Transcript provided by kaisernetwork.org, a free service of the Kaiser Family Foundation[1]
(Tip: Click on the binocular icon to search this document)

XVII International AIDS Conference
The USA HIV Epidemic in 2008
August 6, 2008

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

[START RECORDING]

DAVID MUNAR: Good afternoon. My name is David Ernesto Munar and I am HIV positive, Colombian-American and a gay male. I proudly serve as Board Chair of the National Association of People with AIDS and work at the AIDS Foundation of Chicago.

This afternoon strikes an emotional chord in me. How much data must we amass before we invigorate efforts against HIV/AIDS? As we reflect on the data and questions raised by the presentations today, please keep forward in your mind the people and the lives behind every statistic and every graph.

I intentionally opened today's session in the language of our host country and is also the primary language of 47 million people in the United States, including many of the 250 to 300,000 Americans living with HIV/AIDS.

For this afternoon session, we will invite our five presenters to speak one right after the other and then open the floor for your questions.

It is my distinct honor to share the podium with such a distinct panel of experts and committed public servants. Co-moderating today's session with me is the honorable Barbara Lee, who co-authored the Lantos/Hyde U.S. Global Leadership Against HIV/AIDS bill signed into law last week and was instrumental in repealing the stigmatizing HIV immigration and entry ban from federal law [applause].

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Representative Lee chairs the Congressional Black Caucus Taskforce on HIV/AIDS and is leading efforts in Congress to improve HIV prevention services.

Please give a warm welcome to U.S. Representative Barbara Lee [applause].

REP. BARBARA LEE (D-CALIFORNIA): Well, good afternoon and let me just thank you so much for being here, thank you so much for your work each and every day. We all know that, yes, we will stamp HIV and AIDS from the face of the earth. Thank you, again, so much.

Let me thank you David, from the AIDS Foundation of Chicago, for all of your work and for serving as Co-Chair for this really important session and also to all of our panelists today.

Let me just acknowledge and thank the IS and Craig McClure and Dr. Helene Gale because when I talked to them about having a focus in the session, looking at what is taking place in our own country, they got it so quickly and they said, "Let us see what we can do," and here we are today. So, I just have to say to the IS and to Craig McClure and Dr. Gale, thank you very much for bringing this focus to this wonderful International AIDS Conference.

Of course, with the release of the new HIV incidence numbers from the CDC, this satellite session could not be more timely. That is right. Will you all kind of check out what

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

they are saying to you today? Let us give them a round of applause [applause].

Now, let me say, I have been a delegate at each of the last five International AIDS Conferences, including, of course, this one and I have long-spoken about the need to integrate the U.S. HIV/AIDS epidemic into discussions about the global pandemic.

At the last conference in Toronto, we say the first major discussion of HIV and AIDS among the African-American community. We were pleased and we were participating with great leaders such as Julian Bond of the NAACP, Congresswoman Maxine Waters, Congresswoman Donna Christensen and many other prominent African-Americans.

I believe that this time around in Mexico City, we have gone one step further. The thought-provoking and ground-breaking report from the Black AIDS Institute of Left Behind has for the first time, for the first time equated the epidemic in black America in terms that the international community can understand very clearly.

It has really shown some sunshine into what is going on in the United States of America. If black America were a separate nation, it would rank 16th in the world in the number of people living with HIV.

The release of the new incidence numbers by the CDC are, frankly, confirmation of what many of us have said all along. Of course, we know just as with the census in America,

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

communities of color are always under-counted. We knew that there was glaring undercount as it relates to HIV and AIDS in the African-American community. So, I am glad the CDC has finally acknowledged what we knew all along. Thank you Dr. Fenton, very much.

Dr. Fenton will, of course, discuss the numbers themselves and let me just say that, of course, we all have been disturbed to read that the estimate of the new annual infections had risen by over 40-percent. However, it is no surprise that 45-percent of infections were among African-Americans and 53-percent were among men who have sex with men.

Clearly, we have not done enough to address the AIDS epidemic within the African-American community, within the Latino community, among men who have sex with men, with African-American women, but those who I am most concerned about are young, black gay men who carry the burdens of both of these communities [applause]. The U.S. failed to fight AIDS. Thank you very much.

We do need to re-invigorate and revitalize our response to our own epidemic. I hope that the CDC numbers and the Black AIDS Institute report will help spur the political will. And let me tell you, it takes a lot of political will. I serve on the Foreign Affairs Committee and I am also on the appropriations committee. I am on the committees that fund our foreign development assistance initiatives and the sub-committee that funds our domestic HIV/AIDS initiatives, Ryan

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

White, our minority AIDS initiatives. And I could just tell you, the political will is not quite there yet, with the exception of members of the Congressional Black Caucus and the Hispanic Caucus and the Progressive Caucus.

So, we have to understand this is a political struggle also and begin to mount a major political battle in America to combat HIV and AIDS with the seriousness and with the urgency that it deserves. That is what we have got to do and [applause] our brothers and sisters are beginning that right now today.

Let me give you an example. In my home town of Oakland, California, and I am really proud of Oakland. Get Screened Oakland, Marsha Martin, Mayor Ron Dellums, we have taken the lead in making sure that our community organizations are funded, that testing is a priority, that all of the initiatives that we all know so well work we are beginning to do in Oakland.

We had to declare a state of emergency in Alameda County in 1999, as it relates to the African-American community. We tried then to declare a state of emergency in Washington, D.C. at the national level, but we could not quite get there, so I think it is about time that we do that and that we call for a national AIDS strategy and a national AIDS plan [applause]. That is what we need to do.

And so I know that when I return to the United States tomorrow, I will be talking with my colleagues in Congress,

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

like I do after each International AIDS Conference, Speaker Pelosi, members of the Congressional Black Caucus, Progressive Caucus, Hispanic Caucus, I am going to talk to all of my colleagues about how we strategize so we can address our own epidemic in a way that it deserves to be addressed. And that is, how do we begin to put together a domestic PEPFAR because that is what we need, that is what the — hey, that is exactly what we need [applause]. That is what the Black AIDS Institute is calling for.

So we have a few opportunities, though for action on some matters before we adjourn in September. Chairman Waxman, who has been a leader in so many efforts in terms of oversight and healthcare, he is going to hold a hearing on the new CDC incidence numbers and the oversight and government reform committee in early September.

The Congressional Black Caucus' Annual Legislative Conference, that will take place at the end of September and in our annual HIV and AIDS Brain chasse, which I chair with Congresswoman Christensen, we will be talking about the impact of AIDS on the African-American community.

We need to explore what opportunities are available right now to provide increased funding to the CDC, which is severely under-funded. You need that 1.3, 1.4 billion just to get started. I mean, that is just to get started. So, we are going to talk about what we need to do and what we need to

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

mount to begin a real prevention mission. So, that is going to be discussed as soon as we return.

Quite frankly, this is long overdue. Some of the on-going flaws of PEPFAR, let me just say, provide us with certain lessons that we need to translate to our own response to AIDS in America [applause].

First, let me just say, we need to develop a single AIDS strategy. Secondly, let me just say, it is shameful that 27 years into this global epidemic [applause] that we do not have national strategy. We do not have one.

Like PEPFAR, such a strategy must orient our domestic AIDS response toward achieving clear and ambitious objectives and I mean ambitious objectives in terms of reducing HIV infection rates, increasing access to care and reducing racial and ethnic disparities. And we must insist on universal healthcare. We cannot forget. That is part of our struggle in America, [applause] universal healthcare.

A PEPFAR for the United States should build stronger partnerships between communities and our public health service agencies. It should include a re-commitment to rebuild our healthcare system and infrastructure in our country. And so, those are part of the components that we must look at and we all have to make a commitment to eliminate that federal ban on funding needle exchange programs. [Applause] that needs to go. That needs to go.

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

And our own domestic PEPFAR must include comprehensive sex education for our young people, [applause] comprehensive. 70-percent of young people infected now are African-American teenagers. Sixty-five-percent are newborn babies, African-American newborns.

My bill, I hope you know it, HR-153, the Responsible Education About Life Act, is to be for real, that repeal the abstinence only policy of our own country and provide for comprehensive sex education. We did that in PEPFAR this year. We got rid of that 33-percent earmark. People told us we could not do it and I said, "Yes, we can." We did it. We did it and so, we are going to have to commit to doing that in our own country, in our own domestic PEPFAR.

So, let me just say, thank you again for being here. Thank you for the work that you do each and every day because we never would be at this point with PEPFAR, the Global Fund, our orphans and vulnerable children initiatives, CDC, our minority AIDS initiatives, our testing initiatives. This is almost — the stars are almost lined up.

They are aligned now and we have got to use this moment. It is a defining moment to pressure our own government, to pressure the Congress and the next President and, of course, you know who I am supporting as the next President, [applause] — you know — to insist and make sure we that we develop our national AIDS strategy and plan and move forward and stamp HIV and AIDS from the face of the earth.

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Thank you, again and let me now take a moment and introduce our first panelist, Dr. Kevin Fenton, who most of know, who has done a phenomenal job at CDC as the Director of the National Center for HIV and AIDS, viral hepatitis, STD and TB prevention. Throughout his career, he has directed and established a number of research programs and forums related to HIV and AIDS and sexual health.

This afternoon, Dr. Fenton will discuss trends and future challenges responding to HIV and AIDS in the United States. As a chief consultant in the BA, it was in their strategic health group — excuse me — I am going to wait and hold off on introducing our next panelist. I think Dr. Fenton should be introduced as Dr. Fenton first and then we will move on to our next panelist.

Okay, so give Dr. Fenton a round of applause and I want to thank him [applause] for being here with these new numbers, these new unfortunate numbers, but he is ready to deal with them and he has got a deep commitment to beginning to help us turn this around. Thank you, Dr. Fenton.

KEVIN FENTON, M.D.: Thank you very much and good afternoon, everyone. Thank you for joining for this session and thanks to the co-chairs for having invited me to be here for this session.

This is an important time for us in the United States. It is a moment in time. There has been a wonderful of confluence of focus, not only on the domestic epidemic in the

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

United States, but the global leadership that the U.S. is providing in HIV prevention.

In the talk that I will give today, I am going to be focusing on the new figures for HIV in the United States. I am going to be focusing on incidence in the United States and as I speak today, I would like you pause and to think about these figures. Pause and think about what they are saying to us in the United States, about where we need to be going with ending this epidemic within our lifetimes.

It does not have to be this way. We need to ensure that HIV does not become a rite of passage for gay and bisexual men and for gay and bisexual men of all races in the U.S. [applause]. We need to end the burden of HIV/AIDS among African-American communities and to end the burden of HIV/AIDS among Latinos in the United States and we need to ensure that all of our young people in the United States grow up with knowledge, the skills, and the confidence to prevent HIV infection throughout their lives.

Over the next ten minutes or so, I am going to be focusing on three key areas. I am going to be introducing the new incidence figures. I am going to be walking through the methodology for assessing these incidence figures. We are going to be looking also at HIV prevalence and then we are going to be talking critically about where do we go next, CDC's response and opportunities that we will have for moving forward with this epidemic.

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

So first of all, let us reflect on the epidemic and where we are with the U.S. epidemic. So, we are going to reflect where we are with the epidemic today. Okay, well, I am being asked to increase the volume on the microphone as well and I will lean into the microphone and I also need — wonderful, thank you.

Okay, so I will re-cap. I am going to focus on the HIV incidence figures, I am going to also reflect on prevalence in the United States and we look at the implications for prevention as well.

So, just as a bit of a recap, I would like to just bring you back to where we were prior to the release of these data. Earlier estimates of HIV incidence were based on cruder methods, on indirect methods.

The first assessment was done in 1995 and at that time, we thought that there were between 40 to 80,000 new HIV infections occurring within the United States. This estimate was later updated and reported in 2001 and this is the figure that most of you in the room are most aware of, the 40,000 new HIV infections occurring in the United States.

For the new methods, which were published in *JAMA* this week, Sunday, we used two approaches to assess HIV incidence in the United States. It was a stratified, extrapolation approach. This is based on ensuring that we had new surveillance information, standard HIV testing and new HIV

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

testing technologies to directly measure incidence in the United States.

The new laboratory technique is called the Stars technique and it combines an HIV test with BEDSA, which enables us to determine recent HIV infections within a five month period. The BEDSA and the Stars approach enables us to distinguish between long-standing HIV infections and new HIV infections and therefore, by using this and complicated mathematical models, we were able to extrapolate to determine the number of new HIV infections which are occurring in the United States. We use a sample of 22 jurisdictions in the United States and we worked with individuals who were newly diagnosed with HIV to perform the Stars approach.

The second method which we used that I am going to be presenting today is the extended back-calculation approach and this enabled a retrospective view of the evolution of HIV incidence in the United States and we were able to [inaudible] change of HIV incidence since 1977.

The extended back-calculation approach uses both AIDS surveillance data as well as HIV surveillance data as well as data on HIV testing patterns in the United States.

This is a figure that all of you in the room should be aware of now. Highlight [inaudible] 2006, CDC estimated that there 56,300 new HIV infections which occurred in the United States. This is approximately 40-percent higher than had been previously estimated.

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

But as you will see in the presentation as I move forward, that this does not necessarily represent an increase in HIV incidence. In fact, the level of new infections have remained relatively stable since 1999. But 56,300 new HIV infections are too many in the United States today.

So, let us focus now on who are those individuals who are newly acquiring HIV in the United States. First, let us look by gender. Seventy-three-percent of the new HIV infections were among men and 27-percent among women. This slide shows data from the extended, back-calculation approach and I am going to walk through it so that you are very clear about what I will be showing in subsequent slides related to the evolution of HIV in the United States.

I would like you to focus first on the green bar. This shows the total number of new HIV infections by year or year groups since 1977 and the data confirms that we saw a peak in HIV incidence in the mid-1980's.

Between 1984 to the early 1990's, we saw a decline in HIV incidence in part, a result of population-wide responses to the HIV epidemic, but also in part to the differential mortality to individuals who were infected with HIV and died with advanced HIV disease.

Between the early 1990's, we saw another uptake in HIV incidence occurring towards the mid to late 1990's and since then, we have seen a stabilization in new HIV infections in the United States.

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

The trend for men follows the general trend for the total population in part because most of the new infections are actually occurring among men in the U.S.; again, a peak in the mid-1980's, a subsequent decline and a relative stabilization since the late 1990's.

In the pink, we show the trends for HIV incidence among women, a slightly later peak, which occurred in the late 1980's and stabilization to some declines since that period.

Let us look at HIV incidence by the transmission category and again, these are data for 2006. As you have heard, 53-percent of new HIV infections are occurring among men who have sex with men, about 31-percent among heterosexuals and 12-percent among injection drug users.

Again, focusing your attention on the extended back-calculation approach and the trend since 1977, we will first look at the trends among men who have sex with men. We saw a peak in the mid-1980's and subsequent declines, but I would like to draw your attention to the fact that men who have sex with men are the only sub-group in the United States where we have seen consistent and sustained increases in HIV incidence since the early 1990's and you can see the clear upward trend of HIV incidence since the early 1990's.

Among injecting drug users, we saw two peaks occurring, one co-terminus with the peaks among gay and bisexual men and another which occurred slightly later in the early 1990's. And

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

since that time, we have seen consistent declines in HIV incidence among injection drug users.

Among heterosexuals, a slightly delayed peak occurred and we have seen a relative stabilization in incidence. For most of the 1990’s, a slight uptake, towards the late 1990’s, but some evidence of decline since then.

The third group that I would like to focus on for HIV incidence is the looking at the trends by race ethnicity and again, as we have heard today, we see the severe and disproportionate burden of new HIV infections which are occurring among minority communities in the United States. Forty-five-percent of the 56,300 new HIV infections occurred among blacks in the United States, about 35-percent among whites and 17-percent among Hispanics. And for those of you who are not from the United States, black and Hispanics account for approximately 13 to 15-percent of the U.S. population, so this really highlights the severe and disproportionate disease, which we see in these communities.

With the race investigator we are actually able to assess the rates of infections in 2006 by applying this data to population data using the census data. Again, you see that the rates for new HIV infections in the United States are approximately 22.8 per 100,000. You see that rates among African-Americans or Blacks in the U.S. are nearly seven times as high as whites and among Hispanic, at 29.3 per 100,000, about three times as high as the rates among whites.

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Let us now focus on the trends overt time for HIV incidence by race ethnicity in the United States. Again, we begin with HIV infections among whites in the U.S. bearing in mind that the predominance were likely to be white, gay men, especially at the beginning of the epidemic.

Again, we see consistent trends. We see the peak of HIV incidence, which occurred in the mid-1980's, the subsequent declines and then a suggestion of sustained increases occurring since the early 1990's.

Among blacks, we see a slightly delayed peak, which occurred in the early 1990's, declines in the mid 1990's and uptake again in the late 1990's, but then relative stabilization in HIV incidence in the more recent time periods.

Among Hispanics, we saw a peak in the mid to late 1980's and we have seen relative stabilization in the number of new HIV infections among Hispanics since that time.

In this graph, I have separated out the numbers for Asia and Pacific Islanders as well as for Alaskan Natives and American Indians, in part, because the numbers are relatively smaller than the other racial and ethnic groups in the United States. But, again, the trends are quite startling and you can see for Asia and Pacific Islanders the peak which occurred early to mid-1980's and a second peak which has occurred towards late 1990's.

There has been a gradual and sustained increased in incidence among Asia and Pacific Islanders, the majority of

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

whom we believe to be, again, bisexual men. And for American Indians and Alaskan Natives, we again saw a similar peak occurring in the mid-80's, but relative stabilization in incidence over time.

The final sub-group and sub-category I will be focusing on today is the estimated percentage of new HIV infections which occurred by age and what is startling here, is the number of new HIV infections occurring in young people in the United States. The data estimates that approximately 34-percent of new HIV infections occurred in individuals less than 30 years, the majority of whom would be between 20 and 29 years of age. Thirty one-percent were among 30 to 39 years and a substantial proportion, another third, in individuals aged over 40 years.

Again, we can look at rates by age group and the data really confirm the disproportionate burden of the disease of individuals aged 30-39 years in the United States. So, those are the incidence data.

I am going to be moving on now briefly to discuss prevalent infections in the United States. The last estimate for prevalence was published in 2005 and at that time, CDC estimated that there were over a million people living with HIV in the United States and the range for the prevalence estimate are highlighted there.

But, it is particularly important to recognize about prevalent HIV infections is that we believe that approximately a quarter of these individuals remain undiagnosed and this

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

really suggests that there remains tremendous unmet need and opportunities for us to scale up our HIV testing promotion and activities in the United States.

The prevalence data, we know, prevalence of HIV in the United States is clearly not randomly distributed in the population and I have included here data from an N. Haynes [misspelled?] survey, which looked at data between 1999 and 2006. I would like you to focus your attention on the red bar, which highlights the overall prevalence of HIV in the United States and this is from a household survey for individuals aged 18 to 49 years. And this suggests that approximately 0.5-percent of Americans are HIV positive.

But, I would like to draw your attention to the tremendous variations which we see in the U.S. population, whether by male, female ratio, the gender, where we see the preponderance of prevalent among men, whether by age, where we see increasing prevalence with increasing age in the United States. And certainly and perhaps unsurprisingly, the disparities which we see by race ethnicity.

But, I would like to draw your attention that in this population-based survey of household respondents, we saw a prevalence of two-percent among non-Hispanic blacks in the United States and approximately .3-percent among Mexican Americans, who were including in this survey.

In terms of AIDS diagnosis and accumulative deaths, we know that since the beginning of this epidemic, we have lost

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

56,565,000 Americans to this epidemic. These are our brothers, these are our sisters. These are our family members our peers, our friends.

In 2006 alone, we continued to see in the United States more than 14,000 individuals dying from HIV/AIDS in part because these individuals were diagnosed too late, in part because of the stigma and discrimination, which are still serious and severe in the United States. And we know from our data that more than a third of individuals, who are diagnosed with HIV, develop AIDS within a year of that HIV diagnosis.

This suggests that we do have unmet needs in ensuring that we are testing people earlier and people who are positive are able to avail themselves of the effective antiretroviral therapy.

So, in the final few minutes of my presentation, what I would like to do is to focus on the implications for prevention. And I know that it is on your hearts and on your minds as we reflect on the panel today. I think the figures are confirming. The fact that we still have a quarter of individuals with HIV in the United States who remain undiagnosed are a huge challenge to us.

We know from the data that men who have sex with men remain at increased HIV risk and new infections are increasing and in fact, MSM are the only group where we are seeing consistent increases in incidence in the United States. The data confirm the disproportionate burden of disease among

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

African-Americans and Hispanics and we know that there are concerns about limited access to effective prevention, whether this is the proportion of individuals who are HIV testing in the U.S., whether it is the coverage of our prevention programs, whether it is the penetration of our prevention programs within communities.

And we also know that there is tremendous concern about complacency regarding HIV, AIDS and prevention within our society and this complacency cuts across all sectors of society and will be one of the main challenges that we will have moving forward.

Other challenges have been spoken about quite clearly at this conference, that stigma and discrimination are [inaudible]. It is a stigma and discrimination against AIDS testing, against those living with HIV, against people who are diagnosed with HIV, who are afraid to access effective treatment and care because they do not want to be seen going to their nearest HIV clinic.

We know about issues about the co-terminus epidemics of substance, which is rife among sectors of our communities, which are driving epidemics of HIV in the United States today.

We know about the internet as a means of facilitating partner change and acquisition, but also the tremendous opportunities that the internet provides for us for enhancing our prevention efforts.

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

And finally, we know that we need to have more culturally competent interventions moving forward and part of that cultural competency would be looking at interventions to focus on structural factors which address poverty, which address housing, which address racism and which homophobia and which address homelessness in our society [applause].

Now I could not end this presentation without briefly reflecting on CDC's response and I know we will have to time to talk about this in the discussion. Briefly, we have already begun to respond to this data. These data are our wake-up call. There are no surprises. They confirm what we knew before regarding the disproportionate burden of the disease and they are a wake-up call to all of us, collectively and individually about enhancing our [inaudible]. CDC has already begun to expand TB testing and I will be happy to speak about this in more detail as we look at increasing our fiscal investments in HIV testing.

We are committed to expanding access to effective programs, to mobilizing at-risk communities, especially African-American, Latino and now, we will be focusing specifically on the MSM communities and leaders within the MSM community moving forward. We are re-assessing our efforts for prevention for men who have sex with men and other hardest-hit communities.

We are conducting research on new interventions, but as we move forward, there are many other things on our agenda for

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

responding to these data. We hail the calls for a national HIV plan and CDC is supportive and wants to be an active player and an active contributor to that national HIV plan and we are hoping that will be a reality in the near future [applause].

We are committed to reviewing our prevention portfolio and we are committed to doing this by an independent panel of national experts to ensure that we are doing the right things, that we are targeting those things in the right ways and we are looking at opportunities for scaling up our prevention efforts moving forward. And as part of this review of our prevention portfolio, we are committed to developing a new, strategic roadmap for HIV prevention, with measurable and bold objectives, leaving us to 20/20.

So, with that, I would like bring the presentation to a close. I would like to thank my CDC colleagues who have worked tremendously on getting this data out in a timely manner, in a manner which will ensure us that we have accurate and reliable data, data that we are confident about and a new system of surveillance and measuring HIV incidence in the United States that will ensure that we have better clarity on the epidemic and can ensure that we now know how better to evaluate and to enhance our prevention responses moving forward. Thank you very much [applause].

DAVID MUNAR: I want to thank our protestors for keeping the session alive and real and focusing on what has to happen, so thank you, protestors [applause]. Thank you, Dr.

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Fenton. Our next speaker is Dr. Ron Valdeserri, who as Chief Consultant on the Veteran's Administration Strategic Healthcare Group, through ex-VA programs that relate to public health policies across the VA healthcare system. Prior to joining the VA, Dr. Valdeserri served as Deputy Director for CDC's National Center for HIV, STD's and TB Prevention. He will present on the HIV/AIDS epidemic among MSM's in the United States, Dr. Valdeserri.

RONALD VALDISERRI, M.D., M.P.H: Thank you very much. If we can get someone up here to put my slides on, we will get started in a minute. Here we go. There we go. Thank you very much. Good afternoon. I would like to thank the organizers of the session for inviting me to overview the HIV/AIDS epidemic among men who have sex with men or MSM in the United States. And throughout this presentation, I will use the acronym MSM to include all men who engage in same-sex behavior, regardless of their sexual identity, thus the term encompasses gay men, bisexual men and homosexually-active, straight-identified men. I guess we use this, great.

Kevin Fenton provided an overview of epidemic trends in the United States including the very important and highly relevant new incidence estimates. Now, let us take a closer look at specific trends in AIDS cases among men who have sex with men. This bar graph shows that the number of AIDS cases among MSM in the United States peaked in 1992 and decreased

through 2001. However, between 2001 and 2005, the number of new AIDS diagnoses among MSM in the United States increased.

This line graph attests to significant changes in the racial/ethnic composition of MSM with AIDS in the United States. We see a dramatic decline in AIDS diagnoses among non-Hispanic white men throughout most of the 1990’s and increases in diagnoses among black and Hispanic men.

What can we say about more recent trends? As this pie chart shows, MSM accounted for the single largest transmission category or 43.5-percent of 36,790 new AIDS cases reported in the United States in 2006. A smaller percentage of new AIDS cases, five-percent, were reported in MSM who injected drugs.

In this slide, we are looking at 2006 data from 33 states with mature reporting systems, meaning that they have had confidential, name-based HIV reporting since at least 2003. Here we see that of the over 35,000 HIV/AIDS diagnosis made in 2006, half were among MSM and three-percent were among MSM who inject drugs.

The next two pie charts portray age distribution and race ethnicity among the over 97,000 MSM who were diagnosed with HIV/AIDS during the years of 2001 through 2006 in 33 U.S. States with HIV name reporting. As demonstrated, HIV/AIDS is diagnosed in all ages of men, but the majority of MSM diagnosed, nearly two-thirds, were between the ages of 25 and 44 years.

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

In terms of race ethnicity, whites accounted for 42-percent of diagnosis, blacks for 36-percent of diagnoses and Hispanics for 19-percent of diagnosis. Asian Pacific Islanders and American Indians and Alaskan Natives were one-percent and less than one-percent, respectively of all diagnoses. Now, because we do not know the total number of MSM in each racial and ethnic group, we cannot generate MSM-specific rates of disease burden by racial ethnic group.

However, the disproportionate burden among MSM of color is obvious when we consider racial ethnic distribution in the general U.S. population. Namely, while blacks represent 13-percent of the overall U.S. population, black men account for 36-percent of HIV/AIDS diagnoses among MSM. Likewise, Hispanics account for 14-percent of the overall U.S. population, yet 19-percent of MSM with HIV/AIDS are Hispanic.

A recent analysis by the CDC compared estimated annual percentage changes or EAPC's of HIV/AIDS diagnoses among MSM in 33 states between 2001 and 2006. While EAPC's decreased for injecting drug users and high-risk heterosexuals, they increased for MSM. Among MSM of all ages, significant EAPC increases were seen in blacks, Hispanics and Asian Pacific Islanders.

The largest EAPC increase was seen in MSM 13 to 24 years old, especially young black men. Data such as these and obviously the data presented by Kevin, have raised serious

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

concerns about a resurgent HIV/AIDS epidemic among men who have sex with men in the United States.

Now, what do we know about MSM behaviors that would help us understand factors that may contribute to increases in HIV infection rates? Useful information comes from the CDC's National HIV Behavioral Surveillance System or NHBS. Using ethnographic techniques, the NHBS interviewed over 10,000 HIV uninfected MSM from a variety of venues in 17 metropolitan areas in the United States between November 2003 and April 2005.

MSM reported very high rates of HIV testing with 90-percent that they had ever been tested and 77-percent reporting testing in the last 12 months. While this is a positive health behavior, testing by itself is not a magic bullet against HIV infection. And other studies have revealed unrecognized HIV infection as a serious issue among MSM, especially MSM of color.

Directly relevant to our understanding of increased HIV infection among U.S. MSM is the observation of high rates of anal intercourse without condom use. 47-percent of the men surveyed reported having unprotected anal sex with a male partner during the preceding 12 months.

Peer norms around safer sex, especially condom-protected anal intercourse, are simply not as robust as they were in the first two decades of the American epidemic. Further, as this survey reveals, at-risk MSM do not appear to

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

be receiving adequate levels of proactive HIV prevention. Only 15 and eight-percent respectively reported participating in individual and group level HIV programs in the last year.

Drug and alcohol use, especially non-injection drug use continue to be correlative unsafe sexual behavior among MSM. Over 40-percent of MSM surveyed, reported non-injection drug use in the past 12 months. Although not the only drug of concern, several studies have shown a clear association between methamphetamine use and HIV-sera conversion among urban MSM in the United States.

In summary, epidemiologic data, including trends in sexually transmitted diseases, like syphilis and gonorrhea, indicate an increase in high-risk sexual behaviors among MSM and support the concern that incident HIV infections are increasing among some populations of MSM in the United States.

As this slide summarizes, there are a number of factors associated with resurgent HIV infection among MSM. Two that have not yet been touched upon and deserve specific mention, are the on-going stigmatization of same-sex behavior in the United States as well as the general population attitude that HIV/AIDS is no longer a major public health issue nor a serious health threat in the United States.

This data and these numbers mean very little if we do not use them to improve and enhance our efforts to prevent HIV infection among the various populations of MSM living in the United States. As such, it is very important that we continue

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

to inform funders and policy makers that HIV prevention is scientifically proven to be effective and is cost-saving. And most importantly, effective HIV prevention programs can spare successive generations of MSM from what remains an incurable, life-long disease.

Our strategy to ensure effective HIV prevention efforts for MSM in the United States must rely on men being aware of their current HIV-sera status. In this study of MSM from five American cities, nearly half of the infected men were unaware of their infection. An unrecognized infection was especially high among non-whites and men younger than 30 years of age.

Promoting routine HIV testing in healthcare settings and developing culturally-sensitive, community-based programs for MSM are two important ways to achieve this goal. But testing alone will not end this epidemic. We must continue to implement evidence-based interventions for uninfected MSM as well as those who are already diagnosed and living with HIV. And once these interventions are tested and proven to be effective, it is essential that they be replicated at a level and scale that will ensure effective dosage.

Sadly, a recent study conducted in four American cities found that among nearly 4,000 HIV-infected persons only one-third had received any prevention services in the last three months. And MSM were especially likely to have gone without such services, even though they were more likely to report risk behaviors.

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Finally, in the words of Nobel Laureate, Mother Theresa, "To keep a lamp burning, we have to keep pouring oil into it." And by this I mean it is imperative that as a nation, the United States continue to invest in HIV prevention research, both biomedical and behavioral. Further, this investment cannot stop at the level of publication, but must extend to include efforts to better understand how to replicate and operationalize effective interventions, especially for racial and ethnic minorities. Thank you [applause].

REPRESENTATIVE BARBARA LEE (D-CALIFORNIA): Thank you very much. Now, we are privileged to hear from a real expert on adolescent and teenagers, Dr. Laura Kahn. Dr. Kahn is with the Division of Adolescent and School Health at CDC's National Center for Chronic Disease Prevention and Health Promotion.

She will describe trends in HIV-related risk behaviors among United States adolescents. Thank you very much, Dr.Kahn, for being here.

LAURA KAHN, Ph.D.: Thank you to the organizers for the opportunity to present these data and thank you for the kind introduction. I think you will see by the end of this presentation, this is another version of the wake-up call that Dr. Fenton just described. The purpose of this presentation is to examine changes in sexual risk behaviors among high school students in the U.S. from '91 to '07. We did this by using data from CDC's National Youth Risk Behaviors Survey, which bi-annually measures the six categories of priority health risk

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

behaviors listed on this slide among adolescents, generally ages 14 to 17 who attend school.

For this presentation, we examine trends in four HIV-related risk behaviors: ever having had sexual intercourse, sexual intercourse with four or more persons, current sexual activity and condom use at last sexual intercourse. To identify possible disparities in secular trends, we looked at five sub-groups of students: females, males, white not-Hispanic students, black or African-American, not-Hispanic students, hereafter referred to as black students and Hispanic or Latino students who might be of any race hereafter referred to as Hispanic students.

We used data from nine national youth risk behaviors surveys conducted from ’91 to ’07. Each survey used an independent three-stage cluster sample. We first selected schools with probability proportional to size and then randomly selected classrooms to participate. All students in selected classes were included. To allow for separate analyses, black and Hispanic students were over-sampled at each stage.

Data are representative of all public and private school students in grades 9 through 12 in all 50 states. This slide shows the sample sizes and response rates and how they varied across the nine national youth risk behavior surveys. Sample sizes ranged from nearly 11,000 to over 16,000.

Survey administration procedures were designed to protect students’ privacy by allowing for anonymous and

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

voluntary participation. Before survey administration, local parental procedures were followed. Students completed a self-administered questionnaire during one class period and record their responses directly on a computer-scanable booklet.

A weight based on students' sex, race ethnicity and grade was applied to each record to adjust for non-response and over sampling of black and Hispanic students. Trends over time were analyzed using logistic regression analyses, which controlled for sex, race ethnicity and grade and also simultaneously assessed both linear and quadratic time effects.

Trends that include both significant linear and quadratic components demonstrate an overall increase or decrease over time, plus some non-linear variation within the overall increase or decrease. Cross-sectional sub-group differences were analyzed for statistical significance using T-tests.

Now, let us turn to the results. For each of the four risk behaviors, I will begin by showing cross-sectional data from '07 by sub-group and then three slides that describe trends overall and then by sex and by race ethnicity.

Nationwide, in '07, 48-percent of high school students had ever had sexual intercourse during their life. The prevalence of sexual intercourse was higher among male than female students, high among black and Hispanic than white students and high among black than Hispanic students.

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

This slide shows the prevalence of sexual experience over time. From ’91 to ’07, sexual experience decreased 12-percent. A linear decrease also was detected among female students shown in red and male students shown in yellow. In addition, among male students, the prevalence of sexual experience declined from ’91 to ’97 and then leveled off from ’97 to ’07.

Among white students shown in blue and black students shown in orange, a linear decrease was detected. Among black students, a quadratic trend also was detected, indicating that sexual declined from 91’ to ’01 and then leveled off from ’01 to ’07. Among Hispanic students shown in green, no change was detected.

Moving to the next behavior, nationwide in ’07 15-percent of students had had sexual intercourse with four or more sex partners during their life. The prevalence of having multiple sex partners was higher among male than female students and once again, higher among black and Hispanic than white students and higher among black than Hispanic students.

This slide shows the percentage of high school students who had multiple sex partners. From ’91 to ’07, the overall prevalence of this behavior decreased 20-percent. A linear decrease also was detected among female and male students. In addition, among male students, a quadratic trend also was detected. The prevalence of multiple sex partners among male

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

students declined from ’91 to ’97 and then leveled off from ’97 to ‘07

Among black and white students the prevalence of multiple sex partners decreased from ’91 to ’07. However, among Hispanic students, once again, no change was detected.

Moving now to current sexual activity, in 2007, 35-percent of high school students had had sexual intercourse with at least one person during the three months before the survey. The prevalence of sexual activity was higher among black and Hispanic than white students and higher among black than Hispanic students.

This slide shows the percentage of high school students over time who reported current sexual activity. From ’91 to ’07, this behavior decreased seven-percent overall. However, no changes were detected among male and female students when examined separately and no changes were detected in current sexual activity among white or Hispanic students.

Among black students, the prevalence of current sexual activity decreased from ’91 to ’07. And finally, in ’07, among the currently sexually active students, 62-percent reported that either they or their partner had used a condom during last sexual intercourse. The prevalence of having used a condom was higher among male than female students and higher among black than white students.

This slide shows that the percentage of high school students who used a condom increased 33-percent from ’91 to

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

’07. In addition, a quadratic change was identified indicating that condom use rates also leveled off within this overall decrease from ’03 to ’07.

A linear increase in condom use was also detected among male and female students. In addition, among female students, a quadratic trend was detected, indicating that condom use also increased from ’91 to ’03 and then leveled off from ’03 to ’07.

Among white, black and Hispanic students, a linear increase in condom use was detected. However, among black students, once again, a quadratic trend also was detected.

This is a summary of the data I just reported by behavior and sub-group. A single arrow in a box indicates a linear increase or decrease only or level rates. No change at all from ’91 to ’07. Two arrows in a box indicated quadratic change in addition to a linear increase or decrease. In these instances, the behavior went up or down and then leveled off more recently, in addition to an overall increase or decrease.

Focusing, then on just the first row of data, it tells us that progress has been made during the past 17 years in decreasing overall the prevalence of sexual experience, multiple sex partners and current sexual activity and an increase in the prevalence of condom use. However, even though condom use rates have increased since ’91, since ’03 no additional progress has been made.

Further, though I did not show these data, no changes were noted for any behavior between ’05 and ’07 overall or

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

among any subgroup of students. Further, if we look at the three highlighted rows on this slide, it shows that among male students, black students and Hispanic students there is further cause for concern. Since among male students sexual experience and multiple sex partners has been level since '97 and current sexual activity has not changed at all, among black students sexual experience has not decreased since '01 and condom use has not increased since '99.

And black students have significantly higher rates of sexual risk behaviors than white or Hispanic students. And among Hispanic students, no changes at all have occurred in sexual experience, multiple sex partners or current sexual activity since 1991.

At least three limitations should be noted. First, these data, of course, only apply to youth who attend school and therefore, are not representative of all persons in this age group. Nationwide, in the U.S. in '05, of person's aged 16 to 17 years approximately three-percent were not enrolled in a high school program and had not completed high school.

Among some sub-groups of youth, the percentage of youth not enrolled and who have not completed high school is much higher. Second, the extent of under or over reporting of behaviors cannot be determined although the survey questions demonstrate good test, re-test reliability. And third, the National YRBS only asks about a very limited number of sexual

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

behaviors and does not tell us anything about why students do or do not practice sexual risk behaviors.

Clearly, renewed efforts are critically needed to delay onset of sexual activity and to increase condom use once students become sexual active. This is especially true for male, black and Hispanic students and these efforts need to involve parent and families, schools, youth-serving community organizations, healthcare providers, the media, government and of course, youth themselves. Thank you [applause].

DAVID MUNAR: Thank you Dr. Kahn. Our next presenter is Dr. Gina Wingood, a full professor at Emory University Rollins School of Public Health. Dr. Wingood's research explores strategies to reduce high risk sexual behavior among African-American women and develop efficacious intervention to preventing HIV. Please welcome Dr. Wingood [applause].

GINA WINGOOD, SC.D., M.P.H: Good afternoon and some assistance with the slide set. Good afternoon. Thank you David, thank you Congresswoman for all of your efforts, thank you very much. Also, thank you everybody here for allowing me to present on African-American women.

I am presenting on the efficacy of a trial to reduce instant non-viral STI's as well as high-risk HPV among African-American women. I would like to thank my colleagues who have worked day, night, evening and morning and every other day to actually reduce, to work with me on this study. Thank you for all your efforts.

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

The rate of HIV among all U.S. women is 12.2 per 100,000. Among African-American women, it is 60.2 per 100,000, astonishing and sad. Among women in the U.S., marked racial as well as regional disparities exist, specifically, women in the deep, Southern U.S. are severely affected. Currently, among all U.S. women, one-third of new HIV infections are diagnosed among women in the Deep South, with African-American women being diagnoses disproportionately.

Traditionally, HIV interventions for women have focused on enhancing condom penal-vaginal sex. However, more novel HIV interventions are incorporated. They need to offer a range of female-initiated as well as female-controlled safer sex choices. This is particularly important for women at risk; African-American women residing in the Deep South.

You may ask, where is the Deep South? I am from Massachusetts. I do not know anything about the Deep South. So, where is the Deep South? The Deep South is actually the southern belt of the U.S. It includes the states of Alabama, Georgia, Louisiana, North Carolina, South Carolina and Mississippi.

To address these racial disparities, we designed a study called STARS. STARS is an acronym called Sisters Talking About Real Solutions. The objective of STARS is to test the efficacy of a program for African-American women in Georgia, a deep southern state. The primary outcomes are to reduce incident STI’s, specifically Chlamydia, gonorrhea, and

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

trichomoniasis as well as to reduce unprotected sexual intercourse.

We wanted to look at a range of secondary outcomes. Specifically we want to look at incident HPV, types 16 and 18. HPV is also quite prevalent among women and what we are trying to do is it also occurs sexually. We want to reduce high risk HPV. We want to reduce multiple male sexual partners. Non-insertive or non-penetrative intercourse, we want to actually enhance this.

We want to look at STI testing practices. Douching practices, which are very prevalent, particularly among African-American women in the South and have been associated with STI's.

Partner selection practices, something other, again, than condom use and, of course, psycho-social mediators such as knowledge, condom use self-efficacy.

The study sample was recruited at a health maintenance organization. A database was obtained from this organization and we randomly selected women from this list to participate in this study.

Eligibility criteria including being an African-American female, 18 to 29 years of age, providing written, informed consent, false reporting, having unpredicted vaginal sex in the prior six months.

This was a randomized trial design. The population of African-American women were screened. They had to be between

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

the ages of 18 to 29 and sexually active. At baseline, six and 12 months follow-up, women completed an [inaudible] that assessed self-report behaviors, demographics and mediators. Additionally, women provided vaginal swabs for STI analysis for Chlamydia, gonorrhea, trichomoniasis and HPV.

Women were randomized to one to two study conditions. The HIV intervention, which was two sessions, with each session being four hours in length or comparison condition, which focused on general health promotion.

The content of the HIV intercession was two sessions. The first session talked about fostering ethnic and gender pride. What that talked about is really enhancing self esteem, self awareness and self worth in being an African-American female. We know that many women in this age group have high rates of abuse or histories of abuse. Therefore, as part of this session, we talked about healthy and unhealthy relationships. We defined abuse and talked how abuse can lead to HIV risk taking and potentially, HIV acquisition.

We discussed a range of prevention options. We described it as the AMOUR prevention package. Each letter in AMOUR stood for a prevention strategy. A stood for abstaining from unsafe sex and douching. M stands for mutual stimulation, enhancing non-penetrative sex. O stood for oral sex, however protected oral sex. U stood for uninfected partner, encouraging partner STI testing and R stood for regular use of

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

condoms, which we talked about consistent and proper condom use as having a reduced number of partners.

Session two actually reinforced these activities via role plays as well as talked about partner selection. Analyses were conducted used of intention to treat analyses. At baseline, we compared both conditions on demographics, sexual behaviors, medias of safer sex. Co-variants were identified. We employed logistic linear rush-in as well as GEE to assess for repeated measures.

I am going to ignore that. Socio-demographics, mentioned that on average, women were 24 years of age. Also, a majority were in relationship, specifically, more than 85-percent of the women were in relationships and also these relationships were long-term relationships. Women were in relationships for almost two years. And we know that it is much harder to change your HIV risk practices when you are in a long-term relationship.

Looking at the results, participation rate for this study was 85-percent. The intervention session was implemented with fidelity, with 99-percent of intervention activities being completed. Most of the women, 96-percent, came to two of the intervention sessions. Over 70-percent of women completed six as well as 12 month follow up sessions in the intervention condition. The comparison condition was also completed. Ninety-nine-percent of the activities were completed with

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

fidelity and we had relatively high or moderate to high six month and 12 month retention rates.

So, let us look closely at the results and specifically, what was the effect of STARS in reducing incidence biological outcomes? This is looking at the effect of STARS in reducing non-viral STI's, high risk HPV as well. It is what we call any STI, which is a combination of all of these STI's. Specifically, women who were in the intervention condition were a third less likely to acquire a new non-viral STI. Additionally, they were two-thirds less likely to acquire high-risk HPV, that is type 16 as well as 18.

Let us look at how STARS was effective in terms of reducing behavioral outcomes. I look at these outcomes in relation to the AMOUR strategic model. Women in the intervention were less likely to douche or more likely to abstain from douching. They were more likely to advise their main partner of their STI test results.

They were also more likely to ask their partner to get a STI test. The women were also much more likely to practice non-penetrative sex, such as masturbation. They were more likely to practice oral sex. They also will more likely reduce having multiple sexual partners, having a casual sexual partner and also were more likely to [inaudible] the male partner who wanted children.

Let us look at some of how the intervention impacted psycho-social outcomes or mediators of safer sex. Women in the

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

intervention had greater or higher knowledge scores. They had higher scores on condom use self-efficacy and they had reduced barriers to safer sex.

This trial demonstrates that a two-session HIV intervention can reduce high-risk HPV incidence. Non-viral STI's such as Chlamydia, gonorrhea and trichomoniasis and can enhance safer sex practices and mediators of safer sex among a sample of African-American women who are in relatively long-term relationships.

The intervention affects may be attritibutable to providing women a package of female-controlled or female-initiated safer sex options in allowing them to combine these strategies. Encouraging consistent condom use, as we do in many studies, is very important. However, for this prevention treasure to be effective, it has to be adopted.

In this study, we offered a prevention package that included behavioral options such as douching, partner selection, consistent condom use and non-penetrative sex. We looked at biomedical options as well, such as encouraging partner STI testing as well as social options such as partner selection.

A single prevention strategy may not be feasible, practical or even realistic. Future HIV interventions for women may considering expanding their options for safer sex and offering prevention packages. Thank you [applause].

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

REPRESENTATIVE BARBARA LEE, (D-CALIFORNIA): Thank you very much, Dr. Wingood. Let me encourage as many who can stay to be please stay because after our final panelist, we will be opening for a few questions and answers.

Now, we will hear from Daniel Kidder of CDC's Global AIDS program. He will present data on study exploring the connection between housing status and HIV risk behavior. Thank you very much, Daniel, for being here.

DANIEL KIDDER, PH.D.: Thank you — very much.

REPRESENTATIVE BARBARA LEE, (D-CALIFORNIA): We look forward to hearing you.

DANIEL KIDDER, PH.D.: — very much. Good afternoon. It is truly an honor to be presenting at this conference and with such a distinguished panel. When I was thinking about this distinguished panel and the topics they would be discussing, I was wondering how I could raise the profile of what I was going to talk about.

So, I thought to myself. Well, President Bill Clinton is talking this week, maybe he can talk homelessness and HIV in the U.S. And I thought to myself well, that may not be enough. How about if during his speech while he is talking about homelessness and HIV, there are people who walk in front of the stage holding signs about homeless people living with HIV and AIDS?

Then, as an additional part, maybe they could march for a couple of days during the conference. Well, all that did

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

occur, so I am glad that all of you have heard of this issue and are here to listen to my presentation on this topic. But, in all seriousness, I think this is an issue that is receiving much more attention, especially in the last few years and so, without further adieu, let me begin my presentation.

Okay, is that better? I would first like to thank my co-authors on this project Drs. Rich Walitsky, [misspelled?] Sherry Pallis [misspelled?] and Michael Campsmith [misspelled?].

Determining the numbers of homeless people in the U.S. is difficult. Homelessness is often episodic with people cycling in and out of homelessness and there are those who are chronically homeless who are living on the streets or in other places not meant for human habitation and those are difficult to located and count.

Social and economic factors associated with HIV in the U.S. are also associated with homelessness, including being male, black, using substances, having mental health issues, lack of education and a history of physical or sexual abuse. And homeless persons also have more chronic diseases and physical health problems than the general population. Homeless persons are more likely than stably-housed persons to engage in HIV risk behaviors including injection drug use, risky sexual practices and engaging in sex for money, drugs or a place to stay.

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

So, perhaps not surprisingly, HIV/AIDS diagnosis rates are three to nine times higher in homeless persons compared with those in stable housing. And these differences in rates are due to differences in sample characteristics and locations where data were collected. Yet, few studies have conducted research at the intersection of these two groups which are homeless people living with HIV or AIDS and most of the studies have been single-sight and small scale.

So, the goals of the study were to conduct — we used bi-varied analyses to examine the differences between homeless and housed people with HIV and AIDS, on HIV sexual transmission risk behaviors and substance use risk behaviors. We used multi-varied analyses to examine the independent affects of homelessness and on sex and substance use risk, controlling for potentially confounding factors.

This study was a secondary analysis of the U.S. CDC's supplement to HIV/AIDS surveillance or SHAS project, which is a behavioral survey of adults recently diagnosed with HIV or AIDS in the U.S. It extends information routinely collected in AIDS surveillance. It is a cross-sectional survey and was conducted in multiple sites.

These are the participating sites: There are 19 health departments across the U.S. that participated in this project. Some recruitment occurred across states and others in certain facilities or cities. Ten health departments conducted population-based sampling and those are shown here in red and

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

nine health departments conducted facility-based sampling in yellow.

Though information was collected across a variety of domains through individual interviews, the SHAS data were collected from 1990 to 2003. The current study includes data from May 2000 to December 2003 from persons who had valid housing data and this was 8,075 people.

Housing status was based on respondents' living situation at the time of the interview. Persons were homeless if they reported living in a homeless shelter or on the streets, this was four-percent of the sample and the housed respondents were those living in a house, an apartment, a medical care facility or a correctional institution and this was the remaining 96-percent.

This slide shows bi-varied analyses comparing the homeless and the housed groups. We used high squares for categorical variables and T-tests for continuous variables. Those in yellow are the variables in which there were significant differences between homeless and housed groups.

As you can see here, the average age was 40 for both groups and was not significantly different between groups. The sample was mostly male with significantly more male homeless respondents. It was mostly black in both groups. The homeless had a lower education with nearly half having lower than high school education.

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

The homeless were also more likely to be unemployed with 90-percent unemployment and perhaps, not surprisingly, the homeless were more likely to have a yearly income of less than $10,000. They were also less likely to be married.

These are the bi-variant sexual behavior analyses. Although the housed were significantly more likely to be sexually active, the homeless were more likely to have a had a greater number of sex partners in their lifetime and in the past year and almost half of the homeless had exchanged sex in their lifetime and were more likely to have exchanged sex in the past 12 months. Homeless were also more likely to have had unprotected vaginal or anal sex and will have had sex with an unknown sera-status partner.

For substance use bi-varied analyses, there were significant differences between homeless and housed on all of the substance use variables. The possible alcohol abuse was the CAGE scale, which is a widely used, standardized screening tool for possible lifetime alcohol abuse. And nearly 60-percent of the homeless had used drugs in the past 12 months. Nearly twice as many homeless reported ever injecting drugs. And among those who had ever injected, nearly half of the homeless had done so in the past year.

In order to examine the independent effects of housing status, we conducted multi-variant logistic regression analyses, using the dependent variables, the sex risk and substance use variables that I just mentioned and we controlled

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

for socio-demographic and HIV risk group factors that are often associated with homelessness.

The socio-demographic factors were age, gender, race ethnicity, marital status, education, income and employment.

The HIV risk group variables were men who have sex with men, injection drug use, MSM and IDU and high risk heterosexuals. And the goal of these analyses was to examine whether housing status was significantly associated with sex and drug risk behaviors even after controlling for these factors.

So, is housing status significant above and beyond these factors? These are the sexual behavior regression analyses and each of these were separate multi-variant regression analyses, controlling for the factors that I just mentioned. Presenting the adjusted odds ratios in the 95-percent confidence intervals for the homeless compared with the housed groups for each analysis.

So, for this first one, since 1.0 falls within the lower and upper bound of the 95-percent confidence interval, housing was not significantly associated with sexual activity in the past 12 months. However, housing was a significant predictor of the remaining sex variables.

The homeless had 1.5 times the odds of the housed respondents of having greater than nine partners in their lifetime, as well as higher odds of having more than one partner within the last year.

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

The homeless also had nearly two and half times the odds of ever exchanging sex and nearly the three times the odds of exchanging sex in the past year. The homeless also had two times the odds of unprotected sex with an unknown status partner.

It is possible that these sex risk behaviors would be associated with substance use variables as substance use and risky sex behaviors often occur together. So, we re-ran these analyses also controlling for alcohol and drug use and all of these remain significant except for the lifetime number of partners.

For the substance use regression analyses, all of the substance use regression analyses were significant, like homeless having greater odds of substance use including 1.6 times the odds of possible alcohol abuse. Over two times the odds of recent drug use, nearly two times the odds of ever injecting drugs and over two and have times the odds of recent injection drug use, among those who had ever injected.

So, in summary, compared to the house respondents, homeless had greater odds of having more sex partners, having exchanged sex for money or drugs, having unprotected sex with an unknown status partner, having possible alcohol abuse, having used drugs and having injected drugs, even after controlling for possible socio-demographic and HIV risks group confounding factors that might be associated with housing status.

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

There are some limitations for this study. This was conducted only in a limited number of locations, so SHAS in not representative of all people living with HIV or AIDS in the U.S. and some sites only interviewed people with AIDS, which may produce different results than interviewing those with HIV.

This is also not a study of homeless people, so we do not have detailed information about homelessness, such as the amount of time that they were homeless. In addition, homeless were only included by chance. The sampling may under-represent the number of homeless people living with HIV or AIDS because homeless persons are often some of the most difficult persons to locate.

These are also self-report data and thus, subject to recall biases and socially desirable responding and there is no way to verify the data that was reported. This is also a cross-sectional study so we cannot determine which came first, the homelessness or the HIV risk factors.

Homeless people living with HIV or AIDS in the U.S. experience more challenges than housed people living with HIV or AIDS, yet little research has been reported on homeless people living with HIV or AIDs in the U.S. This is the first large, multi-site study investigating HIV risk behaviors among homeless people living with HIV or AIDS.

As mentioned previously, the four-percent of people living with HIV or AIDS reporting being homeless in this sample may be low estimate. However, even using this figure of four-

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

percent, means that of the estimated one plus million people living with HIV or AIDS in the U.S., there are potentially tens of thousands who are homeless. Thus, the results indicate the importance of screening for housing status and the importance of behavioral interventions for people living with HIV or AIDs.

And homeless people living with HIV or AIDS should be a special priority for substance abuse and HIV prevention programs. Thank you [applause].

DAVID MUNAR: Thanks Dr. Kidder. I want to thank my incredible co-moderator and our distinguished panel and I especially want to thank you, Dr. Fenton, but not for the data that you presented, which I have to admit, took way too long to release. This is data that we needed a year ago when it was ready. If we had had it at October, the President might have had second thoughts about calling for a million dollar decrease in HIV prevention services.

Congressional appropriations committees might have not fought funded, recommended flat funding for HIV prevention for the Minority AIDS initiative. Colleagues of our distinguished member of Congress here might have taken action on her bills that are pending, the Real acts to add abstinence only funding, the Justice Act to make sure that there are condoms available in Federal Prisons, that we actually take responses.

It is very disappointing to be at this conference and hear so many things that are wrong and yet, we are not hearing enough solutions and that is why I really wanted to thank you

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

for endorsing the National AIDS Strategy. We do need a National AIDS Strategy [applause].

We need one that is outcome-based, that has clear goals and objectives, that is coordinated across the federal government and includes all agencies, including all the agencies under HHS, that is CDC, NIH, HRSA, SAMPSA, CMS and the Veteran's Administration, the Department of Justice, HUD, Homeland Security, labor, we need a comprehensive response and we need all of you, the American public to call on Senators Obama and McCain to make this happen.

There are going to be so many priorities moving forward. This may not happen and we may be here or we may be in similar meetings in two years, having the same discussions and seeing even worse data. So, that is why we really thank you Dr. Fenton for agreeing to a national strategy. We want to ask you that really raise with your colleagues in the federal government.

And we actually have a T-shirt for you. We really want to encourage everyone to go to the nationalaidsstrategy.org [laughter] [applause]. Yes, ma'am.

NIKKI MONGOULI: Hi, my name is Nikki Mangouli [misspelled?] from advocates for youth in Washington, D.C. and once again, I just wanted to thank Barbara Lee for being such an incredible advocate for young people everywhere, but my question is for all panel members. Have you made a commitment

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

at the Youth Commitment's Desk at the Youth Pavilion in the Global Village yet?

KEVIN FENTON, M.D.: We have not yet, but we will be going there en mass, I am sure, after this [laughter] to see what commitments we can make. Thank you for bringing that to my attention.

RICHARD ZALDIVAR: Hello, my name is Richard Zaldivar, I am from Los Angeles from The Wall, Las Memorias Project and I want to applaud all of you in the tremendous work you do. But I need to be honest with you. Coming here from Los Angeles, I am Mexican-American, coming to Mexico, very impressed with the work that they are doing here, but coming to a session to oversee, to receive an update on HIV/AIDS in the United States, I feel like I am left out.

I know that when we come to conferences, when we look at HIV/AIDS, we look at categories. We look at sub-categories, but you know what? We are not looking at the whole story in the United States. We are not looking at the migrant issues. We are not looking to people in Mexico and the migration from Latin America and how that impacts HIV/AIDS. Until that is in there, I am absent. My people are absent.

I say that because I am extremely passionate that the HIV/AIDS response should be include of all people. Puerto Ricans are Latinos and their numbers should be counted with Latinos and a follow-up question I would like to pose to Dr. Fenton and I appreciate all the work that you do. Back in

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

April, a few months ago, we had a national discussion on HIV/AIDS and the Latino community leaders, with many of the folks from CDC, created an agenda and asked for a response for a lot of the suggestions and advice that was made on a national level and I wanted to know where are we at with that Dr. Fenton?

KEVIN FENTON, M.D.: Thank you very much for that question and first of all, let me acknowledge the work that has been done in the community to develop this national agenda and strategy. I have reviewed the strategy and agenda and it is a formidable work. It is very clear in what needs to be done. It is very specific in what you are trying to achieve and I applaud the community on the work.

I know that colleagues within our agency are looking at the document. We are looking at ways in which we can support Dovetail and to enhance some of the work that you want to achieve in the strategy. Many of the things that you have called for, we are already working within the agency and we are hoping to make that explicit to you. But, there are also areas that you have highlighted to us that we need to enhance or to work with other agencies to meet those needs, so just to say that we are committed to looking at this, reviewing it and to responding in a timely way. Thank you.

Hi, Matt Epperson [misspelled?] from New York. I know we cannot cover everything in just an hour, but I do think that one issue that did not come up once that I think is very

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

important is the criminal justice system and that it is basically absent in many ways in terms of HIV prevention, medical care, testing availability, continuity of care, the prevalence is higher in the criminal justice system for pretty much every demographic grouping. It goes on and on so, I guess my question is for any of you within your sort of sphere of influence, what are you doing to really integrate with the criminal justice system and not just in terms of public safety, but really integrating with the criminal justice system to make it a public health issue?

DAVID MUNAR: Congresswoman?

REPRESENTATIVE BARBARA LEE (D-CALIFORNIA): Let me just quickly respond. This is an issue that, of course, has been swept under the rug and just on the congressional front, there are several efforts taking place that are uphill battles, of course.

First of all, we are very pleased that Congresswoman Maxine Waters was able to get her bill off of the floor requiring testing and counseling in prisons, in federal prisons. Secondly, I mentioned the Justice Act, which would require the distribution of condoms in federal prisons as well as the development of an overall plane to reduce sexually-transmitted infections, HIV and AIDs and what have you.

Again, at the federal level, we have got to build political support for these issues because we recognize the fact that there is denial taking place, that many inmates,

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

formally incarcerated individuals are coming out and it really is an issue that has to be dealt with in a public health context and a social justice context. And so, we have to look at how we develop the political will in our country to address this.

DAVID MUNAR: We only have time for two more questions. We have a panel waiting for us, so we will take one from here and one from there.

ABBEY MARK: Hi, I am Abbey Mark [misspelled?] from Advocates for Youth in D.C. My question is actually for Dr. Kahn. As a young person who graduated high school in 2005, I know how I would explain the leveling off in the past seven to eight years, but I was just wondering how you would explain the leveling off in a lot of data in the past seven to eight years and how you propose the U.S. government works to delay the onset of sexual debut and increased condom use in young people?

LAURA KAHN, Ph.D.: Thank you for your question.

DAVID MUNAR: Speak up.

LAURA KAHN, Ph.D.: Is this on? It is on, okay. Thank you for your question. Unfortunately, with YRBS data, we cannot answer that question because the YRBS only tells us what kids are doing not why, but we do know from other research that sexual behaviors, like all behaviors, reflect a wide variety of factors and it is hard to either credit or blame any one particular intervention or any one particular strategy for our successes or our failures, more recently.

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

We obviously need interventions with proven evidence of effectiveness that will not only help kids delay the onset of intercourse, but also to use condoms once they do become sexually active. Thank you.

Hi, my name is Kenyan Ferrell I am with Queers for Economic Justice, New York City, also here with AIDS2008.com, blogging with Champ. My question is in listening to the research and the panel and having been a part of other conversations with scientists at the CDC and at other levels, we know that in the African-American community, and speaking particularly as a black, gay man, that what is happening in our community is not about higher rates of unprotected sex or higher rates of drug use or higher rates of multiple sex partners when compared to white MSM, for example.

But, what I see missing and what is always a footnote is these structural issues like poverty, like homelessness, like prisons, which not only are [applause] just about what is happening inside of prisons, but massive imprisonment in and of itself, creating instability in terms of people's social and sexual networks and communities, that are driving the epidemic in and of itself. So, at what point are we going to stop making footnotes of the things that are driving the epidemic among people of African descent in the U.S. an actual priority in terms of the actual research and the policy priorities and the work being done at the federal, state and local level? [Applause].

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

REPRESENTATIVE BARBARA LEE, (D-CALIFORNIA): Well, let me just respond and say you are absolutely correct. This is an issue that goes right to the heart of our economic and social system in America. And until we recognize the fact that we have to get very involved — again, in politics and demand re-ordering some of our budget priorities so that we can eliminate poverty or reduce poverty, universal healthcare, housing, this foreclosure crisis is wreaking havoc on low-income people, the poor, middle income. And so, we really have to have a discussion about what we want to see on the political agenda in terms of the Congress, the House, the Senate and the President. Because until we do that, this will be piecemeal together and we will never be able to deal with some of the systemic causes of the disparities that we are seeing in communities of color.

I just want to support what you have said. There are two individual level factors, which I think are also in addition to structural factors, which may be explaining some of the disparities we are seeing among black, gay men.

The first is the high background prevalence of disease, so for any active intercourse, black, gay men are going to be at a much higher risk of acquiring HIV than other gay men. And we also know that some data suggests that the higher rates of STD's, which we see in the African-American community are also present among black, gay men and that may also be facilitating disease transmission.

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

But, I am not saying this to take away from your point, which is around how do we have a national discourse on structural interventions, on the social determinance of health. Certainly, at CDC, we are beginning to do that work within the National Center, which I run. We are looking at more effective ways of tackling health disparities by adopting a social determinance framework, a framework that really encourages us to move upstream, to think not only of the individual factors, but to look at sexual networks within the community, to look at the healthcare infrastructures within the community and to also look at what unique role CDC should be playing to address poverty, the high rates of incarceration, access to education and access to health services. There are roles that we must play as a public health agency, but we cannot do it alone. But, we are having this conversation now within our center and you will be seeing more guidelines and more papers coming from us at CDC about this issue, so thank you for raising that.

Walt Centerfit [misspelled?] from CHAMP in Los Angeles, USA. Dr. Fenton and Dr. Valdeserri and numerous other speakers at this conference have highlighted the continuing, profound, pervasive homophobia, stigma and discrimination against people of sexual diversity as a significant driver of the epidemic in the U.S., confirmed by the new figures that an absolute majority of incident infections are occurring in men who have sex with men.

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

But yet, there is a profound lack of a national, active, multi-faceted campaign explicitly against homophobia, coming from and funded by the government, but also joined in partnership with all levels of civil society. What I want to ask you, Dr. Fenton and Congresswoman Lee, is are there currently in place laws or governmental policies that would prohibit an undertaking, active campaigns and in all forms of intervention and modalities that we have available to us against homophobia and discrimination and if so, what are they so that we can work to change them and if not, what are you waiting for?

DAVID MUNAR: And this will be our last question.

REPRESENTATIVE BARBARA LEE, (D-CALIFORNIA): Well, just on the congressional front, I have to say that this is an uphill battle. We did pass NDA out of the house, a non-discrimination bill, but left out was trans-gendered, bisexual individuals, which was wrong, we have to fix that. Secondly, often times when I talk about the MSM community at the end of a hearing, members come up and folks ask me, what are you talking about? And I have to remember I have to educate members of Congress also. So, this is something that I think is going to require massive grassroots mobilizing around because until we hear from everyone in our country on Capitol Hill, I do not think we are going to be able to address homophobia the way we should in a very real way. So, we all have to work together to raise the level of awareness with regard to the United States

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

government on the serious discrimination that takes place in our country.

DAVID MUNAR: Please remember what you learned this week about the epidemic in the United States when you exercise your right to vote in less than three months.

REPRESENTATIVE BARBARA LEE (D-CALIFORNIA): Oh, let me just —

DAVID MUNAR: I want to thank —

REPRESENTATIVE BARBARA LEE: Can I just say one thing?

DAVID MUNAR: Yes, ma'am.

REPRESENTATIVE BARBARA LEE (D-CALIFORNIA): We were able to life the travel ban, finally and that took an act of Congress [applause] but, we are trying to get the regulations implemented now, so that is one small step in the direction that we need to go so that we will, hopefully, have an International AIDS in America.

DAVID MUNAR: Thank you, Congresswoman Lee and our distinguished panel. Thank you, everybody.

[END RECORDING]

kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.