National HIV Prevention Conference 2009
Monday August 24th, 2009 Afternoon Plenary Session

Mujer: Yo uso la píldora anticonceptiva para protegerme,

por eso no necesito condones.

Hombre: Detén los mitos.

Las pastillas anticonceptivas
sólo sirven

para prevenir el embarazo.

No hace ningún efecto
sobre el VIH, SIDA

u otras enfermedades
de transmisión sexual.

Usa condón y barrera dental
para cada acto sexual.

Cuídate.

VIH negativo o positivo:
tú decides.

Hombre: No me hago la prueba

porque no quiero
que compartan mi información.

Mujer: Detén los mitos.

Las pruebas del VIH
en los Estados Unidos

son confidenciales o anónimas;
esto quiere decir que

no se comparten
los resultados con nadie.

Durante el proceso,
recibirás ayuda

por parte de personas
capacitadas, especializadas.

No tengas miedo.
Cuídate.

VIH negativo o positivo:
tú decides.

Hombre: Yo me hice la prueba VIH

al día siguiente
de tener una relación riesgosa

y dio negativo
así que no estoy infectado.

Mujer: Detén los mitos.

Si te hiciste una prueba del VIH
inmediatamente después

de una relación íntima
peligrosa, sospechosa

y te dio negativo
y estás aliviado:

el periodo de incubación del VIH
son una ventana de tres meses.

VIH negativo o positivo:
tú decides.

Hombre: No tengo porque decir
que soy VIH positivo

a todas personas con quien
tengo relación sexual.

Hombre: Detén los mitos.

En el estado de la Florida,
si eres portador del virus

y vas a tener contacto sexual
con alguna persona

y no le informa,
tiene grandes consecuencias.

Es un delito en tercer grado.
Piénsalo, porque es la ley.

VIH negativo o positivo:
tú decides.

Hombre: Sólo los gays
pueden infectarse con VIH.

Hombres: Detén los mitos.

Hombre: No importa quién eres...

Hombre: Sino lo que haces.

Good afternoon.
Great.

The title
of the plenary session today is

"Future Directions and Updates

from the Division of HIV/AIDS Prevention at CDC."

And I'm delighted to be
with you today

and to have the opportunity
to moderate presentations

by three Deputy Directors
at the division,

the part of CDC responsible
for HIV prevention in the U.S.

DHAP consists of 10 branches
which are divided

among the Deputy Directors
who will speak today

about some of their activities.

And the division consists
of a truly dedicated

and insightful group
of men and women.

As a new Director
of the division,

I wanted to share some things
about myself

since we will all be working
together on a shared vision

for HIV prevention.

I know everyone here has a deep commitment to working on HIV.

Much of our commitment represents the flip side

of painful experiences,
of seeing loved ones fall ill,

of seeing communities paralyzed by this epidemic,

or having HIV ourselves.

My commitment to HIV started
in 1986 in Massachusetts.

This is a time
when The Boston Globe

published editorials asking
whether people with AIDS

should be quarantined
on an island off the coast,

and whether men with HIV should be tattooed on their butts

and not, in this case,
to make them more attractive.

I was profoundly disturbed
and wanted to make a difference,

so I left college for a year
to work on issues of AIDS

and public policy,

helping to bring science
and common sense

into debates on health policy.

I later moved to California

and spent nine years
in medical school

in residency caring for women and men with HIV.

It was an intense time.

And I understand why
Tony Kushner wrote

in "Angels in America"

that Heaven was like
San Francisco,

"a beautiful place, overgrown with flowering weeds,

"voting booths
and big dance palaces

full of music and lights
and gender confusion."

But every day, I was with
friends and patients

for whom we had so little ability to help medically.

The first patient I had in
my primary care clinic

was a man with HIV who brought
far-fetched stories

and small gifts to his visits.

I suffered with him
through pneumonia,

cryptococcal meningitis,

and two episodes of a near-fatal
skin reaction

from his taking Bactrim
every day to prevent PCP.

We discussed his loves
and his losses,

and it was in my last month
in San Francisco that he died.

And that night, at the end
of a long shift

at San Francisco General Hospital,

I remember bicycling home through the Mission District

feeling the pain of the epidemic
at its most excruciating.

During that decade, I learned
how to care for people,

work in community-based
HIV programs,

and better understand
the HIV epidemic.

When I moved to Africa in 1999 to set up AIDS work for CDC,

I arrived informed
by the energy,

community activism
and knowledge

of the HIV community here
in the United States.

And it felt remarkably similar

to earlier times
in this country.

The average Ugandan could name

40 people she or he knew
who died of AIDS.

HIV was the leading cause
of death in the country.

And everyone felt the way
gay men

and communities of color
felt in the 1980s

and often feel today.

HIV was a constant companion
in our home, our kids' school,

our office, our community,
and among our friends.

But in Africa, I also had
an opportunity that came

with substantial
resources from PEPFAR.

Working with local teams, we provided U.S.-government-funded

ART for the first time
in Africa,

we expanded prevention programs
countrywide,

and we openly dealt with
the injustices of the disease.

We learned the importance of
using a partner,

family and community approach
to HIV,

as Magic Johnson

reminded us last night,

and we learned that bringing
services closer to people works.

And just as the speakers living with HIV emphasized yesterday,

today, just as 20 years ago,

HIV affects the very fabric
of our society,

impacting not just health,
but our social, cultural,

economic and political lives.

AIDS was and remains

an archetypal
human rights issue.

Now I'm delighted to have
the opportunity to work again

with the U.S. HIV community
that has set the stage

for so much
for the rest of the world.

The American public is also optimistic about HIV.

60% think that increased spending on HIV/AIDS prevention

in the U.S. will lead to meaningful progress

in slowing the epidemic.

And they are right.

DHAP is committed to several approaches over the next year.

We will listen to you
and the nation

and we'll be a transparent
and accountable partner.

We will continue to provide information that enables people

to effectively work
against HIV,

ensuring that the best science drives our prevention programs

and where we allocate

our resources.

We are also committed to continue to work

hand in hand with partners
to build capacity

and improve the effectiveness
of our programs

and to reduce the unacceptable racial and ethnic disparities

and extraordinarily high rates
of HIV among MSM,

African-Americans, Latinos,
and drug users,

that continue to present
challenges to all of us.

Over the next few months,
DHAP will begin to develop

a strategic plan
for the division.

This process will involve

internal
and external stakeholders

and will incorporate useful information

from a recent external
peer review

that involved over 70 partners
in HIV prevention

from throughout the country.

Our planning process will be
a part

of the National AIDS Strategy

being led by the Office of
National AIDS Policy.

Recently the new Director
of CDC, Doctor Tom Frieden,

laid out four major priorities
for the agency

that resonate with DHAP.

One -- improve our support to states and localities.

And for DHAP, this includes community-based organizations.

Two -- strengthen the quality
and use

of surveillance data
and epidemiology.

Three -- improve policy effectiveness.

And four -- position CDC to best address health reform.

Which for us includes doing
everything we can

to communicate the importance
of HIV prevention

in the National Health Plan.

Effective HIV prevention
not only works,

but it saves money and is simply the right thing to do.

And doing it well
is the only way

we will reverse and ultimately
end the epidemic.

So it's now my pleasure
to introduce Doctor Amy Lansky,

the Deputy Director for Surveillance, Epidemiology

and Laboratory Science.

Amy began her career at CDC
in 1991

and has spent most of that time
within the division,

focused on surveillance
and epidemiological research

on a variety of topics,

including HIV risk and testing
behaviors among MSM,

injecting drug users,
and heterosexuals;

prevention of perinatal HIV transmission;

and behavioral surveillance
methods.

So it's my pleasure, Amy.

[Applause]

Thank you.
Good afternoon.

Thank you.

I'm pleased to have
the opportunity

to provide some updates
and to give a preview

of some future directions
in Surveillance,

Epidemiology and Laboratory Science within DHAP.

Since I can't review everything we do in 10 minutes,

I've focused on two areas
that cover surveillance,

epidemiology, and lab,

monitoring the epidemic
and the development

of biomedical interventions.

Through DHAP's program
of surveillance,

we collect data to enhance
both the breadth and the depth

of our understanding of
the epidemic

in the United States
by covering the spectrum

from risk behaviors among those who are uninfected

to infection, diagnosis, AIDS
and death.

Our program of surveillance
is comprised of multiple,

interrelated systems.

We have case surveillance,
which is truly the foundation

or our ability to monitor
the epidemic.

Our Core Surveillance is
the basic system

that every state
and territory has,

and many of you are familiar
with core surveillance data

as they form the basis
for our annual

HIV/AIDS Surveillance Report.

Incidence Surveillance is integrated

with core surveillance

and serves to monitor
new infections

and track the leading edge
of the epidemic.

The Variant Atypical
and Resistant HIV Surveillance,

or VARHS, is also linked to our core surveillance system

and serves to evaluate HIV-1 drug resistance

and HIV-1 subtypes
and associated factors

among persons newly diagnosed
and reported with HIV.

The Medical Monitoring Project,
or MMP, provides information

to supplement what we learn
in case surveillance,

collecting detailed behavioral
and clinical care information

through interviews and medical
record review

from a nationally
representative sample

of HIV-infected persons
in care.

And the National HIV Behavioral Surveillance System, or NHBS,

is a unique system in that it's focused on at-risk populations,

that is, persons who are not infected but at increased risk,

including men who have sex
with men,

injection drug users,
and heterosexuals.

Putting the systems together
with the spectrum

of HIV infection
looks something like this,

with Core Surveillance and MMP providing

the broadest spectrum
of measures,

Incidence and VARHS providing
detailed information

at the time of infection
and diagnosis,

and NHBS providing
information

on the front end
of the spectrum.

In terms of future
directions,

I want to share one example
of new developments

in monitoring the epidemic.

We've been working on developing new data

that will enable us to calculate
disease rates

among men who have sex
with men.

What I'll be presenting
are preliminary data

from analyses that are pretty far along

but not completely finished.

To be able to calculate
disease rates for MSM,

we need to know
the population size

or what proportion of U.S. men
are MSM.

There's not one standard estimate of the number of MSM

in the United States.

In order to estimate
the proportion of all men

who are MSM, we first conducted a literature review

and meta-analysis to estimate
the proportion of males

who are MSM.

Next, we used surveillance data
and the estimated proportion

to calculate the rate of disease among MSM.

From our literature review,
we identified seven studies

for use in the meta-analysis,
which are listed here.

These are all national population-based surveys

that asked men about sexual behavior with other men.

From these seven studies, we ended up calculating estimates

based on three behavioral
recall periods --

the past year,
which is shown on the left;

the past five years,
which is in the middle,

and ever,
which is on the right.

We believe that the past
five years

is the most appropriate measure to use on our surveillance data

so we'll be focusing
on that.

So our preliminary findings
from the meta-analysis indicate

that MSM make up 4% of men,

with a confidence interval
from 2.8 to 5.3.

If MSM are 4%
of the male population,

and males are 49%
of the overall population,

then MSM represent around
2% of the overall population.

However, they comprise nearly half of all AIDS cases

in the United States.

What the population estimate does is help to quantify

the disproportionate impact
of HIV and AIDS among MSM.

We can use the estimated proportion of MSM

to calculate rates by applying
the 4% MSM proportion

to the population of men,

and for the purposes of showing how this can be done,

we have the rate of HIV diagnoses in 2007,

and we see here that the rate

of 692 HIV diagnoses
per 100,000 MSM,

and the other numbers are based on the confidence interval.

To put the MSM rate
in perspective,

here we see rates for other men and for women.

The rate among MSM
is more than 50 times as high

as other men and women.

So while the proportion of MSM helps quantify

the disproportionate impact
of the epidemic on MSM,

the rates allow us to compare
that impact in other groups.

These data underscore the fact
that HIV remains

a critical concern
in our country,

with particularly high rates
among MSM.

Now, just a reminder -- these estimates are preliminary,

and we're planning more
complete analyses.

We'll refine our meta-analysis estimates

and then recalculate rates
as needed.

And we're looking into being able to calculate rates

by race and by age among MSM
to get a clearer picture.

And we may also conduct
a separate meta-analysis

for young MSM.

We'll also be looking into identifying

population estimates for IDU
and heterosexuals,

but we're planning to move
the MSM analysis further

and apply those lessons learned.

Our surveillance systems
and data are expected

to continue to inform what we do
in research, program and policy.

They're a critical contributor to our ability

to inform
the course of the epidemic

and our response to it.

The second part of my talk
will focus on DHAP's work

in developing
biomedical interventions.

In the area of biomedical interventions,

there have been many exciting prospects.

Some have demonstrated efficacy
and many are in development.

Given the need to develop
prevention interventions

on both the behavioral
and the biomedical fronts,

we must remain hopeful
and prepare for a time

in which there will be
additional

biomedical interventions
with demonstrated efficacy.

Today I'll talk about what DHAP is doing

related to pre-exposure prophylaxis, or PrEP,

which is using
antiretroviral drugs

to prevent HIV infection.

PrEP provides a good example

of the research to program continuum.

In DHAP, our studies
among animals have provided

models for potential efficacy
in humans

and have informed
our clinical trials.

Should the clinical trials show that PrEP is efficacious

in preventing HIV infection,

the trial results will in turn inform our program development,

and I'll show you how
that works.

This diagram illustrates
how our animal studies,

in the green boxes,

and clinical trials,
in the white circles,

have progressed
and informed each other.

CDC's first PrEP trial began
in 2005

among IDU in Bangkok, Thailand.

This study is testing
the HIV medication Tenofovir

for its efficacy as PrEP.

Similarly, our lab branch studied animal models

of daily Tenofovir as PrEP.

Finding success,

our lab branch then did
the next set of animal studies

and changed the PrEP regimen
to assess

a different drug, Truvada.

This regimen, too, showed efficacy in the animal studies.

CDC had a clinical trial
in Botswana that was

just getting underway,

and based on our findings
from the animal study,

we changed the PrEP regimen
in the Botswana trial

to Truvada.

Our animal studies then
moved on to examine

whether an intermittent dose
of PrEP every few days,

or around the time of sex
rather than every day,

was effective in preventing
HIV infection.

And those results, too,
showed efficacy.

So these examples give you some idea of how our studies progress

and the interrelationship between

our laboratory-based studies
and our clinical trials.

This figure shows the current projected timeline

for various PrEP
clinical trials.

Efficacy trials sponsored
by CDC

and other partners
are ongoing,

and final results
for the first trials

may be expected next year.

Although the trials are ongoing, CDC has already begun

planning efforts focused in
two priority areas --

preparing for the development
of rapid guidelines

for proper use of PrEP,
should it prove effective,

and beginning to assess
the potential role of PrEP

in our portfolio of publicly
funded HIV prevention programs,

again, should PrEP prove
effective.

In terms of our guideline development,

CDC has begun collaborating with other federal agencies,

health experts, researchers,
advocates,

and affected communities
to begin exploring elements

of guidelines that can be developed prior

to the study results.

And to determine the potential
role of PrEP in our portfolio,

CDC has been consulting with public health partners,

providers and others
to understand how PrEP

would most effectively
be delivered.

Because PrEP will not be
100% effective,

it must be delivered
in combination

with other proven prevention
approaches

and also support services
such as testing, counseling,

and monitoring.

So, although the medication
may be a simple pill,

implementation of a PrEP program is complex.

We must also consider the cost
and cost effectiveness of PrEP.

The cost for PrEP implementation will be substantial.

So given the cost and complexity of a PrEP program,

it will be likely recommended
only for those at very high risk

and we need to identify
the best ways to identify

and deliver PrEP
to those populations.

So I've really just scratched
the surface here on PrEP issues,

and there was an excellent
day-long session yesterday

in which more than 300 conference attendees

were grappling with many
of these tough questions.

What is becoming more clear,

based on what we know
from our animal trials,

what we hope to learn
from the clinical trials,

and what we already know about HIV prevention

in the United States

is that strategic planning for
and strategic use of PrEP

will be critical to its success

should it prove effective
in clinical trials.

So to summarize the future directions

from Surveillance, Epidemiology
and Laboratory Science,

we have new systems and new data for monitoring the epidemic

and we are hopeful about
the potential

for biomedical interventions
that will expand

our portfolio
of prevention tools.

Thank you.

[Applause]

Thank you, Doctor Lansky.

It's now my pleasure to introduce Doctor Richard Wolitski,

who is Deputy Director

of Behavioral and Social Sciences at DHAP.

For more than 20 years,
Doctor Wolitski has done research

that has focused on better understanding and preventing

HIV risk
among people living with HIV

and diverse at-risk populations.

He's an Associate Director
of the journal

AIDS Education and Prevention

and serves on the editorial board of AIDS and Behavior.

Doctor Wolitski.

[Applause]

Hello, everybody.

It's nice that we could all have lunch together today, isn't it?

So, what I'm here to do
is to give you

just a brief overview of some
of our key activities

that are focused on putting
HIV back

on the national radar,

identifying and developing

effective
behavioral interventions,

and our efforts to monitor

and evaluate our HIV
prevention programs.

Now, you've all heard about
Act Against AIDS, haven't you?

Act Against AIDS was just launched four months ago.

It's a five-year, multi-faceted campaign that is being conducted

both in English
and in Spanish.

The overall goal
of Act Against AIDS

is to reduce HIV incidence
in the United States --

by refocusing attention on domestic HIV and AIDS

and combating complacency;

by promoting awareness,
targeted behavior change,

and HIV testing;

and by strengthening
and establishing

networks
and other partnerships

to extend the reach
and credibility

of prevention messages.

Now, this figure just shows
the overall framework

for the campaign
and some of the activities.

The activities fall
into two broad categories --

activities that are designed to leverage public health assets,

including partnerships,
the Act Against AIDS website,

social media,
interpersonal outreach,

advertising and news media.

The other set of activities

are focused on leveraging

private sector assets
and getting organizations

involved in HIV prevention

who don't have public health
or HIV as their primary focus.

These activities include

the Act Against AIDS
Leadership Initiative,

the Global Business Coalition partnership,

the Act Against AIDS
media initiative coalition,

which includes Univision,

and the Black AIDS Media Partnership,

or BAMP.

Supporting all of this
is message development

and diffusion of these messages

through various
communication channels,

research focused
on the development

of prevention messages,

and evaluation of all
of our activities.

Now, I'm going to talk with you
a little bit about

the various phases
of the campaign.

Now, in the campaign,
we're using both traditional

and new media,
including the Internet.

And one of the most recent campaign phases

is focused on young black men

who have sex with men.

This phase was developed
in partnership

with a group of national experts
who work with

African-American gay
and bisexual men.

The focus of this campaign is
increasing regular HIV testing.

Shortly, we're going to be ready to roll out another phase --

"Take Charge. Take the Test."

Which focuses on promoting
HIV testing

among African-American women.

Last night, we gave you

a little preview of
the "I know" campaign,

which is focused on
increasing knowledge,

dispelling myths among
young African-Americans.

We also have a few phases
that are focused

on healthcare providers.

"One Test. Two Lives."

Which increases HIV testing
among pregnant women.

HIV screening,
standard of care,

designed to increase routine testing in healthcare settings,

and "Prevention IS Care,"

to increase prevention counseling

for people living with HIV as part of their healthcare visits.

And of course,

the "9 1/2 minutes" phase
of the campaign,

which is designed to increase
awareness about

the current impact
of the HIV/AIDS crisis

in the United States.

Already we've had a number
of key successes

as part of
the Act Against AIDS campaign.

The Act Against AIDS
Leadership Initiative

is one of them.

The Leadership Initiative involves

14 national organizations
that have a long history

of serving
African-American communities.

They include the NAACP,

the National Council
of Negro Women,

and the National Urban League.

Each of these organizations has
a dedicated AAALI coordinator

whose job it is to ensure
that HIV prevention

is incorporated into

these programs'
national conventions,

websites, publications,
and existing outreach efforts.

And we're going to be expanding
this initiative in 2010,

with resources from
the Minority AIDS Initiative

to add two additional organizations

who will work as part
of this initiative

who have demonstrated credibility

and a history
reaching African-American

gay and bisexual men.

Members of the Act Against AIDS Leadership Initiative

have already sponsored more than 123 HIV-related events

and trainings that
have been attended

by more than 80,000
individuals.

More than 11 million people
have been exposed

to HIV prevention messages
through AAALI outreach efforts.

The Act Against AIDS
media initiative

is a media partnership that's designed to disseminate

HIV/AIDS awareness
and prevention messages

to those at highest risk.

The Black AIDS Media Partnership, or BAMP,

is the first of a number
of media partnerships

that address
at-risk populations.

BAMP is convened by CDC

and managed by
the Kaiser Family Foundation

and their media partners.

And the Black AIDS Institute
is providing guidance

and technical assistance

as part of this partnership.

And already BAMP has launched
the Greater Than AIDS campaign,

which, if you haven't already checked out their website,

I encourage you to do so.

Now, this is just the beginning

for the Act Against AIDS campaign.

A little bit later
in the session,

you're going to get a chance
to have a little preview

of the new "9 1/2 minutes"

television public service
announcement.

And we've already begun working on developing a campaign phase

for Hispanics and Latinos
that will be launched in 2010.

We're also working to expand
the knowledge base

for HIV prevention programs.

And we're doing it
in the following ways --

by identifying effective
behavioral interventions,

by developing and adapting behavioral interventions,

and testing the efficacy of

researcher- and community- developed interventions,

and by monitoring
and evaluating interventions

as they're used
in prevention programs

in the real world.

And we're also assessing
the cost

and the cost effectiveness
of these programs.

CDC's Prevention Research Synthesis project

systematically reviews
the published

and in-press
HIV prevention literature

to identify interventions
with evidence of efficacy.

And as part of that effort,
we publish

the Compendium of Effective Behavioral Interventions.

Currently, the interventions
in the Compendium are focused

on reduction of sexual
and injection risk behaviors,

but in 2010, we're expanding
the focus of the Compendium

to include interventions that focus on adherence to care

and linkage to medical care.

We're continuing to update
the Compendium

and are committed to updating it on at least an annual basis.

Earlier this year, we added five community-level interventions,

and at this conference, we're announcing that we're adding

six additional interventions
to the Compendium

for a total of 69
interventions.

One of these interventions
fills a critical gap

for black men who have sex
with men.

"Many Men, Many Voices" recently underwent a rigorous evaluation,

supported by CDC, and had positive outcomes that confirm

the continued effectiveness
of this intervention

for black gay
and bisexual men.

Two interventions are being added to the Compendium

for injection drug users.

"Real Men Are Safe," for men in substance abuse treatment,

and "Safer Sex Skills Building" intervention,

for women in substance abuse treatment.

Two new interventions are being added for women --

the "Female Condom Skills Training" intervention

for women
in family planning clinics,

and the "Motivational Interviewing HIV and Partner

Violence Risk Reduction" intervention

for women with criminal justice involvement.

And finally, we have one new intervention

focused on young women,
which is "Horizons,"

which is focused

on African-American
adolescent females

who are seeking
sexual health services.

Now, we're well aware that there continue to be gaps

in the number and types of proven interventions

that are available
to prevention programs.

And we're continuing
that research to develop,

adapt, and test the efficacy
of a variety of both

researcher-developed

and community-developed interventions,

for women living with HIV,
black and Hispanic MSM,

methamphetamine-using MSM,

black heterosexual men,

and black and Hispanic women.

We're also committed to evaluating the effectiveness

of these programs as they're delivered, implemented and used

by community-based organizations.

As part of the Community-Based Outcomes Project, or CBOP,

we're supporting 22 community-based organizations

that are implementing
and evaluating

one of five DEBI interventions.

So far, the results from
this project --

some of which are being

presented here
at the conference --

demonstrate that with the appropriate level of resources,

community-based organizations are able to successfully

collect, enter, and submit
program-monitoring

and client-level outcome data.

CBOs can collect longitudinal follow-up data from clients,

and we've already seen that
these data are having

an impact on programs,

by helping organizations improve their targeting

and recruitment activities,

by helping them to provide
the services

as they had originally planned,

and by focusing on achieving
anticipated outcomes.

We're also expanding our efforts
with regard

to national HIV monitoring
and evaluation

of prevention programs.

We've made considerable progress in this area.

We now have standard program monitoring data

that are being collected
by 59 health departments

and approximately 150
community-based organizations.

These data include agency data

and data about the allocation
of DHAP funds,

data on HIV testing services
provided,

as well as client-level data
for health education

and risk reduction interventions

that include demographic
and risk information,

details of the service provision,

the population served,
when and where, et cetera.

Now, we've already been collecting and reporting

some of these data,
as Doctor Mermin mentioned

in his opening plenary talk
yesterday.

But we're working to improve
how we use those data

and how we make those data
useful to you.

CDC's been working to develop
a national monitoring

and evaluation system
that will better integrate

information from both long-standing

and newly established surveillance systems

and program monitoring data.

Together, these integrated data sources will allow us

to better monitor our progress on key indicators,

including both our impact
on the epidemic

and our program performance.

We'll be developing
an integrated report

at the national level that will begin reporting in 2010.

But before then, we're going to start providing you

with snapshots of how we're doing on individual indicators

starting in October.

We'll be working to develop
at least semiannual reports

for both CDC project officers
and health departments

that will better support
program monitoring

and improvement activities,

and we'll be engaging health departments in discussions

about how to make these reports
most useful

in the coming weeks and months.

In these tough economic times,

and with our limited HIV prevention resources,

assessing the cost
and the cost effectiveness

of our prevention programs
is critical.

A few years ago, we established
a prevention economics team

within the division that focuses on assessing

the cost of intervention delivery,

the cost effectiveness of prevention programs,

and is doing work to model
the potential impact

of various HIV prevention strategies

and the allocation of resources at the national level.

And some data from these activities

are also being presented here
at the conference,

so take a look for them.

In conclusion,
I just want to reiterate

that we're committed to working
with you, our partners,

to combat complacency,

to extend the reach
of prevention services,

to further strengthen
the science and the tools

available to support
HIV prevention programs

and to further improve
the efficiency,

the effectiveness,
and the impact

of our HIV prevention
programs.

Thank you.

[Applause]

Thank you, Doctor Wolitski.

It's now my pleasure to introduce Ms. Janet Cleveland,

who's the Deputy Director for
Prevention Programs at DHAP.

Ms. Cleveland has held
several leadership positions,

including Chief of the Capacity Building Branch at DHAP,

where she provided counsel
to the whole division

on national programs
and policies

to develop and sustain
community capacity for planning

and implementing
HIV prevention programs

and providing priority
prevention services

to affected communities.

Ms. Cleveland?
Thank you.

[Applause]

Good afternoon.

Okay, so, it is my pleasure
today to share

just some brief updates
with you

about our HIV prevention
and capacity building programs

within the Division of HIV
and AIDS Prevention at CDC.

Just as a reminder

that our primary goal
within our programs

is to decrease HIV incidence,
with a particular focus

on eliminating racial

and ethnic disparities.

And how do we get to that goal?

Well, we work with

our state and local
health department colleagues,

as well as
community-based organizations

and capacity-building
assistance providers

to decrease the risk
of transmission

and/or risk behavior among people living with HIV

as well as people at risk
for HIV,

to increase the proportion of HIV-infected people

who know their status,

increase the proportion of HIV-diagnosed people

who are linked to prevention
care and treatment,

and to strengthen capacity
to monitor the epidemic

and develop, implement and evaluate effective programs.

So, given all the information
that you've heard

from both Amy and Rich,

how do all of the pieces
fit together

in terms of impacting
our prevention programs?

Well, we know that surveillance
is the cornerstone

for what we do at CDC
in terms of

any good and strong
public health program.

And that feeds into our research agenda, as well as our policy,

which then leads to implementation of our programs

and how we do so.

And then evaluation, of course,
is critical because

the evaluation then feeds back
to help us to determine

how best we should be monitoring our programs

and how well our programs
are doing

in terms of accountability
and meeting program performance.

And then at the basis

of all of these important mission categories,

we have capacity building
and technical assistance,

which help to ensure that
not only are we doing the work

that we need to do in terms of strengthening our work

on HIV prevention but that we are also providing that support

to our partners in the field

for them to be able to also
do their work.

And then, of course, the goal is to decrease HIV incidence.

Our primary areas of activity for funding

for our prevention programs
actually occur within the areas

of health departments and community-based organizations.

You will see on this slide
that our total

Division of HIV and AIDS Prevention budget

for external, or extramural,
use of dollars

in terms of our programs totals

to around $392 million,

with about 86% of those dollars going towards health departments

and about 14% of that budget

going towards community-based organizations for them

to carry out their work.

As Doctor Mermin has already said, we are committed

to being transparent and being
accountable in terms of

what we're doing in terms of
health departments

and within jurisdictions

in terms of our prevention
program funding.

So I am happy to announce that at this conference,

we are actually, for
the first time, showing you

this newest link on our
DHAP website,

where you can actually go
to this web site and you can

click on any of these states
to see how much funding

and for which programs
are activities happening

within specific jurisdictions
so that you can get

a better idea
of what is happening

in terms of the use
of our dollars.

Unfortunately, we're not able to show you the technology today

in the interest of time.

But this is the website,
or the URL, I should say.

And I encourage you to go

at your leisure to our website

to be able to obtain
this information.

Now, I'd briefly like to highlight

a very special initiative
that we actually funded

in the fall of 2007,

our Expanded Testing Initiative.

And the goal of that initiative was to test 1.5 million persons

for HIV and identify 20,000
new cases.

The purpose of this testing initiative was to support

the 2003 Advancing HIV Prevention initiative,

which many of you remember,

by making HIV testing a routine part of medical care

and to also support the adoption
of the 2006 recommendations

for HIV testing
in clinical settings.

And lastly, we wanted to be able to increase

HIV testing opportunities
for populations

disproportionately affected
by HIV,

and primarily HIV
within African-Americans.

This slide actually shows you
just a visual

of the 25 jurisdictions
in total that have been funded

over the course
of the project period.

These jurisdictions had
at least 140 AIDS cases

among African-Americans

within their jurisdictions,

during the year 2005.

And these jurisdictions also represented 95% of AIDS cases

among African-Americans
in the United States in 2005.

Looking at this chart,

you can see that during
the first six months,

testing was not exactly where we would have liked to have had

our testing initiative
at that point in time,

but understanding
the caveat that,

given the goal
that we had established,

there was some startup time
that was needed.

The first six months was a time
that the health departments

had to use to be able to get
venues onboard

to establish relationships
to begin this work,

to conduct training to make sure that staff

were able to conduct the work.

And so, as with any program,
you usually can anticipate

that there's going to be about
a 6- to 12-month startup time.

But you can also look at
the subsequent time frames

in which testing dramatically
increased,

and so we are excited about
the work that has been happening

in the jurisdictions in regard

to this initiative.

Also, when you look at distribution of HIV tests

and new HIV positives,
you will recall

that one of the primary purposes of this initiative

was to test African-Americans.

And you will see that within
all tests,

about 65% of tests have occurred among African-Americans,

with about 67% of African-Americans

being diagnosed in terms of
new positive tests.

So again, the jurisdictions
have clearly upheld the intent

of the goals of this initiative.

So, what have some of our successes and achievements been?

Well, today -- understanding that the previous slides

that you have seen were only
18-month data --

today, over one million people
have been tested

under this initiative.

And we congratulate the health departments on the hard work

that has been done.

Absolutely.

Again, African-Americans represent about 65%

of all tests.

Over 6,859 new positives
have been identified to date,

with about 76% of those
being linked to care.

We've been able to foster
the uptake

of the 2006 testing guidelines,

and new partnerships have been facilitated

that may not have existed prior to this initiative

between health departments
and clinical facilities.

Our infrastructure has
been strengthened.

This was a paradigm shift,
not only for health departments

but for our staff internal
to CDC.

And we have been able to support

the goals of our center
around PCSI,

Program Collaboration
and Service Integration,

in terms of integrating HIV,

STD, hepatitis
and TB prevention.

And so again, we are proud
of those successes.

Now I will move on to our
capacity building program.

And this just gives you
a highlight

of what that extramural budget
looks like.

The majority of those resources are actually allocated

to our Capacity Building
Assistance Program,

in which we work with national organizations to provide

support to communities, CBOs,
and health departments

to build their capacity to do effective HIV prevention work.

The next larger portion
of this budget actually goes

towards the Diffusion
of Effective

Behavioral Interventions project.

As you all know, we effectively call them our "DEBIs."

Now, with the DEBI project,
you will remember

that this project is designed
to bring science-based

community, group
and individual level

HIV prevention interventions

to community-based
service providers

in state and local
health departments.

Rich has already given you
an idea

of some of the new updates
in terms of the Compendium

which we are really
excited about.

These slides just also give you
an opportunity

to see some of the new
and upcoming,

as well as existing, interventions that we will have

in our arsenal as we begin
our new funding opportunities

over the course of this year
and the next year.

So, what are those new
funding opportunities?

Well, our CBO Program announcement,

our flagship
program announcement

for community-based organizations.

That announcement will be
released very soon.

We have already scheduled
pre-application workshops

to help people to get prepared for making their applications,

and these workshops are scheduled for Chicago, Oakland,

Philadelphia and Atlanta.

We're also working with
CBA partners,

or Capacity Building Assistance partners, to provide trainings.

And the project period for that new program announcement

begins in July 2010.

Our health departments that we work with are entering

what we're calling
a two-year bridge period

to the next five-year cycle.

It was important for us to
do this because, as we know,

and as Doctor Mermin
has already mentioned,

there is a number of things
that are --

or there are a number of things

that are coming
down the pipeline

that we really need to be able
to consider to help inform

our thinking about
our prevention directions

for our programs, and so we will be working closely

with our state and local
health department partners

and other communities
and stakeholders

to look at how do we move
forward in terms of

having the best impact upon
this epidemic

during the next several years.

Our Capacity Building Assistance program announcement

has already been announced
and that project period

is scheduled to begin on
September 30th of this year.

So now I would be remiss if I didn't talk about, as a nation,

some of the challenges
that we have

around prevention programs
as well as capacity building.

You know, we know that there is
a need to reach more people.

We know that there's a need to reach more of the right people.

In other words, we need

to be able to take our interventions to scale.

Whether they be testing interventions,

prevention interventions,
structural interventions,

we need to take them to scale.

We need to be able to have
the ability to meet

the current and future
training demands,

to include biomedical interventions

that we know are coming down
the pipeline.

Funding now often supports
testing,

but we need to make sure
that if we're testing people,

we need to also make sure
that we're linking them to care

and to partner services

and that prevention with positives is also strengthened.

We need to continue to deal with the longstanding disparities

that have existed throughout
this epidemic,

the history of it,

that exists within communities
of color, and in particular,

African-Americans and Latinos
and Latinas.

We know that incidence continues to increase among MSM.

We've got to do something differently in terms of

how we're better reaching MSM.

And we also know that with increased prevalence means

that there is an increased need for treatment, care,

and prevention services for HIV-infected persons.

So, with all of those challenges,

we also know that this is not
the responsibility

of one federal agency,
one program, one community,

but it is our collective
responsibility

to ensure that prevention
and care work together,

that all HIV-positive persons
know their status,

receive medical care,
prevention services,

and that they are linked
to mental health, housing,

and other supportive services.

We need to make sure that
HIV infection does not

become a rite of passage
for gay and bisexual men.

We need to relieve the unjust and disproportionate burden

of HIV and AIDS
in communities of color.

And lastly, we need to ensure that all of our young people

in this country grow up with
the knowledge, skills,

and confidence to protect
themselves.

[Applause]

So...

I'll leave you with this quote and I ask you to remember --

as in the words of
our President,

Mr. Barack Obama --

"Change will not come if we wait for some other person

"or some other time.

"We are the ones that we've
been waiting for.

We are the change
that we seek."

Thank you.

[Applause]

Wow.

Thank you very much,
Ms. Cleveland,

and to all the presenters.

I wanted to just say
in conclusion

that all of us
at the Division are very opened

to your suggestions
and your comments

about how we can improve
HIV prevention.

So as you see us wandering
the halls of this conference,

please take the time to stop us and share your ideas.

Thank you.

[Applause]

Ladies and gentlemen,
it is truly an honor for me

to share
this afternoon's plenary

with the Secretary
of the Department

of Health and Human Services,
Kathleen Sebelius.

[Applause]

And the Director

of the Centers for Disease Control and Prevention,

Doctor Thomas Frieden.

[Applause]

I'd like to welcome both
of our distinguished guests

to this first day

of the 2009 National HIV Prevention Conference.

Our conference opened yesterday
with the voices

of those living with
and affected by this disease,

reminding us yet again
that the HIV epidemic

in the United States
remains severe, pervasive,

and heterogeneous.

We heard that success can only be achieved by sustained efforts

to apply and target the most impactful

and appropriate interventions
to those in greatest need

while holding each other
accountable

for making real gains
at all levels in our society.

So it is within this context

that this morning's
plenary presentations,

which focus on the prospect

of the first
National HIV/AIDS Strategy,

brings hope to so many.

It is a real chance for strategic, coordinated,

accountable and bold leadership

in the fight against HIV
at home

with the same vigor and passion
that we have applied

to the epidemic overseas.

Collaboration, accountability,
leadership

across federal agencies

will be key to the success
of the national strategy,

and we heard clearly that CDC
and our sister HHS agencies

are ready, willing, and prepared
for this enhanced role.

We were glad to have them here
to ensure

that the right voices
were at the table

to strengthen federal partnerships

and to share their expertise.

I'm therefore pleased to say
that we also have

the right voice at the head

of the Centers for Disease Control and Prevention

in the room with us today,
Doctor Tom Frieden.

Doctor Frieden received his medical training in internal medicine,

infectious diseases,
public health, and epidemiology

at Columbia
and Yale Universities,

and he's published hundreds
of articles

and received numerous awards.

He's well-versed and committed
to HIV prevention,

having worked in this area early in the days of the epidemic.

He joined CDC
in the early 1980s

where he led, as an EIS Officer

working in the New York City Department of Health,

where he led a program to rapidly reduce tuberculosis,

including reducing cases of
multiple drug resistant TB.

He later worked in India
to assist

the national TB control efforts

and tremendous success was achieved over the years,

with more than 10 million patients treated

and more than
one million lives saved.

As Commissioner of the New York City Department of Health,

he championed the call to reduce tobacco use

and deaths from tobacco,

banned trans fats in restaurants
in 2006,

and required chain restaurants to post calorie counts

on their menus, all done under
the public eye of the nation.

Last night you heard a very clear message from Doctor Frieden,

that rigor must inform not only our investigations

but also our evaluation

of the impact
of our investigations,

that we must know the who,
the what, the where, the why,

the when, and the how
of both the disease

and of our prevention programs
if we are going to change

the course of the epidemic
in the United States.

Please join me now to welcome
Doctor Tom Frieden,

the 16th Director

of the Centers for Disease Control and Prevention.

[Applause]

Good afternoon, everyone.

And thank you, Doctor Fenton.

It's great to be here
and to be with you

and to really support the work
that's going on

in HIV/AIDS prevention.

More than 25 years --

that's a long time.

It's too long.

And we need to work together
to reduce the burden of HIV,

to address the fact that it's continuing to spread,

especially among young gay men,

and to address the fact that risky behaviors are increasing

in recent years.

We have a lot of work to do
together to make HIV prevention

even more effective.

More information, more testing,

more opportunities for effective treatment are all critical.

We have to find new ways to ensure that every person

who tests positive has every opportunity to get

state-of-the-art treatment,

including state-of-the-art
prevention care,

that people who are on treatment stay on treatment

and have the prevention tools
and information they need

to protect themselves
and their communities.

CDC and our federal partners

and all of us, I think,
in this room are committed

to finding out what works
and what doesn't

to reduce HIV in the U.S.,
and then to scaling up

those things that are
most effective.

It's now my honor to introduce
the 21st secretary

of the Department of Health
and Human Services,

Kathleen Sebelius.

Secretary Sebelius has more than 20 years in public service,

beginning as a member

of the Kansas
House of Representatives

from 1986 to 1994,

as the Kansas State Insurance Commissioner for eight years,

where she was a steadfast advocate for Kansas consumers,

helping senior citizens save
millions of dollars

on prescription drugs
and drafting a proposed

National Bill of Rights
for Patients.

As governor, Sebelius expanded
Kansas's newborn screening

and renewed an emphasis
on childhood immunizations.

More than 50,000 additional children were enrolled

in health coverage
in her time in office.

She worked closely with Kansas first responders

and law enforcement to prepare
for natural disasters

and other emergencies.

In 2005,
for these reasons and others,

Time magazine named her

as one of the nation's
five top governors.

In the area of health protection and disease prevention,

Secretary Sebelius is committed

to effective efforts

to ensure a healthy America.

For more than a decade,
she has shown leadership

in this area
with a special focus

on helping those who are
least able to help themselves.

Today, as Secretary of
the Department

of Health and Human Services,

Kathleen Sebelius is leading
one of the largest

civilian departments in
the federal government.

She is committed to leading HHS and its 67,000 employees

to ensure effective prevention
and care for all Americans.

Prevention is on the map
as it has never been before.

Secretary Sebelius
and President Obama

are keenly concerned
and committed

to preventing HIV/AIDS.

Together, we can end complacency and reverse this epidemic

in the United States.

Secretary Sebelius.

[Applause]

[Crowd chanting "Stand up
for healthcare now!"]

Thank you.

[Chanting continues]

You're back.

I think they're standing.

Well, thank you for
that kind welcome,

both from the Healthcare Now advocates

and the nice introduction
by Doctor Tom Frieden.

I am so pleased we have
Tom Frieden

at the head of the CDC
at this historic moment,

this moment of opportunity.

[Applause]

As the previous speaker said,

we are the change
we've been waiting for,

and the good news about

the Department of Health
and Human Services

is that health and human services are back.

We believe in health
and human services once again

in the United States
of America.

[Applause]

Doctor Frieden did
a terrific job

as the Commissioner
in New York City,

and he is poised to be
a great leader

at the CDC, not only
of this effort,

but a whole series of initiatives

that are under the leadership

of the organization based

right here in Atlanta.

And I also want to acknowledge
the extraordinary work

of Doctor Kevin Fenton.

[Applause]

Not only does Doctor Fenton
bring great energy

to the fight against HIV/AIDS
in the United States,

he's helping build new partnerships and reach out

to underserved minority communities,

who continue to make up
a disproportionate percentage

of HIV cases.

Now, we have a real challenge
on our head.

Six years ago,
the United States announced

the most ambitious plan to fight global HIV/AIDS

in the history of the world.

And the plan combined
new levels of focus,

new funding,
and a new commitment

to proven approaches.

PEPFAR has been
a great success,

and that's very good news.

But while we've made strides
in Africa and around the world,

our progress toward ending
the disease

here in the United States
has stalled.

In 2006, more than 56,000 Americans

were newly affected
with HIV,

a rate that's been stable
for the last 10 years,

and stable is not good news.

Because the HIV infection
is fatal if not treated

and its transmission
can be prevented

with proven interventions,

this isn't just another statistic,

it's a national tragedy.

If the current results
aren't changed,

our actions
have to make them change.

And that's why one of the first things President Obama did

after he took office
was begin developing

the first-ever National
HIV/AIDS Strategy.

And the strategy will take

a page from the success
of PEPFAR.

A new level of focus,
a new commitment,

new funding, to provide
new approaches

here in the United States.

And the strategy comes
at a critical moment,

a time when more Americans
than ever

are living with HIV/AIDS --

an estimated 1.1 million of

our friends and neighbors.

And unfortunately, fewer Americans are worrying about it.

In 1997, just to go back
a few years,

one out of every four Americans said they were very concerned

about being infected
with HIV/AIDS.

Today, it's one out of eight --
half as many.

Over the last five years,
the share of Americans who say

they've seen a lot of AIDS-related messages went down,

from one in three
to one in six.

So we're at a critical
turning point in the country.

Either we choose to get used
to HIV/AIDS,

to accept that it's a permanent part of our landscape,

to be satisfied with just
the lengthening of lives

instead of saving lives,

or we decide here today
at this conference,

today and tomorrow,
by the work you all do

around this great country,

that we double our efforts

and start bringing down
the number of new infections.

President Obama has asked us
to be committed

to the second course

by calling on us to focus on reducing HIV incidence,

getting the people

living with HIV into care,

and working to reduce the HIV-related health disparities.

Earlier today, you heard about

the new National HIV/AIDS
Strategy from Jeff Crowley,

the Director of the White House
National AIDS Policy.

Jeff, you want to stand up again and let us thank you again?

And tomorrow you'll have
an opportunity

to share your input on how to improve the national response

to HIV/AIDS.

But for now, I'd like
to tell you a little bit more

about what the Department
of Health and Human Services

are doing to advance
the President's agenda.

In the coming weeks, we are going to have conversations

like this around the country,

so this is not a one-time
event and experience.

We want to make sure that we
drill this message out

throughout the United States.

Our Department of Health
and Human Services

deals with HIV/AIDS in every aspect of the agency.

Taken together, Medicaid
and Medicare make up

the largest share of
all federal funding

for HIV/AIDS care
and services

and provide a cornerstone for

the HIV care delivery system.

In SAMHSA,
our agency on mental health,

we know that many people living with HIV/AIDS

have concurring mental health
or substance abuse problems.

And the Substance Abuse

and Mental Health Services
Administration

provides critical
evidence-based intervention

to help support people
in recovery.

The National Institutes
of Health,

another critical agency
under HHS,

conducts and funds
cutting-edge research

that has led to lifesaving
antiviral therapies

and can bring us even better treatments in the future.

They're looking
at behavioral interventions

and hopefully viable vaccines
in the future.

The Health Resources
and Services Administration

operates the Ryan White programs

that provide support
for crucial medical care

and supportive services
around the country.

And let me pause and just say
that the Obama administration

is committed to working with you
to reauthorize Ryan White

this year, making sure that
the funding continues

long after September.

[Applause]

Another critical component of our work on HIV/AIDS,

I'm going to mention last
but certainly not least --

the Centers for Disease Control and Prevention here in Atlanta

works with health departments and others around the country

to provide an array of HIV
prevention services

to the American people.

The HHS Office of HIV/AIDS Policy hosts an aids.gov,

a gateway portal for AIDS information

and policy information
nationwide.

So we continue to look for
ways that we can address

what's happening with
the transmission and spread

of this disease and encourage
new strategies and intervention.

We're looking to continue
to increase the effectiveness

in all of these areas.

For example, we absolutely know that testing is one of the keys

to stopping the spread
of HIV/AIDS.

We know that it's a key
to lengthening the lives

of people living with HIV.

And since earlier --

since the earlier you learn about your HIV status,

the earlier you can start
taking steps

to protect your own health

and reduce the risk
to transmit HIV to others.

And that's why we recently made
a subtle but significant change

to our testing policy.

CDC already recommended
an opt-out routine screening

for HIV healthcare settings
for adolescents 13 to 64.

Two months ago, we took a step,

clarifying for state
health officials

that federal payments are
available

when they switch from
an "opt-in" testing

to an "opt-out" policy under
Medicaid and CHIP.

That's a very significant
step forward,

and one that we need
to make sure is adopted

in states around the country.

Now, individuals will still
have total freedom.

They can still choose
not to be tested.

But the test will be offered
as part of routine care.

And it may not seem like
a major switch to some of you,

but researchers looking at
other areas of government

that have gone from an "opt-in"

to an "opt-out"

have found it to be
very dramatic.

For instance, when workers are given the opportunity

for a 401(k) plan signup,

the change from opt-in
to opt-out,

enrollment goes up as much
as 30%.

So this can have a very significant impact

on the numbers of young adults
and adults who get testing.

We know it's something
that works.

But information like this
is only useful

if we can get it into
the hands of people

working on the front lines,

in state and local health departments,

in clinics, in community-based organizations,

in state organizations.

That's why we're also in
the process of refocusing

the Presidential Advisory Council on HIV and AIDS

to continue to advise us
on global HIV/AIDS issues,

but also to spotlight attention
on the domestic epidemic.

We hope the Council can be
a platform to share plans

and insights
with public health community

and the broader public.

And we also hope that it's

a great vehicle

to carry your ideas back
to those of us in government

trying to implement
the policy.

Now, I have a special announcement

that you're the first
to hear today.

I'm very excited to announce
that I'll be appointing

an internationally acclaimed leader with a long history

to end the epidemic around
the world,

but also here at home
in the United States,

to serve as Chairman of
the President's Advisory Council

on HIV/AIDS.

Doctor Helene Gayle...

[Applause]

Doctor Gayle, who is the President and CEO of CARE,

a former Director of CDC's National Center

for HIV, STD and TB Prevention,

has agreed to serve
as the new Chair.

And I would note
that Helene sponsored

the first National HIV Prevention Conference,

so you're here in part
of her legacy.

The President and I
are very grateful

for her willingness to serve,

and look forward
to her leadership.

That announcement is being
announced to the press

simultaneously, but I wanted you
to hear it first.

We're thrilled she's coming
to work with us.

[Applause]

At HHS, we're eager
to know what you think.

We're committed to reaching
an even broader audience.

That's why CDC has launched
the first federal

HIV education campaign
conducted since 1987.

It's entitled
Act Against AIDS,

and it's a $45 million investment

over the next five years,
to let Americans know

the threat of HIV/AIDS
hasn't gone away.

The effort will focus particularly

on underserved communities,

to include racial/ethnic minorities,

women, gay and bisexual men.

We're targeting our efforts
at high-risk groups

like African-Americans.

Today, African-Americans make up

just over 10%
of the American population,

but they account for nearly half of new HIV infections.

1 in 30 African-American women

will be diagnosed
in her lifetime.

1 in 16 African-American men
will be diagnosed with HIV.

In 2005, the CDC reported
that in five major cities

in the United States

almost half of
the African-American gay men --

half -- were HIV positive.

The situation is also dire
for Latinos.

Now, think about this.

Imagine, if it were half

of the straight white women
in Atlanta.

Wouldn't we be calling this
a national emergency?

Shouldn't we be calling
this a national emergency?

[Applause]

It is a national emergency.

And I'm here to tell you
that that's how those of us

at HHS are treating this.

So we're experimenting with
innovative new ways

to reach these groups.

From an online banner campaign
that targets

gay African-American men,

to partnering
with stakeholder groups

like the Black Women's
HIV/AIDS Network.

But this is just the tip
of the iceberg,

it's just the beginning.

We're also reaching out
to the Latino community

and expect to introduce
culturally appropriate campaigns

early next year.

And we'll continue to do
the same for other populations

at heightened risk
for infection.

Now, our outreach campaign
as you all know far too well,

we're battling
two opposite forces.

On one hand,
there are people who think

this is the age
of the multi-drug cocktail

and AIDS is just no big deal.

And we need to reach them
with a message

that AIDS is still
a devastating disease,

killing 14,000
Americans a year,

costing hundreds of thousands
of dollars to treat

over a person's lifetime.

On the other hand, we know that HIV/AIDS stigma

still remains a huge problem

with real
devastating repercussions

in people's lives.

There are lots of people

who don't get tested

because they're afraid
they could get beaten up

or lose their place to live,

or lose their jobs
if they come back positive.

They don't pick up a flyer
about treatment

because they don't want anyone to see them with a flyer.

They don't want anyone
to make a judgment

about their sexual orientation
or their drug use.

Because we care about

all our friends and families
and neighbors,

we need to send
a very strong message

that HIV/AIDS may be
a serious condition,

but we now have the knowledge
and tools to help people live

successfully with the condition.

And we plan to take
an important step

sometime later this year

where we will strike
a major blow against the stigma

when we lift the rule,

sometimes referred to as
the HIV entry ban.

This process began...

[Applause]

We began the process
on July 2nd when we issued

the new travel rule which would lift the ban

on HIV positive individuals

from coming
into the United States.

We're now in the comment period,
that lasts for 45 days.

And we've gotten about
20,000 comments.

We need to work our way through
the comments

and then we'll published
the final rule.

But this change has been overdue
for a long time.

The ban was not only unfair,
it was also unsafe.

The more accepted people feel
with HIV and AIDS,

the more open they will be
about their status.

And the more open
they are about their status,

the more likely people are
to get tested.

The more likely they
are to be tested,

the slower the spread
of HIV will be.

So we need to start
this as a virtual cycle

and make sure we play our role
in ending the stigma.

So, overturning the entry ban
is not all

the Obama administration will be doing this fall.

Some of you may have heard --

and there was a little reference to it earlier today --

we are in the middle of
a major push

for health reform
in our healthcare system.

Now, I know I'm speaking
to an audience that understands

what's at stake in this debate
and how important it is,

not only for those individuals living with HIV/AIDS

but for all Americans
to have access

to high-quality healthcare
in America.

We leave way too many people
uninsured and underinsured.

And even with the array
of government programs,

we know that,
day in and day out,

people fall through the cracks.

So there's been a lot of noise
in the media

and in conversations
around the country,

but let me clarify
a couple of things.

The President's plan
to expand coverage

and improve
our health insurance system

has very clear benefits
for all Americans,

and certainly for Americans living with HIV/AIDS.

For example, once and for all,
it will end

the insurance companies being able to pick and choose

who gets coverage based on
a pre-existing condition...

[Applause]

...giving more of our citizens insurance options.

It would end the cap

on out-of-pocket
insurance expenses,

which can quickly add up,
for people living

with a variety of diseases,
including HIV/AIDS.

Reform will be a help for Medicare beneficiary with AIDS.

Right now, given the high cost
of medications,

often we have people who hit
the so-called doughnut hole.

And part of health reform is
to begin to close

that devastating gap that affects far too many Americans,

and that needs to happen.

Now, your voices in that debate
as Congress returns

are critically important because
hearing from citizens

about the impact
on everyday lives

is one of the ways that we
will make sure

a bill gets to the President's
desk this fall.

We have another challenge
on our hands on the horizon,

with scientists predicting
that the H1N1 virus will spread

far more significantly
as school reopens

and as kids head back
to college this fall.

What we know is
Americans living with HIV/AIDS

are especially high risk.

Which means it's important that we get the message out

about practicing prevention,
hand-washing frequently,

coughing into a sleeve,
staying home when you're sick,

prior to the time when vaccine is available in mid-October.

But also encouraging people
to get ready

to be part of
the vaccination campaign.

Seasonal flu vaccine is available starting in September.

So we need to encourage
our friends and neighbors

to get their seasonal flu shot and then be ready

to be vaccinated against
this new virus.

Luckily, it isn't presenting
right now

as more lethal than
seasonal flu,

but we know that Americans with underlying health conditions

are particularly at risk.

When it comes to HIV/AIDS
in the U.S.,

we have a choice.

We can choose to get used
to the status quo,

that HIV/AIDS population
will be part

of an ongoing scenario
in America,

to accept it as a permanent feature of our society,

to be satisfied with
lengthening lives

instead of saving lives,

but the President has asked us
to join him

and take the other path,
to work to lower HIV incidence,

to work to get people
living with HIV

into safe programs,

to improve their health outcomes,

and to work to end the HIV-related health disparities.

When you do the math
on new HIV infections,

it turns out that one American gets infected with HIV

every 9 1/2 minutes.

That means
since I started talking,

two other Americans have acquired this fatal

and totally preventable disease.

So while the Obama administration

is enormously grateful
for the incredible work

you all have done
and continue to do,

we want to tell you
we want to work with you.

We're excited about bringing
a new focus, new resources,

and a new commitment to
the approaches we know work

to solving this problem
together.

And I'd like to end
by introducing

one of the spots from
the new ad campaign,

Act Against AIDS.

It's called "9 1/2 minutes."

And it will be airing
all over the country.

It's a reminder to Americans
that HIV/AIDS

has not disappeared --
and a reminder to all of us

about how much work
we have to do before it does.

Thank you for what you do.
God bless.

I look forward
to working with you.

[Applause]

Right here
in the United States,

every nine and a half minutes,

someone's father...

mother...

brother...

sister...

someone's friend...

someone's co-worker,

someone's neighbor --

every nine and a half minutes,

someone is infected with HIV.

Be the solution.

Visit actagainstaids.org.

Learn. Know. Act.

Thank you.

Let's hear one more round
of applause for the Secretary

and all the exciting news
she had to share with us today.

[Applause]

All right, I have a few
more announcements,

particularly for
the One SAMHSA meeting.

The onsite registration time
for registering

for the One SAMHSA Minority AIDS Initiative has changed.

The new registration time
for the onsite registration

is now on Wednesday morning,
from 7:00 A.M. to 12:30.

The location for the onsite registration remains the same,

which is in front
of Regency 6 and 7.

Need to get there
as early as possible.

And given that the closing session of this conference

ends at 12:30,

and the working lunch starts
the One SAMHSA Institute,

also at 12:30,

it's critical that you move
to the Regency 6 and 7

as quickly as possible following the end of the plenary session.

So we'll be providing
more information

to the One SAMHSA grantees
in subsequent plenaries.

Don't forget, this afternoon
we have the NGO Village,

so be looking for that.

And...

CHAMP is sponsoring
a meeting

from 8:00 to 10:30 tonight...
and party!

Meet-up and dance party
for HIV Prevention Justice,

featuring D.J. Taurus.

Who says Prevention Justice
is no fun?

Join us for great music
and fantastic company,

as we come together
to celebrate our accomplishments

in the struggle for HIV Prevention Justice

and get in rhythm
for the road ahead.

Thank you all very much.

Our next session starts
at 2:00 P.M.

See you later today.