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## Conference: 15<sup>th</sup> Annual International AIDS Conference Summaries of Highlights by the Chief Rapporteurs July 16, 2004

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**MECHAI VIRAVAIIDYA:** Good morning ladies and gentlemen. Good morning a second time for those who were earlier and good morning for the first time for those who've just entered. We are now entering the session where the rapporteurs from all the different tracks and sessions will be reporting what they believe has transpired during the last few days and after which, if you have additional comments, please write them down and provide to it the rapporteur. They've just done a job that they believe contains the basic issues that have been discussed. And then after that

if you believe certain things are missing, please make certain notes and give it to the secretariat. Before I introduce [inaudible] as to part of new movement, so ladies and gentlemen I hope that this will begin and get more and more people involved.

And now may I introduce the two handlers of the session. And firstly let me say how hard the rapporteurs have been working on this and what a tough job. Imagine all the poster sessions, imagine all the tracks and all the discussions that have been going on and then trying to combine it and make it into a sort of special fruit salad. And so Dr. Presert who is on your extreme left and then Dr. Pakdee will handle the session. Thank you very much.

[Applause]

**PAKDEE POTHISIRI:** Thank you Senator Mechai Viravaidya. I serve as chairman of the scientific committee program and I would like to introduce you to the rapporteur for Track A will summarize the highlights for you Germain Brazil [misspelled?].

**GERMAIN BRAZIL:** Thank you. I'd like to firstly start out by thanking my co-rapporteurs for helping with this very onerous job in Track A, the basic science track. To Tony Kelleher, to Charles Kucher [misspelled?], to Stephen Ziechner [misspelled?], Eric Arts, Mario Parichi [misspelled?], Jane Dale and our track organizing committee Richard Kalban Kiel [misspelled?].

So where is Track A and what basic science happened at this meeting? There seems to be a perception generally that the basic sciences only accessible to the experts, so I'm going to try and cover some of the interesting things that we went through on Track A. The virility, where we looked at new targets, antiviral intervention, viral evolution and tropism, new antiviral approaches, post responses to virus both adaptive and now innate immune responses coming onto the radar screen and vaccines where the question is are measuring the right things and are we measuring in the right model.

In this picture here, if you take only one thing away sums up basically where we are with our understanding in the basic science. So who's controlling this journey in this photograph here. We

have potential for antiretroviral drugs which could act like a chain to keep the elephant here in place. We're quite interested in the immune responses of are these the things that are really controlling the issues here. And there are three important players here. We don't know which one is most important, the T-cell responses, antibodies or innate factors. We're coming forward with vaccines but these really look just like that stick. They're able to do something but they're really not in control of the situation. The control really rests with the virus with an HIV infection or with the elephant in this scenario. If the elephant wants to go somewhere then that's what's going to happen.

So in sessions looking at potential new therapeutics for HIV, we saw several very exciting small molecule entry inhibitors firstly targeted at the virus, T-20 binding site type small drugs that target the fusion region of GP41. So instead of an injectable these ultimately may be orally bio-available. But an interesting thing was new cellular targets so instead of targeting the virus with drugs, finding essential components on the host cell proteins that the virus must use and target these with drugs. Importantly, entry receptors featured heavily here, so the CCR5 receptor, GSK have a very imaginatively named compound, 873140, that was presented and looked very good activity in oral bio-availability in low IC50 doses. But there are others that weren't presented that we know about in clinical development such as UND [misspelled?].

Other approaches were humanized anti-body fragments, small peptides, one known as Pro140. And in a similar vein targeting the other entry receptor, chemokine CXCR4 chemokine pro-receptor, we saw protein epitope pneumatics or PIMs developed presented by Klemkai [misspelled?].

CD4 was another cell surface molecule targeted by a small bio-available compound, importantly targeting the very binding site on CD4 with low toxicity. We saw very on maturation inhibitors such as PA457 as well as cellular targets from interesting comparative genomic studies where the genome is analyzed for gene expression. We saw interesting new compounds, new pathways targeted by drugs such as

Glevat [misspelled?], something that's already approved for cancer therapy but may be of use for HIV. And Tony Faci [misspelled?] presented other leads.

We saw other therapeutic interventions that were useful targeting the latent reservoirs for example Aisle 7 was shown in a nice study by Roger Pomerance to activate a different pool of latent virus from the reservoir pool than the current Aisle 2 in OKT3 regimes similarly Pitassis [misspelled?] Toxin B polymer as well as what I just mentioned, new host cell functions targeted by new compounds coming out in these genome screens such as Sclebak [misspelled?].

Proving that we also have interesting sessions in the posters, we found a very interesting poster on therapeutic vaccines that was to be presented by Barbara Felber from NIH but instead presented by George Peplakis from the same institute. And here a very interesting optimized DNA vector that was expressing different forms of gag and nth and in something that might mean a bit more in a moment, this was tested in a very difficult model system, the Rhesus SIV MAC 239 infection system where these animals were infected, placed on antiretroviral therapy, given doses of vaccine that promoted cellular responses during that time and then when therapy was removed the cellular responses were maintained and virus was controlled.

We also saw interesting molecular evolution that has implications for spread and vaccine development. So dual infection and rapid temporal evolution of unique recombinant forms of virus were noted. So this is very common it seems in communities with different HIV subtypes. It seems to be driving by migration, ARV therapy and eventually vaccines. So this is going to be an increasing issue.

There was a documentation using new assays of cross-subtype super-infection. So this is a different dual infection where you're infected with two viruses at the same time. This time you're infected at a later time and not protected immunologically from the incoming virus. HIV evolution was seen through recombination and this is one of the slides presented by Francine McKutcheon [misspelled?]. The central circle there shows that 28% of all of the infections that she saw in 98 patients followed in Tanzania were

in fact dual infections. And in other work that she looked at, looking at these dual infections, there was a large amount of recombination going on in the different sequences within those virus strains. So it's going to be quite difficult to keep up with those viruses.

Another interesting study looking at what this sequence difference might mean in the context of why happens with virus replication in the laboratory was presented by Eric Gatz [misspelled?]. And he did his assay looking at the relative fitness for competitive replication in culture in peripheral blood mononuclear cells with these different groups of viruses. And quite a striking result is that the Group M virus is the common viruses clustered together as a group and they have relatively high level of fitness. They can out compete or replicate at capacity against the HIV two isolates and the less common root O outlying HIV's. But really the surprise was where the C subtype viruses came here down in the lower end of the fitness scale. And there was a lot of discussion as to the significance of this and the different relative fitness capacities may have bearings on the ability of the subtype C to have maintained longer in the community the infected pool and to have therefore a higher transmission capacity than other circulating viruses. That is obviously going to be something for further analysis.

Also effecting replication capacity and viral fitness, presentations by Simon Milau [misspelled?], the immune responses exerting a selective pressure directing the sequences and phenotype of virus. Interesting presentations looking at the long-term exposed seroconverters. So these are people, partners of HIV positive people that then become infected. And the interesting finding was that for example here one long term exposed seroconverters patient number 63 had a totally different sequence to her sexual partner. So this demonstrates that their being infected by their partner so they have some level of protection to their partner's virus, but not to a different perhaps Recombinate virus strain circulating in that community.

In the HIV vaccine arena, a lot of discussion about assays. Are we measuring the right thing? We

saw progress with vaccines, but one issue with that is you have to be able to measure something from your vaccine in order to push the vaccine through into further trials. And there were several presentations that showed some efficacy in the Simeon [misspelled?] HIV or SHIV model, but they could detect no functional assay that correlated with the protection observed.

**PAKDEE POTHISIRI:** Please, you have two more minutes.

**GERMAIN BRAZIL:** Okay. I will just skip over that and just to say that there are assays now that can better distinguish the important cells and instead of assaying or [inaudible] also assaying for TNF. And an encouraging vaccine result from Julia MacElray [misspelled?] showed that in the column under vaccines they received, they got the right responses gamma interferon responses, TNF responses and that these cells were also proliferative, meaning that they actually had function for killing. Similarly T-cell assays instead of just looking at the gamma interferon, looking at gamma interferon and interleukin two responses. And finally the animal models for HIV vaccine development, the so-called SHIV models, basically this was a lovely slide presented by Wayne Coff [misspelled?] saying that most of the studies are done with the SHIV 89.6 strain which is very easy to protect against whereas the SIV MAC 239 strain is very difficult to protect against. And at the same time in another auditorium, Malcolm Martin was presenting evidence showing that this SHIV strain exclusively targets the X4 [inaudible] receptor and infects a different pool of cells, naïve T-cells which make up 95% of circulating T-cells compared to the 239 strain which targets R5 and the effective memory cells. There is very little progress on neutralizing antibodies, difficulties with assays, and there is no one size fits all answers.

So there are vaccines coming through. We've heard these from Jose Esparza and from a final statement here from Track A, maybe with all these vaccine candidates coming through, we're learning a lot from other aspects of the presentations at the meeting and it seems that the basic science if it seems inaccessible the eventual success with the most

difficult scientific problem, making an effective vaccine, the basic science must be fully integrated with and learned from all sectors responding to the AIDS epidemic. And this meeting is a unique forum for this engagement so I would urge everyone to promote Track A.

[Applause]

**PRASERT THONGCHAROEN:** Thank you. May I ask Dr. Pakdee first one who be the chairman of the leader program.

**PAKDEE POTHISIRI:** So next, I'm very pleased to introduce Bernard Hirschel, the chief rapporteur from Track B's incentive program to make a summary report. You have 12 minutes sir.

**BERNARD HIRSCHEL:** I couldn't have done it and indebted to Carlos Zala, to Sarah Pett, to Lisa McNally, to Sinata Koulla-Shiro and to Joseph Eron.

Here is a slide from Dr. Kiat's plenary. There are 20 anti-HIV drugs now licensed in the USA. And if I counted right, that makes 1,333 drug combinations. Now you want me to tell you which is the best one and I will but not just yet. I would like to start with the beginning, which is prevention of mother to child transmission.

Yesterday appeared two papers in the *New England Journal of Medicine* that were also extensively discussed here. The PHPT-2 trial compared three ways of preventing transmission from mother to child. The mothers all received zidovudine from the 28<sup>th</sup> week of pregnancy on and the infants all received one week of zidovudine. In addition in Arm I both mother and child received one does of nevirapine, in Arm II only the mother and in Arm III neither the mother nor the child. Both interventions were effective in reducing mother to child transmission from close to seven to less than three percent. There was a price to pay however. As you can see here, resistance mutations were selected in the mother present in 32% of the mothers who had received nevirapine compared to 0% in the mothers who had not received nevirapine. That is a problem because those mothers will need treatment in the future as you can see on this Kaplan-Meyer plot.

Does the selection of nevirapine resistance mutation influence the chances of success of subsequent

therapy by the now most commonly used combination of antiretroviral drugs in the world which is nevirapine, d4T, 3-TC? Unfortunately the answer seems to be yes. As you can see only 38% of mothers exposed to nevirapine and with resistance mutations obtained a viral load of less than 50 copies after six months of treatment compared to 52% of mothers who had been exposed but did not have detected nevirapine mutations and 68% who had never received nevirapine. The treatment with nevirapine, 3-TC and d4T currently costs about \$350 in Thailand for one year. If you cannot use it, alternative regimens cost at least ten times as much if they are available. So the prevention of nevirapine resistance in the mothers is an important issue and it may be possible.

Yesterday in a late breaker, McIntyre from Johannesburg showed results from a study where in Arm I mother and baby both received one dose of nevirapine, in Arm II they received one dose of nevirapine plus four days of Combivir and in Arm III same plus seven days of Combivir. In the mothers who had not received Combivir, 9 of 18 or 50% had nevirapine resistance mutations compared to only about 10% in those mothers who received Combivir in addition to nevirapine.

Let's shift topics now and go to the problem of monitoring therapy. In a country like Malawi, the cost of one viral load plus one CD4 count is now about equal to the cost of six months of treatment. In other words no monitoring is done there for reasons of cost. Is it possible to monitor cheaper? Here is a presentation evaluating a new type of fluorescence activated counting with a machine which costs about half as much as the competitors and reagents cost of only \$2 per test. In addition this runs on a car battery and is therefore independent of the household current. This graph establishes the equivalence of a reference method and a new method for quality of counting.

Alright, now let's go to the question of best treatment. It's partly a question of definition. We may define it by a high proportion of patients who attain a viral load of less than 50 with load toxicity. The final results of the Gilead 903 study were presented here which compares tenofovir and stavudine,

both in combination with the efavirenz and 3-TC. After a follow up of 144 weeks antiviral efficacy was equal in both Arms. Eighty percent (80%) of patients had viral load below 50 after 24 weeks and 70% still had a viral load below 50 at 144 weeks. However, tenofovir had clear-cut advantage regarding toxicity. Peripheral neuropathy in three and ten percent respectively. Lipodystrophy in three and 90%. And a much better lipid profile. Caveats. There is the question of the loss of bone mass in both groups which will need further study. And patients with pre-existing renal failure which is a worry for tenofovir were excluded from this trial.

Eighty percent at 24 weeks is fine but can we do better? Well the answer is yes at least in Thailand. Here is a study of 167 treatment naïve patients treated with a combination that you see here, once daily ritonavir boosts, saquinavir, d4T and DDI, evaluated at 24 weeks. And the red bar shows that 91% of patients obtained a viral load of less than 50 which is higher than the approximately 80% in the most recent prospective randomized study. So there's a lesson here for drug companies. If you do have a good product, testing it in Thailand will make it look even better. And there are excellent researchers here.

Alright, second definition of best treatment. Long-term efficacy without resistance. Here are the current record holder seems to be lopinavir. We saw data from a five year follow up of the study 720 where lopinavir and ritonavir was combined with 3-TC and d4T. On the left the percentage of patients with undetectable viral load very impressive. If you manage to stay on the combination it's almost guaranteed that your viral load will remain undetectable. Even more impressive to my mind is the graph on the right, showing phenotypic resistance test in those who had rebounds during treatment for instance because of lack of compliance. As you can see there is zero evidence of development of resistance during five years.

Finally, best treatment definition number three, long-term survival. I like the title of this presentation, presented by Sanny Chen from San Francisco. And what she did, she attempted to compare drugs included in the WHO's 3x5 plan. They are listed

here with other drug combinations. Asking which regimen gives the best odds of survival. Now the methods were controlled, case controlled study. A case was a patient who was dead by the end of 2002 and a control a patient who was alive through 2002. And these cases and controls were matched with regard to several characteristics that I can't go into detail here. Now the statistics are complicated but grasp the essential. An effective drug regimen is going to be associated with the living and ineffective regimen with the dead. So the question was did patients initiating with any of the 3x5 regimens have better odds of survival compared to those initiating with other regimens? And the answer is yes. When combined, the 3x5 regimens performed better than all other regimens with an associated odds ratio of death of 0.47.

So in conclusion avoid the perfume or should I say Fuzeon fallacy, which is to believe that what's expensive is necessarily better.

[Applause]

And with that I conclude and let's hear from Track C. Thank you.

**PRASERT THONGCHAROEN:** Thank you very much Bernard and thank you for promoting Thailand as a site for clinical trial.

**PAKDEE POTHISIRI:** Now may I invite John Kaldor to report on Track C please. You have 12 minutes sir.

**JOHN KALDOR:** Thanks very much. I would like to start by thanking the organizers for this excellent conference for this opportunity to present this report on Track C, and acknowledge the great team that I have had the privilege of working with. It's Gail Kennedy, June Petercressak [misspelled?], Liz Montgomery, Stephan Pontenack [misspelled?], Mary Wongai [misspelled?]. I'd also like to recognize the wide range of impressive presentations that we've had the opportunity to review.

In fact my team also had the opportunity to do a little etymological research in between our rapporteuring duties. And I'd like to present the results of our study first. Into the patent of session attendants of conference participants, we found the following. First of all, rapporteur team members had

the highest rate of attendance.

[Laughter]

Closely followed by students and scholarship holders, but this difference was not significant.

[Laughter] There was a big drop however to department's heads and it was closely correlated with their role as chairs of the session. Finally, global superstars we're always pleased to see at AIDS conferences.

[Applause]

They only attended sessions if they were session.

[Laughter]

This years conference theme Access for All was no doubt intended by the organizers to be inclusive meaning access to all to all kinds of HIV services whether prevention or treatment, but in many people's mind the theme undoubtedly spoke of the urgency of expanding treatment access. And indeed this issue has been at the heart at much of the conference whether in the formal sessions or behind the scenes. It's therefore intriguing that there seems to be a renewed dynamism in the biomedical prevention agenda over these last few days.

How has this happened given the fact that there have been little in the way of starting new findings on the means of HIV prevention presented at this conference. Perhaps it's just a question of some kind of natural cycle of these two yearly get-togethers. Four years ago in Durbin the mood was somber when the first Phase III trial of the germ microbicide M9 showed that product actually increased rather than reduced the risk of HIV infection in participating women. And then last year there was the release of the findings from the first Phase III trial of the prophylactic vaccine which at least didn't seem to make participants more likely to get infected but certainly showed no hint of efficacy.

So given these less than encouraging findings from key lifestyle trials is the new mood in prevention science simple a surge of blind optimism? In fact there's much more to it than that. Over the past few years, a whole new range of biomedical options to prevention have been imagined and debated. And they've

taken their first steps down the long road to what industry calls product development. Of necessity, these prevention options are generally being tested in countries where the risk of infection remains unthinkably high. Mostly the developing world and in circumstances where there is no guarantee of basic healthcare let alone an established research infrastructure. Complex consortium arrangements have been struck to make sure that funding and expertise are made available in appropriate ways in these developing country settings. And we are learning by experience as each new idea in prevention moves from conception through pilot phase to effectiveness trials. For several years no Phase III studies of the germ microbicides were commenced. Now we hear that half a dozen different agents are on the verge or in the field trials for effectiveness. Also on track are large scale trials of the effectiveness of the female diaphragm as a cervical barrier against infection, of male circumcision, of treatment for Herpes Simplex Type II to reduce HIV transmissibility and the use of antiretroviral therapy in two different ways. In one trial they used with the goal of suppressing virus in infected people to make them less infectious and in another group of trials a therapeutic agent will be tested in unaffected people to see whether it can reduce the likelihood that they'll become infected. And then there is the new generation of vaccine trials.

Given that it will be some time before these trials produce results either way, the mood among people committed to prevention science is probably as much one of relief that so much is moving ahead even if we have the collective feeling of having to hold our breath for a couple of years until the results start coming through. Meanwhile there is much formative and operational research that we need to do and are doing before a product that is proven effective in a trial can be made available in a community setting. And we've heard about some of this work at the conference. There are acceptability studies in both women and in men, guiding us on the delivery and future marketing of the prevention agents under investigation to maximize the chance that they will actually be taken up on a large scale if they are indeed shown to be effective.

Work is also being presented on ways to expand and improve voluntary counseling and testing services which will increasingly become the gateway not only to the treatment but also to some of the prevention strategies should they prove to be effective in trials, particularly those that involve the administration of antiretroviral agents.

And we have come to a collective resolution on some of the big controversies that are raised back and forth in the design of lifestyle prevention trials. Yes we do have to offer the best practice preventive interventions to all participants in prevention trials whether in the intubational control groups, which means counseling, education and provision of condoms or sterile injecting equipment. And yes we do have to provide access to best clinical management, best practice clinical management for those who might become HIV infected when they are on trial. And yes we do have to look out for the clinical needs of those in the trial if we are to adequately manage any adverse events and record and follow up their outcomes.

With so many large scale prevention trials underway and so much riding on their outcomes participants of the next International AIDS Conference will be eagerly awaiting comprehensive progress reports from these investigations in terms of numbers enrolled, changes to the protocols, projected dates for completing the study which always seem to be extended and extended no matter how meticulously a study is planned.

I would like to call upon the organizers of the next conference to make sure that we are all in a position to hear such reports.

In contrast to the biomedical prevention area where we know that there is much action taking place in the field but very little in the way of outcomes that can be presented at these conferences for the present, the more traditional areas of behavioral prevention have been presented by some quite concrete advances of the conference. The behavioral studies have moved well beyond the simple questions about what you do and what group you identify with to much more sophisticated investigations of sexual and injecting risk culture. For example from these studies we know that in a number

of developing countries a substantial proportion of men identified as heterosexual are regularly having sex with men or in some countries transgender people. Similarly, sex workers often undertaken by women and men who inject drugs. We are now seeing an increasing willingness for countries to recognize the reality of risk and its context through large scale empirical studies and put into place appropriate evidence based mechanisms. There's a still along way to go in this area though.

**PAKDEE POTHISIRI:** You have two more minutes.

**JOHN KALDOR:** Late breaking reports from China at the end of this conference spoke of harm reduction such as methadone maintenance and the provision of clean needles and syringes not only being implemented but subject to rigorous evaluation. Prisons often with their triple stigma of incarceration, drug injecting and HIV infection, represent another area in which several developing countries have re-proven themselves by the reports at this conference to be unexpectedly pragmatic in allowing NGO's and government health services to run prevention and care programs that are being well documented. Behavioral prevention research presented at the conference is also starting to interact more closely with the clinical environment and answer equations about risk behavior in the context of the new and effective HIV treatments.

Despite the future promise of biomedical prevention and the new realism that it's bound to be applied to the more traditional areas of behavioral prevention, at least in some countries, we do have to acknowledge to ourselves and to those whom we serve that the global effectiveness and prevention does not score well at all. One small statistic from one study, one poster on Monday, told us that half, yes half the women aged 20-24 randomly surveyed in the rural South African district had HIV infection. This is a figure that retains the ability to shock even those who have worked for decades in HIV prevention. Indeed if it doesn't shock you, it probably means you should be working in another area.

On the topic of surveillance, we've seen recent debates played out to limited extent at this conference about the accuracy of the estimated numbers

of people living with HIV in various countries. The main issue is seems to be the allegation that past estimates were inflated by those with a vested interest in making the epidemic keep on growing and the funds keep on flowing. In response there has undoubtedly been well meant a search for the best way to analyze, model and interpret surveillance results. Some have called for the scrapping of our alliance on internatal prevalence surveys in countries with high prevalence and shift to using household survey methodology to make sure we get it right. In fact our household surveys are very good tools for estimation; they also have their own inherent biases and are expensive to repeat on a regular basis. I would like to take this opportunity to call on my colleagues in public health surveillance not to drive each other and the various ministries of health crazy with ultimately futile searches with perfect ways to estimate the elusive number of people living with HIV at any given time.

[Applause]

We actually all need to know and can never know the exact number. The best we can do is track some repeatable and affordable index in a way that allows us to see the key changes that are occurring over time. The measurement of incidence on the other hand is another matter. The most important of qualities this most important of qualities has been for too long seen as an optional extra in surveillance. It's not. We have now several assays in various stages of availability that have very good properties for detecting newly acquired infection. But making them a large scale commercial reality seems to be a ponderously slow process despite the efforts of a small group of excellent and committed laboratory scientists working in collaboration with epidemiologists. A concerted effort by key publications is to evaluate available technologies and give strong support to the best performers is long overdue.

Finally, I turn to our region, the Asia-Pacific region, where we've gathered in a country that has in the past experienced and responded to the most widespread epidemic of this region. The epidemiological descriptor that we hear about our region time and time again is diversity within

countries, between countries, from population to population the variability and the risk environment is indeed vast. However we can make three key generalizations from the information that has been presented at this conference.

First, many if not all parts of the region have larger or smaller population groups that are at higher risk of HIV infection. Second, although some of these groups have already experienced intense epidemics most of the region has in fact been touched in unlimited ways by the experience of HIV. Finally, and most important, we have a range of evidence based prevention that is ready to go already without waiting for the biomedical answer to come through including open communication about sexual risk to young people, condom promotion in the sex industry, harm reduction strategies to people who inject and diagnosis and treatment of other STI's. If these strategies are implemented comprehensively and soon, millions of HIV infections over the next decade can be averted in this part of the world.

Thank you very much.

**PAKDEE POTHISIRI:** So next may I introduce Ian Askew from Track D to give the report.

**IAN ASKEW:** Good morning ladies and gentlemen, it's a pleasure and an honor to report on Track D, the social and economic issues on behalf of a great team, Judy Dennisen [misspelled?], Amy Kahn [misspelled?], Julia Kim, Anne McCauley [misspelled?] Susan Tudnum [misspelled?].

Track D highlighted three major areas of scientific investigation concerning the social and economic dimensions of this epidemic and its impact. The major proportion of sessions in this track addressed our understanding of risk and vulnerability, the means to prevent it on population scale, strategies to maintain the quality of life of people living with HIV/AIDS and ways to mitigate the impact on individuals, families, communities and society at large. Other sessions highlighted methodological issues and the transformation of research findings into action.

The theme of the conference is well reflected in many of the presentations in this track although the

presentations did tend to raise more questions than answers. Access to what? Access for whom? Access by when? What are the social and economic consequences of increasing access?

As has been well documented we are living through a maturing epidemic to the extent that we have both concentrated and generalized epidemics around the world and in some cases both concentrated and generalized epidemics can be found in one country. Unfortunately this dual occurrence of different forms of epidemic in the same country is most commonly found in the poorest countries that are least able to respond effectively thereby creating tremendous social and economic pressures.

We are also now at the stage of having epidemics of both HIV and of AIDS simultaneously. And each epidemic brings different social and economic challenges. And again these are most strongly felt in resource poor settings.

Fortunately many presentations in this track demonstrated that our understanding of social and economic issues has matured also to the extent we are now able to move from identifying, defining and framing the issues and using this understanding to operationalize the responses both locally, nationally and internationally.

The nature of the responses are also maturing in that we've increasingly nuanced and increasing the effective response that are being developed on the basis of this understanding. However, they still tend to be rather programmatic responses rather than interventions that deal with the underlying structural determinants of vulnerability.

Although we do know better now how to frame the social and economic issues and we are rapidly using this knowledge through applying it to designing and implementing and evaluating responses, several sessions in this track revealed methodological, ethical and utilization challenges facing those undertaking research into these issues. For example, presentations were given about the difficulty of abstaining, of efforts to evaluate abstinence programs in Kenya and Mexico largely because definitions and understanding of the concepts vary between the teachers and the pupils

and because abstinence is being discussed with little or no discussion of alternatives for those who are already sexually active.

Ethical issues will always challenge researchers and in this field and merging issue that came out is how to insure that children participating in AIDS vaccine trials are engaged ethically and treated ethically throughout the trial.

Thirdly, with the move towards larger scale responses the question was raised about how useful and about how generalizability are data that are collected through ethnographic and other data collection methods that specifically try to get a better understanding of the specific needs and context in which the interventions will be implemented.

The majority of the sessions in this track improved our understanding of the context in which groups of people are vulnerable to infection. Entire sessions focused on differently defined groupings of people. If you see the slide you'll see a whole listing of session titles to illustrate these different groups that were addressed. And this reinforced the fact that the maturing epidemic and especially countries where it is now generalized has not only increased the number of people at risk but also it reduced and blurred the former distinctions between high and low risk groups.

As planned by the organizers several papers gave useful and insightful analyses of the youth including papers on the problems facing youth who are positive, enabling youth to remain negative and youth living in difficult situations. I'm not sure however that we can be confident that women were adequately addressed despite the intentions of the organizers. Certainly each of the groupings were desegregated by gender but very little evidence was presented about the vulnerability of the single biggest group of women, those who are simultaneously young, poor and married. Presentations about this group seemed to be restricted to satellite sessions only and we hope that they will be on the main program in Toronto.

[Applause]

Many presentations went beyond simply describing the contextual factors that enhance over

vulnerability to explaining the structural reasons underlying these vulnerabilities such as poverty, lack of rights and the associated stigma and discrimination and the advisability of those who have traditionally not been active in promoting their needs such as the elderly and the very young as well as identifying possible or actual responses that could reduce their risk.

The challenge for 2006 will be to see what progress has been made in following upon these suggested responses as surely they do need to be the next generation of prevention strategies.

Those papers that described or reviewed the social and economic issues of responses indicate a clear period of transition that we're currently going through. We've moved beyond prevention clearly but we seem to be at a stage of conflicting and competing priorities between prevention on the one hand and treatment and care on the other. Rather than being able to describe and analyze responses that are comprehensive and local appropriate to context of epidemic due likely it seems to budgeting and funding and opinion on approach.

All three responses are clearly important and are clearly related and we do need to move towards this third phase of looking at all three together but how much will be addressed over the next couple of years. Let's please revisit this in Toronto.

For example some issues arising in papers included whether the wider access to treatment and care impact some prevention efforts. For example the so-called phenomenon of AIDS optimism and whether awareness of access to ART is likely to increase the use of VCT to understand one's treatment, one's status if you know that treatment is available. Along the same lines the beginning PMTC Plus Program is very welcome and an exciting example of how these three approaches can be brought together and we look forward to hearing about them in Toronto.

But these are still largely programmatic responses. As we learn more about the structural determinants that place such a large number of people at risk we also have to experiment and place much more emphasis and more resources on vigorously examining the

structural and mainstreaming responses to the determinants especially in developing countries with generalized epidemics. Some examples of these were given particularly by those working in Malawi and elsewhere and can include some models such as micro credit schemes to functional literacy programs and so on. So let's hope we hear more about those approaches in Toronto.

Several papers indicated that there are many problems of this change, this transition as we would expect with how societies are managing it. Some positive findings were those most immediately affected by the epidemic and are beginning to become included but in what are they being included and with what influence still remains questionable.

A second aspect of the change that emerged was trying to develop one model for each situation is clearly no appropriate but we heard examples to our lack of attention to the need and evidence and an over reliance on ideology have skewed the nature of the response without adequately addressing the social and economic context. Questions are being raised about who is defining the needs and who is designing the responses. This maturation process is being played out very clearly in the context of evolving relations between the key stakeholders as their roles, responsibilities and expectations change. Several papers emphasize the importance of leadership be it by women, by people living with AIDS, by youth, by political and celebrity leaders. And we do hope that in the future we'll have a better understanding of how these roles and relationships can interplay more positively.

But with this maturity clearly attention comes. How to best mature the response without getting stuck in differences of opinion and differences of approach. Governments, NGO's, communities, activists are all still in the stage of assuming responsibilities without the adequate resources, knowledge or experience with which to implement programs. Paternalism and rebellion still seems to be the dominating characteristics of the interrelationships between the key stakeholders. And who leads this whole process is unclear. Each thinks the other is leading and there

seems to be a leadership gap which a lot of people are trying to fill.

The issue about growth during this period was highlighted in several papers but it appears to be uneven growth. In several areas in terms of funding there is an unevenness in the scale of funding where it's provided, unevenness in who controls in where the funding comes from and tremendous unevenness in how the funding is spent.

In relation to the third point we seem to be having some disproportional responses in different areas. We've seen I guess in relation to

**PAKDEE POTHISIRI:** You have two minutes left.

**IAN ASKEW:** The last couple of years, rapid growth around treatment, slow growth in areas of care, an attempt at prevention as you heard from the previous speaker. There seems to be a bit of a mix around both the biological and behavioral approach to prevention.

Given that we are now at the state of epidemic where we have a large proportion of people, large populations who are infected and affected, a number of issues were raised in sessions and I've put them up on the board here for you to see. Stigma discrimination and the rights of those infected and affected were at the forefront. The problems of double and treble stigma that my colleague Jon just related came up several times. Enabling people infected and affected to live full lives not only economically but socially and sexually was raised in several meetings. The issue of disclosure was a very hotly debated topic on one session. How to organize and how to cost the treatment of people infected with HIV/AIDS was discussed but no clear conclusions drawn. And we do need to put a lot more education in this area.

With an increasing number of people infected by AIDS, in terms of being either carers be they health workers, family members elderly caregivers the general community, NGO's and those affected because they have been orphaned. Some papers are beginning to come through with this theme and we do hope that the next conference will have a much bigger role to play in presenting data for all of these.

People living with AIDS are far more involved now than they have been previously but there is still

and quite rightly so many advance and increased level in designing responses and some interesting examples were given from case studies in developing countries of very positive examples of how this has worked.

**PAKDEE POTHISIRI:** Your time is up

**IAN ASKEW:** Sorry. Finally just we have the group put together four questions to ask ourselves in 2006. Are we getting the balance right between prevention, treatment and care? Are we addressing the clinical, the behavioral and the structural determinants both of vulnerability and of treatment and care? Are these responses socially and economically appropriate for the context? And are our responses to a generalized epidemic equitable given that we have more people to treat and care and more people who are vulnerable to infection? And the main question, the obvious one will be are we protecting and treating and caring for the majority of the population affected? And as you know that majority these days are the poor, the young and the married women. And one thing we did notice was apart from a lack of sessions on these, this particular major subgroup, a lack of attendance and participation in the conference and we do hope that the \$1000 registration fee may be waived so that more of this group can attend next year.

[Applause]

**PAKDEE POTHISIRI:** Thank you very much Ian. Now may I ask Edward Green from Guyana to report on Track E. You have 12 minutes. Please be on time because we have to close this session to begin the closing ceremony.

**EDWARD GREENE:** Mr. Chairman, ladies and gentlemen it is really my pleasure to present on behalf of Track E and I wish to acknowledge the rapporteurs that really collaborated in this project, Anita Boya [misspelled?], Villaly Komara [misspelled?], Edward Emmanuel, Jacob Gayle, David Stevens, and Angela Trenton-Enbondi [misspelled?].

What are the objectives of this report? First of all we have to deal with 15 panels and numerous poster sessions within the track which highlighted progress lessons learned and evolving challenges. It is therefore clear from the richness of the presentations and discussions and from the evidence

based illustrations of practices around the world that there is some justification for optimism of a kind inconceivable just two years in Barcelona, this therefore augers well for the collective fight against HIV/AIDS. The objectives really revolve around the guiding principles that we established as a group, because it was very difficult to deal with a schematic construction of all the SU's that surrounding these panels. Secondly we have tried to identify from among the several SU's some key ones and some key themes. And thirdly we are hoping to end with a call to action related on the progress from Bangkok to Montreal.

Now what are these guiding principles? In fact the main guiding principles resonate from the panels themselves. And the first one is that lessons learned from successful programs should guide the development of policy such as a more coordinated approach to resource mobilization, program planning and implementation. And you would note that these are consonants so to speak with the three ones enunciated in the UNAIDS platform for action. Secondly policy especially externally driven ones that impede success should not dictate program goals and a good example was a debate here at this conference between abstinence and ABC. Thirdly we thought that programs and policies should be based on scientific reality rather than on ideology and idealism.

[Applause]

Now having established these guiding principles what emerged from the panel were a series of themes, key themes and these are nine in all that we flagged as major ones. And let me just briefly indicate the first national leadership and we think that we should national and visionary leadership. And we think that visionary leadership is pivotal to insuring that the global goals do not override the national or regional responses. For effectiveness and efficiency, the panels indicated that governments, donors and civil society must decide on one conclusive coordinating authority, one national action framework and one national enemy [misspelled?] sister. Again this is consistent with the three ones enunciated in the UNAIDS plan of action.

Secondly there is the importance of involving

communities in policies and programs and this cannot be over emphasized. The role played by people living with AIDS, public-private sector partnerships including civil society for profit sectors, faith-based organizations and indeed the empowerment of vulnerable groups in this partnership. And then thirdly the building of human capacity which is essential and can be achieved in a variety of ways using partnerships and technical programs targeted to enhance the deficits and acceleration of the HIV/AIDS agenda. A fourth key theme that emerged was human rights and in this respect in order to eradicate HIV related stigma and discrimination there was need to flag in particular respect for gender specific needs and context to support vulnerable at risk populations that are socially marginalized. Fifth is the raging problem of the trade agreements that affect our country's negotiating position especially countries in the developing world. And it was clear from the panels that there is need for greater effort to be made to make sure that countries are aware of their rights and take full advantage of the flexibility in global trade agreements such as the trips rather than being railroaded into inadvertent action.

[Applause]

The sixth theme that emerged was the one of resource mobilization and here most of the presentations that dealt with this issue agreed that there is a need for a more coordinated response and approach and indeed identification of specific priorities, the involvement of partners and the minimizing of the burdens of multiple reporting to donors which are quite demanding especially in small or poor countries with limited human resources.

[Applause]

The seventh theme really is a very important one raised by all the presentations preceding mine. And it has to do with rooting policies and programs in knowledge-based activities. The rationale for this is illustrated in the cases that have been made at this meeting for greater emphasis to be placed on evidence versus prevalence and for developing, monitoring and evaluation not as a duty but as an essential component of knowledge-based policy and programming. A recurring

challenge is how to link communities to resources, how to evaluate the effects of policies on program impact, how to create an understanding of the role of policy emerging out of research.

**PAKDEE POTHISIRI:** You have two minutes left.

**EDWARD GREENE:** Indeed there is an eighth principle and a ninth emerging from this one, access to treatment for all which was the theme of the last but one presentation and access to prevention for all. In the latter, access to prevention again is one in which the panels that we monitored were all concerned that we should move towards a combination of tools rather than any one insulated tool. And this leads us to some of the gaps that the rapporteurs in this track identified. One major gap was already referred to by the last speaker. We found too little was said about the issue of gender and HIV/AIDS in particular as HIV/AIDS affect our young women especially in the developing world.

[Applause]

We think that another major gap here is dealing with the human capacity and the need for strengthening the human capacity. We also think that we cannot go to Toronto still guessing about the policies and programs with respect to stigma and discrimination. And we also identified that access to prevention must be resolved by Toronto and that we cannot afford to have the dichotomy that we had at Bangkok. And finally

[Applause]

Finally, we think that as we move from Bangkok to Toronto and we call for action that we have to focus on scaling up advocacy to activism and this involves establishing a human rights framework, more inclusion of effective communities and governance, achieving the 3x5 initiative which means a greater proportion must be allocated from local purchasing power rather than the enormous rates that are now charged for the ARV's and in fact what we think to be most important is that we need to move towards the consideration of free access to HIV care and treatment in many countries. Thank you very much.

**PAKDEE POTHISIRI:** Thank you Edward. And now for the Community Program may I invite Shaun Mellors to come forward. You have 12 minutes. Please.

**SHAUN MELLORS:** From presidents to republicans, princesses to priests, sex workers to politicians, activists to advocates, drug users to youth, movie stars to pop stars, it is indeed difficult to do justice to the many varied community sessions and events that were covered in the conference program. This is therefore a reflection of a few key issues as identified by the community rapporteur team on sex, lies and the entire AIDS conference.

Let us reflect for a moment on the conference theme, Access for All. What do we mean by access, access for what, access to what? Do we need to talk about access to integrated health programs, health infrastructures, about access to education for all, about access to clear, candid and uncomplicated information, what about access to prevention technologies, to condoms, to microbicides, and vaccines and what about access to these conferences?

[Applause]

Sex. For leaders to put question marks where there ought to be exclamation marks is not irresponsible if not immoral.

[Applause]

People pay with their lives if we override science with ideologies. ABC for example as a strategy has been discussed at this conference but by severely twisting the concept some have reduced the strategy to AB with little or no attention to condoms. As many people have demonstrated during the conference, condoms are a vital component of an effective HIV prevention strategy and play a decisive role in preventing the transmission of HIV.

[Applause]

While abstinence and fidelity are important factors in prevention, marriage and monogamy are increasingly a risk factor for many women where vulnerabilities intimately link to power and negotiation. The Bangkok conference may be remembered for highlighting the issues of women and youth but women are not a homogenous group and the diversity of the lives and realities were unfortunately not as effectively reflected in the content program. We did not hear the voices of the women drug users, women prisoners, lesbians, trafficked women and the girl-

child. Women living with HIV have had a higher profile in the corridors, the satellites and some programmatic sessions but their voices were silent at the plenaries and other critical sessions.

[Applause]

We have to put the sex back into the epidemic rather beyond just a root of transmission. There was no celebration of positive sexuality, no celebration of lesbian, gay, bisexual and transgendered identities, no celebration or discussion of diverse sexuality or of our sexual rights.

[Applause]

Although the issue of male to male sexual behavior made it onto the program and we are very grateful for that, the sessions covered it from a behavioral or intervention perspective and did not necessarily address the sexuality and identity.

Lies. Access to treatment and the infrastructure to sustain that treatment require strong leadership. What or who defines a leader? What does it take to be a leader? What constitutes a leader?

[Applause/laughter]

Some of the sessions in the leadership track confused leaders with leadership. Not all leaders show leadership.

[Applause]

For one week every two years many leaders are given a microphone and a photo opportunity and continue to make empty promises and unimpressive speeches without action after the conference week.

[Applause]

How do we hold our leaders accountable? How do they hold us accountable? How do we ensure that we stop paying with people's lives for failed commitments and empty promises? We require leadership and we have to hold you Graffi Achelle [misspelled?], Kofi Annan, Peter Piot, Randall Tobias, [inaudible], Richard Gere, Miss Universe, and ourselves accountable for promises made and for accountable actions. Kuhn Mechai [misspelled?] who is the community co-chair publicly declared and committed to have a monthly public meeting in a park in Bangkok to report back to the Thais, to monitor progress about the promises that were made by the prime minister in the opening ceremony.

[Applause]

Commitment. There were commitments made since Barcelona, 3x5, PEPFAR, and funding to the global fund for example, but who do we hold accountable if this is not achieved and how do we hold these people accountable. The director of the world health organization said we should not waste any more time on what is not possible but rather make it happen. Well 8,400 people have died during the conference week simply because they do not have access. We all need to be accountable to deliver now and into the future beyond 2005. What about 4x6 and 5x7? The UNGES [misspelled?] declaration is falling off the political agenda and is in danger of becoming yet another declaration of commitment sitting on our shelves as we struggle to move beyond the rhetoric. We can all be leaders and are all leaders in some way. For doctors, for nurses, the frontline community workers, activists, sex workers, and drug users. We need to share the responsibility and be accountable to insure that UNGES, global fund and other commitments do not become more empty promises.

Aids conferences. In Barcelona in 2002 we referred to the Bangkok conference as the accountability conference, the conference where we would get answers, measure our progress on international commitments and address issues of access for all. We have heard terms commitment, leadership and accountability bandied over and around during the week, but is this going to lead to access for all? How easy we forget our history. How quickly we become silent. Jackson [inaudible], some of the activists from Asia and many other friends, activists and loved ones who have passed on have fought the battles and guided us by not only questioning, fighting, making their voices heard but also providing leadership and the vision for the future.

Accountability is a two way process and part of taking accountability is taking responsibility. Protocol or not, what happened at the opening ceremony what happened at the Paisan exodus was uncomfortable, disrespectful and we need to insure that it does not happen again.

[Applause]

**PAKDEE POTHISIRI:** Two more minutes please.

**SHAUN MELLORS:** Moreover we also need to take a critical look at ourselves, the conference participants and co-organizers. How can we the co-organizers and the community co-organizers have agreed to the community representative as the last person on the program? Surely we should have learned from our history. We need to hold ourselves accountable, the thousands of us, the activist, community representatives, those with HIV, NGO's, those that walked out of the opening ceremony. We owe Paisan our community voice a collective apology.

[Applause]

The art and cultural program demonstrated that culture is at the heart of everything that we do. It shapes our ideas, behavior, expression and perception of the world around us. The cultural program was truly extensive, interactive and covered the different components that depicted love, life, sexuality and helped us connect as a global community. The PWA Lounge also needs special mention as the wonderful volunteers and staff of the community department and lounge created a piece of heaven right in the conference center. While not everyone can attend an AIDS conference this conference has reached out to the broader community through things such as the community impact project, skills building program, the global village, the press advocacy parade and the form festival to bring the conference message and meaning to Bangkok, Thailand and to the world.

Has the unified program worked? Who knows? Did the abstract sessions acknowledge and highlight the role of communities in the response to the epidemic, work and community projects analyzed thoroughly for effectiveness and impact? Did Bangkok address and elaborate on the role of communities in designing, implementing or interpreting evaluation? We have made significant changes in these conferences over the years since 1988 when Stockholm added a lunchtime community session. The conference program was full and diverse and ironically many people have thought the quality of the content has been diluted.

In conclusion the community rapporteur team therefore has the following recommendations for Toronto

and future conferences. The abstract form and process should be reviewed and creatively changed to insure that the lessons learned at the country level could be realistically captured and transferred to other situations and settings.

[Applause]

**PAKDEE POTHISIRI:** Please wrap up.

**SHAUN MELLORS:** The abstracts review committee should be renewed and reviewed to represent the diversity of experiences and realities on the ground and not simply a list that is passed on from conference to conference. Creative means for improving networking interaction between sessions and informal gatherings need to be developed. The global village was a creative concept that brought the conference to the people and should be adapted and perhaps even institutionalized for future conferences. And each conference should report on commitments made at the previous conference and what has happened about those commitments.

[Applause]

None of this presentation or work at the conference would have been possible without the support of the community rapporteur team and the committed staff and volunteers at the community program. Let us hope that in Toronto 2006 we would have moved many more discourses forward, identified effective strategies, applied what has been learned about the epidemic and save many more lives. And hopefully, the community rapporteur team will get more than 12 minutes. Thank you.

**PAKDEE POTHISIRI:** Thank you Shaun.

[Applause]

This is the first time that the village program has emerged as one of the three main program of the IAC and now it has come to a successful conclusion so I am very pleased to introduce Debrework Zewdie, co-chair and chief rapporteur of the leadership program.

**DEBREWOK ZEWIDIE:** Thank you Dr. Pakdee. It is a singular honor for me to report back to you the results of the first leadership program. As a famous wartime leader once put it and I paraphrase lightly, women and men make history and not the other way around. In periods where there is no leadership,

society stands still. Progress occurs when courageous skillful leaders seize the opportunity to change things for the better.

Why do I recall the words from a wartime leader? Because that's what we need, a new campaign with all the urgency of a war to throw back HIV/AIDS and the leaders to force it into retreat so we can one day find ourselves the world over saluting the demise of this once perilous disease.

This year's conference was the first to include a full program devoted to amplifying the importance of leadership in the local and global response. When the UNAIDS family, the International AIDS Society and the Thai government first proposed the creation of a leadership program some people questioned why an international conference should focus on leadership at all. It is not the time to undue science. Science has taught us what was. We have a responsibility to put this science to use. We cannot afford to water down our prevention strategy into an A and B approach knowing very well that lives are at stake. To me the reason is glaringly obvious. Leadership has been the missing link.

Ever since the first AIDS conference in Atlanta 20 years ago these meetings have yielded a vast body of knowledge of how to fight AIDS. Let's remember that we have long known how to prevent HIV transmission and how to alleviate the epidemic's impact. Brazil, Senegal, Thailand and Uganda have all reversed their national epidemics by putting these lessons to use. With more money for the fight than ever before and with the tools for treatment at hand, we are now poised to achieve similar results on a global scale but we cannot do so until we supply the missing link of leadership especially from our political leaders. This is why we say that nothing spreads HIV faster than silence and the worst kind of silence is at the very top. For our fight to succeed the scientific and technical knowledge we have seen this week must be matched with determined and driven leadership committed to putting into practice what we know to be effective.

The Bangkok conference has attracted more leaders from more walks of life than ever before, heads of state, captains of industry, cultural stars,

community champions, and over 80 cabinet ministers from all sectors. The leadership program devoted dozens of sessions to different aspects of AIDS leadership. It convened 17 multi-sectoral leadership fora [misspelled?] where diverse groups produced their declaration of commitment to be delivered at the closing ceremony. And it laid the groundwork for accountability. All leadership program sessions were evaluated and more than 90% were found very useful by those in attendance.

So what did we learn about leadership? We learned first of all that leadership comes in many forms, from people living with HIV to young people to mothers in small villages to men who have sex with men to Buddhist monks to priests to immans to our scientists who have made such heartening progress in understanding the disease and how to fight it and towards the public and the private sector. To reflect the spread of leaders we have launched a web-based series on AIDS leaders or profiles in courage that will continue after the conference ends. Profiles in courage are about ordinary people who through personal courage and commitment have made an extraordinary difference to improve the lives of others.

**MALE SPEAKER:** [inaudible] by my life because [inaudible] medicines cost me less than 350 [inaudible]. The same medicines four years ago cost more than 4,500 [inaudible] that has been the effort, an enormous effort, of everybody here, these conferences.

**DEBREWOK ZEWIDIE:** We learned that real leadership takes courage. It take courage for a 21-year old like Ricky Thambe [misspelled?] to speak openly about his HIV status and to demand that young people be meaningfully involved in the response to AIDS rather than patronized and therefore disempowered.

In the case of President Husefini of Uganda, it took huge courage 18 years ago for a young, newly elected leader of a poor country facing so many challenges to recognize the AIDS threat and to speak openly and forcefully about a problem that others only whispered about.

We learned that leadership empowers others. In the case of [inaudible], Miss HIV Stigma Free

Botswana, her work to reduce stigma has empowered people to learn their HIV status and if positive to get the help they need to keep living life to the full.

The Sonacha [misspelled?] sex worker initiative in India has proven so effective in preventing infections because it does not treat sex workers as plants or patients. It empowers them to take control of their own health.

**MALE SPEAKER:** [inaudible] respect and uphold the human rights of all who are vulnerable to HIV/AIDS, whether sex workers, drug users or men who have sex with men, have sex with men, have sex with men.

[laughter/Applause]

**DEBREWOK ZEWODIE:** We have learned that leadership is respectable. As we have heard in many sessions of the leadership program this week the time has come for donors to submerge their egos in the interest of uniting behind country ownership. This requires the wisdom to relinquish some control over national decisions even though they are writing the checks.

Sometimes true leadership lies in letting others lead. Leadership means translating the three ones into action now.

We also learned that leaders listen. In the fight against AIDS leaders must listen above all to people that are living with HIV even when it may be neither palatable nor convenient to do so, and especially when what they say may challenge leaders to think and act differently.

We learned that leadership is about accountability. Throughout the more than 20 years of this epidemic, political leaders have made countless promises and commitments.

**FEMALE SPEAKER:** If all the donor countries delivered just one single target which is the 0.7% of GDP for developing systems we'd come very far in getting the funds needed for HIV/AIDS treatment, HIV/AIDS treatment, HIV/AIDS treatment.

**DEBREWOK ZEWODIE:** The vast majority of them have never been kept. As the secretary general mentioned during the opening ceremony, many countries are well on their way to failing short of their commitments made at the 2001 special session of the UN

General Assembly.

So what can we do? From now to Toronto, the leadership program intends to monitor the many commitments made here in Bangkok and call the leaders who made them accountable for delivering on them. In the 70% of the leadership program sessions, specific commitments were made on policy, resources, scaling up and closer collaboration. At the 2006 conference in Toronto, we will report back on our success or our failure in following through these statements of result.

As I mentioned earlier, we are all AIDS leaders. The burden the leadership program has placed on our leaders is a burden we must place on ourselves. As we leave Bangkok, each of us must learn within ourselves to renew our resolve and redouble our efforts to turn back the tide on HIV/AIDS.

Last night I had the honor of accompanying President Nelson Mandela during the special leadership event in the arena. By persisting in his work on HIV/AIDS long after his retirement from public office, Mr. Mandela has embodied every crucial element of leadership, wisdom, resolve, perseverance, creativity, faith in a better future and a commitment to justice, openness and inclusion.

[Applause]

In closing, let's recall that rarely has the ancient admonishing been so literally true as it is in the era AIDS. Where there is no vision, the people perish. Here in Bangkok, new leaders have lifted our sights with bold new visions.

**MALE SPEAKER:** We are now implementing a harm reduction program; Live to Reduce the Risk of HIV Infection.

**DEBREWOK ZEWIDIE:** The prime minister of Thailand pledged to insure universal access to ARV's and to implement harm reduction programs. Six national governments from different regions pledged to work together to manufacture and distribute antiretroviral drugs. And parliamentary leaders vowed to introduce legislation to protect the rights of people living with HIV.

We applaud their vision and the thousands of other examples that all of you as AIDS leaders show

every day. Let's now make it our common cause to convert analysis into action, resources into results and advocacy to access for all. Above all let's hold one another and ourselves accountable for all that we do or fail to do.

At the end of a hectic week, let's take with us the wisdom, hope and inspiration of Mr. Mandela's example. When we gather again in Toronto, let us be able to say that because our battle was joined in Bangkok by leaders of courage, vision and respect we finally began to lay the foundations of a just world where neither AIDS nor anything like it could every divide and conquer our human family again. I thank you.

**PAKDEE POTHISIRI:** Thank you very much Debrework Zewdie. And for all the excellent presentations may I ask the audience to please give a big round of Applause for all the speakers.

[Applause]

**PAKDEE POTHISIRI:** I will now close the session but please stay on for the closing ceremony which will begin in about 15 minutes from. But thank you very much. Hoping to see you again in Toronto in 2006.

[END RECORDING]