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4th IAS Conference on HIV Pathogenesis, Treatment and Prevention
Newsmaker Interview with Kevin De Cock, M.D.
International AIDS Society and Australasian Society for HIV Medicine
July 22, 2007

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JILL BRADEN BALDERAS: Dr. Kevin De Cock, thank you so much for joining us today. The UN General Assembly Meeting on HIV and AIDS last year agreed on working towards universal access to prevention, care, treatment and support, all by 2010. It is certainly a laudable goal. In your mind, is it an achievable one?

KEVIN DE COCK, M.D.: I think it's an achievable goal in some places. I think we have to be realistic that we may not achieve it everywhere. But I think in some parts of the world, scale-up of prevention, treatment, care and support has really gone very well and perhaps best measured, as far as treatment is concerned. Some countries are doing very well and others are lagging behind.

JILL BRADEN BALDERAS: What are some examples of success stories?

KEVIN DE COCK, M.D.: I think the Caribbean, in terms of treatment scale-up, has done extremely well. We estimate that about 75-percent of the people needing therapy in the Caribbean are actually receiving it. A country like Botswana, in Southern Africa, has achieved very high rates of access to lifesaving antiretroviral therapy and also prevention of mother-to-child transmission. In some other places, it is lagging far behind.

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JILL BRADEN BALDERAS: What are the keys in those countries that you just mentioned that have helped them to improve their scale-up?

KEVIN DE COCK, M.D.: Well, there's many. The most important thing is political commitment and determination to do it. A second one has to be organization and everything that goes with that, systems that work, transparency, lack of corruption, et cetera. Obviously, things like infrastructure and external support, which some countries, under difficult circumstances, have done quite well. It shows that with determination, it should be able to be done anywhere.

JILL BRADEN BALDERAS: Now, one step in the direction of universal access is certainly getting people to know their HIV status. Two months ago, WHO and UNAIDS issued new guidance on HIV testing, representing a move towards a more opt-out testing or provider-initiated testing and counseling. What are some of the challenges facing low- and middle-income countries with a generalized epidemic that are now attempting to follow this guidance?

KEVIN DE COCK, M.D.: Let me emphasize that WHO and UNAIDS think that all methods to getting to know their state is on a voluntary basis that should be scaled up. The guidelines you refer to really dealt with how to address testing in health care settings. But we need to do much better in community-

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based settings in getting people to come forward and take up HIV testing and use that information to run their lives.

This guidance dealt with clinical settings where people come usually because they're ill or they need health advice. Obviously, that is extremely important for scaling up treatment. It has prevention benefit as well, but it is more oriented towards people who are ill. But in developing countries with generalized epidemics, there is an enormous need to scale up knowledge of HIV serous status. The challenges are legion. They range from infrastructure to stigma and discrimination in some countries to fear — people being afraid to know their status — and so on. But, again, I think progress in some countries has been very encouraging. We can do this, and we have to do it. You cannot address HIV/AIDS if we do not scale up knowledge of HIV serous status.

JILL BRADEN BALDERAS: You mentioned community-based testing. Why is that important as well, in addition to the clinical-based testing?

KEVIN DE COCK, M.D.: Well, when people come to hospitals and health facilities, often it means they're already sick, so they already have immune deficiency from HIV that is quite advanced. People need to learn their serous status before they get ill, not only for protecting their health, but also to prevent transmission to others. So there has to be

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across-to-board, widespread scale up of different modalities of HIV testing and counseling, but in a way that’s voluntary and respects people’s rights.

JILL BRADEN BALDERAS: With more people getting tested, there are obviously going to be more people who need treatment, so how can low- and middle-income countries get prepared for this influx of people needing treatment?

KEVIN DE COCK, M.D.: That’s absolutely true. More people knowing their serous status may apparently raise treatment demand. Of course, HIV is very unforgiving and if people are not tested, the disease will declare itself sooner or later, so they will require therapy and care at some stage. The advantage of coming forward for HIV testing earlier is that it’s actually more cost effective to treat people before they get seriously ill, but we do need to invest more in assessing the magnitude of the problem and estimating the costs to deal with HIV/AIDS, which, let me emphasize, is a problem for decades and for generations. This is not a five-year project.

JILL BRADEN BALDERAS: Multi and extensively drug-resistant tuberculosis is an increasing threat. How can HIV and TB programs better coordinate their care?

KEVIN DE COCK, M.D.: This is a very important issue. Tuberculosis is the single most important opportunistic infection complicating HIV. It’s the leading cause of death in

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patients with HIV, particularly in sub-Saharan Africa. We need to expertise of both HIV programs and TB programs in their specific diseases, but we need to them to work together. At the point of care where patients actually come when they're ill, the services really need to be integrated for those individuals. Without that, we are simply going to be unable to address some of the really serious issues, like the control of transmission of tuberculosis in healthcare settings, for example, and the delivery of antiretroviral therapy to TB patients. We have to ensure that at the point of care, services are integrated in an effective way.

JILL BRADEN BALDERAS: Does this challenge of integration between these services speak to a larger problem of the health care infrastructure in a lot of these countries?

KEVIN DE COCK, M.D.: Yes, I think one of the biggest issues around dealing with the HIV/TB problem, and especially the drug resistance problem, is that of health systems. By that, you mean the whole panoply of aspects — human resources, infrastructure, supply chains, logistics, procurement systems, et cetera. But a particular difficulty as far as XDR and MDR TB are concerned is the lack of capacity to diagnose it because of lab infrastructure that is simply not there.

JILL BRADEN BALDERAS: One of the other issues that will probably be talked a lot about at this conference is male

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circumcision. The WHO has recommended that in countries with generalized epidemics and heterosexual populations that they urgently consider scaling up access to male circumcision services. Is this happening?

KEVIN DE COCK, M.D.: It is beginning to happen, but it needs to happen more quickly in the most heavily affected parts of the world. Male circumcision has been found, through carefully conducted clinical trials, to reduce HIV infection in men by 60-percent. That is an extraordinarily powerful intervention. It is more powerful than any other biomedical intervention we have, other than mother-to-child transmission prevention. It is urgent in these countries with high incidence and prevalence that we use every tool that we have. So, in a limited number of settings, scaling up male circumcision really needs to be addressed much more urgently and in different and imaginative ways.

JILL BRADEN BALDERAS: And how is the WHO working with different countries and advising them to help scale up male circumcision access?

KEVIN DE COCK, M.D.: Well, one of the WHO’s main roles is the provision of technical advice, our so-called normative function, giving guidance and helping countries set policy and so on, so we are working with countries helping them to develop and implement tools to look at male circumcision and at the

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sorts of logistic requirements that are there, giving training packages and talking to countries about how this might be done and so. But, obviously, this is not an easy intervention. It is relatively simple, as far as surgery is concerned, but it is still a surgical intervention, so it comes with many challenges. Unusual as this may be, it is a priority for some of these heavily affected countries to consider this.

JILL BRADEN BALDERAS: And last question for you — a number of people that I have talked to have said this is going to be one of the most exciting years for science, in terms of what is coming out of this conference. To you, what are some of the most exciting things that are going to be discussed here this week in Sydney?

KEVIN DE COCK, M.D.: I think it's a very high-quality conference, so there are many things being discussed. Even if there is no radical new data — things like male circumcision, for example, and other modalities of prevention — some of the discussions are very high level. But there are some very important individual pieces of science that we do expect to come out. There is some data on the use of acyclovir to suppress herpes in people with HIV to see whether that has any effect on acquisition or transmission of HIV. There is an important clinical trial of antiretroviral in infants that will be presented and there are some interesting discussions on

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preexposure prophylaxis, so there are some different issues that do indicate this is quite a rich scientific program.

JILL BRADEN BALDERAS: Dr. Kevin De Cock, director of the Department of HIV/AIDS at the World Health Organization, thanks for joining us today.

KEVIN DE COCK, M.D.: It's a pleasure. Thank you.

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