WEBVTT

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Jim Pickett: You are consent.

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00:00:01.910 --> 00:00:20.400
Jim Pickett: You're consenting to the recording. We will share this recording with everyone on Thursday. So everyone who registers will get a email and some links to all the Cbc's, including today's will also share any juicy information that comes up in the chat. So we'll make sure we capture all that.

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00:00:20.540 --> 00:00:24.720
Jim Pickett: Speaking of the chat, please use that promiscuously.

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00:00:24.780 --> 00:00:36.610
Jim Pickett: Ask questions, leave comments, we'll be monitoring that. But we also would love to hear you and see your beautiful face. So if you want to join in the conversation, make a comment.

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00:00:36.660 --> 00:00:56.269
Jim Pickett: Ask a question, you can raise your hand, and our wonderful moderator, Annette, who is a colleague of mine on this scientific planning committee. She will we will call on you and and have you go on video, ask your question, live. So without further ado, and since time is short, and

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00:00:56.460 --> 00:01:01.940
Jim Pickett: soon we'll be getting on our roller skates to head over to Croy. I am going to turn this over

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00:01:02.000 --> 00:01:09.249
Jim Pickett: to our moderator, Annette, who will introduce herself and bring on our speakers thanks again. So much for being here.

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00:01:10.140 --> 00:01:32.259
Annette Sohn: Hi, everyone! I'm Annette Zone from Amvar Street Asia program in Bangkok, Thailand. I'm also voluntary faculty at Ucsf. In the department of Pediatrics and really honored to be here today to help moderate. Today's Cbc. And our 2 speakers are Alison and Judy. So I'm going to ask them each to introduce themselves. So, Allison.

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00:01:32.650 --> 00:01:33.880
Annette Sohn: please go ahead.

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00:01:33.960 --> 00:01:51.320
Allison Agwu: Alright. Good morning, everybody. Alison agu from Johns Hopkins in Baltimore, where I'm a professor of adult and pediatric infectious diseases. I also in in relevant to this. I'm the chair of HIV Medicine Association in the Us. So really excited to be here. It's early but later for me, being on the East coast, so really excited to be part of the conversation.

11
00:01:51.930 --> 00:02:18.540
Judith Currier: Thanks, Alison and Judy. Hi! I'm Judy Courier. I'm at Ucla, member of the program committee for Croy. I'm an adult infectious disease doctor and HIV. Provider at Ucla, and I'm also chair of the Aids Clinical Trials Group, and I'm also thrilled to be here, and so impressed everyone getting up so early. Thanks for the music. Jim got got us all moving a little bit here for before we start.

12
00:02:18.780 --> 00:02:43.750
Annette Sohn: Okay, thank you, Judy, and a brief shout out to my colleagues and friends in the Asia Pacific. I see you and I know it's really late. So thank you for joining. So for today's format, each of our speakers are, gonna speak for about 10 min, and then, after each talk, we will go ahead and take questions from the chat as well as people who have raised their hands. Directly after that we'll do our best to include all of them

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00:02:43.750 --> 00:03:06.650
Annette Sohn: and then move on to the next speaker. So we're gonna try to balance out the time, because it would be great for us to have a joint discussion between Alison and Judy, and not just for one or the other. So we'll try to do that. And again, we'll do the best we can, and if we can't answer your question, live, we'll try to do it in the chat itself. So first of all, turn it over to you, Allison.

14
00:03:07.850 --> 00:03:19.639
Allison Agwu: Yeah. So I think doing this this morning. It it made me really focused. Sometimes you can be super distracted at the conference at all the hugs you give, I think, excited. We'd be talking about

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00:03:19.720 --> 00:03:26.390
Allison Agwu: how complicated it is. I think someone in the chat put, introducing themselves, saying, they're a lifetime thriver. I love that

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00:03:26.990 --> 00:03:53.639
Allison Agwu: flip of it, and not surviving, but thriving, and then claiming the name and being a thriver. I think there's been a lot relevant to the surviving lifetime with HIV at the at the Conference. I selfishly want to point out the session yesterday that if you were not in

the room that you need to virtually go back and be in the room, which was a session about essentially living into young adulthood with HIV, which was a focus on people born with HIV or the deadlines of the lifetime survivors.

17
00:03:53.640 --> 00:04:17.930
Allison Agwu: and I wanna spend most of my time out. But half of my time talking about it there because it was really so well flavored in the sense that, and that you Jennifer Chow and Elaine, really put together a session that was co-moderated by Victor Ray's. I don't know if Victor is on the call this morning. Who is a a lifetime thriver born with HIV, but it was flavored with not just the

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00:04:17.930 --> 00:04:32.289
and I think, where I sit in the Us. Lens. We oftentimes talk about the 12,000, you know, 10 to 12,000 young people who are born with HIV or going into adulthood, and how that is aging. And we're seeing them in our clinics and and making sure that we spotlight them.

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00:04:32.540 --> 00:04:44.619
Allison Agwu: But Dr. Mutza and and Sabizi pointed out that actually worldwide by 2047, there'd be 2 million people who have both been born with HIV growing, and who will be adults at that time? And it makes.

20
00:04:45.290 --> 00:04:58.429
Allison Agwu: I think, the call to action different. Right? Not that 12,000 don't matter. 12,000 is really important and a big number that we focus on 2 million. And and we're looking at what's going to happen to those 2 million individuals over time.

21
00:04:58.490 --> 00:05:25.469
Allison Agwu: And then Ezra Kang gave probably one of the most impactful talks that I've seen about really the mental health and well-being of of lifetime thrivers and talked about how they reflect the epidemic and what it's meant to their Psyche and Victor, you know, Cosign and said, Yeah, actually, he spoke to exactly what it meant, moving from coping to thriving from innocence, the culpability. Really, if you didn't see this talk, please go back and look at it. And then last not, but not least, with Sarah.

22
00:05:25.470 --> 00:05:36.670
Allison Agwu: the original Fargo, talking about the cardio metabolic complications to to disbelieve pre lifetime. Frivers. Right? I've already coined it or stolen it. And how and what that would mean?

23
00:05:36.670 --> 00:05:51.159

Allison Agwu: So II think again, you know a lot of times II if you've heard me talk, you've heard me say that there's a lifelock commercial where we there's a people it's in a bank, and there's a bank is being robbed, and there's a security what appears to be a security guard standing there

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00:05:51.160 --> 00:06:14.700
Allison Agwu: and like, do something. Do something. The bank is being robbed, and he's like, I'm a security monitor. I'm not a security guard, right? So the bank is being robbed, and I feel like a lot we've been talking about the bank being robbed, and it it in looking at the talks and what's been being presented, there's a bit more about not just understanding what's being what's happening with inflammation and with, you know, markers of what's happening. But then what

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00:06:14.700 --> 00:06:41.840
Allison Agwu: to do with it in a in a way that feels actually reachable. So yeah. And things are under embargo site. Know the reprieve stuff is gonna happen Wednesday. In terms of the big session. But people may or may not know that there have been a huge, huge data, a huge study of 5,000 people on it. To this, to the statin, which is a a cholesterol lowering medication which was given to people who wouldn't quite qualify for to to be on cholesterol lowering medications and showing that

26
00:06:41.950 --> 00:07:05.309
Allison Agwu: essentially there was a decrease in hard outcomes. Right? So heart attack strokes things that actually, we know under or entities or non technical diseases that can impact people with HIV, and that led to a change in the Us. Guidelines in terms of the the Department of Health and Human Services, recommending statins for for people with HIV to improve survival. So again, not just monitoring, but now doing something.

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00:07:05.310 --> 00:07:31.560
Allison Agwu: You know I would be remiss if I didn't say that that that that study did not include anybody below the age of 40. So while we're talking about lifetime drivers and saying, Hey, we, we know they're gonna have things that are gonna happen to them. We do need to to untangle this question of will do today beyond statins earlier. And I think we're gonna be talking about that. I know some are are starting to do that. But I think there is an argument to say that 35 or 40 years

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00:07:32.140 --> 00:07:46.020
Allison Agwu: born and living with HIV is probably the same as, and if not worse than being a 65 year old, 40 years of HIV. So I think that conversation is one that I would love to have, and I think, push for us to really think about how to

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00:07:46.350 --> 00:07:50.490
Allison Agwu: decide who may be the best people to do that, to to benefit from that

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00:07:50.750 --> 00:08:16.309
Allison Agwu: in that range. I don't want to steal your your thunder Judy, cause I know there's gonna be. You're gonna highlight, the the whole session on weight change and semiglotides. I'll I'll leave that for you to talk about. But I think exciting to see the semiglotide does impact weight change so decrease in weight. And it's a diabetes drug, I should say, or a glucose me management drug does decrease weight, but also decreases inflammation. So again, not just seeing something. But what can we do?

31
00:08:16.750 --> 00:08:27.029
Allison Agwu: There was another talk. So thinking about the heart thinking about inflammation. There was a session on the brain yesterday, and I think it's been a lot of time thinking about how do we

32
00:08:27.130 --> 00:08:28.740
Allison Agwu: make sure that

33
00:08:28.830 --> 00:08:37.879
Allison Agwu: people are living their best and having a mom who has Alzheimer's and watching what happens to the brain and how it robs people? How do we

34
00:08:38.350 --> 00:08:54.950
Allison Agwu: for people who are living lifetime with HIV? How do we think about how to best protect their brains, and what are the things that we can do again? Not just monitoring, but potentially implement or intervene. And the session yesterday there was one talk that I thought was really interesting because was depression and stroke.

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00:08:55.040 --> 00:09:02.150
Allison Agwu: And looking at the impact of depression, we're all doing these Phq. Nine's and monitoring depression in our patients and

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00:09:02.200 --> 00:09:17.180
Allison Agwu: our mental health system is variable right in terms of how well we actually address depression. But this study a small study, nonetheless, but showed a connection between depression scores moderate to severe depression scores, and the incidence of stroke. After

37
00:09:17.380 --> 00:09:43.770

Allison Agwu: controlling for all the other things, and that that association was highest in those who are under the age of 50, and didn't say perinatal or not, but under the age of 50, so should we be doing. But I think these things are all highlights for me, a call to action, and maybe we should see something, say something, do something, and there being maybe more that can be done, and some of this may be low hanging fruit that we can address. You know, diet exercise addressing people's depression, counseling, etc. So I think a lot of really exciting

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00:09:43.870 --> 00:09:58.179
Allison Agwu: for me things and I love to hear people's thoughts are as well about that. So really, looking forward to the interactive section on again the cardiovascular things more on brain coming up in the next few days, and the plenaries, I should should say. Really.

39
00:09:58.280 --> 00:10:07.899
Allison Agwu: I think amazing plenaries about what could be coming, whether it's been Abs or other pieces that may be coming down the line, and how they impact people across the spectrum, pre

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00:10:07.980 --> 00:10:12.809
Allison Agwu: getting HIV to maximizing life with HIV. So with that, I'll stop and turn it over to Judy.

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00:10:13.250 --> 00:10:35.820
Annette Sohn: Oh, thanks, Alison. Actually, we're gonna go ahead and take a few questions and comments now, so that you know people have these things in their minds, and then we'll move over to Judy. So the first thing I want to raise is Nina. I don't know if you wanted to raise your hand, so anybody who wants to raise your hand, you can. But we had a comment about. There's a difference between lifetime surviving and lifetime thriving.

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00:10:35.820 --> 00:10:46.140
Annette Sohn: And so why don't we ask Allison to to reflect on that. But anybody who wants to. Just please raise your zoom hand or note something in the chat, and then we'll go ahead and refer to you.

43
00:10:46.530 --> 00:11:01.810
Allison Agwu: Yeah, I I'm blanking on the end, the the investigator, or the paper. But there's a really neat paper. I think it was in Jama a couple of years ago that looked at the difference between individuals who are living with HIV versus those who are not, and the difference between lifetime

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00:11:01.910 --> 00:11:13.469

Allison Agwu: and then lifetime, with or without comorbidities. And so, while we've made lots of strides in terms of improving people's survival, the years of comorbidity, free survival

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00:11:13.700 --> 00:11:14.890
Allison Agwu: are actually

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00:11:15.040 --> 00:11:30.380
Allison Agwu: last. We have, you know, people live with HIV have fewer years. They're they're based. They're living longer. But those years are filled with more co morbidities. And so to me, thriving means that we maximize life. And we've minimized the amount of that time you're dealing with the co morbidities that impact your life.

47
00:11:31.780 --> 00:11:45.499
Annette Sohn: Okay, thanks. And and another point that Daniel raised, although it's also kind of getting to Judy's point. But II want, since you brought it up, Alison, maybe we could address that is that, you know, adding a pill

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00:11:45.500 --> 00:12:07.950
Annette Sohn: to your regimen, especially thinking about the complexities of where people may have recently changed to regiments to different drugs or potentially new, injectable things, kind of get complicated, as Jim said at the beginning. And so what are your thoughts about that? I mean. There are data that show it could be beneficial. But that's not the only thing we're thinking about here. Right?

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00:12:08.080 --> 00:12:14.729
Allison Agwu: Yes. So you know, II completely yeah, no, I completely agree. I mean, I think. You know. Certainly

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00:12:14.830 --> 00:12:39.050
Allison Agwu: we're we're. I have a little us lens, and if there's a pill we want to put it on board right? So you know, we we focus on. We pay for these pills with those pills. I think you're absolutely right. And then, you know. Certainly it's harder to do studies of what if you write up somebody a prescription for healthy meals that they could get for whatever? How does that impact. We actually cover things like that. Right? So I think we have to. It is about

51
00:12:39.050 --> 00:13:02.289
Allison Agwu: optimizing the options available to improve survival. Now, if a pill is not for you. What else do we need to be thinking about to be able to help you get to that thriving without adding a pill, and so is it that you do injectables and appeal. Is it that we we cover other things

like therapy for people in in our in a in a meaningful way that can get you there. So the point is absolutely well taken.

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00:13:02.290 --> 00:13:09.340
Allison Agwu: Because adherents is challenging, and one more pill can just be that literally the peripheral straw that breaks the camel's back. So very good point.

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00:13:09.660 --> 00:13:38.039
Annette Sohn: Okay, thanks. And when we have a question from Lou, and I hope my Google translate is accurate, but from the French it looks like what are the pris provisions for? People who are elderly in prison in terms of treatment, and maybe I know that it's it's a different context from country to country. But can you comment on at least the Us. Context, or whether kinds of new treatments are being made available to people in prisons.

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00:13:38.230 --> 00:13:45.959
Allison Agwu: That's a really good question. I do not I do not take care of individuals in primarily in that context. So you do. But I

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00:13:45.960 --> 00:14:08.440
Allison Agwu: certainly no HIV treatment accesses available if we put them in our guidelines. Right? So which is, I think, is really critical. We put in the guidelines. I think the person healthcare system, and I will defer to anybody who's actually in there. If you put in the guidelines. Then we then have to follow those guidelines in terms of getting people on those appropriate treatments. But I will happy to take, you know, comments from others who may know more practice it in that context.

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00:14:08.700 --> 00:14:31.710
Annette Sohn: Okay, it looks like, maybe there was a typo, or my Google translate was wrong. So I'm sorry about that. But but it it does sound like what are the current provisions for elderly people on treatment with regards to maybe the statins you were talking about, and this this has come up a few times now, and questions for both

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00:14:31.710 --> 00:14:56.229
Annette Sohn: Judy and Alison. So maybe, since no one's raised their hand, I think maybe we'll ask Judy to comment, and then we'll have both of you answer some of these questions they get at, as someone said, you're surviving for 1020, 30, 40 years living with HIV, and that this kind of this is a common challenge for people in that in that group, and so separating it by whether you were

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00:14:56.230 --> 00:15:13.550

Annette Sohn: born with HIV versus not born with HIV. There are certainly some differences that Alison you mentioned, but then there are other a lot of similarities. So maybe we'll go ahead, and people please keep putting questions in the chat, but we'll turn it over to Judy to to raise some of those points that Allison was alluding to

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00:15:13.740 --> 00:15:17.519
Annette Sohn: Judy. Alright, thank you, Annette, and thank you, Allison.

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00:15:17.640 --> 00:15:40.659
Judith Currier: Yeah. So I think it is complicated. But I think what you know what this conference helps us see is that we are getting new data to address many of these different issues. And so, you know, I wanted to talk about a few things that have been presented, and and highlight some things that are coming up, that I are embargoed. But I want you to go and see, because II think there's a lot lot of important things

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00:15:40.660 --> 00:15:54.650
Judith Currier: on the horizon, and just going back to the plenary yesterday from Nellie Mugo, that about cervical cancer, you know, she reminded us about the importance of cervical cancer worldwide

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00:15:54.650 --> 00:16:18.759
Judith Currier: being the fourth most common cancer in women and for women living with HIV higher rates of having Hpv. The virus that's associated with cancer, higher persistence of the virus. And this is a this is a disease for which we now have a vaccine that is so effective. And I think if you're thinking about across the lifespan.

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00:16:18.770 --> 00:16:27.800
Judith Currier: you know anything that we can do to facilitate vaccination of young women. Screening for cervical cancer and improving treatment

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00:16:27.800 --> 00:16:50.270
Judith Currier: is so worthwhile. And it it just. It was such a juxtaposition between the talk about the HIV vaccine. And then the talk about a vaccine that's here that we have. Now that prevents Ca, cancer prevents cervical cancer, and we still can't figure out how to get it to people who can benefit from it the most. So the the challenges of

65
00:16:50.330 --> 00:17:04.690
Judith Currier: implementation of that of our, you know discoveries and findings just need to move so much faster than they have. And I think the work that's been done has been incredible. But it's about really having the

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00:17:04.690 --> 00:17:20.969
Judith Currier: political will and the resources to to make this a priority. So cervical cancer is a really important topic. And I thought there was a phenomenal on plenary, and if you didn't get a chance to hear it, I'd put it on your list of recordings to listen to.

67
00:17:21.089 --> 00:17:46.780
Judith Currier: I think that you know, as we think about aging with HIV there, there are a lot of different challenges that we face as we age, and that people living with HIV face, and it has to kind of be personalized. What are the issues that are most important to you? And maybe the challenges that you that you have a higher chance of, and you know of encountering and making your own personal plan about what you can do.

68
00:17:46.780 --> 00:18:10.650
Judith Currier: And I think at this meeting. We are hearing a lot about cardiovascular disease as one of those things we're hearing and learning about weight gain as another. And I'll talk about those a little bit but we're also hearing about HIV treatment, maybe for the first time in a while. It's a lot of new data on new drugs and new strategies and development, and

69
00:18:10.650 --> 00:18:26.270
Judith Currier: and that also has to continue to be at the core of how we optimize living healthy over a long period of time is that we are getting some new regiments coming along new we heard yesterday about

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00:18:26.270 --> 00:18:37.090
Judith Currier: new once a week. Oral regiments, and you know, injectables are are have been approved, have not been widely made available yet.

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00:18:37.250 --> 00:18:51.879
Judith Currier: and I think there are. There's, you know, some really great things about the current cab, Patel, and real pivoting. But it's not for everyone. It's not for people who have hepatitis. B, and it's not for people who've had resistance to

72
00:18:51.880 --> 00:19:14.950
Judith Currier: the n in Rtis. But there are other things coming along. And II think that's really encouraging. We're trying to figure out, what's the role of the broadly neutralizing antibodies, long acting in treatment? And so we heard more about that yesterday which I think was was good. And then Lena Capra, combined with broadly neutralizing antibodies as a potentially 6 month regimen.

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00:19:15.050 --> 00:19:39.650
Judith Currier: So these things are still in the early days of of being fully developed. But I think there's there's hope that drug development for HIV is not stopped and that we are continuing to look for new ways to make treatment easier, and and to have more options. As Allison was saying, it's about choice and what what's gonna work best for individuals. And then we heard the really exciting

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00:19:39.650 --> 00:19:46.779
Judith Currier: II thought, study about long acting habitgivarine in the African context from

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00:19:46.780 --> 00:20:09.180
Judith Currier: was Sissy Kitcho was supposed to be doing the presentation from Uganda, but was unable to get her visa. And so Nick Patton gave the presentation and that that study, you know, demonstrated with the more of a public health approach that for people who are suppressed on treatment with tld tanfavir Limited

76
00:20:09.430 --> 00:20:47.009
Judith Currier: and tdf, that they could switch to this if they didn't have hepatitis B, and and that was a big thing in the study that they screened a thousand people, but almost 400 couldn't be enrolled because they had hepatitis measures of hepatitis B, but for those who did enroll, they did just as well. 96%, 97% remain suppressed, and they only check the viral load once every 6 months. So that was really great to see some progress in in that regard. So I just wanted to just make a few points about HIV treatment, because that was already presented. And and I could talk about it.

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00:20:47.050 --> 00:21:12.559
Judith Currier: But you know, I think that the studies with injectables have have shown that for people who choose to enroll in them, and that's very important, because they aren't for everyone. But for those who choose to enroll in these studies they do report that they have high, you know they feel better, higher quality of life, but not. Everybody chooses to do this because they aren't for everyone. I think that's the point. That Jeff has also just made in the chat.

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00:21:12.790 --> 00:21:27.310
Judith Currier: So in terms of the other topics, you know. I think one thing that we we don't talk enough about and pay attention to enough about as a a health related behavior, and that's our sleep.

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00:21:27.420 --> 00:21:51.829
Judith Currier: Sleep is becoming, you know, really appreciated as this could be one of the factors that contributes to so many chronic diseases.

For people who are unable to sleep well during the night and and rest. May contribute to inflammation, depression, weight, gain. So understanding what are the factors that influence sleep, disturbance, and people with HIV

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00:21:51.830 --> 00:22:16.830
Judith Currier: is a is a really interesting topic, and there was just one poster about sleep, apnea, which is a condition where you wake up during the night, cause you stop breathing sort of and that was not more common in these clinics. In the Kaiser system, in in people with HIV but there were PE people who had HIV that was not well controlled, maybe had a little bit more frequently. But I just think

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00:22:16.830 --> 00:22:30.249
Judith Currier: seeing more stuff about sleep was good, and I hope that that continues. And then finally, the cardiovascular disease. There's a lot at this meeting, and there's a lot today. So the

82
00:22:30.600 --> 00:22:55.419
Judith Currier: this session at 100'clock about complications, I encourage you to go to, because it includes great presentations about risk factors for heart disease, but also for weight gain, and particularly among women. So I think that's an important presentation. And the posters today is more data from reprieve. About how good are we at predicting an individual's risk

83
00:22:55.420 --> 00:23:00.840
Judith Currier: for cardiovascular disease? We use these equations that you put in your age and

84
00:23:00.840 --> 00:23:17.119
Judith Currier: different parameters, and it says, What your 10 year risk is. It turns out that these may not perform as well for people with HIV, and particularly for women. So we're gonna learn more about that today. And I think that's gonna be a important topic moving forward

85
00:23:17.300 --> 00:23:42.290
Judith Currier: and then finally getting back to the statin issue. As as as Alison said, the reprieve study did demonstrate this benefit in reduction of cardiovascular disease, you know, and that the population that was enrolled were people over the age of 40. It did not have a strong representative representation of transgender men or women. And so I think that somebody did raise

86
00:23:42.290 --> 00:24:00.539
Judith Currier: this in the chat. It's very important that we focus on what the hormonal effects are in terms of cardiovascular risk. But the

the guidelines did know, suggest shared decision-making with your provider about whether this is a an intervention that it could be beneficial to you?

87
00:24:00.540 --> 00:24:13.149
Judith Currier: You know, and I think that's a that's a personal choice, and I think it's just something. And I was nice to see one. Somebody mentioned their provider just brought it up this week, so their providers on it and thinking about it. And

88
00:24:13.150 --> 00:24:39.690
Judith Currier: I do think, you know, for people who finally, who've decided to make the switch to injectables finally gotten off taking pills. This thought of now you have to take another pill is something that you know you need to work through. But it it's a it's a decision based on your understanding of your personal risk. And but I think it's good to have this data. So, as Alison said, people have more choices and can make more informed decisions about

89
00:24:39.690 --> 00:24:58.670
Judith Currier: what interventions they wanna do to try to have healthy aging with HIV. So I popped around with a bunch of different topics. But II do feel like I'm very hopeful from this meeting that we are getting more data to help make to. So people can make decisions and have choices.

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00:24:59.620 --> 00:25:23.510
Annette Sohn: Thanks so much, Judy. And and I think you've addressed some of the questions and comments in the chat about statins and the reprieve. Reprieve, reprieve, I mean, it is everywhere, and those of you are not at the conference. It's gonna there's gonna be a lot in the media. And so this question of Well, is it really for me? And you brought up the importance of shared decision making. And we've had some comments in the chat about that.

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00:25:23.510 --> 00:25:46.739
Annette Sohn: The data are not there for Cis and trans. Women. And what does that mean for? And and Allison, as you brought up for young adults? And so how and that there were questions about vitamin d supplementation and other pills, and just adding to the burden of these data. As you said, there, the trials are there, as was mentioned by Nina and the chat. Individuals make up these trials. But

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00:25:46.740 --> 00:26:08.549
Annette Sohn: these trials are not everybody. They're representative samples. So so Allison and Judy, can you share a little bit about that and kind of respond to those questions or comments about when the data may not fit in individuals, personal health care requirements, and also

about supplements that and data on that. If there's anything at the conference.

93
00:26:09.580 --> 00:26:12.790
Allison Agwu: Oh, go ahead, Judy, I see you. No, you can go ahead.

94
00:26:12.950 --> 00:26:21.469
Allison Agwu: No, I mean III think I would not. I can't underscore, not the importance of shared decision making. I think you know. Certainly

95
00:26:21.620 --> 00:26:24.000
Allison Agwu: there, as no matter how

96
00:26:24.100 --> 00:26:50.319
Allison Agwu: good we do with trials and recruiting people. There is always something right there. There is not representative, these people without people. I think we've gotten better where we have better representative representation of diverse populations, but it's not always perfect. And as you all pointing out in the chart, the in the chat, that I don't see myself here, and so can you just extrapolate this to me. And I think this is where it absolutely is important to not just

97
00:26:50.700 --> 00:27:14.740
Allison Agwu: receive, but to engage. And if your provider is just having you receive information, then you have the wrong provider. It should be an engagement it shouldn't be. This is the only thing that you can do. And I think Nina is very vocal about this is suggested. But I don't think this applies, and that is okay. I think actually, it is about choice and and and it may not be the right choice for you, with all of these things that that we're talking about. In terms of the question of vitamin des supplementation.

98
00:27:15.040 --> 00:27:35.190
Allison Agwu: I have brown skin, and we certainly know vitamin d deficiency is more common in those who who have melanin more melanin, and so I do see a fair amount of vitamin d deficiency in Baltimore, where I practice, and from the young to the very old. I take care of the whole spectrum. And I think again, this is what it is hard to take. It's once a week. It's hard to remember, but I do

99
00:27:35.640 --> 00:27:59.029
Allison Agwu: feel, and there are studies to say that vitamin d can impact all kinds of things, of metabolism to fatigue, to what have you? And there are times where you take it to the personal, where people feel better when they do get supplementation. II think not doing it for longer than you need to, or, you know, making sure that you're again sharing

decision making and following up is important. I didn't see a lot on vitamin D at this conference here. Today, but it's certainly a

100
00:27:59.030 --> 00:28:06.839
Allison Agwu: conferences. There's been lots of vitamin D, and certainly depending on again, what's happening with your bones? What's happening with lots of things I think important to have those conversations with your

101
00:28:07.600 --> 00:28:13.900
Annette Sohn: yeah, II don't have a lot to add to that. I think it is. It's hard to make a general. Just you know, general

102
00:28:14.000 --> 00:28:37.980
Judith Currier: proclamation about the importance of it. It, you know, despite the fact that we've seen low vitamin D, and it's been associated with lots of different things. Really, studies have had a hard time showing other than for bone, low bone density, that that giving it changes that outcome. But I think it is a it is an individual thing, and so I think it has to be made sort of a one on one with your provider.

103
00:28:38.330 --> 00:29:03.599
Annette Sohn: Thanks, Judy. So why don't we look at Andrew's question? Kind of about What is happening now? As people are aging into their fifties and into their sixties. People are retiring, maybe moving around in their local countries. What should we be advocating for in terms of services and support systems in more rural care facilities.

104
00:29:03.760 --> 00:29:12.759
Annette Sohn: So any thoughts about that I know that you're you're speaking from the Us. Perspective. And it may be a little bit different from Malaysia where Andrew is. But any thoughts about that?

105
00:29:14.960 --> 00:29:20.370
Judith Currier: Yeah, I mean, I think it's really hard. about the

106
00:29:20.370 --> 00:29:46.510
Judith Currier: just the fractured healthcare systems we have globally and then in many places, for for people living with HIV. The focus is just on the HIV medication and the delivery of that medication, and not all the other services and things that are needed. So I it. It's a it's a very challenging issue. And II think that as people age and migrate. I think it is something that we're not prepared for.

107
00:29:46.540 --> 00:29:54.749

Judith Currier: In terms of how to to manage how to manage some of these issues. So II think it's a big, it's a big issue that needs more attention.

108
00:29:55.360 --> 00:30:12.100
Allison Agwu: Oh, sorry. I mean, I think certainly the context matters, and I think you know particularly, we have fractured healthcare system, but also depending on where you are the the sort of the structures of families where people are available to actually support people as they. Age

109
00:30:12.310 --> 00:30:35.310
Allison Agwu: don't exist for some place in isolation is a huge thing. And so I think you know, a lot of the services that Andrew alluded to that are needed to support people beyond medications maybe covered by Ryan white case management and things like that. And that funding is being threatened. So I think other things to do. It's to advocate for funding and to be expansive, and what that funding can do to support people as they

110
00:30:35.310 --> 00:30:43.650
Allison Agwu: go on to live and to to try to optimize their their aging with HIV. So really important question and an opportunity for advocacy.

111
00:30:43.980 --> 00:31:08.910
Annette Sohn: Thanks, Alison, and maybe we can start talking a little more about the injectables. There's been a lot of comments in the chat from people who are on them as well as people who are thinking about them, and potentially others of you in the group now, who frankly don't have access to them, because these drugs are not yet approved for importation in your country, especially in low and middle income country settings. But any updates on some of the data you mentioned, the

112
00:31:08.910 --> 00:31:22.140
study Judy, that Nick presented yesterday Nick is from Singapore, and so maybe share a little bit more about where you think the field is going. And people have asked about. Well, what about

113
00:31:22.140 --> 00:31:31.679
Annette Sohn: stretching that out to more months, or what about a once weekly pill, I mean, where are we with these kinds of innovations for treatment.

114
00:31:32.490 --> 00:32:00.909
Judith Currier: Yeah, I mean, I think there was a question in the chat about, you know, once a like what a like once a week pill. Is that gonna be a game changer or not? And II think it goes back to this issue about

having choice. You know, I think, for for some people taking a pill once a week rather than once a day, could be something that was found to be, you know, a an advantage, but for others not so much, you know. You forget it might forget. And

115
00:32:01.000 --> 00:32:30.130
Judith Currier: so you know, I think this is an area where one size doesn't fit all and are currently available. Eject injectables are not available everywhere, as you as you highlighted, but the capate of combination. You know it. It does have limitations. You can't use it if you have hepatitis B, or you've had, I know, previous resistance, significant resistance to Nrtis but if you've been suppressed on a regimen

116
00:32:30.130 --> 00:32:52.219
Judith Currier: without that you can switch. And we're gonna hear more later this week about people who've had challenges to adherence in the past, but are able to become suppressed on an oral regiment being able to to utilize and benefit from this. But that's not till Wednesday, so I can't really talk about that yet. But II do think it is. You know. Is

117
00:32:52.290 --> 00:33:21.370
Judith Currier: it inner sort of intermittent dosing of of treatment, whether it be injected or oral. There's a lot of work in in developing it. And but but I think what we're learning is that we have to figure out the access in parallel with the development, because, with cabate variable pivoting which has been approved in the Us. We still don't have the infrastructure in many of our clinic locations to actually operationalize this.

118
00:33:21.520 --> 00:33:44.729
Judith Currier: And for some people, you know, who take a daily pill and are doing well and come to the clinic every 6 months. Well, now they have to come every 2 months and and get a shot, and they have to make sure they get it scheduled. And you know. So the infrastructure for managing that and really busy clinics is was not really developed in parallel with the development of the products. And I think that's an area

119
00:33:44.730 --> 00:33:56.990
Judith Currier: where II do see more focus on you know, funding studies to look at implementation and and how to set these things up, and really need to be done in parallel with the development of the products.

120
00:33:58.110 --> 00:34:06.250
Allison Agwu: No, I don't have much to add. I think the access piece and pushing. thinking access

121

00:34:06.340 --> 00:34:20.939
Allison Agwu: at the time you are actually designing the studies is super important and and not just access, as a team thinks about it. But the country, the layers that are going to be involved to actually do it. I think that the the comments about it's not for me.

122
00:34:20.969 --> 00:34:34.310
Allison Agwu: I think that's important, but it's for someone, and I think it's all again. It's about creating the allocard of options, and it may not be for someone at one time, but it's them for them for another time, it may be, for while I'm traveling, doing the peaceful for a year, but I think

123
00:34:34.310 --> 00:34:54.150
Allison Agwu: I'm so excited about seeing what's next or long acting. You know patches, I think that's where we need to be. So you literally can be at a menu and and decide what works for you. But we have to work out the access issues, or we're going to continue to see disparities growing disparities with with who gets these and who doesn't know which is? It's unacceptable.

124
00:34:54.550 --> 00:35:08.840
Annette Sohn: Thanks, Alison, and you use the word choice. And and that's such an important thing. I think people have talked a lot about options for prevention. But what about options for treatment, especially in global guidelines? Everybody supposed to be on Tld now? Well.

125
00:35:08.840 --> 00:35:31.860
Annette Sohn: that it? What about people who have serious insomnia with that regimen? What about people with Tb, all of these studies that are coming out? Now? What about kids? And and so that kind of brings me to the comment that Judy shared about sleep. And so there were a lot of responses from people are like, sleep is so important. So a any other comments about that, and also linking it to Covid.

126
00:35:31.860 --> 00:35:39.409
Annette Sohn: and potentially that overlay between long Covid symptoms, side effects or medications.

127
00:35:39.970 --> 00:35:43.089
Annette Sohn: HIV. Other thoughts bout that, Judy.

128
00:35:43.350 --> 00:36:06.869
Judith Currier: Yeah, I did see a question in the chat about this long covid session yesterday, and I I'm regret I wasn't able to be there for the the last 2 talks about suggesting potentially whether the risk of long Covid was higher for people living with HIV. There may be others on

the call here who can comment on that? That we're in that session. And you know, Long Covid is a really serious issue that

129
00:36:06.870 --> 00:36:21.329
Judith Currier: that we're grappling with, how to make the diagnosis. You know. What are the options for treatment? If if any, and and the very different manifestations of long covid. It's not everybody who suffers from long covid has the same symptoms. They can be

130
00:36:21.330 --> 00:36:48.850
Judith Currier: more neurologically focused. They can be more fatigue and post exertional malaise focus. They can, you know, they they can be more sort of having dizziness and other sort of symptoms when you move around. So it. It's it seems like it impacts people in many different ways. So finding one treatment that is is gonna be effective, I think, is really a big challenge. But there are studies that are going on now, finally. And they're.

131
00:36:48.850 --> 00:36:51.919
you know, I think, that we're going to be learning a lot more

132
00:36:51.950 --> 00:36:59.979
Judith Currier: and so I would. I'd like to, you know, if somebody was at that talk and wants to say what it found. That would be great to share that here.

133
00:37:01.060 --> 00:37:06.760
Annette Sohn: Thanks, Judy. And I say Jim has raised his hand. So, Jim, do you want a comment about this, too, or something else?

134
00:37:07.290 --> 00:37:16.960
Jim Pickett: I mean there's so many things I want to comment. You all are having just the best conversation, and the chat is on fire again like yesterday. Oh, my God, there's just so much to take in.

135
00:37:17.010 --> 00:37:21.830
Jim Pickett: Just a couple of things. I just you know I'm really glad we're talking about choices

136
00:37:21.860 --> 00:37:31.789
Jim Pickett: as someone who's been living with HIV, for for since 95 I get a little concern when everything is injectable, everything is like injectable or implants, or so I'm

137
00:37:31.930 --> 00:37:42.659

Jim Pickett: let's, you know. I think a weekly pill may not be for everyone. I think it could be for me. And II just appreciate like, let's not get just in that injectable kind of framework, because

138
00:37:42.790 --> 00:37:56.189
Jim Pickett: the whether it's available or not doesn't mean it's accessible. And even if it's you know you can, it's in your neighborhood who can like take off like, come to the clinic 12 times a year, or 6 times a year.

139
00:37:56.430 --> 00:38:01.779
Jim Pickett: living with HIV. As long as I've had twice enough is a twice a year in my clinic is enough.

140
00:38:01.800 --> 00:38:10.979
Jim Pickett: I like my doctor, and I like my the staff who work there, but I don't wanna see them anymore than that. I don't wanna make my healthcare my full time job. And so

141
00:38:11.070 --> 00:38:17.129
Jim Pickett: we need things that can be controlled by the individual. And all these things that have to be delivered in the clinic

142
00:38:17.350 --> 00:38:36.409
Jim Pickett: are kind of problematic. So I'm also interested in which you all are thinking about in terms of task shifting. So. You know, like Rupert Patel, that Whitman Walker, who was at Whitman Walker in DC. Did this amazing prep and and injectable treatment clinic where they trained a bunch of staff

143
00:38:36.440 --> 00:38:51.060
Jim Pickett: who weren't clinicians to give shots just to improve access and time frames for for appointments. So I'm wondering how much further can we push that, I mean, can we have injectable for treatment that can be delivered by your partner.

144
00:38:51.090 --> 00:39:05.590
Jim Pickett: you know, by the nice neighbor lady who will. Happy to give you a shot in your butt every month, you know. Can we? Can we move task shifting outside of the clinic into the home. So I don't have to ever leave other than to see my doctor. Once or twice a year.

145
00:39:06.380 --> 00:39:31.870
Allison Agwu: I'd love to. Yeah, no, no, I mean, I think I'm I just respond to Victor. Raise the same point in the chat, and II think there is a move to do some of this I know. In in our state our pharmacists

actually petition the board to the pharmacists can actually give the injectable. So you don't have to actually have your provider do it, because honestly, if you're gonna have your provider do it. One, we don't give shots, usually. What us give me the shot right? So it's a nurse. So there's some sort of process.

146
00:39:31.870 --> 00:39:47.160
Allison Agwu: But if it can be given in the community someplace close to you, particularly when we are living, many of us in areas where there are deserts where there are no id doctor, clinics and people having to travel for so far to go to their clinic, so can imagine you having to do that on a regular basis to get the shot. It would not be

147
00:39:47.160 --> 00:40:05.829
Allison Agwu: feasible, sustainable. So your points are well raised. So how do we test ships of someone else can give the shot, whether it's my pharmacist? Could we get to me giving my shot at home. We do this fertility treatment. So can we do that in other ways. And I think this is what needs to continue to be pushed. Does it need to be done this way, asking those questions and pushing the envelope?

148
00:40:06.220 --> 00:40:25.010
Annette Sohn: Thanks, Allison, and I think Mitch put it in the chat. And so and and kind of addressing this, there's a difference between developing biomedical options and delivering feasible choices. And that's not just here in the us, but also around the world as has been mentioned. So, Jeff, you have your hand raised. Go ahead.

149
00:40:25.010 --> 00:40:44.840
Jeff Taylor: Yeah, thank you. So there's been a lot of talk about kind of the behavioral things we can do. And certainly in the setting control, the HIV other than having all these comorbidities happening earlier, we're not that much different from the general population, and it's a huge body of research out there. But it needs to be validated. HIV, and report. This often requires really big cities. We did it with reprieve.

150
00:40:44.840 --> 00:40:51.689
Jeff Taylor: And I'm wondering, you know, where is the political will to make these studies happen? So we get the data we need, because, you know.

151
00:40:51.720 --> 00:41:16.229
Jeff Taylor: prescribers can't write prescriptions. They can't policymakers can't fund, you know. Use Ryan. White money is for gym membership. Things like that unless we've got that evidence to support those choices. So I mean, how do we do that? And it's where international colleagues have you managed to get over this off. And Judy and I have long conversations over this over the last few years. And it's it's

structurally, you know, we're not designed to do this in our current HIV research.

152
00:41:16.290 --> 00:41:20.929
Jeff Taylor: you know, network. So how do we get over that and get people what they need to get providers, what they need?

153
00:41:21.260 --> 00:41:47.200
Judith Currier: Yeah, I mean, I think I think we have to prioritize because I don't think we we can study every single, you know, chronic disease in a 7,000 p. Participant study to demonstrate the the benefit or the the need. In the case of reprieve, we found that the Ne. Or the indication or the benefits of, for statins were occur in people younger with HIV than had been previously.

154
00:41:47.200 --> 00:42:12.040
Judith Currier: If you just went by the regular guidelines, so I think for for most things we should be doing, that things that have been shown to be associated with healthy aging without having to wait until we have a study that shows it's beneficial, and for that exercise I cannot emphasize how clear the benefits of regular exercise are for for mental health, for healthy, you know, for just longevity

155
00:42:12.040 --> 00:42:24.030
Judith Currier: in general, and we don't have to wait until there's a study. And there are studies and people living with HIV showing the benefits of exercise. To to to say that this is something that people should be doing.

156
00:42:24.030 --> 00:42:51.689
Judith Currier: Now, what's the optimal type of exercise? And how you know, how do you implement that. How do you get that into people's lives? What are the ways that make that possible? Ii think those are things that you know, that can be studied through implementation. But I do. Wanna be careful that people aren't waiting for us to study everything you know in giant studies before they think about in, you know, be, for they think about incorporating into their life.

157
00:42:51.920 --> 00:42:56.410
Jeff Taylor: Yeah, I mean, think people know it. But in terms of you know. allocating resources.

158
00:42:56.430 --> 00:43:02.920
Jeff Taylor: They demand that evidence the evidence base. That's what the challenges for those of us who are doing policy advocacy.

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00:43:04.400 --> 00:43:06.330
Annette Sohn: Thank you. Thanks, Jeff

160
00:43:06.340 --> 00:43:08.740
Annette Sohn: and Ayesulu. You have your hand up.

161
00:43:10.450 --> 00:43:20.689
Aisuluu Bolotbaeva: Hi, everyone. And I think you know something really interesting that was brought up yesterday during the luminary session for community educators was the fact that

162
00:43:20.770 --> 00:43:31.859
Aisuluu Bolotbaeva: what we do when we have access to this innovative medications as a participant of clinical trial. But then, because we live in a low or middle income countries.

163
00:43:32.040 --> 00:43:58.399
Aisuluu Bolotbaeva: When the clinical trial is over. We don't have access to this medication, and we have to wait until it becomes genetic, or until you know, like the Brand Company signs an agreement with the generic company, and it takes sometimes ages. So we have to be very smart about like, you know every time. If we have a possibility to attend and review clinical protocols, make sure that we are demanding for access to this

164
00:43:58.400 --> 00:44:15.939
Aisuluu Bolotbaeva: treatment for everyone who attended the treatment so that they don't have to switch back to something less maybe effective or less wanted once they had access already to something new is that work for them, and something that also struck me during the whole

165
00:44:16.000 --> 00:44:32.240
Aisuluu Bolotbaeva: croy presentations. Is that how little data we have related to women. Most of the clinical trials are usually male participants, and even when it comes to animal species, you know.

166
00:44:32.400 --> 00:44:55.139
Aisuluu Bolotbaeva: you see, that most of the species were male, not female, so we don't even have a hint. What could go wrong? From the animal studies that could actually help us to maybe be. You know. Take some precautions, or vice versa. Be more open to suggest that this actually could be a drug for a pregnant woman as well.

167
00:44:55.900 --> 00:45:06.799

Annette Sohn: yeah, thank you. I, Sulu. I know Allison and Judy are both big advocates for more research data and care specific for women. Do either of you want to comment.

168
00:45:07.030 --> 00:45:18.220
Judith Currier: Yeah, I mean, I think it's a really important point. I would highlight the care study that was done looking at long-acting, habitagre and real pivoting had over 50% women enrolled.

169
00:45:18.290 --> 00:45:35.809
Judith Currier: And you know, that was in in sharp contrast to some of the early phase studies that were really small. With 10 or 11 people where there were maybe 2 or 3 women. Where makes you sort of cringe when you see that? And but the studies in

170
00:45:36.170 --> 00:45:51.840
Judith Currier: as the drugs are moving, you know, across development, we're we're seeing we're doing better, we we can always do better. But II was really pleased to see that in the care study you know that it was really representative of the population living with HIV in those settings.

171
00:45:52.610 --> 00:46:04.599
Allison Agwu: III saw your point as well taken. And II think that's the first thing I tend to look for is is sex. And then look for, you know, demographics, and you know, is racially representative, and all of that. I think you know, with

172
00:46:04.600 --> 00:46:28.610
Allison Agwu: the attempts to do it. And now, with all your grants that you're right. You're supposed to write. If you are not including certain groups, why you are not and justify why you are or not. I think we have to keep pushing that and and justifying, you know. Should you? Actually, you want to get the population enrolled, not to great and get our studies done. But if there's a need to make sure that we have (102) 030-4050% women. Then we have to state that

173
00:46:28.610 --> 00:46:39.299
Allison Agwu: and and and to push for that. So your point again well taken, we have to keep people pushing go to way ahead than where we were years ago, right even in. We used to sit in it, and it was

174
00:46:39.330 --> 00:46:51.839
Allison Agwu: conference abstract at the abject. It was all males, all white males of 40 years of age or older reading age. Of what have you? And I think that is changing, but it's because of advocacy and pushing for the change, and so continue to to highlight that.

175
00:46:51.840 --> 00:47:10.119
Aisuluu Bolotbaeva: And I think we should now, you know, to bring this fight back to the pre clinical trials. As well make sure that animal species as well. We have sex days through. Because, okay, I can get all your ethical, you know. Arguments, why you are not wanting to involve women. But when it comes to the animals come on.

176
00:47:11.380 --> 00:47:21.320
Annette Sohn: That's a good way. II see. Look when it comes to the animals. Come on, I think that's a good point I also want before we move to the next point, emphasize

177
00:47:21.320 --> 00:47:45.700
Annette Sohn: also the transgender women are routinely excluded from these types of trials. And then, when we have data, we still get data and analyses like at the Journal of the International Society. Sorry for the Plug, but where Msm. And transgender women are combined repeatedly, and we have to tell the authors to disaggregate those data. This should not be something that researchers don't know about at this point.

178
00:47:45.700 --> 00:48:05.879
Annette Sohn: and this includes involvement in clinical trials, and so I won't add, I mean, I think we oftentimes talk about trans women, but we don't frequently talk about trans men, and I think that is also an important population. And then the spectrum right? And the argument would be, well, you can't have a bucket for everybody, right? But I think we have to be inclusive

179
00:48:05.890 --> 00:48:09.659
Allison Agwu: as often as much as we can. So just wanted to make sure I mentioned that.

180
00:48:10.090 --> 00:48:37.749
Judith Currier: Thank you. Yeah. And II think that we also have to be careful. I don't. I think that we need better representation. I don't know that necessarily, if the study doesn't show a a specific group that they were excluded. But they weren't enrolled. And so I think we need to make a differentiation between actual exclusion and and lack of inclusion. Because there they are, 2 different things, and we need to figure out ways to make the studies more inclusive.

181
00:48:37.750 --> 00:48:43.190
Judith Currier: Because II think that we're that. I'm not seeing studies specifically exclude

182

00:48:43.190 --> 00:48:52.040
Judith Currier: trans. Men or women. But but make sure they're they're identified when they're enrolled, and to increase efforts to be more inclusive.

183
00:48:52.170 --> 00:49:13.500
Allison Agwu: I think that part Judy is is is also key. Because I you know, I often times we say, Oh, they're they're hard to reach. That's why we don't enroll them. But II often flip it, or they're hardly reached right? So how do we make sure we because they're not included, necessarily excluded. But if we're not making efforts to make sure they know they're included, they may not be included. So I think just, you know, emphasizing.

184
00:49:14.390 --> 00:49:38.349
Annette Sohn: Thank you. There. There's a comment a little early on in the chat from Kennedy that I thought was something that we can think about, as we sort of move toward the end of our hour. Shocking! It's already been like 50 min. And Kennedy said, we have no global consensus or guidelines in the management of HIV. And aging our healthcare system of policies in Africa are not providing for HIV and aging support programs.

185
00:49:38.350 --> 00:50:02.100
Annette Sohn: What can we do as aging activists to push this agenda into the global agenda. And and I would say here, when we define aging, we're talking about living 30 years with HIV, 2030, 40 years with HIV, whether wh. However, it was acquired. So any any thoughts about that? And and actually, we're not the best people to answer the question about

186
00:50:02.100 --> 00:50:12.960
Annette Sohn: how do we advocate? I think you are in this room so would really encourage you to respond to Kennedy in the chat, too. But any thoughts about that. And then I can also comment Allison or Judy.

187
00:50:13.800 --> 00:50:37.080
Allison Agwu: Yeah, II think it is really the integration of primary care into HIV care. And all these settings around the world, and how and and how that's, you know. And it may be country specific and maybe program specific. But just making sure that primary health care is a part of a of HIV care. And then thinking about what are the priorities? For

188
00:50:37.080 --> 00:50:55.619
Judith Currier: for the for these needs, you know, diagnosis and management of hypertension is really an important thing for long term health. We're gonna hear more about that today in the complications session. Some of the interventions that are being done to integrate hypertension, hypertensive care into HIV care. So I guess, in terms of

189
00:50:55.670 --> 00:51:06.780
Judith Currier: advice for advocacy, I would try to focus on where the priorities are for the things that need to be incorporated. To to be as specific as possible.

190
00:51:07.470 --> 00:51:14.660
Allison Agwu: If you did it. I apologize. I didn't see it. But has there been an is issue? So S focused on aging.

191
00:51:15.460 --> 00:51:16.689
Allison Agwu: not young, but

192
00:51:17.070 --> 00:51:42.779
Annette Sohn: at the older age? Yeah. Actually, one of the guest editors for that supplement was. Here, let me see if Reena is still in the chat from Malaysia. Yeah. Hi, Rena, so there there are. And Rena, if you are available to put into the link the the issue, the the supplement issue. But it was mentioned that maybe is a better place to to talk about some of this kind of advocacy. But perhaps I would say

193
00:51:42.780 --> 00:51:52.450
Annette Sohn: Jeff, more in the context of it, being more of a global meeting, and Croydon, not necessarily identifying itself as a conference as a place for advocacy.

194
00:51:52.450 --> 00:52:16.749
Annette Sohn: I wanna highlight that a lot of the people who are speaking at this conference presenting their work, are invited to sit on who guideline development groups and committees. So to one of today's plenary speakers, Charlie Flexner, he is advising the who the Clinton Foundation Unitaid online acting extended delivery medicines. And so I think the people

195
00:52:16.750 --> 00:52:35.329
Annette Sohn: who are at this conference are still potentially those who need to hear these sorts of advocacy messages. And the Martin Delaney talk was incredible. And and I just saw a lot of scientists from basic clinical epi just wowed and really amazed, and and so

196
00:52:35.520 --> 00:52:43.679
Annette Sohn: shocked some of them about some of the information that they had never heard before, and Croyd would be the only place that they might hear it.

197

00:52:43.950 --> 00:52:50.509
Annette Sohn: So any any other thoughts from the group. Anyone wanna raise your hand about that

198
00:52:51.900 --> 00:52:54.270
Annette Sohn: other other comments about that

199
00:52:54.460 --> 00:53:18.710
Annette Sohn: so well, like there's so many chat comments on like my eyes are, are, you know, like crossing? Because there's a lot of information there, but a a theme, perhaps that is coming up is about inclusion of of different people in research studies, and the difference between equity and equality, like the numbers of participants versus who are are there and where they are

200
00:53:18.710 --> 00:53:32.639
Annette Sohn: in terms of location as well. Geographic location, country income, level location things like that. I think that's something, and that we should keep our eye on. And somebody a few people have pointed out like, look at the author list

201
00:53:32.690 --> 00:53:50.179
Annette Sohn: people. And and I think sometimes that's not something people emphasize very much they look at the data. But for us to be in a time when, for example, you're doing an analysis that includes transgender people or highlights, issues of transgender people, and you have no transgender people

202
00:53:50.500 --> 00:53:57.570
Annette Sohn: on your authorship list, or there aren't advisers involved. II think I would hope that we are beyond that.

203
00:53:57.920 --> 00:54:17.169
Annette Sohn: So as far as other clinical questions. Maybe we can have a final comment actually, at this point now, because I just looked them like Whoa! We only have 3 min. So maybe a final comment. For because, Allison, you went first, how about Judy? You go first on the final comment. And then Allison. And then Jim is gonna close us.

204
00:54:18.080 --> 00:54:45.250
Judith Currier: yeah, I would just thank everybody for the great comments and and input today, and and just encourage everyone to continue intending these sessions and and make a list of the ones you didn't get to listen to and listen to them when you go for your your morning exercise walk over the next few weeks. There, there's just so much data here. We all need time to process it and and figure out what it means. But it's it's so great to have all this. This discussion.

205
00:54:46.540 --> 00:55:06.239
Allison Agwu: Yeah, no echoing Judy. Thanks for inviting me to talk. It has been great talking with you all on the chat has been on fire, I think. All I would say in addition to Judy's is, it's not just a 10. But don't be afraid to go up. Not that this group is afraid. Go up and challenge. Ask the questions. Challenge, because sometimes, honestly.

206
00:55:06.690 --> 00:55:32.629
Allison Agwu: it's just not been thought about right. And so you may spark someone to do something or think about something differently. So ask the questions, why and why not and push? It's it's really from integrating with the voices of the people. With the lived experience such as you all that. Actually, the questions come out, and oftentimes you all are the canary and the co-mines that spark the research or say, how does it get back to us? Right? So really think these are the sessions that

207
00:55:32.630 --> 00:55:45.910
Allison Agwu: have to happen. I can't believe it's the first time I've actually experienced a Margarita breakfast, whatever. But II think really important and a critical part of how we then interpretive and move what we do forward. So thank you for involving us in this conversation.

208
00:55:48.660 --> 00:55:50.119
Annette Sohn: Jim, over to you.

209
00:55:51.160 --> 00:56:04.179
Jim Pickett: Okay? Well, first of all, let's everyone give some love in the chat or with reactions to this amazing panel. Judith and Allison and Annette, I love these roundtable discussions. They're so rich, and

210
00:56:04.320 --> 00:56:32.360
Jim Pickett: it's hard to keep up. So we will when we share the recording we will also capture everything in the chat and put it in a document. So people can go back and pour through there and see the questions and and find resources for yourself. So we'll include that, because I know for me I've not been able to keep up and this is kind of what I do, and I can't keep up. So thank you for making it hard to keep up. Thank you. To everyone who has been so active in this chat.

211
00:56:32.420 --> 00:56:54.749
Jim Pickett: You're right, Allison. We have to challenge. And I think you got the right people in this room who are born to challenge and are wired to challenge, and I encourage everyone to continue to do that in every single room and every single venue you are. That is how change happens. Sometimes people are just not aware, and sometimes people are aware, and they need to be pushed.

212
00:56:54.850 --> 00:57:08.559
Jim Pickett: and they need to be pushed, and they need to be pushed and nothing for us without us. And I'll end with, you know, the old act up phrase that is as true as it was in 1,988 as it is today.

213
00:57:08.670 --> 00:57:10.370
Jim Pickett: Silence equals staff.

214
00:57:10.660 --> 00:57:30.319
Jim Pickett: So if there's an issue, if there's a problem, do not stay quiet, raise your voice. People living with HIV like me, and many in this room are experts on our lives, and no one can take that expertise away from us. No one has expertise on me than better than I do, so I have a responsibility

215
00:57:30.360 --> 00:57:39.309
Jim Pickett: to really share that in every way I can, and even if it makes me annoying or obnoxious, which it does all the time. So with that said, it is now

216
00:57:39.330 --> 00:57:41.040
Jim Pickett: the top of the hour.

217
00:57:41.060 --> 00:57:48.100
Jim Pickett: the next the croy opening plenary for this morning starts in a half hour, so, as I said yesterday. Get on your roller skates

218
00:57:48.120 --> 00:58:13.760
Jim Pickett: head over there. Tomorrow morning we'll be back here at the same time. Same place. We have a panel of 4 folks, 2 researchers and 2 advocates who will be breaking down all the things they found fascinating at this conference. So you can bet is going to be a crazy, wild ride for another 60 min, so I hope you're all there. And with that we're gonna close out and send you on your merry way. Thank you so much.