

TIME Global Health Summit
What Must We Learn From The War Against AIDS?
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Attention and dollars flow toward finding vaccines and cures for, and stemming the tide against the spread of, HIV/AIDS. Is it being well spent? What have we learned from the drug patent fights, the debate over treatment versus prevention, and the successes and failures of PEPFAR and the Global Fund? What can these lessons teach us about fighting other diseases?

Panelists:

Dr. Agnes Binagwaho, Executive Secretary, Rwanda's National Commission to Fight AIDS

Gary M. Cohen, President, BD Medical

Dr. Mark Dybul, Deputy U.S. Global AIDS Coordinator and Chief Medical Officer, Office of the U.S. Global AIDS Coordinator

Dr. Helene Gayle, Director, HIV, TB and Reproductive Health, Bill & Melinda Gates Foundation

Dr. Peter Piot, Executive Director, UNAIDS

Moderator:

Dr. Jim Yong Kim, Director, Department of HIV/AIDS, World Health Organization

At the TIME Global Health Summit, held in New York Nov. 1-3, TIME magazine convened leaders in medicine, government, business, public policy and the arts to develop actions and solutions to the world's health crises.

More information, including archived webcasts of sessions, transcripts and downloadable photos, available online at www.time.com/globalhealth.

TIME MAGAZINE PRESS CONTACTS:

Diana Pearson, Director, Public Affairs

212-522-0833

Diana_Pearson@timeinc.com

Kimberly Noel, Publicist

212-522-3651

Kimberly_Noel@timeinc.com

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EILEEN NOUGHTON: Thank you, Glenn. I have always liked Glenn Close the actress. I like Glenn Close the person even better. She is here out of the goodness of her heart. She is here because she is committed to these issues and I thank her for spending two days with us here.

A brief announcement – you were handed as you came in this morning an evaluation form. I think it is blue. Would you really pay attention to these so we would love you to fill them out and when you do so if you haven't already given us your e-mail address you can pen it in there because that would be helpful to us.

Now our next discussion to lead our next discussion it is my pleasure to introduce the Director of the Department of HIV Aids of the World Health Organization, Dr. Jim Young Kim.

JIM YOUNG KIM: Thank you very much.

Thank you, Eileen. I am very glad to be here to guide us through this important discussion. One lesson that I can't forget is that heroes never talk to five minutes. And we are going to get as much time as we possible can for this session.

We have a really terrific panel to look at the question, what have we learned from the war against aids? Are we working together as a community to stem the tide and advance the research towards the cure? Are monies being well spent? What have we learned from drug patent sites? How well is the global (INAUDIBLE) doing? What about treatment versus prevention?

I would like to ask the speakers to (INAUDIBLE), the Executive Secretary of Rwanda's National Commission to fight aids, Gary Cohen, President of Beck and Dickenson Medical, Dr. Mark Dybul is Deputy U.S. Global Aids Coordinator, Office of the U.S. Global, Aids Coordinator with the U.S., Department of State, Dr. Helene Gale, Director for HIV and Reproductive Health with the Bill and Melinda Gates Foundation and Dr. Peter Piot is Executive Director of UN Aids.

But first let's take a look at RX for Survival.

(BEGIN VIDEO CLIP)

UNIDENTIFIED: I believe that the country is going down and going down fast because there is no way you can have a 40 percent prevalence in any country and not face extinction. In 2002, (INAUDIBLE) very survival (INAUDIBLE) created MASA (ph) Africa's first national aid's treatment program.

The cornerstone free drugs for everyone who needed them. (INAUDIBLE) 33 year old Ernest (INAUDIBLE) was given the darkened task of setting up new clinics, hiring and training staff, establishing treatment policies and generally transforming this bold vision into a reality. (INAUDIBLE) streamlining (INAUDIBLE) tracking, budgeting.

UNIDENTIFIED PARTICIPANT; I hardly ever have a minute except maybe when I am deep asleep when I am not thinking about the program.

UNIDENTIFIED: I think I would, he was born in Africa and raised in America. He has an MD. He had a degree n business. He had a degree in Public Health and he got drawn into this thing by the challenge, by the fact that no one had gone at Aids in Africa before this directly.

When exactly did this arrive? This ground breaking effort received substantial support from major global health contributors. MASA quickly became the test case for fighting Aids in Africa.

UNIDENTIFIED: Even if the timing, I mean

UNIDENTIFIED: There was starting such a massive program from scratch would not be easy.

UNIDENTIFIED: Maybe a national program. I don't have a land line because the systems for me to get the phone line are quite slow and inefficient. So have to use my own personal cell phone. Now I have mentioned it to them.

UNIDENTIFIED: At every turn (INAUDIBLE) encountered bureaucratic difficulties. Nut there was another obstacle waiting for him. Even with new clinics starting to open, people were refusing to get tested. They didn't want bas news.

(END VIDEO CLIP)

JIM YOUNG KIN: Great, let's begin. We are going to ask some very basic questions. This panel is really extraordinarily distinguished with so much experience and I think we only need some very simple

questions. But let me start by asking Peter where are we Peter and what are the most important lessons in your mind that we have learned?

PETER PIOT: I think that we are still in the early phases of this epidemic from a historic perspective. That may sound very depressing but I think that is true. Certainly we are still in a very expanding phase. The epidemic has globalized. Where is the fastest spread of HIV today in the world? It is in Eastern Europe in the countries of the former Soviet Union.

It is in part of Asia, so and more and more in Central American and the Caribbean. So that is the first thing and an important lesson and that is that the epidemic continues to change every day. Secondly we are seeing a clear feminization of the epidemic. Remember when this was discovered in '81, 25 years ago nearly this was a disease of white, gay, middle class men. Today half of all people with HIV are women. They are living all over the world.

And I would say that thirdly that one of the main lessons I would say is that this is a problem with a solution. We can do something about it. Despite all the doom and gloom there are now an increasing number of positive examples. I wouldn't call them success stories but I definitely would say that we have made enormous progress certainly over the last few years and I hope to come back to that.

The last lesson for me is a double one. One is that I often get letters of people at conference like this and they come to me and say Dr. Piot if only you or the world would do this you know we would stop this epidemic. One thing I have learned is that any sentence with the word only in doesn't work for Aids, treatment only or abstinence only or condoms only, or testing only, it just doesn't work.

We need a package and that the only thing that no money can buy is leadership. That is what is making the difference all over the world. I think that is where we are.

JIM YOUNG KIM: Helene? What are some of the most important lessons that you have learned in your role both as head of CDC and now at the Gates Foundation?

HELENE GAYLE: Well I think in addition to some of the some of the things that Peter said one of the most important things I think we have learned is that we waited too long. This is an epidemic that in many ways was predictable. We made predictions early on.

We knew that it was going to get worse and we knew that with a disease that had such a long incubation period that by the time you realized the problem you were already way behind. WHO in the early '90s estimated that if we spent in the range of \$2.0 to \$3.0 billion we could have had the number of new infections by 2000?

At that time we were spending \$200 to \$300 million. Now UN Aids and WHO estimates that we need to spend \$12 billion a year to keep pace with treatment and prevention needs. But had we acted when we knew it was a problem, acted with the kind of urgency that it demanded we could have been in a very different situation now. That being said I think as Peter said there is a lot of important examples and I am sure we will get into it more.

You know I think the scale up of treatments has been tremendous. It has shown us what can be done and when you put together resources and political will. We have examples of how prevention efforts have worked. So I think we have learned some important lessons both about what we should never do again standing in the face of such an emergent issue but also what some of the ways are that we can respond and make a difference.

JIM YOUNG KIM: You know when we see the example from (INAUDIBLE) the interesting thing is it seems like ancient history. It was the first full frontal attack on HIV with treatment and prevention but Mark you are now the quarterback of a program that is in 15 countries really trying to do the same thing and in many more. It is not just the 15 (INAUDIBLE) countries. Tell us what we have learned now that we are doing the full frontal attack everywhere.

MARK DYBUL: I think the most important thing we have learned is that it can be done, that you can scale programs on national prevention, care and treatment programs and Agnes can talk about that much more eloquently than I can. But we have learned that it can be done and I think there is enormous hope in that and I think that is the second we have learned.

Hope is one of the most powerful engines in all of this and when you go to a country in six month intervals now you see a night and day change from the attitude, the energy, the hope and you say it at the local level from among the people in the villages doing the work and you see it at the national level. That is hope.

Once you have hope, you can't go back and it is extraordinary what is happening there. I would say that the other piece of the lesson is that this myth that has been portrayed not too long ago that this can't be done you know Africans can't do this is just nonsense. This is the Africans running their programs, the Caribbeans, the Asians, the (INAUDIBLE); the people on the ground don't need much.

What they need is support from us but that is all they need. They are running with this because there is hope and the third thing I would say that we have learned is that accountability matters. It matters greatly. It matters here when we are trying to convince folks that dollars can be put to good use and I think that everyone always understood that. The piece I don't think we paid much attention to and that we have learned greatly is that accountability matters in country.

That is it creates good governments. I was told by a 20 year old in (INAUDIBLE) that the program that were being supported there at the local level, the accountability, the reporting is building democracy because they are now say well if I am accountable for my Aids dollars why isn't the government accountable for me on water?

Why aren't they accountable to me on malaria? And they are pushing is accountability out and so you said you are building democracy and that is an important an incredibly important lesson we have learned, the importance of accountability in many different way.

JIM YOUNG KIM: Gary I think that we could say that in the Aids response the participation of both multinational companies and local companies, Anglo-American in Africa for example has been really extraordinary. As a representative of the private sector what do you think are the most important lessons?

GARY COHEN: Well thank you Jim. A few things I want to share. One is let me just mention that the learnings I will share are based on personal experience in the nine countries (INAUDIBLE) and Africa. And my teachers were not only leading researchers and clinicians.

But people living with Aids in families, children who have been orphaned by Aides, children who have been orphaned with themselves HIV positive and these have been lessons not only in the disease but in the fundamentals of humanity. I think we have made a lot of progress. I want to second what mark said.

The foundation has been set because it wasn't long ago that people doubted whether treatment could be administered effectively with all the sophisticated testing that surrounds it in Africa that has now been proven. So the foundation has been set but I think the reality is we have come from here to here. We have to get to here. So the question now becomes how do we make that giant leap over the company years to take the foundation that has been laid and turn it into a success in the battle against this disease.

I will point out a few things during our dialogue. But let me point out two to start. Infrastructure and capacity to deliver health care and laboratory services I personally believe is now the key gating factor. There is a need for a lot more funding but the funding can not overcome that gate. The facilities have are proving HIV treatment are bursting at the seams with people.

As recent as two weeks ago I visited some of these facilities. People are standing in the hallways all day because there is not enough capacity to deliver health care and also to deliver the appropriate laboratory

services. That has to be expanded. It is not just a matter of urgency for expanding access to treatment. There are unintended consequences that will result if we don't do this.

For example in discussions with some of the leading people in this area on the ground in Africa a few weeks ago I was sobered by the concern about massive resistance to first line drug therapy emerging because in many cases treatment is being administered without the appropriate means of monitoring the effectiveness of the treatment so this is yet another incentive to make sure that we expand these service.

Closely related to that is the need to train and protect clinicians. Ultimately it will be clinicians and healthcare givers, providers in Africa who will accomplish this mission for us. Not only are there an insufficient number of the, they are putting their won lives at risk. There are facilities that have HIV prevalence rates of 78 or 90 percent.

It is very different from the circumstances in the western world there may be a one percent reference rate and yet our health care workers are protected from blood born exposures, clinicians in Africa don't have this protection. We can't afford to have them dying off when they are trying to save other people's lives.

JIM YOUNG KIM: (INAUDIBLE), What a situation number one that we know most of us know what happened during the 1990s and yet you have built one of the most outstanding HIV treatment and prevention programs in the world. What have you learned and what would you tell this audience.

AGNES BINAGWAHO (?): I have learned a lot of things. First of all I have learned that we can actually (INAUDIBLE) if we don't go (INAUDIBLE). That mean all the sectors are affected by the disease, communities, private sectors to (INAUDIBLE) sector. So we all need them on board to (INAUDIBLE) to programs and to implement them. If one (INAUDIBLE) is not on board, we are not going to success.

The other ting I have learned is that we need ownership in our program. Like (INAUDIBLE) and support that and also (INAUDIBLE), while we success is because we have the ownership of our problem. Everything we do in the fight against Aids go in our national program. And we never have to forgot, to forget sorry for my English that HIV Aids is a (INAUDIBLE) problem. If we (INAUDIBLE) disease (INAUDIBLE) the disease only we and overshadow the other problems we will never succeed because the other problems are part of the disease, are part of the program.

(INAUDIBLE) equity, education for all, water and sanitation, that means we need to fight this disease with the vision of the (INAUDIBLE) not forget any part of that and don't leave any part of the society aside, often (INAUDIBLE) part of the population. The other thing we have learned in (INAUDIBLE) and accountability.

As community (INAUDIBLE), among the policy makers for (INAUDIBLE) but also in the (INAUDIBLE), never forgot that in this country while we have a lot of support we needs those who accountability because all this money flowing in the site. It is a lot of money. This money belongs to the work of somebody. In respect of that work we need accountability and (INAUDIBLE). I have learned a lot things but I think it will come (INAUDIBLE) discussion.

JIM YOUNG KIM: What happened to the treatment versus prevention debate? It wasn't very long ago; in fact it was only two or three years ago where we were still having a raging debate about whether we should do treatment at all. What has happened to that debate? Anyone want to, Helene.

HELENE GAYLE: Well I think it is hopefully largely disappeared. I think we recognized that it is not treatment or prevention that we need both of them. Unless we have a comprehensive response we really are not going to have really be able to have an impact. Clearly they reinforce each other. By having treatment available more people are willing to get tested because they feel an incentive to know that.

Getting tested we know can be a powerful motivator for risk reduction, safer behaviors. So we know that they are very synergistic and I think as we have gotten increased resources it has also enabled us to get out

of the stance where we are pitting one against another. Clearly when we think about the goal for treatment, three by five, we may not get to three but we know we have really massively increased access to treatment.

But we can't keep up with our treatment needs if we don't reduce the number of new infections, five million new infections occurring every year. We can not keep up with our treatment goals without also making sure that we reinforce what we are doing in prevention. We are seeing over and over again in countries where they have let down their guard around prevention rates of new infections do increase.

I think we have all seen enough to recognize that it cannot be treatment or prevention. It must be both. They reinforce each other and in the end that is how we are going to have an impact on this epidemic. I think all of the programs represented here are trying to do that in a more integrated fashion.

JIM YOUNG KIM: Peter?

PETER PIOT: Just to reinforce what Helene just said it is an example first of all of what was a dream of a few people as now common wisdom is accepted by everybody. I remember the days when in the (INAUDIBLE) needs we really had fights where we were totally isolated and were the words irresponsible.

When I would say you know treatment for all that was the most common comments that I would get from the donors particularly but also from the governments of the developing countries. So it is an illustration if we determine if we are doing the right things that we can really change policies and change practices.

Secondly I would say that I am very concerned and I am very worried today that in many cases the right emphasis on treatment is an excuse for not having to deal with the really difficult questions when it comes to Aids and that is sex and drugs, drugs not of medicines but injecting drug use and so on.

And that as Helene said in many countries what we are seeing and are monitoring of the response to the epidemic is that HIV treatment is slipping off the agenda. And I hear this even here when we talk about capacity and it is always about health systems. Health system strengthening is absolutely essential and the capacity to provide a treatment.

But that is not going to fix this epidemic. We also need capacity for prevention. This is where companies are important, the workplace, where it can be a youth movement in the media. This whole management of that capacity for prevention is extremely important and today we can really not be content with less than universal access to treatment, prevention, support for orphans.

That is the agenda for the future because we are working now more and more on the long term agenda, still managing the crisis. But if we only are going to be reactive to the crisis today we risk to be totally without any ammunition in the future. So that means investing in prevention, investing also in new technologies, (INAUDIBLE) vaccines, microbicides and I suspect we will come back to that.

JIM YOUNG KIM: Agnes (ph)?

AGNES BINAGWAHO (?): Yes, in addition of what Helene and Peter have said, there is an importance in the (INAUDIBLE) program. What we want in this disease is to break the chain of transition. And how do you want people to come and (INAUDIBLE) is if just to know that I am (INAUDIBLE) disease, go home. That means the (INAUDIBLE) and have the (INAUDIBLE) of treatment. Then we can change the behavior and even (INAUDIBLE) the people HIV positive in the prevention activities.

Treatment is absolutely necessary. Prevention is absolutely, is a necessity treatment as well. Take one and not the other, we are going to fail. We need to take both. But we need (INAUDIBLE) to keep on (INAUDIBLE) on prevention because in the future the world would not afford to put money in treatment. It is too expensive. Today prevention is expensive. We still have problem to know how to change behavior. Because we all know how we are infected, through blood transfusions, through sex commitment without protection et cetera. We know why people continue to be able to have such a behavior. This is the problem which we need to give the people the treatment if we want to break the chain of transition.

JIM YOUNG KIM: Mark

MARK DYBUL: I think it is important to note particularly around lessons learned that what the prevention versus treatment taught us is that if you ever begin an argument on HIV Aids of something versus another you have missed the boat already. There are no versus. It is not either or, it is almost always both and. It is prevention and care and treatment.

It is "A" and "B" and "C" not "A" or "B" or "C" and it is "A", , and "C" plus testing plus dealing with alcohol plus dealing with gender issues plus dealing with prevention of mother to child transmission plus dealing with safe blood plus dealing with safe medical injections. If we don't take a comprehensive approach and get away from these versus arguments we are never going to be on track. So it is I think, I hope we have learned to stay away from the versus in almost every discussion.

JIM YOUNG KIM: Let me ask another question. When you look at the data on where we are in prevention, we are just failing miserably. PMTCT, prevention of mother to child transmission which can be a very simple intervention, a single pill during labor less than eight percent of the women in the world who need that have access to it.

If you look at condom distribution, if you look at the effectiveness of our social messaging we have been failing. And at first when people said to me when we were, at Partners in Health when we were arguing for treatment to access the argument was that treatment will take attention away from prevention. But in fact there was very little attention to prevention in developing countries.

What can we do to generate the kind of pace and rhythm that we are seeing now with treatment scale up in the prevention response? Are there new things? Can we get the same kind of excitement in prevention as we have for treatment?

UNIDENTIFIED: I think that is a good point. Prevention is always and it is not just for HIV, prevention is always much more difficult to get people to rally around. It is the (INAUDIBLE) essential non- event. If something doesn't happen, it doesn't bring it to people's attention as visually.

So I think that in general it is much more harder, is much more difficult to get people to rally around prevention. And (INAUDIBLE) that prevention is also difficult in HIV because it touches again things that are difficult for people to deal with. It is much easier for most people to rally around the care of a sick person and accept that in a compassionate, humanitarian way than it is to talk about working on population (INAUDIBLE) for HIV because of sexual and drug behavior. And I think we have to accept that and I think we have to talk about that openly and honestly.

But I am encouraged that many of the same communities that developed activism around treatment are starting to also recognize the importance of raising their voices around prevention. I think as we get more communities engaged understanding the importance and the imperative of prevention, getting some of those voices to the table that we will start to see that.

But I think that we have to have an honest and open dialogue about the things that keep us from attacking preventions. It is in many ways much more difficult than tackling the issues of treatment. I think the issue of political will is clearly important. The importance of getting more communities involved, when you are talking about prevention.

This is you clearly have to get the whole community as Agnes was saying earlier engaged in this our base communities, business communities, civic leaders. Get the communities themselves engaged in this so they can take these issues on in the way that makes sense for them and again I think we will talk about it more the issues of can we expand the options for prevention as well as we look for new tools that can add to our armamentarium for prevention efforts.

JIM YOUNG KIM: Peter and then Gar.

PETER PIOT: I have many people who told me thank you doctor for saving my life because you provided this treatment. This was at a time when I was still a practicing physician. I have never, ever had anybody who told me thank you for saving my life because you gave me a condom when I needed it.

It is the same thing. It is about saving lives. That is the first point. Secondly, there are, there are programs on prevention. When you look at what is going on today in east Africa, in about all the countries in eastern Africa there is a reduction in the number of new infections on a national wide scale several countries.

Some of that is published. Some of that is still unpublished, even in Zimbabwe (ph). And it is always among young people, 15 to 24 year olds. It can't be a coincidence because it is so consistent whether it is in Uganda or in Kenya or in the capitals, I mean like in (INAUDIBLE), Zimbabwe (ph), Cambodia. It is always 15 to 24 year olds and it is always the same thing, postponement of first sexual intercourse, less partners, more condom usage.

It is not more complicated than that. So I don't think we should say as some people say that prevention of HIV infection is impossible. It is just globally we are failing and it has to go to a scale that is much bigger. The first point I would like to make is the fact that we need to make sure to work with new constituencies. There is a strong constituency for access to treatment and that is why today access to treatment is only a (INAUDIBLE) like the work in South Africa effect. I mean that will be a prime example I think of political action that lent to societal change.

The same thing happened basically in the northland countries at least in this country. Where is that constituency for prevention? I think there we need to broaden the front. If we only have this discussion among Aids experts who want to be very pure and don't reach out to other people with whom we may not agree on everything, on 100 percent.

Let's work together with everybody who agrees on a common minimum program which includes respect for human rights, gender and so on and a certain number of basic principles and then move on together. And come up with a broad spectrum of options and make sure that permeates throughout society.

So I think this constituency building in addition to let's say better packaging of the message is very key. But again I am very worried that often the discussion on floor like this are all on ok how can we train medical doctors, nurses, the health system is extremely important but pretty useless when it comes to HIV prevention. Then journalists and priests and so on are far more important.

UNIDENTIFIED: Let me just, I just want to say one other (INAUDIBLE) that Peter reminded me of when he was talking about scale up. I think we also tend to think that prevention is cheap. I think people think that prevention is handing out leaflets and that you can do it inexpensively. Prevention is labor intensive and costs and apart of the reasons that we have failed is that we have not scaled up our prevention efforts anywhere.

As you said one in five people who are at risk don't have access to prevention services across the board which includes education but it also includes the provision of commodities like condoms, treatment of STDs, services like access to testing and so, and it takes a wide range of people being engaged to reinforce the behavior change.

So I think one of the biggest lessons is that we have not put the resources into prevention that we need and we have great pilot programs but we have not scaled up at a national level other than in a few examples.

JIM YOUNG KIM: Gary?

GARY COHEN: I will just comment briefly that first I think it is very fortunate we are beyond the argument of prevention versus treatment. I think that has been one of the accomplishments of recent years. For prevention we are dealing beyond provision of medical services and treatment.

We are dealing with human behavior and social norms that require leadership. I think that we need to depend on effective leadership particularly in the countries affected to send a clear example that can ultimately have impact on human behavior and social norms. It is not easy but it is possible. I will use, it is not a great analogy but let me share an analogy. 20 years ago this city had a high crime rate, was filthy, was filled with graffiti and you couldn't drive into the city without having your window washed by a dirty rag.

That changed completely over a ten year period. Some of it was economically driven but it was also driven by leadership that changed human behavior and social norms. It is feasible to do so. It may require accessing some expertise that is different from the type of expertise that has been deployed against this disease to date.

It will ultimately happen because in some region in Africa, in some areas the HIV prevalence rate among women of child bearing age or young women is over 50 percent. At some point when all the women who we all depend on are wiped out things will change. The key is we can't let it get to that point.

JIM YOUNG KIM: Agnes (ph).

AGNES BINAGWAHO: (INAUDIBLE), really prevention is a (INAUDIBLE) today, (INAUDIBLE) things to do. And we start with education of children and to see that access of prevention at that time because you have to change the future. Even for leadership, a lot of leaders want to help in the fight against HIV Aids. But most of them don't know how to think about it.

They are afraid I am going to talk about sex and I will be quoted in the newspaper et cetera. People are stuck how to vote, how to say, how to act and I think this is the next battle we have to do because the (INAUDIBLE) talk about prevention are not well done.

JIM YOUNG KIM: Mark, let me ask you a question you can (INAUDIBLE) if you like but the question for you is do we have the right target in prevention? You know you guys were the first to set a prevention target that was concrete and had a time limit which we thought was fantastic.

Now it turns out it is difficult to measure infections averted but other targets I am very encourage by what I see in (INAUDIBLE) where the minister has agreed to offer a test to every person there. It seems to me that that gives us some pace and rhythm on World Aid's Day he is going to announce what it is going to take. You have to have many more DCT workers, many more prevention workers.

He is going to go door to door to offer people a test and it may be the first conversation that any of these households have about preventing HIV. What, how can we make targets work for us and do we have the right ones? Again back to the question, where is the pace and rhythm in the response? WE always say it has to be multi (INAUDIBLE). We always say that. But where is the drive going to come from?

MARK DYBUL: I think it is a great question and really relates to your last question and what everyone said. At the risk of at meetings like this where everyone just repeats what everyone says I do think we need to put a point on why it is so difficult. Setting the targets is critical. You know the seven million was really a 60 percent reduction in the projected rate that is a pretty reasonable target.

60 percent reduction over a five year period in the projected rate and if we can get to those types of targets I think we will and you now there are data that suggests we can get there. So, the difficult is and I think one of the reasons that treatment has been so attractive is not just because we weren't doing it before because it is relatively easy.

We know how to do it. Prevention is a fundamentally different thing. One thing we have learned is awareness does not lead to behavior change. We this in our own country in heart disease and diabetes and everything else, being aware of HIV doesn't lead to the behavior change. So get to these door to door hand to hand combat, you know we have 90 percent awareness about aids in some of these countries now.

It is how do you move to behavior change? These door to door thing can be very effective. In Uganda we supported the Ugandans government to do a district wide door to door counseling and testing effort. There was 94 percent uptake in an entire district, 94 percent uptake. The identified kids who were infected, the homes and it was the reverse of stigma.

Everyone thought oh this would be stigmatizing. It was just the opposite. Everyone n the district had someone go into their home, do a lipid (ph) test. The only people who know the results are the people sitting in the home. Everyone knows everyone got tested. They don't as opposed to walking into a clinic and people can see you walking into the clinic. AT the same time you do test, you do the behavior change messages.

You talk about how you protect yourself. One of the most important things we need to do is behavior change within HIV positives. Every time someone comes into clinic there should be behavior change activity. Only an HIV infected person can transmit the virus which leads to the needs for care.

So unfortunately unlike treatment it is a whole array of things and if we don't do these door to door person to person behavior change leadership is important but it really gets lower and lower and it has to be very different. I know the Minister of Health from Mozambique is here. He told us once that in Mozambique in one of the, in each community there is a though leader. In fact it can be an Auntie.

It can be a Chief. It can be a traditional healer. It is different in every community. If you don't get to those people, if you don't get to that behavior change thought leader you can do all the posters you want. So it really is getting to know the communities and leading to behavior change.

UNIDENTIFIED: I think it is as if for years we really haven't believed what we said that prevention can work because we have never really rolled it out at this scale that could make a difference. So we have to far more ambitious. I mean look for example, we all know that mobile population, mobile men truck drivers and so on are at very high risk, very vulnerable to HIV infection in their communities. You know one of the best projects now in the world I think is in India.

I mean the National Aids Program is supported from Gates where for the first time you know it goes to where the problem is. It doesn't wait until people come to the clinic or whatever. Working with the truck drivers, applying the principles like (INAUDIBLE) said, working with the people who are affected and I think that will have results because the coverage, the reach is enormous.

But most of the time we say there is a failure because on the base of a little project here a little project there, what do we expect that is going to make a difference? No.

JIM YOUNG KIM: Let me, there is no time limit here so we are just gong to keep going but we have some great people in the audience and I want to get the audience involved now. Vecky Okma (ph) is a TIME hero and one of my heroes. Vecky was one of the leaders in the treatment action campaign in South Africa.

He refused to take (INAUDIBLE) until they were available to everyone. Surely he has some thoughts on the discussion and I invite him to make a comment or to ask a question.

VECKY OKMA (ph): Thank you Jim. I didn't expect to, I want to say I probably agree with most of the things said there but I want to point to some of the possibilities and some of the difficulties. First to some of the possibilities, I agree with Peter that we really need to develop a minimum program of everyone agreeing around issues of prevention, treatment and care.

And that is very simple for all of us that is we accept the fact that everyone has the right to life, to dignity, to (INAUDIBLE) and above all to health care access and so on then that becomes a global public good which of course is enshrined in all our universal declarations, our treaties and declarations.

And I think that it is critical that we have a common minimum program around which business, government, labor, (INAUDIBLE) everyone can agree on but all communities can understand. So that

could be the first thing. I have some difficulties on questions around what is happening in governance in HIV.

Mark mentioned the issuance of governance in a positive example. I want to give you some bad examples. In our country in South Africa for instance our (INAUDIBLE) control counsel seriously undermines by denialism. In different ways our institutions are undermined. But about all it is a possibility that institution (INAUDIBLE).

If you take a 12 percent (INAUDIBLE) among our teachers with 50 percent of those who are HIV positive having (INAUDIBLE) counts below 200 which means they were three to four years with treatment. That means a serious undermining of systems not health care systems but a broader institution building education and so on. So those are some of the things that I really want us to also look at. In addition to which on the issue of prevention and I think it is very, very complex but at the same time it requires both an emergency response and the emergency response needs to be to scale up the access to the tools we have, mother to child prevention, clean needles, methadone, very simple things but also understanding that in the long term there is a human rights and a development agenda.

The human rights agenda clearly has to be around the issues of gender equality, but also in Africa something which we scare to talk about, men who have sex with men. I think it is really critical that we do that. Then I want to come finally to the question of linking institutions, denialism, institutional (INAUDIBLE) governance and denialism and for me that is critical around obviously you have strong, powerful regional country, countries like Kenya, Nigeria, South Africa, Ethiopia possibly.

Those countries lead the smaller countries around us, we will survive. But let's take example of South Africa. South Africa is a very strong country in the region. You have around us three smaller countries with much bigger problems; (INAUDIBLE) always from the remarkably with international assistance. But in the long term the program has to be sustainable. So the question how do we maintain the sustainability of programs like (INAUDIBLE)?

The second thing is if you look at (INAUDIBLE) in the (INAUDIBLE) and (INAUDIBLE) focus on (INAUDIBLE) but I want to raise the difficult questions are a country like (INAUDIBLE). South Africa is the place where most people from (INAUDIBLE) work and that is where most people in (INAUDIBLE) in Mozambique get infected and then they go home.

But no one in South Africa and not our businesses for whom most of those people work nor our government accept any degree of responsibility for assisting with the building of the human resources and of the institutions in (INAUDIBLE). I have spoken too much but I want to raise those difficult questions. I really think are some of the things that we need to engage in and I think critical to this.

There is no way that we can sustain the epidemic if we don't deal with prevention. We have 500,000 new infections in our country last year. That means for an individual there is illness, for a family there is loss and about all for the economy and for the community there is entire loss. So I want to emphasize that it is critical that we deal with prevention. So you have.

JIM YOUNG KIM: But how do we sustain the response? Peter?

PETER PIOT: Well I think there are several ways. First of all we need results. We need results for sustainability of funding. We need results for the people and the accountability is both to the people in the first place and to the one who give money.

Secondly we need to make sure that the leadership continues and that is why I insist so much on this very strong the common minimum program. That is going to be for the long term sustainability. Thirdly, let's not forget the investments we need in R&D, the vaccines and all that. I will stop here because I want.

JIM YOUNG KIM: Mark?

MARK DYBUL: Yes, I would just like to say on the sustainability because (INAUDIBLE) raises a couple of time. I am a firm believer in the 90 percent rule. 90 percent of people agree on most things. I mean there are very few people who think a ten year old should get anything other than abstinence and there are very few people who believe that someone who has decided with information to be sexually active should not get a condom.

On most of these issues 90 percent of the people will agree. The problem is we wind up arguing the five percent and shooting arrows at each other all the time instead of forcing that 90 percent (INAUDIBLE) that's on prevention, care and treatment. It is sustaining dollars. It is doing all of that. If we don't keep everyone going in the same direction, keeping the targets in the 90 percent range we are going to get into trouble. That is what we are going to need to do to sustain.

JIM YOUNG KIM: The wrap sign has gone up unbelievably.

UNIDENTIFIED: Yes, just quickly on sustainability, first I think we have to recognize that this is a long term commitment and we have to be willing and ready as a world community to keep resources ongoing for the foreseeable future especially with the commitment that we have made for putting people on treatment which is life long treatment.

That being said, I think the best way to make this sustainable is to make sure that it gets integrated into the health system. We can't continue to see this as an Aids only issue. We have to figure out how to better integrate it with other health issues and have a long term commitment to building health infrastructures that will also help with the sustainability.

JIM YOUNG KIM: We have to wrap up so I am going to take the moderator's prerogative to just say a few words. First, I was on the Advisory Board of the TIME Summit. I want to thank the people at TIME and say that I think there are three points to this meeting that you have heard today in the panel.

The first is that TIME Magazine has made it clear that knowing about and caring about global health is part of the citizenship test for being on the planet. I thank them for that; they have really put it in the forefront. But I hope what you get out of what we are talking about and what you heard today is that global health is really fun. It is fascinating. It is exhilarating.

You know treatment we know is not rocket science. But prevention is rocket science. If we can solve this problem of how to get people in casual sex to use condoms in Africa, wow, that would be like going to the moon I would think and worthy of the challenge.

But the great thing about global health too is that it will break your heart. It will break your heart and it just might fracture your soul enough so that you become a better person. I know that every time I go and visit projects I feel like I am a little bit better person.

Finally I think what the TIME folks have been trying to say is that you can make a difference right. Now, where is the energy going to come from in making sure that funding is there for the prevention that we need to do to really save a huge chunk of Southern Africa from dying from Aids?

The economists said that there was an article that was entitled "(INAUDIBLE) Land, Will it be the First Country to Die of Aids?" (INAUDIBLE), are all at risk and maybe South Africa as well. So thank you everybody. Excuse me for taking the last word. We, this has been far too short. We could have gone on forever. Thanks to all our panelists.

UNIDENTIFIED: Ladies and gentlemen please be back at 10:00 a.m. The session will promptly start at 10:00 a.m.

END

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