

**25 Years of AIDS: Current and Former CDC HIV/AIDS Leaders
to Discuss State of U.S. Epidemic
Centers for Disease Control and Prevention
May 5, 2006**

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KEVIN FENTON, MD, PhD: Great, thank you. Good afternoon everyone and thanks for dialing in. I am Dr. Kevin Fenton, director of CDC's National Center for HIV, viral hepatitis, STD, and TB Prevention. I want to thank all of you for joining us today to talk about the state of the HIV/AIDS epidemic nearly 25 years after CDC published the report of the first cases of a nameless, deadly disease that had affected a handful of gay men in New York and Los Angeles. I hadn't had the opportunity to work with many of you as of yet, so please indulge me while I tell you a little bit about myself. I was raised and educated in Jamaica where I went on to become a medical officer with a local health department, and in that position I experienced first hand the devastation of HIV and AIDS in a resource-strapped country, and it was the reality of the scarcity that many HIV and AIDS programs overseas faced on a daily basis, especially in developing nations. But I have also had the experience of directing HIV and STD prevention efforts for a wealthier government when I accepted a position and worked with the British Government's National Health Service. Although HIV prevention programs are typically better funded in industrialized nations, as long as individuals in these countries including the United States continue to become

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infected, we must do more, but at home and abroad we must continually step back and evaluate what is working and what is not. We must advocate for prevention resources to keep pace with the epidemic. We must be bold in our actions and fight complacency as it returns, for scarcity abroad and complacency at home are both enemies of progress as we mark this milestone of 25 years battling the epidemic. I am honored to be joined today by one of CDC's and our nation's heroes in the AIDS fight, Dr. Jim Curran, dean of the Rollins School of Public Health of Emory University here in Atlanta. As I am sure most of you know, Dr. Curran lead CDC's HIV prevention programs for over a decade. He was CDC's chief scientist in the efforts to investigate the first known case of AIDS cases in the early 1980s and he is one of the most articulate and passionate public health leaders we have today. In fact, when the final chapters are written about how we as a global community finally put an end to this epidemic, I am sure that Dr. Curran will be seen as a central force, from the earliest efforts to define HIV and AIDS to the tremendous successes we have had in the United States in preventing mother-to-child transmission to the critical work of Emory's Center for AIDS Research, which is doing in a search for a vaccine. Dr. Curran has been and continues to be front and center. I am pleased to have him with us today

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to talk about his experiences and his unique perspectives about the epidemic.

Now I know most of you will be writing stories marking 25 years of AIDS shortly. Our purpose today is to briefly comment on the state of the epidemic, then and now, and to give you a chance to ask questions to inform your reporting about this anniversary. I know that a number of other agencies, UNAIDS for one, will be providing background, context, and statistics about the global epidemic. For that reason, we are focusing today's discussion on the domestic epidemic. Since CDC has the largest megaphone available to many organizations and agencies that work to prevent HIV/AIDS in the United States, we feel a responsibility to focus your attention in that direction today.

As you all know, that nameless syndrome discovered 25 years ago has become one of the deadliest epidemics in human history, killing more than 25 million people in the world, including more than 500,000 Americans. In the last decade, major advances in treatment for HIV/AIDS have prolonged and improved the lives of many, but as they will be the first to say, living with HIV infection is not easy. The drugs often cause serious side-effects and sometimes don't work, especially over the long-term. In 2004, 16,000 Americans died of AIDS. The inescapable truth, therefore, is that to

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defeat AIDS, both here and abroad, we need to reduce the number of people who become infected in the first place. Twenty-five years into the epidemic, prevention is still the only cure we have for HIV/AIDS. Now I will always be impressed and inspired by the work begun by Dr. Curran and colleagues and carried out by the committed public health professionals at CDC, and by thousands of individuals, communities, and organizations across the country over the last 2.5 decades. CDC staff played an important role in identifying the roots of transmission, quickly informing and educating the public about transmission and protection, providing guidance on HIV counseling and testing, protecting health care workers, creating an impressive partnership with national organizations, health departments, and community organizations that implement evidence based prevention programs. The list could go on and on. These efforts have yielded some very important results. First, the number of annual infections has declined sharply from an estimated 150,000 new infections, new diagnoses at the height of the epidemic in the 1980s to about 40,000 infections in recent years. Annual HIV infection rates among injecting drug users declined during the 1990s from 10 to 14-percent to less than 2-percent. Perhaps the greatest success story to date is the dramatic decline in mother-to-child transmission of HIV in

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the United States. Today, only about 300 children are born each year infected with HIV, down from a high of 2,000 per year in the early and mid 1990s. The HIV burden also appears to be decreasing in some of the hardest hit groups, including African Americans according to our most recent data on HIV diagnoses in the United States. Finally, our surveillance methods have improved, helping us to better target prevention efforts. Forty-three states now have confidential name based reporting of HIV diagnoses and CDC has put into place a new nationwide system to more accurately estimate new HIV infections. The first results of this system will be reported later this year.

Now you all have CDC fact sheets on the burden of HIV and AIDS in the United States, so I won't discuss the data in any detail, though I will highlight a few points. First, more than 1 billion Americans are currently living with HIV/AIDS and nearly a quarter of these are still unaware of their HIV status. HIV/AIDS has hit African American men and women the hardest. They account for half of all new HIV diagnoses in this country and more than a third of AIDS deaths to date. African American men who sleep with men, or MSM, are especially hard hit. Recently data showed significant declines in HIV diagnoses in nearly every group of African Americans, except black MSM. Indeed, one recent

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study in five cities found that almost half of black MSM were infected with HIV. Now overall MSM represent nearly half of all HIV diagnoses. They were hardest hit early on, and remain a particularly vulnerable group today. Women represent a great proportion of those affected by HIV, accounting for 29-percent of all HIV diagnoses in 2004.

So, what about the future challenges and priorities? Well for me and for everyone at CDC wanting to stop HIV/AIDS, the fight is more than professional. It is also personal, so looking ahead all of us at CDC are committed to a strong prevention response. Experience has shown us that there is no single magic bullet but there are several key strategies that CDC is pursuing in partnership with communities across the country that can and will help us to reduce the suffering from this entirely preventable disease. First, we must greatly increase access to voluntary HIV testing. CDC estimates that most new HIV infections in the United States are transmitted by the 25-percent of people with HIV who do not even realize that they are infected. We need to expand access to HIV testing dramatically by making it a routine part of medical care and by ensuring easy access to new rapid HIV tests. Second, we must focus prevention on both HIV positive and HIV negative people. More than 1 million Americans are living with HIV and AIDS, and while it is

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critical to help keep that risk, avoid contracting the virus in the first place, equally important is helping those who are HIV positive to avoid transmitting it to others. Third, it is critical that we reduce the racial and ethnic disparities by working with local communities to develop and implement culturally appropriate and effective methods at the local level. Fourth, we must continue to address the role of substance misuse and abuse from intravenous strokes, to alcohol, to methamphetamine, substance abuse is a key reason that people who know how to protect themselves and others from HIV still take serious risks. Preventing substance abuse and increasing access to treatment is critical in helping people make the right decisions. In 2006, we are committing 650 million dollars to pursue these and other effective HIV prevention strategies that reach the people most at risk, and thus speak their language. HIV infection remains a serious and potentially fatally condition. We have learned over the past 25 years that HIV prevention is not easy. It requires a lifelong commitment from everyone, from those infected, from those at risk, and from society as a whole.

Finally, I would like to summarize two important and related CDC events that will be of interest to you. The first is the 2006 national STD prevention conference which

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will be held in Jacksonville, Florida, next Monday through Thursday, May 8-11th. We will be holding telephone press briefings at 12:30 p.m. EST Monday and Tuesday, and at 12 noon on Wednesday to release new data on syphilis, chlamydia, and trends in oral and anal intercourse among young people, and little known but potentially serious STD such as bacterial vaginosis, trichomoniasis, and lymphogranuloma venereum. You can get further details on these events from CDC's press office. The second key event is to let you know that our MMWR publication will be releasing a special issue commemorating the 25th anniversary of HIV/AIDS on June 2nd. That issue will publish reports on HIV epidemiologic trends between 1981 and 2004, HIV prevention accomplishments over the past 25 years, and current challenges, and the successes and challenges in preventing mother-to-child transmission of HIV. I will conclude my remarks by saying that on this 25th commemoration, the best way we can honor the 500,000 Americans as well as the many millions across the globe who have died of AIDS is to stop the spread of this deadly disease. Now I would like to turn it over to Dr. Jim Curran.

JAMES CURRAN, MD, MPH: Kevin, thank you very much, and welcome to everybody. I see from the press list that I have many old friends and colleagues and many veterans of AIDS reporting, some even going back all the way to 25 years,

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so I would like first of all to thank all of you in the press, to welcome those relative newcomers to reporting on AIDS, and to thank especially the veterans who have been reporting for many years on this problem. Your extensive reporting and information during the 1980s and early 1990s really brought the AIDS epidemic to the forefront and really helped reduce those transmission numbers a great deal due to the public information campaign. For those of you old timers, we are the last generation to really know what a life in a world without AIDS is like, and we are the transition generation to the newcomers, to those who live in a world with AIDS.

It is sometimes difficult to reflect on 25 years about going back to five cases of Pneumocystis in gay men in June of 1981 to understand how something which began so slowly and so quietly and so silently could now be the number four cause of death in the entire world. Something that is continuing to grow with 2 million more people becoming infected than are dying each year, and something which seems to know no bounds in its insidious stretch around the world as a cause of death and causing 40 million human incubators carrying other infectious diseases, something that we thought was a small problem back then, and I am always back to thinking that even in the early 1980s we were always greatly

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concerned that we would underestimate the burden and impact of AIDS on the population in the United States and throughout the world, and I think we still have to consider that we may be underestimating the burden and impact of this insidious global epidemic, and that perhaps silence does still equal death on the worldwide scene, and that denial and complacency are still the greatest enemies to progress. Twenty-five years seems like a long time in one sense, but I can say that the time has gone by in a heartbeat, and I am amazed by the scientific progress and the progress of many of the people who work to prevent the disease, but I am even more amazed by the insidious inexorable progress of the virus around the world.

From 1981 to present, the CDC has played a very important role and continues to play a very crucial role in HIV prevention throughout the world. Initially it was the discovery of the epidemic and the excellent case definition and surveillance, which define the epidemiologic patterns, and lead to prevention recommendations well before the virus was even discovered, so that the blood supply could be protected, that health and laboratory workers and people like gay men could be protected from further spread of the disease before it could be protected. That surveillance was perhaps the most important thing early in the epidemic and good

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surveillance continues to be very important in the United States and throughout the world in designing and targeting prevention efforts to those at greatest risk and evaluating the extent to which those efforts are effective.

In terms of lessons learned in the last 25 years, the first lesson I have already mentioned and that is the importance about standing surveillance systems, both in the United States and abroad, measuring both HIV infection rates as well as behaviors at greatest risk and those populations at greatest risk. Second of all, I am impressed that innovative science has overcome skeptics, both in the early discovery of the virus itself, the fact that antiretrovirals would have any affect whatsoever on the disease, people were very skeptical that the #076 trial, giving antiretrovirals to pregnant women, would be effective, and yet it is has led to this dramatic decline in the number of babies born in the United States with HIV, and finally HAART itself, which has revolutionized a treatment for HIV with something that people were very skeptical would ever work. So with that in mind, I think we shouldn't be skeptical about curative therapy. We shouldn't be skeptical about an effective vaccine, and we shouldn't continue to be skeptical about prevention efforts. The third lesson is that HIV prevention works. It works if its hands are not tied by local, national, or international

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political considerations and if the things that we know and think work that are peer based, population based efforts can be undertaken and the they can be resourced at the appropriate levels. Prevention is difficult, though, because of stigma and denial and because of the poverty that many people that are most affected by HIV are mired in. Stigma remains, I think, the greatest barrier to prevention and it is a reason that many people refuse to be tested or are not tested for HIV. That, as well as poverty, so I think the thing that I would hope is that you guys in the press take a new look at HIV and become activists again. Push all of us hard. Become investigative reporters, and act like the AIDS epidemic is in danger of threatening the world as I see it. Thank you very much for what you are doing, and thank you for your continued interest.

KEVIN FENTON, MD, PhD: Thank you very much, Dr. Curran. Now before we take questions, I would like to introduce you to some CDC colleagues who are here with me today in order to make sure that we provide you with the kinds of information you need for your stories. We have Dr. Tim Mastro, who is the acting director of the division of HIV and AIDS prevention; Dr. Rich Wilepski, chief of our prevention research branch, Dr. Matt McKenna, chief of our HIV incidence and case surveillance branch, and Dr. Greg

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Millet, also in our prevention research branch. Now let's proceed with your questions.

MALE SPEAKER: Thank you. Ladies and gentlemen, before we go to questions, this conference will be available for replay after 4:30 EST today through June 12th. You may access the AT&T teleconference replay system at any time by dialing 1-800-475-6701, and entering the access code #828348. International participants dial 320-365-3844 with the access code #828348, and if you wish to ask a question, please press star then 1 on your touchtone phone. You will hear a tone indicating you have been placed in cue, and you may remove yourself from cue at anytime by pressing the pound key. If you are using a speaker phone, please pick up the handset before pressing the numbers. Once again, if you have a question, please press star 1 at this time. One moment please for the first question.

Your first question comes from the line of Christine Gorman from *Time* magazine. Please go ahead.

CHRISTINE GORMAN: Yes thank you. My question is, there have been a couple of reports recently talking about the possibility that AIDS is peaking, the epidemic is peaking, can you help us understand what that means in terms of where the epidemic might be going, what efforts are

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working, is it just the natural history of the epidemic, do we still need to push and why?

KEVIN FENTON, MD, PhD: I am going to have Dr. Mastro to respond to that.

DR. TIM MASTRO: Thank you. I think you may be referring to a publication in *Lancet* about two weeks ago, which had a report from Southern India about rates there declining and an accompanying editorial that talked about perhaps globally the number of new infections per year had reached its peak within the last couple of years, I think today we are going to talk mainly about the U.S. domestic situation, and we are very concerned that there is a continued large number of new infections per year in the United States, estimated around 40,000. Probably the number of new infections in the U.S. peaked quite some number of years ago, perhaps back in the 1980s, and it was really the result of the prevention efforts in the United States that resulted in a dramatic decline in the very high incidence rates we experienced in the '80s and we now however have reached a situation where we have a frustratingly difficult ongoing epidemic of ongoing transmission in the U.S.

CHRISTINE GORMAN: So even though in the U.S. cases peaked, I guess to the untutored person they would say well if the epidemic peaked back in the '80s why do we still have

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to do anything? Won't it just have to burn itself out and how do you respond to that?

DR. TIM MASTRO: Well, from an epidemiologic point of view, we have an ongoing long-term epidemic. This is not like a point source where there is a burst of infections and then it peters out over time, so we are in this for the long-haul. We are now 25 years into it, and despite our efforts on HIV prevention to date, while we have made great success in some areas, the epidemic continues to change and there are, we think, an ongoing 40,000 infections in the United States, so we have to continue, and we would actually like to do much better than this and actually bring the number of new infections down considerably.

MALE SPEAKER: And your next question comes from the line of Mike Stilby from *Associated Press*. Please go ahead.

MIKE STILBY: Hi, thank you for taking the question. Dr. Fenton, I think it was you who mentioned that we need to keep moving forward and one of the things we need to do is increase voluntary testing in different settings, what is the CDC and the government doing on that front? What are the next steps to increase testing in the general population?

KEVIN FENTON, MD, PhD: Well, as you say, increasing testing is definitely a key issue for U.S. government and for CDC. It is vitally important that individuals are aware of

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their HIV status, and if they are HIV positive, able to be linked to effective treatment and prevention care services. CDC has a number of initiatives currently in progress to promote HIV testing among the U.S. population. Perhaps one of the most exciting developments upcoming is the revision of our HIV testing guidelines for adults, adolescents, and pregnant women in clinical care settings where we are really moving to modernizing HIV testing in these settings to make HIV testing far more routine than is currently done in clinical settings. What we are also looking at doing is simplifying the process for HIV testing by removing the onerous requirements for pre-test counseling in clinical settings, so that we effectively remove some of the barriers to HIV testing in these sites.

MIKE STILBY: I'm sorry, what is the proposal to remove pre-test counseling? Is that legislation or is that some guidance you are sending to, how would that work?

KEVIN FENTON, MD, PhD: It is guidance and what we are proposing to do is to simplify and remove in some circumstances the requirements for extensive pre-test counseling in clinical care settings, bearing in mind that for HIV testing to be occurring outside of clinical care settings, it will still be a requirement for pre-test counseling to be done for individuals in those settings.

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What we are essentially trying to do today is effectively address the barriers for HIV testing in clinical care sites. In our discussions with many of our clinical colleagues, we know that a significant barrier is the current time it takes for HIV pre-test counseling, and this is a barrier for colleagues in clinical settings to actually raise the HIV testing and to deliver HIV tests.

MALE SPEAKER: And your next question comes from the line of Jeremy Manier from *Chicago Tribune*. Please go ahead.

JEREMY MANIER: Thanks very much. I think that Dr. Curran and others alluded to the mother/child transmission issue having come down so dramatically, I wonder if you could just comment a little bit more on that as far as the importance of having come down to is what the low number or what is the significance of that number today? What are those kids, who were born with it and are still around, having to deal with now, having dealt with HIV all their lives up to 20+ years in some cases and if you have time, what does this mean for the global picture?

KEVIN FENTON, MD, PhD: Okay, I am going to ask Dr. Mastro to respond to that.

DR. TIM MASTRO: Thank you for that question. As Dr. Fenton pointed out, we think the prevention of mother-to-child transmission has really been one of the great success

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stories in the last 25 years and Dr. Curran alluded to this, that when the original study was done, it was done at the #076 study, to give antiretroviral agent AZT to pregnant women in the hopes of preventing transmission. There was initially skepticism that it would work. Indeed it was a great success and that trial showed a two-thirds reduction in the probability of an HIV infected woman passing the virus to her infant. Since then, we have improved on that and we now with multidrug therapy have reduced the probability of an infected woman transmitting the virus to her infant down to less than 2-percent, so in the United States the foundation on this program really is comprehensive HIV testing of pregnant women. CDC issued recommendations in the mid-'90s, recommending that all pregnant women be tested for HIV, and this has allowed women to learn their status early in their pregnancy, take advantage of prevention modalities such as antiretrovirals and the infant is also given antiretrovirals at the time of birth and this has resulted in this dramatic decrease in transmission. This of course does result in some cases of perinatal transmission and we are now to the situation of children that were born with HIV are now reaching adulthood, and we had great improvements in treatment and most of these children are now on antiretroviral treatment themselves for their own care.

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KEVIN FENTON, MD, PhD: Dr. Curran, would you like to respond as well?

JAMES CURRAN, MD, MPH: I think in the United States, this has been a tremendous achievement and it has been an achievement that has been made possible by the overall wealth of the United States and the capacity for many of these children's mothers to be treated with highly active antiretroviral therapy so that they continue to have a family unit, so you have a combination of HIV prevention to the newborn and HIV care to the mother fit in to a society where things can work. Unfortunately throughout the world, HIV transmission occurs in the context of abject poverty in many nations where pregnant women, even if they are treated with antiretrovirals, may give birth to a baby who then must be breastfed and it goes through a further risk of transmission and the mother herself may end up dying, leaving the baby as an orphan, so it is even more necessary to overcome tremendous burdens of poverty in developing countries in order to put in to context preventing transmission from the mother to the newborn. It points out that this is really a family disease in many cases, and that all members of the family must be provided for in order to assure a healthy society.

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MALE SPEAKER: Your next question comes from the line of Victoria Elliott from *American Medical News*. Please go ahead.

VICTORIA ELLIOTT: Yes I wanted to ask a little bit more about the use of testing guidelines that will be coming out. I was wondering if you knew when the new guidelines would be coming out and I have heard rumors that they might endorse universal testing and I was wondering if you could comment on that.

KEVIN FENTON, MD, PhD: We are anticipating that the guidelines will be released in the summer, and that would be June/July of this year. Regarding the second part of your question, could you repeat that for me please?

VICTORIA ELLIOTT: Sure I heard rumors that it might recommend universal routine HIV testing, and I was wondering if you could comment on that.

KEVIN FENTON, MD, PhD: I'll ask Dr. Mastro to respond to that.

DR. TIM MASTRO: Thank you. One of our current strategies is really to increase the number of people that know their HIV infection status, and these new guidelines address clinical medical settings, and they recommend routinizing the nature of HIV testing so that it is not based on an assessment of the risk of the individual or the

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prevalence of the community in which the person resides so that there would be a routine screening for HIV of all persons between the ages of 13-64 and that would be again separated from risk assistance or prevalence. People that have identified or ongoing risk behaviors should be tested more frequently, but we think that at least everyone ought to be tested at least once if they are in the 13-64 age group.

MALE SPEAKER: Your next question comes from the line of Delthia Ricks from *Newsday*. Please go ahead.

DELTHIA RICKS: Yes I would like for Dr. Curran if he could to recount for us when scientists first realized they were dealing with a virus in the early '80s. Did they realize early on that it was a virus or perhaps another type of pathogen?

JAMES CURRAN, MD, MPH: When the first cases of *Pneumocystis pneumonia* were reported to CDC, they were reported in gay men. Shortly thereafter, in the next few months, cases were reported in the injecting drug users. Many of us on the task force at CDC had worked closely with the gay community in the studies of hepatitis B transmission and on vaccine trials to prevent hepatitis B, so our leading hypothesis really from day one was that an underlying virus could be the cause, could well be the cause of the epidemic. Now having said that, that could have been an alteration of a

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current virus or an abnormal response to a current virus, or it could be a new virus. I must say that this was not uniformly seen as the likely hypothesis, and there were lots of other hypotheses out there, and it wasn't until cases were diagnosed in persons with hemophilia who were a very small population in the United States, known to be infected with bloodborne viruses through the receipt of their concentrates that there was uniform acceptance of the viral hypothesis. That would have been in the summer of 1982.

DELTHIA RICKS: Thank you very much.

MALE SPEAKER: Your next question comes from the line of Paul Shin from *New York Daily News*. Please go ahead.

PAUL SHIN: Thanks for taking my call. Dr. Curran, if I could ask you to sort of walk down memory lane, back in June of 1981, do you recall seeing that first patient with Kaposi's sarcoma and do you have vivid recollections of that?

JAMES CURRAN, MD, MPH: It's a sign of aging when people ask you questions about walking down memory lane, but I will tell you that after the first five cases of Pneumocystis were reported, we began to both receive and make additional calls to colleagues in California and New York and elsewhere and we learned about a young gay man, a patient with Kaposi's sarcoma being seen at New York University Medical Center, and the person who received the call was a

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veterinarian, so since I was a physician they asked me to go meet this man in New York the week after the first MMWR article, and I recall walking in to NYU Medical Center and meeting a man who was almost precisely my age, who had come from a suburb of Detroit as I had, and had attended a Catholic high school as I had. He then went on to Yale and I went on to pursue my studies elsewhere, and we were now back together if you will 20 years later, him with what I thought initially was a rare skin cancer that frankly I had never heard of until the week before, and me now investigating this case. The differences between us is that he was a gay man who had gone to New York to pursue an acting career, and that I had gone in to medicine and medical epidemiology, and as I got to know him, and watched his health decline and see him eventually die over the next several months, I realized that it was a virus that really separated us and a virus that none of us could have known about and I have thought about that many, many times since then.

PAUL SHIN: I have a quick follow-up question for Dr. Fenton relating to the perinatal infections, do you know if New York City actually has the cumulative number, the largest cumulative number of perinatal infections?

KEVIN FENTON, MD, PhD: I'll refer that question to my colleague, Dr. McKenna, to see if he can respond to that.

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DR. MATT MCKENNA: I'm not sure. New York City definitely has the largest burden of any of the areas that report from around the country that we are aware of, but I am not sure. That total number we don't have available right now.

KEVIN FENTON, MD, PhD: If you would like to follow that up with our press office, we will be very happy to help you with the numbers on that.

MALE SPEAKER: And your next question comes from the line of Duncan Osborne from *Gay City News*. Please go ahead.

DUNCAN OSBOURNE: This is a question for Dr. Curran. Dr. Curran, you talked about, you said HIV prevention works if its hands are not tied by local, national, or international political concerns, do you think that the hands of HIV prevention are tied in any way in the United States, and if they are, how are they tied?

JAMES CURRAN, MD, MPH: Well I would say that the problems that we have with HIV is that when there is nobody paying attention to it, then of course there are no resources. When there are resources, people pay attention to it at all levels, whether it's the U.S. congress or whether it is the mayor's office or the county commissioners or the state legislature, and so the politics of HIV are often national or even sometimes international, but the prevention

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has to occur at the level of the community, and if you have community people, whether they are gay men or whether they are poor, urban, or rural, African Americans, or they are migrant populations, and they are talking about sexuality, they don't simply trust government at any level. They trust their peers, and they trust their peers to give them the best messages about what works and what doesn't, and a lot of times at the political level, things get distorted by other agendas, so I think the easiest example to talk about in the United States is how long it took us to deal effectively in any way with the epidemic in injecting drug users, because as we know virtually no one has respect for injecting drug users. They are virtually disliked by all, including their own ethnic populations in their own cities, so they have no political constituencies to speak of, and when it is found that needle and syringe exchange programs are effective or when it is found that more effective and larger drug treatment programs are needed, it's very difficult to provide these kinds of services to people that can deal with an addiction problem, and we were very slow in the United States in delivering effective services, and when it was done it was done largely because of local initiatives.

MALE SPEAKER: Your next question comes from the line of Ryan Lee from *Southern Voice*. Please go ahead.

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RYAN LEE: Thank you. I have a two part question for Dr. Curran, and anyone else who would like to comment, and it kind of piggybacks on the previous question. You talked about the slow response for IV drug users, but there was also a slow response in identifying it or combating it with gay men, I was wondering are there any parallels between the ignorance that exists in the early '80s among the media and general public about AIDS and today's public medial message that seems to suggest HIV and AIDS is only a problem in Africa? The second part of that question is what role does sexual orientation play in that discussion in terms of, is it still easier for us to talk about this disease as it relates to third world countries than it is for us to talk about it as it relates to gay Americans, particularly black gay Americans as you mentioned in the data earlier.

JAMES CURRAN, MD, MPH: Well, thank you. I think that the leadership of the gay community has been strong throughout the past 25 years, and has been responsible for much of the decline in transmission in the United States. I would like to think that we in public health played a role, but I believe that much of the reason for the decline in transmission among gay men in the United States was related to the overwhelming presence of the epidemic and the openness within the gay community to discuss HIV and to accept people

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who are infected with HIV, and to get tested and know about it. The other thing is that AIDS was palpable in the gay community in virtually every community in the highly affected cities on the streets. Virtually everybody knew people who were sick and knew people who were infected and knew people who had died, and that presence of it led to a fairly constant discussion which led to the young people. Each year in the United States now, you know, a cohort of 4 million people have sex for the first time because that many people are born each year, and as we don't pay a lot of attention to AIDS, both in the media and in our public life, it becomes more difficult for young people to take it as seriously as we did in the 1980s. Now I think we should not be mistaken to think that homosexual and bisexual men and women are a distinct discriminated against minority throughout the world. The U.S. military policies, for example, remain institutionally homophobic, and are accepted as such, and of course gay marriage is something which is accepted in very few places. These two things alone are institutional examples that society does not hold gay and bisexual men and women equal in all ways and would certainly be a reason for them to show some continued distrust of governments.

RYAN LEE: If I could follow that up with again, how does that influence public conversation and the media

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attention? Again, whenever there is a special report on TV or in the news, it seems as though it is always relegated to discussions on Africa and how much of a role does sexual orientation play in the domestic debate about HIV and AIDS?

JAMES CURRAN, MD, MPH: Well, I think that there are, I don't want to diminish the extent of the global epidemic. I think it is quite unusual that the United States and the United States media and press and the United States public are focused on the dire consequences that are associated with poverty in the rest of the world. We are often talking about oil or war or something like that, but when it comes to a health problem I welcome the global progress that the AIDS virus has made and the difficulty in addressing it. The other thing is of course that new things are news, and old stories aren't news, and I think that it has been more difficult in the highly active antiretroviral therapy era to find newsworthy items in AIDS that relates it to domestic situations. Now having said that, the continuing spread of the epidemic, particularly among young gay men is not as compelling a story as it would be if it were more broadly spread among middle class people, and I think that continued invisibility and stigmatization of homosexuality is probably a factor.

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KEVIN FENTON, MD, PhD: I would just like to add to your statement, which I agree with entirely, that complacency really is an issue that faces us domestically today, and in the face of 40,000 new infections occurring each year, clearly the work is cut out for us in terms of presenting these infections, and I think it is important that the discourse is not only on new infections occurring among men having sex with men, but indeed other populations which are marginalized in our society, and that is why it is really important that we work with partners such as yourself and the media in getting these messages out and ensuring that these data are made available to as wide an audience as possible, and that the strategies to ensure prevention, both at the individual and at the community level, are constantly reiterated for the public.

MALE SPEAKER: Your next question comes from the line of Daniel Denune from WebMD. Please go ahead.

DANIEL DENUNE: Thank you. Dr. Fenton, when one looks at the U.S. numbers, one can't help but be appalled by the astonishing progress of the epidemic among African American men and women, I wonder what, we hear often and over and over again the phrase that prevention messages must be tailored to the community, can you talk to me first of all what specifically CDC and others can do in a specific way to

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address this astonishing change of numbers, and secondly I wonder if you could take this question very personally from the position of your own race and your own sexuality and talk about how you might affect this issue?

KEVIN FENTON, MD, PhD: Thanks for your question.

Well I think first of all, the nature of the evolution of the epidemic means that we need to look at the driving factors in a whole new way, and it is clear that factors such as poverty, drug use, and the high rates of sexually transmitted diseases really places many African Americans at increased risk of acquiring HIV; however, if we are beginning to think about ways in which we are going to effectively tackle the problem, I would argue that first of all, there is no simple solution. We need to look at the complex factors and therefore a comprehensive strategy is going to be required to really curtail HIV among African Americans. One of the elements of this comprehensive approach; first of all, it will involve involving communities who are at risk very early on in developing interventions and the implementation of interventions and even in the evaluation of interventions; in other words, to have participatory approaches towards interventions. We also need to ensure that we work more closely with community leaders to ensure that our interventions are acceptable and appropriate to those who are

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going to be receiving them as well. Thirdly, I think it is important that we don't view communities as homogenous, that we need to realize that there are differences between men and women, the differences by sexuality, by age group, etc., within each of these communities and therefore part of a comprehensive approach will dictate that we use our resources as effectively as possible to meet the needs where they are. Now to answer your second question, clearly all of us in public health will bring our own personal experiences and our backgrounds to the work that we do. From my perspective, my commitment to fighting this disease began in the early 1990s, and yes as a man of African descent, it is worrying, it is hurtful to see the evolution of the epidemic both internationally as well as here in the United States, and that is why I am committed to working very closely with partners across this country to work very closely with international partners to ensure that we do tackle this epidemic effectively in new ways that we haven't really taken advantage of in the past.

MALE SPEAKER: Your next question comes from the line of Benjamin Ryan from *Gay.com HIV Plus* magazine. Please go ahead.

BENJAMIN RYAN: Hi, everyone. My question is more of a concern I wanted to address. It follows up on the

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discussion that you were having from Ryan Lee from *Southern Voice*, I understand very much when it comes to packaging these press reports that we received to get the attention of the news media, and I think it is fantastic that you are highlighting the African American concern and the concern with Latinos because that is so important, but one sort of soapbox I wanted to get on coming from the perspective of somebody in the gay media is the constancy of the fact that about half of all new infections are among MSMs, if you consider the 45-percent new diagnoses that are in MSM and the other 5-percent that are in both MSM and IDU, and I guess I am a little disturbed that there wasn't also a fact sheet highlighting those statistics as well, since they are such an important factor and they continue to be, and hoping that the media would pay attention to that, in particular the studies that have shown the very high prevalence rates of HIV infection in urban areas that you alluded to with the mention of the high rates among black men, so I was wondering how you would respond to those concerns of mine that perhaps you haven't packaged the news to try to get the media to continue to pay attention to the gay issue.

KEVIN FENTON, MD, PhD: Thank you very much for that question. We can provide you with additional and more detailed information on the burden of disease among men who

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have sex with me, but I think your question is really getting at the heart of how we classify new infections according to risk groups within our populations, and yes unfortunately, we are limited by the fact that oftentimes our data appear dichotomous, either people of color or men who have sex with men, so what we really are trying to convey are simple messages for a very complex issue where we have minority men who have sex with men, high rates of disease within these communities and in need to effectively address those as well. We have certainly published data in previous releases regarding the continuing burden of disease among men who have sex with men in the United States, and statistically the role that men of color, MSM of color, are playing in the ongoing transmission and acquisition of HIV. In fact, we know from a number of studies that we have done that men who have sex with men, there is [inaudible] more variations across the country in the burden of HIV, either by prevalences in cities or prevalences across risk groups, but the data are fairly consistent that no matter where you look among these larger metropolitan areas, that black men who have sex with men are more than twice as likely to be infected with HIV than other men who have sex with men. So, there is a complex intersection between race and sexuality, and in presenting our messages, and I agree with you that it is important that

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we do acknowledge this complexity, but at the same time try to present messages which will help both local as well as state level colleagues to really get the message of prevention out.

JAMES CURRAN, MD, MPH: Let me add something to that, I would like to just add to the concern that Mr. Ryan had that we don't underestimate the risks to gay men throughout the United States for the foreseeable future. The reason is simple. It is not simply related to how many partners you have, it is related to the likelihood that your partner is infected, and of the million Americans, perhaps half a million or more who are infected are gay men, and gay men of course represent only a small percent of the American population, so for the foreseeable future, particularly for young people who are figuring out their sexuality, figuring out their sexual lives, their early sexual partners are much more likely to be infected if they are gay than if they are straight simply because the prevalence is so much higher, and it is this particular group of people, this group of young people emerging each year, these young gay men that will, until there is a cure or a vaccine, will always be at much higher risk when they have their first sexual contact than heterosexuals, and we shouldn't lose that emphasis.

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KEVIN FENTON, MD, PhD: That is correct Jim, and just to add a bit of data on that issue, we know from some of the studies that we have done in large cities across the United States that the prevalence is in young men who have sex with men are staggering. In one study, young men ages 18-24, we found the prevalence of HIV of approximately 14-percent and by their 30s, these men who have sex with men, approximately 30-percent of them were infected, and even more worrying, young MSM are least likely to know that they are affected. Indeed, among the 18-24 year old age group, approximately 80-percent of those who are infected did not know that they were infected, so absolutely correct, and I agree with what you've said that this really is another group that we do need to focus on in our future efforts.

MALE SPEAKER: And your next question comes from the line of Joanna Buchen from BBC. Please go ahead.

JOANNA BUCHEN: Thank you. My question is really based as an outsider looking in and listening to this discussion, which of course is based around what is happening in the United States. But when Dr. Curran spoke about hands being tied, we have seen most of my work is done outside the U.S., obviously, and particularly in Africa, India, Russia, China, places like that, and there we have seen PETFAR is the public face, is the international face if you like, of what

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the U.S. is doing about AIDS, and PETFAR is tying the hands of people in countries from Uganda to Thailand to Vietnam when it comes to AIDS prevention work because of things like not using condoms, not wanting to go with evidence-based prevention strategies, and that is having an incredible impact on AIDS prevention work around the world, and I haven't heard any mention really, apart from this sort of fairly vague "hands tied" reference to what the U.S. government is doing at home with its policies around prevention work in the U.S. Surely with the U.S. law at the moment says that you can't talk about abortion for instance if you get federal funding if that applies abroad, it must apply at home in the U.S., so how realistic is it? These plans aren't working in countries like Uganda, Kenya, Thailand. How realistic is it to think that the new policies that are being put in place under these same rules in the U.S. are going to work?

KEVIN FENTON, MD, PhD: Thanks. Well first of all, just to say that we are not dealing with any international issues on this conference today, and we would like to refer your questions related to the global HIV academic and the PETFAR response to our colleagues in the office of global AIDS coordinator, and we would be happy to give you numbers for that, but in response to the second part of your

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question, which is the impact therefore on policies and politics on policies, I think we are all very cognisant of the fact that we as public health practitioners work within a political context, and it is important that as we take the messages and our interventions for prevention forward, that we do look toward comprehensive approaches to prevention. Also remember that a federal approach is not the only approach to prevention in the United States, but in many circumstances this is added to and supported by local as well as state level prevention interventions and prevention initiatives, which have oftentimes far more scope to address difficult issues or to make decisions around the nature of prevention interventions in different ways, so do view this as a number of players involved in national HIV prevention in the United States of which the federal government is a part.

MALE SPEAKER: And your final question today comes from the line of Jordan Light from *New York Daily News*. Please go ahead.

JORDAN LIGHT: Hi. I have two questions. One would be a follow-up to the previous question. Since we are talking about history, can you maybe provide some context as to how easy or challenging do you find your prevention work to be these days under this administration as compared to past administrations? The second question would be, we have

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been hearing for years that there are an estimated 40,000 new HIV diagnoses or cases maybe, not people who are aware of their status, but an estimated 40,000 new cases annually in the U.S., and I am just wondering how you came up with the number and why it is that the number never seems to change?

KEVIN FENTON, MD, PhD: Okay we will start with the second part of your question first, and then I will end with the first part.

DR. MATT MCKENNA: Yes, this is Dr. McKenna, the 40,000 number was first directly measured in the early 1990s using a methodology known as back calculation from the number of AIDS cases, and then going forward when AIDS changed, the epidemiology and progression of AIDS changed because of effective therapy, we had to abandon that method, and developed sort of a triangulating from a variety of different data to see whether or not there were changes in the trends in transmission. Really, as has been expressed earlier, all the information we had either measuring number of diagnoses, AIDS cases, doing prevalent studies from blood, indicate a disconcerting stability in those numbers over that period of time and then also all point to really no change since the early 1990s in the number of new infections each year. We will have later this year a much more precise and direct measure of that incidence, as we call it, because of the

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system we have put in place that has funded 34 areas throughout the United States using a new technology that allows us to discriminate between recent and long standing infections and be able as I said to come up with a real direct measurement of that as opposed to this indirect approach that we have had to use traditionally.

KEVIN FENTON, MD, PhD: Thanks, Dr. McKenna, and just in response to the first part of your question which is: Is prevention any more difficult today than it was say 10 or 20 years ago? I think the considered view of all of this is that prevention is always difficult but it is truly still the only cure for HIV and AIDS, and effectiveness of our prevention efforts really depends on the dynamic entity between a number of factors, the amount of funding we receive, political context. It certainly interrelates to the populations that we serve, and we have mentioned on the call today the importance of complacency which perhaps makes it even more difficult for some of our target populations to receive our messages, and of course, the epidemic is continually evolving and changes, and therefore we have new populations who are affected by the disease, some of whom are hard to reach, some of whom are not in contact with health care services, and therefore new approaches will be necessary, so rather than saying it is more difficult than

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today, I think we have a little different set of challenges which we need to constantly bear in mind and we need to respond to as we take HIV prevention forward.

This is the end of the telephone conference. I would like to thank all of you for calling in today, and once again, just to confirm that if you have further questions, we would be happy to deal with them through our press office here at the Centers for Disease Control and Prevention. Good afternoon, everyone.

[END RECORDING]