

D for diagnosis and E for everything else



WHO

Dr Kevin M De Cock

Dr Kevin M. De Cock, a Belgian-born citizen of the United States, received his Bachelor of Medicine and Bachelor of Surgery from Bristol University in the United Kingdom in 1974, and a Tropical Medicine and Hygiene diploma from the Liverpool University School of Tropical Medicine in 1979. De Cock is an infectious disease specialist with expertise in HIV/AIDS, tuberculosis, liver disease and tropical diseases. He has served in senior public health posts, most recently as Director of the US Centers for Disease Control and Prevention (CDC) Division of HIV/AIDS Prevention from 1997 to 2000 and Director of CDC's activities in Kenya from 2000 to 2006. De Cock has served on numerous professional committees and editorial boards. He co-edited the supplement to the journal *AIDS*, entitled *AIDS in Africa, Second Edition*. He was appointed Director of WHO's Department of HIV/AIDS in 2006.

New technologies to fight HIV/AIDS — male circumcision, pre-exposure prophylaxis, microbicides and vaccines — came under the spotlight at the Toronto AIDS conference in August. Dr Kevin De Cock talks to the *Bulletin* about these as well as the ethical issues that must be addressed as HIV testing is rolled out in developing countries. In this interview, he calls for better coordination of donor funds, given the new global target of universal access to prevention and treatment services by 2010.

Q: Should health workers offer free HIV testing even if antiretroviral treatment is unavailable or unaffordable?

A. Strong arguments can be made for free universal access to prevention, diagnosis and treatment, since user fees impede access to these services and adherence to treatment. The absence of antiretroviral therapy (ART) should not be an absolute impediment to the routine recommendation of HIV testing by health-care providers because it is clear that a great deal can be done — even without ART — in terms of providing life-prolonging care. Provider-initiated testing and counselling must, however, be scaled up in the context of national plans to expand access to treatment and care.

Q: Is there a shift from voluntary HIV testing and counselling (VCT) to provider-initiated testing?

A. WHO believes that a diverse range of approaches is needed, including both voluntary HIV testing and counselling and provider-initiated testing and counselling. Provider-initiated testing and counselling refers to testing of patients who visit health-care facilities or are visited by health workers. The process must remain voluntary and emphasize consent, confidentiality, counselling and information. A key aspect of provider-initiated testing and counselling is to ensure informed consent by providing

the patient with an opportunity to decline testing. WHO and UNAIDS also continue to strongly support client-initiated VCT, which occurs mainly outside health-care settings for people who want to know their serostatus.

Q: When will WHO issue revised testing guidelines for HIV?

A. The guidelines being discussed consider only provider-initiated testing in health-care settings, a narrow focus. Following an international consultation in early July 2006, co-sponsored by WHO and UNAIDS, a further draft of the guidelines is being developed for public comment. WHO and UNAIDS plan to issue the guidelines later this year.

Q: Is it ethical to encourage self-testing in countries where counselling and treatment are not available?

A: Self-testing is largely unexplored. The traditional view is that testing should not be done without counselling, but some of what is said about counselling is not evidence based. With much more experience with testing, one has to ask whether the negative attitudes towards self- and home-testing will not, in future, seem paternalistic and inappropriate. If we believe in self-empowerment and rights of the individual, why should self-testing not be allowed, when self-testing (diabetes, pregnancy)

or self-examination (breast and testicular cancer) are actively promoted for other conditions? However, more work and reflection are required before offering specific advice, and some form of patient information and education will always be important.

Q: How will testing be free and widely available in countries where HIV/AIDS prevalence is high?

A: There has been a tremendous scale-up of HIV testing in developing countries, especially in Africa, mostly through VCT programmes. There is increasing emphasis, for example in Botswana, Kenya and Malawi, on the additional approach of provider-initiated testing and counselling in health-care settings. In many settings testing is free, through the support of donor initiatives.

Q: If home-testing were widely available in developing countries, how would you counsel people on the implications of a positive or negative result?

A: Self-testing would obviously need to be carefully handled and protocols and standardized information will need to be developed and evaluated. Self-testing is not likely to become the dominant form of testing. We need to ask ourselves, however, whether universal knowledge of HIV serostatus in heavily affected countries is not a requirement if we are

to achieve universal access to HIV/AIDS prevention, treatment and care.

Q: Is WHO disappointed that the “3 by 5” campaign failed to achieve its stated goals?

A: “3 by 5” was about more than a numeric target. This campaign fundamentally changed the landscape of how the world is addressing HIV/AIDS. Treatment and prevention are inseparable parts of the response and both are needed. Concerning treatment scale-up, we have learned many lessons as a result of “3 by 5”, for example, about health systems weaknesses, and that more focus is needed on previously under-served populations, such as children and injecting drug users.

Q: South Africa attracted considerable criticism in Toronto. How do you view the situation?

A: Clearly, there is much dissatisfaction with the official response to HIV/AIDS in South Africa. In my view, this has resulted in at least three important missed opportunities. Firstly, South Africa, with its political and economic authority, could have been a leader in the fight against AIDS for the rest of the continent. Secondly, enormous international support, financial and technical assistance, and goodwill could have been mobilized if the unorthodox discussions and controversy had been avoided. Thirdly, treatment and prevention scale-up could have occurred much faster and gone further. As it is, South Africa is not among the 20 or so low- and middle-income countries that have achieved 50% HIV/AIDS treatment coverage of those in need.

Q: There is more donor money to fight HIV/AIDS than ever before, but is the money being spent in a coordinated way on evidence-based interventions?

A: Coordination can always be improved and this is certainly necessary in the struggle against HIV/AIDS. WHO and its partners are working to improve how we work together, for example through implementation of the recommendations of the Global Task Team on Improving Coordination among Multilateral Institutions and International Donors. We do also need to do better in the use of evidence in the design of public health interventions; for example, on policies and practices concerning male circumcision, isoniazid preventive

therapy (for tuberculosis), post-exposure prophylaxis, and abstinence. It is part of WHO’s role to synthesize existing knowledge, support operational research and disseminate the evidence in support of different interventions and approaches. But decision-making will never be simply about evidence alone. Political choices obviously influence practice, such as restrictions on needle and syringe exchange in many countries. An emphasis on human rights also represents more of a value or moral judgement than an evidence-based one, but this judgement is essential.

Q: Do some donors attach conditions to the use of funds for HIV/AIDS regarding sex workers, injecting-drug users and condoms, ignoring the scientific evidence?

A: I assume you mean PEPFAR (US President’s Emergency Plan for AIDS Relief) policies on ABC (abstinence, be faithful, condoms). The furious political debate around this, which is polarizing and often impedes genuine discussion, has generally been brought in by politicians or individuals with vested interests on both sides of the political spectrum, including in heavily affected African countries. I hope we can move beyond the ABC debate — there will not be a single magic bullet for HIV prevention, it is more complicated than fixating on the alphabet, and we also need D and E. D for diagnosis (HIV testing) and E for everything else!

Q: Can such funds still be used in a constructive way?

A: If certain programmes indeed impede or do not fund certain initiatives, needle exchange, condoms, or whatever, there is nothing to stop other donors stepping in and filling the gap, or coordinating assistance. Why is this not done more? This again represents missed opportunities for collaboration and coordination.

Q: The Bill and Melinda Gates Foundation is one of public health’s biggest sponsors, but one could argue that it is focusing on hi-tech solutions while the technology to prevent, treat and control HIV/AIDS is known and available but needs to be rolled out universally?

A: I think the Gates Foundation is under some criticism for excessive emphasis on technologies and under-emphasizing basic programmatic work required to improve global health. This was rather evident in

Toronto with the great attention given to technological interventions such as pre-exposure prophylaxis. Understandably, the Foundation does not want to take on “entitlement programmes” without an end in sight. I think Foundation staff recognize the predicament and that it is the subject of intense discussion. Whether we have the knowledge and technology we need is an interesting question. Most of the world faces HIV epidemics concentrated in specific groups: men who have sex with men, sex workers, injecting drug users, sex partners of such persons, and their children. We have the knowledge and interventions to control these epidemics, and in some settings this has been done effectively. At the other extreme, we have generalized epidemics with very high rates of HIV infection in the general population, for example in southern Africa. Targeted interventions cannot control such situations, and we have not had the difficult discussions about what additional technological and social interventions are needed to turn such situations around. We have basically applied similar approaches to very different epidemiologic contexts and should not be surprised this is not successful.

Q: There are technological developments that are keenly awaited. When will the world see these widely available?

A: It is dangerous to predict how fast things will happen. In terms of new technologies, I think the likely order of more expanded use will be (i) male circumcision; (ii) pre-exposure prophylaxis with ART; (iii) microbicides; (iv) vaccines.

Q: How would you define universal access to antiretroviral treatment? When will this happen?

A: In the speech Dr LEE (Jong-wook) was to make to the 2006 World Health Assembly on the day he died, he wrote that universal access means that “no one should die because they can’t get drugs or there aren’t clinics”. He called for “a relentless push to make sure people know how to prevent HIV infection”. WHO and UNAIDS are working with countries to convert a political and aspirational target into country-owned, specific targets that can be linked to programmatic work. Irrespective of targets, WHO is responsible for setting standards and norms and needs to provide guidance on what constitute acceptable levels of availability, coverage and impact. ■