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**XVII International AIDS Conference
Looking to the Future – The Epidemic in 2031 and New
Directions in AIDS Research
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FRANCOISE BARRE-SINOUSSE, PH.D.: Good afternoon. Are you ready to look for the future? I am very pleased to chair this special session on the occasion of the 25 years anniversary of the discovery of HIV. This session will be organized as follows. We will have two speakers' 20 minute talks, and then follow it by three other 10 minute talks. And at the end of the session our moderator Richard Horton from *The Lancet* will ask questions for 20 minutes.

So, I am very pleased to call the first speaker because we would like to be on time. And indeed the first speaker does not need to be introduced, everybody knows him. I am very, very glad to call Tony Fauci. Everybody knows Tony. Tony is the Director of NIAID. You all know the scientific accomplishments of Tony in the field of HIV since the very, very early years.

Tony, please? [Applause]

ANTHONY FAUCI, M.D.: Thank you very much, Françoise. I want to express my appreciation to the organizers for giving me the opportunity to address you today on this very important topic, Looking to the Future. I will discuss the arena of new directions in HIV/AIDS research in 20 minutes, which is going to be somewhat of a task. I obviously cannot go into the detail on all the important aspects of HIV research, but I would really like to focus and highlight several issues, a

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little bit disproportionately, namely to talk a bit more about some of the questions that I get asked more often, particularly regarding what we call a cure or a potential for a cure and a vaccine. But before I do that, the five major areas of new directions in AIDS research will certainly be focused on: the arena of pathogenesis, which as we all know serves as the basis to form new interventions in both prevention and treatment, diagnosis and monitoring particularly at the point of care, therapy with all our major successes and still remaining challenges, prevention both behavioral and biologically based, as well as the formidable problems that we have been facing with vaccines. So, let us get right to it and talk a bit about pathogenesis.

The pathogenesis research of the future will be focused on areas such as the structural biological studies of the components of HIV and how they interact with host factors both intracellular, receptor mediated, cellular and humeral. We have gained a considerable amount of insight, for example, regarding targets of therapy, and that will continue in the coming years. Host genetics has loomed large, particularly over the past year or two, in informing us about an individual's propensity to progress or not. Clearly the basis for that underlies pathogenesis.

Another arena which will be continued to be pursued is the early events in HIV infection at the tissue and organ

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levels, and I will get back to that in a moment, particularly the formation of HIV reservoirs and the role of immune activation and the differences between certain non-human primates and the human species in how they respond to infection with these related viruses with immune activation. So, let me spend a very short time, a minute at the most, on the issue of understanding and addressing the early events of HIV disease.

We refer to that as a window of vulnerability. But they also can become a window of opportunity because in that very short timeframe with the bursts of viremia and dissemination and seeding in particularly of the gut associated lymphoid tissue and the establishment of a reservoir with a latent component. It is in that very small timeframe that our success or failure with vaccines as well with our ability to ultimately control, perhaps even cure HIV will rest. So, that will be very important.

A few facts about that early period. My own group, as well as others, has demonstrated years ago that that reservoir, which Bob Siliciano spoke about so eloquently this morning, is established literally within days of acute infection. So, our window of vulnerability and opportunity is short. A recent paper just a few days ago from Bart Haynes' group in Chaves and Duke showed that not only is a reservoir formed early, but byproducts of CD4 positive T-cell deaths increase significantly within days and are capable of suppressing the human immune

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response to the virus. So, we have a double whammy. We have a reservoir that almost immediately is formed and we have products of the death of cells suppressing the immune response that would hopefully prevent the establishment of that reservoir. Bottom line, the window of opportunity and vulnerability is very narrow measured in days.

Now, what about the issue of high-throughput assays and the future of HIV pathogenesis? We have learned that this has now become common practice. Virtually every lab uses micro-array analysis of gene expression to determine the various levels of expression of genes that are up and down regulated during infection. Whole genome association studies have informed us on the host factors related to progression or lack thereof. Functional genomic screening, particularly large scale, small inhibitory RNA screening will in the future open up avenues of new targets. And I refer you to this paper that I am sure many of you are aware that came out in February of this year in *Science*, in which using selective small inhibitory RNAs, over 270 proteins were identified, only 36 of which have been previously implicated in HIV replication. In other words, there are scores and scores of intercellular targets that we can use in a new pipeline of interventions.

I am going to move quickly onto diagnosis and monitoring. The bottom line that I can tell you on this, is that we must and will bring sophisticated molecular diagnosis

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to the point of care and we must do this cheaply and expeditiously or else it will not work in the developing world where it is needed the most. And I refer to some selective needs for optimum support of the treatment of both HIV and opportunistic infections. Both a rapid and accurate point of care diagnosis, monitoring of the immune system, monitoring of therapy and particularly with something like TB to make a proper diagnosis not only for the microbe, but for whether or not it is drug resistant to initiate the appropriate therapy.

Speaking of therapy, some of the greatest successes in the translation of basic biomedical research to the application of doing good for people with HIV infection, therapy clearly is very, very much a true overwhelming success. This is a schematic diagram of the replication cycle outlining some of the vulnerable targets for which we have successfully made drugs and some of which are in the pipeline. And this, as you know, a list of the 25 drugs approved by the USFDA, similarly approved by the regulatory agencies of other countries of the many drugs that have now truly transformed the lives of HIV infected individuals.

So, what does this mean for us and how does it portend for the future? The survival benefits of treating people appropriately for HIV, are now well established and documented. This paper from Rochelle Wolinsky from the last year showed that in the United States alone from 1996 to 2005 there were 3

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million years of lives saved, and similar studies from Canada, Australia and the European Union showed the same thing.

Importantly, due to programs that now bring access of drugs to the developing world, if you look on this slide at the end of 2002 there were just a couple hundred thousand people receiving lifesaving anti-retroviral drugs. And at the end of 2007 that number tops 3 million people, a major success story with a big caveat. And the big caveat is that there are so many more people that need to be on therapy.

So, despite this progress, as you heard this morning from Bob Siliciano, there have been no well-documented cases of HIV infected individuals truly being cured. So, I would like to take a couple of minutes to frame the issue of what we might mean by a cure, because this elicits interesting reactions in people, some who get upset to even bring up the word, and others who say we should be pushing even harder for it. So, in order to understand it better, I would like to just frame it a bit.

What do we mean by a cure? I think everyone in this room knows, but let me just outline it for you a bit more specifically. Mainly the treatment of a disease such that no patient any longer needs to continue therapy. A typical example is bacterial or pneumococcal pneumonia in which you treat an individual with penicillin, you completely clear the infection and they indeed are cured. They do not need therapy

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to live well. The same with certain tumors. When you surgically excise a tumor that has not spread, you have cured the person of that tumor. That is to be contrasted with the issue of suppression or successful management of a disease. Typical example, diabetes with good insulin control. You do not cure diabetes, but you control it well. Rheumatoid arthritis and other inflammatory autoimmune diseases are virtually never cured, but many are very well controlled. And here in August of 2008 we say the same for HIV. We have successfully suppressed replication with anti-retroviral therapy that many people are living essentially normal lives.

So, that being the case, why do we even need or talk about a cure? We do need a cure. Whether we will get it or not we will talk about over the next minute or so. First of all, as you all know anti-retroviral therapy is currently a lifelong commitment. 2.7 million people were newly infected in 2007. Treatment is currently reaching only 30-percent of those who require it by standard guidelines of treatment. For every person we put on therapy, two to three people are newly infected. Putting these numbers together, it is extremely unlikely that we will have the logistic or financial capacity to reach and treat for life everyone who requires anti-retroviral therapy.

So, in order to understand what we mean by a cure, I like to divide it up into two major components, a sterilizing

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cure and a functional cure. I will explain what I mean. The main obstacles to a sterilizing cure is that HIV hides from the immune system, but most viral infections you treat with an anti-viral or anti-bacterial and the immune system then cleans up afterwards. We do not have that with HIV to a great deal. HIV forms a latent reservoir, which protects it from drug therapy. This is an old paper from our group and others have repeated this in individuals who were treated for three plus years with no detectable viral load who we empirically discontinued therapy, and in virtually everyone the virus came back to its normal pre-therapy set point. Clearly the reservoir did not allow us to eliminate therapy.

However, over the past several years we have now followed patients for up to 10 years and indeed you can get that reservoir down very, very low, sometimes undetectable in the blood and lymph node by PCR, but still it persists in the gut. So, although the reservoir is attenuated, it is still there. I have hope and many of my colleagues do that with an either intensification or a more aggressive therapy to begin with, particularly with integrase inhibitors which would block the integration leading to the establishment of a reservoir that we may be able to get that down to a very low level.

In fact, we published last year a group of patients that we treated very, very early with HIV, right around the time of acute infection, which logistically is difficult to do

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with a lot of people. The slope of the curve of the decay of their reservoir was quite dramatic and we are doing, as others are, a number of studies over the next few years to see if that aggressive therapy early on will work.

So, I want to spend a few seconds about bringing the point up to you that a cure, if we talk about either a functional or a microbiological cure, will likely require early diagnosis and treatment. Now I am not by any means recommending changing any guidelines, but studies, clinical trials need to be done in the next few years to determine if very aggressive therapy early on will in fact allow us to at least get a functional cure.

And what do I mean by a functional cure? Let us try this scenario. You treat with aggressive ARV early on, you preserve a substantial level of specific immune response, you get prolonged suppression of viral load, you either add drugs or not, give HIV specific immunotherapy or not, and you have continual attrition of the HIV reservoir. And ultimately, carefully in a controlled manner discontinue therapy to see if the prolonged suppression of viral rebound will occur by preserved and amplified anti-HIV immune responses.

Quickly moving onto prevention. Prevention research is alive and well and we have a lot to do. As you know for every person put on therapy, 2.5 people get infected. Prevention is a very important part of our future research endeavors. There

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are proven prevention strategies; you are very well aware of them. I need not go into them both sexual, blood born and mother to child. And there are examples of pipeline, namely those that have promise but that have not been proven, such as preventing and treating co-infections, topical microbicides with the unfortunate situations that we have had of a number of failures, but we still have hope for that, ARV as a prevention, I will get to that in a second, and vaccine.

What about ARV as a prevention? We have been successful very well in two areas, prevention in mother to child transmission and post exposure prophylaxis. We need to do research in the next few years on a very promising area of pre-exposure prophylaxis and as Julio Montegnas [misspelled?] earlier in the meeting, treatment of people with chronic infection, would that be feasible to bring down viral load enough to have a preventive aspect to it? A caveat on that is that you have to treat a large number of people.

And then finally with vaccines. When I explain to people who ask me the question why do we not have an HIV vaccine there are a lot of reasons. But the most important reason is that HIV is very different from every microbe or virus that we have encountered. If you have polio, smallpox, measles, the body in natural infection already does the most important experiment for you. It shows you that the body can

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clear these viruses. So, you know that a vaccine is not only feasible, it is likely.

Not the case with HIV for the reasons shown on this slide. So, historically we took the classical vaccine approach. We took the outer proteins, thinking that hopefully we would induce a neutralizing antibody. What we learned as we were going along this pathway, is that very few people naturally produce neutralizing antibody, and the neutralizing epitope seems to hide itself from the immune system. So, the famous protein based studies failed and you are all aware of the history of that.

We moved on to T-cell based vaccines because of animal studies that were encouraging, namely do not block infection but try to get the viral load down. Again the last several months have been sobering times for us and you are aware that we had to discontinue and call off the trial both of the STEP trial and the Phambili trial. You are also aware that I had to make a very difficult decision a few weeks ago of deciding whether we would go ahead with a large clinical trial on a product that is different from the Merck trial that is based on the same principle. And the reason that I rejected the trial was because of its size, because there were those who would say you do a large trial and even if you do not get a positive efficacy signal, you can look at subsets of people and try and make immunological correlates. And my feeling is that an

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immunological correlate in a failed trial is very unlikely to give you enough information to validate the need for a very large trial, which brings us to the important point that we have a lot to learn. And that is the reason why many of you heard of the meeting we had in March and the paper that just came out in *Science* and we looked at the way forward to answer some very important unanswered questions, such as the early events in HIV, which I mentioned, the importance of the innate immune response particularly in that window of vulnerability or window of opportunity. Neutralizing antibodies loom very large in any chance for success as does an amplification of animal models in looking at vaccine induced immune protection.

This is a schematic diagram based on structural biology of the binding sites of neutralizing antibodies for which we have monoclonal antibodies that have been made. And what it tells us is that this is possible. It is difficult but it is possible. And what we will be doing in the next few years, as shown by these two representative papers, is to look at how we can turn those epitopes to which neutralizing antibodies bind by proper scaffolding of the epitope to turn them into immunogens that will actually induce a neutralizing antibody.

So, finally, let us just answer the questions that I keep getting asked and they are not solid slam dunk answers. Will it happen? Will we have a cure and/or a vaccine? I believe with regard to a cure that we will be able in some

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patients, not very many, but in some with the drugs we have and will use eradicate HIV microbiologically. We will have a functional cure, as I defined in a previous slide, and many more others, but this will likely require aggressive drug regimens and will likely depend on the timing of the initiation of therapy and how we handle that recalcitrant reservoir.

With regard to a vaccine, I believe with cautious optimism that we will be able to protect against HIV acquisition in some patients. It will not be like a classical vaccine. And we will slow progress in others. But as we have learned, this will likely depend heavily on the genetic profile of individuals because we know from some of these early trials that people who have a genetic profile that would actually make them a long-term nonprogressor have a much better chance of doing well on a vaccine.

So, how do we harness that with regards to T-cell immunity? With neutralizing antibodies, I believe if we get the right immunogens we will have a much better chance to have a more broad, global success with regards to vaccines.

And so in summary, I believe that the future for AIDS research indeed looks bright and promising. The history of AIDS research is one of quite frankly breathtaking accomplishments. However, we are gathered in Mexico City still in the middle of a ranging pandemic. To be sure there are multiple and daunting challenges ahead in how we confront HIV

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globally. Not all but certainly some of these challenges can only be addressed through biomedical research. And so our future success in the arena of global HIV will heavily depend on biomedical research. Thank you. [Applause]

FRANCOISE BARRE-SINOUSSE, PH.D: Thank you very much, Tony, for this really terrific presentation as usual. Peter, it is my real pleasure also to introduce Peter. We have known each other for quite a long time. Peter, everybody knows him and I do not need to introduce him much, also. As you know, Peter is the Executive Director of UNAIDS since 1995 and you all know that his leadership in UNAIDS has become the chief advocate for worldwide action against AIDS. So, it is my real pleasure to call Peter and to hear his own vision of the AIDS epidemic in 2031. [Applause]

PETER PIOT, M.D., PH.D: Good afternoon. Thank you Françoise. I will never forget the day that we got the results of what was then still called LAV antibody testing sero that we had collected with Tom Quinn and Balack [misspelled?] Peter in then Zaire in Kinshasa. We had given to you under code and you picked out every single person we had diagnosed with AIDS based on the criteria we had then. And the only problem that we saw then, "problem" was that in the control group there were a few people who also had antibodies. But that was one of those days in a scientific life where you have the aha labels or the prickling odor of white truffles in the air as the one who got

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a Nobel prize for neurology. So, thank you so much for your contributions.

Now, you can wonder with a crisis on hand, like this, like AIDS why would we spend so much time in talking about the future and particularly the long-term future? And in essence we know that, of course, the present determines the future, but the other way is also true. How we envisage the future determines the present. Look, for example, at the fact when we had a three by five goal that was set, shorten future, that was driven quite a while and are many other elements in society that we can see

Secondly, it is now clear, it has been said so many times here, that AIDS is a long wave event and three, we need to be certainly extremely concerned about the sustainability of the achievements that we have. And as I said in my opening speech, we are entering into a new phase in the response to AIDS because there are real results, because of the emergence of new challenges that have to do with in the first place with sustaining the efforts, persistent old challenges particularly around taboos, the war on drugs that is often the war on injecting drug users. And we could say the same thing about sex workers and men who have sex with men. And the fact that when you deal with the long-term and the long wave event, your strategies basically should be quite different. And AIDS is again very unique because it is a combination of a crisis,

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7,000 people dying everyday, that is by any standard a crisis, but at the same time also long wave event. There are no precedents in terms of public health or in societal responses that have tried to tackle both.

What I will do is to briefly discuss where is the epidemic going? How do we respond to the future? Who will pay and how? And how can we sustain leadership?

Where is the epidemic going? We had a great plenary on the first day by Jeff Garnet that addressed some of these issues. Growing heterogeneity, new or resurgent waves of infections, and treatments far behind new infections. The future spread of HIV is subject to so many uncertainties that should give us some modesty in what we are saying.

And how will the epidemic evolve? It is critical to know on a practical side what we have said something that Maria Lagoa [misspelled?] launched about two years ago, is that we need to know where the next 1,000 infections are going to happen when you deal with prevention, and not base it on your epidemiological surveys of the past or who is coming for treatment. That reflects the epidemic of several years ago.

Heterogeneity without going into details, but here you see an analysis by incidence by modes of transmission in Kenya, Uganda, in Thailand and in the U.S. And just looking at the rainbow of colors, it tells you that the patterns are incredibly diverse and they are changing also. Even between

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Uganda and Kenya there are differences, just as there is difference in the type of virus that you find between Kenya and Uganda with subtype A dominant in Kenya and B in Uganda, for example. But it is also true in terms of behaviors and who is becoming infected.

But it is still changing. The epidemic is still in a very dynamic phase. Here you see the evolution of transmission in population groups for new infections. In Asia it is based particularly on the patterns in Thailand and where you see that today the highest rate of new infections in Thailand is among married women. Who would have thought that 10 years ago? And that requires a different type of approach, even if the engine can still be other groups. And, for example, the extremely high infection rates among injecting drug users and men who have sex with men in Thailand are a matter of great concern.

And, finally, in terms of the epidemic, this epidemic has always come up with new surprises. Here you see HIV prevalence in men who have sex with men in 17 cities of Eastern Southeast Asia. What we are seeing today in Asia, particularly in China but also in Southeast Asia is reminiscent of what happened in the '80s in gay men in the West and in Australia. And so you can wonder what is next. We are see popping up epidemics among injecting drug users in Africa, Moresius [misspelled?] in the Indian Ocean, in Africa it is now injecting drug users that are the main affected group. And we

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see that popping up in quite a few countries. Still very limited but we have got to be very vigilant in what can come up. And as Jeff Garnet said we can fairly with certainty predict where the epidemic will go in the short and medium term, but the long-term we do not know. And in the long-term sometimes slow spread but in much larger populations can have a far bigger impact in terms of numbers than high spread in small populations. It is a bit of a difference between relative risk and attributable risk for the epidemiologist amateurs.

Also, let us put treatment in perspective at the moment. You see here the curve of the number of people living with HIV between 1990 and 2007. And what I have done here is also plot the number of people with treatment that you saw popping up at the bottom and it puts things in perspective how many people are on treatment today. And we should realize that at the end of the day, after how many years we do not know, but everybody will probably need anti-retroviral therapy. So, that is the kind of gap that we are up against when we take a long-term view.

Now, a few thoughts on treatment in addition to what Tony said. But let us first go to the basics. We all talk about universal access. But universal access is only a means to get to our real goal, and that is nobody dying from AIDS and everybody living with HIV having a good life physical and mental and socially. So, where will we be in the long-term

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future? First, we still have a big challenge of individuals either in communities at risk or in general population knowing their HIV status. Hopefully in the future we will have made much more progress than we have made over the last five to ten years. Without that it will be difficult if not impossible to come to universal access and to prevent people from dying. Even in high income countries today people still come in very late with their diagnosis when they come for treatment. There is something wrong there that we have to address.

In terms of drugs, we heard from Tony the various scenarios that are there. A thing that I am concerned about is that making sure the drug development remains in step with the evolution of the virus. And that industry continues to invest. There are worrying signs that is not the case. And that is something where we have to put that also on the table, which we have not done that. Probably more durable and better tolerated first and second line regimens and effective third line if still necessary. Most patents for existing drugs will have expired by 2031. Let us also remember that.

We still have an issue and that will, I think in terms of competitive pricing will have an impact, but maybe a negative for innovation. Greater equity in access. We have to make sure that the same groups underserved in treatment as in prevention will not be there in the future. And in high income

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countries it is predictable also that treatment will become far more tailored including on genetic makeup.

Tony mentioned, and just as Julio Montenas, treatment as prevention is an exciting area, but I think a bit early to make any practical conclusions certainly for on the individual level. And in terms of treatment for prevention, you can look at it from a different perspective, prevention of mother to child transmission definitely can be in that category, and that is something where we should really without any hesitation go for elimination of mother to child transmission. That is feasible, that is a realistic aim in about all countries. [Applause] But it will require more than drugs. It will also require that we team up with stronger material and health services and health systems.

We have also post exposure prophylaxis, whose impact in general quite limited. But it is most probably that we will have effective and maybe even more effective pre-exposure prophylaxis and it is high time that we are going to develop strategies for how to introduce it, how to use it in the real world. And a better understanding, as I said, about the actual chronic treatment for prevention.

That brings me to prevention. Prevention is by nature long-term. That is one of the reasons also that it is harder to get support for it, but also that it is so important that we are dealing with it now. I forgot one slide was omitted and

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that is one on hyperendemic Africa. Southern Africa is a special case when it comes to AIDS and also to HIV prevention. And this will require nothing less than a total society wide mobilization. I do not believe in any technical fix for the epidemic in Southern Africa. Remember what President Wahid said in his opening speech. He got it completely right and this is an area where we have got to use every single intervention that has an impact that has proven effectiveness. We are changing the social norms, will be extremely important and where the leadership has to become far more forceful.

On HIV prevention for the future, it will fundamentally be different whether we have a vaccine or not. And I will not go into that but Tony addressed some of the biomedical aspects of it. But the one thing I would like to say is that we should not think only in terms of biomedical innovation and technology when it comes to HIV prevention. It is time that prevention programs embrace Facebook, texting, all the communication means, the new information technology that young people are using. It is not by billboards that we are going to introduce social change and personal behavior change on a large scale.

So, we need to change also our mode of operations in terms of prevention and behavior change. And in terms of tools that we desperately need is a test for HIV incidence that is simple because evaluating what we are doing is becoming more and more important. Yesterday there was a terrific session; I

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can say it because also our Chair was there, our moderator and a special of *The Lancet* on HIV prevention. And I think the messages are very strong and there is a real roadmap for the future in terms of HIV prevention. And I will not go into detail because many of you were in that room.

Combination prevention, more tailored made to specific settings and communities and generating systematic and systemic social change. One of the pausing aspects is that we see this increase of HIV in gay men, it is gay men often, men who have sex with men in the Western world. Take my own country, Belgium. We have same sex marriage, same sex couples can adopt children. There is still discrimination but it is completely different from many other high and low income countries. And yet we have a dramatic increase in HIV infections among young gay men. So, we need to really work with the communities to find new ways in terms of HIV prevention, even in a context that is quite supportive.

And let us never forget that social change can go into many directions. It can go for more openness, but it also can go the wrong way for more closed societies, more conservative ones where women are more oppressed, where it is impossible for men who have sex with men to be open about their sexual orientation, where as I mentioned there may be a war on prostitutes and sex workers and whatever terminology is used in different languages. So, these are things that we should bear

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in mind. Social change is not just something that will happen in a positive sense and it is not true that in history we always see progress for the good. And that is why we have to try to influence it.

Again, what we discussed yesterday leadership is going to be most important when it comes to HIV prevention because of these difficult issues. But for me that leadership will also be stimulated to say this at the least if there is activism. And one of the most significant developments that I have seen in terms of HIV prevention is that TAC, and the T in TAC is for treatment, Treatment Action Campaign, has taken on prevention in the communities. It started to work on treatment.

And the final point that I would like to make is that the business of HIV prevention has to become real business using business methods. Along the lines of what is probably the largest and most successful program of HIV prevention in higher risk populations, Avert in India, and by using business like management, solid marketing, but grounded in the community, connected with the community. No company will try to sell soap or whatever if they have not really done some research with the community. MTV knows exactly what young people want and do and think and they will use that in their marketing.

So, that will be maybe the most important change that we need. It is not so much the what, but the how that needs to

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change when we are doing prevention and bringing in the people who know about marketing. They are expensive, that is true. But with the sums of money that are available today, it probably would be paying off if we are bringing that expertise from the business world in our pretty amateurish public health approaches to HIV prevention. And I am one of them, so in the public health, so it is not to blame anybody, but it is the case. This is too serious, this epidemic, to be left to improvisation, cottage industry or amateurism.

Now, this is a slide from Tim Hollett from Jeff Garnet's group at Imperial and what it basically says is that in order to decrease mortality in the long-term it requires an intensification of both treatment and prevention. The more successful we are in terms of prevention, the lower the mortality will ultimately be. But that is going to take time before we will see that impact. But it will also mean that if we are doing very well on HIV prevention now, the costs of this epidemic and of treatment will dramatically be reduced.

Now, how will we pay? At this conference there were more than the usual number of sessions on financing. And it is an indication of growing concern about financial sustainability.

What will it cost to end the epidemic? Many scenarios are there and they depend in the first place how effective we are going to be today in terms of treatment and in prevention.

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At what point and how could costs begin to come down? We know that if you muddle it out at some point, particularly the cost of prevention will come down and therefore, with a lag time of maybe 10 years also the cost of treatment.

How can current AIDS funding be optimized? Yesterday Stebra Tolsey [misspelled?] gave a great talk on how we should become more efficient. And where will the money come from? Again we need to be more imaginative and this should be something where both international solidarity should continue, but also that many of the middle income countries can do much better, and that is a political decision, of allocating resources. But it is not done often because in these countries, let us take in Latin America, the epidemic is there with groups like men who have sex with men that are not so popular with the authorities.

Finally, when you look at the financial requirements for scaling up anti-retroviral therapy and there are many scenarios there, but if you take the blue line that is where we would continue to have about 1 million new people in treatment, you see that the cost of anti-retroviral therapy are really staggering. And earlier this week we heard Frank and also Stebra Tolsey suggested this year that we should think in terms of pension schemes rather than insurance schemes when it comes to AIDS treatment. Julio pointed out that insurance schemes prepare for uncertain events, catastrophic events. Pension

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funds build a fund for known future events. In the case of AIDS we know what the future needs are in terms of treatment. And we know everyone who is HIV positive will ultimately need treatment. So, start now to build funds for the future as a pension fund. And I think that we need to change our approach there. So, we need to turn the classic entitlement paradigm that is now popping up and we need to turn it on its head into an entitlement to life and a pension scheme.

Finally, what does the long-term view mean? When we design work plans and budgets for outcomes in 2009, the next three or four years or next year, we will have a different set of activities than if we designed them for outcomes now and in 2031. We should have funding planning that is going to not be tackled on the basis of a fiscal year, but with really sustained long-term and predictable funding. And there should be more focus on structure and social change.

We are sitting here in Banamex and only talking about AIDS, but the world out there faces many problems, food security, conflict, post conflict, undeveloping countries because of AIDS, countries in rapid economic transition where the risk for HIV may increase as disposable income increases and issues around climate change. So, this is what we have to look at in order to position AIDS in that context and work together.

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We are trying to address many of these issues in our project that I launched last year, AIDS 2031, and that will come up with an agenda for the future next year and that really is involving not only the classic AIDS crowd but also others. And as I said in the opening, if we think it has been tough up until now, well folks, consider what is going to come. The easy bit is over even if it was never easy. And it is a combination of all the new challenges that we are facing. And for that we will need more of the same, let us not throw that away, but also radically new approaches. And history 2031 and more will judge us on what we do today. And business as we are doing now will not stop the epidemic. As I showed the gap will get bigger and bigger. It is clear we cannot predict the future, but at least we can influence it. Thank you very much.

[Applause]

FRANCOISE BARRE-SINOUSSE, PH.D: Thank you so much, Peter, for really beautifully raising all the critical issues that we will have to face and that we will have to solve within the next 20, 25 years. We have to move on and I must say I have a very easy task because I do not really need too much to introduce the speaker of our special session. Our next speaker is indeed Mark Harrington. We all also know Mark. Mark is the Executive Director of Treatment Action Group, TAG. Mark has been involved in the eighties and was enjoying act up

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[misspelled?] at that time in 1988. And so Mark will tell us about his vision for the future of AIDS advocacy, I guess.

[Applause]

MARK HARRINGTON: Gracias. And merci, Francoise for that nice introduction. It is a great honor to be here today. I wanted to thank Francoise for discovering the virus in 1983 early enough for many of us, including me, to survive because of the research that started early.

[Applause]

And I may not get an opportunity to thank Peter again for his service in the last ten years at UNAIDS, but he really has shown, and we have been, often are more happy to criticize than to praise UNAIDS, but they certainly have shown to the shame of other UN agencies how you can involve civil society and the governments in the running of a global program to address a global health emergency, and I want to thank Peter for all that he has done for people with AIDS, and around the world.

[Applause]

And I want to thank Tony Fauci for being a visionary and flexible enough a politician to open the doors to activists and people with AIDS in 1990 and thereby setting the standard for the involvement of people with AIDS at all levels of the AIDS research enterprise. And Tony even sometimes even still listens to what we say, although he does not always do it.

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[Applause]

And I am very honored to be here with my two activist colleagues from the global South, Vuyiseka and Frika, and I am very happy to be with all of you today.

And before I do my talk I just sort of want to position where I think we are right now in the epidemic. I agree totally with Peter and with Tony that we do not have a scientific crystal ball and so we do not know what the future is going to hold scientifically. But we do know that we have human power and that we can change human institutions. And so a lot of my talk is going to be about the institutional changes that we need to achieve in order to make progress as we continue the research that we hope will bring us to the end of the epidemic.

We are in a dangerous lull right now because in some ways we may become the victim of our own success. Infighting within the AIDS community is at a shockingly low point. We are certainly more united than we were in 1998. We have some amazing short term accomplishments. And many millions of people are alive because of what we have done. And we are the vanguard of an unprecedented and awesome citizens' global movement for comprehensive and universal primary health care for all. And we should be very proud of that and never be ashamed that we are fighting for AIDS as well as for health systems.

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Now, UNAIDS says that deaths might be dropping for a year or two and that, too, is unprecedented. But all of these gains are fragile. They may be transitory and they may be undermined by forces viral, demographic, and political. And we must certainly not be lulled into any slackening of our efforts. Because there are many forces that would like to take money away from AIDS and spend it on other issues, either worthy or unworthy ones.

Where is the advance? Can someone show me how-?

So, 20 years ago some of us were in the one of the first major demonstrations by AIDS activists at the AIDS Coalition to Unleash Power, seized control of the FDA demonstration on October 11th, when more than 1,000 AIDS activists from around the US surrounded the FDA and demanded that it accelerate access to experimental AIDS drugs and speed up approval of them. And this was sort of like; this caused the avalanche of changes that happened in the US federal government. Which led later to the development of HAART and of many drugs for opportunistic infections. And many demonstrations later we were in Geneva ten years ago at a meeting that was mistitled Bridging the Gap. And I was asked to address the question of Cure: Myth or Reality, along with Bob Silicano [misspelled?] and of course I did not have the answers. I showed some pictures of my lymph nodes before and after HAART that showed that replicating virus was basically

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wiped out by HAART, but also that provirus continued as we all know. I still do not know whether a cure is a myth or a reality, but I will recall that in Geneva I called on activists, scientists, and political leaders to work together to bring AIDS treatment to the world and to the developing countries where most people lived and died.

Now, Richard Horton was Track B reporter at that meeting and he issued a scathing condemnation of the delegates from the North at that meeting and he mentioned that he described how at every time a person got up from Africa or India, South America, or Eastern Europe, all of the Americans and Europeans, and Australians fled almost in horror from what they viewed as the uncontrollable and hopeless epidemic in the South. And he shamed us and everyone there for the lack of solidarity that we showed at that Geneva conference. And I am happy to report that ten years later we seem to be much more unified and what is one of the reasons why we have become more unified? Because finally money has become available and we have learned how to use it. We have learned how to deploy it effectively, and we proved that it can be used to prevent new infections and to save lives.

And so the last ten years of scale up are described as an unprecedented arc in global history of scientists, policy makers, doctors, clinicians, and front line workers, and people with AIDS working together to address and not yet to reverse,

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but to make a huge impact on this unprecedented pandemic. And so I think it is important for us to recognize those successes at the same time as we face the abyss of the uncertainty that faces us both politically and scientifically. We must seek a cure and a vaccine, because lifelong triple drug therapy for the currently infected will already require 990 million patient years of HAART to be administered over the next 30 years. And if UNAIDS is right that 2.7 million new infections are going to occur every year in the next 20, 30 years, then we will need another 81 million people who will need 30 years of HAART which would be 2.43 billion patient years of HAART.

Now, that is starting to be a lot of tons of molecules, and it is going to be very hard to deliver it. So we need massive investment on a cure, not just lip service and not just reinserting it into our talks at meetings. And we need better prevention methods and combination prevention methods to end the epidemic. We must continue to accelerate current scale up and we must scale up faster. We are still way behind the epidemic. Three people get infected for every person put on therapy.

So, I am going to talk about some structural and scientific and programmatic changes that we should make to reduce new infections, put more people on treatment, and improve the rights of people with HIV. In my view, and it is not yet confirmed by all the studies, but I believe that the

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only way to eliminate pediatric HIV infection is to put every HIV infected woman in the world who is going to have a baby on full HAART, to keep her on HAART throughout the time breastfeeding, and then for life if needed. This is the only way that we can prevent the baby from becoming infected. This will be universal treatment for women and it will be universal prevention for infants. At the same time, we must ensure that every infected baby is diagnosed at birth with one of those new viral load dipstick tests that Tony was talking about, and treated for life.

Secondly, we must end gender based violence and strengthen the legal and health rights of women and sexual minorities. We must demand and achieve equal status for gay men, lesbians, bisexuals, transgender people everywhere. No more judicially sanctioned hangings of gay men in Iran. No more killings of lesbians in South Africa. No more murders of transsexuals in the United States.

[Applause]

Or anywhere else.

We have to end the war against sex workers. We must insist on the decoupling of efforts to stop human trafficking from the current stigmatization and exclusion of sex workers from their full human health and economic rights to live and work in dignity, legally and safely. It is not okay to conduct

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prevention trials in sex workers without also working to improve their health rights and legal right to work.

[Applause]

We have to end the war on drug users. And not just talk about harm reduction. We have to talk about removing the legal barriers that put people away for life for non-violent use of drugs. We must work with countries around the world to decriminalize possession, provide universal access to drug substitution therapy, and all the other elements of harm reduction and to provide, which will be expensive, reentry services for people who have been unjustly incarcerated.

I have a modest proposal to buy the entire global opium crop from Afghanistan and everywhere else and give it to the global drug facility of the World Health Organization to have them send it to India to be manufactured into palliative care tablets for people who are dying of cancer and other diseases in the developing world.

[Applause]

I hope the UN ODC will endorse my proposal. Fifth we have to end health disparities everywhere. And not only in the global South. And I refer you to the incredible Black AIDS Institute Left Behind report that was a press conference about yesterday that showed that the black AIDS epidemic in the US is bigger than that of half the PEPFAR focus countries. And the t-shirt I am wearing says the US must develop a national AIDS

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strategy. We impose them on our PEPFAR grantees, but we do not have one.

[Applause]

We have to scale up HIV testing and improve epidemiology so that people no longer get stunned every time CDC or UNAIDS releases a new number. We have to define when to start ART and Tony, I refer again to your promise in 1997 renewed last year at Sydney where you said you would fund a long overdue study of when to start HAART. Right now there is only \$5 million available for our INSIGHT pilot. Please fund the full study. We urgently need to know when to start HAART in the global, in the context of the global scale up of ART to maximize its benefit.

We need to, you guys here all have the power to prevent, diagnose, treat, and cure TB. And there are a lot of ways to do it, and you guys should stop hesitating and start using Isoniazid for infection control and intensified case finding. We must do, Tony mentioned the dipsticks. We need them for RNA, we need them for CD4. We need them for TB. There is one poster at this conference about an innovative effort to develop a CD4 dipstick but, we are not spending enough on diagnostics research.

I want to add viral hepatitis and the most common opportunistic infections to the universal health package. And we need to add some of the most important opportunistic

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infection prophylaxis drugs to that as well. We need better and more durable first line ARV regimens. We need to increase, massively research funding in the US and internationally.

We need to show solidarity with our colleagues working in other fields of global health. It is not okay for us to be at war with people who are fighting for maternal/child care or for drinking water, or for food security. We need to lead the way in reaching out a hand of solidarity with them to be in the vanguard of the fight for primary comprehensive health care for all or our enemies will divide us and we will fail. We cannot afford to descend into those quarrels. We must hold governments rich and poor to their commitments. We must reform the World Health Organization, which like John McCain, has done heroic activity in the past, but needs to be restructured for the 21st century. The regional offices in particular are inefficient, egregious cesspools of nepotism and corruption. Civil society needs to have an explicit role in governance of the WHO.

We need to stay focused because the next years will be challenging. And we need greater unity. We need to stop fighting about things. Even if we disagree, we need to be rationale. We need to become an even more powerful force for global public health, human rights, and social justice, and join our goal of universal HIV prevention, care, and treatment with the goal of all for universal and primary health care for

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all. To those who say it cannot be done, we must reply that we have shown in can be done. [Foreign language] Yes, we can.

Thank you.

[Applause]

And thank you most to all my activist colleagues around the world who impress and amaze me with your work every day.

[Applause]

FRANCOISE BARRE-SINOUSSE, PH.D.: Wonderful, terrific, Mark. Thank you so much for raising all these issues, and we just have to continue to work together, all together.

[Applause]

We are going to move on to the two last presentations, to have the vision also for the community response in other parts of the world, and I am very pleased to introduce our next speaker, Vuyiseka Dubula from South Africa. She is working with the Treatment Action Campaign and she is currently the Chairperson of the Board of TAC. Please Vuyiseka?

VUYISEKA DUBULA: Thank you.

Thank you, Madame Chair. I think you made a mistake by asking Mark to speak before me, because he has said everything. But anyway, I think there is a reason why I have to speak, because I am representing the vision and the future of activism and advocacy. Because look at Mark, he is aging. So I will be around in 2031. And Frika will be aging, too.

[Applause]

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And I guess also I am representing the future of advocates and activists in my region, because mainly HIV is among mainly women. So for me the future of activism; I am very bad with technology. I hope this works today.

There you go. So today it worked. Okay.

I think for me what we know that is clear, that has worked and it still has to continue to work is the human rights approach in our advocacy for the future, but we know that there are still some countries today that need to change their mindset, and I am going to name them. And unfortunately, I am going to name China because China does not deserve to hold Olympics because of their human rights violations against people with HIV.

[Applause]

We have also stop criminalization today because if we want to stop or to have HIV free generation tomorrow, we have to stop criminalization of HIV today, including criminalizing homosexuality, criminalizing sex work, because we know from what we have heard from Mark without stopping all those criminalizations, we are nothing for the future.

For me because I am supposed to be speaking about community response, and I am a big fan, Mark, of a healthy mother means a healthy child. And I am saying that because I have an HIV negative child today because I started treatment two years before I was pregnant and I started when my T cell

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count was above 200 and where I come from women start treatment very late and therefore their babies tend to have very few chances of not having HIV. And they are still using [inaudible]. Recently they just added UR [misspelled?] therapy. And for me we have to continue mobilizing our communities because our communities are leading in the struggle and we have to continue supporting our communities to lead on HIV and to mobilize. But the next future for me, there will be less face to face contact. As we know, we have heard from Peter that my generation uses Mixit, Facebook, Skype, internet, so is that the way we would like our community to be mobilized? For me, I am coming from a region where still access to internet is still a luxury. So I think we still have to continue going door to door and advising people to go and test. We still have to continue going door to door and asking women to go and test because it is better for them so that they can also access health care.

But I know because dealing with HIV in the future as an exception is going to be very difficult. And I know coming from South Africa for example, from Treatment Action Campaign, we started dealing with gender based violence and prevention of sexual violence against women in 2003, but because we are a Treatment Action Campaign people still think we are fighting for access to treatment only. We cannot divorce, even when we think about strategies for the future, we cannot divorce social

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economic challenges that create or that perpetuate or drive the epidemic, and we know that one of them is sexual violence against women. And we know that also by not improving social services and for example, unemployment, microeconomic policies that do not allow women to also have economic empowerment, if we do not address those today, working towards the future, we still have to advocate for those things to change.

Also, we have to continue monitoring governance and leadership, especially around politics. And I am sad today to also say that when we are looking at the future, I was very disturbed by this conference by not addressing TB as a priority by only having one session on TB on Sunday. The whole eight days there is no mention on TB while I come from a region where TB is one of the number one killers. And I am mentioning that because people live with HIV. There is only 1 percent of people with HIV who are diagnosed early of TB. Our workforce in South Africa is dying of multidrug resistant TB, so for me I do not see a future if we do not start stepping up diagnosis and better treatment for TB today.

[Applause]

Also because people thought that a Treatment Action Campaign also is about treatment, we also started assisting people who are fighting for access to housing. One of the women who fought for access to housing in the Western Cape in the Holburn Case [misspelled?], she won a court case in 2000.

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And she passed away this morning in 2008. She died in a shack. After a judgment eight years ago that guaranteed that she has to be provided housing. So, in the future we have to be addressing other social issues that drive the epidemic that put women at the lower levels of society that are actually perpetuating or driving the epidemic in my region.

Also, our future of advocacy cannot ignore the fact that we can no longer only address HIV in isolation without talking about sexual violence, as I have mentioned. Without mentioning social welfare, because we know that some people in the borders where I come from, people move from Zimbabwe, from Mozambique to go to South Africa, but when they come to South Africa they receive bad reception. Because people in South Africa themselves are in a situation where there is so much imbalance in services. And there is now animal farms where you have people who have some and the others do not have. And then there will be tensions between the same working class. And we have to stop that because people have to remain in their countries, and we have to start today to address the social injustices in other countries. And also start moving towards social development in our countries and not just addressing HIV and TB in isolation, because we know that if we are going to keep doing that, we will be firefighting only one thing in isolation, but not working towards addressing the social problems in our communities.

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I think when I have to speak on leadership in terms of what we know, in terms of risk populations, we know that men who have sex with men are at risk, and we know from the data that was presented by Peter, and we can no longer find excuses and drag our feet when we have to start implementing policies that we know can help, but now we should be discussing how we implement it. For example, there has been so much discussion on circumcision. And there has been evidence that circumcision works, but we want to know when circumcision if it has to be policy, when is it going to be policy? What is its benefit for women? Because we know that circumcision in Africa, it has so much to do with, because people are in relationships, what is in it for women? Is it going to prevent women from getting HIV? Or is it this fantasy that male circumcision will prevent only men? It has to address other issues as well.

Also, we know that we have move beyond just clean needles, but also to know that people who are using drugs, it is legalized that if people are using drugs, then there is no law that blocks them from using drugs if they want to use drugs, but there has to be preventative tools for them to access them.

We know that advocacy in the future will have more challenges. Because donors today, and I am coming from an organization that mainly does advocacy, we are facing a crisis in terms of funding because donors, they want short term goals.

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How many people are we going to reach by this time? And it is not clear in the future if you are going to be dealing with housing, gender based violence, HIV, TB. There are so many things that influence how many people should be on treatment. There are so many things that will be influencing how many people are actually getting the messages you are giving. So therefore funding today has to be also thinking towards 2015. It has to be thinking of the fact that we want to address social development, and not just HIV in isolation of where we exist. We exist in this community that has these problems. So short term results will no longer be achievable because we are not also thinking about short term in terms of HIV, we are thinking beyond 2015.

And I think also there is going to be a problem in terms of how people are perceiving HIV today as an exception. We know that we can draw strength on how we have done activism on HIV. And we have actually created an opportunity for some of social problems that were not given attention. Through HIV we have managed to bring up activism around gender based violence. We have actually brought up activism around unemployment because we know that all of these things, they are in the same community so addressing one will not be able to solve the problem.

And lastly in the future, for me I think there is going to be a growing need for leadership, as we know that also

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leadership is under threat because as I said, most of our activists are tired. They are burned out. So we therefore have to continue sustaining leadership, both in terms of government. When Peter Piot leaves the UNAIDS, who is going to take over for Peter Piot and continue having this vision of not having HIV in the future? And when Mark leaves TAG, who is going to continue with the activism? So that for me, we have to start building that leadership today and developing that leadership today. I am very bad with PowerPoint. I am sure you have noticed.

And our leadership has to be accountable. Accountable in the sense that we cannot be feeling that we are invited in [inaudible]. We have to feel that we own the space as well as people with HIV. Not just be there as people who open or close the conferences. Or check commissions. But we want to feel that we are part of that leadership.

[Applause]

But also I think we need to intensify our leadership and when we are looking into the future, at all levels of community. We cannot have a global leadership and not have a community leadership. We need to balance that and have community leadership right through to provincial leadership up to national leaderships, and up to global leadership. And that leadership has to speak to each other. It has to be accountable. And I do not like these terms, these people who

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are faces of AIDS. And there is a tendency of people being abused because they are labeled as being faces of AIDS or ambassadors where I come from. And for me, the future leadership has to be proactive, not reactive. Because at the moment, when we add to what the environment says, in my country if the policy is bad we react, but now this is an opportunity to think how can we think beyond what we see today? If the policy is bad today, what will it mean for the next 20 years or the 50 years? So, that we start building campaigns that will actually gear towards 2031. Because by 2031, if we have not done anything today, it will be too late.

And also lastly, Madame Chair, I think for me we have to strike the balance between that we are coming to an era where we have to be as activists to learn also to show government how to do service delivery and be there to support government when they are doing service delivery. But at the same time, do advocacy. Because we as activists, we are very famous of being known as people who shout a lot and confront a lot and when it is time to do the work, we are not there to support. So, we need to be able to strike that balance. But also without bending ourselves out, but also to be able to take some rest and give new leadership some time if we have started today to build that leadership. Thank you.

[Applause]

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FRANCOISE BARRE-SINOUSSE, PH.D.: Thank you a lot, Vuyiseka for this vision of a new generation. We move to the last speaker because we are already very late and I will ask please, Frika, if possible to keep in time. Just a few words to introduce Frika Chia Iskandar from Indonesia. She is the Coordinator of a women's working group of Asia Pacific Network of People Living with HIV and AIDS and she will tell us about the vision of women, I believe.

FRIKA CHIA ISKANDAR: Yeah. Thank you. I would like to talk more into the future of advocacy and the community response. And it is actually really a burden to talk after the two colleagues because they are really, really good. But I will try to make it simple. I will not tell you what you need to do for the future of advocacy, but it is more to the what I think the basic things; we go back to the basics.

So, the first time I was asked to talk on this session, my immediate response was how would I know about the future? I am not a fortuneteller. I cannot really predict. I can have some ideas, but still they might not be true. Then I let the water sink in and start thinking about it. There are a couple of ideas. There are a couple of points of view. But I would really like to remind everyone that there is no right point of view. This is what I read from a book. It says that there is a conventional or popular point of view. There is a personal point of view. There is a large point of view which the

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majority shares. There is a small point of view which few share. And there is no right point of view. There is, you are always wrong, and you are always right. It just depends on which poll you look at.

So, here I would like to try to give you my point of view on the future of advocacy and a community response. You might not need a new idea. Maybe you have thought about it over and over again, but as someone who is young, I would like to give my ideas. And it is actually really good that I can share with the panel who are actually different in terms of generations and age.

So, when we talk about the future of advocacy, we need to understand that advocacy is not something that we do anymore. Advocacy is something that you allow to happen. And it happens. If there are elements, the critical elements happen and are just there. So, I am trying to make a diagram on how my thoughts and my ideas are. So advocacy, like I said, it is not something that we do anymore in the bracket. It happens. And if you allow it to happen. And it naturally happens. To make the advocacy to happen, of course we need to help the leaders. And for the future, I would like to say we need more young leaders. And I would like to quote here from Zacke Achman [misspelled?], for Zacke Achman was saying for me the critical question relates to leadership and what type of leadership you want over the next 20, 30, and 50 years.

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So, I would like to pinpoint here about the young leadership. The leadership that I want to see, or that I want to have in the future is people who are brave enough to take the responsibility, people who are accountable, and also brave enough to take and to demand for authority to make the change.

And of course, to have these critical elements of the young leaders, or the leaders of being responsible, being accountable, and also being given authority, you need to have the right or constructive attitude. And the way of thinking. And I would like to also pinpoint here, also when I talk about leadership or when I talk about leaders, it is not about age only. It is not about, that is why I put the young leaders in the bracket. Because we also want to have young ideas that maybe it is outside the AIDS response. I think for the future of advocacy we need to start to look at also what is out there. That we actually do not keep making ourselves exclusive. Maybe there are out there people who have these new ideas who can help make our life better, or our response much better.

So, the next question I would like to ask actually, or for me would be how are the people who have been in this AIDS response for tens of years going to actually create the demand on the young leaders? Understanding the art of letting go. Understanding the art of giving. From both sides, both parties, the young leaders and also the older leaders, or the mentors. And contributing to the life cycle of AIDS response.

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Maybe there are out there a lot of young people who are ready to take it up. Who are really brave and vibrant and who want to do something about this AIDS response, but the questions, my next question would be are you ready to let it go?

I will try to put an example as someone who is in the fight let us say, for 20, 30 years now. Or maybe there is someone who is already in 20, 30 years now. How do you start to unpack your box of knowledge to the ten year old child who maybe in 20 years from now will be standing here at the podium to speak and inform in this field? I mean, I was in the opening sessions where we heard young people, really still a teenager, Karen, 13 years old, from Honduras who was standing here talking on behalf of teenagers. How can we actually get more people like Karen to actually speak and start taking the lead from now? So I think this is the future of advocacy. We need to start looking at these young people.

[Applause]

Just now my other two activist colleagues actually talked about the human resource and also about the activisms and talked about accountability. But I also want to talk here about you have to move to talk about accountability, move from talking about accounting on the money only. It is also about what you do, about having the platform, the platform of communication, of the leaders. How can we actually communicate so we can actually exchange and where we can actually exercise

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the right to ask, and actually to speak for ourselves? And sometimes in this response, it is not there. It is not enough. So, maybe for the future, we need to look at it. Either it is through internet, my other colleague talked about it before. Or either through face to face. We need to have that communication phase.

So, I will try to make it fast. For me to wrap it up, actually, I will go back. Here, for the attitude of having the constructive attitude and the way of thinking, this is where the mentor, like I told you the senior leaders here now are people who have been experienced in this field. To start doing the mentoring, because we talk about this with the young people before. That we actually are ready to take it up and it is just that we need to identify more mentors to do it.

And for the future advocacy, I will go to the basic what it means to me. Having the mentors. Shaping the attitude. Creating the demand. In this lifetime we can use the advantages of internet and [inaudible]. With all of these elements meaning we are doing things differently which will lead to change, and that change means advocacy happens. And above all, it is also contributing how to keep the idealism alive. And this is what we need to understand, that for me the future of advocacy is not only about understanding the art of letting go, or the art of sharing, but also understanding how you can contribute to the idealism of the AIDS response.

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Because there are a lot of people who are too long in the response and then it is just enough, and then how we can actually keep the ideas alive through the young leaders. And to also create the space of having the right to ask and the right to speak for themselves. And investing in the young, new ideas.

So, with that, I would like to conclude that, are you ready to actually unpack your box of knowledge to people like me who are young and people who are young out there? And share it with us, with the mentoring, and for us to reach our goal and to keep the idealism alive together? Thank you.

[Applause]

FRANCOISE BARRE-SINOUSSE, PH.D.: Thank you, Frika. I would like really to thank all our speakers for sharing with us a vision and we would like really to move very fast and I will give the floor now to our moderator, Richard for making the conclusion of our special session.

RICHARD HORTON, M.B., B.S., B.SC., F.R.C.P.: We have run out of time. So I am going to tell you the questions I would have asked if we had had the time, and they are questions that still need to be asked because we have not had answers to them. And I regret the fact we have not been able to put them to our fabulous speakers today. We know that HIV has surprised us many times in the past 25 years. And I also know that it is impossible to predict surprises. But what surprises would we

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wish for if we could wish for those surprises? And can we create the conditions for those surprises to happen? We are not visionary enough in our ambition to create a future to defeat this epidemic.

Second, financing for global health is becoming increasingly competitive. The AIDS community has come under attack for taking too big a share of the available resources. How can HIV/AIDS communities sustain their position and advance their work in that competitive environment? It is essential that they do.

Peter said on Sunday that we need to broaden the AIDS movement, and again today he mentioned climate change, energy and food crises. But what are the boundaries of this broader movement? Is there a risk that we might dilute our response to the epidemic by taking on too many of the world's problems within this movement?

Jaime Sepulveda identified research and evaluation deficits in his talk on Monday. Do we need to rebalance the research funding agenda to incorporate implementation and policy research, and if so, how, and how urgently?

Will UNAIDS exist in 2031? Should UNAIDS exist in 2031? Its existence has been called into question. Its relationship with WHO remains occasionally uneasy. How do we see a future for this UN agency once Peter departs this year?

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What more can we do to protect our communities from the consequences of HIV/AIDS? How do we bring more political leadership to bear on the epidemic? Why is WHO so silent at this conference? Why have WHO personnel been told not to make front page news during this entire meeting? Why is WHO scared of HIV/AIDS?

[Applause]

The voice of children continues to be silent. How do we do better to integrate HIV treatment and prevention services into child health programs, antenatal care, and maternal health more broadly?

And how do you see the relationship between research, the clinical community, the public health community and advocacy communities? Because when we look at this conference where we are supposed to bring these different groups together, we are actually seeing a divorce. Scientists come to this conference less and less. It is a reality that everybody acknowledges in the corridors but does not face up to during the sessions. How do we bring scientists back this meeting? And how do we get them discussing side by side with community and advocacy leaders how we are going to shape the future research agenda?

[Applause]

And how do we create these new leaders for the future?

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We are part of a social movement. It is a social movement that needs leadership, your activism, fantastic science, peaceful and constructive collaboration and sometimes confrontation, and perhaps most of all, optimism. Our enemies continue to be fear, doubt, occasionally I am sorry to say dishonesty, and most of all, silence. We have got to recommit ourselves to challenge power, money, and conservatism, and ensure that our goals remain clear in our minds. Equity, justice, and love, yes love for our fellow human beings in every part of the world.

I am sorry we did not have a chance to put these questions to our speakers and to you, the audience. But please join me in thanking them, thanking our co-chair, and thank you for being here this afternoon.

[Applause]

[END RECORDING]