Provide and Conquer

Can we treat our way out of the epidemic? Edwin J. Bernard looks at the promise—and price—of treatment as prevention.

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Last November, in the scientific journal *The Lancet*, The World Health Organization (WHO) argued that putting everyone who is living with HIV on antiretroviral (ARV) treatment could potentially eliminate HIV/AIDS within 50 years. Finding and treating all people living with HIV so that their viral load becomes and stays undetectable, the theory goes, will make them be less infectious and therefore less capable of spreading HIV.

The WHO developed the idea—called "treatment as prevention"—from Vancouver's top AIDS doc, Julio Montaner, MD. Currently, the president of the International AIDS Society, Montaner has been pushing the concept of treatment as prevention since 2006. At last year's International AIDS Conference in Mexico City he said, "We believe there is now enough evidence to say to policymakers that if you roll out HIV treatment with 100 percent coverage, you will see a reduction in HIV transmission."

While the WHO paper acknowledges that treatment alone is not enough (behavioral changes must take place too), it highlights that most new HIV infections worldwide result from people who are unaware of their status. Therefore, the WHO reasons, by identifying everyone with HIV through "universal voluntary testing," followed by ARV treatment, the world's "transmission pool" becomes ever shallower until, after 50 years, everyone with HIV is tested and treated. Translation: The epidemic can be contained, maybe even completely curtailed.

The global AIDS community's response to treatment as prevention is mixed. This past April, I attended an international conference on Positive Health, Dignity and Prevention (PHDP) in Hammamet, Tunisia, cosponsored by UNAIDS and the Global Network of People Living With HIV/AIDS (GNP+). Many people found the idea of treatment as prevention incredibly exciting, yet equally as worrisome.

It's exhilarating because this approach could provide much- needed meds to poverty-stricken and middle-income regions in Africa, Asia, Eastern Europe and Latin America. Less than a third of all HIV-positive people who should be on treatment receive meds. What's more, in these regions, by the time people are treated, many have developed AIDS (this is because WHO's guidelines for treating HIV in low and middle income regions recommend starting treatment at lower CD4 counts

than in wealthier countries). Treatment as prevention could allow more people with HIV to get access to care earlier, which could lead to longer, healthier lives for millions more.

However, from a human rights standpoint, it could set some dangerous precedents. If public health trumps personal autonomy, we could lose the right to choose if and when we want to start treatment. Many who attended the PHDP meeting expressed concern that the "right to choose" might get buried under the excitement and eagerness to expand treatment for those who currently don't have anything to keep them alive. Bottom line: Are we defined as HIV-positive individuals with free will or HIV-infected subjects who need to be controlled?

In addition to the issue of who will pay for expanded treatment (individuals, governments and/or relief organizations?), there is legitimate concern that people—positive, negative and those who don't know their status—will forgo condoms (and clean needles) because they mistakenly believe there's no longer a risk of HIV infection. In fact, the Swiss federal AIDS commission stated that serodiscordant couples had little or no risk of transmission when having unprotected sex, but they had to meet the following criteria: They are monogamous heterosexuals in which neither had any other active sexually transmitted infection and the positive partner had to be on ARV treatment and have an undetectable viral load for at least six months. The WHO and the U.S. Centers for Disease Control and Prevention dismissed that statement, but the WHO is considering combining treatment *with* condoms and other proven prevention methods as the ultimate form of prevention—"combination prevention."

Discussions like these have uncovered an apparent growing disconnect between what the experts know about treatment's ability to potentially reduce the odds of transmission and what they want us to know. While many experts agree that successful treatment makes us uninfectious most of the time, they don't agree on how and when we might still be infectious and whether people living with HIV can manage the complex uncertainties of fluctuating viral loads—and still keep others from contracting HIV. In this climate of uncertainty, I give kudos to the Swiss for suggesting that we should be able to make up our own minds about the relative risks of potential transmission, based on what we do know.

But then there is the issue of personal responsibility, a constant elephant in the room that too many ignore. A key principle to come out of the PHDP meeting was that HIV prevention is a shared responsibility. In light of that, treatment as prevention seems to place an unduly heavy burden on those who are positive. The French National AIDS Council, in a recent statement on treatment as prevention, argued that if treatment becomes the sole means of preventing HIV transmission, then the positive partner "wholly bears the responsibility to contain the risk for the other. Treatment as an individual prevention tool redefines the issue of responsibility in the fight against AIDS. It vests seropositives who use it with the specific and unreciprocated responsibility to protect the other."

Many current global HIV exposure and transmission laws provide grounds for criminalizing people living with the virus for transmission during consensual unprotected sex. This plus the new guidelines of treatment as prevention could result in the positive community bearing even more responsibility for keeping the virus to ourselves. Is relinquishing our personal rights a necessary

price to pay for a public health concept that could help millions of people living with HIV around the world? I would like to think that both sides could carry an equal load.

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