Association de lutte contre le sida déclarée le 26 07 1989 (loi de 1901) – SIRET 394 895 569 00025 – APE 913E

Press Statment
08.13.2006

16th World conference on AIDS at Toronto

Act Up-Paris will report daily (in french) on the conference on its Website at www.actupparis.org : *on-going progress will be reviewed by members of the association present at Toronto and belonging to the Treatment and Research commission of Act Up-Paris; images of protests and interpellations will also be available.*

From the 13th to the 18th of August 2006 will be held the 16th World conference on AIDS at Toronto. Thousands of people will be there who revolve around the fight against the pandemic: researchers, politicians, physicians, delegates from artistic, cultural or religious circles, representatives from the pharmaceutical industry … and sick persons. Historically, Aids activists had to fight to ensure that people living with HIV – by far the first implicated – could get the right to participate to these conferences.

This year, ten Act Up-Paris delegates will participate to the Toronto conference. It will give us the opportunity to unfold the three means of action that have always been the strength of Act Up-Paris: collecting and sharing data (by participating to scientific sessions whether as a speaker or in the audience); lobbying on the numerous national and international leaders who will be present; and finally protesting when it is necessary to show the light on responsibilities or when negotiations are in a dead-end. Lastly this meeting will also enable us to act in synergy with other activists from the whole world, to share data, make new alliances and to combine forces.

Delegates from Act Up-Paris will give two oral presentations:

- during the session "Ethical Issues in Clinical Trials: Tenofovir and Beyond » (http://www.aids2006.org/PAG/PSession.aspx?SessionID=217), on Tuesday the 15th at 4:15 pm, Hugues Fisher (Co-president Act Up-Paris) will present a communication entitled "Influencing legislative processes and policy development in order to improve research ethics".
- during the session « Accelerating Research: Approaches that Work » (http://www.aids2006.org/PAG/PSession.aspx?SessionID=314), on Thursday the 16th at 12:45 am, Hugues Fisher will present a communication on "responsibilities of state, community and private sector on research ethics policy: looking back on recent CCR5 antagonist trials ".

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Treatments access in South countries

UNITAID tax

A representative of the French government will undoubtedly be on hand in Toronto in order to promote the new UNITAID tax.

Since July 1st of this year, several Euros have been set aside from the cost of each airplane ticket purchased in France in order to fund UNITAID. The funds collected are destined to buy medicines for patients suffering from AIDS, tuberculosis, and malaria. The tax has, no doubt, come about because of France's own initiative and one can imagine the good publicity that Jacques Chirac or Philippe Douste-Blazy will be able to garner from it during the conference.

For Act Up-Paris, the UNITAID initiative will only serve the interests of patients in poor countries under certain conditions, which are not, as of yet, fulfilled :

-The new tax must not exempt France from its other financial obligations vis-a-vis the fight against AIDS. In June of 2001, the richest nations promised to finance this fight to the tune of 10 billion dollars per year, yet France's own contribution, like those of other countries, was never fulfilled. In 2006, need has increased to 15 billion dollars (18 billion for 2007, according to UNAIDS). This has not prevented Philippe Douste-Blazy, French Minister of Foreign Affairs, from affirming that "in terms of international solidarity, France has done better, much better, than keep its promises." We are waiting for the government to respond to this debacle, and to make a future commitment that France will fulfill the pledges it made in June 2001. Under no circumstances should the UNITAID tax, which can only be considered as a new source of funds, linked to a new tax, serve to absolve the French government of its other responsibilities towards patients in poor countries.

In addition, the money flowing from the new tax must be used in the most effective and well-reasoned manner possible. However, in order to fall into line with Jacques Chirac's planned speech to the UN next September, UNITAID has prioritized programs that are easy to fund, but not necessarily in need of its support (such as the question of mother-child transmission), while ignoring delicate but potentially more useful areas (such as physical exams)

UNITAID's introductory document thus indicates that in 2007 the organization will purchase the medicines necessary to double the number of pregnant women in poor countries who benefit from Prevention of Mother to Child Transmission Treatments (PMTCT). However, virtually all public health experts around the globe, including those in France, agree that the price of medicines alone will not allow increased access to PMTCT treatments for HIV positive women. In actuality, free PMTCT treatments are already available. UNITAID, on the other hand, does not plan to pay for competent personnel who will know how to best distribute the medicines sent from Europe, and nothing is planned to protect women from discrimination linked to their HIV positive status.

Today, a number of programs aimed at increasing treatment access show the road blocks preventing the inclusion of new patients are less about the cost of medicines as the cost of physical exams. While the cheapest generic versions of tri-therapies are available for only 10 euros per month, physical exams still cost around 200 euros; these exams are indispensable, since they allow one to determine the HIV positive status of the patient, the progression of their sickness, or the effectiveness of their prescribed medications.

Act Up - Paris asked the directors of UNITAID about these issues in hopes of hearing the reasoning

that went into determining its objectives for 2006 - 2007. UNITAID admitted that it would have been necessary to carry out studies in order to determine the areas in which UNITAID would be most effective. A job that would have taken a number of weeks but which is incompatible with Jacques Chirac's political and public calender! In effect, Chirac would like to announce the official start of UNITAID next September during a scheduled speech at the UN. When rigor and effectiveness give way to spectacle...

Funding by rich countries

Context

More than 40 millions of people are HIV positive, and the virus has already killed 25 millions of women, men and children.

In june 2001, a special session held at the United Nations had set up the minimal amount of money necessary to stop the pandemic worldwide. And the richest nations, spearheaded by France, had committed themselves to grant enough money to efficiently combat the HIV/AIDS.

The reality of the promises made by France and other countries

The G8 countries haven't kept their word. For instance, the program led by the WHO -whose main goal was to have 3 millions of people treated- in 2005 was a failure. this is mostly due to a lack of funding.

At the G8 summit at Gleaneagles, in July 2005, the G8 leaders gave their word that they would do their best to enable a universal access to therapies by 2010. In August, 2005, the UNAIDS released an official estimation of the amount of money needed to stop the soaring pandemic. It said that 12 billions of dollars were needed in 2005, and another 15 in 2006. It also noted that, at that date, only 8 millions had been allocated[1]. To reach 15 millions, 7 extra billions would have been needed. Yet, the actual promises made by the rich countries amount to less than an extra billion for 2006. Let's just recall that 7 billions equal to a mere 0,03% of the 7 richest countries' GDP for 2005 (Estimated to a total of 27 000 billions by the OECD).

Claims

We ask that:

- In 2007, the G8 governments end up keeping their financial promises. According to the report "Ressource Needs" released by the UNAIDS in august 2005, 18 billions are needed to stop the pandemics in 2007. Due to the current under-funding, 10 extra billions have to be donated in 2007, in addition to the 8 millions allocated for 2006. Only the rich countries can devote that sum. France's GDP being equal to 6% of the OECD GDP (may 2006), it should raise it's contribution in the combat against HIV / AIDS of 600 millions of dollars in 2006-2007.
- The way the funding against the HIV / AIDS is currently done at a world level proved to be a failure. Based on voluntary, *ad hoc* donations, each country highlights the bright side of its contribution to the international fund. It thus claim that it is not the one which needs to increase first the sums it devotes to the fund. To put an end to this wicked logic would require for the rich countries to reach an agreement on the mode of repartition of the fund (in other words: "who gives what?"). It could for instance be a donation equal to the country's share in the OECD's GDP.
- Before the end of its term, Jacques Chirac should propose and organize a summit with all the heads of government of the OECD, whose goal would be to find an appropriate way of funding the combat against the HIV / AIDS.

[1] Ressource Needs, ONUSIDA, august 2005, p. 12.

Intellectual property and the use of the generics

General situation
Resorting to the generic drugs is necessary in order to have the price of the treatments lowered, thus enabling a broader access to the treatments. Unfortunately, the most efficient antiretroviral treatments have been released after the enforcement of the WTO agreement in 1995. Since they are protected by a patent worldwide. the monopoly of the companies producing them cannot be contested, their prices remain high, and the poorest countries –unable to afford them-- remain excluded from any therapy.

Legal Context
Yet the ADPIC/TRIPS agreement of 1994 on intellectual property holds that **(**art. 31**)** a government can suppress the monopoly created by a patent if the general interest of its citizen is at stake. The government has then to pay compensation to the patent owner.
This is termed *licence d'office* [an exceptional patent waiver] in French law. Yet, the paragraph (f) of the article 31 sets limits the right to export the goods produced under that specific patent. The *Declaration on the TRIPS agreement and Public Health* (2001) holds that the TRIPS agreement can be read in a way which is favorable to the access of everyone to the treatments, and that each state belonging to the WTO remains free to determine the context in which a *licence d'office* can be granted as far as its national law is concerned. Both the WTO decisions of August, 30th 2003 and December, 6th 2005 implemented a procedure supposed to enable the international trade of treatments produced under *licence d'office*.

Reality
These legal devices, which were supposed to facilitate the distribution of generic therapies at a world level, did not prove efficient. Why so? First and mostly because of the pressure made by the United States of America, first lobbyist for the big pharma industry. Most of the time, these pressure are exerted through bilateral agreement between the USA and developing countries. The bilateral agreement include clauses which prevent the enforcement of the Doha agreement on the *licence d'offices*, and are accompanied by threats of economic retaliation should the agreement be violated. This is how the USA make sure that their true position is known and understood by all the developing countries on that matter, and how they let them know about the extreme commercial sanctions they would face if any of them was to transgress the agreements.
It results from this a vicious circle: on the one hand, the producers of generic treatments do not want to invest in generic versions of drugs under license as long as they are not sure that they will be able to sell their production. They rather wait for the developing countries to release a *licence d'office* for these products. On the other hand, no government in the developing countries has the will to release a *licence d'office* to import a product as long as this very product has not been developed, which can lead to a delay of 18 to 36 months.

No developing country is big enough a market to justify in itself the conception of a new product by a company specialized in the elaboration of generic treatments. These companies actually need large markets and a vast number of countries to break even. **That's why the release of a *licence d'office* by a single country is not enough of an incentive for the companies producing generic treatments: they definitely need that several countries open their market through the release of a *licence d'office* so as to rationally decide to produce generic treatments.**

Claims
We ask that the French government, and especially that the Foreign Affairs Secretary Philippe Douste-Blazy, **call for a meeting of both the Secretaries for the Industry and of the Health Secretaries from the developing countries willing to resort in 2006 to the licence d'office and**

other waiver clauses. This meeting would lead to the joint release of licence d'office for the import or for the production of generic antiretroviral treatments in the country of exportation.

Such an international meeting would:

- Reinforce the developing countries' power to oppose themselves to the US government, especially regarding the enforcement of the Doha agreement (sharing the opprobrium among the countries releasing simultaneously would largely contribute to tipping the scale in their favor).
- Open an important part of the international market of the antiretroviral therapies to the competition.
- Lead to a real step forward regarding the access to the treatments in the WTO, which would actually be more than and void promise.
- Lead the companies producing generic treatments to commit themselves to a precise schedule, detailing the drugs they will develop soon, and pushing them to do so for the most useful and less affordable treatments.
- Lead the Health Secretaries for each country to enforce the WHO's policy of prequalification of generics, through the creation at the national level of a marketing authorization for drugs pre-approved by the WHO.

Stockholders' or PWA's logics ? Norvir® Meltrex developing by Abbott

In France, Abbott is on the verge of receiving authorization to put a new formulation of Kaletra® on the market, Kaletra® Tablets (Meltrex), which can be conserved at room temperature. There are no plans, however, for Norvir® (ritonavir). What's worse, we have the suspicion that Abbott is deliberating delaying distribution of the non-refrigerated form of Norvir®.

Kaletra® (which combines lopinavir and ritonavir in a single capsule) is widely used today but must be conserved in a cold environment. This is also true for Norvir® capsules, which are also produced by Abbott. Norvir® is usually taken as an anti-protease booster in conjunction with a normal anti-retroviral treatment.

The advent of capsules

Norvir® capsules (like Kaletra® capsules) can only be conserved for one month outside of a refrigerator at a temperature below 25°C (77°F). Above 25°C the capsules begin to melt and become unusable. The capsules must, therefore, be kept either in a refrigerator or, for short periods, in an isothermal bag. Storing Norvir® is impossible at temperatures over 25°C if one does not have access to a refrigerator. Such temperatures are frequently surpassed during the summer months in temperate regions (Paris, for example). Likewise, for patients in precarious living situations (homeless, etc.), all treatments using a boosted anti-protease are removed from the arsenal of available therapies.

In addition, there is the question of confidentiality for those in a shared living situation (with parents or friends) who do not wish to reveal their HIV positive status for personal reasons. For such people, the necessity of storing their medicines in a common refrigerator presents a problem. Norvir is packaged in an inconvenient manner, with 4 large boxes that one must pack into the refrigerator. Moreover, for patients traveling to warmer areas keeping up with their treatment schedule quickly becomes problematic, forcing some to disrupt their regimine and thus risk developing resistances.

The sirop formulation of Norvir®, which does not need to be refrigerated, can be used temporarily, but its harsh taste does not encourage patients to observe their treatment and can have a negative impact in terms of quality of life. It goes without saying, therefore, that in hot countries, where few have access to a refrigerator, the use of Norvir® and Kaletra® is next to impossible. Without these options, the number of powerful and effective treatments is severly reduced.

Kaletra® and beyond?

The new formulation of Kaletra®, «Kaletra Tablets» (dry tablets that use the Meltrex process: Melt Extrusion Technology) is a partial solution to the problem. With the tablets, Abbott hopes to incorporate those patients facing storage problems related to their treatment. The problem remains in full, however, for those taking an anti-protease other than Kaletra that requires Norvir® as a booster. Abbott, however, continues to deny the problems with Kaletra® and keeps delaying the development of the non-refrigerated version of Norvir®, which could be of interest for all those taking it alongside an anti-protease not made by Abbott.

Abbott's sole aim is to reinforce its monopoly, showing once again that it couldn't care less about

patients.

The bad conscience of managers

Abbott's attitude towards Norvir® is motivated fundamentally by its projected profitability. On the one hand, Norvir's® monopoly allows Abbott to profit from its use as a booster. On the other hand, they hope, naively, to impose Kaletra® over other anti-proteases, given that the revenues brought in by a treatment with Kaletra® are superior to those with Norvir® at weak doses. This business decision, to the detriment of the health of patients, requires that Abbott's representatives publically avoid the issue through lies that attempt to justify the delay in the release of the dry form of Norvir®.

One should remember that Abbott has already increased the price of Norvir® five fold, with the justification that it was necessary to finance the development of Norvir® Tablets (dry form); and today we are still waiting!

Since 2003, Abbott has strung patients along. Today, it pretends that the Meltrex form with ritonavir is difficult to stabilize above 50mg. But why not choose to produce Norvir® tablets with a reduced dosage of 50mg?

Abbott is also pretending that, without presenting any supporting numbers, Norvir® is not widely used as a booster, in order to cast doubt upon the value of requests that are made directly to them. Such logic removes the focus from all those HIV positive patients who need Norvir® but who cannot use it so long as it must be refrigerated. It is for this reason that, even though it isn't recommended, Reyataz® (atazanavir) is often taken without Norvir®, which increases the risk of developing resistance and virological failure. Moreover, prescription numbers in France show both that Norvir® is in fact used more and more frequently and that the importance of its use is linked to the increase in anti-protease treatments other than Kaletra®. One can also note that the number of treatments using Kaletra® have fallen off an appreciable amount, while use of its main competitor, Reyataz®, has increased accordingly.

On can thus understand that the effort to keep the dry form of Norvir® on stand by and instead focus attention on Kaletra® Tablets is part of a somewhat desperate strategy by Abbott to fend off the competition presented by Reyataz®.

During a meeting with the members of the TRT-5 (an association bringing together 8 organizations related to HIV theraphy) on June 16, 2006, represenatives from Abbott France indicated that if a pharmaceutical producing a competitor anti-protease were to ask them, they would be ready, as with Kaletra®, to develop a pill combining both drugs. This announcement is overdue, and what's more no one knew about it until now ...

Yet, Norvir® Tablets are more simple to produce than Kaletra® Meltrex or any other dry combination between ritonavir and a second anti-protease. Access to Norvir® Tablets in the upcoming year depends, therefore, solely upon Abbott. For patients, the earlier they are released the better.

Medical trials: no ethics without mobilization

The fight of HIV positive people living with Aids has shown that HIV research was all the more efficient given that the very people benefiting from it knew the topic, the stakes, whether individual or collective, the benefits and the risks of the studies in which they participate. The research ethic – i.e., the right of the people included in the trials not to be considered as mere guinea pigs but as *bona fide* actors for the research – is not detrimental to the efficiency, including financially, of a research dictated by urgency. On the contrary, whenever these rights are called into question, this always further postpones the availability of new solutions to the ever renewing issues raised by the epidemic. This obvious fact is constantly challenged in Southern countries as shown during the tenofovir trials carried out with African and Cambodian prostitutes, and is also a concern in Northern countries, and as such thus requires a permanent mobilization of sick persons.

In 2004 at Bangkok, the issue of preventive trials in the South was very topical at the moment. Clinical trials aiming at studying tenofovir as a preventive drug raised numerous issues, including, more particularly:

- a dubious individual counselling (to incite participants to use condoms) since it was performed by the promoters of the trial themselves and not by an independent institution ;

- an absence of complete follow-up of participants tested HIV-positive during the recruitment or the trial (medical monitoring, treatment against opportunistic infections, access to antiretroviral drugs if necessary).

The ethical issue in medical research has been keenly raised twice since the tenofovir trials. In France, Act Up-Paris mobilized to modify the protocols of several trials which may have endangered the health of participants. Thus, the BMS laboratory Induma trial aiming at evaluating a therapeutic strategy consisting in induction and maintenance could have induced virologic failure among participants and hence treatment resistance, if plasmatic dosages were not performed. Modifications have been introduced for the French participants, but BMS did not adjust the trial configuration in other countries where the trial was performed.

Because anti-CCR5 trials were central to the race between laboratories for the first approved molecule, they have been the subject of a large mobilization from all the French associations. Schering Plough, GlaxoSmithKline and Pfizer laboratories tried to set up trials disregarding admitted standards on CD4 levels of naïve participants. The first two companies finally stopped the trials because of serious side-effects in certain participants. For instance, the hepatic toxicity of the GSK compound required a liver transplantation in an Asiatic patient. However, Pfizer – the last company still pursuing the trials – decided to go on with massive recruitment of patients without worrying about the risk, although it is quite real for the future health of participants. The anti-CCR5 symposium organized by Pfizer a few hours before the beginning of the conference may shed a new light on their somewhat opaque strategy.

In the future, we will keep on expressing disapproval of clinical trials which do not provide the necessary guarantee in terms of safety for all the people involved in the research. Toronto will give us the opportunity to say it all over again.

Harm reduction

Harm reduction will be one of the central points addressed at the upcoming conference of the International AIDS Society (IAS). Without taking into account the many satellite meetings, there will be 14 sessions and workshops that address questions of prevention and treatment amongst drug using populations. For Act Up – Paris, these questions have been recently undermined in France by arguments in favor of classifying Subutex (a treatment for opiate dependence) as a narcotic.

The debate brought up by this proposition, which was put forward by the French MILDT (Interdepartmental Commission for the Fight Against Drug Addiction), has for the moment remained focused on the consequences it would have on a national level. The destructive consequences of this decision will no doubt also be brought up on an international level during the Toronto conference. This will be particularly true in relation to those who are in the midst of developing harm reduction programs linked to drug use. In Eastern Europe and in Asia, intravenous drug use remains the principle contamination vector of HIV. It is, therefore, of the utmost importance to convince local public agencies of the effectiveness of substitution treatments by considering the results obtained where they have been previously made available.

It is in this context that numerous voices from the international community have risen to denounce the classification, on the basis that it would represent a set-back for France and would severely compromise the promotion of substitution treatments. A large number of social actors and researchers who have come out against the project will be present in Toronto, one of whom, Alex Wodak, will take part in the very first plenary session. We demand, therefore, that Xavier Bertrand, French Minister of Health, who will be present at the conference and with whom the final decision on the matter will fall, to take the opportunity to announce the definitive abandonment of the project.

Beyond this particular debate, however, the IAS conference will also provide an opportunity to build more positive perspectives (with regards to new and innovative practices as well as the development of self-help strategies) than those catastrophic views of epidemiological realities and ever expanding need.

The HIV epidemic amongst drug users has never been so dynamic, but we must also move with urgency to control the dizzying evolution of the "other epidemic" hitting drug users head on, that of HVC and HIV/Hepatitis co-infection. In France, cirrhosis could result in 10,000 deaths in the coming 3 to 5 years without the government proposing a single measure that shows any recognition of this new tragedy. Where will we be 5 years from now in countries with exploding epidemics but where needle exchanges are still forbidden?

HIV & Hepatitis Co-Infection care

Today, HIV & Hepatitis Co-Infection (HHCI) is treated as a junction of two different diseases : managed according to two different sets of rules, by two different professions of medical doctors. However, for people living with HHCI, there is not two but only one reality to cope with : a health that is steeply worsening, and specifically cirrhosis and iys associated complications.

This reality must urgently be understood and integrated by public health policies meant to deal the epidemiological catastrophe announced. And the Toronto conference program (which devotes only one session among hundreds to HCCI) only confirms the necessity of this integration.

Cirrhosis care for people living wih HIV

In France, in 2001 and 2005, studies by the National Institute of Health Surveys showed that 40 % of HIV-HCV coinfected are at least in pre-cirrhosis, which means severe hepatitis. From the 2005 update of this study and the 2005 CPAM study about HCV and HBV national prevalence in France, it is estimated that there is about 8 000 people co-infected by HIV and viral hepatitis in France.These alarming data reflect the lack of awareness of consequences of late taking charge of viral hepatitis among people living with HIV.

About three PLWHHCI out of four have been contaminated through illegal drug injection, even though today most of them are no longer injecting. Many studies have demonstrated that, however, they still have a high consumption of alcohol, psychostimulants and hepatotoxic psychotropic medicines. The taking charge of PLWHHCI is therefore a specialty that requires more than ever implication of multidisciplinary teams. Today in France, such teams are ready. But without new treatments, more potent and less toxic than interferon, nothing will stop the announced hecatomb. Dr Pascal Melin, vice-president of the national network of people living with hepatitis (PWH) « SOS-hepatites » had declared at the 2006 French Aids Research Agency symposiumon Cirrhosis Management in HIV+ Patients : "*Evolution towards cirrhosis is one and a half more frequent in case of HIV coinfection and could lead to 10 000 deaths for the next three years in France* ".

However it is also to the phamaceutical industry that we must take our concerns in order to turn this situation around. Indeed, many new promising molecules are already in development, though there are yet no plans to make them available to PWHHCIs. In July 2006, during the closing session of the ANRS symposium on HIV and hepatitis coinfection, Jean Francois Delfraissy, the new ANRS director had declared : « *Today, there are least three promising new molecules against hepatitis within our grasp in the research pipelines. We direly need patient organisations and activists in order to get access to these drugs as soon as possible!* "

Like we need in the early weeks and years of HIV protease inhibitors, Act Up-Paris now demands that the pharmaceutical industry open compassionate access and Temporary Use Authorization programs for their new molecules against viral hepatitis. And we demand from drug regulators and the pharmaceutical industry that they prepare a production and supply chain capable of responding to the tre size of the need.

Liver tranplants for People living with HIV

During the HIV and hepatitis consensus conference in Paris in march 2005, Pr Miro from Barcelona, revealed that the median survival time, for 109 PWHCCI having a first decompensated cirrhosis complication, was about 14 mouths only. This is barely the time necessary to prepare the patient for a live transplant, provided the blood type is not too rare.. In Spain, the rate of death in the waiting list for liver transplants was about 64 % for HIV-HCV coinfected people versus 17 % for HCV mono infected people. Because of the immunodeficiency produced by HIV, PWHHCIs see their life expectancy dramatically shortened after even one event of decompensated cirrhosis. Pr Miro estimated in July 2005 that in Western Europe and North America, there are about 8 700 coinfected people who have already had one event of decompensated cirrhosis. This means that these 8 700 are in urgent, vital need a liver transplant. But since 1998, no more than 300 liver transplants have been performed for PWHHCIs.

In France, the latest data about liver transplantation for HIV-HCV coinfected confirm that soon after the surgery, the graft reinfection is particularly rapid and really severe. In a French cohort of 33 transplanted PWHHCI, two years after the transplantation, one out of three were back in cirrhosis, instead of fifteen years usually. Pr Didier Samuel have recently published an alert about the major difficulties for managing to plan for a liver transplant sufficiently in advance for PWHHCI.

It's clear that those liver transplants for coinfected people, are still relevant for research trial. Meanwhile great efforts to combine immunosuppressive drug and HAART, the researchers must found today how to add and manage an Interferon biotherapy as soon after the surgery, to limit as late as possible the venue of cirrhosis. Today, it's not reasonnable to consider and publically present that liver transplantation could be a faisable solution for the 8 000 coinfected people on cirrhosis in France, knowing that 1 000 to 2 500 of them shall probably need a liver transplantation before 2010. But all this also allowed us to devellop new strategies that could help this system to progress, because it's still the last survival chance in case of strong decompensation of cirrhosis.

Since fifteen years, Spain had yet prooved that only a brave political decision giving priority to graft DON in case of death, and promoting life and public health, instead to protect only the family request, could permit to double the number of graft possible to use. For an equal population, Spain do three times more liver transplantation than in France. Even if PIONNIERS in this issue had begun to teach to other centers in France, only a national network with enough financial possibility could permit to implicate all the liver transplantation center on HIV coinfection issue, help by the expertise of PWA and PWH group. At an international level, the I.A.S. today, must take the initiative of a global network to coordinate all the different national trial on liver transplantation for coinfected people, to minimise the worst consequences of national competition between scientifical teams.