



Transcript provided by kaisernetwork.org, a free service of the Kaiser Family Foundation<sup>1</sup>  
(Tip: Click on the binocular icon to search this document)

---

## **XVII International AIDS Conference Official Press Conference August 7, 2008**

[START RECORDING]

**CRAIG MCCLURE:** Welcome to day four of our post plenary press conferences. Today's plenary really had a focus on treatment scale-up, the link with health systems and the role of people living with HIV and AIDS, and we had another day and dynamic set of speakers who are with me today.

The first is Anton Pozniak on my right, a consultant physician, senior lecturer at Chelsea and Westminster Hospital, where he is the Executive Director of HIV research. Anton is also an executive member of the European AIDS Clinical Society and Vice Chair of the European AIDS Trial Network, or NEAT. The title of his plenary was Advances in Anti-retroviral Therapy.

Our second speaker was Rolake Odentoyinbo, who is the Chief Executive Officer of the Positive Action for Treatment Access, a non-governmental organization dedicated to the promotion of the rights and well-being of women living with HIV in Nigeria. Also, she is an activist, advocate, writer, trainer, public speaker, television producer and presenter, and Rolake spoke on the role of GIPA in strengthening health systems through the AIDS response.

Our third speaker on my far right was Gregg Gonsalves, who coordinates a program to educate communities in Southern Africa on AIDS and TB treatment and how to advocate for their rights to healthcare, which is administered by the AIDS and

Rights Alliance for Southern Africa, based in Cape Town. As the only regional network on human rights and AIDS in southern Africa, ARASA promotes a rights based response to the epidemic through advocacy, training and capacity building and Gregg spoke on ART SCALA.

So just a quick reminder again about the headphones that are available. You can ask questions in Spanish or English, we all have headsets and I believe English to Spanish is 2, though they sometimes switch to 1.

So each of the speakers will briefly make a few brief remarks summarizing their presentation, and then we will open it up for questions. Anton?

**ANTON POZNIAK, M.D.:** My presentation related to what changes there have been in HIV therapy since we gathered together in Toronto in 2006, and I started off saying basically that the treatment works if you have access and take it all the time, and that life expectancy for a 20-year-old should be 40 years and for a 30-year-old about 30 years and that if you have an undetectable viral load and CD4 count that is over 500, the risk of you dying is similar to that of somebody whose age/sex matched in the normal population. There are some issues still though, in terms of life expectancy for drug users and for women.

I then covered some of the other interesting topics that are going on in terms of anti-retroviral treatment, which

is when to start treatment, and there is a move now for the IAS/U.S.A Guidelines for people to start treatment earlier, in other words, not just when their CD4 counts goes below 350, but also to look at people whose CD4 counts above 350 and individualize whether they need treatment.

The reason for this is that there are benefits of taking treatment early in terms of tolerability, but we now know that people who are untreated, even though their CD4 count is high, can develop cardiac disease, renal disease, liver disease and malignancies, even with a high CD4 count. So if somebody is at risk of any of these conditions, than perhaps with a CD4 count over 350, we would starve.

I talked about some of the debates about what to start with, and obviously, most of that is around access, and also I spoke to say that if you are in resourceful countries, and are on the standard Navarapine/D14/3TC type therapy, and have virological failure, I know there are issues of over how you might measure that, what to go to next, and really, with that much technology, you could be switched in terms of a program to a boosted PI and a new class of drug. But unfortunately, we do not have access to those sorts of compounds universally in resource poor countries.

I then really finished off in a way by saying if you are on treatment, you should not stop treatment, as we know from the smart data, because if you stop treatment, not only

have you run a risk of developing AIDS or death, but also, these non-HIV related conditions that you should start treatment really early, if you come in very sick with HIV, which will again prevent you from progressing to AIDS or death. And some of the [inaudible] issues are also covered, but I am sure you have heard a lot about those in this conference, and they are going to be covered this afternoon.

Finally, the public health message about treatments, the issue of ads will an HIV positive person, who has an undetectable load transmit to their HIV negative partner? There was a whole session on that here. And I think that has just got to be further discussion over this issue in terms of public health.

And secondly, what they have described in Vancouver, that if you treated everybody you could who have got HIV and link it with prevention, would you have an impact on transmission of the disease.

And finally really, we do need good programs so that not only can we treat patients rationally in places where we have got lots of resources, but also, treat them rationally where resources are scarce.

**CRAIG MCCLURE:** Thank you Anton, I would like to turn to Rolake now please.

**ROLAKE ODENTOYINBO:** Thank you Craig. My name is Rolake Odentoyinbo. I live in Lagos, Nigeria. I work as a

treatment activist; I work as a treatment educator. Today we talked about the role of people living with HIV in healthcare, and the first thing that we established is that healthcare, the health system is everybody's business. It is not one individual, it does not belong to the government, but it belongs to all of us.

Some of us come from poor countries, some of us come from resource poor countries, but in reality, quite a number of us—my country is really a resource mismanaged country, not a resource poor country. That is because we have so many people who play different roles.

Our governments find what I have chosen to call neo-colonists, who come in under the guise of giving us AID and then loans. However, it is really about dictating what should happen in countries and dictating our policies and sponsoring these loans that are not effective to us.

People living with HIV have played roles that contributed immensely to healthcare systems. We are not just patients, we are not just receivers of services, but really we are the leaders when it comes to delivery against HIV and AIDS. Because we have taught ourselves, we have taught our communities, we have raised our voices; we have helped people understand what is happening.

I studied dramatic arts. I have no science background, however, I have learned the science of HIV because I realize

that that is what my life is about and that is what we are teaching our communities to understand this disease. So we played a huge role in healthcare.

However, we should remember that in spite of all of this, women still bear the brunt of the burden, so we have our women who are still there, and they are still the beast of burden really. Girls are also right now, greatly disproportionately affected in terms of their roles as healthcare providers.

Finally, we also need to understand that criminalization is harmful. In the work we do we have taken the initiative. People living with HIV could not want to spread this virus that is not our primary intent. That is not our intent at all.

However, we are having laws that are coming in criminalizing even wrong disclosure of HIV status, criminalizing spreading the virus, criminalizing a woman living with HIV who infects her baby. These are really things that are drawing this response back.

However, for things to happen, it is important that greater involvement of people living with HIV begin bring greater investment in people living with HIV. So we need to invest in people for them to be involved.

People living with HIV should be reaffirmed, should be celebrated and really should be respected for the work they have done in the community. Thank you.

**CRAIG MCCLURE:** Thank you Rolake; I would like to turn to Gregg now please.

**GREGG GONSALVES:** Good morning everybody. I basically talked about ART scale-up, the scale-up of anti-retroviral therapy, and I reflected back on where we were eight years ago in Durban at the International AIDS Conference when the first push for getting AIDS treatment to resource poor, low to middle income countries started.

Basically, eight years later the point I tried to make is that ART scale-up is a health system success. It is the most ambitious public health undertaking of my lifetime, and it was something that was done against the conventional wisdom of the time. What we can do now is that 30 years ago we had the Alma-Ata Declaration of health for all. We can take that and build on what we have done in AIDS and build towards a movement for comprehensive primary healthcare.

For a lot of the talk I talked about technical challenges, about infrastructure, about data monitoring, about drug supply, about task shifting. We talked about choice of drugs and when to start and not just based on issues around what might be clinically important for individual patients, but what are the ramifications for national ARV programs.

The way we have been able to scale-up anti-retroviral therapy over the past eight years has largely been through keeping it simple. There have been enormous pressures from researchers in the north and others, to basically throw more complexities onto national AIDS programs, which would make it harder to scale-up beyond the three million people we have on therapy now.

Finally, I talked about some of the political challenges, the political threats, not just to ARV scale-up, but actually to push primary healthcare. Some of the debates we have seen in the International Herald Tribune, and the New York Times, and the Financial Times and the British Medical Journal are repeating a mantra which is actually regressive and destructive.

It says AIDS gets too much money, AIDS is destroying health systems that the threat of AIDS has been exaggerated, and basically the rhetoric that is coming out of these people is not about how do we get more care to more people, it is about how to do less with less. What I tried to say is that we are the heirs to Alma-Ata.

We are pushing ahead of progressive primary healthcare movement. The people who have been writing like Roger England and the BMJ are basically saying let us do less with less. And if anybody has been around since the 1970's, you will remember right after Alma-Ata, there was a group of people at the World

Bank who said you know what? This health for all is not a good idea. You need to have selective primary care. Let us do less with less.

And it is a Malthusian option saying you know, we do not have the money to pay for health for poor people, but largely, this debate is being lead by people who have pretty good access to healthcare in Washington, D.C. and London and other places around the world.

So basically, my plea to people in the audience is that we need to gather together as advocates for AIDS, for TB, for Malaria, but also for primary healthcare and human rights. To build a movement to make sure that nobody dies of any disease just because they are poor any place on the planet.

**CRAIG MCCLURE:** Thanks Gregg. I would like to ask one question to each of the participants before we open up.

To you Anton, on the clinical side of things that this conference has been quite a bit of evidence and discussion about HIV now being clearly a chronic, inflammatory disease, and HIV damaging the organs of the body well before immunosuppression begins to set in, which has lead to guidelines to treat earlier.

I wonder if routine testing under circumstances where stigma and discrimination were not a problem, routine testing was implemented throughout the world. Can you see a day where people would be treated immediately upon diagnosis?

**ANTON POZNIAK, M.D.:** Okay, so planning for the future, yes, if you could, that would be fantastic; but you need a drug that would have a fantastic side effect profile, you would need a drug that was incredibly cheap.

You would need a drug that if you miss a few doses it would not matter, and you would need a drug that if you were in any small village in any part of the world, you could get access to. But first of all you would need access to that test.

So is it a pipe dream? Maybe. Could it be a reality? It possibly could, but I have been in this business a long time as most people on the panel, and if you look at the achievements we have gotten already, you know, we might get there and I sometimes believe that if you do not dream, and try to pursue things, than you do not achieve.

So realistically, no, but in my dreams I hope we can get through something like that.

**CRAIG MCCLURE:** Thanks Anton. Rolake, could you give us any shining examples, if there are any, where people living with HIV are centrally involved in designing strategies, delivering services and managing them, engaged in monitoring and evaluation and in a sense playing a central role beyond the critical advocacy role that they play. Any best practices?

**ROLAKE ODENTOYINBO:** Any practice that takes in everything, I am searching, are there any? Well, let me speak

for where I come from. On the continent, I have not seen. Where we have people living with HIV involved in designing, planning, evaluating in the entire spectrum.

We have roles that for some reason we have been pigeonholed into. So people who have HIV would work as volunteers, would work as councilors, but really taking on the broad spectrum of things, it is a dream. It is what we want, it is what GIPA means, it is what we want promoted because that really is the idea that should be involved in things that affect our lives. However, we are still waiting to get to that point.

If there are some, I do not know, I have not seen them on my continent.

**CRAIG MCCLURE:** Thank you, and finally, Gregg, you talked quite a bit about targets and the importance of targets, how 3 x 5, though it was not reached in time, the target itself helped galvanize the field to move faster.

How would you see targets being set to reach universal access? And how they might link to strengthening primary care?

**GREGG GONSALVES:** Well, first of all I am going to get into so much trouble, because I was at the planning meetings for when they set up the universal access initiative, which was sponsored by UNAIDS and the Department for International Development. There was a huge fight in that room about whether we were going to have global targets.

This was just as, 3 x 5, when was it 2005? 2006? The French delegation, the Brazilian delegation, the Civil Society Delegation, a bunch of other delegations argued that we need global targets. That is what got the momentum going for 3 x 5. We were told "no". This is going to be a country driven response, with country developed targets.

Well, let us go back and look at the data and see where we are. I think what we can say is that the global targets in 3 x 5 basically said to the world we are all going to reach for a goal together.

Do you know what the target is for Argentina? Do you know what the target is for Mexico? Do you know what the target is for Costa Rica? Do you know what the target is for Egypt or Botswana or China? None of you could answer that question today. It just obscures the goal that we are trying to reach.

Now if we are talking about primary healthcare, we need to have a set of indicators, you know what Anton said about dreaming? We dreamed with 3 x 5. We did not let the "realists" tell us that it could not be done. We said we are going to reach 3 million people by 2005 and we were late a couple of years, but we did it.

We can do the same thing for primary healthcare, but we need to have visionaries who say you know what? Let us not take the Bill Easterly and Roger England, and let them guide us

into the future because they are pessimists. We need to be optimistic, set targets and milestones and deadlines and reach for them.

I think we can do it. I think we can really get 10 million people on anti-retroviral therapy over the next five years, but it means really scaling-up resources, scaling-up commitment and to feeding some of this defeatism that is emerged among journalists, among the chattering classes and think tanks and in other places.

**CRAIG MCCLURE:** Thanks Gregg, I will open it up now, and again, just say your name and your media house before your question. Larry first—

**LARRY ALTMAN, NEW YORK TIMES:** It is a two part question, linked. Have the similar guidelines been written by European AIDS groups as the American one in terms of treating at 350, and have the committees that have written this, has that been scrutinized in terms of drug company connections with those who have written the guidelines to determine how much conflict of interest there may be in what would therefore be raising the number of people being treated?

**ANTON POZNIAK, M.D.:** Let me just deal with the conflicts of interest, because I am totally conflicted, I give a lot of advice to pharma companies and talk on that board ect, but I am very well balanced because I usually give advice to all of them.

I must say that all the people that are on guideline committees have to declare all their interest, whether they are financial, whether they are non-financial, whether they are to do with relationships, family connections.

So, I also believe that everybody on the committee is not looking at any financial or political gain in terms of writing the guidelines, these are basically to help physicians and healthcare workers think about how to treat the patients.

So the major issue when I call them guidelines, because that is what they are, they are not a cookbook, they are not a prescription, they are guidance for people when they are dealing with patients difficult choices about starting therapy or switching therapy. Have the other guidelines put this in? No, not yet because guidelines take a while to revise.

The British Guidelines are still in draft on the web. The EX Guidelines have taken into account a lot of the data in the last six months, but they are renewed every six months, so the European Guidelines this time, do not include anything much about the 350 apart from it is possible. But the next revision of course, would take into account all of the recent data.

So in summary, I am aware of conflict of interest, but I am very confident that my colleagues sit on these committees and do a lot of hard work, spend a lot of hours for no personal gain except for the altruism of helping colleagues and other

healthcare workers and also to influence some healthcare systems where we have influence.

The fact that they would not fund certain treatments unless they were in the guidelines, and we have to say that we have got very good data that these treatments work, and therefore we put them in the guidelines, and without us doing that, some of the treatments would not have been available to patients today. So I think that is a really strong message from guidelines.

**CRAIG MCCLURE:** Am I correct Anton that the WHO anti-retroviral guidelines for use in lower to middle income countries are currently under revision?

**ANTON POZNIAK, M.D.:** Yes, I mean the major thing about guidelines to say is that none of them are set in stone; they are always continuing to be revised.

**CRAIG MCCLURE:** Next question please.

**FEMALE SPEAKER:** [Speaking Spanish]

**ANTON POZNIAK, M.D.:** I think here that Gregg has also addressed this issue, that the WHO guidelines have not yet come out on whether or not you should start earlier, the only guidelines that have suggested that might be the case have been the IAS/U.S.A ones, and I think that probably the European and the British ones and other guidelines will have something to say about this.

So the issue is, what is the risk of starting early in terms of having the drugs? Are the drugs toxic? Will you get resistance? Will you get problems with the drugs? The data only comes from cohorts, not from randomized, clinical trials. They all suggest the cohort's data, that there is a benefit from starting early.

Now I am not saying we should all do this, I agree that we should individualize, and that is what the IAS has said about looking at the patient's risks who have got a CD4 above 350 and if say they were hypertensive, with diabetic or got heart disease or liver disease, you might think then that perhaps starting anti-retrovirals would be better for them than delaying it.

As far as people in resourceful countries, I think it is still a major issue that those people who have got a CD4 below 200 do not get access, and if you have to grade it, who should get access first in the developing country? Obviously those people at risk of progression to AIDS or death should be in the line up first.

So I understood, and maybe Gregg wants to say something about this, but if you suddenly put this as a whole philosophy for the whole world, that suddenly you burden and stress out a lot of healthcare systems. Really, this recommendation should be looked at on an individual patient level, not that everyone over 350 should start.

**CRAIG MCCLURE:** Gregg?

**GREGG GONSALVES:** Well, look, the question is about what is good for an individual patient and what is sustainable in a National HIV program. Tony Harry [misspelled?] said he has been under a lot of pressure to switch from D14 to Tenopavir [misspelled?] in the national guidelines, but what does that mean?

It means basically that he can give ARV's to fewer people who will have fewer side effects, but saving fewer lives. So there is a balance between what is good for an individual patient in a situation like in the UK where you have a national health service, or in the United States where you have fancy private insurance, where you can pick and choose among any drugs, any tests and go to any doctor.

But if you are in Malawi or in Mozambique, or if you are in other places where the choices of drug are limited by costs, or the healthcare infrastructure cannot bear a fancy lab test to monitor your liver enzyme levels or your kidney function, you are really going to have to think about this, about effectiveness, risks and benefits on a program level from a very public health approach, which is different than what a doctor would do in London or New York.

**ANTON POZNIAK, M.D.:** Yes, there is an old quote that the best is the enemy of the good. I think that what we have to do is make sure that everybody gets good enough care at the

moment, and it does not mean that we should not try and get rid of, in first line, some of the drugs which inevitably will lead to side effects. But that takes a lot of action from individuals all the way up to governmental support.

**ROLAKE ODENTOYINBO:** Just let me say here quickly, that while we talk about side effects, we all know that these drugs have side effects, however, if you come from the context where you are fighting for your very life, then you will ask yourself, when people talk about side effects, ask from a person who has had AIDS, and ask that person to choose what would you rather have?

AIDS or these drugs with side effects. When you know that you have side effects that can be managed, your drugs can be changed, can be treated, when you are fighting for your very life, the drugs are ultimately and absolutely important.

While we do not want to dismiss or discountanize the fact that some of these drugs have side effects, it is important that we realize that we are talking about fighting for our very existence, and just remaining alive.

So when we go on with a debate of the cost benefits of drugs and side effects, look at you fighting just to stay alive, and be there for your children, and keep your family together, it is not a very balanced for most people in my sex and in my culture.

**CRAIG MCCLURE:** Thank you. Question over here?

**GU.S. NAYSMITH:** Gus Naysmith [misspelled?] from the Rutland Herald in the United States. Having been with Grassroots Organizations in resource poor countries, I know the problem they face of keeping it simple, not only in treatment priorities, but in the reporting requirements to funding agencies, and that if some of those funders would actually just go to where these people are, they would see transparency and data that may be not on a computer, but it is very clear to the eye.

Perhaps that is part of the colonialism that you talk about Rolake. I know that you are not a victim, but it affected me that you emphasize new colonialism, but did not mention anything that I hear from my friends in Africa and part of Asia about corruption, favoritism within their own countries, blockages in the bureaucracies and stigmatization that prevents treatment and education to get to marginalized groups. So I want to give you a chance on that.

**ROLAKE ODENTOYINBO:** Thank you very much. I actually did say that looking at the problems that we have with health systems, the very first group I mentioned—talking about our governments, and like I said, most of them are self-centered.

Then I talked about even those of us within the system, and most of us, even if we are not active participants, the fact that we would keep quiet and keep silent when things are going wrong, means that we are equally guilty. And of course,

you have the third partners, and they are the ones that I [inaudible] called new colonists, because when you see what happens in countries, it is appalling.

Now, when we ask ourselves, and we say looking at HIV and AIDS and looking at the response, what are the challenges that we have on the ground? You talked about monetary [misspelled?] evaluation and it is true, you have one hospital working with six partners, all six of them expecting six different ways of reporting.

I am going to go and look at the Nigerian Global Fund Grant for example, where we lost a grant because [inaudible] report was what is happening, and we are looking at different ways of reporting and different formats for different groups and what is the national requested format and everybody just wants to claim figures. So you are having over reporting.

If I am working in this clinic, I need to report that I have given U.S. PEPFAR money as going to treating 10 people with ARV's. However, what else are you supporting? Is it just about appeals? And really what is our criteria for monitoring? And what exactly are we monitoring? It is the number of appeals we are throwing out or the number of people that we are really able to really make a difference in their lives?

**CRAIG MCCLURE:** Thank you. While the choir practice continues, can we have the question from the middle please?

**TREVOR CULLEN:** Trevor Cullen [misspelled],  
Biotechnology News. Anton, you talked about the importance of  
having dreams. Do you think finding a vaccine for HIV will  
remain a dream or a realistic possibility?

**ANTON POZNIAK, M.D.:** When they first discovered the  
AIDS virus, I remember we all got very happy because we thought  
there is going to be a vaccine. So in 1984 I was at the  
Middlesex hospital in London, and they all told me we will have  
a vaccine in five years.

Now, if you ask any vaccinologist today, they will say  
probably wait five years. So I am waiting still, but I have  
not given up waiting, because I think there has been a lot more  
focus on vaccines in the last five years than there has been  
way before that.

Now, there was a very good plenary at Croy, looking at  
the way the vaccine development goes and I think that part of  
the problems with vaccine development is not only the virus and  
the immune system, but it is to do with funding, it is to do  
with innovative thought about vaccines and it is to do with the  
way that some of the basic signs should be translated into  
creating a basic vaccine.

I still am very weary about some vaccine trials which  
have very limited targets for HIV and we have had two important  
lessons from that, and I think that we have a little way to go  
before really good vaccines are actually prepared for man. But

you have to then weigh up how long do we wait before we test out some new vaccine and the whole world is waiting for something that might be effective.

But as I say, I have not given up the hope that we will have an effective vaccine, but I am not going to give you a five-year target, I do not know when that will be.

**CRAIG MCCLURE:** Another question? No further questions? Larry?

**LARRY ALTMAN:** Dr. Pozniak, you said also that we need clinical trials to document the 350 or whatever number it is, so how do you balance that versus the recommendations so that they are not?

**ANTON POZNIAK, M.D.:** Okay, so first of all, I want to reiterate that guidelines are only guidance. So there will be many physicians and others who will look at the guidance and say, well, that is not for me. Or they will say I have an individual patient who, yes, the risk is there, and I think that I will start early, and there will be pressure from patients as well, and advocacy in everyone, so they are only guidance.

But what the guidelines have thrown up is a scientific question that needs to be answered. Now, cohort studies are pretty good actually, if you have lots of them, if they all lead to the same answer. You usually end up getting that answer from clinical trials.

So what has happened is the inside group, it is an excellent idea, is going to do a clinical trial to look at starting above 500 versus starting below 350, so there is going to be a big separation of these people, and they are going to look at all these issues that I have discussed today.

Also, there is a plan to do the same in Africa, using slightly different cut offs, because the above 500, less than 350 is not quite relevant to the situation in Africa, and I really hope that that gets support to go ahead.

What will happen is that over the next two or three years, the various guidelines may all come up and converge to say the same sort of thing based on the cohort data. But then we will have the clinical trial data and the clinical trial data hopefully will be definitive, and will actually tell us what to do in these situations.

That is why we are doing it. If you look at most guidance, a lot of it is based on expert opinion and cohort data, but randomized clinical trial data is what we need today.

**CRAIG MCCLURE:** Gregg?

**GREGG GONSALVES:** You know, there is a great book called *Overtreated* in the U.S. by a medical reporter that talks about how the American health establishment over-treats people with lots of procedures for cardiac care, for back pain—there is a lot of expert opinion which drives clinical practice, that necessarily does not get worn out by the data.

So I think that Anton's comment that we need a clinical trial both in the setting of the U.S. and Europe, and in the setting of Africa to give us randomized clinical trial data on when to start is just absolutely essential. Otherwise, we are just going on an expert opinion, and we know from medical history that it does not always work out to be born by the evidence.

**CRAIG MCCLURE:** Just to play devil's advocate as the Chair, can you talk a bit about—both of you, all of you—cohort studies are becoming increasingly important. They are larger, better run, well designed; give lots of longitudinal data that often we would need to wait many years for a randomized clinical trial to get.

And in light of that, what it seems looking at the ISU.S.A recent guidelines, is what became clear to the panel was that people who were treated earlier seemed to have fewer negative clinical outcomes, more sustained responses, people who stopped therapy had damage that was clearly related to the inflammatory response that was coming back.

The question is, randomized clinical trials being the gold standard, versus cohort studies becoming increasingly important, I guess where is the balance?

**ANTON POZNIAK, M.D.:** So I guess do we need clinical trials is the question? The best level of evidence is a metro-

analysis where you get all randomized clinical trials together, then there is clinical trials, then you have cohorts.

Now, the interesting thing is, if the cohorts are setup very well, and there is one question to ask from the cohort rather than going on a fishing exercise, then usually they predict what the clinical trial, any randomized clinical trial does.

And there is a very good report on this that out of 18 very well set up cohorts, 17 of them had the same answer as the randomized clinical trial. But the issue is that while you are setting up cohorts to ask the question, we might as well at the moment, now set up the randomized clinical trials to ask it even better.

**GREGG GONSALVES:** Also, a lot of the cohort data is from the developed world, from Europe and North America. Also, you know, cohort studies—we cannot get into a statistical discussion, but cohort studies have an opportunity for bias that randomization helps to get rid of.

So we do not rely on randomized control trials just because we want to be like sticklers for evidence, it is because cohorts have weaknesses methodologically. So that is why we are arguing for the data. Especially in Africa where we do not have the cohorts to even guide what the recommendations should be.

**ANTON POZNIAK, M.D.:** I think the philosophy really for me is that we have to get on and treat people; we have to get on and get the healthcare system into place, and in the meantime, while you are doing that in parallel, do good research. And it does not mean that you have to spend millions of dollars on doing good research, you can do good research without having to spend a large amount of money.

**CRAIG MCCLURE:** Thank you. Final question here.

**JANE DRAPER:** Jane Draper from the BBC. Sorry it is a late question. Question for Anton Pozniak, I know it is not the main thrust of what you were talking about today, but do you have any thoughts about what Gregg was saying about Roger England's skews and some of those debates that are emerging?

**ANTON POZNIAK, M.D.:** I worked a long time ago in Zimbabwe, from '89 to '91 and they had a really good primary healthcare system. I mean I do not know what the situation is now, but I am sure it has probably degraded.

I agree entirely about what has been said about the HIV influencing primary healthcare systems and using primary healthcare systems to deliver quality care in all chronic diseases. I see the model that we have in terms of very hospital based, expert based, not being sustainable in any resourceful country really.

It has got to come from bottom up, and we have to make sure that the resource and the energy are of the people

involved go into strengthening primary healthcare systems in all of these countries. And even in resource rich countries, we are thinking about how primary healthcare systems can be more involved in the treatment of HIV positive people because it is up until recently been really the area only for experts.

**GREG GONSALVES:** You know, do not take Anton or my word for it, the Ethiopian Health Minister is here, the Lusutu [misspelled?] Health Minister is here, and they will talk about how HIV programs have helped to build up primary care in their countries. You can do things the wrong or the right way, the big problem with Roger England's critic is that what about structural adjustment in the 70's? What about chronic under-investing of health and development in the 70's?

Those probably destroyed health systems more definitively than HIV programs which have been around for the past four or five years in terms of providing medical care in terms of ARV's.

**CRAIG MCCLURE:** The big question we have at the International Aids Society is who is Roger England? Health Systems Workshop in Grenada, which you can Google, has very little information. Our question is what is Roger England's legitimacy? On that note, this will be my last press conference chairing.

Tomorrow for the closing press conference, Julio Montano will be chairing while chair the rapporteur session.

So I just want to thank Karen Bennis and all of her staff, all of the volunteers, and all of you for your energy and time and passion this week and I will see you next time.

[END RECORDING]