprehensive way.

I do believe that there are mothers, both mothers accessing Option B and B+, and mothers who are not bringing their children into the clinic for diagnosis for the very reason that mothers found it so difficult when we only had single-dose nevirapine, where we asked the mothers to come out of their communities and out of their villages and identify themselves as HIV positive to save their child when there was nothing for them. I think in a way we didn't have any other options then but imagine the break of trust with that mother when there was nothing for the mother. I think Option B and B+ are going to help us there where mothers feel like they're being cared for, where they feel like their children are being cared for, but we have to overcome that 10 or 15 percent that

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we know are throwing away their pills on their way home because they can't confront the stigma and the community.

I think involving the churches who are very important fabric of the community, involving the community leaders, involving the localities to make sure that no one is turned away from services and becomes more vulnerable to disease because of what we're doing ourselves. You're absolutely right. The community piece is essential and is - it remains a barrier for both mothers and babies.

JEN KATES, PHD: The last question on-

DEBORAH L. BIRX, MD: Optimism.

CHRIS BEYRER, MD, MPH: Optimism.

JEN KATES, PHD: -optimism and also a little bit about the post-2015 agenda, and just to start it off, I actually, as anyone has heard me speak, I am an optimist. I always approach it very optimistically, but I do think this in general that was a feeling at the conference so if we didn't convey that, I think we felt, I've - most of us felt it. I think what's changed from my perspective is just in the last four or five years, we can actually say now we know what to do and the fact that there is more of a - or is a consensus on those things.

A few years ago, we both didn't necessarily have all of the evidence and the tools. We did have a lot but not all of it that we have now and there wasn't all this consensus around doing those things. Those are two things that have come

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together at this moment that I hope would get carried forward in the next few years to really reach those goals, but anyone want to add on optimism or post 2015?

CHRIS BEYRER, MD, MPH: Let me just say that in my incoming address at the close of the conference, also tried to share in that optimism but also back away a little bit from putting ourselves in a position where our concerns are 2030 and saying really what do we want to do by Durban which is two years from now. If we just keep the pace that we're going at, we should add at least 4 million or so more people on to treatment between now and then. That would be actually where we are plus a little better. It seems to me that what we need to do with this every two-year global convening is to start to use it more as an accountability tool and really to use it more as a formal way to measure where we are and what we've achieved.

I feel just for myself that the new goals, the 90:90:90 is laudable. It makes sense. 2030 makes sense. It's a long way off. I think we're right now at a place where we have I think the community that cares about HIV. This consensus that you've heard about - about now we really know so much more about what to do. Probably the single biggest change in that is the recognition that treatment is prevention and that by getting folks on therapy, we really are impacting the dynamics, but there are notes of caution there for me. One is the key

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populations, the way with homophobia, these bad laws that actually go in precisely the opposite direction. And the second is a geographic one, which is Eastern Europe, Central Asia. Which we know the epidemic is expanding given what little data we have, and it's a very, very tough challenge.

I will say that one bright note of optimism there is that Olive Shisana who will be my co-chair for the Durban 2016 conference is South Africa's representative to the think-tank on the BRICS and is working very closely with the BRICS and that is, of course, Brazil, Russia, India, China and South Africa. Maybe there is some hope that that forum - which will not include us in the US - maybe is a place where the HIV issues and the global health issues and public health practices can really be brought to the fore in a different and new forum that maybe will be something of a way forward. I know that we've already discussed that in some detail, and Olive is very committed to it and so I think that's a stay tuned.

DEBORAH L. BIRX, MD: Just one quick comment. If you look in the Gap Report again, there's this great diagram that shows if we continue to do what we're doing today at the rate of which we're doing it today, the number of new infections creep up. What's missing in that is where you end up at 2030 is 80 million people infected and a treatment gap of \$31 billion - \$31 billion - every year. There is this imperative for us to take the tools that we have, all of us in the room,

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and accelerate that in all of our programs, because treading water gets us to twice as many people infected and by 2020, it gets us to another five or six or seven million people infected but an \$8 billion treatment gap.

These are not small numbers. These are not numbers that we could make up. They're not numbers that any country could make up, that PEPFAR could make up, that Global Fund could make up, but look at that diagram and actually count out the number of new infections there are per year and realize the cost of only doing what we're doing. We're doing a lot but we're not going to be on the right line unless we do more. I think that's the call of action to all of us that somehow we have to do more with what we have and we've done it before and maybe we'll get some additional funding but we can't wait for that. We have to figure out now how we can get more control now rather than just doing more of what we are currently doing at the rate that we're doing it.

I think that diagram to me is one of the most telling diagrams in the Gap Report. I think we should all look at it and study it and understand it and understand what those differences in lines really mean, how you have one case maybe 43 million total infected patients, and then now you have 80 and we can't afford another 80. We've already had 75. To then put on top of that over 200 million, 150 million people that

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have been infected with HIV. It's too many, one is too many, that is truly too many.

JEN KATES, PHD: Okay. Let's go to some more questions. Someone who's back there, you have somebody back there Katie or—okay and over here. Yes?

SISTER VERONICA SCHWEYEN: Thank you. My name is Sister Veronica Schweyen. I worked in Tanzania for many, many years, and I worked for 12 years HIV/AIDS program. And we were very grateful when PEPFAR began in the early 2000s. What is happening today, I've received two e-mails today, one from Kenya and one from Tanzania, and they are saying that because PEPFAR is being lessened, their funding in Kenya and the funding in Tanzania now will go down quite a bit I understand. They're saying who can we pressure, how can we start to get that funding back again to a level, because now the incidence, they're afraid the incidence will rise again. Thank you.

JEN KATES, PHD: Yes, over there.

JULIA HOTZ: Hi there.

JEN KATES, PHD: Hello.

JULIA HOTZ: I'm Julia Hotz from Inter Press Service and I apologize, I actually spoke with Ambassador Birx earlier this week about this, but I would just like to ask the question to the rest of the panel, which is about especially in terms of educating these populations about the need to seek treatment and diagnoses and what not. I'm wondering if and how you've

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utilized the expansion of social media and the internet and mobile technology to help raise awareness and about proper treatment and just even correcting some misinformation about HIV/AIDS? Thank you.

ANNA FORBES: Hi, my name is Anna Forbes. I'm an independent consultant working primarily on women and HIV prevention. I wanted to thank all of you for a very helpful discussion, but I particularly wanted to thank you, Dr. Beyrer, for editing the *Lancet* series on sex workers and HIV. I think it's a brilliant issue for any of you who haven't seen it. It seems to me as though the empirical data that we have in that issue, particularly in the study by Kate Shannon and her colleagues, is sort of equivalent – the empirical data is showing the connection between decriminalization of sex work and reduction in HIV is sort of equivalent to the data tipping point that we reached in 1996 with syringe exchange where it really became irrefutable that these two things were connected and that we couldn't achieve HIV reduction in the way we want to without syringe exchange in the one case and decriminalization of sex work in the other. What I'm wondering is what kind of political response can we expect to see based on these data and even more specifically how much we can expect the research community to step up and use its political clout to advocate for decriminalization? We certainly saw with syringe exchange that after the 1996 data came out, there was

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significantly increased pressure not only from the advocacy community but also from the research community for syringe exchange to reduce HIV.

Now, we have Canada on the verge of possibly changing and decriminalizing its HIV - sex workers laws or possibly not. We have the South African National AIDS Council pushing its government to decriminalize sex work. I'm sure the discussion is coming out even more strongly in other countries. How much do you think we can expect the scientific community to step up and make an issue out of what we now know is true?

JEN KATES, PHD: Thank you. Great questions. One was around funding concerns, focus on Kenya and Tanzania but I think it's a larger question. The second was on social media and mobile technologies. The last on this I think a very important question is what's the role of science now in the political sphere on the issue of sex work and the relationship with incidence and criminalization? Who wants to - would you like to start?

DEBORAH L. BIRX, MD: Yes. I can talk briefly about the budgets. I think we had Tanzania come back for a week of discussions with us last week. A very important discussion because - we're not cutting the budget in Tanzania. The budget hasn't been cut, and the budget isn't being cut in Kenya. Their total funding envelope is the same. It's the mix of how old and new money and creating that total funding envelope, but

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that I think what your question is do you have enough resources. What we're doing right now is trying to look at how to get to 90:90:90 in high-prevalence areas, and that will mean that there will be areas that don't have HIV and don't have HIV cases but we had service provision there that we may not be able to support any longer, so that we can move that human capacity and the funding to where HIV-positive patients are, where they can be found and to the communities that surround those patients. We're looking very carefully at the geographic analysis and using data down to the site level of every single site showing how many positives they have for every six months based on the number tested. We're going down to a very granular level so that we can make public health decisions based in the funding level that we have.

I think once we do all of that and see what can be done, I think your question begs that bigger question of do the countries have enough resources between PEPFAR, the host country and the Global Fund to meet the demands of controlling the pandemic? I think that's the very question that's on the table, and that's why we are really – when he says there is consensus, there is enormous working relationship between Ambassador Dybul, Michel Sidibé and Gottfried and myself because we've known each other basically since we were babies. We've grown up together. We've done nothing but this. We've only done HIV/AIDS. We're passionate about turning the tide of

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this pandemic. I think there is consensus of how we utilize every dollar we have collectively to have the biggest impact, so I'm reassured by that.

I have one social media thing that I'll do quickly. I heard, saw this incredible work coming out of, I think, Cambodia, I'm not sure, on different internet communication strategies that resonate with not only different age groups, different sexual practice, so that everybody can click on a site and find a voice that resonates with them and gives them the knowledge that they need. I think it was just incredible. They had 40 or 50 different individuals talking, and you could click through them and decide what voice resonates with you based on some profile that was done anonymously. And I just found that so incredibly powerful. If we could figure out how to do that and get broadband throughout sub-Saharan Africa, it would be terrific. I'm sure you saw more of them.

JEN KATES, PHD: Yes.

CHRIS BEYRER, MD, MPH: Well just quickly. It's interesting. I was on a conference call with our Tanzanian colleagues today, and of course, they dropped and all the connectivity problems and you know. It just remains a reality that we all have to deal with.

I think there's actually a lot going on in terms of innovations in technology and not only in mobile technology and internet-based technology but also in some other domains like

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self-testing, home testing, getting testing out of clinics, getting it to people, so there's lots of effort around that. Point of care, CD4 and other point of care diagnostics where again now, the technology is moving to a place where there are much more local kinds of facilities that can actually do staging, and you don't have these big problems with people waiting forever to get a CD4 and then being told to go somewhere else with their CD4 results - all of those challenges. That area, which broadly is in the implementation science arena, is as I said now the largest area of scientific endeavors, really very striking, at least for what we see coming to the conferences.

I think part of what we're learning is one size doesn't fit all with these innovations. It turns out that, for example, then there were several studies on this looking at interactive supports for treatment and for PrEP adherence and use. They are very age dependent differences, even among one population like men who have sex with men. Men under 25 really like interactive SMS messages and want to be notified all the time. Older men - no thank you, leave me alone. It is very age specific, and we're going to have to get that right.

I would just say as something of a plea that I think one sector that hasn't engaged very much in HIV has been the social media sector - Facebook, Google or all of that Silicon

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Valley, and we need them and we would love them to be way more engaged than they are. There was another question.

JEN KATES, PHD: On the special issue—

CHRIS BEYRER, MD, MPH: Yes, on the sex work question. Thank you for that. When you do one of these comprehensive reviews and really try and look at the field, you have an army of graduate students harvesting publications. One of the things that really is striking is that basically for the last 10 years of innovation in HIV prevention and in other domains of HIV, sex workers have not been a part of the research agenda. None of the trials, prevention trials in men, women or transgender people have enough strata of sex workers in them to be able to do independent analysis. The way that sex work is assessed in the research agenda is inconsistent and unhelpful. There's a lot of confusion around what is transactional sex, what is survival sex, what is sex work. Sex workers themselves have been reluctant, many of the organizations, to engage because of feelings of mistrust, of concerns around coercion and the whole issue of the legal and policy environment that has been seen quite rightly as hostile to their interest and needs.

One of the things that really came out of this series was, and we hope that this will really resonate with the research community, is that we need to be doing prevention research studies with this community very much in a new way of

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engaging our communities that includes them really in meaningful assessments, because right now, we don't, for example, have an answer about PrEP for people who sell sex. We haven't assessed vaginal microbicides in women who sell sex in any meaningful way, and that in 2014 is a real gap. So absolutely we sincerely hope that that happens.

I have to say that in terms of the issue around decriminalization, obviously, that is going to be a government by government, country by country element. Certainly, the communities and the people who work with them, the community-based sectors, CBOs, NGOs, really have embraced these data, and they're taking it and running with it. And as a researcher, that is what you always hope, that people will find what you do useful and go with it. I think you'll see hopefully a lot more evidence-based activism now that the evidence basis is a little better.

JEN KATES, PHD: I think we'll take two more quick questions because then I want the panelists to talk of – to look forward on Durban a little bit and what that means and we'll just have to wrap it up. Now, I see a lot of hands, of course, so we have one over here and one in the back.

CHRIS BEYRER, MD, MPH: Michael–

JEN KATES, PHD: Wait.

CHRIS BEYRER, MD, MPH: All set?

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JEN KATES, PHD: Yes and then, yes and a third over here. Chris and I are conversing. We'll take your question too but make it quick please. Yes?

ANDREW FORSYTH: Great. I'm Andrew Forsyth. I'm from OHAIDP, the office here at HHS that's charged with implementing the National HIV/AIDS Strategy. One of the things we've learned is that by – to make the most of existing dollars means that we need to reallocate to have – to really maximize those dollars. It means that we won't be able to do everything, and part of our decision making depends on the cost effectiveness of new interventions, the efficacy of them. Can you say a word or two about how that process is informing what you think is going to take place through PEPFAR and other international donors? I mean, what will not continue to be or be able to be supported in order to have those greater impacts in terms of PrEP or home testing or whatever those new innovations are?

JEN KATES, PHD: Yes, second?

ANGELI: Hi, I'm Angeli, and I'm from IntraHealth International. You mentioned that a central consideration in the future global HIV/AIDS agenda include ensuring treatment, follow diagnosis, advancing technology like early initiation therapy and long-acting PrEP, et cetera. However, we know that having a well-staffed, well-trained local health workforce is also essential to delivering these services. With the current enormous shortage of global health workers, even if new

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treatment and prevention options were developed, many countries would lack the capacity to administer these services so I wonder where health workforce strengthening fits specifically within this global HIV strategy going in the future.

JEN KATES, PHD: Our last question.

MICHAEL IGHODARO: My name is Michael Ighodaro. I am a fellow at the International Gay and Lesbian Human Rights Commission. My first question is concerning youths. During the AIDS Conference, we had the Youth Action – the Melbourne Youth Force released a Youth Action Plan and looking at how PEPFAR and on Global Fund is looking to engage the youth more in regard to the action that was released. Secondly, regarding the AIDS Conference, we added on several panels on discrimination and on criminalization in Africa. One of the key population that is attributed right now is adolescent MSM and adolescent transgenders, their issue have not been discussed and new research that is costing them and looking how are we engaged into that and having programs targeting this population.

JEN KATES, PHD: Thank you. Okay. Anyone want to address those and then we're going to have you all have the last word. Steve, you want to–no? Okay, Chris.

STEPHEN MORRISON, PHD: No. I think those are for Deb and Chris.

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CHRIS BEYRER, MD, MPH: Thank you, Michael, for that question. I'll just say that happily, we now have an Adolescent Trials Network that is also expanding its footprint and trying to do meaningful research and is going to look at adolescent key populations.

The other I think really encouraging thing is again relates to the WHO Guidelines. The WHO guidelines for the first time addressed adolescent key populations, really included them in all of the recommendations. In some countries, WHO guidelines don't necessarily mean so much, but for many, they play a normative role that really allows then for all kinds of activities to occur and for people who want to do more of this critical work with adolescents including LGBT adolescents and adolescents who are selling sex and who are using drugs. They are empowered by having those guidelines and being able to say this is WHO standard of care now. We have to do this.

DEBORAH L. BIRX, MD: Yes. Let me just quickly address the National Strategy and the great work you've done realigning and also congratulate USAID on their realignment of programs to really have a bigger impact on maternal and child mortality, really extraordinary work. We're learning from those groups, and that's why we have these 12 countries we have coming back emergently before we release the '14 money to really work with the countries to see - we know we can't do everything

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everywhere but what can we do in certain places? What are the right things in the right place at the right time? And getting that right will be absolutely key to either going on this line or this line, and we feel such a strong moral imperative to do the hard work that you did and do the hard work that USAID did.

We're running as fast as we can because I also discussed those gaps. It's not only a matter of doing what we have been doing, but it's also finding out how to do that cheaper so that we can address young women, so we can deal with issues of stigma and discrimination, the training at the community level. There's all of those pieces that we feel like we have to respond to at the same time that we're trying to focus the programs both geographically and in these core areas to control the pandemic.

It's an exciting time. It linked to that and we've started the entire program of high-level HRH and health system strategies. We've gone to every one of the agencies where we know there is incredible talent, and we've said give us your talent. Every agency has come forward with 5 to 10 additional people to send to OGAC to work on these core strategies. We've gotten Janis Timberlake and a team coming over from USAID, really helping us looking at the HRH strategy, what has really worked. Task shifting we know has worked extraordinarily well. The nurse prescribers in Botswana are among the best physicians

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I've ever seen. And then we need to bring them to the children's world too and to other worlds.

I think we are looking at each of these aspects. We know they're all interconnected, but the human rights piece is such an important piece to us also and we're trying to weave that through this whole healthcare worker piece because that's where patients come and that's often where they first get stigma and discriminated against. We have to ensure that our training also cover those areas and make sure we've funded that adequately.

JEN KATES, PHD: Great. We only have a few more minutes and I would love to hear from each of you your just concluding thoughts and forward looking thoughts on Durban, which is where the next big conference will take place for the every two-year conference going back to Durban after being there in 2000 which for those of us who were there or who followed it was quite a turning point. What are your hopes for getting us there? Chris, I'm going to end with you since you're really the person who's going to take us forward and you can use this opportunity to solicit input. Steve, I'll start with you and get your thoughts and then move to Deb and then Chris.

STEPHEN MORRISON, PHD: I think coming back to Durban, coming back to the epicenter of the global pandemic, coming back in partnership with Olive Shisana and Salim Karim and

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others in South Africa is - that's just an exciting and bouyant opportunity for us, and the memory of 2000 will be very much there. I'd say a couple of things could be done that have been a problem, to address recurrent problems. One is to work really assiduously to recover high-level African leadership into this. That if you go into Durban and you don't have them, it's going to be yet another sort of sense that the leadership has walked. Addressing that problem frontally is a top priority.

Second is to figure out in practical real political terms how to address the homophobia and the surge of bad laws and who needs to be there that was not there this time, who needs to be there that is credible and can be empowered and can come out of the woods and talk about these problems and not feel threatened and be able to put forward a concrete agenda. I think if you do those two things, you will have advanced the agenda very dramatically.

South Africa's transition, of course, many of those people that need to be brought on treatment that both Chris and Deb referred to are going to be South Africans. The US will also be in the midst of its own transition towards lowering its support and handing that off to the South Africans, according to current plans, so trying to highlight some of that. And the fact that you're coming into a zone where our own programmatic achievements and engagements and our partnerships and

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everything are so rich and so deep, it gives us all sorts of opportunities to be much more creative I think in the way the conference is used to build congressional support, to get other people excited. It's a very promising set of opportunities that we face. Thank you.

JEN KATES, PHD: Deb?

DEBORAH L. BIRX, MD: I love the way you talked about the road to Durban as a way to really mark our progress. I think if we reflect back to 2000 and that very difficult time between then and about 2007 in South Africa where there was difficulty with even awareness of HIV/AIDS as the agent causing AIDS, I think putting road marks down about each of these things, about stigma and discrimination and in a legal framework, South Africa has some of the most progressive and most important laws, and working with our South African colleagues to say let's in this next 24 months work with other countries on the African continent to move towards your vision of how - and really accelerate South Africa's leadership in this area and celebrate their leadership and investment in HIV/AIDS. They've stood up like Botswana and are investing the billions of dollars that it's going to take to control the pandemic in their country, and they've identified the young women issues. I think getting them to have that discussion now so that that leadership exists on the roll up to Durban I think will make it such a much more vibrant conference where it is

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almost a report card and did we deal with the issues we identified in Melbourne and did as a continent we move together. I think it will be so exciting so you have a lot cut out for you.

JEN KATES, PHD: Chris?

CHRIS BEYRER, MD, MPH: Alright, well thanks to you both for those – yes, very helpful and believe me, you're both, all three of you are going to be part of this effort so please, please, your engagement really matters in a big way. I'll say a couple of things. One is, of course, we have not had or won't have had an International AIDS Conference in Africa in 16 years so it's been a very long time. Of course, South Africa's story and trajectory from 2000 until now is just a sea change, an extraordinary transformation, and that obviously will be a huge part of the story.

We always try and have the conferences in places where we hope it will make a difference. People don't know this but Steve does that when the President lifted the HIV travel ban and we could in fact come back to the United States, many of you were there in DC in 2012, we've made the decision to come back to the US and then we had to choose cities and we ended up choosing Washington because it was the highest prevalence city in the country sadly. KwaZulu-Natal is truly ground zero for women and girls in HIV, the highest rates in young women and girls in the world. We will truly be in that epicenter of that

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component of the epidemic, and as you've heard, that is obviously a critical part of all of what we need to do in prevention and treatment, in human rights and stigma and community and all of it. I think for reasons, it really is the right place.

Olive Shisana who's the Head of the Human Sciences Research Council and has been one of the architects of South Africa's National Health System is really a leader in how you integrate HIV into a health system. That's one of the reasons why we asked her to do this. She will be the first woman in history, first woman from Africa to chair an International AIDS Conference. We're very excited about that, and when I brought this up with her and said that to her and said, so, of course, you're going to focus on women and girls. She said, well I think it's really important that we focus on human rights and key populations and men who have sex with men in Africa. I said, alright, Olive, you're on. We're going to do both of those things and all the others that need to be addressed as well.

Finally, I would say that the IAS is a member organization. I hope all of you are members. If you're not, please join us. You actually do have quite a lot of input. It's an elected representation. Your new regional representative for North America on our executive committee is Professor Ken Mayer at Harvard and Fenway Community Health

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Center, a real leader in the field, and so please go on to the IAS website. Join if you're not a member. Get involved. We think that Durban is probably we hope going to be the same kind of landmark that it was in 2000 but in a very different way. There, we were trying to prove a point, a rather simple one, that HIV is the cause of AIDS. This time, we're really going to be at we hope a real turning point where we can start to say, alright, we have the measures, we have the deliverables, how are we actually doing on this progress? That will be the key.

STEPHEN MORRISON, PHD: The date is on?

CHRIS BEYRER, MD, MPH: Yes, July, the third week of July. It's always during that time. I think it comes out to 22 to 27, 2016.

JEN KATES, PHD: Thanks, Chris, and we're here to help you for sure.

CHRIS BEYRER, MD, MPH: Wonderful.

JEN KATES, PHD: Thanks to all of you. Please join me in thanking our panelists for a really good conversation, and thank you everybody for joining us.

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