Official Press Conference
Kaiser Family Foundation
July 24, 2012

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CHRIS BEYRER: — Plenary Press Conference. I have just one brief announcement to make before we begin, and that is that one of the Plenary speakers, Assistant Secretary Herbert Coe will not be joining us for this session. He had another engagement and sends along his apologies.

My name is Dr. Chris Beyrer, I am the incoming President-Elect of the International AIDS Society, and I'm Professor of Epidemiology at Johns Hopkins, which is quite close to here, in Baltimore.

Today's Plenary, "Challenges and Solution" focused on challenges surrounding the implementation of treatment as prevention, in those settings most affected by HIV/AIDS. It's a pleasure to have today's speaker sitting beside me, and without further adieu, I would like to introduce our first speaker, Dr. Javier Martinez-Picado.

He is ICREA Research Professor at the AIDS Research Institute in Barcelona, Spain. And the research programs he is leading focuses on understanding how HIV causes disease in recently infected people, exploring the best anti-retroviral treatment strategies, fighting drug resistance, and collaborating on global HIV/AIDS vaccine development projects.

His very important plenary this morning follows some of the cure discussions that happened at the pre-conference, led

by our incoming President, Francoise Barre-Sinoussi. Dr. Picado.

JAVIER MARTINEZ-PICADO: Thank you very much. I think that, I don't want to repeat exactly what they did during the presentation, but I want to leave a couple of ideas for you. One is that we made important progresses in the last 2 to 3 years in terms of exploring the issues of HIV eradication. I mentioned that it can be focused from the sterilizing perspective, or the remission perspective. Both options can be very valuable.

We do have new compounds, we have new immune treatments that are now focusing ion exploring HIV eradication, HIV cure. We have gene therapy as well, that may be a little bit down the road in these strategies. What I didn't mention in my talk is there is a huge effort to find new compounds in the drug libraries. Compounds that might be able to specifically be used in HIV reactivation without inducing global [inaudible] activation in the patients.

So I think that we will be existing in the next 2 to 3 years, numerous studies showing how new compounds might be able to reactivate latency, and contribute also to the cure and eradication.

CHRIS BEYRER: Next, Nelly Mugo is a research scientist, and obstetrician/gynecologist at the Kenyata National Hospital in Kenya. She has worked on 2 really

critically important multi-site AIDS prevention trials, as Regional Director for the Landmark Partners in Prevention, HSV/HIV Transmission Study, and Site Investigator for the Partners PrEP Study. Dr. Mugo.

NELLY MUGO: Thank you. I think, as we move towards thinking about implementation and changing how we do HIV prevention, what is key is what has changed. And what has changed is we now have the proof that ART can be used for prevention. The question is how we will utilize this to actually make a difference in the epidemic.

We have a large set of tools that we can use. We have [inaudible], we have condoms, we have [inaudible] issues, now we have treatment. And I think the way to approach patients now has to come from the focus of those people who are at risk of getting infected.

Understanding that population, understanding their vulnerability, and coming up with a package that is useable for them, as a group. And in this thinking, I think one of the things I feel I didn't emphasize, and which is key, is the aspect of youth. If we see that 42-percent of the infections are occurring before people reach the age of 24, we have a really great window in which to intervene, and make a huge difference in the coming generation.

So if we think, if we could concentrate our effort in this population, in another 5, 10 years time, we would have

made a real big difference in the number of HIV infections.

And this is also prevention of mother-to-child transmission. Because if we can't prevent young women from getting HIV, we cannot eradicate neonatal infections.

Finally, I think it's just the lessons learned from other programs, like circumcision. Even when we know what we need to do, it takes time. We have to learn from what has happened in other programs, as we move forward to implementing the tools that we currently have.

But finally, we just need to do it. As much as there are challenges, we shouldn't allow this to hold us back. If we start, and we evaluate what we are doing, we can find ways to overcome the challenges as we meet them. And I think, even as we talk now, there are things that happen that can help us overcome challenges that have been identified in implementation.

CHRIS BEYRER: Thank you, Dr. Mugo. Appreciate that. And our last speaker this morning, Dr. Bernhard Schwartlander. Dr. Schwartlander currently holds the position of Director of Evidence, Innovation and Policy at UNAIDS in Geneva. He previously served as the United Nations Country Coordinator on AIDS in China, and before joining the United Nations, Dr. Schwartlander was the Director of the National AIDS Program in Germany, his native country. Dr. Schwartlander.

BERNHARD SCHWARTLANDER: Thank you Chris. I just want to focus on three main themes of the presentation I just gave. The first one is that we have to, and we can do better with the resources we have. If we focus on the right things that makes the biggest differences, and stop the things that really don't make that much difference. But also looking into how we can deliver those services more efficiently, saving cost. So that we can put people on treatment, on prevention, with the same amount of money that we have.

The second [inaudible] theme that we have is the world is changing dramatically around us. The numbers are significant in growth, economic growth, especially in low and middle income countries, in Africa, in Asia, and if we can apply this growth in wealth to health, that's one of the theses I Put forward, we can really get much closer to this gap, to filling that resource gap that we have now, through increased commitment, and steady commitment, and also domestic leaders.

The third point is, while we—and just to finish that point—the world will have changed dramatically in the next 8 years, and the number of low income countries was at 73 in the year 2000, will be down to 20 in just eight years from now in 2020. So there will be a much smaller number of very poor countries. Most countries will be in the middle-income category. We have to make sure that we apply that increase wealth to health, as one of the best investments.

The last point is we really do need more resources in terms in international solidarity. There is no question that we need to have more of the international support. And it would be the very worst point in time to pull back now that we actually know what works. We have seen major success. We have seen domestic resource commitment come up dramatically.

For the first time ever, the majority of resources for the fight against AIDS is actually coming from domestic sources in the low- and middle-income countries. So it would be the wrong point in time to pull back for the international donors at this stage.

We will be able to really turn around the epidemic and go towards zero if we build, as a shared responsibility, and solidarity, where all parties basically do what they can do, as I mentioned, deliver services more efficiently, cut cost where possible, focus, but also give the additional resources that we do need to go to the end. Thank you.

CHRIS BEYRER: Thank you Bernard. I'd like now to open up the floor to questions. I'd ask for the journalists out there please state your name and your media organization, and indicate which of our three tremendous speakers you'd like to address your question to. I'd also ask you to keep your questions as brief as possible, and to the point. Please.

JUNHAR BLOUNTS: I have a question for Bernard Schwartlander.

CHRIS BEYRER: Could you please state your name and your media organization?

JUNHAR BLOUNTS: I'm sorry. *Dutch National Radio*, my name is Junhar Blounts [misspelled?]. Domestic, do you mean Abuja Agreement? And is there something familiar like that in Asia as well, for instance?

BERNARD SCHWARTLANDER: I understand there are 2 parts to the question. One, when I speak about the increases in domestic financing to AIDS that's an observation that we had. How much money countries in lower and middle-income countries actually put forth themselves out of their own budgets, to fight AIDS, and that has increased significantly, and is now outweighing, collectively outweighing, international sources.

JUNHAR BLOUNTS: But could you split it up for Africa and Asia? That's my first question.

BERNARD SCHWARTLANDER: Yes, we have done that. And of course the—about half of the total increase that we have seen is actually coming from Africa. Which is very significant, including some of the poorest countries. So there is commitment. The poorer countries, of course, not in terms of absolute amounts, is less, because it's a fair share.

But clearly only very few countries actually fulfill their own commitments towards the 15-percent Abuja target and we postulate that if we could achieve that, obviously we could generate significant additional resources which could help to

really close the gap, the total gap that we see right now of 7 billion dollars between now and 2015.

CHRIS BEYRER: Other questions?

MONIQUE DEWALL: Hello, Monique Dewall [misspelled?], ABC News. This is a question for Dr. Picado, please. Could you highlight what you think are the most important of the various research projects going forward in the next couple of years? In other words, what should we be keeping our eye on, and particularly in terms of cure research.

JAVIER MARTINEZ-PICADO: I am almost sure that the next 2 years are going to be based in basic science, so we will have one big challenge. And the big challenge is that what we are looking for in people who are on anti-retroviral therapy, the residual viral replication, or the latency, is a tiny amount of virus that is there. So we have to develop the assays, and the studies to be able to pick that in a sensitive way. So one of the goals is to move into tissues.

I mentioned during my presentation that so far, most of the research on HIV has been done in blood. But we are almost pretty sure that there are at least some issues in which we can find more virus than in blood. So those will be the first places to look for those viruses.

And then there is another, I think, challenging idea, is to try to develop animal models in which we can explore latency and persistence. I'm almost positive that the next 2

years will be basically focused on that, and that can be, or should be a little preliminary, before moving into big clinical trials with the drugs we might be finding.

So, again, clinical assays, basic science, and probably animal models will be the 3 priorities.

JUNHAR BLOUNTS: I am still the same person. Could you elaborate, Dr. Mugo, on the resistance issue. Because, well, it's a resistance on the individual level, people might not be able to profit from first-line pills, but of course there is also public health issue that people might contract a new strain of a virus, if I understand well.

NELLY MUGO: Is that for treatment?

JUNHAR BLOUNTS: That is about—the prevention question, yes. Sorry. The PrEP type of—

NELLY MUGO: For PrEP?

CHRIS BEYRER: The potential resistance issues in PrEP. In PrEP yes. Because they are quite different. The resistance issues for treatment, and the prevention issues for PrEP.

JUNHAR BLOUNTS: Yes that's why I ask what the effect might be if people on PrEP might get resistance, and then what is the first-line follow up?

NELLY MUGO: For treatment, yes. I think one of the encouraging things from the data from the PrEP trials is that the majority of the resistances that were observed were amongst those who were infected at the time that they started. When

they were enrolled. And there are very few of them. So a total of about eight infections. And the majority of them lost their resistance, and it was not to the drugs that were utilized.

The other encouraging issue, actually in the data set, is that people who did not adhere at the beginning, tended no to adhere. They had very low drug levels. And I think that's part of the reason that didn't see a lot of resistance. And for people who adhered and had high drug levels, then the drugs were very effective. And actually when we looked at samples of people were high adherence, efficacy went up to 99-percent. So I think this is a plus for PrEP. And as we go forward to [inaudible] long-acting PrEP products, that will be even greater because they are log-acting, and then adherence stops being an issue, and resistance becomes less of an issue.

The third thing to think about is the issue of number of infections averted, versus resistant cases. In the absence of prevention, how many people would acquire HOV? And should they then be on treatment, how much resistance, over a lifetime of treatment, would you see? So we are not saying that there will be no resistance at all, but that one has to make a balance on what you're getting, and what you're receiving on the other end. I hope I've answered your question.

RAFAEL: Hi, my name is Rafael. I work for *Folio Daily Newspaper* in Brazil. I'd like to ask Dr. Mugo a question on

the problem of stigma because you talked a lot about focusing effort on people who are most at risk, and back in the 80s and 90s when we did this in Brazil, the stigma of the disease towards gay people and people who were having problems with drugs, increased, and there was a problem for the government. And then we had to have a campaign to try to convince people that HIV and AIDS were not a gay disease, or a drug-addicts thing. So do you think these kinds of things are likely to happen in Africa, and in other developing countries too, now that you are willing to try to put more focus on those groups most at risk?

NELLY MUGO: Thank you for that question. I think, something I didn't bring up in my talk, but stigma and discrimination are really important. And they undermine our efforts for treatment and prevention. I think, yesterday I was just talking to somebody and we were sharing information about people we know. People who are even health care providers, who did not accept that they were HIV-positive. And we observed them die, and we buried them. As recently as between this year and last year.

So stigma is a big issue. And if people have issues of self-stigma mostly, they will not take up treatment or prevention. If people don't accept their risk again, they will not take any prevention—they will not use a condom, they will not use PrEP, they will not use behavior interventions.

In our cohort, when we asked HIV-positive people if they take treatment as prevention, the ones who said no, one of the reasons was stigma. People don't want to start medication because they don't want people to know that they have HIV. And they said that every day they swallowed the pill reminds them that they have HIV. So you are absolutely correct that we need to engage the issue of stigma. Thank you for bringing it up.

CHRIS BEYRER: Alright, if there are no further questions, I'd like to ask—oh okay, one more.

MALE SPEAKER: Another question to Dr. Mugo. You mentioned FDA's last week's approval for those new PrEP treatments as pre-exposure treatments bode well, for now it's here in the US. Do you think it's something that is likely to have an impact in developing countries, if these drugs start to be used in pre-exposure PrEP treatments?

NELLY MUGO: Approval for using truvada for prevention in developing countries—I think we all just have to engage our various government organs, and one of the most frequent questions is, who will pay. That's actually—it's not the science, the question is, who will pay. People are still saying we give PrEP to retreat. But I don't think that contest actually exists between PrEP and treatment. Because if we can give somebody—if we can prevent somebody from infection for a while, and save the money from life-long treatment, we will be gaining more. But until our governments engage in engage, and

sort out who will pay, I think that we are not yet there for that reason. But the FDA approval goes a long way in helping people, even to start prescribing. Just knowing that there has been rigorous review of the data.

CHRIS BEYRER: [Inaudible] I'm sorry. Bernhard Schwartlander tried to make a projection about economical profit, when you start on PREP, in Africa for instance? And how much money you might save on treatment?

BERNARD SCHWARTLANDER: There is a number of modeling exercises that have been made and I must admit that at this stage is really more art than science. Because we really don't know how we can apply this. We are at an early stage of rolling out PREP and I can't really give you a number here.

I mean clearly it is an additional tool, which is important, and we are very happy that such a tool exists now as part of the combination portfolio, as Nelly has indicated, and others. But we really need to understand now how best in terms of public health to apply this, so we can actually get maximum benefit out of it, in terms of reducing the number of new infections and of course, then, on a much larger scale, reducing the number of people who need treatment, and so on.

CHRIS BEYRER: I'd like to thank you all and I'm going to bring the press conference to a close. Let me just say that I think some of our speakers are available for further questions and may be able to stay in the room for a few

moments, so please feel free to approach them. And please join me in thanking all 3 of these speakers for their tremendous contributions to the Conference. Thank you so much.

[applause]

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