

**Official Press Conference: Meet Today's Plenary Speakers
XVI International AIDS Conference
August 16, 2006**

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CRAIG McCLURE: Welcome again, I'm Craig McClure, executive director of I.A.S. This morning, I'm really pleased to have with me the four speakers from today's plenary session. The theme of the plenary today was "Advancing Treatment and Universal Access - A Report on State-of-the-Art and Progress." The speakers provided us with key on-the-ground perspectives as well as international perspectives and calls to action, important new data, and a vision for the future of HIV treatment.

As per usual, I am going to introduce each of the speakers in turn to give very brief remarks on summaries of their talks, and then we will open it up for questions. Our first presenter this morning was Dr. Julio Montaner of the BC Centre for Excellence in HIV and AIDS, and the incoming president-elect of the International AIDS Society. Dr. Montaner.

DR. JULIO MONTANER: In brief, I tried to outline in my presentation, firstly the dramatic evolution that highly active antiviral therapy has had over the last decade. When we look back at Vancouver, there was the birth of a new way of approaching treatment for HIV aiming for full suppression about application, but very rapidly we realized that those treatments were cumbersome, they were difficult, and that they had a number of side effects and toxicities that precluded the long-term benefit of the places that most needed it.

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Great efforts have gone on to simplify therapy. I don't want to repeat the presentation, but I think that the fixed-dose combination tablets that we now have available in North America in particular or in Europe are very much an improvement on previous approaches. There are some fixed-dose combinations in the south part of the world. More needs to be done to spread to this approach widely.

The recent approval of the single one pill once-a-day regimen should have an impact on everything that we are doing, but then I moved on to discuss the concerns that we have regarding the sustainability of the antiretroviral therapy effort not just in the south of the world but also in the north of the world. We are currently very concerned about this, and as a result, we started to explore we started to explore the potential that highly active antiretroviral therapy could have on enhancing our prevention efforts and, I will emphasize it every time, this is not to replace prevention this is to strengthen prevention over and beyond the traditional operation measures, and over and above the current efforts to expand prevention which is the top priority.

We cannot ignore the fact that a highly active antiretroviral therapy has the potential to decrease infectiousness, and therefore in an environment where prevention continues to be strengthened we should have a significant decrease in new cases of HIV just by doing what is right, which is to treat people with HIV who need treatment.

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Beyond that, we have created a hypothesis, which is simply a hypothesis, that requires a lot more work but is really very interesting because it tells us that if one day we were to have a simple treatment that is free of side effects that is readily available we could envision that these treatments could come together to synergize with current prevention strategies to help us get rid of HIV in the world, or at least control the expansion of HIV in the world in a dramatic fashion.

I think I will leave it at that and then answer any questions that you may have. My main goal though with this kind of thinking is to provide a further argument for the expansion of antiretroviral therapy to those in medical need of antiretroviral therapy in the world today, as I said earlier, one dollar invested in antiretroviral therapy is cost effective for the patient, but it also generates a two dollar additional savings in the prevention equation, so this is very important. Thank you.

CRAIG McCLURE: Thanks, Julio. Our second speaker today was Dr. Ruth Nduati of the College of Health Sciences at the University of Nairobi who presented on issues related to treatment and care for children with HIV and AIDS.

DR. RUTH NDUATI: Thank you, Craig. My presentation this morning was very focused on the issues of children and AIDS, and in particular in Sub-Saharan Africa. I began my discussion with contextualizing HIV, this epidemic is evolving in the midst of our chronic crisis of child health and poverty in Sub-Saharan Africa, and

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the problems of poverty aggravate the HIV epidemic, and the HIV epidemic in turn aggravates the poverty that is being experienced.

I highlighted that every year, in spite of having interventions that can prevent mother to child transmission of HIV, every year we have more than 600,000 new infections. I think that the figures are maybe like 800,000 new infections, most of them in Sub-Saharan Africa. We have 14 million orphan children in that region, and the issues of adult illness affect other children, for example lack of food security, it interferes with children's learning when teachers stay away from school.

I talked a little bit about the rapid cause of illness in children which is much more rapid than in adults, the very high mortality of HIV infected kids, but then the reality that these children respond well to treatment when it is provided. The challenge that is facing us now is how to roll out the care, you know, the prevention and the care of HIV exposed children.

I talked a bit on the issues of testing and integrating HIV testing as a provider initiated testing, our top points of contact in the healthcare system where children are accessing care, whether it is in a maternal child health clinic or in patient services.

I also highlighted the issues of the chronic shortage of health care providers making it very difficult to deliver these services, and the progress made in the region in developing training resources and collaborations that will hopefully go towards scaling up care for kids, and also carrying out the necessary research to

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support this public health approach to HIV care for young children as well as their families. Again ,I'll be happy to answer specific questions regarding the presentation I made.

CRAIG McCLURE: Thank you, Ruth. Our third speaker today was Dr. Agnes Binagwaho, the head of Rwanda's National AIDS Control Commission, who discussed critical issues related to prevention and treatment and outlined some of the successes and challenges in sustaining Rwanda's HIV/AIDS response. Doctor.

AGNES BINAGWAHO, MD: Thank you very much, Craig. I had the honor this morning to talk about giving the perspective of a developing country that is doing well in the field of the fight against HIV/AIDS. I can summarize my presentation in 10 issues.

First of all, we should know that universal access to treatment and prevention are indivisible, equally critical, and complimentary. There is no doubt and no way to go and fight HIV in another manner. Secondly, we need political tools and technical good tools to fight HIV/AIDS, and we have to situate the fight against HIV/AIDS in the overall MDG approach. All of the aid goals have to be tackled.

The third thing is that we need to think about the familiarization of the HIV epidemic. We need to give special tools to the woman to have access, that means we need then, again, political commitment and legislation adapted to the fact that the woman does not have the same right, even if on paper they do have the same right, culturally they don't go to take their right, so we need a

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special approach for the women to have this access to care, treatment and prevention.

Never forget that among the population of 15- to 24-year-olds, 75-percent of HIV-positive persons are young women, 75. The fourth thing that I would like to say is that we need to succeed in the fight against HIV/AIDS to integrate fully the fight in the sectors, and to run for the 3-1 principle, strengthening the national institution because those institutions are the spinal cords of services that will remain after all of the projects that are going on now.

The fifth one is that we have a big constraint, it's the matter that the fact that the fight against HIV/AIDS is externally financed so we need to be careful with the end of those projects, and many interventions are under funded, mostly no one wants to fund the nutrition part of that. We all know that nutrition is absolutely crucially necessary for the people to swallow their tablet in the beginning. The stability issue of IV therapy remains beyond the financial means of the majority of developing countries, and there is a balance to be done between advertisement, human [inaudible] gap, and running projects.

Also I would like to appeal for some institution or organization like F.R.O., we say in French, in my point of view they don't do their job. They have been in Africa for years and years, and I don't understand why our people in Aguguteria [misspelled?] who are not more stupid than us, doesn't catch up, so I think that they

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should change their way to work, and after that I appeal for support to Scientists for helping them to find a good vaccine, and to find the true microbicide that can help women because this will be the only way they don't have to negotiate for sex, and almost that's it-

CRAIG McCLURE: Okay, thank you very much, Agnes, I think we're going to want to open it up to question quite soon. So our fourth speaker was Dr. Kevin De Cock, who is the director of the HIV and AIDS Department at the World Health Organization.

KEVIN DE COCK, MD: Thank you very much. My presentation was really in two parts. Firstly assessing where we are with global treatment scale up and then secondly discussing what universal access may mean, and what the role of health sector is.

At the end of June of this year, WHO estimates that there were 1.65 million people on antiretroviral therapy in the lower middle income settings including over one million Africans, global coverage is about 24-percent. This does represent a very substantial achievement over the past two and a half years, although there is obviously a great deal more to be done.

Looking at equity, the things that stand out are the very limited progress with mother to child transmission prevention, with the treatment of children, and with the treatment of injecting drug users, and those are probably the three biggest issues in terms of inequity in scale up.

As far as treatment outcomes is concerned, drugs clearly work as well in the South as they do in the North, adherence is

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excellent. But there are two major problems. One is that patients are starting on therapy too late, diagnosed too late and started too late with advanced disease. And secondly, the issue of user fees is a real problem because it is a risk factor for poor adherence, and, in fact, has been shown to be associated with adverse outcome including increased rate of death. As far as moving toward universal access in concerned WHO has prioritized five strategic directions for the health sector working toward universal access and these are: expanding testing and counseling, maximizing prevention, accelerating treatment scale up, strengthening health systems, and investing in strategic information.

I finished the talk with some slightly more detailed consideration of a very important issue of provider initiated testing and counseling, that's the HIV testing and counseling in healthcare settings for diagnosis, treatment, and care. WHO and UNAIDS will be issuing guidance on this later this year, this is rather important and somewhat a topic of some discussion at this conference.

CRAIG McCLURE: Thanks, Kevin. Okay we will open it up. I know that, Larry, you had a question that you asked just before we began. Would you like to? No, okay, let's take it from the floor, go ahead. Please stand up and say your name and affiliation.

FEMALE SPEAKER: Okay, Margo Kamir [misspelled?] from gender and development Oxfam. My question is to WHO. You talk about universal access to treatment and there are two things that are happening now that worries us about access. One is the fallout of the

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trips' implementation in India, whose company is filing for [inaudible] and for drugs that are basic treatment now according to WHO guidelines. The second thing is the U.S. trade agreement that is blocking, or would be blocking access to new medicines. And I am just wondering what is the role of WHO and what would WHO do about that? Thank you.

KEVIN DE COCK, MD: Let me make two comments. One is that obviously WHO believes that access to therapy should be as broad as possible with the best quality drugs for the greatest number of people at the lowest possible prices. The spokesperson here for issues around intellectual property selected by our director general, our acting director general, is actually Dr. Howard Zucker. And I don't know where he is, but he should actually answer that question which is somewhat outside of my expertise. Behind you is Anne Winter who can put you in touch with Dr. Zucker.

CRAIG McCLURE: Marilyn.

MARILYN CHASE: Marilyn Chase [misspelled?] from the *Wall Street Journal*. Dr. De Cock, just a quick question. When you talk about 24-percent coverage now in terms of treatment and the progress that that represents over the last two and a half years, could you bracket it for us, what was the coverage as a percentage two and a half years ago?

KEVIN DE COCK, MD: I don't have that figure at my fingertips, it's [inaudible] around. Does anybody know the coverage of two years ago? I mean, let me just give you the African example.

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At the end of 2003 there were about 100,000 people accessing therapy and it's now over one million, so it's more than a 3- or 4-percent.

CRAIG McCLURE: All right, you need to use the microphone, Marilyn, because there is translation.

MARILYN CHASE: I am just confirming then that the coverage rate has grown from between three and four percent two and a half years ago to 24-percent today, thanks.

CRAIG McCLURE: Great, next question, you in the front row.

TERRY MURRAY: I'm Terry Murray from the *Medical Post*, which is a weekly newspaper for Canadian Physicians. My question is for Julio, you mentioned that you were going to be doing some trials in BC to test your hypothesis. Can you talk any more about that?

DR. JULIO MONTANER: Thank you. I did mention that we do intend to move to the next phase which is to actually plan the clinical trial. The minister of health has encouraged me to do this, and I am very pleased that that's the case, provisional, the provisional minister of health has encouraged me to move in that direction.

The health authorities have expressed their support to develop this plan, so has the British Columbia Persons with AIDS Society, and more recently Giliat [misspelled?] has expressed an interest in becoming a part of this effort.

Of course, the details still need to be worked out. In principle, what we are intending to do is take advantage of the opportunity that is afforded to us by the fact that only 50-percent

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of the people that have a medical indication to be treated in British Columbia, not unlike cities in the rest of Canada and most of North America, are accessing treatment. And as you know, we [inaudible] extensively on what the reasons are for incomplete access to antiretroviral therapy in our environment, and that can be common realities; homelessness, poverty, addiction, etc. etc. etc. Our treatment programs have a bit of a diwinient [misspelled?] prevision quality at the moment, treatments are available but you have to be fit to access those treatments. What we want to do is remove that prevision, and in doing so bring that treatment to the people who need treatment medically as per current guidelines.

And in the process of doing, in my opinion what we should be doing anyways, we will have an opportunity to measure the impact that this has on incidents by monitoring incidents perspectively, and in doing so within a period of about three years, expanding the treatment program from about, say the current 4,000 to, say, about 6,000 to 7,000 people, which is our estimate of what needs to be done. We should be able to, with care and support, and with voluntary testing and treating those that want to be treated, let me emphasize, we should be able to show a similar impact to what we saw in 1996 to 1999 with the HIV incidents.

The other thing that is essential to all of these is single treatments and rapid diagnostic tests. There are now technologies that allow us to do rapid testing so that we can go into the communities and have the answer right away, of course, following all

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of the norms that word has cast, including the voluntary nature of testing, the counseling, and everything but having the test available that you can go prick somebody and give them the result in a minute changes the dynamics of case finding, so based on what we learned in tuberculosis case finding, contact raising, simple therapies should allow us to enhance capture coverage of antiretroviral therapy to nearly, as close to 100-percent of those in medical need as we possibly can imagine. Therefore we could characterize before and after transmission situations and that will give you the answer.

Once that is done, we will be in a position to assess the cost effectiveness of these kinds of efforts, and in my opinion whether it works or it doesn't work it doesn't matter, we've done the right thing anyways.

CRAIG McCLURE: We'll take a question from Ed in the front row.

ED SUSMAN: Yeah, Ed Susman with UPI. Dr. De Cock, I just wanted to get some figures straight. The estimates of the number of people living with HIV/AIDS is somewhere near 40 million yet we have, you saying 1.65 million under treatment that represents 24-percent, which means that you're aiming at about six and a half million people to be under treatment. There seems to be a disconnect there on those numbers. Can you explain that?

KEVIN DE COCK, MD: Yeah, I think there is a misunderstanding. The estimate of, the global estimate of people living with HIV is 38.6 million, the estimate of people requiring

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antiretroviral therapy now, that is people who on the basis of natural history might be expected to die in the coming two years if they didn't access ARV is 6.8 million, and the number on treatment is 1.65.

CRAIG McCLURE: Okay, we'll take a question from the third row.

MALE SPEAKER: This is to Dr. Montaner. Daniel Treca [misspelled?] from Spain. Dr. Montaner, with 30 new drugs in the pipeline, what were the main contributions of these drugs, and from a global perspective what will be, in the story of AIDS, what will be the main contribution of these conferences to the story of AIDS?

DR. JULIO MONTANER: Well, those are very broad questions but I will try to be very brief.

Well, actually with drugs in the pipeline I think if you look at the history of the development of antiretroviral therapy what we see is that these compounds are needed predominantly, not exclusively, predominantly to deal with issues of resistance and treatment failure. The treatment today is working quite reasonably well; our rates of success are very high both in North America and as our link has shown in the developing world as well.

Of course, we could improve in various aspects, but the urgent priority is second, third, and salvage therapies, second- and third-line therapies and salvage therapies. I am concerned that this is not penetrating to the rest of the world as it should, and I support, as everybody has said, the need to do something about it so

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that we engage people in treatment but then we can sustain them on treatment, and as they fail we can move them on to treatments that are viable. That's for the pipeline.

On the other hand, your question regarding the role of these conferences, I think that these conferences have tremendous value in renewing our commitments toward the fight against HIV in the world, and even more important than that in my opinion is to awaken some of those sleeping giants that have been ignoring HIV, or have not been doing what it should have been doing over the years. Let me give you a couple of examples. We brought heart to the world as a result of an encore conference in 1996, and it's not that the conference did it, it's partly some of us we were involved; but the IAS strategically organized that conference and took the best science available to put together a story that changes the course of the epidemic.

We followed that, for example, and Mark Wayne [misspelled?], the person at IAS has a lot of credit to his, should be accredited personally for his efforts in bringing the IAS conference to Durban. That was incredibly courageous and really opened the door for the expansion of antiretroviral therapy to happen. And, believe me, I'm not pretending that the IAS has done it all, absolutely not, but we play a role as a catalyzer and our friends at the WHO are there to do a tremendous amount of work, and so is the Clinton Foundation and the Gates Foundation, and a number of others including PEPFAR, et cetera, et cetera.

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But we used the International AIDS conference as a strategic mechanism to open doors to awaken efforts and to initiate critical developments that will have a cathartic effect there after. In my opinion in these conferences you could trace the history of the epidemic around these conferences, and we are very proud of that.

CRAIG McCLURE: Ruth or Agnes, any comments on how this conference specifically –

AGNES BINAGWAHO, MD: I would like to add something regarding the importance of this conference. This conferences also opens eyes on future possible gaps, we are not there, but knowing that we still have no fear; and all of the people, all of the 1.6 million who are already on treatment are there for life, and there are still almost more than four million that are waiting and dying within the two years, and those people we need for starting treatment will probably dose very expensive treatment one day. We have to face this reality. This type of conference will help all the [inaudible], the politicians, the donors, the founders, and people like Bill Gates, [inaudible] to face the reality of the epidemic today.

DR. RUTH NDUATI: This conference is also a very important occasion for bringing together all of the different players in addressing the HIV/AIDS epidemic. It brings in the basic scientists, it brings in the doctors, it brings in the community, and it also brings in the media as we have here, and the beneficiaries of these treatments. It gives us a unified look at where the problem is. All of the science and all of the new drugs will not make a difference

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for this AIDS epidemic unless the communities, the media, and other players are involved.

The AIDS conferences also offer an opportunity for people to learn where the science is going and what possibilities are there. I worked at the 1996 AIDS conference and that conference brought ART to the world stage, but that conference also clearly defined the discrepancies between the developed world and the developing countries, and that meeting in North America you are the one talking about preventing mother-to-child transmission of HIV, and you are talking about people living with HIV now, not dying with HIV but actually living with the disease. And we were in a situation where our children continue to die from HIV and our children continue to be infected.

I think that stark reality was a very major driving force to all of the interventions that have come up in terms of prevention of mother-to-child transmission of HIV, developing new protocols that were simpler and cheaper, and using it to implement in resource-constrained settings. Truly, the International AIDS conferences are very important for developing an agenda around HIV.

CRAIG McCLURE: Okay, first, the question halfway back on the right.

MAGGIE FOX: Maggie Fox with Reuters. Just as a comparator, did you guys also get the latest figures on people in the developed world who are getting treated? If we can do a comparator of what

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percentage of people in the developed world are being treated,
thanks.

KEVIN DE COCK, MD: Not for this exercise, we haven't.

CRAIG McCLURE: Okay Larry was next.

LARRY AULT: Larry Ault with *The New York Times*. Kevin, WHO set as a goal three million people being treated by 2005, and it failed in that. How would you then fill in the blank for three by will it be seven, eight, nine, 10? When will we get the three million of the original goal?

KEVIN DE COCK, MD: You know one of your colleagues wrote something that I really took to heart, which was that he said in economics, give them a number or give them a date but don't give them both at the same time. You know, I don't think - it's not wise including based on experience to give a number and a date at the same time, so I would hesitate to speculate on a date, but I think with the rate of increase right now, it is pretty steady.

The danger I think that we shouldn't forget about, well there are several dangers, one obviously is funding. The second one is that though treatment scale-up obviously concentrates on where it is easiest to do initially, if you look at the inequities I described like children that Ruth talked about and injecting drug users, those are more difficult tasks, and therefore certainly may take longer. But on the other hand, don't forget that there is 70-percent of global unmet treatment need is still in Sub-Saharan Africa, where scale-up is the most rapid.

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DR. JULIO MONTANER: I want to make a comment on that. I would like to ask you people for a favor, and it is that through you we hope that we can rally the masses in the developed world so that they can, both with defeat and make themselves heard at the political level so that our political leaders for once and for all will do what is right, and deliver on their promises. So it is very difficult to put Dr. De Cock on the spot because it's not his bank account that is the problem. It is the donors that is the problem and we need you to help us to wake them up, and if they don't wake up, to wake the voters up and tell them that this is not acceptable.

AGNES BINAGWAHO, MD: I would like to add also that this 3x5 idea was a very generous idea. WHO never promised to pay for all, WHO promised to guide the world to reach that point, so that means without such visions and ideas we probably would be very far from the 1.6 million people that are on treatment today. So it is very important to have a good slogan and good vision to lead the world to access to treatment.

RUTH NDUATI: I'd like to make a statement that 3x5 was not a failure. Actually 3x5 was a great success. Today if you walk the villages of Africa HIV infected people know what a CD-4 count is and they know what ARVs are all about. Old grandmothers know that treatment is available and they are the applicants for treatment. This could not have been possible if we didn't have a clarion call of 3x5, so it gave us a vision, a possibility that could be achieved, and actually believe that we will get close to universal access.

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CRAIG McCLURE: Okay, the gentleman at the back.

STEVE SMITH: Hi, Steve Smith with the *Boston Globe*. This is for Dr. Binagwaho and Dr. De Cock. What is the status of negotiations with funders, as Dr. Binagwaho mentioned, there is deep concern about funding agreements expiring. Where do negotiations stand and what is your hope for sustaining those funding streams?

AGNES BINAGWAHO, MD: Well, we have hope. Negotiation is very hard because let me tell you something, we have some funders say that this is the envelope for your country, you want it to fund AIDS so take it, so we have funds for education, energy, etc. that don't want to keep AIDS as a specific issue, they want to put it in the common basket of support.

In my point of view, it's a failure because you have put so many people on treatment, we have a global fund project that is ending now, this project called VISITENT AGREE was one of the best of the world, and we got all congratulations for management, for transparency, and for going over the target before the planned time. It's ending, because it's three years it's ending and will stop. It's not normal, and let me tell you it's not good etiquette, and I guess that all of the good people in the world should start to have bad dreams about that. What we call in French some [inaudible] because it's not good etiquette at all, the support should go up to the moment that we can take over.

KEVIN DE COCK, MD: I mean, it's not WHO's -

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AGNES BINAGWAHO, MD: And sorry, I need all of you media to be with us in that fight because Rwanda, we are happy, we are not bad, some countries are so bad.

KEVIN DE COCK, MD: It's not, WHO gets involved in these discussions but WHO is not a funding agency itself, neither is it the principle seeker of funds. Treatment scale-up, and I mean I want to commend what has been done, treatment scale up is largely funded through PEPFAR, the Global Fund, and the World Bank, those are the three biggest sources of funding. There are other bilateral donors and to a lesser degree the pharmaceutical industry.

Now, Dr. Mark Dybul from PEPFAR is actually here, PEPFAR is, the legislation is up for reauthorization next year, that's a critically important issue, and Dr. Bernhart Schwartlander [misspelled?] from the Global Fund is here as well, and he is probably the best person to ask that particular question.

CRAIG McCLURE: Okay, I know that there have been a lot of hands and we can only take one more question. We'll take the woman in the back in the middle.

FEMALE SPEAKER: Thanks, I'm Uanne Chan [misspelled?]. I'm a Beijing-based journalist. I have a question for Dr. De Cock. VCT has always been seen as the gold standard for testing, but we're seeing increasing calls from National Governments, and it seems we're getting hints from the UN agencies also that movement towards the kinds of mass, various forms of mass screening, routine testing, and mandatory testing are beginning to gather ground. I would like to

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hear what are your views on that, whether you think it will undermine the efforts to scale up VCT. And also, you have reiterated in your address that it's very important to respect human rights when talking about these issues, but some governments aren't actually very responsive to arguments from a human rights perspective, so can you tell us from a public health perspective what the dangers are when testing and mass screening is conducted without these safeguards?

KEVIN DE COCK, MD: Can I clarify one thing? There isn't any UN agency that supports mandatory testing or is calling for mandatory testing, and mandatory testing is a thing on it's own, it's quite separate from what others have been talking about as routine testing, they are not the same. I think this is a lengthy discussion, my answer will be brief.

I think the first comment is that there are many different categories of HIV testing, all of which have their own requirements. There is the classic VCT which is tremendously important, it's client initiated, people do it as a prevention activity to take charge of their lives, and it's being scaled up very successfully. I refer you to this week's JAMA, the special issue that was released at this conference which documents Kenya's experience, very important and very impressive.

A very different issue is testing in clinical settings where people access hospitals and clinics for diagnosis, treatment, and care. The operational requirements are different, and that's the context, and only that context is for so-called provider initiated

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testing and counseling. There are other categories for testing still further: blood, organ, and semen donation, research, surveillance, they all have their separate operational requirements, but there are some commonalities. Consent is important, consent, confidentiality, counseling, and information. But they are all different in the different contexts, and provider initiated testing in health care settings can be ethically done with informed consent defined as the right to decline, coercion is wrong, but so is it unacceptable to have people dying with end stage, undiagnosed, untreated HIV disease and then pretend that that's some form of empowerment. That's nonsense.

CRAIG McCLURE: Okay, I'm sorry, but I'm going to have to stop it there. I want to thank all of our presenters and I want to thank all of you.

[END RECORDING]