

**International AIDS Society:
2nd IAS Conference on HIV Pathogenesis and Treatment
Michel Kazatchkine, Director of Agence Nationale de
Recherches sur le Sida and Conference Co-Chair
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LARRY LEVITT: This is Larry Levitt from www.kaisernetnetwork.org, and I'm here with Dr. Michel Kazatchkine who heads up France's National AIDS Research Agency. Doctor, thanks for joining us.

DR. MICHEL KAZATCHKINE: Thank you.

LARRY LEVITT: You're co-chairing a major scientific meeting on HIV AIDS here in Paris this week. Could you start by giving us a sense of some of the key developments, or scientific themes, that you see coming out of this conference?

DR. MICHEL KAZATCHKINE: Let me first say for some of the viewers, this is called the 2nd Conference on HIV Pathogenesis and Treatment. Many people are used to the so-called International Conferences on AIDS that happen every second year, there was one in Barcelona last year, and Germany in 2000. These meetings are more aimed at being an advocacy meeting for HIV, rather than meetings where scientists would exchange the latest scientific news. So the International AIDS Society felt that it was necessary to create a forum where [unintelligible] scientists and clinical scientists, would meet together and exchange the latest information. And that's the purpose at this conference. It's the second of this kind. The previous one was in Buenos Aires in 2001. And so we had two aims. One was to precisely have a mix of basic science, identical science. I think we've achieved that through the

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program. And the other aim was to fully integrate the issues pertinent to access the treatment in the developing world, in the body of the conference. And I hope we have achieved that as well since 30 percent of the participants, and over 20 percent of the abstracts presented here, half are from the developing world. I thought it was important to say that to help me answer your question, the issues have been the [unintelligible] discussed here, precisely in the field of basic science, particularly about positive and negative regulation of HIV transcription themselves, and the regulatory proteins that either enhance or decrease replication. There's then a lot in clinical science with emphasis on new drugs. Either the drugs that are still in the pipeline, to be developed within three to five years, or data about the drugs such as T-20, that have been on the market for a few weeks or months. Also, new developments from a strategic point-of-view, particularly with regard to therapeutic vaccines. And a lot on adverse events for HIV treatments that is distributed. Also, a large body of information, as I said earlier, on everything that pertains to access the treatment in the developing world. People have been reporting lessons learned, obstacles, successes, and those issues are, of course, broader than just scientific issues. So we have a lot about the social cultural aspects and also a lot about the economy. And there we had some very new data, and really I'm not talking about theories

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here, but about scientific data showing that both prevention and treatment are complimentary, that is when you have two things coming in the developing world, this is where the prevention becomes the most effective. And we have data now telling us that at the current price of the drugs, which is still decreasing and still to decrease in the future, that at the current price, we know now that treatment becomes cost effective in the large number of either countries in the developing world, or at least groups of populations within the poorest countries. So economic argument cannot be opposed anymore to access the treatment.

LARRY LEVITT: You mentioned the economics of AIDS and your agency released a report, coming up to this conference, on the economics of AIDS, talking about the cost effectiveness of treatment in the developing world, which there's some dispute about in the past. And you talked about this conference being about science, but of course hard to talk about treatment access without talking about money as well. Is there a sense, you think, in which the scientific progress in treating HIV/AIDS has outpaced the world's willingness to commit resources to the effort?

DR. MICHEL KAZATCHKINE: I hope not because, you know, a few years ago, even two years ago, there would be a number of things that people would oppose to treatment. They would say that if resources are limited prevention should be preferred

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over treatment. And now we know that it isn't either prevention or treatment, that it's prevention and treatment that we should go for, and that one enhances the other. People would say the drugs are too expensive. Now the drugs, they're still too expensive for many people, or for governments to buy for their citizens; however, they decreased by like 95 percent in some countries such as Senegal, one of the most successful countries in negotiating prices. People would say treatment is not cost effective, and now we have data that precisely shows that treating is--can be guided by a rationale, even an economic rationale. People have been saying that we don't know about whether the treatments are effective. Well taken, what about the compliance, the adverse effects? Now here we have reports of like over two years of follow-up, of large cohorts, in Uganda and Senegal, in Cote d'Ivoire, and these reports show that the compliance is very similar, if not better to what we know in the north. And that surprisingly, some of the adverse events that we see in the north are not seen in the south, and for example the dizziness, and the neurological adverse effects of the (unintelligible) ends for some reason are hardly seen in the south. People were saying, and even (unintelligible) said the other day during the primary session, which I think is unacceptable and totally inappropriate, that if we hurry too much in bringing treatment to the south, we will lead the way to an epidemic of resistant strains, which would be even more

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pathetic than the current epidemic as if there could be something more tragic than the current epidemic. And I just don't understand this statement. First, from the scientific point-of-view, reports that we have here at this conference show that the incidence of resistance in the cohorts, I know well the one from Senegal, which was hunted by our agency, the incidence of resistance at two years of follow-up, is no higher, if not in fact lesser, than what we saw in the north. And then, I don't see why we would apply to the south different standards from what we apply to the north. We started monotherapy in '87, we started double therapy in '94, triple combination therapy with just one regimen, basically (unintelligible) in 1996. There was no other option. And no one had ever thought, at that time, that we should prevent ourselves from doing so because it permits a resistance. Which anyway, we know, will almost inevitably occur in all treated patients at one time, at one point in time.

LARRY LEVITT: In other countries, you mentioned Senegal, another country where some of these arguments have come up, and they've overcome some of these barriers as Brazil. And the conference opens with an address by former President Cardoza of Brazil talking about his country's efforts. In your view, is Brazil, Senegal, are they both models for the rest of the developing world?

DR. MICHEL KAZATCHKINE: Yes, well Brazil, of course,

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is a middle-income country, but Brazil has been the model because Brazil has produced its own drugs at this part of the-- within the spectrum of antiretroviral drugs. Brazil has produced new drugs that they were allowed by the WTO rules to produce as generics because they had imported those drugs prior to them agreeing to the WTO system. And Brazil has really been a pilot country in deciding that it is an obligation for the government to bring treatment to their citizens. And this is because in Brazil it is in the law that every citizen should enjoy health and that health care should be provided to all citizens. So the right for health is in the law in Brazil. And this is why they just had to adjust to the times, and find the ways with their budget to treat HIV infected people. Senegal is another model, which I think is interesting because Senegal is a model where treatment is subsidized for the poorest patients. Many people talk about Uganda. I think Uganda is a very interesting model in the way it organized itself from hospital centered reference to more peripheral, and district, and rural centers. However, in Uganda, patients have to pay for their treatment. So all patients who can't afford treatment, are sort of middle class patients, or patients who receive treatment from outside sources at times. Senegal has decided to have some sort of national health insurance system so that depending on your income, either the drugs are free, or you pay 25 percent, or else you would pay 50 percent. And

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interestingly, in the compliance studies that we have performed there, the only group of people who are not so compliant, that is 60 to 65 percent compliance, are the group of people within the middle-income group, because they have economic choices. They can buy either treatment, or a mobile phone, or a motorcycle. And that's where the trouble comes.

LARRY LEVITT: You talk about subsidies, and subsidies take money. Another meeting, major meeting going on in Paris this week is the supporter's conference with the global fund to fight AIDS, TB and malaria. And you chair the technical review panel of the global fund. So I think you know as well as anyone there the operations of the organization. There's still some debate, particularly in the U.S., about multilateral efforts, like the global fund, versus the effectiveness of traditional bilateral programs that countries in the developed worlds kind of initiate. What's your sense, having seen the review of the proposals, and seeing the fund's progress of how it's doing?

DR. MICHEL KAZATCHKINE: What I heard Secretary Thompson say, earlier today, when he was asked that question, is that the United States didn't want to put all the eggs in the same basket. And you know, to some degree I think this is very reasonable, and all countries are going bilateral. France has been doing bilateral assistance to many counties in Southeast Asia and Africa for many years, and the same is true

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for Britain, and to some degree for Scandinavia, and Italy, for example. So I can understand that at the time when the global fund is not yet fully operational, that is it has signed agreement with almost 80 countries that had succeeded in their applications for grants it has already dispersed almost \$50 million U.S. dollars in the very last 2-3 months after signing the agreement, that it's still not yet fully operational, that is, the programs, for which the money has been committed at the global fund, and that should bring 300,000 patients on treatment within the next three years. Since it's not fully operational I can understand that the U.S. Congress, or whoever decides about this, would feel that, let's see before putting all our money there. On the other hand, the HIV/AIDS crisis is a global crisis, and if I was a country in the developing world, I wouldn't really understand why the response is not global, why the solidarity is not global somehow. And I would rather wish that the same standards are applied to everyone. And we know that, of course, you know, bilateral help implies that the bilateral donor, that the donor would select target countries. And we would even have a number of criteria to select programs that may be different from the criteria that we in the global fund on the merit basis have applied in which are fully, internationally backed because our technological review panel is composed of people from countries in the north, countries in the south. There is expertise in TB, in malaria,

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in AIDS, and there's also what we call cross-cutting expertise in building up programs, in epidemiology, and I think, I personally think of course, you know, as I said (unintelligible) that I would rather like multilateral aid to be predominant.

LARRY LEVITT: Are you hopeful that the supporter meeting this week's action by the European Commission--

DR. MICHEL KAZATCHKINE: [Interposing] Well, yes and no. I mean, first we're still--I would say yes, because I think at the end of the day, from what I understand, the European contribution that France is putting in \$150 million. If the British put in what they have announced. I know we will have an announcement from Germany. Europe may come with maybe \$600 million. And if that is the case, and if this is--and the Americans come with 200 or 250 or something, that would be a significant share from Europe. But of course, if you come with a global figure, then we're still very far from (unintelligible). However, first I think people should not expect this conference as a conference where people will come and announce. It's not like, you know, you're playing cards and you're saying I'm coming with \$150 million I'm going with 200. This is not the purpose of the conference. The purpose of the conference, as it was called by France and the DA, for to say look, we are worried about the future of the global fund. And we want the world to meet and discuss so that the

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(unintelligible) will find ways to not only to refurbish the fund, but also to think about sustainability. So that's the purpose of the conference. It's also to think about the mechanisms that will allow for sustainability in the future. And I would also like to add that, particularly, you know, in this conference where this has been one of the major topics, the two conference are linked and we did that on purpose. I wouldn't like people to think that action is depending on the north. You see? Of course every one of us feel like the action is, (unintelligible) on the stage yesterday during President Mandela's presentation, and said where are the 10 million? Everyone agrees that we're too far from those (unintelligible). But don't forget, in those (unintelligible) or something and part comes from the south. And one of the reasons why we are so slow at this event, in implementing treatment in the developing world, is that the commitment is so often very insufficient, and although I'm of course a very strong advocator, militant, for resources, I would hate also to be faced with available money that we would be unable to spend.

LARRY LEVITT: Dr. Kazatchkine thanks for speaking with us, and best of luck in your work.

DR. MICHEL KAZATCHKINE: Thank you.

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