

**Newsmaker Interviews: Kevin De Cock, M.D.
XVI International AIDS Conference
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JACKIE JUDD: Thank you for being with us. At the last conference in Bangkok, World Health Organization officials were still talking fairly optimistically that they would meet the goals of the Three by Five Initiative. We know that didn't happen. With some distance from the end of 2005, how do you now look at that program and see what went wrong, things that went right? How do you analyze it today?

KEVIN DE COCK, M.D.: Three by Five did not meet the numeric target of three million, that is true. It reached about 1.3 million by the end of 2005. That in itself, obviously, was regrettable because of the numbers of people that did not access therapy, but it had a major effect on the landscape around HIV/AIDS treatment internationally. It really taught very many lessons, and I think changed how we view treatment access in the developing world. It laid the foundation, really, for what people are talking about today, which is trying to get as close as possible to universal access to prevention treatment and care.

JACKIE JUDD: When you say it changed the view - in what way?

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KEVIN DE COCK, M.D.: In a number of ways. Firstly, it endorsed the technical approach that WHO recommended about a public health approach, a decentralized approach. An approach based on simplifying and standardizing what is fairly complicated treatment of HIV infection, but doing all of that in such a way that access could be greatly broadened.

It also, I think, gave us insight, very useful insight into what some of the real problems are. For example, the fragility, the frailty of the health systems, and the infrastructure in the most heavily affected countries, which I think is very useful for informing donors, governments and the world at large about the real problems that need to be addressed.

Finally, I would say the Three by Five gave insight into what to do of great relevance to other diseases, as well.

JACKIE JUDD: In what way?

KEVIN DE COCK, M.D.: For example, if we think about tuberculosis or malaria, I think there are lessons from Three by Five about these things I have mentioned, the public health approach, the fact that actually Three by Five helped changed the landscape in a way that it legitimized, if you will, the aspiration of anybody, anywhere, no matter where, no matter how poor. It should not be considered abnormal to

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expect or to want access to lifesaving therapy.

JACKIE JUDD: What was the downside, though, of not reaching the goal? Did it affect the credibility of WHO?

KEVIN DE COCK, M.D.: I think in the eyes of some it may have done, but we are fairly persuaded. But what we regret is that the target was not reached. We think that the positives outweigh the negatives.

JACKIE JUDD: When do you think the target will be reached of three million?

KEVIN DE COCK, M.D.: One of the things we learned from Three by Five –

JACKIE JUDD: Not to set a date.

KEVIN DE COCK, M.D.: Not set a date and a number at the same time, but the number will be reached. It will be reached. I think what has been achieved by all of the partners involved with scaling up, which I think they must be credited. It's the global funds, the presidency, the emergency plan for AIDS relief, bilateral donors, the pharmaceutical industry with its contribution and others. I

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think that they should be congratulated for the scale-up that has happened, which is pretty remarkable. If you look at Africa in 2003, there were probably less than 100,000 people on therapy. By the end of 2005, it was eight times that number. That is in just a couple of years.

JACKIE JUDD: How do you expect the new one-a-day pill to affect people's access to this medication?

KEVIN DE COCK, M.D.: I think that simplifying the delivery of treatment, including making the regimens easier and the formulations easier, is very important, both for making it easier to access large numbers of people, and making adherence by patients themselves easier, and therefore more likely. It is tremendously important.

JACKIE JUDD: Do you expect the one-a-day pill to show up in the low- and middle-income countries, or will there still be issues of cost?

KEVIN DE COCK, M.D.: There are still many issues around cost. I think that we have made great progress in some of these areas, the cost of first-line regimens, generic regimens that are delivered to patients when they initiate therapy, some of them are now down to less than \$200.00 per

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patient per year, but second line regimens remain expensive everywhere.

Pediatric formulations are expensive and not ideal, in that they are difficult to take. Diagnostics remain very expensive, and in many middle-income countries, even the first-line regimens are not available at this reduced cost. The issue of cost and the issue of using the flexibilities under the TRIPS Agreement, these remain important issues to address. There are unresolved problems out there.

JACKIE JUDD: Let's talk about the conference for another moment. You are speaking on Wednesday. I know you can not tell us what you are going to say, but if you could give us a broad outline of what your approach will be.

KEVIN DE COCK, M.D.: Yes. The title of my presentation is "From Three by Five to Universal Access." I will be giving a review based on WHO's information of where we stand with global access to therapy right now, and what some of the outcomes are. I will be also reviewing what WHO thinks the contribution of the health sector should be towards working for universal access.

Let me just add that WHO thinks there are five strategic priorities that we should be focusing on, and with partners in the health sector. These five are the following:

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One, we must expand HIV testing and counseling. More people need to know the Sirus [misspelled?] status including in health care settings. Secondly, we need to do much better with prevention. Third, we need to continue treatment scale-up, especially for populations that have been underserved. Fourthly, we need to work towards strengthening health systems, and fifth, we need the right kind of strategic information, data, epidemiology to both guide and evaluate all of this.

JACKIE JUDD: It is a large order.

KEVIN DE COCK, M.D.: It is a large order, but if we pull together, we think we can make a difference.

JACKIE JUDD: I know that you have spoken before about your frustration that AIDS is treated differently. Will that be incorporated into what you bring to the conference this week?

KEVIN DE COCK, M.D.: To a degree. AIDS is different in many ways. Otherwise, we would not have these huge conferences. They would not be necessary. It is different in some ways, but I think the treatment scale-up that has occurred and that must continue obviously requires us to treat HIV more like some other problems, like tuberculosis if

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we are to scale up rapidly, while at the same time, very importantly protecting people's rights and protecting them from stigma and discrimination.

JACKIE JUDD: Finally, doctor, what would you define as success at this conference?

KEVIN DE COCK, M.D.: These conferences are an opportunity to re-examine, to discuss, debate and hopefully seek consensus about some of the difficult issues and trends. Firstly, I hope they will be a vigorous discussion about use of antiretroviral access. What it means, that it means something. It is not just an aspiration that we can work towards, and the funding requirements associated with that. I think the discussion is important to international governments, donor agencies and so on. I hope there will be commitment from those groups.

Secondly, where we are right now in the epidemic, I think we need to get prevention back onto the table at the center of our AIDS response, in addition to treatment scale-up. I hope there will be vigorous discussion and a meeting of minds about the sort of prevention needs we have in some of the newer technologies in prevention.

From the WHO perspective, I hope that the discussions about HIV testing will be useful. Again, that there will be

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progress towards implementing, particularly, provider-initiated testing and counseling in resourceful settings, because if people do not get tested, then some prevention modalities are impossible and, of course, access to therapy is impossible. This is extremely important.

Finally, I hope that the five strategic priorities that I've outlined as WHO's guidance to the health sector, I hope that these will be taken onboard and endorsed. This actually is a – for WHO – an important conference, and at this moment in the epidemic, an important one as well.

JACKIE JUDD: If they are endorsed, how does that translate to action outside of this conference hall? I'm talking about accountability after the conference ends.

KEVIN DE COCK, M.D.: I think what it means is trying to get people who are involved with global policy, people at regional level, and people at country level in different health sector organizations to agree around defined road maps. We would like to see policy around HIV testing, actually leading to implementation. We would like to see prevention scaled up.

One example is we have done badly with the prevention of mother-to-child transmission, and yet this was one of the areas where antiretroviral drug research first focused on. We would like to do better with treatment scale-up, particularly

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for neglected populations. The two specifically to mention are children and injecting drug users who have really not done as well as other sectors of the population.

So there are a number of areas we can agree on where we really need action to move forward.

JACKIE JUDD: Dr. Kevin De Cock with the World Health Organization, thank you very much

KEVIN DE COCK, M.D.: Thank you.

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