
Tom Whipps

Straight talk with…
Peter Piot

Peter Piot was a freshly minted doctor, still working toward his PhD in microbiology, when he co-discovered Ebola virus. The experience launched him on a successful career in global health, including a 12-year stint as Executive Director of UNAIDS until 2008. More recently, he was appointed director of the London School of Hygiene and Tropical Medicine (LSHTM), where he is due to start next month. Speaking with **Asher Mullard**, he discusses the world's failed pledge to deliver universal access to AIDS treatments by 2010, the advances that have nevertheless been made and the changing paradigm of AIDS programs.

How did you get involved in public health?

I never had a career plan, but have always been ready for opportunities. In 1976, I was working at the Institute for Tropical Medicine in Antwerp, Belgium, where I was in training [for a PhD] in microbiology. We received samples from a Belgian nun living in Zaire who had died of hemorrhagic fever. To make a long story short, we isolated a virus, which we now call Ebola virus, that looked unlike anything else we had seen under the electron microscope. I then participated in the investigation of the outbreak in Zaire with the US Centers for Disease Control. It was scary, because we knew that the epidemic was deadly. Through detective work—by talking to people, analyzing data, using basic epidemiology and very primitive statistics—we found that the virus was transmitted by needles, from mother to child and sexually. In retrospect, it was the same case for AIDS, although this disease would only be discovered years later. During this experience, I was bitten by the bug of public health.

In 2006, while you were still at UNAIDS, governments worldwide pledged universal access to AIDS prevention, treatment and care by 2010. Where do we stand on that promise?

It's clear that we're not even close to providing universal access. If you take the pledge [literally]—with 'universal' meaning for everybody everywhere without any restrictions—then it was not a realistic goal for 2010. But if you take the pledge as an aspiration, then you can say we've made enormous progress. There are now probably 5 million people on antiretroviral therapies [ARTs], and countries like Botswana, Namibia, Rwanda and Uganda have close to 80–85% access to ARTs. But I would say universal access is the wrong slogan. People have to stop becoming infected and stop dying from AIDS. That's what we want, and universal access is just a means to get there.

How do you think we should go about getting there?

With AIDS, we are moving from an epidemic to an endemic. We need to take a long-term view and adopt a lot of our strategies toward sustainability. I'm talking about not only financial sustainability, which in our difficult financial times is not a small thing, but also societal sustainability, political commitment toward dealing with AIDS and even personal sustainability—there are people who have been on ARTs for 14 years, which is a long time to take drugs every single day.

We also need to do more to emphasize prevention. Before we had ARTs, we only thought about prevention. With ARTs, we initially only thought about treatment. Now I think the paradigm is shifting again: we need both. And we should invest far more in evaluating what we're doing and learning from that. There is no systematic learning. We may need different methodologies for different programs; it's not the same to evaluate a new drug and a community intervention to change social norms. But we need to invest enough in serious evaluation of all our programs so that the next ones will be better.

What challenges do you expect to face as the director of LSHTM?

The global health space is becoming very crowded. Until a few years ago, LSHTM was the only game in town and, with the Liverpool School of Tropical Medicine, the only game in the country. Now University College London has a dynamic Institute for Global Health, and so does Imperial [College London]. In the US, driven by enormous funding from the Bill and Melinda Gates Foundation and the US President's Emergency Plan for AIDS Relief [PEPFAR], other programs have emerged too. Also, although students currently come to the EU and US to study, I think that British, American and Canadian students will soon do their PhDs in Shanghai or Bangalore. How will LSHTM position itself in this globalized space? Several universities in the US are setting up campuses in the Middle East and in China. Perhaps that's the way to go, just as companies have gone multinational.

What health challenges do you expect to focus on?

LSHTM is extremely strong in epidemiology, randomized trials, health policy, economics as well as in infection and immunity lab science. I will play on these strengths. But when you look at the global health developments, the major cause of death and morbidity are now noncommunicable diseases: cancer, diabetes, cardiovascular disease, smoking, obesity. It's no longer infectious diseases outside sub-Saharan Africa.

How have your own research interests shifted?

I'll always have an interest in AIDS, but my research interests are moving more and more towards policy, translating science and evidence into policy and turning policy into action. It's an underdeveloped field, and yet it's key if you want to change the world. It's not enough to do the study and publish the paper and say more research is needed and think it's done. Findings have to be translated into policy, into money and into changing behavior.