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**XVII International AIDS Conference
IAS 20th Anniversary
August 5, 2008**

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[IAS 20th Anniversary Film playing]

PEDRO CAHN: Good evening. Welcome to the International AIDS Society 20th Anniversary Session, Reflecting Back and Looking Forward. It is my privilege as my almost last task as President of IAS to chair this panel together with Julio Montaner, our new President, and Craig McClure, our Executive Director.

We started to think about this about one year ago with Craig, realizing that 20 years have been passed since the IAS was created. And, really I think that during these 20 years we, all IAS members and governing counsel and staff, hope to make a difference in the field. One way tried to commemorate this 20th Anniversary was with a series of speeches of former presidents and relevant leaders in the field that help us in some way ramp up the achievements during these 20 years.

Before we start with our series of speakers, do not be afraid they will speak for 10 minutes each, so it will not be that long. I would like to welcome and ask for round of applause for our new members and positions.

First, our incoming president, my friend, Julio Montaner, from Canada. [Applause] People from Vancouver, please keep quiet. [Laughter]

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Also, it is a special satisfaction for me to introduce our President elect, the first one from Africa, Elly Katabira. [Applause]

And also our incoming Treasurer and watch dog of our finances, Alan Whiteside from South Africa. [Applause]

Please join me in welcoming our new members in our governing counsel. From the U.S. and Canada region, Chris Beyrer and Cheryl Walmsley, Cheryl Walmsley as a reelected member. [Applause] In Europe we have one re-elected member, Michel Kazatchkine and a new member, Anton Pozniak. [Applause]

From Africa we have one reelected member, Viola Onwaliri, from Nigeria and four new members, Fautine Ndugalile from Tanzania, Papa Salif Sow, from Senegal, Robin Wood from South Africa and Debrework Zewdie from Ethiopia. [Applause]

From Latin American and the Caribbean, the new members, Celia D.C. Christie Samuels from Jamaica and we have two reelected members, Hector Perez and Celso Ramos from Argentina and Brazil respectively. [Applause]

And last but not least, from Asia and the Pacific Islands we have Dennis Altman from Australia, reelected and Sai Subhasree Raghavan from India as new governing counsel members. [Applause]

So, Craig?

CRAIG MCCLURE: Thank you Pedro and thank you everyone for coming. This 20th Anniversary Session also doubles as our

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Annual Members Meeting so I want to welcome all of you members and anyone who is not a member this is your chance to become a member.

As Pedro said, this is a special year for us, 20 years of the International AIDS Society. We have also been through a lot of change in the last four and a half years since moving to Geneva. In order to try and capture the history from the times in Stockholm to the times in Geneva, the first Secretary General of IAS, Professor Lars Kallings, sitting to my right and I put together with the support of Rodney Court, our Editor, he is in the front, history of the last 20 years of the IAS. Particularly as seen through the conferences but also through the policy advocacy and education work that we have done.

The film that we had to unfortunately to cut off because we are short of time is on a CD. It is in every delegate's bag. I think we got up to 1996 so there was still another 12 years to watch. It will actually be re-edited and refined and then released as a documentary later this year.

I would just like to thank all of the donors of this meeting and in addition, the core donors of the IAS. The Ford Foundation and then we have support from The Bill and Melinda Gates Foundation. It takes a lot of support to put this meeting together. For this meeting I want to thank the Government of Mexico and in particular the Mexico Ministry of

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Health, the Government of Mexico City, the Joint United Nations Program on HIV AIDS, UN AIDS, WHO, The Global Fund, a whole range of bilateral governmental donors, Spain, Sweden, The Netherlands, Canada, Norway, Great Brittan, Ireland, Australia, and France. There are a number of private foundations, The Ford Foundation again, The Bill and Melinda Gates Foundation, again. The OPEC Fund for International Development, The Carso Health Institute, The Pfizer Global Health Fellowship Program, I did mention the Government of France, the NARS. Our major industry sponsors, Abbot, Boehringer Ingelheim, Bristol Meyers Squibb, Guliad, Glaxo Smith Klein, Merc, Pfizer, TBO Tech, Berko, Roche as commercial industry sponsors. And locally, Microsoft, Coca-Cola and The MacArthur Foundation. Thank you all for making this event happen. [Applause]

I would like to without further adieu, introduce our regional representative for the USA and Canada on our governing counsel, Diane Havlir who will introduce our first speaker. Diane?

DIANE HAVLIR: Thank you, Craig. It is now my pleasure to introduce our first speaker, Professor Lars Kallings. He is a graduate of the Karolinska Institute and has been working on the AIDS epidemic since the early 1980s. He worked with Jonathan Mann in the late 1980s. He is the founding father of the International AIDS Society serving as its first president in 1988. At this time, he and a number of visionary leaders

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recognized the need for a global forum to address one of our greatest public health challenges that we face today.

Professor Kallings served as Secretary General of the IAS from 1994 to 2002. Among Professor Kallings numerous contributions include his role as a crusader for HIV prevention and for vulnerable populations. He is currently the UN Secretary General's Special Envoy for HIV AIDS in Eastern Europe. He has spoken out vocally against stigma experienced by those living with HIV and he has spoken out against subordination of women that is guised under cultural norms.

Dr. Kallings, we welcome you, we thank you, and we look forward to your talk on the earlier years of the epidemic and the IAS. [Applause]

LARS KALLINGS, PH.D.: Thank you, Diane. My dear friends I would like to say both old friends and new friends, so many among you that I have been working together with for the decades. This is a real pleasure.

About the early days of the epidemic and IAS I would like to remind you about the sudden appearance of AIDS in the USA in 1988. It caused emotional shock due to the relentless cruel and fatal course of the disease in a rapidly increasing number of young and previously healthy people. Scientifically it constituted a challenge due the enigmatic cause of the disease.

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The first time was chaotic but soon enough it was obvious that we dealt with an infectious disease and the transmission roots were demonstrated. In 1983-'84 a virus was found as a causative agent and already in '85 a diagnostic test was commercially available. During the meantime, we had realized that a much bigger and heterosexual epidemic was ongoing in parts of Sub-Saharan Africa. This rapid development prompted CDC in Atlanta to arrange an International AIDS Conference in 1985. Gary Nobel of CDC was chairman of the first International AIDS Conference which focused quite naturally on the biomedical aspects.

Of course, nobody was an expert on AIDS or the causative agent from the beginning as both were new to science. Most experience of AIDS research during this early days existed in the U.S. and in France. Therefore, the second International AIDS Conference was arranged in Paris in 1986. The idea was to alternate these conferences between France and the States which also had to do with national prestige and glory.

Consequently, the third conference took place in Washington D.C. the next year chaired by George Kallaso [misspelled?] of NIH. This was consistent with the U.S. policy to recognize the two major federal stakeholders, CDC and the NIH. However, in North America there were other contenders which wanted to be acknowledged as organizers of these series

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of conferences. Notably in San Francisco on the West Coast where the first AIDS cases had been reported.

A big local epidemic was raging and science was outstanding with names like Uri Levy and Paul Popiding [misspelled?]. Boston was key contribution from Mark Essex Group at Harvard on the causative retrovirus and Montreal with the McGill University.

When in Paris, during the second International AIDS Conference the Canadians had arranged a promotional luncheon. The luncheon was for the leading circles of AIDS researchers in an attempt to get the fourth conference to Montreal in 1988. The competition between other North American candidate venues became obvious. But actually, the next conference after Washington should have been alternated to Europe. IAS was a dark horse and proposed Stockholm in the 1988, Montreal in 1989 and San Francisco in 1990. To my consternation it was so decided.

I had just jumped in on this opportunity, however, this pointed to the haphazardly selection process and the need for a more orderly and less spontaneous policy. Therefore, IAS was founded during the fourth International AIDS Conference in Stockholm in 1988. IAS was to establish an orderly planning process to coordinate future International AIDS Conferences which were growing in size, complexity and importance.

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Already in 1988 the conference included 7,500 participants from 140 countries. A group of prominent scientists from different regions of the world met to formally found IAS and elect an Executive Committee and an Advisory Board.

I have made these slides from the original document so they are scanned and they look, as you can see, very original. [Laughter] I hope that you can read them. [Applause] The only one that many of you might not know is the Executive Secretary, Professor Fredrick Dineout [misspelled?] of Munich, West Germany at that time. A well know virologist particularly about the hepatitis virus, he was a great personality with a big heart and unfortunately he died in 1992. This is how he looked and perhaps one can see that he was a person who was committed to the cause.

The Advisory Board at that time might of historical interest because it is like a Who is Who in the AIDS world at the beginning. And you will recognize several names, Tolcie, Gallo, Hacitine [misspelled?] who then moved on to the Human GENO Project. Jared [misspelled?] you might not know in this circle because he was a veterinarian who worked with the retroviruses in animals. That was very important at that time to know about the other diseases caused by retrovirus although in animals, like in cats, like in cattle and so on. Montaner of course and Peter Piot.

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Among the African members Peter Kabita [misspelled?] should be mentioned, he was the head physician of the Mamaneoubor [misspelled?] Hospital in Kenshacha [misspelled?] and played a great role in the beginning. Sumon, Enbook, Fred Maloe [misspelled?] some people are still active. And from Asia, Osiana, [misspelled?] Gary Cooper of course and Praphan Phanuphak who is here. He seems to be as eternal as I am. [Laughter] It is very nice for me to meet him again.

The aims of the International AIDS Society as seen already in 1988 might also be of interest because not so much has changed because they actually illustrate the heart of what we are doing. For instance, to organize the annual conferences and what we call it at times, small specialty conferences in AIDS which we have seen now. IAS was to add international status and recognition to AIDS research, prevention, treatment and control. It was very important to get stability as to how AIDS and HIV was considered at that time. It was to represent the scientific community as a voice of reason in AIDS controversies which has been very important during those the years.

As an example, we already on the World AIDS Day in 1988, issued a declaration. Scientists Against AIDS Discrimination which was even more obvious, even if it is very obvious now. A lot has happened actually. This is too long

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for you to read it is just to show this original document and I will not dwell on that.

It is interesting that the objectives of the International AIDS Conferences were formed together with The Global Program on AIDS. I worked together with Jonathan Mann to write these objectives and you will recognize many of them. For instance, create an environment conducive to effect communication among participants and to inform the media and public. And to foster global approach to the pandemic and to promote international participation and solidarity and respect for human rights on dignity for people living with HIV AIDS.

I would like to mention that already in 1988 in Stockholm we had a program and an important part of the program what was called the face of AIDS. This was people living with HIV AIDS was contributing to the conferences and had a specific role in the conference.

The politicizing of the conference and influence by activists had started already during the Washington Conference. There was protest against President's Reagan's dilatory and reluctant approach to AIDS. Yes, even his aversion to get his tongue around the word AIDS, even when already tens of thousands of his countrymen had died of AIDS. The activists and the advocacy exploded during the Montreal and San Francisco Conference in 1989 and 1990 as you can see on the film shown before the formal part of this presentation. And newspaper

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headline, International AIDS Conferences would never be the same after Montreal captured the sentiment of the full Conferences which has incorporated political discussion and activist protest demonstration and debates. It is important to mention that IAS policy of avoiding violence by police and security has largely prevailed balancing freedom of expression and protest action.

In the name of shortening my presentation I would just like to finish by mentioning that in 1994 the IAS was reconstructed. We had before only honorary officials and as there was a need, particularly after the death of Fritz Steinhart to have a permanent secretary with an employed secretary general. The staff was very small at the beginning as I am showing in this yellowed family portrait. [Laughter] That was me and two assistants which was the entire staff in the beginning. I would like to finish by saying that I am deeply grateful to have had the possibility to serve IAS. I would like to thank you for this opportunity to wind up some experiences during some defining moments of the IAS history. And to be with you once again and witnessing the every increasing importance and success of this great society. Thank you. [Applause]

CRAIG MCCLURE: Thank you very much, Lars. We are very honored to have you with us this evening. I would like to introduce now Dr. Jerry Kbadu [misspelled?] of South Africa who

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will introduce our next speaker on the basis science of HIV.

Jerry?

JERRY KBADI, M.D.: To my colleagues on the table and members, it is my pleasant duty and responsibility to introduce a figure who has been central to the IAS during my 18 years of association with the body. That person is, Mark Wainberg. I am not going to spend too much time on his academic accomplishments. You know that he is a Professor of Medicine, Microbiology and Immunology.

It always amazes me how North Americans are professors in three major fields each of which requires at least five or ten professors in the developing worlds. But Mark and people like him achieve things which are almost impossible for us.

Mark has is a Director of Research. He is mostly at the Jewish Hospital in Montreal and works at McGill University in various positions. He has had numerous awards. He belongs to numerous international bodies as an advisor. He is working mainly in drug development and has been responsible for the development of, a very important one, 3TC. He continues to expand his interest outside of that to issues like prep and to microbicides and so on.

My main purpose of introducing him now is to tell you that he has been President of the International AIDS Society towards the end of the '90s. Also, he was the co-chair of the very successful Vancouver Conference.

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I am sure it has not missed your attention that much of the emphasis of the AIDS Conferences before 2000, were in the developed world. Most of the problems, probably 70 to 60 percent of the problems were in developing countries. It is to the foresight and the vision of Mark, as President in the latter part of the '90s that he fought for some of his other colleagues in IAS to bring that Conference to Durbin in South Africa. It was a symbol of the movement of the issues of the developed world to the problems of the majority of AIDS sufferers. That is quite an accomplishment. But in a way, it resulted in much, much more because what he did required a little bravery and some courage. To recall for those of you that do not remember, it was a particularly fragile period. It was a very dangerous period in fact for science.

It was a period in a country where there were challenges from the highest sources almost unique in a democracy to the very idea of science and the causes of HIV AIDS. Mark and his colleagues made it possible to fight that. It made it possible to mobilize 5,000 if I remember scientists, and at least 10 Nobel Laureates in a declaration. It was important to say to people in power that you cannot judge against science and scientific methods and discovery. That was called the Durbin Declaration.

I can go on and on the impact of that meeting reverberates up to today. I think Craig wants me to stop.

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[Laughter] He thinks we get carried away with what we achieve but it has left a legacy that has been almost unparalleled. I am really grateful to Mark who has actually made that possible. So, once again it gives me great pleasure to ask Mark to come here and I look forward to hearing his speech.

MARK WAINBERT: Thank you very much, Jerry. I must say that one of the highlights of my personal life was to have been President of IAS at the time that we organized the Durban Conference. I began my life-long fight with President Mbecki of South Africa during the days and weeks and months leading up to the Durban Conference. Unfortunately, it is a fight that still continues because he is still the President of South Africa and I am a long time has been past President of the International AIDS Society.

With that in mind, I also want to pay tribute to Lars Kallings and really pay tribute to his enormous memory skills. He remembers everything about the origins of the International AIDS Society. To give you an indication of how we are different as individuals, my own memory is not anywhere near as good as Lars. So, when I was looking into the question of the International AIDS Society I actually decided to a Google search. If you do a Google search, IAS is which is what I put in, [laughter] you bring up the International Association of Sufism. A non-profit NGO of the United Nations and you can see here there is a picture of the Dali Llama on the right hand

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side in San Francisco. He is meeting with the co-founder of the IAS but I am sorry I do not see Lars Kallings in this photograph anywhere.

I show you this because we are in the days immediately preceding the opening of the Olympic Games to take place in Beijing. I think as many of you know I made a conscious decision along with I think many of you to boycott the Olympic Games this year. I wanted to be here instead in Mexico [applause] at the Conference of the International Aids Society.

I wanted to show solidarity in the fight for an independent Tibet but you probably do not know this, I gave up my place on the Canadian Olympic athletic potential. Someone else is taking my place in the high-jump. [Laughter]

I want to first begin with a photograph of someone who is a dear friend and she is sitting in the third row, Francoise Barre-Sinoussi. [Applause] Because if we talk about accomplishments in basic science in our field I think that we have to acknowledge that discovery of HIV. The first isolation of this virus really gave forth to everything that we have accomplished in diagnostics and in drug development. Without the identification of HIV as ideological agent of AIDS we would not have been able to accomplish any of the progress that has taken place these many years. So, I think we should all extend a deep appreciation to Francoise for her seminal work in this area. [Applause]

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We heard about drug development and drugs like 3TC. I want to point out that the initial synthesis of the molecular structure that is known as 3TC and for that matter the original synthesis of the molecular structure known as FTC were conceived along with several other drugs that are still in development. One of which you heard about this morning and it is Episidibine ATC [misspelled?] a drug on which Pedro Cahn has actively worked. Give credit to the late Doctor Bernard Bello, one of my colleagues at McGill University. He was a Professor of Chemistry at our University who conceived biosynthesis of these structures. The reason of course that I say this is that if we speak about basic science research we need to give credit to the chemists. They designed complex synthetic pathways that gave forth to the drugs. This is truly basic science. Unfortunately we do not give enough credit to the chemists who have led us down the pathway of drug discovery that ultimately has resulted in the savings of many lives.

Really, I also want to show a picture of perhaps other people whom you know. Ray Shanazzi [misspelled?] and Dennis Leota [misspelled?] who took a basic structure and figured out how to separate [inaudible]. They then came up with the structures that represent the actual drugs that we use in therapy today. Of course the list is way too long to mention in terms of each and every chemist who has contributed in a compelling way to the field. As for example, Dr. Holy, the

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founder of Tenofovir and many others. Really, one has to give credit to all of these individuals.

What about all the rest of basic science? How can I possibly go through a litany of every accomplishment in the field? It is just impossible so I thought instead I would just quickly run through the Track A and the various subtopics. I mean to do this very quickly.

Biology and pathogenesis including all of these topics on the slide, basic retrovirology, viral diversity and bioinformatics. As well as pathogenesis in all of its manifestations, the immunology of HIV and HIV drug resistance. Drug resistance is a field that as many of you know is still very close to my heart after all these many years.

AIDS vaccines and microbicides and our quest for effective prevention tools will always be important to all of us. As we have said, drug development in all of these aspects is important. We have made progress in many of these areas but clearly we need to make more progress. Of course I want to underline that it is ultimately the clinicians whom we rely on to teach us how to use these drugs effectively. Without whose expertise we would also never have been able to make it to first base.

We also have here gene therapy, vaccine research, microbicide research. I think that I can only point to this slide and we now have a much better understanding of what will

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not work. I hope we will accomplish progress of a meaningful type in the next several years. We have heard talks at this conference that have asked us to be optimistic and I must say I agree with that approach. We have no choice. As was stated so eloquently by Mike Cohn this morning, vaccine research must go forward. We must strive toward the attainment of success and it does not matter how many years it takes. We have to accomplish this goal.

Prevention science prep is the new great hope. I think it will work but let us stay tuned and find out. Thanks to all of you for your attention and for giving me the opportunity so many years ago to have served as your President. [Applause]

CRAIG MCCLURE: I wanted to introduce our next speaker. She is the only member of the Panel who has not been a President of the IAS. I think perhaps in the future she might be. [Applause]

Kate Thompson is the Chief of Civil Society Partnerships at the Geneva Headquarters of UN AIDS. She has been active in the field of HIV since her own diagnosis in 1987. That same year she set up Positively Women in the United Kingdom and then became a founding member of the International Community of Women Living with HIV and AIDS.

In 2002, she moved to Geneva to be part of the founding secretariat of The Global Fund to fight AIDS, tuberculosis and malaria. She then moved over to UN AIDS in 2005, where she

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also founded UN Plus. This Organization is a staff association of UN employees working across all UN organizations throughout the world. This also includes HIV positive directors, technical experts, every level within UN including drivers in the field working for UN offices.

She is my great friend and I have enormous respect for her. At the risk of being politically incorrect, I think she is one of the sexiest, most dynamic women I know, Kate Thompson. [Laughter] [Applause]

KATE THOMSON: Good evening everyone and thanks, Craig. Tonight, I am going to share a brief personal prospective on the history of positive involvement both in the AIDS response and the International Conferences.

Although it involves many individuals, they all have their own memories and versions of events. The history of our involvement is by nature a collective history. It is our collective action that has often been the most effective vehicle in moving forward the AIDS response. Without the passion, courage, desperation, audacity, and sheer bloody mindedness of people living with HIV throughout the last quarter century, I dread to think what the response might be today.

When I was preparing for this presentation it became clear that the information that exists on our history as people living with HIV is difficult to find. Unlike this Conference,

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where we have many hundreds of people living with HIV, so few were actually at those early meetings. There are even fewer are alive to share their memories.

In spite of medical information it is still a tall order to encapsulate the vast history of positive involvement in just 15 minutes. We are talking about the engagement of many thousands of individuals spanning the whole globe. Mostly are unsung heroes whose voices never make it to the podium in events like this. Their piece of the story usually gets lost. So, what I will share is a small personalized snap shot of some key events and milestones from a very northern prospective.

My own history of AIDS starts in the early 1980s, '81 or '82 when I was infected most probably either in San Francisco or in Amsterdam. Around the same time the first cases of KS, PCP and other opportunist infections were beginning to emerge among gay communities. In 1992, as GRID became AIDS pioneering organizations such as the San Francisco AIDS Foundation, Gay Men's Health Crisis and the Terrance Higgins Trust in the U.K. were established by those affected.

Some of you may have heard of the Denver Principles. These were drafted in 1983 by people living with AIDS during a National Conference in the U.S. They articulated for the first time the idea that the rights and personal experiences of people living with AIDS could and should shape the response to

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the epidemic. They provided a framework which subsequently informed the activism of positive communities.

As you probably know, the first International AIDS Conference was convened in 1985. Participants were, to quote Dennis Altman, "A bunch of medicos and a few gay boys."

[Laughter] I imagine it was the same in Paris for 1986.

Meanwhile in Europe, Dittmer Boll [misspelled?] a German nurse living with HIV decided to organize an International Conference for people living with HIV. Plans came together and the first Conference was held in 1987 in London.

At around the same time in New York, people living with HIV and their allies came together to form ACT UP. Their first action was to demonstrate on Wall Street in New York to protest against the profiteering of the pharma companies.

The year 1987 was also the year people living with HIV, including my UN AIDS colleague, Eric Sawyer, who you may have seen earlier, protested outside the International AIDS Conference in Washington. They were confronted by police wearing yellow rubber gloves. Eric's boyfriend began a chant that was taken up by the rest of the protestors, "Your gloves do not match your shoes, they will see it on the news."

In January of that same year in the U.K., I received my HIV diagnosis. As a woman it was impossible access appropriate information or support, even though I was living in a household

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of gay men. It was through this desperate unmet need for answers for services and for hope that I was catapulted into the dynamic messy world of AIDS activism.

There were a few people living with HIV, as we heard from Lars, at the Stockholm International AIDS Conference in 1988. David Barr, now of the Collaborative Fund for Treatment Preparedness was among them. He recalls one of the most striking things about the Stockholm Conference was the lack of organized community participation. They had a presence but not a strong one.

But, 1989 in Montreal was the real the real turning point for positive and community involvement in the IAC when ACT UP, AIDS Action Now and Reaction CEDA [misspelled?] stormed the stage at the opening ceremony carrying Silence equals Death posters. Tim McCaskill [misspelled?] took the microphone and officially opened the Conference on behalf of people living with HIV. From that moment on it was clear that the Conference had moved towards greater participation of community.

The same year, Grupo Pella Vita [misspelled?] was founded in Brazil. The group's declaration was the rights of the people living with HIV and AIDS was adopted unanimously by more than 50 organizations.

Meanwhile, an international steering community was formed to organize future global people with HIV conferences. That committee later became The Global Network of People Living

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with HIV and AIDS. A network that continues to evolve and to organize international gatherings of people living with HIV such as the Positive Leadership Summit which was convened last week.

I am a relatively late comer to the International AIDS Conference. In 1990 many of us living with HIV were excluded from San Francisco because of U.S. entry restrictions on people living with HIV. So, Florence 1991 was first, I confess I do not remember anything about the science. I remember taking part in a protest against the U.S. entry restrictions. I remember receiving fascinating insights on Florence from the [inaudible] and I remembering drinking far too much wine.

But as far as the actual Conference goes, in spite of being pulled onto the stage at the last minute to speak about women and AIDS, I felt a bit like an outsider looking in.

We organized the People Living With HIV Conference in London that year by which time it was really truly global. During the opening, Jonathan Mann announced Harvard's relocation of the IAC from Boston to Amsterdam. He told us that this decision is clearly; unequivocally result of the U.S. policy on HIV and immigration. It is an extremely serious matter when America's oldest University has to leave the country to host a conference about a pandemic.

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Let us hope that we will not be disappointed again and that the wheels of the U.S. bureaucracy will turn now and that the Conference can soon return to the U.S.

In 1992 a group of positive women came together for several days in advance of the IAC in Amsterdam and we formed the International Community of Women Living With HIV. We took the stage during the opening to show the world that we refused to remain silent. Afterwards, members set up positive women's groups in countries such as Uganda, Malawi, Kenya, and Trinidad in Sebago.

Berlin, 1993 brought disappointing results on combination therapy from several clinical trials including Concord. [Inaudible] at the time working for WHO spoke at one of the Plenarys on the role of gay men and the fight against AIDS. In that presentation he also came out as living with HIV. He was the first person to be public about their HIV status in WHO or maybe in the UN. Sadly, he did not last long in the system after that disclosure.

Another first was the speech of the late John Mordin [misspelled?] the first person to address the Conference Plenary as a person who opening used drugs. Our memories of these conferences are so entwined with the memories of people who are no longer with us.

In 1994, the Paris GEEPA [misspelled?] Declaration was signed by 42 leaders of governments. It was resolved to

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facilitate the greater involvement of people living with HIV and the AIDS response and gave a name to that principle. In spite of many advances to people living with HIV involvement at all levels in subsequent years much lip service and not enough investment have been paid to [inaudible].

There is still a widespread lack of understanding of the value of our involvement. According to my friend, [inaudible] from the Global Fund, a wonderful human ideal has been utterly dehumanized by a depressing UN acronym.

But if there is one International AIDS Conference by which those of us who are long-term survivors can measure our histories, it is Vancouver. For me there is a life before Vancouver, and there is a life after Vancouver and those two are a million miles apart. My life before Vancouver had been a time of plummeting T-cells and constant infections. It was a time of intense relationships in community solidarity as we buried friends on an almost weekly basis.

Life after Vancouver miraculously and rapidly transformed this form of reality for those of us in the North and our lives shifted to another phase. One of slow realization that maybe we might not die so soon. That maybe we could be there to plan for a future. Many of us returned to work and the volunteer element of U.K. based activism faded.

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Meanwhile, a chasm appeared between those of us in the North and our friends in the South who could not access affordable treatment and who kept dying.

Vancouver was also the time that people living with HIV through DMP were included officially on the Conference organizing committee. ICW joined the committee two years later. That year also saw the establishment of UN AIDS modeling a new way of doing UN business. It included people living with HIV and assorted representatives on its governing board.

In 2000, the Durban Conference brought the scientists to the communities most devastated by AIDS. Many were changed forever by this experience. Post Durban, the broader AIDS community began to embrace the possibility of making access to ART a reality to those in the South. This change of heart would not have happened without the Plenary speech of Edwin Cameron and the visit [inaudible] Treatment Action Campaign. The Campaign participants and other activists from around the world joined them in a united voice to call for treatment for all as we marched together through the streets of Durban.

In 2001, the UN held the first ever Special Session on AIDS in New York. After that was born the Declaration of Commitment which took the spirit GEEPA [misspelled?] to a new level. It provided our communities with a valuable tool to demand more involvement and to hold our governments

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accountable. And out of [inaudible] that was also born The Global Fund another crucial event in the history of positive involvement.

Next year at the 2002 Barcelona Conference [inaudible] told participants we are aiming for three million people worldwide to be able to access ARVs by 2005. A concept that was later developed into the Three by Five campaigns, a significant moment in our history because as my boss, Peter Piot, said sometime back, to be a leader, you need to be alive.

In March 2003, a network of people living with HIV and treatment advocates, The ITPC was formed at the International Treatment and Preparedness Summit in South Africa. From ITPC came the Collaborative Fund which has proved that GEEPA can be given life when communities are able to make their own funding decisions.

Today, in Mexico City, many millions of collective [inaudible] later I have been on the community program for the last two conferences. I have seen first hand the levels of involvement that positive communities have in the Conference now. I have seen the IAS employ people living with HIV on its staff. I have seen it join the Living Partnership which organized the Positive Leadership Summit just last week.

We are present in the committees, the Plenarys, and more of the sessions than ever before. Over the years, people living with HIV have become partners in their response

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increasingly, not just as themselves but as experts. More of us openly living with HIV our now working in the large global AIDS Institutions. We have crossed from influencing through activism to another form of influence and a quieter more subtle activism from inside.

But what does this really mean for people living with HIV, for our communities, for this Conference? How far have we really come? In many ways we can see the evidence of our advocacy for grater involvement in the AIDS response and in the IAC. We are here in greater numbers we have our global village, but is it really the global ghetto? What more can we do to enable positive leadership in the IAS?

Despite our best intentions are we successfully facilitating a new positive leadership and involvement? Are we organizing Conferences that effectively build links between science, politics, and the positive community between activists and institutions? How much longer do people like Jorge Severdra [misspelled?] and Edwin Cameron have to carry the weight of senior positive leadership in our movement. What is it going to take before we have an HIV positive President of South Africa, a positive Executive Director of UN AIDS or for that matter a positive President of the IAS? [Applause]

I am convinced that it is this type of leadership that is needed to get us to the next stage of involvement. When being HIV positive ceases to be something that people notice or

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remark on when it is no longer a barrier to employment or other opportunities. When no one cares one way or other about our status.

So, that is the question that I leave you here with tonight. What more is it going to take to get us there?

Thank you. [Applause]

PEDRO CAHN: Now is my time to introduce our next speaker. Our next speaker was supposed to be an Italian clinician, Stefano Vella, former President of IAS. Stefano could not make it because his mother is sick and he had to stay in Rome. The new speaker has gently agreed to replace me in a couple of days.

I could say that Julio Montaner was born in Argentina and had his medical education there. Then he moved to Canada where he built an extraordinary career becoming now the Director of the B.C. Center on Excellence for HIV AIDS. Professor at UVC at the University of British Columbia, Head of the AIDS Division and as such I could describe him as a Canadian.

But you know Julio living in Canada, born in Argentina has always cared for the developing world. So, his program not only cares for people in Vancouver. His program also has constructed very strong links with Latin America, with Africa and other regions in the world. So, Julio is not only an Argentinean, Julio is not only a Canadian; Julio is a truly

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international leader both in terms of science and advocacy. It might not be important for you but it is important for me. I am very pleased to introduce the new President of the International AIDS Society, my friend, Julio Montaner.

JULIO MONTANER: Thank you Pedro. As they say, I am the imminent President of the International AIDS Society. Pedro is the imminent President of the International AIDS Society. [Laughter] When the boss said, "Julio you are stepping in for Stefano Vella," I said, "Yes, Sir, I am stepping in for Stefano Vella."

Stefano was kind enough to send me his slides. He sent a collection of about 96 slides. [Laughter] If you know Stefano he would have given the talk with the 96 slides. So, I threw them all out and I started over again. I hope that you will forgive me for that. He already did.

What I am going to do for you in the next few minutes is give you a bit of a bias overview of what the relevant developments have been in the field of antiretroviral therapy. It really has changed the history of this epidemic forever and trust me; I think this is only the beginning.

The first decade of our fight against HIV is best depicted by this slide. It shows in red the very bad outcome that the disease had and the very little success that we had in therapeutic front. The [inaudible] were skyrocketing.

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Then came Vancouver, so there you go, a full decade in one slide. As Kate said, quite rightly, we saw a tremendous transformation after Vancouver. I must confess that we came up with the One World One Hope theme; we did not know what we were talking about. The reality was the hope arrived much later than we had trusted that theme for Vancouver.

Three things came together in Vancouver that allowed us to move the field forward. The first one was John Miller's recognition of the prognostic value of plasma viral load. This by itself was a very significant discovery which really changed the way we looked at the disease altogether.

The second development was the Metro [misspelled?] 35 study presented by [inaudible] at the Conference. Which for the first time demonstrated that Protease Inhibitor based triple therapy and not even [inaudible] for the most part you could actually achieve sustained undetectable viral loads and these in turn was associated with immune recovery.

We contributed to that debate by bringing forward an alternative approach, this was triple drug therapy based with NRTIs on to nuclear [misspelled?] sites.

I want to tell you a story that is something that most people do not know. We really did not even hope that we were going to reach undetectable viral load. Mark Wainberg will attest to the fact that in December of 1995 we met at one of those consultations that we were doing in Toronto or Montreal.

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Mark called me aside, I was reading the INKA [misspelled?] Study that we call it. Mark called me aside and said, "Julio, I think we have a problem. Most of the samples that you guys are forwarding to me appear they were not able to grow the virus. I wonder if we are doing something wrong."

Little we knew that we were doing something right. It was at that point that we rapidly ran those samples almost within a week. The first six months of accumulated samples using a test that we were exploring with Roche, a plasma viral load test. We did not know what prognostic value it had. We surprised ourselves when we found that in a blinded study approximately a third of the samples were actually undetectable. Of course when the blindness of this study was broken we figured out that most of those patients were being treated with triple therapy.

If it was not for John Miller that explained to us at the Conference what the meaning was of the undetectable viral load [inaudible] study that validated this finding we would have been in the darkness still today perhaps.

This led to the new recommendations that IAS USA Guidelines which basically described the use of triple therapy. It started the race for putting people in treatment both in the North of the world, at first and then after Durbin, in the South of the world. Outcomes changed dramatically and that still is today among those who access treatment. The outcomes

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have improved dramatically as shown by [inaudible] slide here where you see death rates going down after 1996 and staying down quite low every since.

But then we ran into problems, we ran into complications and you are all familiar with these kinds of pictures. More recently even the cardiovascular risk was noticed to be elevated in people treated for the heart. Multiple complications made us shy away of aggressively pursuing treatment at other stages of the disease and we became more conservative. Eventually, things started to become more clear.

Perhaps the single most important new development in the last while comes from the sub study from the Smart Trial. It became apparent that actually once again it is more problematic for individual to have unchecked [inaudible] than dealing with the side effects of the medications. As illustrated here, patients who interrupted therapy in the Smart Trial were found to have skyrocketing levels of IL6 and dedimer [misspelled?]. Both of them as them as markers of inflammation and [inaudible] leading to cardiovascular risk, stroke and other complications.

More importantly, elevation of a variety of a inflammatory markers has been associated with increased risk of death in individuals with HIV. Once again this demonstrates that and David Host [misspelled?] said at one point it's the

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virus, stupid [misspelled?] and it is not just about the immunity it is also about chronic inflammation.

So, in 2008, HIV infection has really been reassessed and is now understood as a chronic inflammatory disease. Inflammation is an important driver of non AIDS events. This affects the heart, liver, kidneys, and in due course we are going to learn the rest of the assorted organs in the body.

This is also probably a factor contributing to the malignancies that we are starting to see in people with HIV. Inflammation at the end of the day is also an important driver of CD4 decline leading to AIDS at the late stages of the disease. We are now looking at HIV as a chronic inflammatory disease with two separate endpoints if you want. One is multi-organ dysfunction throughout the course of the disease and the final stage of immune deficiency.

The other thing that has happened in the last couple of years is that we have begun to understand that antiretroviral therapy is a lot more potent at decreasing transmission of HIV than we ever realized. That has allowed for the successful implantation of [inaudible] mission programs where we can use antiretroviral therapy to prevent infection of new borns. This has been extremely successful where access to triple therapy has been available both as illustrated here in the USA and Canada for example. I have the denominator here of pregnancies occurring in HIV infected women. You can see a negligible

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number of infections among the newborn babies. This is indeed very good news.

This has fueled an interest for us to look at the potential added value of antiretroviral therapy as we try to support our prevention effort. There are new studies [inaudible] that demonstrate quite clearly that lower viral load equates with a lower risk of sexual transmission. The truth is I would just say lower risk of transmission [inaudible]. I do acknowledge the fact that there is a debate ongoing as to whether or not a properly treated individual with either [inaudible] is non-infectious. I am not going to enter into that. From the public health perspective I think that we have enough evidence to state that lowering the viral load in our communities will lead to a decrease in the transmission in the [inaudible] on our preventive efforts with massive antiretroviral therapy.

This is modeling that we have done on based on real data from British Columbia. It demonstrates that if we work to use antiretroviral therapy at the current rate we will continue to see a stable epidemic. We would like to increase the current coverage with antiretroviral therapy from 50 percent to 75 percent of those individuals without medical indication. This is something that we can do easily particularly now that we have expanded the [inaudible] Guidelines, as I will discuss in a moment. We could see a very significant drop in new

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infections as demonstrated here which could be in the order of 50 percent or thereabouts. That is also that the expectation is that this would be a sustained benefit on the epidemic.

This Conference has seen the release of the IAS USA Guidelines for antiretroviral therapy. I think that most people have failed to read the fine print of these Guidelines. I truly do believe that the Guidelines that came out of this Conference are going to revolutionize the treatment of HIV. It will totally change the way we approach the disease. That is because they incorporate as I said the fundamental principle that HIV is a chronic inflammatory disease. Although it is true that the table looks the same, the title looks the same, the authors look almost the same that reality is that this is a dramatic departure from what the Guidelines have been up to date.

The 200 CD4s now become the new 350 CD4s. The thing that is most relevant is that there is no upper threshold where we recommend that people are not offered the treatment. We include a caveat whereby individuals who have a variety of other conditions including increased cardiovascular risk or chronic hepatitis, chronic hepatitis C or nephropathy or so on and so forth. Even a high viral load should be encouraged to consider antiretroviral therapy because of the [inaudible] effect that unchecked [inaudible] will have on their organs and ultimately and ultimately their survival.

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So, for all these reasons I do believe that Mexico will go down in history as the Conference where treatment married prevention. And we actually expanded the Guidelines to greatly increase the number of people who should be on treatment. Of course the core for these [misspelled?] is that the gap between the North and the South will grow again. Our hope is that we will be able to roll out antiretroviral therapy in a more aggressively in view of the benefit that this treatment has on prevention.

As of recently, new numbers came out from UN AIDS giving us a sense of optimism that we are starting to see progress in terms of [inaudible] antiretroviral therapy. As it has been said earlier in this Conference that the glass is half empty and not half full and we should be very cautious with regard to this optimism. We are only beginning the fight and this is a fight that is going to last for many years to come.

Thank you very much. [Applause]

PEDRO CAHN: Thank you, Julio. I just introduced the President elect and now it is my privilege to introduce our past President, Helene Gayle.

Helene was trained as a pediatrician and in public health. She rose in the ranks of the US Center for Disease Control to become Director of HIV and TB. She moved to the Bill and Melinda Gates Foundation in 2001 to become the Head

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the HIV, TB and Reproductive Health. In 2006 she became the President and CEO of CARE, a position she still holds.

From 2004 to 2006 she was the IAS President, our first woman President. Helene will discuss an area she knows very well, the link between HIV, poverty and development.

HELENE GAYLE: Thank you, Pedro. I would just like to add my thanks to all of the Panelists and all of my predecessors and colleagues at IAS. It was wonderful to hear Lars' history of IAS. Many of us count our professional lives by these Conferences in so many ways. We think back on how the response has changed through the eyes of these Conferences and the contribution that IAS has really played in that. I feel very proud and pleased to be part of that tradition and so I want to add my thanks along with all others to my colleagues who are sitting here as well as so many others who have made such a difference to this response and have played such an important role.

I am going to talk, as Pedro said, about AIDS, poverty and development. In many ways what I am going to talk about mirrors my own professional career first starting as a pediatrician, epidemiologist, researcher and public health physician. I think as we who have been working on the epidemic started very much from a very biomedical perspective on this disease. We have gradually grown to recognize that we cannot look at this epidemic and the response without also looking at

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the broader societal context and some of the underlying causes that fuel the epidemic. They are very much a part of whether or not people are able to take advantage of the many things that we are now able to provide. We now have better technologies and better knowledge of what it takes to make a difference for this epidemic.

Let me just start with a quote by Rudolph Virchow who is the father of pathology. He knew back in the 1980s a lesson that I think we are just learning now that disease and society are so linked. He said that if a disease is an expression of individual life under unfavorable circumstances than epidemics must be an indication of mass disturbances. I think we recognize now that we cannot ignore the link between disease and society.

From the prospective of an organization that works on trying to eradicate extreme poverty around the world I think our response to HIV very much mirrors our response to the way that we try to have an impact on the lives of the poorest of the poor around the world. I am going to talk a lot about the issues of AIDS, poverty and development from the prospective of what we do at CARE. I am going to use some of the examples from our own work to make clear how you can in fact use a development approach. How it is possible to incorporate the issues both of causes as well as consequences to be able to

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really look at a more comprehensive approach to fighting the epidemic.

As we look at our approach to reducing poverty we look at both, how do you meet people's basic human needs? The need can be water, access to food or access to health services in an effort to help to attain the Millennium Development Goals. In going beyond looking at basic human needs we need to recognize it is also important to look at people's social positions in life. This can be promoting empowerment, equity, social inclusion and all the things that we know have an impact on the lives of the poor and we know have an impact on driving HIV. If you do not also look at its influence the enabling environment and look at policies, social responsibility and engagement of all aspects of society we will not have impact on making a difference.

Women are core to our efforts in reducing poverty. Just like we know that women are core to the effort to making an impact on HIV and AIDS. This just looks at the virtuous cycle that occurs that no matter where you have an impact on the lives of women. You have an impact on creating sustaining change that does not just help women but also improve the lives of their families.

All that we know about health; including HIV AIDS is both a cause and a consequence of poverty. The link that everyone in this audience knows so well that poverty whether it

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is the situation of lack of service, the inequities that come from lack of economic opportunity, exclusion or marginalization that come with poverty clearly have an impact on poor health. Poor health also contributes to poor economic growth and poverty because the illness prevents people and their care giver from being involved in income generation. It affects productivity. We know that with HIV it effects people in the most productive years of their lives. Therefore, the interconnection and link between poverty, poor health and HIV is mutually reinforcing. If we can break the back of one we know we can also break the back of the others.

We are involved in providing services in health in 350 programs in over 60 countries. A majority of those programs have a component of HIV and AIDS. We are involved in over 200 programs in 40 countries working on HIV and AIDS and again our approach tries to address underlying causes. Some of these causes can be education level, lack of income and gender discrimination. We also are helping to build local capacity of programs to increase the sustainability so that once we leave communities have ownership of the response.

I am going to give three examples of programs that we are involved in. I would also like to talk about some research that we are involved in that really looks at and explores the issue of empowerment particularly looking at how that affects women and the response to HIV.

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These three different projects look at addressing some of the obstacles and underlying issues. These issues are barriers. Even if we do we have the best approaches to providing support and providing treatment to people living with HIV if we do not look at some of these underlying causes we are not going to those same long-term impacts.

In Kenya we have a program that looks at addressing barriers and linking services for PMTCT. In Rwanda we have a program for community ownership and psychological support for orphan and vulnerable children. In India there is a project that looks at empowerment of sex workers.

Let me just start with the example of Kenya in Nyanza Province where as we know in many programs while the services for PMTCT are available people actually accessing those services is poor. We know that issues of stigma remain a major obstacle to accessing services. Often times particularly for women to access these services we find they are concerned about the fact that other needs are not being met. They do not have places to go to link to services for their children, for themselves, for their sexual and reproductive rights and overall basic family needs. Often times the capacity of the public sector where these programs are often located is weak and unable to provide the quality of services.

This program looked at how we overcome some of these obstacles and without going into all of the details looked at

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some of the things that we knew were obstacles to women actually accessing the services. Improving the quality of the Ministry of Health to be able to provide quality services. Making sure that services were linked with other related services so access to antiretroviral therapies, voluntary counseling and testing and other related services particularly family planning services were available for women as they accessed prevention of mother to child services. Insecticide treated bed nets and safe water for infant formula and for basic needs.

In addition to the strategies for linking health services, we recognized that without community mobilization to fight the things like stigma, gender based violence and the fear of violence that women had because they knew that if they were identified as a woman who needed these services it is very likely that they would have repercussions within their families and within their communities. We provided support groups and buddy systems for women who are HIV positive so they did not have go through this experience alone. We provide savings and loans group so that women's economic needs and food security needs were in addition to these other things.

We saw over a three year period of time that the uptake of the PMTCT services increased from 30 to 90 percent. I think that we saw that this approach to have a more integrated approach that met the needs more broadly really had an impact

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on overall intervention. We changed social norms that perpetuated stigma, built a more supportive environment for women to seek the supportive care, and had a more integrated approach than health services.

Let me talk a little bit about the program that looks at orphan and vulnerable children. This was a program in Rwanda and is called the I Love Children Program. People know that the effects of the genocide in Rwanda combined with the devastation of AIDS led to a high number of child-headed households. These children were often isolated within the communities. They were vulnerable to physical as well as sexual abuse and other physiological trauma as a result and their basic needs were not met. This program helped to provide community mentors that were chosen by the children themselves. These community mentors helped to provide basic life skills for children, school support, economic security and food assistance. They also help to provide basic livelihoods by giving small livestock so people were actually able to meet their economic needs in the context of these child-headed households. The program helped provide mentors the ability to provide the children the support that they needed.

Results again showed this type of model that integrated the overall needs and gave community ownership really had great improved results with children enrolling in primary school. Children who would have otherwise been left outside of the

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school system. They were able to increase literacy; life skills and households were able to gain other access to health services through health insurance and were able to get to other services that were critical for them and their caregivers.

Now just finally the third project, it looks at the issue of empowerment. This is a project in India called the Socsum [misspelled?] that looked at providing prevention support among the sex workers in Andhra Pradesh in India. It tried to focus on how to make sure that HIV focused interventions addressed again the broader needs. We did not just look at the interventions that were necessary that we know can reduce HIV but looking at the issues that prevented women from protecting themselves from HIV. These issues were gender and equality rights violation, discrimination and stigma. The fact was acknowledged that condom promotion and knowledge alone were never going to be effective for women who otherwise faced violence, faced discrimination, and faced fear within the community. The program worked by looking at establishing collectives and community based organizations within this community. We looked at established drop-in centers, mobile clinics and particularly training sex workers as peer educators and giving them the sense of mission and purpose and empowerment.

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This led to again, encouraging results with increased rates of condom use, 80 to 90 percent reported using a condom during their last encounter.

By increasing access to services including STD services, screening and voluntary counseling and testing decreased levels of violence. There was a greater sense of solidarity and unity among the sex workers and an effective collective action to advocate with local authorities particularly in the case of decreasing the violence that these women often face by police and others in the community.

We tried to look at issue of women's empowerment and HIV prevention because as we all know, this is going to be key particularly as we see increasing rates of HIV infection. This is just preliminary data from research conducted in six different countries to look at the impact and the implications of empowering women.

What does it really take to empower women? We talk about this all the time but I think understanding what it really is will make a difference to change the status of women and give them the opportunity to prevent their vulnerability to HIV.

There are three things that we found and again these are things I think we have known. To be able to look at them and look at them in variety of different ways puts it into prospective.

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First of all, context does matter, in some contexts women feel that can make decisions on safe choices and in other things they cannot. This is a study that was done in Bangladesh that said sex workers reported they do feel empowered to use condoms. Condoms are used almost 90 percent of the time, 87 percent of the time with their clients but only 30 percent of the times with their spouses. We see this over and over again, so it is not as if these women cannot do it but it is the context. So, what about this context? I think these are the kinds things we need to look into further.

The solidarity networks as simple as that may seem can offer critical space for growth. In Burundi 61 percent of members of solidarity groups went for HIV testing compared with 27 percent of those who did not. In a study in Peru woman said sometimes when we go alone it is as if we are not taken seriously. But if you say you belong to an organization it fills you with energy and with courage. We know that there is something about this sense of being part of network that does give empowerment and really gives women the opportunity to do some of the things that they would not do otherwise.

Finally we know that it is essential to involve men. We have talked about this in many forums. When we talk about empowering women we cannot forget the fact that we have to include men in this response. Women say that the men in their lives must be included as husbands, clients, lovers, police,

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taxi drivers. Again from the study in Peru they said by being sex workers we do not stop being sisters or cousins or whatever. We feel the same for the seller on the corner as for the female cop. We are the same and in the end we are all women and we feel the same.

I think these give us some lessons about what we still have to learn and what some of the important ways in which we can look at not only the approaches that we know make a big difference. Also do we put some of those together in ways to really mobilize communities and look at some of the underlying issues that are the vulnerability for HIV and also look at some of factors that keep people from taking advantage of the strategies that we know work.

Let me just close by a quote by Gandhi I think we are all here because we want to make a difference. We have heard a variety of different presentations that look at a variety of different aspects of the response to HIV. I think for all of us this is a test. When we think about our work and put it into context whether we are looking at basic science, clinical science, poverty and HIV or any of the ways in which we try to make a difference. This is a quote that I often think of when I want to make sure that I am doing whatever I can to make the biggest difference in the world. "When in doubt apply the test recall the face of the poorest and the weakest person whom you

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may have seen and ask yourself if the step you are contemplating is going to be of use to him or her.

Thank you.

CRAIG MCCLURE: Thank you, Helene. I would like to introduce now a governing council member, Professor Aikichi Iwamoto from Japan to introduce our next speaker.

AIKICHI IWAMOTO, PH.D.: The Executive Director of UN AIDS since its creation in 1995 and the Under Secretary General of the United Nations, Dr. Peter Piot comes from an academic career focused on AIDS and women's health in the developing world.

Dr. Piot earned a medical degree from the University of Ghent, a PhD in microbiology from the University Of Antwerp, Belgium and was a Senior Fellow at the University of Washington in Seattle. After graduating from medical school, Dr. Piot co-discovered the Ebola virus in Zaire in 1976.

In the 1980s Dr. Piot launched and expands a series of collaborative projects in Africa including Project SEDA in Kinshasa, Zaire, the first international project on AIDS in Africa.

Born in 1949 in Belgium, Dr. Piot is fluent in three languages and is the author of 16 books and over 500 scientific articles. He has received numerous awards for scientific and societal achievement and was knighted as a Baron by King Albert II of Belgium in 1995.

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Please join me to welcome Dr. Piot.

PETER PIOT, M.D., PH.D.: Thank you very much Professor Ito. I was the IAS President in '92 - '94 which seems like the prehistory or something like that. IAS was run out of my office at the Institute of Tropical Medicine which was one fifth of the size of this podium and with a half time person. When I took it on there was not even a member list. Now, this is the time to reveal all the secrets. When I ended I shipped a few boxes to Lars in Stockholm and Lars you told me that you have a picture of it.

I must say that it was a very exciting time on the one hand but it was a time of great depression in the response and original hopes that AZT or others in mono therapy would do it. They were soon collapsing and this was a time when myself I was still seeing patients and I was wondering myself also, where is this leading? Are we ever going to find solution, to say the least, a treatment for people living with HIV. Fortunately a few years later the hope came and it changed for ever how we deal with this epidemic '96 in Vancouver.

Tomorrow there is a special session with Tony Fauci or moderated with Richard Horton where and I will talk about the future so I am not going to talk too much about the future. I thought that I would be a bit more provocative than usual. I want to talk a bit about myths and facts which I think can be

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dangerous and have been a recurring theme in the history of the epidemic.

The first myth is one that has come up recently again and that there is too money going to AIDS. It reminds me also of a letter I received at '99 or 2000 on behalf of all the donor agencies. They were telling me that I should keep a bit quiet and not call for all this money to deal with AIDS because one, the money is not there and two, funding for AIDS will go down in any case. It illustrates also that even for people having senior positions in donor agencies that it is difficult to predict the future because since then there is about 20 times more money. I am glad we were not too much intimidated by what classically has been approach in international development and public health and that is demand reduction. And making sure that we did not ask for what are basically rights and that we did not ask to for the full pocket to solve a problem.

The truth is that there is not enough money going to it but also of course that there is not enough money going to other health or development issues. Governments, take Africa committed in 2001 in Abidjan to spend 15 percent of their GDP annually on health and AIDS. Very few are doing this. We have the commitment by donor admissions to spend 0.7 percent of the GDP on international development. Only a handful of countries all based in Northwestern Europe are doing it. None of the G8 countries are doing it. We always talk about the G8 countries

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and at the same time we forget those countries that are making a major effort.

Here you see what the needs are and they may even grow depending on the price of drugs particularly for second and third line treatment will evolve. That is a major determinate of the future cost of this epidemic. You see that the treatment gap really continues to grow.

We have a new attack I would say that is coming. It is people who say, oh, we should not do that, we should not give all this money to treat these people with HIV because we are creating entitlement programs and that is unacceptable. I say this is entitlement to life and is the absolute right thing to ask. It is again a completely different prospective that we in the AIDS movement have from some people who have legitimate concerns about where the money will come from. What we are saying is these are the needs and we will find the money. We will make sure that it is there.

This is an extremely dangerous recent attack on people with HIV it is immoral and it is unethical. That is what we are faced with and that is what we will have. We will counter it, do not worry.

Remember the times when it was said that the Africans they cannot read the time on their watch so we should not come with antiretroviral. In any case the health systems are not functioning and so on. That was not so long ago.

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There is a myth that there is so money going to AIDS. Here is the WHO estimates for total health expenditure in the lower middle income countries. This was figures for 2006 the most recent we have and was 644 billion dollars. The same year the world spent under nine billion dollars on AIDS. Let us just put things in prospective and let us not be intimidated by this kind of [inaudible].

All this is going on even though AIDS is the number one cause of death in Africa, the seventh highest cause of mortality worldwide.

Second myth and it is one that is particularly dominant in the countries like the U.K. Invest in health systems and we will solve all the world's health problems including AIDS. That is all we have to do. The fact is of course that weak health systems are a major obstacle to rolling out antiretroviral therapy. Therefore it is excellent that for the first time ever at this International Conference that there have been so many sessions dealing with the synergy between an AIDS response and strengthening health systems. It is not one or the other. We should not forget that even if we would have perfectly working health systems that it would not do much good for HIV prevention. Because most of it except for mother to child transmission prevention where a functional health system particularly for women is absolutely necessary. It would not

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work for community mobilization, men have sex with men, and harm reduction key elements sex worker interventions.

Another myth again that you hear again from people like in DIFIT [misspelled?] is that the AIDS response deprives health systems of vital funds or is undermining them. In 1976 when I was still a very young man and had much more hair than I have now, I was working in Zaire. There was no doctor in a range of over 150 kilometers, north, south, west, and east there was nothing.

As Margaret Chan said in her opening speech, she said we should not blame AIDS programs for the bad functioning of the health systems. Coming from her is a great statement because the evidence is not there. The truth is that health systems have been neglected since before AIDS first appeared so let us not blame. There is response on it but AIDS itself has indeed undermined health systems in some countries. Particularly in the worst affected.

When I saw for example Botswana in a period of ten years has lost 17 percent of its doctors because of AIDS. There are other reasons in addition and that is not uncommon in many of the countries in the region. You can say the same thing for nurses. [Inaudible] gave a Plenary where he demonstrated clearly if there is any evidence it is that AIDS funds and AIDS funding and AIDS action have actually been the engine for strengthening health and development programs. And

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have save the lives of many health care workers. Because health care workers are equally infected with HIV and sometimes more in some countries than the general population.

Yesterday there was an interesting session on health systems organized by WHO and people like Minster Tewdros from Ethiopia, Minster of Health. He clearly gave a very pragmatic approach to all of this. He said, okay, we have funding for AIDS and we have been using it to strengthen our services even to build clinics, to strengthen laboratory infrastructure and so on. When you introduce quality laboratory services for AIDS and for monitoring people with HIV and on the treatment, I can assure you for sometime introduces for the first time some quality assurance in the clinical laboratory.

There are so many examples and I think the evidence is really now accumulating. We have a lot of myths around prevention, perhaps even more. A general one is oh, we do not know what works. That clearly comes from academics and people and you need to end your article by saying more research is needed. [Laughter] Then what is not written there is give the money to my research, of course. I have done that as well and I will probably do it again in my next job.

At lunchtime this afternoon in this very room we had a great session hosted by The Lancet which is issuing a special volume on HIV prevention. The room was packed and we heard a great summary of the evidence, what is working. It is not

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enough, we need more effective interventions. We have not exploited for example, synergies between behavioral interventions and treatment and structural interventions. What Helene just showed, there are some very practical on the ground examples of what is possible.

We really have enough empirical evidence now. There is enough evidence from the real world. But that fact is that prevention needs more attention and it is been one of the great themes of this Conference to draw more attention to prevention and what to do about it.

Another myth is the one that all we need to do some very targeted interventions and we do not have to care about anything else. The structural interventions and changing the laws and all that. We now have empirical evidence and you can find it in the last UN AIDS Report, that in countries where there is a supportive environment particularly when it comes to the most vulnerable groups to HIV infection. Sex workers, injecting drug users and men who have sex with men that where there is a positive environment there will be better outreach prevention and that saves people's lives.

If you come to harm reduction, homosexuality to use the term the old-fashioned term but is illegal. If sex work is completely legal we cannot do our job and that costs lives and we have some empirical evidence. So, it is not touching feels from some development or human rights people. It is really

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making a difference, and the same is true when it comes to gender and women and HIV prevention there and access to treatment.

And then something that is strong and is a whole industry in its own right and I get often letters for that. Doctor Piot if you only would do this we would stop this epidemic. I always say anything that has the word only in there does not work in AIDS.

We finally go rid of abstinence only, now it makes sure that we do not get with circumcision only or whatever it is. It just does not work and that does not mean that we should not make use of every single opportunity to maximize the effective prevention but it is not going to be that one thing. Maybe one day, but that will be only if there is a vaccine that is kind of 100 percent effective. Which I am not sure is around the corner. I am actually sure it is not and particularly if we have a vaccine the first one probably only provides partial protection. So, we will need to do more.

So, combination prevention that was the theme The Lancet session and nobody in his mind at the moment in terms of treatment would take out one drug and give two drugs. Although I know that is sometimes done but frankly that is malpractice, there are no other words. We need the same for prevention. On the left side you see what we need for treatment. On the right side we need prevention. If you look very well you see a piece

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of foreskin maybe also there. It is not only the syringe and the condom but as we said it is also the laws it is a system that we need it as a protection of the rights.

Another myth is that is no heterosexual transmission outside Africa. Unfortunately it is not true. I remember very well in the '80s that when I was working in Africa and sent an article to The New England Journal of Medicine about some female to female transmission. One of the referees had only one line of comment and it said it is a well know that "AIDS" cannot be transmitted from women to men. And that is for my memoirs. But of course the reviewer was anonymous so I do not know who could be stupid to say that.

That fact is that the heterosexual transmission of HIV can happen anywhere but of course there are many different degrees of intensity that it is taking. Yesterday in his Plenary, Jeff Garnett from Imperial College showed very clearly we can project and model with five degrees of certainty how the epidemic is moving and evolving over the next few years, maybe even a decade. But how it will turn out in the long run nobody can predict that. We have had too many surprises in this epidemic to say with certainty what will happen or will not happen.

This is from Thailand where you can see the evolution of transmission groups and how dynamic this epidemic still is. Today, about 40 percent of all new cases, it is nearly 50

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percent in Thailand, are among female partners of men who have HIV infection. But it does not mean that the driver of the epidemic is not either injecting drug use or commercial sex or men who have sex with men.

And the final one that I would like to put here and I think this Conference has contributed to bust that myth that AIDS is over. That it is sorted. That message was heard loud and clear that AIDS is long wave event. We have just started. There are many more and I am sure each of us we could do a poll in your environment. Why even spend time on all this? Well I have to spend a lot a lot of time on and I know Craig has once we go outside this building [inaudible] this is what is in the real world so it is a realty test for the world outside [inaudible] and it is our daily bread. Because these issues will come back they are important for the future. Some are real issues and we have to take them seriously when should not ignore them. But I think it is really important that we stay on line and that we do not forget what our basic goals are and our basic principles. The IAS has a real key role to play in countering these and other myths and will be more than ever needed when we go into the long term response.

Good luck to Julio and thanks to Pedro and good luck to Elly later on. The world needs you and the world needs IAS.

Thank you so much. [Applause]

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JULIO MONTANER: Next it is my pleasure to introduce for you the last speaker for the night that brings with him a tremendous amount of experience and wealth of knowledge. He has been at the forefront of the fight against HIV in Africa. Elly Katabria is the head of the [inaudible] unit. His professional medicine efforts can be seen in Africa and the newly elected Vice President of the International AIDS Society. He proves the fact that you do not have to be Argentinean to be President of the International AIDS Society.

[Applause]

ELLY KATABRIA: Thank you very much Julio. I have prepared a few slides because I wanted to take this moment to talk about myself. But then I have just been reminded in the reality syndrome of the last speaker. It is no time to talk about myself. So, I will go straight to talk about AIDS in Africa context and future directions of the IAS.

I will talk about the burden over HIV in the Sub-Saharan Africa. The impact, the response, and then a few slides about the future directions and the concluding remarks.

There is no doubt this slide is a common knowledge but deceiving. What you see here when you look [inaudible] for the last 17 years or so, it has hovered around below one percent. But as that in the Sub-Saharan Africa has gone up hit six percent and then slide gradually down. You would go away and you would think that majority of the people in Sub-Saharan

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Africa the percentage is around 6,000 but this is not true, it is much bigger. Here is the reality, in this particular slide you are looking at the percentage for adults aged 15 and above living with the HIV infection among female patients from 1990 to 2007.

Look at the Sub-Saharan graph hovering over 50 percent. Of course, once the disease affects women then there are other problems you would expect.

This is not looking at specific countries in the region whereby some of them [inaudible] prevalence as high as 30 to 35 percent and it is hanging there. [Inaudible] the infection among women is of course as bad in the children.

We know now, this is a slide from UN AIDS at the end of 2007 whereby it is estimated that there are about 400,000 children who were infected in that year. But look at the Sub-Saharan South Africa, more than almost 370,000 people infected. And as a result of that of course the impact is the orphans and other vulnerable children.

In Uganda alone, and this slide is old but still the picture has not changed very much. Two million Uganda children are orphaned by AIDS and an additional one million currently have parents with the HIV infection.

Now, also we are aware what has happened as a result of the epidemic and the life expectancy in the region. Initially, we had mid gains in the '60's and '70s but all this has come

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down as a result of the infection because it affects the young age group.

There is also the impact on the economic growth reduced output, reduced productivity by men in the household and on a smaller scale businesses. Also there is declining savings leading to low investment because people have to pay for health and of course the catastrophic costs of illness and the disability of these expenditures.

As Peter has mentioned, our government in spite of having declared and confirmed doing the Health Expenditure, they all went down so the majority of our people have to rely mainly out of pocket to take health care. Peter Piot has already talked about health systems; I do not need too much time about this but high costs of treating HIV and the length of infection and consults. Health care, of course crowds out if it needs to weed out patients in the wards and increase bed occupancy because of all of the problems. All of this has been going on for the last so many years.

We also in the 1960s had made gains in some of the infections through immunization like TB but all these gains were coming up because there was not yet the epidemic.

For the families [inaudible] the impact has been great. The risk of a lost generation put out socialization because these children lose their parents and in the reality, the best person to take care of any child is the mother and the father.

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If they die, no matter who takes care of them there is always going to be a problem because they saw social upheaval of the economic underclass and soon because they have lost their parents. The effect of losing an adult persists into the next generation. Children are withdrawn from school in order to take care of their sick parents and this has been demonstrated in many cases including Tanzania.

Now in spite of that, we have had a response. There has been a response from the government from through the Minister of Health and other institutions. [Inaudible] particularly donors, UN agencies [inaudible] various communities including civil societies, non-government organizations, local groups like the Tulsa [misspelled?] of Uganda and international organizations have come out to give a helping hand. And in particular, the people living with HIV AIDS have made a tremendous impact on the cost of the HIV infection.

As a result of that there have been demonstrable gains, for example in this particular slide which was 2001 shows the decline of AIDS prevalence in Uganda.

One would say that if you extended this slide into today you would get up to zero but that is not true. One of the dark sides of success with antiretroviral therapy that actually this slide continues to raise because those people who have died and are not alive, they pose a different picture.

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Indeed among the responses is the introduction of the antiretroviral therapy. As some speaker already said, before 2000 people thought that antiretroviral therapy particularly [inaudible] was unattainable in Sub-Saharan Africa because as one said, you could not tell time.

However, in 2003 the WHO came up with the Three by Five Declaration. This was no different for many people. They thought that this was not the friend from the Declaration which was made in 1978 that by the year 2000 everybody will be [inaudible]. Of course that is not true and so this was not necessary. But there is a big difference by the end of 2005 we had not reached formedia [misspelled?] as we had been told but we had made a big way and many countries including Botswana and others had [inaudible].

So, what is the future for the IAS? All those gains they are there but they are small. One of the things we want to do is mobilize membership in the region both for IAS and for The Society of Aids in Africa so they can help them to maintain what has been happening.

Advocacy and HIV AIDS related activities in the region. Including better care and the prevention strategies fighting against stigma in any form through government, through civil society and organizations and through bilateral [misspelled?] agencies.

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Also we want to continue the support of the civil positive responses that we managed to get through the international [inaudible] conferences. Through International AIDS Society which is being launched today on the INS Newsletter so that we can inform our members.

Some years ago I would say that if you use the Internet you reach very few people. I am glad to say that even today the best way for us to communicate from our region is the Internet.

So, it started [inaudible] at the IAS. Also we want to go through the education activities of these Conferences. For example tomorrow we will be having a workshop on how to publish particularly targeting the younger such as WHO would I think and believe the ones that are going to be the pioneers in continuing the successes which have been initiated in our days

I know Pedro is saluting me, we are not going to stay here forever, so we need to bring up the young people to take on the responsibility also to disseminate and deliver publications by [inaudible].

In conclusion in the past 20 years IAS has witnessed the devastation of the African Region by HIV AIDS, they got the response of many of the member states, the helping hand from many international agencies. Some decline over the HIV and the increasing access to care including Heart. However, IAS is aware that there is a lot to be done if the region is to make a

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reasonable dent in the epidemic. Therefore, others out of that we commit ourselves to step up our services to the region to ensure sustainable positive response to the HIV epidemic in Sub-Saharan Africa.

Thank you very much.

[Applause]

CRAIG MCCLURE: Thank you Elly. We are going to skip question and answers due to timing. I just want to say before we finish there are a number of governing council members who finished their elected terms this year. I would just like to thank them including Helene Gayle, Scott Hammer and Andre Horbin, Ian Weller who served as our Treasurer for many years and has been a great support to me. I would like to thank Jerry Kavadia, Sheila Taliew, Suka Dekonsen, M.N. Samuel and the local co-chair of our Conference, Louise Soto-Ramirez who leaves our council as well this year.

Thanks to all of them.

Now, before we leave we just want to acknowledge today because we did not want to keep you here until 11:00 we only had six out of our 10 former and upcoming IAS Presidents. We have something to offer them all the four who are not on the Panel we love you just as much but we just did not want to go for six hours. [Inaudible] and Stefano Vella due to family illnesses are not in Mexico. I am wondering if Paul Boverding [misspelled?] or David Cooper in the audience? No? Okay. In

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that case I have something for you all and for Kate our
Honorary President to be one day.

I want to thank you all for coming. I saw so many
important people in the audience. You know who you are, every
single one of you. Members or non-members who are working in
their response to HIV. Thank you for coming, enjoy the rest of
the week.

[Applause]

[END RECORDING]