Plenary: Dynamics of the Epidemic in Context
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FEMALE SPEAKER: Please welcome Craig McClure, Chief of HIV/AIDS Program at UNICEF [applause].

CRAIG MCCLURE: Fantastic. Ending AIDS will require the scale up of what we know works. The basic programmatic activities of condom promotion and distribution, male circumcision, treatment, including what we've called up till now PMTCT to protect health, and to prevent transmission. Targeted approaches for key populations, including harm reduction for people who use drugs and behavior change, communication, and education that works.

The scale up and the impact of these basic activities cannot be optimized without laws, policies, and program that protect the rights and ensure the access and full and meaningful participation of sex workers [applause]. Women, men, transgender sex workers, girls, and boys, gay, straight, and bisexual, sex workers with disabilities, sex workers who use drugs, and sex workers living with HIV. It is an honor to introduce a woman who has devoted close to 30 years to this issue. Cheryl, it's a pleasure to see you here [applause].

Cheryl Overs founded a sex worker organization with pioneered harm reduction, rights advocacy, and peer education in Melbourne in the early 80s, when HIV was identified she served as advisor to the Global Program on AIDS, before establishing the Global Network of Sex Work Projects in 1992 [applause]. Since then she has worked in HIV policy and

programming for male, female, and transgender sex workers in more than 20 developing countries.

Cheryl is Senior Research Fellow at the Michael Kirby Centre for Public Health and Human Rights at Monash University in Melbourne, and a Visiting Fellow at the Institute of Development Studies UK. She's also a member of the Technical Advisory Group of the Global Commission on HIV and the Law. Her current work includes supervising an online resource center on sex work, a study of the impact of law on sex workers, and establishing a legal service for sex workers in Cambodia.

As well as academic publications, Cheryl has written several key resources on sex work and HIV, including Understanding Sex Work, Sex Work and the New Era of HIV Prevention and Care, and most recently, Only Rights Can Stop the Wrongs. Cheryl Overs, welcome [applause].

CHERYL OVERS: Good morning, everybody. I hope you're not bored at all with the tide [inaudible], yes, because you're going to get some more of it [laughter].

Just like in a real tide there are many waves that make up the metaphoric tide that we're here to talk about turning, and as my reduction from Craig explained, my place in the metaphor is on a beach, and these are some of the waves washing up where we sit on the beach, under the red umbrella of the sex workers right movement [applause].

I'm going to talk about why involving and empowering sex workers is crucial to turning that tide. The first thing to say is that the waves are interconnected, so there's no selecting which waves to turn back. The need for integrated approach that address human rights, and social and economic issues, as well as public health, has been stressed throughout the epidemic. And this is particularly important at AIDS 2002, which is the conference at the dawn of the new era of prevention, Justice Durban was the conference at the dawn of the new era of treatment.

The new era of treatment as prevention, antiretroviral based microbicides and pre-exposure prophylaxis has been rightly described by Michele Sidibe as game changing. And the optimism at this conference is palpable. Millie Katana has summed up that the world, especially the women folk are desperate for technology that will put the powers of preventing HIV in the hands of women, but alongside that hope is tension, between those who want to shift resources away from education and community responses, to biomedical approaches and those who don't.

The Robert Carr Doctrine warns that scientific advances will be wasted when people are denied access to services or they can't access them safely. Some of us are asking is there really a product or a medicine that can change the power of balance between sex workers and their clients. Will champions

of medical prevention being community mobilization, and social and educational planning, and policy advocacy to of failed as the *Lancet* editorialized last year.

The *Lancet's* made its position clear, and now there's talk about avoiding the dilemma by saying that we need to do both, and that sounds pretty good, but then others tell us that there's not money to do both. I don't know which of those is true, but what I do know is that around sex work, law reform and much better planning will be needed if these technologies are going to live up to their epidemic ending potential [applause].

The risk of sex workers of all genders will be enormous if condoms are replaced by partially effective HIV methods that don't protect against STIs or unwanted pregnancies. I mean it's good to talk about an extra tool in the prevention tool kit, but it doesn't all easily on sex workers ears that they're still going to have to get their clients to use condoms. Sex workers know their clients and they know that there will be increased demand for condomless sex. Clients are already talking on the internet how about the new HIV pill is going to liberate them from rubber.

Sex workers also understand that they work in an industry. Like all business market forces and workplace practices play a far greater role in determining what happens than the negotiation between individuals, and they also know

that just as it was for the old prevention methods the cost and the responsibility for the new methods will be on them, not on their clients. When peer educators hear about the new technologies they immediately realize that they're going to have to learn to share very new, and very complex information, including with clients, who have consistently proven to be one of the most difficult populations to convince throughout the epidemic, and I do mean convince there, they're not hard to reach. I'm sure I'm reaching hundreds in this very room right now [applause].

Everybody's concerned about cost. Even if HIV prevention is subsidized, the overall price of the tool kit that sex workers will need to manage their sexual and reproductive health will rise. Of course HIV testing is more important than ever, because ARVs is either as treatment or prevention can only be used by people who know their status. The sex workers taking the HIV test remains flawed, with the risk of violence, discrimination, lack of access to treatment, and importantly loss of lively hood.

Cost is a factor here too, because even if the testing is free, the bus to get to it probably isn't, and time away from work costs money. An instant HIV test might be seen as a solution by some, but on the spot testing in the street, or the brothel, or the police station raises predictable fritz to both public health and human rights.

Sex workers can't expect confidentiality of HIV test results still. HIV test results can and do lead to criminal prosecutions of sex workers in several states of the United States, and the misdemeanor of prostitution becomes a felony if the person selling sex is also living with HIV. Positive results are often shared with brothel, authorities, and even the public.

One particularly outrageous example is when authorities post photographs of HIV positive sex workers on the internet in some kind of misguided attempt at HIV prevention. In many place some sex workers are already subject to punishment if they don't submit to medical procedures, so it's not unreasonable that HIV testing and medical prevention could be thrust on sex workers in this way, or that health services could only be provided to sex workers who agree to the testing.

Now, I haven't raised these issues about new prevention technologies to suggest that they can't work for sex workers. I raised them to illustrate that they create challenges that can't be solved without strong inputs from sex worker advocates, and to underline the fact that the fewer rights sex workers have, the less chance we have of these new scientific developments being successful, as Peter Piot pointed out.

The epidemic is not driven by the lack of a pill or a gadget, the epidemic is driven by repression [applause], and this brings me to law and policy. Sex workers from Sweden to

Singapore to Swaziland all say that the greatest threat to their health and human rights is the law that makes it impossible to find safe places to work, and prevents them from having the in protections as other workers and other citizens.

Conference delegates will have by now seeing the red umbrellas waving, and heard sex workers demanding de-criminalization, highlighting violencing, and condemning the United States anti-prostitution pledge, but perhaps the greatest rage is against the distorted accounts of exploitation and human trafficking, that are used to justify increasingly repressive laws and violent raids [applause].

I'd like to show you what a so called rescue looks like from a mobile phone of a sex worker. [Video Played]

This illustrates what sex workers are talking about when they say save us from saviors [applause], and you know even without violent raids like that the criminal law shapes the sex industry. It creates workplaces that are so inherently dangerous that the workers in them can't be made safe by any pill, or any gadget, or any service. These are some imagines for me to leave that struck me as an unambiguous illustration of that.

No one could mistake this for a safe place to work in any sense, and the used condoms everywhere certainly doesn't mean that every act was risk free. Any HIV positive woman here

is probably amongst the least likely people in Europe to access HIV care, let alone any other sort of healthcare.

Look, these women shouldn't be there, that's clear to everybody, but everybody wants them taken somewhere different, a village, a university, a beauty parlor, a prison cell, or a place where sex can be sold legally, and no doubt the various women there would chose didn't options if they were ever given a choice, even the jail option might be chosen if anybody is being held against their will.

The point is that while migrant sex workers are deprived of rights and the law prohibits legal places to sell sex, these mattresses will stay in these bushes, and no amount of feel good stories about individual women being saved is going to change that, so while other moralize and theorize the only removal that's actually likely to happen here is police action that will send the workers fleeing, they'll be deported, and the whole thing will be banished to an even more dangerous place. We don't need a legal framework that aims to get prevention services to sex workers in dangerous places. We need a law that gets commercial sex out of dangerous places and into safe ones [applause].

For decades the sex workers rights movements been saying that the way to do that is to make sex work completely legal, and to govern it with the same nix of regulations,

labor, and criminal law that apply to other workers and other businesses.

Recently the Global Commission on HIV and the law agreed with this, they recommended to repeal the laws against consenting adult sex, to stop harassing sex workers, prohibit mandatory testing, and to look at taking complimentary legal measures to ensure safe conditions for sex worker, but you know what at the same time, it's inevitable that the word de-criminalization scares some governments, so we need strategies that don't set of moral panics.

We've heard many examples of this here, including prosecuting violence against sex workers, ending arbitrary detention, issuing sex workers national identity cards or passports, and stocking the condoms as evidence, ridiculousness. In the UK the government is backing an initiative that's called the Mugs Game Scheme that will distributes information about violent clients and other sex workers, and legal services and courts are playing a role too.

There have been some important court decisions that render sex workers eligible for services and legal protections. Smart action and policy like this is cost effective, especially where the decision is only to stop doing something, that's free. Conference speakers usually make a case that there constituency deserves a bigger slice of the resource pie, and that barely needs to be said for sex work, where clearly

allocation is dis-appropriately low. This painting by sex work is for the Global Fund carries an important message about better use of resources. Sex workers deliver value for money, and we created the slogan, sex work is part of the solution, to emphasis sex workers roll in the response.

Empowered sex worker communities have resisted not just risky sex, but violent police and thugs, loan sharks, child abusers, drug dealers, missionaries, traffickers, quacks, and everybody else who comes to take advantage of their lack of protection.

Individual sex workers have proven that they can be far more than underpaid peer educators and survey respondents. They can be policy makers, program managers, researchers, and they can operate credit cooperatives and conduct campaigns against violence, child abuse, and exploitation. Over the years we've developed a series of stories about these that you can see in the making sex work safe collection on the NSWP website, and this is one from the Dominican Republic. It better play this time. [Video played] [applause] Mundane organizations like it have been extremely successful.

In the sex workers rights movement we never had any doubt that the largest declines in HIV and STIs would be achieved by programs that fully involved sex workers and addressed clients. The Global Program on AIDS drew that conclusion in 1991 with the scant data available at the time,

and now extensive analysis of contemporary data reaches the same conclusion.

The folks from Johns Hopkins will be presenting on that this afternoon, I think. Never the less, clients continue to be largely ignored and almost all HIV funding is channeled through agencies who established the style, and the content, and the personnel of programs.

It's in this context that I want to recall the words of my friend and colleague, Elena Hanga, coordinator of RedTraSex, the Latin American Network of Sex Workers. At AIDS 2008 in Mexico, she challenges donors to resources and therefore power directly to sex workers. I conclude in her spirit with my list of targeted messages, beginning with those for donors and program planners.

We need more support for educational, social and structural programs now, now more than ever. If those resources are decreased, the new prevention technologies will fail and they may even cause harm. Stop wasting money on programs that sex workers are telling you don't work.

Far too much is spent on useless stuff; rehabilitation is one example, but there's plenty more and if you'd like to hear more about that speak to any of the sex workers here. To researchers and the organizations rolling out the new prevention technologies, you must engage with sex workers as advocates, not just to survey respondents. [Applause]. You

need to focus more on the challenges in the broader environment of sex work, not just getting the products to sex workers.

To the U.N. and to the international agencies, how many sex workers does your agency employ? How many have been on your board? If the answer, none, you need to change it. [Applause]. We hear a lot about evidence-based programming with HIV programming and anti-trafficking programming on facts. We need facts. Sex workers have those facts, not moralists and fanatics. [Applause].

Support meaningful participation. Sex workers need space to grow organically as a movement. It's great to be invited to your meetings and consultations, but not just if the participation is just tokenism that serves the interests of others. [Applause]. Sex workers need to occupy some uninvited spaces. We need tidy advocacy like this and like this woman speaking at a very high level meeting of the UN, we also we need messy activism and we need space for that. [Applause].

To everybody, stop the moralizing and the theorizing. Include sex workers in all communities. Sex workers are only people, as Craig said, they might be young, they might be old, they might be migrant, they might be indigenous, they might be religious or atheists, gay or straight. Some are dull, some are interesting, but they don't always want or need to be a separate community or group. Communities exist in real life,

not as epidemiological categories configured around HIV funding. So include sex workers in all communities.

Look, don't buy into this business about diverting sources from social and behavioral programs to medical prevention. They're talking code. [Applause]. To governments, perhaps the most important, make sex work legal, obviously; some countries have no excuse not to do that immediately. Criminalize real crime, not sex or HIV. [Applause]. Don't push medical procedures on sex workers, it violates human rights, costs more and creates gaps through which the most vulnerable fall.

To the United States government in particular, I'll just go through a couple there: repeal the PEPFAR anti-prostitution pledge, change your policy on trafficking, it currently misses the real abusers. It fails the genuinely help abused and it increases HIV.

Thirdly, thank you for correctly assessing me as a person worthy of entering the country, but no thanks for excluding my friends. Revise the immigration law to allow sex workers to enter the U.S. It's ridiculous that we're here talking about turning the tide together while sex workers and drug users are prohibited from the conference and are watching from Keeockokasha [misspelled?] in Kiev. This contravenes everything that has ever been said about HIV and human rights. Sorry, I'm done right now. One second longer.

Thanks to my fellow seafarers and lifesavers and in particular to the IAS staff who have been absolutely wonderful and particularly to Bebe Loff, my co-author, the first person whoever mentioned the idea of sex workers' rights to me when I was 18 years-old. Happy birthday too, Bebe! To the NSWP, there's the Network address, you can see it all there.

Finally, I just want to pay tribute to two great Americans, Norma Jean Almodovar, as a sex worker activist who was jailed in California after exposing police corruption, and Carol Lee, who's here in the audience, the woman who invented the term, 'sex worker', and in doing so, who illuminated the path to the solution. Sex work is work. Thank you very much. [Applause].

FEMALE SPEAKER: Please welcome Marine Buissonniere, the director of the Open Society Public Health Program.

MARINE BUISSONNIERE: Ladies and gentlemen, it is my great pleasure to introduce you, Ms. Debbie McMillan. I can definitively say that this conference would be greatly diminished without Debbie on this very stage. Debbie is passionate about her. She deeply cares about the issues that African American transgender face. As an employee of Transgender Health Empowerment, she works with people with high risk infections and STIs for the dual prevention plans, to counsel and connect them to care and social services.

Born and raised in Washington DC, educated in DC's public school and currently an undergraduate of the University of the District of Columbia, where she sits on the dean's list, Debbie speaks for the residents of the city. Not the politicians and lobbyists, the people at the frontline of the AIDS epidemics, those who suffer from criminalization, racism and poverty every day. As someone who once was in jail, Debbie speaks for incarcerated people all over the world. People are as much a part of the solution as all of us here.

As a former sex worker and drug user, Debbie speaks for the thousands of people who have been excluded from this conference by immigration laws barring sex workers and people who use drugs for eligibility to get US visas. In solidarity and if you have not done so, please don your crown and your green headbands.

In the response to HIV, we need more organization and people like Debbie, people that stand for human rights, to equality, to bodily integrity and to freedom from punishment for who they are. I hope that the sex workers and the people who use drugs who have been restricted from attending this conference, including those who run the Sex Worker Freedom Festival in Calcutta India, see Debbie on the stage, someone who is not on the outside looking in, but is right up here where she belongs. [Applause]. Please join me in welcoming Ms. Debbie McMillan.

DEBBIE MCMILLAN: Good morning and thank you all for being here. Before I give my presentation, I'd like to invite you to watch messages from my peers around the world. [Video. Applause].

Welcome to the United State. We've missed you for the last 22 years. I want to especially thank the IAS for giving me this opportunity to speak to you all. It's a privilege.

Who am I? Like most people, the sum of who I am is much more than my individual traits, however, there are facts that categorize as high risk in the HIV world. I am African American, I'm a transgender woman, I used to be a drug user, I used to be a sex worker, I used to be incarcerated. For 20 years, I lived a life that virtually guaranteed that I would contract HIV. That should mean that I was then or am now irrelevant. [Applause].

That would gravely underestimate me and there's an opportunity to address HIV. I'm here today because I represent people at the heart of the AIDS crisis, a small group with a big problem. If this is true, then it should be equally true that the solution lies with people like me. When people like me are included in the design and policy and programming, these programs are much more successful, they are much less so when we are not consulted.

While everyone in high risk populations that I represent are individuals with their own set of circumstances,

broaden the lines of my story are not uncommon. I went to the street alone at 14. It seemed the only place for someone like me. I became a commercial sex worker because I believed that was the only occupation for someone like me. I got high to dull the reality of the things I had to do to survive that life.

My addiction to drugs took me to places that I never want to go back to. Crack smokers, my drug of choice when I was using, are three times more likely to be infected than non-smokers. For many years, injecting drug use directly and indirectly account for more than one third of AIDS cases in the United States. Clean syringes are an essential competent to the prevention of HIV in injection drug users. Research consistently demonstrates the effectiveness of syringe exchange in preventing transmission. [Applause].

Syringe exchange programs are prohibited from receiving federal funds in the United States. In fact, Congress just last year re-established that funding ban. Chris Collins of the Foundation of AIDS Research calls that decision anti-science, anti-public health. [Applause].

I don't need research to know that this is true. I've seen it myself, both on the street and later when I worked with HIPS, an organization that provides syringes, clean syringes to other sex workers and other services. Drug use and sex work go together like power and money. You can have one without the

other, but it doesn't happen often and it didn't happen with me.

It's hard to get good data on the rate of HIV among sex workers, but I can tell you that out there, infection is considered inevitable. Having HIV sex workers further into the shadows, further into depression, despair and leads to more drug use. In this country, drug use and sex work are crimes themselves. No matter how risky life is on the outside, being in prison is worse. After one of many arrests for prostitution, I was sent to a men's prison. I was housed in the wing with murderers and rapists. I'm sure you can guess what happened. Nothing is gained by describing those details.

I could have gotten HIV anywhere, but I'm convinced I got it in prison. Americans are sent to prison every day just for using drugs. In fact, the United States incarcerates more of its citizens than any other country on the planet. This ensures that we get multiple public health problems instead of just one.

Instead of helping users identify and decrease risk behavior, the American legal punishes them in a way that significantly increase the chances of HIV infection. If you really look hard at drug addiction, you will see that it's just a symptom. For me, it was the stigma I experienced for most of my life as a transgendered woman. Data isn't uniformly for transgendered populations, so we don't know how many of us in

the United States are infected with HIV, what data there is, indicates high rates.

My mother, an IV drug user and a sex worker, left me with my grandmother. For some, my mother represents everything that's wrong with America, someone who could have risen above her circumstances, stayed in school, but chose a life of drugs and prostitution. For some, she represents the failure of society to take care of the most vulnerable among us. To me, my mother was the only person who ever completely accepted me as I am. [Applause].

I like my mother. My father disowned me when it became clear that my sexual identity was not what he thought it should be. On the street, I looked for acceptance, a family, a man who would give me what my father never did. At some point, my mother was infected with HIV, while she was still alive and living with my grandmother, she had one cup, one fork, one spoon, one plate.

When she used the bathroom, my grandmother followed behind her, bleaching everything she touched. During one of my incarcerations for solicitation, my mother died of complications of AIDS. I had to view my mother's body alone in shackles and handcuffs. Two months later, I was diagnosed with HIV. I was 20 years-old and I was convinced I was going to die.

So there I was, stigma on top of stigma. As a rule, medical personnel don't excel in bedside manner when it comes to transgender people. It's hard enough to face HIV. You want a doctor who understands that your entire life changes the instant you get that diagnosis, not someone who doesn't bother to look you in the eyes and see the very basics of who you are.

On the street, I lived a life of Debbie. I had a different name once, but that name has nothing to do with who I am today. [Applause]. To have a doctor consistently call me by my birth name feels like a punch in the stomach. It feels like one cup, one fork, one spoon, one plate.

When you're using drugs, there are high moments and low moments. In the high moments, you just want to keep getting high, in the low moments, you think about the things that drove you to use drugs and your self-esteem plummets. I broke free in a low moment when I thought I could actually envision living my life as a woman. The single wish to actually wish to actually be Debbie is what made me persevere. I got into the Bridge Back to Recovery Program which was specifically HIV positive LGBT people. The key to its success was they accepted me 100-percent.

Any inkling of a barrier, any whiff of an attitude would have given me the excuse that I needed, actually the excuse I was looking for to leave and go back to the street. For me to kick drugs, I needed to focus on that single goal

without the distraction of being HIV positive; without the distraction of being a sex worker and transgendered woman. When I had that space, I stopped using, then I got off the street.

I came to the organization Transgendered Health Empowerment, the only agency in the Washington, DC area that provides services specifically for transgendered people. Through them, I found supportive housing. Yes, I got a cosmetology license, but my heart is with my family that I found on the street. So I got a job with HIPS. Three years later, I started working in Transgendered Health Empowerment as a comprehensive risk counseling specialist. [Applause].

Our primary goal is to get the sex workers, drug users and transgendered women off the street, connected with social services, medical services and treatment. Now I'm Debbie in every sense of the word, but the Bridge Back program is no more. It died for lack of funding. The lesson that I want to impart today is that if you include people like me in your program design, you get solutions like Bridge Back, you get solutions that work.

No matter how well-meaning, a program that didn't truly understand where my head was when I walked in that door was never going to be successful. We need more programs like Bridge Back, not less. [Applause]. If you include people like me in your advocacy efforts, you get powerful proponents for

syringe exchange funding, changes to drug laws. This conference is the perfect venue to discuss what does and what doesn't work and why. I don't want to be on the outside looking in. I want to collaborate with all of you and my peers in Calcutta and Kiev [applause] because they can't be here.

As you know, the United States, while generous with HIV funding around the world, has policy that makes it extraordinarily difficult for current and former sex workers to enter into the country. If you honestly respond to questions on the application for a U.S. visa, someone who is engaged in either of these activities during the last 10 years will be denied entry. You can apply for a waiver for the cost of $500, but when you arrive, our system says you have confessed of moral in turpitude. You can be denied entry anyway. Your passport is then branded with this confession.

I asked applaud President Obama for lifting the ban for people living with HIV from entering the country and I'll tell him that if I get to meet him, however it will be far more productive for our government to eliminate policies that are more judgments and has nothing to do with public health. [Applause].

The U.S. entry ban says people who have a history of drug use or sex work are not actually included in this dialogue. This is a serious setback for the fight against AIDS. It would be better if this conference were located where

affected groups could participate. In fact, peer driven programs often prove to be most successful in combating this epidemic in both sex work and drug use. Over and over again, my peers and I have proven our value. [Applause].

Don't underestimate our knowledge or our potential for contribution, include us, let us help. If we are truly turning the tide together, than transgendered propel, sex workers, drug users, people like me, should be included and part of the solution. Again, thank you. [Applause].

FEMALE SPEAKER: Please welcome Julio Montaner, director of the British Columbia Center for Excellence in HIV/AIDS.

JULIO MONTANER: It is my pleasure and indeed an honor to welcome to the podium Gottfried Hirschall, who is the director of HIV/AIDS Department of the World Health Organization. In that role, he provides the leadership to a very important component of our strategy to turn the tide against HIV and AIDS.

Having been a proponent for aggressive [inaudible] antiviral therapy for a long time, I am reassured that our fight is going to be made a lot easier by having Gottfried's leadership at one of the most important places and providing us with the normative guidance that we need to move these issues forward. We're in very good hands. Thank you, Gottfried.

GOTTFRIED HIRSCHALL: It's not easy to follow Debbie. That video was fantastic. Thank you. [Applause]. What a testimony. Thank you, Julio, for the kind introduction and thanks for the organizers to having me here. It's a great opportunity. Good morning, colleagues and friends.

I think we all agree that we are at a defining moment. An overarching issue of this talk and indeed of this conference is how to use ARVs most strategically. Certainly with a view toward ending the epidemic. I would like to highlight three issues.

First, as we work towards our current goal of 50 million in 2015, can we reach this goal? I will argue that we can. My second question is whether it will be sufficient to achieve optimal treatment and prevention impact and whether we shouldn't think and plan now beyond the 50 million and I'm strongly convinced that this is the moment to do so. Finally if indeed we want to set the bar higher. How could that be done? What strategic choices can and need to be made and what opportunities exist to affect program reach?

Let me start with the tremendously good news of this conference. 800 million people had retained access to ART by the end of 2011. This is an increase of about 1.4 million or 20-percent in the last 12 months. Clearly despite economics and other challenges, we continue to reap the benefit of a decade of commitment, hard work, and resources. Let's remember

that just nine years in 2003, getting 3 million on treatment, a target of 3 by 5, seemed like a dream to many of us. We should really not underestimate the scale of the achievement to have reached 8 million people now. I strongly believe that we have sustained efforts at a somewhat enhanced pace of scale up in the next three years. We will achieve the target of 50 million ART in 2015. [Applause].

Why am I optimistic? For three reasons. First, we have impressive examples of successful countries that are showing what can be achieved. Second, we have unprecedented opportunities today and in the near future to expand program effectiveness and reach. Third, in 2011, spending in AIDs has not, as many have feared a year ago, decreased, but on the contrary has gone up by about 10-percent. As much fear as we are of course about the flat-lining of external resources, we have seen an encouraging trend on the increase of domestic spending in low and particularly middle income countries.

So let us look at what is possible in countries. I want to take a moment to highlight just three success stories. This slide shows the increase in ART coverage for those CD4 count below 350 between 2003 and 2011 in Cambodia, Malawi and South Africa. These are three different countries which face different challenges, have different academics and somewhat different health systems. Their responses however share a number of common traits.

In all three, we have seen exemplary commitment in political leadership, tailored and proactive approaches to testing and considerable innovation in service delivery. These are just three of the many countries that are showing us what can be done and how to do it effectively.

At the same time, there's wide variation and scale-up across countries, regions and populations. The persistently low coverage in Eastern Europe and Central Asia, shown in red, and North Africa and the Middle East, shown in purple, remains a great concern. By comparison, sub-Saharan Africa, shown in green, even with its high disease burden and health system constraints is making extraordinary progress, having now achieved 62-percent adult coverage. Disparities between populations still do exist. We've just heard three examples.

At 28-percent, coverage for children continues to lack well behind adults and while there may be reasons, there's absolutely no excuse for this. [Applause]. Key populations also have disproportionately low access. As one example, data from Europe and Central Asia consistently show injection drug users while account for two thirds of those living with HIV, still have low treatment coverage of less than 10-percent.

As we have just heard this morning from my speaker colleagues, other groups including MSM, transgendered person and sex workers, have similar to accessing appropriate services including ART. It is unacceptable as coverage expands overall

at global level, that these inequities are not being more aggressively addressed.

Our ultimate measure of success is of course impact. Here in yellow, we progress against scaling up trends in mortality and new infections, shown in green and red, respectively. Also, we have seen a decline in mortality. 1.7 million people still died in 2011 and the number of new infections has certainly decreased, yet it's still at 2.4 million in low and middle income countries. This begs the question, why do so many continue to die? Is it due to lack of access? Late diagnosis? Poor diagnosis of OIs such as TB and hepatitis? Late initiation of treatment or poor quality of services? The answer is probably all of the above.

A second question prompted by this graph is at what threshold of global treatment coverage will we see a more dramatic prevention impact? The answer is unclear, but it is evident that the current level of 54-percent is not enough. We also really do not know how many of these 8 million on treatment have in fact achieved viral suppression, but presumably it is only a fraction.

A major public health question at this point, how much greater could the impact on prevention be if ART were initiated earlier at higher CD4 threshold? For the first time, we have empirical evidence derived from a study in South Africa in a generalized epidemic and presented by Frank Pantani this year

at Croix. It shows the effect of ART scale up of individual risk, innovate of new infections. In essence, we see that forever 10 percentage point increase in coverage, there's a 17-eprcent decline in individual AIDS new infections.

This data offers real encouragement that on a population basis, the prevention benefit of ART can be and should be substantial. It is noteworthy that these effects were achieved on a CD4 threshold below 200 and again, the effect could arguably be greater with more people accessing ART earlier.

An important discourse at this conference focuses on the question whether the clinical and prevention benefits of early initiation of ART either at a CD 4 count above 350 or indeed regardless of CD4 count, outweigh the potential individual and public health risks. Clearly the balance of clinical evidence is tipping strongly towards early initiation. Late breaker sessions planned today and tomorrow for AIDS 052 will provide additional exciting results and I think we all shouldn't miss those sessions. The prevention benefits of course are well established and tip that balance even further.

Programmatically, we have more and better choices over the last years, we have seen substantial improvements in the potency and durability and tolerability of regimens in constrained settings. For the future, we will have a wider of range of regimen sequencing options. On the other hand, the

risk of resistance is sometimes used to argue against early initiation of ART and I want to spend a minute presenting new WHO data on drug assistance that has just been released at this conference in the first global drug assistance report.

A critical question is, should resistance concerns make us more cautious with regard to the scale up of ART? Will much increased use of ART actually lead to massive resistance as we have seen this in TB? From what we see now, it is very unlikely. This slide from the WHO service and transmitted drug assistance, shows that yes, there is a statistically significant association between ART coverage and the emerging of resistance. Transmitted assistance to non-nuclear size, which is low and middle income countries drives the emergence of drug assistance increased the need with increasing coverage, but it remained low. Less than 5-percent, even at the highest coverage levels observed.

Vigilance is of course in order to avoid increases in resistance levels, programs need to ensure the use of robust regimens and fix those combinations, achieve optimal adherence and retention, ensure regular drive and supplies and money to AIDS viral suppression.

Let’s review the issue of ART eligibility and evolving policies and aerials. This slide shows you five such scenarios. Starting on the left, in 2003, WHO recommended initiation in CD4 below 200. Scenario 1. In 2010, guidelines