XVII International AIDS Conference
Plenary, Day 5
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MALE SPEAKER: Believe it or not, today is Friday. So this morning we have the pleasure to introduce the INRS/IAS prize. The INRS is the [French Spoken], that is the National Agency of AIDS Research in France, and IAS is very pleased to have a joint prize with INRS.

INRS has generously donated its surplus funds from the organization of the second IAS Conference on HIV Pathogenesis and Treatment, which was held in Paris in 2003 to support young researchers who demonstrate excellence in the area of research programs related to the scale up and prevention and treatment in research limited settings.

A jury has been formed combining INRS representatives and IAS council members, which have scored the abstract accepted for all our posters at the Mexico City conference. To be eligible, abstracts must meet the following criteria: presenter must be under 35 years of age, must be a citizen of a low or middle income country, the research must have been carried out in a low or middle income country, and the research must directly or indirectly be related to increasing access to prevention and/or treatment in research constrained settings.

A prize of $3,000 has been given to the highest scoring abstract in relation to the above criteria for each of the conference abstracts. They are useful for [inaudible], from the governing council member, for drug BNC, [Foreign Language],

and for drug DNE, Bruno Sphere, Fred Aboco, and Entemen Salwol [misspelled?].

So it is my pleasure to introduce the Director of the INRS, which will be also one of the co-chairs today, and as you may know, Jean Francois Delfraissey, is the Director of the [French Spoken].

JEAN FRANCOIS DELFRAISSEY: Thanks a lot, Pedro. Good morning, everybody. So it is a great pleasure to introduce the three [inaudible] of this global conference. And the first one in basic science, he is [French Spoken] from Paraguay. Please. She is a pediatrician and is fully involved in care of HIV infected children and [inaudible] in such populations, especially in infant exposure to TB analogs for long periods of time. And she has a poster discussion accepted on prevalence of associated mutation in HIV infected Mexican children after multiple treatment. Congratulations.

The second [inaudible] from Uganda. David is fully involved in NGO of Uganda, and is currently working as a managerial official. He is fully involved in the operation and research, as a research fellow, [French Spoken]. David has an oral presentation accepted on [French Spoken] for persons living with HIV/AIDS, in the Tazo and Bali experience.

And the third prize is Joyce Wamoil [misspelled?] from Kenya. Joyce has been involved in sexual behavior research with young people and women in Tanzania. She is currently working on research on the role of family contacts, in infants

and young people, sexual behavior, with a focus on parenting practices. And she has an oral presentation on Woman's Bodies are Shops, [inaudible] and HIV Prevention in Tanzania.

Okay, thanks a lot and, again, congratulations to the three candidates.

MALE SPEAKER: Thank you, Jean Francois. It is my pleasure to introduce the chairs of this morning's session. I have already introduced Jean François. So our first chair, I will go backwards and I will say that he has been appointed as the Dean of the Harvard School of Public Health. He has been also the former Secretary of Health of Mexico, and let me tell you that Dr. Julio Frenk has been one of the founding fathers of this conference. He was the first Mexican official to greet us and to say you are welcome, bring your conference to Mexico, we will do our best, and believe me, the Mexican did.

Then we will have as a chair Miss Nafis Sadik, who is the UN Special Envoy for Asia Pacific. Dr. Sadik is from Pakistan.

And also we will have as a chair, Dr. Sigrun Mogedal, who is the Norwegian Ambassador for HIV/AIDS and Global Health Initiatives from the Norwegian government. And I think I have introduced all the chairs, so with that, I leave you with the session. Thank you.

JULIO FRENK, M.D., PH.D., M.P.H.: Thank you, Pedro, and good morning to everyone, and welcome to this magic day, the eighth day of the eighth month of 2008, the last day of

this historic conference, and I want to start by thanking each and every one of you for having made Mexico your home this week. I hope we will see you back many, many times.

We are here this morning in the first part of this plenary session, the final plenary session, to take stock of the deadly relationship between HIV and TB. The combination, as we know, is deadly and synergistic. It is something of a paradox that one of the oldest and one of the newest effective diseases have found this way of acting in conjunction against the most vulnerable.

TB is now the greatest killer of people living with HIV in Africa, and a major cause of death in this group elsewhere in the world. Our approach to this state has been to treat the two diseases separately, but it has become increasingly clear that if we are to deal effectively with TB and HIV, we must break the deadly partnership between these two. They must be handled together with an integrated approach. We have to move beyond silo mentality and into integration mentality.

This has proven to be difficult, but I think we have the opportunity to build another success story. One encouraging sign was two months ago, the UN convened its first high level meeting exactly to deal with the interaction among these two diseases.

So breaking the link between TB and HIV must be one of our priorities in the response to the HIV epidemic, and this needs to include testing all TB patients for HIV, especially

places such as sub-Saharan Africa. We are up to 70-percent of newly diagnosed patients also have HIV. It also means finding TB in persons with HIV early, before the tuberculosis takes its deadly toll on these vulnerable patients.

And finally, we must prevent tuberculosis in patients who do not have it. Sadly, as we have seen with the outbreak of extremely drug resistant TB in South Africa, the healthcare facilities where AIDS patients go for their care can often be very dangerous places because transmission of TB is all too common in many settings, many patients leave clinics, not only with the medicines that may prolong their lives, but also with a TB infection that can lead to an early death.

And the situation has also introduced a new negative dynamic in the relationship among HIV infected patients and health workers who may be reluctant to treat do to the risk of contagion, so we really cannot sit in any passive way, but really we need to move forward and translate all the evidence we have, all the policy that has been formulated into action, recognizing, first of all, that TB cure and prevention must become an essential part of HIV care. I think this is an enormous opportunity for the AIDS community to once again demonstrate its leadership, the leadership that has been built over this quarter of a century by dealing with very complex situations and implementing complex responses to the HIV crisis.

In this conference, we have had a lot of talk of integration, about diagonal strategies, and I think this dual challenge will test our will to really move in an integrated fashion. I am convinced that if we do this together and in a focused way, we will succeed in saving millions of lives and writing another page in the history of the fight against AIDS.

I very briefly address the problem of HIV and TB coinfections from a public health perspective. But now I would like to turn it over to an expert who can discuss the scientific perspective, as well as speak from experience in the field. I am very pleased to introduce Dr. Chakaya Jeremiah Muhwa as the first plenary speaker today. He will address the topic of HIV and TB. Dr. Jeremiah is Chief Research Officer at the Center for Respiratory Disease Research at the Kenya Medical Research Institute in Nairobi. He is also Chair of the Thoughts Expansion Working Group, and a long standing member of the Stop TB partnership coordinating board, and actually he is currently its vice chair. His research focuses on lung health and he has been practicing lung medicine, including TB in Kenya since 1992. From 2003 to 2006, he was Director of the TB Control Program and in this capacity he has been a leader in developing innovative approaches to tackle the dual challenge of HIV and tuberculosis.

And finally, in my opinion, he is a very special person in the TB community, truly a voice of the field and a voice of the people. Please join me in welcoming Dr. Jeremiah.

CHAKAYA JEREMIAH MUHWA, M.D., M.SC.: Thank you very much for a warm introduction. It is a great honor for me to be here today to speak about TB and HIV. I would like to thank the organizers of this conference for the privilege to speak to you about TB and HIV.

TB/HIV is a big problem as we all know. In the world today, about a fifth of the world population is known to be infected with the germ that causes TB, about 33 million people, we are told, by UNAIDS, are currently infected with the HIV virus and are living with the HIV virus. Therefore, you have a group of people who have got TB and HIV, and the estimate is that there are about 11 million such people in the world today, which therefore means that there is a large reservoir of people who are likely infected with TB and who are therefore likely to develop TB, HIV associated TB, in the future.

The current estimates that we have of all the TB in the world is built on reports that are routinely supplied to the WHO by countries and, at this moment in time from the figures that we see from WHO in 2007, it is estimated that about 9 million people developed all forms of TB in 2006, and there is about 1.6 million people who died of their disease.

If you look at HIV associated TB, there was about 700,000 people, which is about 80-percent of the total number of people suffering with TB that were picked up in 2006. And HIV associated TB killed about 200,000 people in 2006, which is

certainly a very large number of people dying from this disease.

The dramatic thing that has happened with HIV associated TB is actually seen most vividly in sub-Saharan Africa. If you look at the vista here [misspelled?], you see where TB has done in sub-Saharan Africa. There has been an exponential growth in the number of people who are reported to have TB in Africa. We have seen in the last three to four years a slight decline of stabilization of that figure, but still, the problem, the burden of TB and HIV in Africa is very large.

If you look at the distribution of HIV associated TB in the world today, 85-percent of that burden is in sub-Saharan Africa. And the rest of the 15-percent, about 3-percent of that is in India, and therefore, one need not assume that the HIV associated TB is primarily only an African problem. There are countries outside of Africa that also have a large burden of HIV associated TB. In India, for example, a 3.3-percent, because of the large population in India, this is a large number of people who suffer HIV associated TB.

But what you want to look at here is the fact that in south Africa alone, almost a third of the HIV associated TB that are caused in the world are caused in south Africa, so there is a really large burden of HIV associated tuberculosis.

HIV associated tuberculosis remains a problem even in people who are on antiretroviral treatment. If you look at the

number of infections, new infections, that are picked up on people that have started antiretroviral treatment, tuberculosis is far the largest incident of opportunistic infection in both Africa and in the developed world. The only problem, the only issue, really, is one of magnitude. Africa has the bigger problem, but HIV associated TB we look at even in the developed world in Europe and North America.

So what do we know, then, about HIV and tuberculosis at this moment in time? From early on, we did notice that HIV is currently considered to be the most important risk factor for reactivation of dormant or latent tuberculosis infection. We also know that the tuberculosis or HIV is a very important risk factor for the rapid progression of new TB infection disease. We know that HIV leads to an increased risk for a recurrence of TB. HIV also increases the risk of smear negative anti-pulmonary TB, and the clinicians know that these are forms of TB that are extremely difficult to diagnose. If you look at some of the mortality studies, from Africa for example, about a third of the people who undergo post mortem will have TB that was not detected during life because these forms of TB are extremely difficult to pick up. We know that tuberculosis is the biggest killer of people living with HIV today. But there are other problems, the risk of advanced drug effects, and the risk of reactions is increased in people who have HIV.

Because of these things, the World Health Organization and its partners put together a 12 package of activities that

if they were implemented very strongly and very actively, would have a major impact on HIV associated TB. The set of activities are divided into three groups; the first set of activities relate to coordination and collaboration so the issue of how TB and TB and HIV controlled programs should work together. The second set of activities is related to decreasing the burden of TB in people living with HIV, and this talk will be focused primarily on that aspect of decreasing the burden of TB in people living with HIV. And the last set of activities relates to a decrease in the burden of HIV in people who have TB.

The world has moved a little bit in terms of reducing the burden of HIV in TB patients, and the key activity there is, of course, HIV testing of TB patients. And, at this moment in time, some countries have done wonderfully well with HIV testing over TB patients. So, for example, Rwanda here by the end of 2006 was testing nearly 80-percent of the TB patients that it was picking up. About 80-percent of these patients will be on preventive therapy and about 41-percent of these patients will be on antiretroviral treatment.

What we have not done very well globally is with something that is currently called the three I's. The three I's are something that was coined by the HIV department, I believe are in WHO, and the focus is on the three things that should happen to increase the burden of TB in people living with HIV. And it involves isoniazid preventive therapy,

intensified case finding, and TB infection control. And I will start with dealing with TB preventive therapy.

Immediately after the world noticed that TB was a big problem in HIV infected people, there were lots of studies that were carried out to see whether TB preventive therapy would work just as well as in people who were not HIV infected because we know already that, for example, the isoniazid works very well in preventing active TB in people who are latently affected.

The summary of these studies are shown in this slide, and what the studies show is that the incidence of active TB was reduced markedly using isoniazid. There was, of course, no effect on all cause of mortality, and there was only a slight increase in the incidence of advanced effects.

The same effect has been seen in children. This study was done in South Africa. All these children were given cotrimoxazole, preventive therapy, some of them were on antiretroviral treatment, and this was a randomized, clinical trial where half of the children were given isoniazid, and half of them were given placebo. This study was terminated prematurely because there was a significant benefit of isoniazid on mortality, on survival, in children who were given isoniazid as opposed to those who received the placebo. So we know that isoniazid preventive therapy works.

We also know that antiretroviral treatment works to reduce the incidence of TB, and the question that has been in

people's minds is were that, in fact, using isoniazid together with antiretroviral treatment, would have any additional impact on the incidence of TB.

This is work that was published last year, coming from Rio de Janeiro in Brazil, showing very clearly that the biggest benefit was with a group of patients who were given isoniazid preventive therapy, together with antiretroviral treatment. Yes, it is understood that this was a retrospective study, but it does show, it does provide an indication that the combination of antiretroviral treatment together with IPT would have a great impact on the incidence of TB in HIV infected individuals.

But there were problems. Immediately we knew that HIV and associated TB could be prevented, there were issues of whether, in fact, IPT could be done under program conditions. And this, the earlier studies that came out, the so-called visibility studies were rather disappointing. This is work from Uganda, which showed that the number of people who are probably HIV infected, those who are tested, only a few of them return to pick up their results, in those days we did not probably have a rapid test so people had to come back for results. Only a few of those are found for TB screening, of those that are found to TB screening, so few of them are given isoniazid, and very few of them complete treatment. So that was a rather disappointing result of the visibility studies.

From some of those visibility studies and some other issues that the TB controllers know, there has been a very low, and rather unacceptable low uptake of isoniazid preventive therapy. The biggest problem, in my view, was that of fear. People were fearing side effects, people were fearing low adherence, and the biggest problem that has been in our minds is whether, in fact, the widespread use of isoniazid preventive therapy would lead to increase in resistance.

There was also an unclear policy, initially we were promoting isoniazid preventive therapy as possible protection, rather than a public health intervention. And if you do that, then there is a reluctance for NTP's or TB controlled programs to take this one out. It was left to the TB control programs to do this, the HIV programs were not part of these earlier studies and these processes, and there was also very little community engagement.

But a key thing is that we want to move on. The summary of all this is now we are beginning to accept IPT and we want to move forward with IPT, but we need to remember that this is not going to be a short rest, this is going to be a long rest, is it a long rest and therefore we need to scale up IPT with all the precautions that need to be put into place so that we do not intensify, or escalate, the prevalence of isoniazid resistance.

What about intensified case findings? We have already said that the rationale for intensified case finding is that

there are a lot of people with HIV who are about to start antiretroviral treatment, who already have prevalent TB. And, of course, the incidence of TB is much more common in some people, and the mortality is very high, and therefore TB screening would improve the safety of the delivery of ART and also improve the optic of IPT.

There have been a lot of variations in terms of screening people who have HIV for TB. Most people will use symptom or signs screening; sometimes people use physical examination, sputum smears and sputum culture, chest x-rays and tuberculosis skin testing, [inaudible] interferon gamma release acids.

But there are a lot of variations at the country level. The screening tools vary from place to place. People are now beginning to use lots of symptoms, some of them not full specific to TB, and fortunately, the majority of screening tools seem to exclude, or tend to exclude, children and that is the pulmonary forms of TB, and the fact that there is a tool does not mean that that tool will be used at the country level.

And this is what was reported to WHO in 2007 and that is data from 2006. And it tells you that, generally speaking, in the world today, very few people are being screened for TB. But this is to say that this is what is reported. In Kenya, for example, like I can tell you that we are screening people for TB, but because there is no standardized reporting or

reporting tool, we are not able to report to WHO that we are doing this.

At this moment in time, the number of people screened for TB in that region is about 1-percent, and you can see only about 0.01-percent of people are receiving isoniazid preventive therapy. So this is something that we need to do a lot more to try and reduce the burden of TB in HIV infected individuals.

What about preventing transmission of TB in healthcare centers? We know those of us who work in the kind of the world that we come from, there is a lot of difficulties with congestion in our clinics and our hospitals, so our clinics are congested, our wards are congested, and the result of this is that you could end up with a lot of transmission of TB in healthcare settings. We have had infection control guidelines in place for a long time now, but the majority of people have not been using these kinds of guidelines because they were very difficult to use. However, that vision now has come up with an essential 10-step infection control guide that specifically emphasizes the involvement of communities, and that is important because if we involve communities, then you reduce the stigma associated with the infection control.

In countries, including my country, there is a lot of hierarchal confusion. People want to start off with the big things, they want to start with massive and complex ventilation systems, while ignoring administrative controls, which are the most effective for reducing transmission of TB at healthcare

settings. And for those of us who are in the process of, or in the business of, writing global fund applications and a view, sometimes we get problems saying how we will measure the impact of infection control.

So what is needed, therefore, for a nationwide scale up of up TB/HIV collaborative activities? The list is long, but I would want to point out here that national policies are important, recording and reporting is important, type setting is important, and very critical at providing services under one roof.

What are some of the challenges to controlling TB or providing care to TB and HIV infected individuals? Let me start off with our antiretroviral treatment. We all want to give people antiretroviral treatment to reduce mortality and morbidity, and treatment to improve the quality of care. But the issue is when do you, then, optimally start giving antiretroviral treatment? This is a study published by [inaudible] from Malawi, showing that the strategy in Malawi is to give patients antiretroviral treatment after two months, so the intensive phase of anti-TB treatment is without antiretroviral treatment, and then you follow it up with antiretroviral treatment after that. And you can see there is absolutely no difference in the mortality rates so therefore at two months initiating, waiting for two months to start antiretroviral treatment, may not be the best thing to do with HIV associated TB.

What about the immune reconstitution inflammatory syndrome? The majority of people with immune reconstitution inflammatory syndrome do not have a big problem, but a few people have big problems, including for example, brain lesions, and a few of these people can die of their disease. And therefore, I think the critical thing for us to know is that TB immune reconstitution inflammatory syndrome can have a major impact on our ART programs, and the key thing there is that one of the major risk factor for TB IRIS is, of course, the time that you take the antiretroviral treatment. And, for example, this is a study from South Africa that shows that if you start antiretroviral treatment within 30 days of TB treatment, the risk of TB IRIS is much higher. We all see these kinds of things a lot of times before developing hepatitis because some of the communities that we come from are very high endemic areas for hepatitis B and C.

Now to finalize, I want to deal a little bit with emerging threats to TB and HIV care. This is a report that was published on March 24th at 2006, which those of you in the TB world know that March 24th is the so-called World TB Day, which documented that MDR TB, which is TB that is multi drug resistant TB, that is also resistant to the most powerful second line drugs, and that this was documented in all the regions of the world.

This is not really new to us, there have been institutional outbreaks of MDR TB that were reported in the

80’s and 90’s, and the key thing is that these kinds of institutional outbreaks of MDR TB are also associated with a very high death rate. But this particular report from South Africa jolted all of us in the TB world because it showed, for example, that a lot of patients who have MDR TB will die; the HIV rates in these people are very high and many of these patients were probably picking up the MDR TB from the hospital setting.

MDR TB and HIV are not confined to Africa, you see it also, this is a report from the Ukraine showing an association between being HIV positive and having MDR TB. So what do we know about MDR TB and FDR TB? What we know is that MDR TB and FDR TB is a consequence of bad TB control. If you have a program that is not picking up cases and if a program is not picking up cases and treating them well, then you generate MDR or HDR TB. We know that HIV infected individuals have an increased risk of developing MDR and FDR TB and that when they get infected, then the outcomes are very poor, and infection control is an extremely essential thing to do to prevent the transmission of infection in healthcare settings.

So, in conclusion, Mr. Chairman, HIV associated TB is certainly a big public health concern. We have seen very good progress being made with the [inaudible] of HIV in TB patients, testing CPT and ART, these are moving forward well. There is a big of a slow progress in the prism of TB in people living with HIV, the so-called three I’s. The key thing is that this is

not a TB controlled program; this is an HIV community activity. HIV communities are the ones who are seeing people before they develop TB and therefore they should take responsibility in terms, or rather they should take the literal in making sure that the three I's are implemented, and implemented fully. This, of course, requires greater collaboration between the TB and HIV communities. We have said this many times before and we will say it again, we need better and more coordination and collaboration between the two programs. You do need the HIV community does need to take that greater responsibility to ensure that the three I's are fully implemented.

I think, in my view, and this is my closing remark, and Michael, in my view, collaboration between the TB and HIV communities is not optional, it is really mandatory, and we have known this for a long time. But apparently knowing is not enough, we are not applying, we have been willing for a long time, but we are not doing it and we must change these things, we must start doing these things. The HIV and TB communities must start doing these things so that we are able to reduce the burden of HIV associated TB. Thank you very much for listening.

JEAN FRANCOIS DELFRAISSEY: Again, good morning to everybody, my name is Jean François Delfraissey, I am the Director of the [inaudible] of French National Agency on AIDS Research.

But first congratulations to the IAS and the organizers and to the Mexicans for organizing this beautiful meeting. Thanks a lot.

Human and social science are high priority in the research agenda of [inaudible]. However, we need for more integration of human and social science with clinical science. For the long term evaluation of hard treated patients and the detectable viral load and CD4 counts of 500 are necessary, but not sufficient. What is a goal of therapy in a chronic disease? Biology cure, or social?

In France, for example, 45-percent of treated patients do not work at that time. We need for more collaboration between the two communities. In this context, I am very pleased to introduce Bruno Spire. Bruno is a researcher living with HIV. He is currently also President of AIDES, the primary NGO HIV organization in France. Bruno Spire was trained as a medical doctor in Paris, he earned his PhD in virology in the lab of Francois Barre-Sinoussi in the Paris Institute. He started a post doctoral position in London with Professor Robin Weiss lab to study the Vif protein of HIV virus. Then he returned to Marseilles to continue in the same lab to study HIV in the field of molecular biology. That was the first part of his scientific life. Then we have an origin apart [misspelled?]. Dr. Spire turned his research to public health issues in order to reconcile the objectives of scientists and activists. He has been involved in multi disciplinary studies

in order to study patients reported outcome in HIV untreated in our studies in clinical trials. He also led a large number of analyses on the issue of patient adherence, demonstrating that adherence cannot be predicted in advance solely on the basis of social demographic characteristic. In contrary, his research demonstrates that adherence is influenced by the patient experience. Dr. Spire's research has contributed to the knowledge of determinants of patients' quality of life in the ART era. Part of his research was focused on the sexual behavior of patients living with HIV.

A lot of this work has been funded by the INRS, for the INRS, Bruno Spire is a real, real positive scientist and with a good interaction. In the future, Dr. Spire is interested in developing a research program that helps to address the needs of the community. He also wants to build international partnerships with other community based NGO's. Dr. Spire is an advocate for the rights of minorities, gay men, injecting drug users, and migrants to obtain equal access to healthcare. Bruno.

BRUNO SPIRE, PH.D.: Thank you, Jean François for these nice words. Buenos dias, todos. Good morning, everybody. Bon Jour. In this presentation, I will not attempt to review the full range of prevention topics. As a virologist and social scientist and as an activist, I want to bring to your attention some lessons learned from community experiences when considered

with epidemics that should serve to improve prevention activities.

Despite the major progress in the field of HIV care, we only have in hand a limited number of proven HIV prevention approaches, while others are still at the research stage. The challenge is to scale up all HIV prevention strategies that are known to work. An example of a newly proven HIV prevention approach is male circumcision, but it will not fulfill all prevention needs. There is abundant evidence that harm reduction reduces HIV transmission among injecting drug users. Interventions promoting sexual risk reduction in particular with condom use can reduce sexual transmission of HIV.

However, the Nairobi conceived ADC strategy has limitations. Abstinence only programs do not work. Intervention's promoting partner reduction have had limited success among higher risk segments of the population. Finally, lifelong consistent condom use is not acceptable or viable for most people.

I will explore in my presentation three actions that have the potential for improving our efforts to reduce the sexual transmission of HIV. These are combating prevention fatigue, declassifying HIV testing [misspelled?], and being effective against stigma.

Firstly, I would like to talk about prevention fatigue. But whose fatigue are we talking about? Is it the fatigue of prevention promoters or the people they are trying to reach?

Adopting an approach which is more tailored to the needs of individuals might be helpful. The prevention discourse is often preached in all or nothing terms, while the concept of risk reduction has not been sufficiently explored.

Prevention fatigue has been raised as an issue for the gay community in most industrialized countries. In France, repeated cross sectional studies carried out among readers of the *Gay Press* found that the rate of unprotected anal intercourse increased from 20-percent in the 90's to 33-percent in 2007. The gay community has been widely criticized for insufficient action. However, as shown on this table, which describes the national French survey on sexual behavior, the gay community has greater comfort levels with condom use than other segments of the population. The proportion of people who use condoms is much higher in the MSM population, whatever the type of partnership or the number of sexual partners.

Instead of regretting the times, when so many members of the gay community died despite widespread community action, it would be more constructive for all of us to work at developing pragmatic solutions for those who do not consistently use condoms. Understanding the conditions of risk and how people interpret risk is of key importance. On this slide, you can see different situations drawn from real life where systematic condom use is just not happening. For many people, risk is part of the fabric of their life. The issue is how to handle risk and how to minimize the impact of a risky

situation, and this is a complex problem in a society which tends to blame people who take health risks.

That is why we need to renew our discourse by adopting a non-judgmental harm reduction approach to sexual risk reduction. We should assume that with few exceptions HIV negative people do not want to get the virus. And that people living with HIV do not want to transmit the virus. The greatest concern of people living with HIV is ongoing HIV transmission. People do care, people who take risks do also care. There are many strategies that people use to reduce their risk of acquiring or transmitting HIV. Some women use diaphragms because they are discreet. Among HIV positive individuals, the resorting [misspelled?] is frequently observed. Gay men have been observed to adopt the sexual practices through strategic positioning. Of course, the effectiveness of these strategies is uncertain. The parties that people who have problems with condom use do care at some level, or they would not bother to use alternative strategies. That is why we need to move beyond the all or nothing approach to HIV prevention and better investigate the effectiveness of risk reduction approaches.

The viral load suppression is a typical example of sexual risk reduction strategy. This slide shows the results of the study that measured the rate of infection among untreated heterosexual couples. Transmission rates are almost literally associated with the level of viral load. In a

Spanish cohort of sero discordant couples, transmission was used by 80-percent after introduction of ART. In this study, transmission never occurred when viral suppression was achieved in the positive partner.

How these results can be applied to the prevention of sexual transmission is still a matter for debate. Last year, a statement issued by Swiss experts became the subject of much controversy. They concluded that condom use may not be necessary in stable heterosexual, zero discomfort couples in which viral load control had been achieved in the positive partner for at least six months. Many concerns were raised about this statement. Virologic suppression in the blood does not necessarily mean suppression in the genital fluids. In addition, the doctor in this report referred to stable heterosexual couples only. Despite these limitations, the results of the Swiss study may hold promise for zero discomfort couples, the population in which most transmission occurs in high prevalence countries.

It is not, however, clear how these results might apply to other populations exposed to HIV. ART should, however, be retained as a useful, additional risk reduction strategy. But more research is needed to determine its contribution to combination prevention. Interestingly, the Swiss controversy raises the question of when to start ART. Recent results provide a compelling argument that increasing the 200 CD4 threshold globally recommended for initiating ART could lead to

a dramatic reduction of HIV incidence even when considering an increase in risky behavior.

Moreover, in two different studies carried out by my research group and funded by INRS, one conducted in [French Spoken] and the other in [French Spoken], we were able to demonstrate that access to ART increases consistent condom use among sexually active people living with HIV. Consistent condom use is about twice as high in people receiving ART. Such results can probably be explained by the care and support provided to patients who are treated.

Supporting people living with HIV who do not need treatment by providing them with appropriate prevention, care, and counseling services is a huge need. In my contexts, these people are not a priority of interest to healthcare workers as they are not eligible for treatment and, in turn, do not receive psychosocial support. Had their own support programs had already been introduced in several settings, they have been shown to be highly efficient. Similar approaches could be helpful to design new behavioral interventions based for individuals living with HIV, but not yet treated. This would, in turn, empower people to reduce risky behaviors.

For people living with HIV on their treatment, all interventions that maintain adherence and long term virologic success can have an impact on HIV transmission. [Inaudible] cohorts show that ART related side effect is a significant factor in influencing adherence and condom use. The more side

effects we experience, the less adherence we are, and the less likely we are to use condoms. Taking into account the patients reported outcomes, including quality of life, could help when designing the best strategies to reduce viral load and risky behaviors. And that approach, including comprehensive prevention, is needed.

Here are two examples about the relationship between toxicity and inconsistent condom use. On the left, in French, drug users living with HIV, and on the right, in people living with HIV in [French Spoken], we found that specific toxicity had similar affects on inconsistent condom use.

Now I would like to turn your attention to the second topic today, and that is diversifying HIV testing approaches. There are many benefits of knowing one's HIV status. For the individual, shortening the duration of the unknown infection carrier can have an impact on clinical outcomes. From a public health point of view, those who know they are infected are more likely to adopt several behaviors.

A metanalysis indicated that the prevalence of unprotected intercourse was reduced by 53-percent in HIV positive persons who were aware of their status, compared to those who were unaware. However, in most settings, HIV diagnosis was too late with multiple negative consequences.

In order to enable more people to get tested and treated, we need to combine several HIV testing approaches, provider initiated testing, with an opt-out option in high

prevalence countries to significantly higher rates of HIV detection. Stigma, fear of receiving a positive result, issues of confidentiality, and poor access to testing sites are the variables to the voluntary testing approach. Alternative [inaudible] such as mobile vans, can also increase access to an uptake of testing.

On this slide, you can see the mobile community van of our American partner, and despite the low HIV prevalence in this country, such mobile testing strategies have been shown to be effective in reaching HIV infected individuals.

We therefore need to further explore the public health value of community testing. Intervention based on rapid HIV testing paid for by none healthcare professionals may reach the most marginalized populations more efficiently. In addition, the combination of peer based counseling and rapid testing could represent an interesting strategy to enable repeat testing for individuals at risk who are discouraged from seeking services.

We should not forget the importance of primary HIV infection in the dynamics of transmission. This graph shows the natural history of HIV infection. For each phase, primary infection and the symptomatic phase in AIDS, you can see the average risk of transmission compared to act, which is highest during primary infection when viral load is elevated.

Transmission during primary infection may account for approximately half of transmissions. Such data suggests that

zero endurance during the early stages of infection makes a significant contribution to transmission. Strategies to increase access to HIV testing should also make provision for repeat tests, especially for people who are often confronted with risk.

The third and final area of my talk is to discuss how we can become more effective when dealing with stigma, which continues to represent a major barrier to HIV prevention.

There is growing evidence that stigma and discrimination contribute to risky behaviors in positive and negative individuals. In several parts of the world, the fear of stigma is associated with lower uptake of HIV testing and less willingness to disclose positive results. Recent data from the French INRS study show that experience of discrimination is associated with risky health behaviors, such as unprotected sex and non-adherence.

More specifically, we can see the relationship between inconsistent condom use and experience of discrimination. Among heterosexuals and injecting drug users, discrimination in the social environment significantly predicts inconsistent condom use.

A related problem is double stigma. Some groups are already more susceptible to HIV infection. This is the case for injecting drug users, sex workers, and MSM. These groups are already stigmatized independently of HIV infection. Such stigma may contribute to the high level of HIV prevalence in

these groups, as stigma constrains access to information and to services. Yet, these groups are in greatest need of services and care. On this slide, you can see the comparison of HIV prevalence in MSM, with those in the general population in several countries. In MSM, the prevalence is always much higher.

To end my talk, I would like to propose an effective treatment combination therapy to fight against stigma. The proposed regimen must include the following: first, fighting for better acceptance of people living with HIV; second, improving relevant roles and policies; and third, involving prevention users working with people, rather than for people. Greater acceptance of HIV in our society will help people break the secret and disclose their status without fear.

In our experience with AIDE several of our frequent partners, we have found that strengthening the social positions of people living with HIV reinforces the collective ability to talk about HIV. It induces changes in the way society regards people living with HIV. Of course, the ability to talk is associated with the ability to listen. That is why public action is necessary.

This is an example of a campaign you have probably seen during this week. Its advantage is that it makes people think about how HIV could impact the world’s attitudes. This campaign has been popular in terms of capturing the audience

attention. With public testimonies of people living with HIV, it can change the representation of HIV in the general public.

The use of political leaders in this campaign is also of interest. Here you see a poster we use in France during the last presidential election, as well as a poster which features the current French Minister of Health.

The second element is improving laws and policies. Instead of fighting drug users, gay men, sex workers, and immigrants, laws should protect all groups who are more vulnerable to, or at risk, of HIV. In my own country France, AIDS prevention activists are now legally blacklisted by the police. Right now, any person in France who attends AIDS community based organization can be registered in a police database collecting sexual orientation and serogroup status.

Such antidemocratic practices have never happened since World War II in my country. All over the world, several societal factors still contribute to the spread of the epidemic. Fortunately, several Latin American countries have launched policies and programs geared towards reducing stigma, such as homophobia. Such policies need to be introduced in other settings, particularly in Africa where community prevention work can be very risky. We have lived this recently in Uganda and in Senegal with the imprisonment of gay prevention activists.

Similarly, the representation of drug users in several countries runs counter to the public health interest. Changes

will be possible if international institution, and especially financial backers, put the maximum pressure on governments to guarantee a rights-based approach to public health.

Community mobilization among people living with HIV has been shown to be a driving force in increasing access to treatments. It should become a driving force also to improve HIV prevention by involved HIV positive people, as well as those who are most exposed to infection. There must be a real effort to make sure that those living with HIV, or those living with risk, are truly involved, or are in key positions. The mobilization of people who are zero concerned is necessary since professional response will never be sufficient.

For the last 25 years, prevention uptake has improved through community mobilization and peer support, leaving the empowerment of those who are marginalized and those at risk. This slide shows people who are not infectiologists, not immunologists, not sociologists, there are simply nothing-ologists at work.

But these people are, in fact, life-ologists since their expertise is based on their life experience. On the slide, you can see peer based gay prevention activities, harm reduction tools including those conceived by drug users themselves, and mobilization of migrant women who show the advantage of female condoms in their community.

I would like to underline the role of mobilization of sex workers all over the world. Such mobilization has led to

success in prevention programs in Nigeria, in Central America, in my own country of France, where female transgender sex workers have successfully worked together for many years.

Finally, a new important event in the field of mobilization is the open emergence of gay men in the African context. Until recently, MSM were ignored by African and international policy makers. It was argued that gay men do not exist in Africa, or are very few. And as recently supported the mobilization of gay Africans, and I must say that it was not difficult. We learned that gay men are not so few and not so invisible. They want to contribute to public health policies, and can become community health factors, despite homophobic environments.

In conclusion, prevention can work when it reflects the comprehensive needs of people. To generalize, more research is needed to understand how to mobilize those most at risk, but empowerment of communities is a global challenge. To do so, reempowerment of people living with HIV or people living with risk, is needed. My message is please involve us, the zero concern person, the laymen and women in public health action. With this aim, former governmental organizations based on community involvement and acknowledgement of acquired expertise have decided to create a new, international structure called Plus. At the moment, this organization is ISS in Morocco, ACARD in Madrid, and Cokseda in Quebec, and ED in France

[misspelled?]. The aim of Plus is to bring the voices of sero concern people to influence international policy makers.

I would like to thank, of course, all the volunteers and staff members of ED and all groups of collaborators I have the pleasure to work with in my double life as scientist and activist. Thanks, particularly, to the French INRS, as without its existence, no multi disciplinary work could be possible in my country. Thank you for your attention.

NAFIS SADIK, M.D.: Thank you very much, Bruno. I think our next topic leads right in to the remarks that he made. It is on criminal statutes and criminal prosecutions in the epidemic help or hindrance and in my opinion one of the most important topics in addressing our fight against AIDS. It is a topic where leaders need to step up, need to demonstrate their leadership by taking and looking at and examining all laws, practices and worries, ensuring that laws are consistent with human rights standards, changing laws where necessary and enacting new laws and policies to protect everybody. Today as Bruno said, a human rights approach to health is being advocated for all countries of the world and most countries accept that in principle, but not always in practice. It was one of the key recommendations of the Commission on AIDS in Asia, and human rights based approach means ensuring the right to health of all individuals in that country and it means embracing the rights of men who have sex with men, IDUs, sex workers, HIV positive people.

Unfortunately, even today many countries are in fact going sometimes in the opposite direction, criminalizing and even prosecuting people with HIV. I think this really has to change the advocacy that has been demonstrated in this conference I am sure will help greatly and our next speaker is an embodiment of that leadership. Edwin Cameron is Justice of the Supreme Court of Appeal of South Africa, author of the price winning memoir Witness to AIDS in 2005. He was a Rhode scholar at Oxford University where he obtained law degrees and academic honors. He has received many honors and awards for his human rights work including work in the AIDS field. He has been living with HIV since 1986 and has been on antiretroviral therapy since 1997. He gave the key note address at the XIII International AIDS conference in Durban in 2000 which I think many of you might remember. He is very powerful and courageous and these are the words that come to our mind when thinking about Justice Cameron. And we can confidently say that he is one of the most principled and visionary thinkers and activists in the AIDS epidemic someone who we really need today. To our knowledge he is the only high-level government official in the whole of Africa that is open about his HIV status, an incredible statement of leadership and courage. Justice Cameron, please, we are really waiting to hear from you.

[Applause]

EDWIN CAMERON: Many thanks, Nafis and good morning, ladies and gentlemen. I do not think you remember yesterday

when Muralaki [misspelled?] spoke about from Africa. She said good morning and she asked you whether you heard her. Good morning, ladies and gentlemen.

AUDIENCE: Good morning.

EDWIN CAMERON: How are you?

AUDIENCE: Fine.

EDWIN CAMERON: Have you had a good conference?

AUDIENCE: Yes.

EDWIN CAMERON: Thank you very much. I appreciate that response. [Applause] I want to thank not just my co-authors, Scott Baris [misspelled?] and Micaela Clayton [misspelled?], but also Ralph Yergins [misspelled?] of the Open Society on the Initiative on this issue who has done important work contributing to my paper this morning and also Barry Howel [misspelled?] and her colleagues in the International Community of Women Living with HIV for their consultative process.

What I want to do is to ask you this morning to come on a journey with me. I want to give you information of the sort that Nafis has foreshadowed in her introduction. I want to invite you to engage your feelings about it. I want you to feel disquiet about what I am going to set up before you. But lastly, I want to take us back to what Dr. Chakaya told us, that quote from [inaudible], I want to engage your resolve to practical action today. This conference cannot just be about talking about this issue. I want us this morning to think what we are going to do constructively about it. So I want to start

by taking you to two [misspelled?] very different places, three different places on the globe and we are going to start with Texas because it is just to our north here at the bordering state, north of Mexico. Just three months ago, a homeless man was sent to jail while being arrested for drunkenly conduct. He was charged with committing a serious offense during that time. The offense was called harassing a public servant with a deadly weapon. Because of his past encounters with the law, the system ratcheted up the gravity of what he did and he ended up being sentenced to 35 years in jail. He must serve at least half of that before he can apply for parole. Well, you might say that is very sad, but what is our concern with the case? I It is this. The man had HIV. The deadly weapon he was accused of using was his saliva. He was jailed because he spat at the officers arresting him. After sentencing, Officer Wallow is reported to have said, "I know it sounds cliché, but this is why you lock someone up. Without him out there, our streets are a safer place."

Well, let us note some facts about this case. First, according to the most assured scientific knowledge we have, nearly three decades into studying this virus very closely, we know that HIV has never been shown to result in the transmission of HIV. So the deadly weapon this man was sent to jail for using was no more than a toy pistol and it was not even loaded. Ratcheting up the criminal law because the man had HIV was inappropriate, unscientific and plainly wrong.

Secondly, the length of his sentence, whatever his past conduct in resisting arrest and fighting off the law, it stuns the mind that someone who has actually not harmed anyone, who has not actually damaged any property or otherwise spoiled the world could be locked away in these circumstances for 35 years. The inference that his HIV status played a pivotal role in sending him away is unavoidable. In short, the man was punished not for what he did, but for the virus he carried.

Let me take you away from Texas to Zimbabwe, violence wracked Zimbabwe, where a 26-year-old woman from a township near Buluwayo was arrested last year. The crime was having unprotected sex with her lover. Like the homeless Texan, she too was living with HIV and the crime of which she was convicted was deliberately infecting another person. The strange thing is her lover tested negative for HIV which is hardly surprising since the woman was on successful antiretroviral therapy. Before sentencing her however, the court tried to get another HIV test from her lover and he tested negative even after that test where he reportedly did not want to proceed with the prosecution at all. She was eventually sentenced to a suspended term of five years' imprisonment. The threat of imprisonment and the shame and ordeal of conviction will continue to hang over her for the immediate future.

Let me tell you about the statute under which she was convicted because it is important to understanding what is

happening on my continent today. It is an extraordinary piece of legislation. It is not a crime under it merely for another person to infect another. It makes it a crime for anyone who realizes that there is a real risk or possibility that she might have HIV to do anything that she realizes involves the risk of infecting another person. In other words, although they call the crime deliberate transmission, this is a misnomer. You can commit the crime even if you do not transmit HIV. In fact, you can commit the crime even if you did not have HIV at all. You must merely be a risk possibility that you might transmit the virus to someone whatever your status. Stranger upon strange, the statute offers a way out to someone who really does have HIV, but because of the way it is drafted, if you do not have HIV, you cannot invoke that defense.

In short, this law creates a crime of fear, a crime of effect, not of effect and consequence, but a crime of fearful possibility. What is more, the wording of the Zimbabwe statute stretches wide enough to cover a pregnant woman who knows that she has or who fears that she may have HIV. If she does anything that involves the possibility of infecting another person, like giving birth or breastfeeding her baby, the law could make her guilty of that offense of deliberate transmission even if the baby is not infected. In all cases this Zimbabwe law prescribes imprisonment for 20 years.

The third case that I want to highlight before you is Sierra Leone in West Africa. There they have avoided subtle

lawyer's arguments like I have put out before you about the meaning of the law. They have simply enacted a statute that expressly removes all that [misspelled?] by including pregnant women in it. The Sierra Leone also criminalizes exposure to HIV even without transmission. It requires a person with HIV who I aware of the fact to take all reasonable measures and precautions to prevent the transmission to other people expressly including a pregnant woman. It requires her to take reasonable measures to prevent transmitting HIV to her fetus.

Now, ladies and gentlemen no one doubts a mother's will and duty to take reasonable steps to protect her baby, but this law will make it more difficult for her to do so. In addition, a person who has HIV who is aware of the fact must not knowingly or recklessly place another person at risk of becoming infected with HIV unless that person knew of the fact and voluntarily accepted the risk. This also applies to pregnant mothers. The provision criminalizes not merely actual transmission of HIV from mother to child, but makes it criminal of any pregnant woman who knows that she has HIV, but does not take reasonable measures to prevent transmission to her baby.

Well, I can continue giving other examples. In Egypt, men are being arrested merely for having HIV under Section 9c of the law of 1961 which criminalizes the habitual practice of debauchery. I am sure that is a term taken from the colonial time [inaudible] is the Arabic translation. It penalizes consensual homosexual conduct but it is being used this year,

ladies and gentlemen, to arrest people who test positive for HIV because the inference being made is that they have indulged in debauchery.

In Singapore, a man with HIV has been sentenced to a year in prison for exposing a sexual partner to HIV even though the sexual partner whom he fellated was at almost no risk at all of acquiring HIV from him.

In Bermuda, 10 years for a man who had sex with his girlfriend even though she was not infected and in Switzerland, the Highest Court held that a man who did not think he had HIV, but knew that a previous sexual partner had it, was liable for infecting a subsequent sexual partner for negligence.

These laws, ladies and gentlemen, are stunningly wide in their application and they are fearsome in their effects. They attack rational efforts to lessen the impact and spread of this epidemic with a sledge hammer. They represent a rash phenomenon that has taken place worldwide. In Africa, my own continent which carries the heaviest burden of HIV, at least a dozen countries have already adopted laws very similar to the law in Sierra Leone. They have done so with the joyful support of an American-funded organization, which is a grievous pity. I am glad to say that my country, South Africa, and our ambassadors here this morning, Ambassador [inaudible], I am proud to say that our country considered this under the impulse of one of the lawmakers, Johnny [inaudible] and that was turned

down. South Africa has not joined [applause] the drive to promote criminalization.

Ladies and gentlemen, these laws are creating a crisis in HIV management and prevention efforts and they constitute as Nafis said in introducing me, one of the biggest issues in the epidemic right now. We have to understand however what lies behind this drive to using the criminal law in the epidemic. HIV is a fearsome virus, we know that. Its effects are potentially deadly. Public officials want to invoke any available and effective means to counter its spread. This they think includes statutes and prosecutions targeting HIV. What is more, in the abstract and from a distance from social reality, there seems a certain justice that criminal penalty should be applied against those who negligently, recklessly or deliberately pass on the virus even when there is only a risk of that happening, not when it is effectuated. African lawmakers and policy makers in particular have reason to look for strong remedies. Many African countries face a massive epidemic with agonizing social and economic costs. All effective means including the mechanisms of the criminal law and criminal prosecutions are seen to be [inaudible].

And I want to take you to a session that we had on Wednesday here at this conference, ladies and gentlemen, where we discussed criminalization and someone from the lawyers collective in Mumba and India came to the microphone and she said that they have women who come to them reporting that they

had been infected by their husbands and they are seeking justice, they are seeking retributive access through the law. What has to understand that many lawmakers are spurred especially by the plight of women. Many including very young women are infected by unwary or unscrupulous men. Lawmakers feel that they in particular need a special protection and that a criminal statute might be useful to do this. Well that is what lies behind it. That my submission to you this morning is that these reasons are misdirected and they are bad. And I want to take you through 10 reasons why these criminal prosecutions and laws targeting HIV are so bad. We must counter them rationally, powerfully and systematically. Let us start her this morning by going through those reasons.

First, criminalization is ineffective. These laws and prosecutions do not stop the spread of HIV. In the majority of cases, the virus spreads when two people have consensual sex and neither of them knows that one of them has the virus. That will continue to happen no matter what criminal laws are enacted and no matter what criminal remedies are enforced. Criminal laws and liabilities will not stand in the way of the vast majority of HIV transmissions.

Second, criminal laws and criminal prosecutions are a shoddy and misguided substitutes for measures that really protect those at risk of contracting HIV. You have just had a presentation from Bruno in which he sets out what we really can do. These laws are a side show. We know what we need in this

epidemic and this conference has taken our knowledge further. After more than a quarter century, we know that we need effective prevention, protection against discrimination, reduced stigma, strong leadership, greater access to testing and most importantly, treatment, treatment for those who today, this morning, are unnecessarily dying of AIDS. AIDS is now medically manageable condition. It is a virus, not a crime and we must reject interventions that suggest that it is a crime.

I speak with passion about this, ladies and gentlemen, because it is nearly 11 years since I myself faced death from AIDS and was given access to life saving antiretroviral treatment and yet for all my joy in surviving for the last 11 years, I think that today in my continent, in Africa, in this hemisphere, people are dying unnecessarily of AIDS. We must focus on ending those deaths and ending stigma, on ending discrimination, on ending unnecessary suffering and on ending irrational, unhelpful and resource sapping measures like criminalization. [Applause]

For the uninfected, we need greater protection for women. We need more secure social and economic status for them, enhancing their capacity to negotiate safer sex and to protect them for predatory sexual partners. I speak of particular knowledge of that in Africa, ladies and gentlemen. When I go to meetings in my country, women stand up at meeting after meeting, black women, saying we have not got the social par to negotiate social sex, to say when we will not have sex

or to insist on using a condom. We must change the social circumstances that will empower those women to say no when they wish to and to insist on protection when they want to.

[Applause]

And this brings me to my next point, ladies and gentlemen, which is that I understand the impulse behind many of these lawmakers. Their impulse, and many of the lawmakers in Africa are men, their impulse is to protect women, but it is a grievously misguided impulse. Far from protecting women, criminalization victimized, oppresses and endangers them. In Africa, most people who know their HIV status, about 61% of the minority of Africans, a very small minority of Africans who know that they have HIV are women. This is because most testing occurs at antenatal facilities. The result is inevitably is that most of those who will be prosecuted because they know or ought to know that they have HIV will be women. You only need to look to the Zimbabwean case that I highlighted to understand this. As the International Community of Women has pointed out, in a powerful consultation process that preceded our conference, many women cannot disclose their status to their partners because they fear violent assault or being thrown out of the home. If a woman in this position continues a sexual relationship, whether consensually or not, she now risks prosecution in up to 15 African countries that have adopted the moral [misspelled?] law. This is a grievous and I believe shameful position. The material circumstances in

which these women find themselves especially in Africa make it difficult and all too often impossible for them to negotiate safer sex or to discuss HIV at all. These circumstances include subordination, economic dependence, hereditary systems and traditional systems of property that make them dependent on men so that criminal law will hit them hardest. It would expose them to assault, to ostracism and to further stigma. They will become more vulnerable to HIV, not less vulnerable.

Fourth, criminalization is often unfairly and selectively enforced. Prosecutions and laws single out already vulnerable groups like sex workers, men who have sex with men, and in European countries, black males, women who are already marginalize such as sex workers and drug users are placed at risk of further targeting by government officials and agencies under the use of these laws. It is made more acute by the fact that so far paradoxically, these laws have been very rarely applied. There has not been a rash of cases applying them. It is the mere existence which puts people at risk, but those rare prosecutions have resulted form sometimes idiosyncratic decisions by particular police officers and prosecutors. The fact is that if we leave aside cases of deliberate transmission of HIV, the behavior that is prosecuted namely sex between two consenting adults is common. I hope it is common. The prosecutions there have therefore been necessarily arbitrary. I think when a lawyer makes a joke he has to signal it more clearly, ladies and gentlemen. [Laughter] I will point it out

next time I make a joke. [Laughter] Should I do so? This lady got the joke.

Ladies and gentlemen, let me move on to the fifth issue. Criminalization, this is a delicate thing to discuss and I want to discuss it with some attempt at delicacy. It places blame on one person instead of responsibility on two [Applause] and I come from a continent, that is true, it is true that I say it from the background of a continent in which we cannot say that women are equal partners too often. Too often they are not equal partners in the transaction of sex. Nevertheless, HIV has been around for nearly three decades. For nearly three decades the universal public information message has been that no one is exempt from it. So the risk of getting HIV or any sexually transmitted infection must now be seen as an inescapable facet of sex. We cannot pretend that the person with HIV is the person who should be held responsible for introducing that risk into an otherwise safe encounter. [Applause] The risk is part of the environment and practical responsibility for safer sex rests on everyone who is able to exercise autonomy in deciding to have sex with another partner.

The person who passes on the virus may be more guilty that the person who acquires it, but criminalization unfairly and inappropriately places all the blame on the person with HIV. It is true as I have just said that the subordinate position of many women makes it impossible for them to

negotiate safer sex. When a woman has no choice about sex and gets infected, her partner unquestionably deserves blame. But the fact is that criminalization does not help that woman. It simply places that woman at greater risk of victimization. Criminalization singles out one sexual partner and too often, because of her greater vulnerability, it will be the woman. It compounds the evil of sexual subordination of women in Africa rather than combating it.

Ladies and gentlemen, six, these laws are difficult in degrading to apply, this is because they intrude on intimacy and the privacy of consensual sex. I am not talking about nonconsensual sex. If a woman is raped, the perpetrator should be prosecuted with the full might of the law. But where sex is between two consenting adult partners, the operators of proof, the necessary methodology of prosecution, they degrade the status of both parties and they debase the law. Just think of the Zimbabwean woman that I mentioned whose lover did not even want to proceed with the prosecution, whose lover was subjected to a second HIV test because the Magistrate wanted to find out if he was HIV positive when he no longer wanted to proceed. That is a blight on the law as well as a blight on HIV prevention and treatment efforts.

Where there is deliberate intention to pass on the virus and the person succeeds in passing it on, there can be no difficulty about prosecuting such a person and no objection to it, but we do not need HIV specific statutes for that. In

cases where there is no deliberate intention, the categories and distinction of the law become fuzzy. They become incapable of clear guidance either to those affected by the laws or to the prosecutors. Those laws that target reckless, or negligent or inadvertent transmission of HIV only introduce uncertainty into an area that is already difficult to police. We have an HIV epidemic because the reasonable person all too often does have unprotected sex with partners of unknown sexual history and in spite of the fact that the risks are known. That is why interventions to increase safe sex as Bruno said are so important. The potent elements of need, want, trust, passion, shame, fear, risk and heedlessness, normal and reasonable people simply do not always follow public health guidelines. With the best of intentions, they may make assumptions and avoid issues or just hope for the best. HIV is a risk, but if it is balanced in both parties' minds by the possibility of pleasure, excitement, closeness, or even material or social gain, sex will proceed. That is what most people do, ladies and gentlemen. And that is not a joke this time. But import [misspelled?] we look back with a clinical harshness of the lawyer's eye on the complexities of these transactions and I do not believe that it is proper for the law to do so. It is simply unfair to judge people particularly a moralist arbitrarily [inaudible] selected segment of the population by the legal standards of sexual behavior that bear little relation to what we do in real life.

Ladies and gentlemen, seventh, many of these laws are extremely poorly drafted. I will merely give you one example. The Sierra Leone and Kenyan laws said that you have to inform a partner in advance of any sexual contact if you have HIV, does not say what sexual contact is, is it holding hands, is it kissing, is it fondling, is it actual, any intercourse, the law does not actually say. It does not say what in advance is either. The model law would not pass muster in any constitutional state where the rule of law applies. The rule of law requires clarity in advance on the meaning of a criminal provision. We hope that there will be challenges to these laws in some of the West African countries, but in the meantime, the way that they have invoked the criminal law, I think bears a relation to the lack of clarity in their conception and the lack of public health rational for their existence. If you think purely through an intervention of this epidemic, you are going to come up with a poorly drafted statute.

Eight, ladies and gentlemen, most painfully for those of us living with HIV and tying in again with Bruno's presentation, HIV criminalization increases stigma. From the first diagnosis of AIDS 27 years ago, AIDS has carried a mountainous burden of stigma. This has been for an overriding reason which is that it is sexually transmitted. No other infectious disease is viewed with as much fear and repugnance as HIV is. Because of this, stigma lies at the heart of the experience of every person who lives with HIV. It is stigma

that I believe lies behind the enactment of these bad laws. Those laws seem attractive, but they are not prevention or treatment friendly. They are hostile to both. And this is simply because they increase stigma. They add fuel to the fires of stigma. Prosecutions for HIV transmissions and exposure and the chilling content of the laws themselves reinforce the idea of HIV as a shameful, disgraceful, unworthy condition requiring isolation and ostracism. But HIV is a virus. It is not a crime. That is an elementary and all important fact and lawmakers must not overlook it. To go back to Bruno's presentation again, the need for more and expanded diversified forms of testing, criminalization is a blatant disincentive to it. Why would a woman in Kenya want to go for an HIV test when she knows that it will expose her to seven years in jail? And yet without diagnosis, as Bruno showed us, the risk of transmission in the early stages of infection is very high and without diagnosis, even more tragically, we expose that woman to the risk of death from AIDS. The International Community of Women has rightly described these laws as a war on women, but they are a war on all people with HIV and they are an assault on civil liberties.

And this brings me to my last reason, ladies and gentlemen, which is an important point. It is about belief and it is about hope which are words all too seldom heard in this epidemic. Criminalization assumes the worst about people with HIV. And in doing so, it punishes their vulnerability. The

human rights approach assumes the best about people with HIV and it supports empowerment. The prevention of HIV is not just a technical challenge for public health. It is a challenge to all humanity to create a world in which behaving safely is truly feasible in which it is safe for both sexual partners and which it is genuinely rewarding. When condoms are available, when women have the power to use them, when those with HIV or the risk of it can get testing and treatment, when we are not afraid of stigma and ostracism, then we are far more likely to be able to act consistently for our own safety and for that of others. The global consensus on human rights and the enabling environment captures this positive vision of HIV prevention. When compared with a punitive and angry approach embodied in criminalization, that approach reemphasized this week in the UNAIDS policy brief on criminalization is now more important than ever. The principal effect of criminalization is to enhance stigma, to enhance fear, isolation, the dread of persecution and ostracism that drives people away from testing and treatment. Let us use [inaudible] this morning, in conclusion, ladies and gentlemen, to send out a firm and clear message. Criminalization is a [inaudible] for regulating HIV transmission and behavior. There is no public health rational for invoking it. The sole rational is the criminal goal of retribution and punishment which is a poor and distorted aim for public health. In other cases we are left with the sad

burdens, but also the hopeful initiatives that are available to us in this epidemic.

Let us start, each of us today, in this plenary, let us go back to our countries, let us go back to the [inaudible] quote that Jeremiah quoted. Let us do. Let us take away from this conference the start of a campaign against criminalization. Let one of the conference outcomes be a major international pushback against misguided criminal laws and prosecutions. Let us return to our countries determined to persuade lawmakers and prosecuting authorities of the folly and distraction of criminalization and let us return strengthened in our resolve to fight against stigma, against discrimination, and against criminalization in this epidemic. Thank you very much. [Applause]

SIGRUN MOGEDAL: Friends, this was a wonderful step into the next session. This conference has more than anything been about the energy and the imperative of linking up. It is appropriate that the last plenary presentation will link us to the struggle and movement for setting free women and girls for equal rights to participation, respect, contribution and choice. We all know it has been a long way here. Cairo and Beijing were highlights that for many of us generated momentum and hope. Since then it has been hard enough to maintain the gains made. HIV is now facing us with the missed opportunities, urging that we cannot afford to lose any more time. The movement for women's rights and the movement for

universal access must join hands. In this, we increasingly see that women are not just victims, men are not just problems, and this conference has dealt with many aspects of sex, power, identities and structures that are all part of overcoming gender bias to access.

Within this broad gender theme, the presentation that now will follow will focus on the feminization of the epidemic. And Zonie is very well placed to do so. Zonie was a feminist advocate with over 18 years of experience in the women's movement will speak to us about the critical importance of women's rights in the struggle against HIV. Born in El Salvador, Zonie and her family immigrated to Canada in 1984 following the start of El Salvador's civil war. Zonie soon expressed a deep interest in advocacy around issues related to youth and women. From 1993 to 1995, she served as Youth Coordinator for the NGO Forum on the UN Fourth World Conference in Beijing in a series of positions devoted to empowering women around the world.

Today, Zonie has extensive and diverse expertise with women's organizations and has worked on issues related to youth, human rights, sexual rights, reproductive health and HIV/AIDS. She recently as you may know joined the Ford Foundation as a Program Manager and previously served as a Senior Adviser for the International Women's Health Coalition. She also serves on the NGO Delegation to the UNAIDS Program Coordination Board. She has today been invited to share her

personal reflections drawing on her years of experience in the fight to make gender equality and women's empowerment an explicit part of the global response to HIV. So Zonie, we invite you to speak to us. [Applause]

ZONIBEL WOODS: Thank you, Sigrun, for that wonderful introduction. [Spanish Spoken]

Today, I would like to begin by looking back. Two years ago, at the High Level meeting on AIDS and later at the International AIDS Conference in Toronto, we heard a resounding call to address the feminization of the epidemic. Women, we were told, could no longer be excluded. Women, especially women living with HIV had to play a meaningful role in the decision making that shapes our response to HIV and AIDS. Just as important, resources had to be devoted to address the social and economic conditions that put women at risk. Like many others, I left the conference full of hope and energy.

Finally, it seemed the international community had gotten it. At long last, women and girls would matter. I left the conference thinking that we were at the verge of a major shift in the world's response to AIDS. Yet shortly thereafter, at a UN meeting on AIDS, I was shocked to find that despite the rhetoric, little was going to change. The gulf between talk and action had already taken hold. The programs and budgets that could make a difference in women's lives were still not a priority.

So what happened? How could our memory be so short and our commitments so inconsequential? It turned out that words did not meet action. Today, we have the opportunity and the responsibility to ensure that Mexico City is different, to ensure that promises lead not to more promises, but to concrete investments in women and girls that advance our fight against the disease. Let us remember the success of our struggle against HIV will not be determined by what we say in this conference, but what we do after it has ended. The true test of our commitment lies ahead. The consequences of how we act could not be more clear if we choose once again to fall short of our commitments to gender equality, we choose to ignore one of the most important drivers of the epidemic, put simple, we choose to squander our potential to make lasting change in the fight against HIV. Yet the temptation to follow the same path seems very strong. Even today and even among people firmly committed to fighting HIV, there remains a stubborn reservoir of doubt about the value of investing in women to address AIDS, so today I want to address this doubt head on.

Countless studies make one thing very clear. It is undeniable that gender inequality fuels the spread of HIV. Let me tell you how. When a woman is not free to ask her partner to use a condom, she is more vulnerable to HIV. When a girl must look to sex for pay for school or food, she is more vulnerable to HIV. When a woman does not have the right to own property or inherit it, she is more vulnerable to HIV. The

lesson could not be more urgent. When the world denies women their most basic human rights, the world is vulnerable to HIV. [Applause]

Yet today, gender inequality exists in many different forms in every single country. It exists in Canada, my home, where aboriginal women are five times more likely than other Canadian women to die of violence. It exists in Brazil, when a woman's access to sexual and reproductive health and rights is still beyond her reach. It exists in England, when women make up just 19 percent of the House of Commons. It exists in Tanzania when 19 percent of women and girls suffer from female genital mutilation. And it exists in Pakistan when women are murdered by their brothers and fathers for the sake of honor.

Far too often, gender inequality continues to shape the most basic fabric of our communities. We must stand up and say enough is enough. And while bringing an end to gender inequality is a critical goal in its own right. It also serves as an urgent and powerful strategy to address HIV. Both the declaration of commitment and the political declaration specifically recognize the promotion of women's human rights as essential to HIV efforts.

Last week, UNAIDS released the latest epidemiological update for 2008. The progress that we have made must be commended as illustrated by the number of people now able to receive treatment. But the dreadful news is that in almost every region, new infections among women, especially young

women, continue to rise. Women and girls are at risk everywhere in generalized epidemics and in concentrated epidemics. We must do more to understand and develop better responses for female sex workers, women who use drugs, transgender women, women prisoners, young women, and older women. At the same time, we cannot afford to wait until an epidemic becomes generalized to work on gender equality.

I know that you have all heard the figures this week, but they are worth repeating. Today, women account for half of all people living with HIV worldwide with more than 60 percent of new infections in Sub-Saharan Africa. In almost every region, there are increasing numbers of women becoming infected even in countries that have had successful AIDS responses such as Brazil. And in the US, black women represent 65 percent of new infections among women and are 23 times more likely to be diagnosed with HIV than white women. These numbers serve as a stark reminder of a reality that is too often ignored. Without adequate resources for programs that target women, success in the fight against HIV will never be achieved. They are also a reminder that race, class, age, disability and sexual orientation also influence the way in which HIV and AIDS impacts women. These numbers should motivate us to invest and women and reduce their vulnerability to poverty, violence, discrimination, and disease. Today, I tell you that these estimates only provide a limited picture of the challenges that we face.

Millions of women and girls that are affected by HIV are not counted in official estimates of this epidemic. This renders invisible in many ways the great toll of the epidemic on women. If only what gets measured matters, when do women count? What do these omissions say about the value we place in the girls and women who care for the sick, the grandmothers caring for their children's children, the women living with HIV who with great courage and often with little support are mothers, heads of households, farmers, income earners and health care providers. This too needs to be measured as the world seeks to understand the true impact of HIV.

At this conference, we have heard of very promising initiatives that demonstrate that it is possible to make progress with the right mix of leadership, commitment, and accountability. So how do we move forward from talk to action? The answer is not a mystery. In fact, we have been hearing it all week echoing from the voices who are fighting and living with the disease everyday. Together their experiences point to three priorities that must guide our response to HIV. First we, women and men, must confront the crisis of violence against women and girls. [Applause] Second we, women and men, must make sexual and reproductive health and rights a reality. [Applause] Finally we, and again women and men together must in invest in women's organizations so that women can participate effectively in decisions that affect their lives. [Applause]

These priorities can serve as a road map for action beginning from the first day after this conference ends. Overall, they will also contribute to the promotion and protection of the human rights of women. But make no mistake, addressing these three areas will be deeply challenging and controversial. Action requires us to confront entrenched ideas and power relations that contribute to the violation of women's human rights. Ideology must not stand in the way of evidence when it comes to public health. [Applause]

The last 25 years of fighting HIV has taught us that no biomedical intervention will succeed unless we put human rights and women's rights at the center of the response. [Applause]

The first priority confronting the crisis of violence against women cries out for immediate action. According to the World Health Organization, 1 in 3 women around the world will be raped, beaten, coerced into sex, or otherwise abused in her lifetime. Violence against women is both a cause and a consequence of women in becoming infected with HIV. This is what makes it so critical for interventions in stopping violence against women to be integrated into any response to HIV. Being HIV positive may also increase the risk of violence, stigma and discrimination. Take the example of Zambia, a country whose access to treatment has risen by 30 percent in the last year. This rise has occurred in a country with no specific law to address sexual or gender based violence. And as documented by human rights watch, Zambia is

also a country where many women find it extremely difficult to access ARV or to adhere to treatment for fear of violence from their partners or for fear of the potential loss of property. In situations like these, can providing access to treatment be divorced from ensuring women's rights? I challenge us to clearly state that the answer is no. Scaling up treatment while ignoring stigma and discrimination is a losing game. It simply does not work. I am reminded of Jaime Sepulveda's remarks on the first day of the conference when he said that good treatment programs are not just about handing out pills. It is clear that in many countries the legal and policy environment to address violence against women must be strengthened, but as we all know, this not enough. The laws need to be enforced and civil society must be able to monitor and evaluate their implementation. This what will make real difference.

The next priority also voiced by so many women at this conference and throughout the world is the urgent need to ensure full access to sexual and reproductive rights. Our governments have committed to this at countless meetings including Beijing in 1995 and Cairo in 1994. They need to be made accountable for these commitments. At this conference we have heard a clear call for these right to be an integral part of our response to HIV. We must move quickly to make this goal a reality. To reach girls and women, HIV and policies and budgets must expand access to sexual and reproductive health

services. In Mexico City, we have heard many examples of better integration between sexual and reproductive health and HIV services including safe and accessible abortion. These services can also provide male and female condoms, post exposure prophylaxis and emergency contraception. Overall, we must also ensure that sexual and reproductive health services recognize and respect the reproductive rights of women living with HIV. [Applause] Participant in the Living in 2008 Summit boldly proclaimed the right of women living with HIV to enjoy the same sexual and reproductive rights that other citizens enjoy, in short the right to decide what happens to their bodies. It is time for the global community to do the same. [Applause]

We must also invest in innovative programs that teach girls and boys how to treat each other with dignity and with respect. The call for comprehensive sexuality education at this conference is evidence that we all know that this needs to be a priority. But we must learn from our experiences to date and ensure that it provides full and accurate information about HIV. It must help young people build skills to form equal relationships, respect the right to consent in sex and marriage, respect for sexual diversity and end violence and sexual coercion. Girls deserve safe spaces, free from harassment and discrimination. They deserve alternatives to an early marriage and activities where they can build their self esteem and confidence. And boys deserve to learn to take

responsibility for their own behavior and understand that true masculinity is about respecting women and rejecting violence. [Applause]

It is also clear that we need to invest in technologies that put the power of prevention in women's hands, condoms and microbicides. This means providing equal funding for female condoms so that they are affordable and available to all women and girls. [Applause] We must make progress to ensure that the world no longer produces to our shame one female condom for every 467 male condoms. [Applause] And here I also need to raise a concern that has been voiced by many women and men this week about male circumcision. We must understand the full impact of such programs on women and ensure that male circumcision does not place women at greater risk. [Applause]

The final priority is ensuring that affected women are empowered to act as leaders in the fight against HIV and we know that they are. Sex workers are organizing everywhere to demand their rights, the right to work in an environment of safety and an environment of respect. Women living with HIV are documenting human rights violations. Young women are uniting their voices in a call for comprehensive sexuality education. But while stories of individual courage demonstrate that many women are empowered and engaged in the struggle, there are still far too many barriers that prevent women from participating meaningfully in the global response. The barriers have to do with power structures, they have to do with

money and the stubborn sexism that still refuses to see women as capable leaders.

So how do we change this? Women must have a seat at the table. No national AIDS program, no country coordinating mechanism and no AIDS organization can afford to continue to ignore the voices of women. [Applause] No one can better speak to the unique experiences and needs of women that women themselves. How can something that seems so obvious still be so elusive? We have heard this week that rhetoric must be backed with adequate funding for programs that promote women's empowerment and human rights. The reality is that funding for women's rights remains extremely inadequate. Women's rights advocates and their organizations for the most part operate with very limited resources. Organizations of women living with HIV require dedicated resources to sustain their work. [Applause] Investing in women's organizations is a key element of supporting women's leadership, but there is a lot that we do not know about the amount of resources going to gender equality within the national AIDS responses. We need not only sexist aggregated data, but we need to track how and where HIV resources are investing in women. HIV resources need to account for their investments in women and resources for gender equality must account for investments that respond to HIV. Gender equality costs money, but the lack of investment in women and girls comes at a higher social and economic cost.

Recently, the global fund has recognized that more of its resources have to reach women and girls at the country level. They have responded quickly with leadership, with resources and with a willingness to learn and adapt to the way that it does business. I commend them for this action and ask for more institutions to show the same commitment. [Applause] But it is clear that for this initiative to be successful, women's organizations will have to be engaged and they will have to be at the table in setting the country priorities. The panel that reviews proposals must understand the reality of women's lives and the leadership of the fund needs to continue to make gender equality a top priority.

Together these three goals, reducing violence, promoting sexual and reproductive health and rights and investing in women's leadership provide a plan of action for the global response to HIV. They will require a great amount of commitment, but they also offer tremendous potential for increasing our progress in this fight. What is clear is that women are an ideal urgent investment both in resources and in hope for a way out of this pandemic.

Last week, on a flight from New York to Ottawa, I met a remarkable young woman, Sophie Deni [misspelled?] who at 20 years old was among the youngest women who have climbed Everest. Over the last two years, she has climbed 12 mountains around the world. She exuded energy and an attitude of great confidence, of feeling secure in who she is and what she can

achieve. Sophie told me that her motto was "Everything is possible." Here was Sophie telling the world that she was worth investing in because she could do anything including climbing the highest mountain in the world. For many women and girls, their Everest is being able to go to school, to leave an abusive marriage, to survive rape and sexual violence and to live positively, free from stigma and discrimination. Like Sophie, these women are worth investing in because if we do, they too have a chance to do anything. [Applause]

I want to end with a quote by Beatrice Weiring [misspelled?] a strong advocate for the rights of women living with HIV and the rights of women everywhere. Beatrice says "I am often asked whether there will be a cure for HIV and AIDS and my answer is that there already is a cure. It lies in the strength of women, families, communities who support and empower each other and break the silences around AIDS and take control over their sexual lives." I also believe that the answer to AIDS lies with all of us, When our words turn into action and two years from now, when we can celebrate together the progress that we have made for the world's women. Mujeres adelante. Muchas gracias. [Applause]

[END RECORDING]