Prominent Parisian Activist Weighs in on Treatment as Prevention

October 13, 2010 By Sean Strub

Georges Sidéris is Vice-President of The Warning, an HIV/AIDS prevention and community health promotion group in Paris, France. He also is the co-author, with Olivier Jablonski and Jean-Yves Le Talec of "Santé Gaie" (Gay Health), Pepper-L'Harmattan Editors, Paris, 2010.

Georges addressed the "treatment as prevention" strategy in a recent article which he was kind enough to have translated into English. I've posted it below; emphases in bold are mine. -Sean

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Ethics and health: eradicating the HIV epidemic by treating all HIV positive individuals, including those recently diagnosed, raises some important questions.

I have been hearing and reading a lot lately, especially during the International AIDS Conference in Vienna, about using testing and treatment as an HIV prevention strategy. It seems we have found the perfect recipe: test everybody, treat all HIV positive individuals, even if it is not yet necessary for their health, and we will eradicate the virus in the next decades. Such buzz leaves me perplexed.

The fact that a person living with HIV with an undetectable viral load practically does not transmit the virus is an essential element in the fight against HIV/AIDS as well as the fight against the criminalisation of HIV transmission.

Some mathematical models show that increasing the number of PHA's on treatment by 50% can reduce new infections by 50%. It is also important to continue exploring treatments as a prevention strategy for HIV positive and HIV negative individuals, especially in the context of serodiscordant couples who want to stop using condoms or who wish to have children.

Otherwise, outside of serosorting between HIV positive partners, condom use remains the best protection strategy during casual sex, especially when one considers how serophobia, seroguessing, and the fact that 40% of HIV positive individuals don't know their status are barriers to disclosure and therefore barriers to risk reduction strategies such as seroadaptation.

At the individual level, the main objective of treatment, as outlined in treatment guidelines and recommendations, is viral suppression, even if the preventative effect is now also being considered in the French guidelines alongside improved quality of life and treatment tolerance.

However, using treatment as a public health tool and applying this to potentially all PHAs raises some

important ethical questions, particularly ones concerning the over-medicalisation of specific populations. By what right can we dictate treatment to PHAs that don't need it right away?

What kind of medical or judicial instances can force a person living with HIV to undergo treatment right after diagnosis or as soon as his CD4 counts fall under 500? Even if we know today that starting treatment between a CD4 count of 350 and 500 has some advantages, we need to remain vigilant because we don't have enough data on the long term effects and toxicities that treatment can cause.

If the individual's best interest for starting treatment early seems to be getting closer to that general best interest of treating everyone, they are not yet mutually equivalent. Furthermore, the individual's autonomy, well being and choice must remain inalienable.

What have we learned from previous example of public health policies regarding sexually transmitted infection such as syphilis? What would happen to those who refuse to start treatment early?

How can we guarantee their freedom to make informed choices about their treatments without pressure from the medical and legal establishments as well as social and inter individual pressures?

Heading in this direction, wanting to treat everyone as soon as they are diagnosed, can potentially set a precedent and open the door to forced treatment of HIV and other illnesses even if the person does not consent.

This strategy has the potential of reinforcing stigma, especially of those who refuse to start treatment, and classify people in two categories, the "good" and the "bad" PHA.

Setting up "treatment as prevention" as the only solution to stopping the HIV/AIDS epidemic can also cause some collateral damages: HIV negative individuals who believe all PHAs are on treatment will shift the responsibility of taking care of their sexual health onto HIV positive individuals.

Once again, all the responsibility for prevention ends up being on the shoulders of PHAs.
Treatment as prevention is an adventurous idea, especially since we are not yet able to provide treatment, on a global level, to all those who need it.

Even in the United-States, poor and vulnerable population and uninsured individuals are on waiting lists to access much needed treatments. In some African and eastern European countries, lack of financial and human resources are still a barrier for people with a compromised immune system.

Adopting a "treatment as prevention" strategy should not change the paradigm of treating an individual first to preserve their health and quality of life. Therapeutic management of HIV must remain the priority.

In some of the most affected countries, access to improved molecules that are easier to use and cause fewer side effects is still blocked by certain pharmaceutical companies. Access to second lines of treatment in case of treatment failure is also limited, so are medical follow ups and phylogenetic tests to assess resistances. All these are important elements needed when one thinks about starting treatment and maintaining it for the rest of their life.

In this context, starting treatment early, without access to all the needed care, information and regular supply of medication is reckless. HIV testing must also remain voluntary and consensual. It can only be

proposed, not imposed.

HIV testing, knowing one's status is an important element of any HIV prevention strategy. Access to tests must be improved and generalized and testing should be de-stigmatised and made routine. However, it can never be imposed.

By promoting "treatment as prevention" as the solution to eradicating the HIV epidemic, are we considering the eventual consequences of the possible failure of this strategy?

Granich's mathematical model that got this whole debate started can't be replicated in real life considering the lack of funds available. What then? Will PHAs be blamed for the eventual failure of this strategy since "treatment as prevention" puts all the responsibility for prevention on people living with HIV? We need to remain vigilant and reasonable and maintain a nuanced and responsible view of this strategy. It's a question of ethics and health.

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Thank you, Georges Sidéris, for your thoughtful comments on this extremely important and timely question.

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