

National HIV Prevention Conference 2009
Tuesday August 25th, 2009 Morning Plenary Session

Woman: So, good morning.

Attendees: Good morning.

Woman: Oh, we can do
a little better than that.

Good morning.

Attendees: Good morning.

Woman: My name is Marjorie Hill.

I am the proud
Chief Executive Officer

of Gay Men's Health Crisis

and ecstatic to be a part
of this morning plenary.

You know, HIV has changed dramatically

since the early days,

the days in which many of us
only could provide

an opportunity to support individuals who were dying

and to provide dignity

to those individuals
who were dying.

And because of medications
and technologies,

we are able to offer
the opportunity for individuals

living with HIV and AIDS
to live with dignity,

to make significant contributions to not only

the HIV/AIDS community,
but society at large.

This morning's panel will talk

about some of the new technologies that will, in fact,

improve the quality
of the work that we do

and ultimately impact
the work of the epidemic.

These scientific technologies
that support

HIV prevention efforts
continue to evolve

and yield new tools
and new strategies that have

the potential to substantially
improve the effectiveness

of local, regional,
and even international

HIV prevention efforts.

This session will highlight
some of the most important

scientific developments
in biomedical, behavioral,

and structural interventions
to prevent HIV transmission,

and the use of new media
to create innovative programs,

to further collaborations,
and connect with persons

living with, and at risk,
for HIV infection.

Our first presenter is
Doctor Susan Buchbinder.

Susan is the Director of
the HIV Research Section

of the San Francisco
Department of Public Health.

She is also the Associate Clinical Professor

of Medicine and Epidemiology
at UCSF.

Her research focus is
on evaluating

risk factors
for HIV infection

and evaluating
HIV prevention strategies,

including HIV vaccines,
pre-exposure prophylaxis,

behavioral interventions,
and combination modalities.

Doctor Buchbinder.

[Applause]

Thank you very much,
and good morning, everyone.

I'm going to bring up
the slides here.

And what I'm going to be speaking about --

oh, this is -- there we go.

I'm going to be speaking
about the combination

of biomedical and behavioral prevention interventions.

Because no matter what new biomedical preventions

are developed -- and I assure you it won't be

a robot developing a tray full of pills --

there is a very strong behavioral component

that will be a requirement
of that,

both to have people be --
desire and be motivated to take

the biomedical prevention intervention, to adhere to it,

to have access to it,
and ultimately to partner it

with behavioral interventions

to further drive down infection rates, and that's a theme

that I'll come back to throughout the talk.

I just want to say, though, also, that I don't think

that behavioral interventions
in and of themselves

are going to be enough,
as we all know who have

struggled with one kind
of health behavior or another.

And so I think we are going to need the combined approaches.

There have been some
dramatic successes,

as well as some real disappointments,

in the biomedical prevention field of late,

and I want to say that I think
a failure is one in which we

either fail to treat participants ethically

and take care of their physical and emotional well-being

and get fully informed consent for participation in our trials,

or trials that are either
poorly designed

or implemented or planned,
so that we don't get an answer

to the fundamental
questions that we're asking.

Conversely, success is clearly achieved when we develop

interventions that have a major public health impact.

But I think that we can also consider success to be

those studies that --
where the intervention itself

may not be successful
in driving down infection rates,

but in which we gain valuable information that helps

move us forward to more successful interventions.

So I'm going to highlight three major public health successes,

and not surprisingly,

the first one

that I want to point out
is the dramatic decline

in HIV infection rates
in MSM communities,

that were brought about
by behavior change.

This is a really high threshold for all of us who are working

in biomedical prevention strategies to achieve,

because these were
really huge, dramatic

reductions in infection rates.

But what you can see is that we have not been able to get down

to no new infections with these behavioral interventions,

and that, over time, they seem to decline somewhat.

And so we really do need
to augment those

with behavioral --
with biomedical interventions.

This is an example of a really dramatic biomedical intervention

that drove down infection rates

in newborns born to women
who were HIV-infected.

And this reminds us that, again, we need to be able to get people

who most need interventions access to those interventions,

and while we've been able
to make great strides

in the United States, globally, we have a huge challenge

in offering testing and access to care for women with HIV.

We've also had some dramatic successes in male circumcision.

There have been three large randomized trials now in Africa

that have demonstrated
a more than 50% reduction

in infection rates when adult men who are HIV-negative
are circumcised.

Their risk of acquiring HIV
is dramatically reduced.

And we may be further able to enhance that rate of protection

for men who are either
at very high risk

or if we follow men
over longer periods of time

and give opportunity
for the circumcision to heal.

However, with each of these interventions that I talk about,

I'm also going to talk about
the questions that are raised

and the new areas in which
we need to move,

because, for instance,
there were studies then done

to see if circumcising HIV-positive men might protect

against transmission
to their female partners,

and in the studies
that have been done to date,

there does not appear to be protection conferred to women

of HIV-positive men
if the man is circumcised.

We also don't currently have
any data on whether or not

this approach will be successful for MSM globally,

and we know that there's
a global MSM epidemic.

So I'm going to talk
a little bit now

about new biomedical prevention approaches,

and I'm going to start
by talking

about antiretroviral therapy
for prevention.

And that's both for positives,
as well as for negatives.

And we know that we've, again, had these dramatic successes
in preventing mother-to-child transmission
and there are observational data from sero-discordant couples
that suggest that
if the positive partner
has a very low viral load,
they're less likely to transmit,
and perhaps treated couples in which the HIV-positive partner
is receiving antiretrovirals
may be less likely to transmit to negatives.

There's a large randomized trial currently under way,

the HPTN 035 -- 039 --
I'm sorry, 502 --

HPTN 052 study --
there are too many studies --

that's studying that very question, and we also know that
with other infectious diseases, for instance, one of the reasons
that we're so quick to treat people with active tuberculosis
is not only to help treat
their infection,
but to prevent transmission
to others.

So there's a conceptual framework for doing this.

There's also
a conceptual framework

for prophylaxis
for HIV-negatives.

There are animal studies
that suggest

that if you treat animals

with antiretrovirals

and then expose them
to a related virus to HIV

that you can prevent infection.

And there is some weak evidence

from observational studies
in health care workers

that also suggest that post-exposure prophylaxis
may prevent infection.

We also know that for other infectious diseases --

certainly in HIV -- if you treat children who are breastfeeding,

you may be able to prevent
their infection

from an HIV-positive mother,

and that with malaria prophylaxis, for instance,

if you take a pill when you're exposed to malaria,

you may also be able
to prevent infection.

So this idea of testing
for treatment,

offering treatment to HIV-positives, is not new.

What's newer is that if you could test and treat

broad populations
and provide access to treatment

for broad populations
of individuals

who are HIV-infected and start the treatment not just

when you know that you'll have
a benefit for that individual,

but might actually,
even regardless of CD4 level,

you may be able to drive down infection rates,

that through modeling exercises in South Africa,

as shown in this slide,
that you may actually

be able to substantially reduce HIV infection.

Now, this is just a theoretical model, so we don't yet know
whether or not this will work, and there are efforts under way
to try to test the feasibility of this approach in the U.S.

as well as in global regions --

that some of the questions
that are raised

by this test-and-treat
approach are,

"How do we increase uptake
of testing; linkage to care;

access, uptake,
and adherence to medications?"

And that's true for us globally,

regardless of whether we're talking about treatment

for treatment's sake alone
or for prevention.

But when we're talking about treatment for prevention's sake,

we also have to look
at the balance

between long-term effects
for the individual

as well as for society,
and we have to ask,

will this approach drive down infection rates?

What level of testing
and treatment

will we need to achieve?

How will we avoid resistance?

And how will we partner this
with enhanced

risk-reduction strategies to get the maximum benefit?

Now I'm going to talk about

using antiretrovirals
for HIV-negatives.

And I want to make
a differentiation

between PEP,
or Post-Exposure Prophylaxis,

and PrEP,
or Pre-Exposure Prophylaxis.

So if someone is exposed to HIV and has some bad luck,

that sometimes leads
to HIV infection

that will occur and be detected anywhere from a few weeks

to a few months after infection.

If they're tested, that's when it will first show up.

If you offer a 28-day course
of antiretroviral therapy,

combination therapy,
that starts as soon as possible

after the exposure
and lasts for 28 days,

in some cases, you can block
new infections.

What we've learned from animal studies is that if you can

start the treatment as soon as possible after infection,

you're likely to have
the greatest impact,

the greatest reduction
in new HIV infections.

And if you can actually start the medications

before the exposure even begins,

at least in these
animal studies,

you may be even more successful in blocking HIV infection.

So that's the idea behind pre-exposure prophylaxis.

However, we know that people
may be exposed

on multiple occasions and that sometimes it's difficult
to recognize that you're at risk with a given partner
or in a given
exposure situation.

And so, in that case, post-exposure prophylaxis
is very challenging, because you need to start it right away
and you need to continue it
for 28 days.

And so the concept behind
the current round of trials

is primarily focused
on continuous

antiretroviral therapy
for individuals at risk

during these periods
of high risk

to try to prevent
HIV acquisition.

The drugs that are being used

in the current generation
of trials are either tenofovir

or a combination of tenofovir and emtricitabine.

And the reason that these two drugs have been chosen
is because of their safety profile, because there's
a relatively high threshold for resistance, they're easy to take
once a day, and they're generally very well tolerated.

But I think the future
may move us towards testing

new strategies and actually developing a new class of drugs

that could be used solely
for prevention

so that we didn't have to worry about resistance

and limiting treatment options
if resistance does develop.

I want to refer you all
to an AVAC web site --

the AIDS Vaccine
Advocacy Coalition --

that you can get to
through their web site

or directly at PrEPWatch.org,
that provides

really updated and comprehensive information about this approach

of pre-exposure prophylaxis,

as well as other
prevention interventions.

And this is a map of
the 10 trials that are either

currently under way
or soon to be launched,

using either oral
and/or topical tenofovir

or Truvada
in 13 countries,

with over 20,000 participants who will have been enrolled

by the time these trials
are complete.

This is a timeline
of the various trials.

And this is a whole generation of trials that are each asking

somewhat different
populations -- asking somewhat

different questions in somewhat different populations --

that will, as a whole, give us

a wealth of information
about this approach.

We can expect that we may start seeing some results

as early as later this year
or early next year,

particularly
in the safety studies,

and then efficacy results
in the upcoming several years.

So the questions for pre-exposure prophylaxis --

Will we be able to reduce
HIV infections?

How often does it need
to be taken,

and how will it
actually be taken?

So if you give continuous therapy, will people

still take it just around
the time of exposure?

And can we limit the number
of doses that need to be taken?

What will -- will it be safe over the short and long term?

And what kind of monitoring
will be required?

Can we, again, limit
the development of resistance

and perhaps develop
different classes of drugs

that could be used
for prevention alone?

How can we best marry
the clinical expertise

of clinicians offering antiretroviral therapy

with the substantial behavioral expertise of individuals who are

doing risk-reduction counseling to get maximum benefit here?

And how will we be able
to provide this intervention

for those individuals who are
at greatest need, so that it's

not a question of having money to pay for it, but that everyone

who is at greatest need
can actually receive this?

I want to remind you
that there are results

that will be released
later this fall

from another microbicide trial

that doesn't use antiretrovirals,

but it's a topical approach
to blocking HIV entry.

And there were some data reported earlier this year

from the HPTN 035 study using the 0.5% dose of PRO 2000

that showed a modest benefit --
a 30% reduction in infection --

but again, some hints that
for women who used it

most consistently and weren't using other forms of protection,

we saw even higher levels
of protection.

Now, this was just a trend,

it was not statistically significant, and there are data

from a larger trial that will be
out in the next several months

that we hope will shed additional light on this,

because in that trial, individuals who got

a higher dose of this microbicide were not protected.

but we're looking
at this lower dose

to see if protection
is provided.

And I want to end,
in terms of talking

about biomedical preventions, with HIV vaccines,

because we know that vaccines have been critical

to control of a number
of infectious diseases

in the U.S.
as well as globally.

They've eradicated smallpox

and we've had regional control of polio

through the use of different kinds of vaccines.

We did have some disappointing results in the fall of 2007

from the Step study
that tested

Merck's trivalent adenovirus vector vaccine.

And so what that does is,
it takes

a weakened form of a cold virus, that doesn't cause colds

because it's been weakened,
and inserted three different

kinds of genetic information from HIV --

gag, pol, and nef -- to try to either prevent HIV infection

or drive down viral load

in individuals
who got this vaccine.

That was the goal of the study.

The vaccine doesn't contain
any live or killed HIV,

so it, in and of itself,
cannot cause infection.

But what we found is that
it did not provide protection.

When we looked at the first interim analysis

in the fall of 2007,
we saw neither

a reduction
in HIV infection rates

nor a driving down
of HIV viral load.

And surprisingly, in two subgroups of men in the study,
we actually saw that it appeared that they had
higher rates of HIV infection
if they got the vaccine
than if they got placebo.

Now, again, the vaccine did not cause the infection,
but if they were later exposed sexually, it appeared
that they had a somewhat higher risk of HIV infection,
and that was especially true
for men who were uncircumcised,

but also, there was a trend towards that increase in risk
for men who had antibodies against the adenovirus,
this cold virus that was used
as the carrier in this vaccine.

There's an enormous amount
of work being done

to try to understand in what ways might the vaccine
have led to
increased susceptibility.

And what we've seen in following study volunteers over time
is that that effect,
that increased risk,
appears to be going away.

We didn't have enough infections in women -- fortunately,
the risk-reduction counseling
that the women received
drove down infection rates
to such a low level
that there were very few infections in women,
and about equivalent in those who got vaccine
versus those who got placebo.

But we need to learn from each of these trials,

and I actually think that
in many ways,

this was a successful trial,

even though the product
was not successful.

And what was successful about it was that we set out to answer
a question about whether or not this vaccine and this approach

would protect --
provide protection.

And we found that
it did not provide protection.

It gave us critical information about how to better use

these animal studies and how to look at the role

of mucosal immunity,
or the genital tract,

and what's happening with vaccines' interacting

with the genital tract, to try to protect against infection.

And we are starting to see
small glimmers of hope

in that some kinds of immune protections may be resulting

in a lower viral load in some small subgroups of individuals.

So we need to build on
the information

that we get from these trials
in moving forward.

So the HVTN has launched
the 505 study,

which is a focused efficacy trial, proof-of-concept trial,

in men who are both circumcised and Ad5 negative,

to be sure that it's safe.

It's using a somewhat different approach --

it's using a DNA,
three doses of a DNA,

in combination with a different
adenovirus vaccine.

It's got a different backbone
and it's got

different components that are included in the vaccine,
and it generates a different immune response.

So the goal of this smaller, more targeted study is to see,
can we have an impact and bring down viral load in individuals
who get the vaccine
and understand more

about what kind of immune response

it's going to take
to develop a successful vaccine?

I want to remind you that
in the next several months,

we will be hearing about results from the Thai vaccine trial
that started many years ago,
in 2003,

but is now complete
and undergoing evaluation.

And this is an approach using
a different kind

of vector vaccine,
the canarypox,

with a gp120 boost.

We will have results
about this trial towards --

some time this fall, and we'll look forward to those results.

And I want to remind you
that 10 years before we had

the licensure of a highly effective polio vaccine,
one of the lead investigators
in polio research said,

"What -- the kind of immune response that we need

"to generate in creating a polio vaccine is completely unknown,
and it's not clear whether we will ever know what we need."

So we don't know how far along we are in the process,
how long it will take.

We know that for other vaccines, it's taken many years,
that we're 26 years now
since the discovery

of HIV as the cause of AIDS
and counting,

but that there is substantial progress being made.

And I'm going to close by reminding us that if you just,

in these modeling exercises,
if you were just to offer

circumcision to 90% of
the South African population,

you could drive down
infection rates by a third.

If you didn't do
any biomedical interventions

but just had people reduce
the number of partners by 30%

and increase
condom use by 30%,

you could drive down infection rates even further -- by 2/3.

If you combine them, you can virtually eliminate infections.

And so we really have to remember that if we want

to increase the effectiveness
of HIV prevention,

which is why we're all here,

then we need these
combination approaches.

And I'm going to end by thanking my many colleagues

for their input into this talk, and remind you that both

Carl Dieffenbach

and Peter Kilmarx

are going to be giving talks
about biomedical prevention

at 3:30 this afternoon.

Thank you.

[Applause]

Doctor Buchbinder,
thank you very much.

There is often an unspoken tension around the issue
of biomedical interventions
and the general HIV prevention work that many of us do.

The reality is that this is
a new day.

Clearly, there's a new administration

and a new enthusiasm
in the administration that we

as community individuals
and others

welcome and are eager
to partner with.

But one of the things
that we all can agree on,

whether or not our specialty
is in the area

of biomedical interventions, behavioral interventions,
or structural interventions -- that, you know,

HIV is a complicated and complex
medical, social,

and cultural challenge for us
in this century,

and unless we figure out
how to -- we, in this room --

accept, benefit from, and share the information
across our areas of specialty, then we really do

our HIV prevention efforts
a disservice.

So I want to thank
Doctor Buchbinder

for her presentation
and for probably giving

one of the clearest explanations around the difference

between pre-
and post-prophylaxis

that I have ever seen --
that's a great slide.

I can't wait to get it
and show it to others at home.

Our next presenter is someone who is very familiar
to us who work with the CDC, everyone in this room,
and to all of us
at the conference.

Doctor Richard Wolitski is

Deputy Director of Behavioral and Social Science

at the CDC's
Division of HIV/AIDS Prevention.

For more than 20 years,
his research has focused

on better understanding
and preventing HIV risks

among people living with HIV
and diverse at-risk populations.

He is an associate editor

of the Journal of AIDS
Education and Prevention,

serves on the editorial board
of AIDS and Behavior,

and has been a true friend to those of us outside of the CDC.

Doctor Wolitski.

[Applause]

Hello again.

This morning, what I'm going to do is share with you

some of my personal thoughts

about the present
and the potential future

of behavioral interventions.

But before I start,
I'd like to just acknowledge

a few of the many people who have helped to shape and refine

my thinking about both
the science of HIV prevention

and the practice
of HIV prevention.

I'll be talking briefly about where we are in the present,

in terms of efficacy of existing behavioral interventions,

and I want to spend most of
the time this morning

talking about where we might be able to go in the future

and how we might be able
to further improve

the efficacy
of behavioral interventions.

We know
that behavioral interventions

have been proven to work.

There have been a lot
of scientific reviews

that have shown
that behavioral interventions

can reduce sexual risk behavior,

that they can reduce
injection risk behavior,

and that in some cases they can reduce the incidence

of new sexually transmitted infections.

These interventions have been shown to work in a wide range of populations, including men who have sex with men, drug users, heterosexual women and men, sexually active adolescents, STD clinic patients, and people living with HIV.

In 2007, Seth Noar published a review of the meta-analyses that had been published, looking at behavioral interventions and their effects on sexual risk behavior.

Now, you all know that a meta-analysis is really an analysis of a bunch of different studies.

And so, in each of these 18 analyses, there was a median of 19 individual studies included.

And each of these meta-analyses included

a median of more than 9,000 participants.

And what he found in this review is that the meta-analyses showed a significant increase in condom use in all 11 of the meta-analyses that had data addressing this issue.

There was a significant decrease in unprotected sex in 9 out of 11 meta-analyses, and there was a significant reduction in STD acquisition in 4 out of the 6, or 67%, of the meta-analyses.

Nicole Crepaz and colleagues

from CDC's
Prevention Research Synthesis

published a specific meta-analysis focused
on the effects of behavioral interventions on risk behavior
among people living with HIV.

Across the studies that have been conducted

looking at this issue,
they found

a 43%
reduction in unprotected sex

following receipt
of a behavioral intervention.

43%.

They found an 80% reduction
in the odds of acquiring

a new sexually transmitted infection

following an intervention.

You know, as I mentioned yesterday, CDC has recently

added six new interventions
to the Compendium

of Effective Behavioral Interventions,

which now brings the total
up to 69 interventions.

It's important to note that
the majority

of these interventions
were designed

and tested for
communities of color,

and some of the groups that are most represented

in the Compendium include adult women -- 18 interventions --

there are 15 interventions
for youth,

13 for IDUs
and other substance users,

and 10 for people living
with HIV.

And you can access the updated Compendium by going
to www.cdc.gov/hiv.

But there's still critical gaps in the Compendium
and in the availability of tools
to prevent the spread
of HIV and AIDS.

In the Compendium, only seven
of the interventions
were designed and tested specifically
for at-risk
men who have sex with men.

One of the newly added interventions was
for African American MSM,
but that's the only intervention

that is in the Compendium
for black gay and bisexual men.

There's only one intervention specifically designed
for Asian
and Pacific Islander MSM.

And there isn't a single intervention designed
specifically for Hispanic
or Latino

or Native American
or Alaskan Native MSM.

There are many other gaps,
as well.

Only three of the interventions
were designed and tested for heterosexual men.

And other gaps include
a lack of interventions
for American Indians

and Alaska Natives,
transgender persons,
rural populations,
migrant and immigrant populations,
and interventions that were
originally developed and tested in Spanish.

Now, when we talk about
the Compendium,

nobody thinks that
the Compendium includes

all of the interventions
that exist in the world

that are truly effective.

We know that there are a lot
of other programs out there

that are likely to be effective,

but they just haven't yet
been rigorously evaluated.

I want to talk about a study that CDC funded

where we supported
a community-based organization

here in Atlanta, SisterLove,
to rigorously evaluate

their Healthy Love workshop,
or as they call it,

the "Healthy Love Party,"
which is an intervention

that was developed for
the community, by the community,

back in 1989.

It's a single-session intervention

that is theory-based,
and it's specifically

focused on black women.

And in this evaluation,

they compared

the Healthy Love workshop
to basic HIV 101 session

in a randomized trial
with 313 women,

and they found that
the intervention

significantly increased both condom use and HIV testing.

Now, if you want to learn more about the Healthy Love workshop,
there will be an opportunity right after this session.

Dazon Dixon Diallo
will be presenting

in the International Ballroom South.

So...where can we go
in the future

to improve behavioral interventions?

One of the major issues
that we have to address is

the difference between

the efficacy of an intervention
in a scientific study

and its impact
in the real world.

The impact of an intervention
is what ultimately

defines the success
of an intervention.

What matters is whether
the intervention is effective

in the real world
and whether

community-based organizations
and health departments

are able to implement
that intervention,

and if it's an intervention

that individuals are willing

to come to
and willing to stay in,

once they've started
the intervention.

The duration of the effects,
or how long

behavior change lasts, is critically important, as well.

And finally, another major determinant of impact

are the reach and the scale
of interventions.

We know that
the interventions that work

are not reaching all of those who need them.

So when we think about
an evidence-based intervention,

it can be efficacious,
it can change behavior,

but we have to recognize that it doesn't exist in a vacuum.

It exists within
a broader context

of HIV prevention programs
that bring people

in to the interventions,
that provide them

with a range of services, that address their multiple needs,

and that establish and build
the trust and the credibility

and the relationships with communities that are necessary

for the success of evidence-based interventions.

The ultimate impact
of a prevention effort

is also influenced
by the community

and the extent to which community norms

support healthy behaviors
and provide access to the tools,

such as condoms
and sterile syringes,

that are necessary for people
to reduce their risk.

So I'm a community psychologist by training,
and some of my peers are probably going to be

a little annoyed at me
right now, and some of the MDs

are probably
going to be a little happy.

But what I'm going to talk about now are three things

that I think
behavioral intervention research

can learn from
biomedical research.

The first has already been alluded to.

Combination therapy.

We know that a single class of HIV treatment is insufficient.

Where would we be with HIV care today if we had stopped

with AZT, DDI, DDC,
and d4T?

We wouldn't be at a very good place, would we?

Combination therapy for
the treatment of HIV

is the accepted
standard of care.

And for prevention,
as other speakers

have already acknowledged,
there's a clear recognition

that we need different classes of interventions that include

biomedical, structural,
and technological.

But we also need
different combinations

of behavioral interventions.

So I want to use an example
from HIV testing

to illustrate this point.

HIV testing is one of those interventions that's

kind of a little bit
biomedical intervention,

because it's a diagnostic tool,

and it's a little bit
behavioral intervention,

because the knowledge
of sero-status

can lead to behavior change.

We know that HIV diagnosis significantly reduces

risk behavior among people
with HIV.

But it does not significantly change risk

in HIV-negative clients,
when we're talking about

just receiving
an HIV-negative diagnosis.

We do know, however, if you add to the HIV testing

high-quality counseling,

that you can reduce risk behavior and STD acquisition

among HIV-negative individuals.

Project Respect showed
a 30% reduction in new STDs

in the enhanced HIV counseling arms at six months,

and there was still
a 20% reduction in new STDs

at 12 months following
the brief intervention.

And we can still do
better than that.

Jim Dilley and his colleagues
at UCSF

developed and tested

the personalized cognitive counseling intervention, or PCC.

This is a single session --
individual session --

that is for MSM,
for repeat HIV testers,

and it's an intervention
that takes it up a notch.

It's one that is conducted
by a licensed

mental health professional,
and it specifically focuses

on men's self-justifications for unprotected anal intercourse.

So when they compared this additional

single-session intervention

to standard HIV counseling
and testing,

this is what they found --

so in the first set of bars,
at baseline,

which is in the light blue bar,
going to six months,

they found a reduction in unprotected sex from 45% to 31%,

but by 12 months,
there was no difference

between baseline to follow-up.

However, among the men who received the PCC intervention,

there was
a substantial reduction

at one year following
the intervention

that remained significantly lower, compared to the men
who only received standard counseling and testing.

The second lesson
that we can learn

from biomedical interventions is

the value of targeted
and tailored treatment.

We know that everyone
does not respond

in the same way
to HIV treatment.

And we know that you just can't give somebody the medications
and not see them again.

HIV treatment requires ongoing monitoring for both intended
and unintended consequences, such as side effects.

We also know that HIV treatments

are highly effective
for some people,

but they don't work as well
for others.

And here, I just wanted
to illustrate this

with an example from treatment of breast cancer.

So there's a powerful drug
called Herceptin

that is used in the treatment
of breast cancer.

Now, this drug only works, however, for women who have

a type of breast cancer
that expresses the HER2 gene.

If you look at how well
this drug looks overall,

when you just give it
to anybody,

it doesn't look that effective.

But when you identify the women whose cancer has this gene

and you treat these women
with this medication

that is targeted specifically
to their cancer,

it's very powerful.

We need better matching
of the intervention needs

of individuals in communities
to our interventions.

Currently, the way we approach prevention is...

a really broadly targeted way.

We say, "If you're a drug user,
you're a gay man,

"you're a Hispanic woman,
you're a young person,

we've got the intervention
for you."

But what we don't
fully appreciate

is that not all youth
are the same.

Not all women are the same.

We need to better target
our programs

to meet the needs of the people that we're serving.

We also have to look deeper

at the effects
of our interventions.

We determine the success or
the failure of an intervention

by how well it works
with everybody

who participated in the study.

And we've actually done relatively little to understand

why a given intervention works and who it works for.

And we've done even less
to look at our interventions

in terms of who they
did not work for

and to understand, for
an individual whose behavior

did not change
after they participated

in one specific intervention, why they didn't change

and what it was that that individual may have been

dealing with, that they needed to get from that intervention

and didn't receive,
so that we can then

meet those needs better
in the future.

I just want to highlight
an example

of one of the few studies
that I think has actually

done a great job of
looking at this issue.

This is an example from
the ARTAS study,

the AntiRetroviral Treatment Access Study,

and this is a paper
by Lytt Gardner that was

just published in 2009
in AIDS Patient Care and STDs.

The ARTAS trial showed significant overall effects

in improving linkage
to medical care,

but follow-up analyses

looking at the moderation
of those effects --

which is looking at who changed and who didn't --

showed that change only occurred

in 12 of 26 subgroups
that they looked at.

They found that this particular intervention worked best
for Hispanics, those who were unstably housed,
and those who were
not depressed.

And when you step back and you look at these results,
they indicate both
the opportunity

for better targeting
our intervention approaches

and tailoring and further improving our interventions
to increase their efficacy.

So I got to pick it up
by now.

So the last concept
I want to leave you with

is the idea
of sustained treatment.

HIV treatment needs to be sustained over time
to be effective, but too many people seem to expect

that a single
behavioral intervention

will change people's risk forever.

That perspective does not adequately recognize

that behavior change is
an ongoing process

that needs to be maintained
and supported over time.

Now, I don't think
that we need directly observed

behavioral interventions
on a daily basis.

But what we do need is
a layering and a synergy

of our intervention efforts
at multiple levels.

So if we think of someone
who tests HIV-positive,

that person needs to be linked to treatment,

that person needs to be
linked to supportive services

that are provided by programs.

Every time they see
their health care provider

and when they receive
social services,

they need to be getting messages that reinforce

the maintenance
of safer sex practices,

and these norms
and these practices

need to be reinforced
in the wider community.

So we're at a critical crossroads in HIV prevention.

We know that prevention works when we apply

what we've learned, but we've also got to continue to improve

the efficacy, the efficiency,

and the impact
of our interventions.

We have both a tremendous opportunity and a responsibility

to change the future course
of the epidemic.

Thank you.

[Applause]

Thank you, Richard.

I'm going to say something

that may come

as a little bit of a surprise --
or maybe not.

I'm an African American,

and I believe in
call and response.

So, I just need you to do
one thing for me.

I want to hear you say "prevention works."

Attendees: Prevention works.

Hill: Now, if I were a member
of Congress,

and I were about to do appropriation,

that would not convince me.

So, can I hear it one more time?

Attendees: Prevention works!

Hill: Okay, thank you very much.

I mean, I think that the sum of the challenges

around the new behavioral interventions

is that clearly, they work,

but there needs to be
targeted approaches

and that it is not a one-shot opportunity.

In the same way in which we understand there are

medical interventions that go over a course of time,

there is an expectation,
often from legislators,

that one-shot DEBI's, which are very effective and work,

and then that's supposed to last for five years,

10 years, 20 years,
it doesn't really make sense.

And so we need to be clear
about that

but not be defensive about
it at the same time.

Julie Davis, would you stop Twittering me.

One of the new technologies
is the Internet.

If she did Twitter me,
I wouldn't know what to do,

because I haven't gone to
the capacity building thing yet,

but I'm going.

And while
the administration is new

and there's lots of excitement around the President's

new appointees
and the National AIDS Strategy,

there are some people who have been working

within the administration
and within HHS

for some period of time who are long-standing

in their efforts around
HIV prevention and education.

Miguel Gomez helped direct
the creation

of the aids.gov,
an online gateway

for domestic HIV/AIDS information.

As Director, he's responsible for promoting the use

of new media tools in the fight against HIV/AIDS

and the encouragement
of new media

across the federal
government's work

and with
its external partners.

Miguel has worked for

nearly 25 years

to combat the HIV/AIDS epidemic,
and he also has a long history

of working
with federal grantees.

Again, he has many, many credentials.

I won't go into them,
but I will say that --

now he's Twittering me to stop.

Ladies and gentlemen,
Miguel Gomez.

[Applause]

Thank you.

Cool.

It's a new time
and it is a new world.

And I bet you -- be bold.

In the audience, raise your hand

if you don't know
what Twitter is.

That's okay.

You can, and others --
oh, and leave the lights on.

It's morning.

You, if what I present
isn't enough information,

please, during the conference, go and speak to

your colleagues who really know how to use new media tools

or social media tools,

and they will sit down with you
one-on-one.

And I am going to talk about
the adoption of new media.

Because, in reality, we're not sure where we are

within the HIV/AIDS community.

I'm a little bit anal,
so I asked Bob Kohmescher,

the king coordinator of this conference --

and we should give him a round of applause again.

[Applause]

And that wasn't for me
being anal.

But what was really
important was --

so I asked Bob, give me
the registration list

for this conference.

I want to look at the web pages of all of you.

Well, we don't have enough time, but I have an intern

who got a little --

but anyway, really looked
at what you were doing

with your web sites.

But I also talked to
the leaders across

our AIDS service providers,

and who are responsible
for federal HIV programs.

And I'm going to share with you what we learned from them

because it's really important.

And, actually, one thing
I want to do is

really laud this conference
and pay attention

to what's happening
at this conference.

This conference is using Twitter to reach those

who aren't here with us who need to hear the important messages

that you already heard
this morning.

Later on, Jeff Crowley
will do a town hall meeting.

That will be videotaped
so others can share

and engage
in the conversation later.

There's blogging and there's several sessions

on how to use new media
or social media.

But what I'm going to start doing is

I'm going to give you
a lot of data

because we all really need to understand

where our clients are.

And I'm going to
first start with

where we are on the Internet.

Well, first and foremost,

your clients, your brother
and sister, your partner,

your neighbor, your wife,
your husband

want their health information when they want it

and how they want it in whatever quantities they want it.

So, it's not just good enough to do the web page or brochure.

We have to think about
all the tools

that are available to us.

Eight in 10 adults in
the United States

are using the Internet.

And it's true across
all of our communities.

When we look at our
African American

and Latino communities,

the adoption of using our
cell phone

is much higher than our Anglo brothers and sisters.

It is really important to know that people are looking
and using these tools.

And when people are
going online,

they, you know,
are working to --

most folks, they're
sending an e-mail.

They're looking for some information.

Looking for Mapquest.

Or perhaps not Mapquest,
but instructions someplace.

But, third, they're looking for health care information,
medical information.

Next, they're looking for something that interests them,
a hobby.

I'm not going to define
what a hobby is.

Um...

[Laughter]

Okay.

But what's real important is to know that you and your clients
are looking for health care information online.

And I want you all
to reflect on this, please.

150 million Americans last year
were looking for health care information.
And when they found that information,
over 60% of them believed that information was so accurate
they decided based on
what they heard
or what they read on
the Internet
are they going to trust what they heard
when they went into your clinic
or went into a doctor's office.

They believe that
information so much,
it is so trusted,
we have to make sure our information is available.

And, look -- 10 million
American adults
are accessing health care information online
by using their cell phone.

Where is our information?

Is it available on our cells?

And the impact!

Recently, I was talking --

and I won't disclose
the person's name --

to someone who's responsible for millions and millions
and millions and millions of federal HIV dollars.

And I asked the person,
"Well, how do we use
new media in response to AIDS?"

The person's response was,
"Well, the Internet is dangerous."

And I said, "Well, perhaps
we should say

it's a place to start
a conversation."

And there's a lot of myths
about the Internet.

But what's important
is people find,

when they look for health care information online,
it's a benefit for them or someone else they know,
and only a small percentage find that information harmful.

And I bet those are the folks who actually didn't read
what was on the Internet.

But can't judge --
I can't ground that assertion.

I apologize.

You and your clients
are being social

and having a conversation.

You know, it's called new media or Web 2.0 or social media
because it is social.

And people are having
a conversation.

And what's wonderful is clients are sharing information
about their own
experiences online.

And they're going to Wikipedia.

And many of us forget that Wikipedia is a source
that we can actually edit

by pushing one simple button
on that web page.

And 20% of patients are actually sharing content.

There's nothing more important for someone living with HIV

or at risk for HIV to know what someone else thinks.

And there's a wonderful
web site --

I'll call it wonderful.

It's called Patients Like Me,
where over 7,000 people living with HIV/AIDS
are sharing their experience

from all across the country
and the world

where they're just saying
"These are the pills I take.

"This is what I think
of my doctor.

"This is what
I don't think of my doctor.

This is what happens
when I take the pills..."

from stomachaches, to rashes, to, you know, depression.

And they share with each other

how to make things better
for each other.

It's engagement, it's social.

And what's also really,
really important,

there are some wonderful tools that allow patients

to help track
what they're doing.

And, again, I can't
emphasize enough

how much people really embrace

and want to celebrate
these tools.

It makes them happy.

And it's really, really important to know

that when someone feels satisfied with an experience --

as Rich,
you were just talking about --

people act, and they act differently.

But, let's be real.

We all have an obligation
to learn.

Because, as we're looking
at the adoption of new media

in response to HIV/AIDS, there's a lot of unanswered questions.

And we have been talking within our AIDS community

for two years now
about what should we be doing

in response to HIV
when it comes to using

tools available on the Internet.

And, overwhelming, that many of our colleagues do not know

how people are going online
to find health information.

Many times they're not really sure what their clients
are doing online.

And -- and this is okay.

Like, many of you
raised your hand

who don't know what Twitter is.

Many of us do not know
what new media is

or how to fit it into our
health care planning.

And then, sometimes, we hear about something like Twitter
and we get really excited.

I can tell this story

because he's a wonderful colleague and friend --

our acting Surgeon General.

I did a presentation on,
you know, what is new media,

how people are using it, and he got so excited about Twitter.

"It's sexy, it's fun,
it's gonna reach people."

So, he asked
his communication director

to leave the presentation
to sign himself up

for a Twitter account.

And I know it's wrong,

but I threw myself
in front of her.

In the workplace, you're not supposed to touch people.

[Laughter]

But I was like, "Ugh!"
Where's the planning?

What does those he can reach
and serve want from him?

And another thing happens.

For so many of us,
it's something else to do.

Or we don't have access at work.

Or, sometimes, many of our clients don't have access
to these tools.

So, we have to ask ourselves what can we do better
within our own workplace?

Because it really is,
and I want to reinforce,

it's about the planning
and finding out

do our clients want us
to use these tools?

Are they already
using these tools?

But, you know what's
really cool?

The planet's changed.

We've emphasized this
a few times.

A man who announced
in Lincoln, Illinois,

that he was running for President and got

little to no press coverage

is the President
of the United States.

[Applause]

He could not have done it without this.

What can we do with this?

And, you know, what is
new media?

I mean, it's changed,

it's really leveled
the playing field.

You know, so many people were dependent on books,

newspapers, and their doctor.

I mean, we look --
and we still do --

and we should be looking up
to our doctors.

But now I can ask someone living with AIDS in Nebraska,

San Francisco, or Shreveport

what do they think
I should be doing.

What has changed is the power
of the Internet is with us.

It's with you.

And the world has changed.

And what's important again,
it's a conversation.

It has leveled
the playing field,

and it's trusted.

And as panelists, we know
many of you in the audience.

You're smart.

We want your information available on the Internet

because it is trusted.

But we also have to
let go of some power

and let our clients put
the information up.

It's about engagement.

So many times, our clients
and those we're trying to reach

really have the answers.

And I know it's a crowded field.

Lots of tools out there,
but there's ways

in which we can learn and apply these tools.

And, you know,
look at some examples.

Many of you in this room
are already blogging.

Doctor Fenton has a blog.

You heard from Carl Dieffenbach.

He just started blogging, sharing the federal journey

on HIV/AIDS research
and where we should be.

And you know
what's really wonderful,

what we're doing with
Doctor Dieffenbach's blog?

Some people don't like to read.

So, you know what we're doing?

We're reading it into
a recording device

so someone could listen to it.

Took five minutes.

Repurposed that,
made it available

in a different format for folks.

And there are consumers telling their story

that are so important
for us to share with others.

One thing -- you know,
and I really liked the fact

that you talked about Twitter
because Twitter is hot.

People are putting
information out.

I mean, yesterday,
almost 20,000 tweets.

When it was announced
by the Secretary

that Helene Gayle is the new Director of PACHA,

tweets started flowing wonderfully.

It was great!
The information moved quickly.

I was getting
phone calls because --

why isn't there press releases at the White House

or HHS about this announcement

because people were
reading it on Twitter.

Video sharing.

People really want to see
what you're doing.

And this is a slide from
AIDS Chicago Foundation.

And many of you are
using video sharing

because it's really important.

Every minute,
10 hours of video...

How many times have you watched that little kitten on YouTube?

I keep putting photos of kittens with AIDS ribbons.

I mean, I'm doing what I can.

[Laughter]

But what's important
is our Secretary,

who, you heard her yesterday,

who said "It's a new
health department."

Phew.

What was so important is what she did her first day at work --

and she started at 8:30 at night because of confirmation.

And she had to respond to
an event that was being telecast

on H1N1 the next morning.

She had someone
photographing her

as she was meeting her staff

so we could put her photos up
on the Internet.

Because people identify
with their peers --

someone like me.

And we wanted folks to know

who this woman was.

And mobile, it's astounding.

How many people here
in the audience,

please raise your hand

if you know where your
cell phone is right now.

Okay, keep your hands up, please.

Now, all those people who have children,

keep your hands up,
and a cell phone.

Put your hands.

Okay, how many people know where your children are right now?

[Laughter]

Well, you know, I don't know.
Okay.

Just something.
It's an amazing little platform.

Just asking.

I'm sure you're responsible.
You're in public health.

But what does this mean for us?

In DC, our schools start
in about a week.

Our kids in DC are going
to be sending

50 to 150 text messages a day.

Is a new language evolving?

You know, 88% of us across
this country own a cell phone.

50% of mobile users send
text messages.

And the average text right now,

people respond,

is within 15 minutes.

Or they read within 15 minutes and respond within 45 minutes.

That's good.

How do we use that?

You know, one of the number one need for our clients

that we serve across
the United States,

they want text reminders for appointments --

once you ask them
if they can have them.

Because what's cool about text messaging right now,

there's pretty much no spam.

And this use of
social network sites,

people are engaging and using Facebook and MySpace,

Patients Like Me,
and many others.

And I did mention if I perhaps was entertaining

but not giving data,
please go

and visit the new media lab
or the workshops

that are happening later about the adoption of new media.

And the bigger question,
will it help.

Well, right now, we know that
it doesn't matter

about new media.

Well, why did you just say it doesn't matter about new media?

Hmm?

It's about the message
and what we're saying.

It has always been about
the message.

We're just using what tools
are available.

And, number one, of course,
it's about those

we're trying to reach and serve.

And it's about planning.

And, you know, will it
help you manage?

How many of us
are not adopting

these tools within
our workplace?

It's cost-effective.

Many of these tools are available online

and are free.

What's also true is that,
you know,

it does take a little bit
of time

to start to learn how
to use these tools,

but they're so very important.

And there's multiple ones

that can help us make
our jobs better.

And I have to tell you,
don't use one of these tools

if it doesn't take
something off your plate.

We have enough to do.

It should be helping us
do our job better.

For example, at aids.gov,
we blog each week

on how to use new media
in response to AIDS.

But we repurpose it.
We repurpose it.

It's wonderful.

We then just read our blog post into a recording device,
which we do at our desks.

And then what we do is we take two or three messages
from that podcast,
and we create tweets,
which are messages on Twitter.

And then we just automatically put that new information
up on our web page.

It takes us less than 20 minutes to make all of that happen.

Again, reach people
where they are

and how they want to be reached.

And also, soon, people
aren't going to be wanting

to come to our web pages.

They're going to want that information brought to them.

And the CDC has done
a wonderful job

creating things called widgets that allow information
to be cut from their pages to be brought to your web sites.

It's about syndicating

and sharing content
and information.

I mean, the presentations

you heard this morning
were terrific.

Put them up on your web pages.

And this slide was given
to the staff

for Senator Obama when he was running for office

to say, "Listen, it's a process.

Start by crawling, walk,
and then you can move rapidly."

He was able to change what is happening on the planet.

We will be able to continue.

As Rich said, the world
is changing.

We can continue to change things for our clients
and we have the ability to learn how or continue to do.

Thank you very, very much.

[Applause]

Thank you, Miguel.

The world is changing.

Communication is changing.

And the new media
opportunities that --

the opportunities that new media presents for HIV prevention

will enable us to not crawl,
not walk,

but run in our efforts

to enhance those prevention efforts.

Our final speaker
is someone who,

if you have been awake
in the last 20 years

and paying any attention to HIV, we all know --

and that's all of us
in this room, obviously.

Doctor Robert Fullilove
is Associate Dean

for Community and Minority Affairs

and Professor of Clinical, Sociomedical Sciences

at the Mailman School
of Public Health

at Columbia University.

He currently co-directs
the Community Research Group

at the New York State Psychiatric Institute
and Columbia University.

He's also Co-director of Columbia's MPH Degree program,
Urbanism
and the Built Environment.

Doctor Fullilove has published numerous articles
on minority health
with a particular focus on
HIV/AIDS and sexually transmitted diseases.

From 1995 to 2001,

he served on
the Board of Health Promotion

and Disease Prevention
at the Institute of Medicine

and at the National Academy
of Sciences.

Since 1996, he has served on five IOM study committees

and has produced a variety
of reports

including Substance Abuse
and Addiction,

HIV and AIDS,
and Indoor Spaces and Health.

In 2003, he was designated National Associate

for the National Academies
of Sciences

and was appointed to
the Advisory Committee

on HIV, STD, and Prevention
at CDC,

where he was Chair
until the fall of 2004.

And there are many, many
other credentials

that Doctor Fullilove has.

But I will say that he is
an inspiration to many of us,

someone I consider
a personal mentor and friend.

And we welcome him
as he talks about

structural interventions.

Thank you.

[Applause]

PowerPoint Light.

Many of you who've taken
classes with me know

that I started life
as a preacher.

So, it's sort of interesting that I'm following

a talk about new technologies

when I'm a guy who has resisted the use of PowerPoint

for 10 these many years.

In thinking about structural interventions,

I had a variety of
different options

that were available to me
to make this particular aspect

of the work we do
in HIV/AIDS available

to such a broad audience.

I thought about doing a review of the literature,

which is really quite considerable.

But then I opted instead

for doing what preachers
like to do --

I wanted to give you a message.

So, I'm going to give you something

in the way of a history
of our thinking about

structural interventions
that goes beyond

what we've been doing
with HIV/AIDS.

And I want to end with
what I describe as

a kind of a modest proposal
for us to think about

future directions
in structural interventions

that have particular focus
on communities of color

here in the United States.

I want to point out the fact

that for those of you who are academically inclined

and who want to read more
about this topic,

Judy Auerbach and the AIDS 2031 working group

on social drivers of HIV/AIDS

has done an absolutely
marvelous report

that does, I think,
a marvelous job

of describing this field
and putting it into

some real perspective.

But I want to begin
more modestly.

Monica, I don't know
whether you're

out there in the audience,
but I think

this is one of the pithiest ways of thinking about
and talking about structural interventions.

The whole notion that we're dealing with

is that individual choices
are often structured

by the social
and behavioral environment

in which people live.

This is a way of saying that what you choose to do

is often a function
of what's available to you.

What's available to you
in terms of your culture

and what it considers to be appropriate norms for behavior;

what's available to you
in your environment

in terms of what you can
and cannot get.

And it's also a function
in many ways

of how society functions
to direct you

towards those things that will promote your health

and those things that will expose you to disease.

Many of you know that I spend
a lot of time

in France every year,
so I couldn't resist.

[Speaking French]

I want to point out that
while many of us

like to think of public health as being
the quintessential science
of providing access
to medical treatment
and to the marvelous cures
that have dominated much
of the 20th Century
and the beginning of
the 21st Century,
the real fact is that public health had its beginnings,
really,
with some fundamental changes
in the environment of cities
where we were able to accomplish magnificent things
long before we even knew
that such things as germs
and microbes existed.
I want you to think about
the 19th Century
in the Western world.
This is the time of
the Industrial Revolutions.
Cities are springing up
all over the place.
They're expanding.
They're becoming crowded.
Poor folks are being pushed
into neighborhoods
where the sewage is awful,
where animal bodies are
in the street.
Access to clear, clean water
was almost nonexistent.
And cholera was one of
the major scourges
that ran through cities like London, Paris,

and New York City.

If you think about what we did to combat cholera,

it's important to understand that we had

a variety of different ways
that we could approach

the ways in which we were going to control

this particular set
of epidemics.

Farley and Cohen have written what I consider to be

a truly remarkable book.

It's not necessarily directed
at those of us

who are public health professionals,

but it is a terrific read
for the general public

who needs to understand something about

what public health is all about.

And I think some of
the points they make

in talking about cholera provide a sort of a nice foundation

for my own thinking about how we can focus on

issues of structural interventions.

They pointed out that if you thought about the ways

in which cholera
was running rampant

through many poor communities
in urban areas

throughout the Western world,

we had -- if you think
about it --

one of two possible approaches to dealing with this plague.

We could have gone
to a set of strategies

that would have focused on individual behavior.

Cholera comes from
contaminated water.

So, we could have told people "Wash your hands.

Particularly, wash your hands after you go to the bathroom."

We could have told people,

"Before you use water,
make sure that you boil it."

We wouldn't have completely eliminated cholera,

but we would have certainly reduced by a significant amount

the amount of morbidity
and mortality

that was associated
with exposure

to this particular pathogen.

But what we actually did instead was change the city.

We created clean water supplies,
we improved housing,

we improved the capacity of cities to remove trash

so that the water tables that were supplying the cities

with this much-needed liquid were clean.

If you think about it, this is one of the first real

structural changes, and it is absolutely at the core

of the history of
public health --

not just here
in the United States,

but in much of
the Western world.

All right, let's fast-forward
to the HIV epidemic

of the 21st Century.

What are some of

the opportunities
to do similar kinds of transformations
of the social and political environment
that create the kinds of conditions
that expose people to HIV?

Many of you know that for
the last 15 years,

I've been writing heavily
on issues looking at

the impact of mass
incarceration --

prison industrial complex,
if you will --

and its impact not simply
on HIV/AIDS,

but on the distribution
of morbidity and mortality

within poor communities
of color.

It is important to understand that if there was one way

in which we might change
the social environment

that structures a lot of
the risk

that many of our clients confront,

it would be to think about
the legislation

that over the course
of the last 50 years

has made this society one of
the most prison-dominated

on the planet.

[Applause]

Many of you are aware of
the fact that while we make up

5% of the world's population,
we house 25% of all the inmates doing time behind bars
anywhere in the world.

Our rate of incarceration exceeds that
of Russia and China combined.

If you are in a community where rates of HIV/AIDS
amongst people who are currently behind bars
is three to five times
what it is
in the general population,
and if you understand
the degree to which
we have been
in an absolute frenzy
to find ways to combat crime
by putting more and more people
behind bars,
you'll understand the degree
to which we're in a situation
where if we were simply able
to change the structure
of a lot of the legislation
that creates
Departments of Corrections,
we would do an enormous amount to reduce the amount of risk
that is represented
by locking up
so many non-violent offenders,
many of who are in need
of drug treatment,
behind bars in situations where
they're going to be
exposed to HIV.

[Applause]

So, what's a way of taking advantage
of what I consider to be this absolutely unique year, 2009?

I mean, have any of you
noticed, as have I,

the kind of madness
that we're living through

when we think about how Americans are

dealing with issues of incarceration?

There's a report
that is being released

by the National Law Center
on Homelessness and Poverty

that talks about
the degree to which

we are suddenly facing
a situation

as a result of hard
economic times

where we are seeing
a dramatic increase

in the number of homelessness --

number of cases of homelessness in our cities.

In places like Atlanta,
some 30% of all the folk

who are currently homeless
are newly homeless.

They're folks who've just lost their rental apartments,

they're folks who've just lost their homes

within the last year.

Are you also aware of the fact that in many cities,

what we're doing is we're criminalizing homelessness?

You can give me an amen on that.

[Laughter]

What are we doing?

We're saying if you are homeless and you're congregating

in a public area that has
a lot of tourists in it,

you're committing
a quality of life crime

and we're going to haul
off to jail.

We're saying that if you are someone who wishes to aid,

clothe, or feed someone
who is homeless

in one of these public areas,
you may be subject to arrest.

We are suddenly
discovering that

in an effort to make sure
that we maintain

our capacity in many of our major tourist attraction cities

to bring in tourists to see
the city at its best,

one of the things we have to do is sweep the homeless

from our streets, and the way we're doing it

is not by providing them
with new housing,

we're simply sending them
to jail.

Many of you are aware of
the fact, for example, that --

if I can shift the tone
ever so slightly --

in the city of New York,
if you are somebody

who is out on
the street on parole

and a cop rolls up on you
and demands to see

some evidence that you are currently housed

and you can't produce it,
that constitutes

a violation of your parole,
and you go back to jail.

Now, what's the contrast
I alluded to earlier?

Well, think about the state
of California,

which suddenly discovered that it's got too many prisoners.

It's under federal order.

It's got to in the next two years release 43,000 inmates
back into the streets.

They're not doing this because they see the madness
of being in a system that is increasingly incarcerating
more and more adults.

No, they're doing this because they're running out of money.

And because they're
running out of money,

I think they're engaged in something that looks very much
like panic behavior --
"Let them all go -- quick!"

[Laughter]

Well, they're about to let
a large number of folk go

who, like the folk
who are newly homeless,

are going to find themselves
in situations

where they simply cannot cope with the conditions

that they're going to find
in their home communities.

And as a result of this,
they're going to be engaging

in a variety of behaviors

that are going to put them
at risk for HIV.

Not least of which is
engaging in protected sex --

unprotected sex, rather,
as a way of finding shelter

as a way of finding protection,

and as a way of getting out
from under

the police sweeps that are making it difficult

for them to survive.

In these kinds of situations,
I think there's bound to be

major public blowback.

If you were to Google,
for example,

"prisoner release
in the United States,"

you'll see article after article,

editorial after editorial,

where people are frightened about what it's going to mean

in your community to suddenly have large numbers of folk

returning to the community

who have no place to go,
who have no jobs,

who have no real opportunities,

and who are going to constitute an enormous burden

on social services that,
by the way,

we're in the process of cutting

in just about every state
in the United States.

Understand that one half of all the states in the U.S.

are currently considering shutting down prisons
and letting non-violent offenders go.

I want to suggest
that this constitutes

a really dramatic increase
in the number of folk

who are going to show up
at our doors

because the conditions
of their release

and their capacity to survive
in the community

is going to be such that they're going to be engaging

in the behaviors that
put them in harm's way

and expose them to HIV in ways that we have not seen before.

So, what do we do?

I think it's really important for those of you

who haven't seen this report to download it from Google --

"One in 31."

This is from
the Pew Center on the States.

It makes a point that I think
is really lost

on large numbers of us that our system of incarceration
is actually two systems.

The first system is the one
that we know about --

putting people behind bars.

But the second one is the one that is actually

dealing with
probation and parole,

and the community monitoring
of current offenders.

Now, understand only one
in every three offenders

in the United State
is currently behind bars.

But \$9 out of every \$10 spent
on the offender population

is spent on prisons --

on prison construction,
on prison maintenance,

and on prisoner maintenance.

This means that we have
a system that is

in a terrible state
of imbalance.

There are 2.3 million folks doing time in prison

in the United States right now,

but there are 5.1 million who are currently out on the streets

on probation, on parole,

or under the supervision
of the courts.

We spend about \$2.34
per parolee, per probationer

in our current national system of dealing with this issue.

We spend \$78 per day to keep somebody behind bars.

Do you begin to see the nature of the imbalance

that I'm describing?

I think that if you
were to focus

on one structural intervention that might dramatically change

the risk environment that many of us are increasingly

dealing with
in major urban areas --

and in a lot of rural areas --

it would be one in which
we thought about the role

that each of us might play in what I see as a growing movement

to think through the issues

of how we do
the community monitoring

of people who have been recently released from prison.

I believe that part of
the monitoring,

part of the social controls, part of the social services,

and part of the medical services

that are going to
have to be offered

to this growing population
have to include us.

We have to be at the table negotiating a place.

Because much of what these communities are going to see

are increases in the behavior that has created

a growing HIV epidemic
in the United States.

I know that a large number
of people

over the course
of the last 10 years

have increasingly been involved in corrections health,

and I know that I'm not alone
in understanding the degree

to which this is probably

one of the most significant structural factors,

one of the most
significant social drivers

creating the landscape
that many of us deal with

in our daily work
with folk who are at risk

for HIV infection.

I want to suggest that working with Departments of Corrections

is one of the items
that was missing

from yesterday's
plenary session

that talked about ways in which a National AIDS Strategy
would be put together.

Who was missing from this conversation?

The answer is
folks who represent Corrections.

I don't know about your town,
but in my town,

the people who are running
the Department of Corrections,

the folks who are
running the jails

and the folks who are in charge of a lot of the prisons

look exactly like the people
who are behind bars.

[Applause]

They're black and they're brown.

We're the ones who are inside,

and we're the ones
on the outside looking in.

I think that many of us
are in cities

where more and more we're seeing people come to us saying,

"You know, something?

"This system that I'm operating
is getting out of control.

I need your help."

I'm going to make a prediction

that we're going to start to see as part of that public blowback
that I described earlier about having so many new folk released
onto the streets --

I want to suggest that a large part of what's going to happen
is a re-thinking of how we fund many of the services
that are going to be provided for this population.

And I want to suggest that as this re-thinking goes on,
our voices need to be heard.

I don't care
what you're doing --

whether you're a physician working in a clinic setting

or whether you're somebody
who's doing peer education,

the folk who are going to be
in our communities

with nothing to do
and no place to go

are going to be our clients
in the future.

It is inevitable.

And it is important that we start to think
about ways in which to anticipate this change.

I'm suggesting that as part of
a National AIDS Strategy

and as part of what we do locally,

we're going to have to
be with the folk

who are talking about housing.

We're going to have to be
with the folk

who are talking about training and education.

We're going to have to be
with the folk who are talking

about a wide variety
of drug addiction services,

because these are exactly
the set of needs

that people are going to
have to be provided with,

and these are exactly
the kinds of things

that are going to help us
reduce the new risk factor

that I think is represented
by this dramatic change

in the way
in which we are dealing

with our systems
of incarceration.

Let's be real clear.

The one thing that
all of us know

who have been coming to these conferences every year

is that amongst all the folk
who are in professional life

in the United States,
we are the ones who know

that before we get to the floor of this conference,

we're going to be treated to
a lot of really bad news.

This an epidemic that every year gets worse and worse and worse.

I'm not telling you anything
you don't know.

But how many of us have broken out into a cold sweat

when we understand that we
are 30 years into

an epidemic
that continues to grow

at a time when the country
is going broke?

I think that the only
structural change

that really is going to matter for many of us in this audience

is the way in which we are facing a future

in which we're going to see
an incredible redistribution

of social service dollars.

I worry that we're going to be in a system

where folks are going to start to fund public health

simply on numbers.

We're the greatest amount of morbidity and mortality

in American society?

And that kind of reckoning

at a time when AIDS
is no longer,

if I can use Sandy Thurman's term, sexy,

diabetes
and cardiovascular disease

are going to eat our lunch.

As well they might --
as well they might.

I'm suggesting that of all
the things that

we have been thinking about in the course of this conference,

thinking about ways
in which we re-think

the structure
of our interventions,

in which we re-think
the structure

of our policy thinking,

in which we re-engage
our legislative bodies

about what we're going to
do in the future,

that focusing on ways in which we deal with

the prison industrial complex
is an idea whose time has come.

We are facing a new world, brothers and sisters,
ladies and gentlemen.

And in that new world,
I think it is clear

that the thinking of the past
has got to give way

to thinking about the future.

Let me end with this thought.

I'm at Columbia University, which has, on occasion,
hosted a number of people
who've won

the Nobel Prize for Economics.

I happened to be with a graduate student in a bar --

this was a French speaker,
so we were drinking

a lot of very good French wine.

[Laughter]

And on the third glass
of burgundy,

the graduate student
looked up at me and said,

[Slurring] "You know, Bob..."

[Laughter]

"I've been running the numbers.

"I think by 2015,

"we're going to be in
the latest version of

"the Rise and Fall of
the Roman Empire.

"In your lifetime, Bob,
you have seen

the sun set on
the British Empire."

Many of you may know
that I was born in 1944,

so I'm an old guy.

1944 saw the end of the British hegemony in the world

and the beginning or the rise of the American Empire.

Well, my drunken economics graduate student said,

"2015 is the year
when it all ends.

"2015 is the year when

"they're going to start
calling in all the money

"that we've borrowed from
so many banks in Asia,

"and we're suddenly
going to find ourselves

"a second-rate power trying to deal with

"enormous social powers
and enormous social problems

for which we have no money."

Changing our thinking, changing the structure of our thinking

is the most important
structural intervention

that I think we can make
this year at this conference.

Thank you.

[Applause]

So, there we have it --

biomedical, behavioral,

new technologies,
and structural.

New technologies to fight
the war and to win.

Thank you very much.

And now I'd like to have
Bob Kohmescher,

who has done a great job
with the conference,

with some additional morning announcements.

Thank you very much.

Bob, I'd -- Bob? Bob?

I need to correct one statement
that you made

in your presentation
this morning.

Bob said that he was born
in 1944, he's an old man.

Having been born
three years later --

I think you'd actually
agree with this --

you're actually
at the peak of your life.

[Applause]

As I'm sitting in the audience

listening to the speakers
this morning,

I was both -- I couldn't believe the clarity of the information
that was presented this morning.

And it really left me with
a great feeling of optimism

with all of us here and all of the work that we're doing.

And the fact that we are,
each conference,

learning more about what we need to do to change behavior.

Now, this evening, you're going to have an opportunity

to participate in perhaps
the most significant plan

to prevent the spread of HIV
in this country

that we've ever had since
that MMWR article in 1981.

On your chairs, we provided you
a couple of index cards,

and what I think
will be a real keepsake

or a memento from
this conference,

a brochure describing our session tonight.

I wanted to let you know that I've also been coordinating

the involvement of those who have not registered

in this community, and we have had nearly 200 people

from the community register
to attend this conference.

It's quite likely that we will more than fill this room.

So, we've made available
a spill-over room

in the Regency.

So, I want to encourage you
to get there early.

I also want to encourage you
to keep these two index cards

that you received in your bag,

because you're going to get
an opportunity

to write down some of
your thoughts,

some of your questions,
and then turn them in to

Jeffrey Crowley and Ona so they can review their comments.

We won't have a chance,
needless to say,

to listen to everybody that
has something to say,

but at least we'll have a way
of providing feedback.

The other thing I wanted
to let you know,

I've had many people come up
and ask me

if the plenaries
are going to be online.

In a sense, that's a silly question to ask

because, Miguel, you know
the answer to that.

Of course, we're going to put these online.

We also hope to have many of
the PowerPoints online.

When we send you e-mails encouraging you to fill out

the online evaluation,
we'll also be providing you

information about when those will be posted

and where they will be located.

I also want to remind
the 500 people or so

that are going to be registering

for the One SAMHSA meeting
on Wednesday

that we've opened registration from 2:00 through 7:00 today

in the Grand Hall level
of the Hyatt.

And then tomorrow from
7:00 to 12:30.

So, that will give you a little bit more time to register.

I also wanted to point out that in Track G, Session G12,

which is scheduled for
3:30 today,

it's named "Integration of Youth
in the Pacific Jurisdictions,"

should be renamed
"Integration --

"Lessons from the Asian
and Pacific Islander Communities

in the United States."

So, please be aware of that.

Also, it's been a long conference.

It's been a long conference.

And I wanted to let you know that we're going to continue --

the Wholistic
Stress Control Institute

will continue to provide
a morning

movement and meditation class

to get your day started
on the right step.

That's going to be 6:30 to 7:15 tomorrow morning

in the lobby level
of the Marriott

in rooms L706 and L707.

I also wanted to encourage you,

since we scheduled plenaries
at noontime,

do try to get an opportunity,
take the opportunity

to visit the exhibits
and particularly the posters.

As I mentioned yesterday,

we've had 240 posters
on display,

so please don't miss

that opportunity to see these...

the excellent work that was not able to be presented.

By the way, we had well over
900 abstracts submitted

for this conference,

to let you know about
the interest in HIV

that we received this year.

The other thing I wanted
to do is

you've been watching
on the screen,

and I'll turn around and look.

Yes, he is signing
what I'm saying.

That's a very, very
difficult job.

I'd like to hear a round
of applause for our signers.

[Applause]

You know,
we're so focused on AIDS

that we don't want to forget those who have other needs.

And the other thing I wanted
to let you know

is the reason our plenaries will not go up online immediately

is because we are required --

I shouldn't use the word "required."

It's the right thing to do
to make our plenaries

508 compliant so that those
who are unable to read

messages on the web
have an opportunity to see

the presentations in a format that they can read

and take care of --
or to take advantage of.

So, we'll be making those
508 compliant

so that those with disabilities

can also take advantage
of those.

Julie did not send me
a text message.

She actually handed me
a piece of paper.

Which sometimes we have to go back to old technologies.

From 8:30 to 9:30 tonight,
we're having a meeting --

they are sponsoring a meeting
in the Fairlie Room.

HIV Prevention Justice

and the National HIV/AIDS Strategy.

So, come together tonight
if you're interested in

HIV Prevention Justice
and the National HIV Strategy

to meet and discuss
the various issues.

So, that's 8:30 to 9:30 tonight.

I also wanted to mention
that immediately following

the session tonight
from 6:30 to 8:00,

we're going to have a special presentation at 8:15 --

with Bowie State University,

is going to be providing
some entertainment.

So, please take advantage of that this evening.

And for lunch today --

I know that's high
in your minds --

to keep you energized, we're taking care of the lunch problem
that we experienced yesterday.

We'll be making more lunches available.

And we ask you to take
only one lunch.

We had some people taking multiple lunches yesterday,
and that meant that
a lot of people
went without lunch yesterday.

So, in any event, we want to
thank our panelists

for an incredible job.

[Applause]

And let's now take off
for our sessions.

And we'll see you
back in here at 12:15.

Thank you very much.

It's what is saving
a lot of people's lives.

Because if you can
get tested now,

even if you think
you have it or not,

I think everybody
should get tested

because you don't know,
you know.

then there is help...

Thank you

