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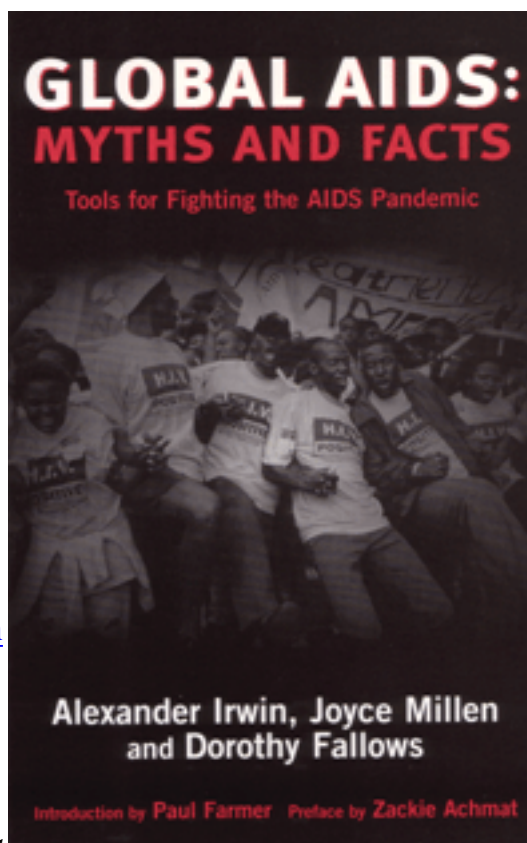
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## Myth Four

### Prevention vs. Treatment?

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**Myth:** *The best way to control AIDS in the developing world is by putting all available resources into stronger prevention programs. In developing countries, costly treatment for people already infected with HIV should wait until prevention programs have been fully funded and deployed.*

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**Response:** Until the mid-1990s, the public health battle against AIDS in both rich and poor countries focused almost entirely on efforts to prevent new HIV infections, because no effective treatment for AIDS existed. Prevention during the first 15 years of the epidemic gradually grew more sophisticated: from behavioral education and condom promotion, HIV counseling and testing, to the treatment of sexually transmitted diseases

(STDs) that can facilitate HIV transmission, and the blocking of mother-to-child transmission of HIV with drugs such as AZT.<sup>1</sup>

Advances in knowledge have strengthened the response to AIDS, yet, with each increment in technology, the gap between rich and poor has widened. In 1996, when highly active antiretroviral therapy (HAART) was introduced at the XI International Conference on AIDS in Vancouver, the gap became a chasm. In North America and Europe, HAART dropped AIDS mortality rates dramatically and improved life quality for people with AIDS.<sup>2</sup> At a cost of more than \$10,000 per patient per year, HAART became and remains the standard of care for AIDS in wealthy countries.

In developing countries, where the world's HIV/AIDS burden is concentrated, a different standard applies. Though the cost of antiretrovirals (ARVs) has decreased sharply, more than 90 percent of people with HIV/AIDS remain without access to these lifesaving drugs. The worldwide struggle against AIDS has become a two-tiered system. While people in high-income regions (along with developing-world elites) enjoy access to effective antiretroviral treatment, public health authorities in low-income countries are advised to concentrate exclusively on prevention, and avoid the technical challenges and expense of treatment programs.<sup>3</sup>

This two-tiered strategy on HIV/AIDS has powerful defenders among academics, public health experts, and leaders of some of the world's most influential international health and development organizations.<sup>4</sup> Writing in the pages of scholarly and medical journals, many experts insist that for the foreseeable future, a choice between prevention and treatment will be unavoidable for poor countries because of the inadequacy of global AIDS funding and the weakness of many developing countries' health care systems.<sup>5</sup>

While respecting many of the scholars and health experts who defend this view, we disagree with their claims. We join the growing number of voices -- represented by groups of people living with HIV/AIDS, various NGOs, and health care providers -- who are challenging the prevention vs. treatment dichotomy.<sup>6</sup> Prevention of HIV and treatment of those suffering from the disease should not be seen as mutually exclusive, but as mutually reinforcing, complementary arms of a comprehensive global AIDS strategy. The following considerations argue for the immediate scaling up of prevention **and** treatment: (1) moral and social implications of denying treatment to millions of people already infected; (2) the structural limits to the efficacy of prevention programs when no treatment is available; (3) the evidence of synergy between HIV prevention and treatment, and (4) treatment's role in providing political leverage for AIDS control, including stronger prevention efforts.

## Moral and Social Crises

By recent UNAIDS estimates, more than 42 million men, women, and children are living with HIV and AIDS worldwide. At current rates, each day more than 15,000 people are newly infected with the virus and 8,000 die. The vast majority of people with HIV/AIDS live in the developing world and currently have no access to medical treatment for HIV disease itself or for the opportunistic infections associated with AIDS.<sup>7</sup> A strategy that emphasizes prevention to the exclusion of treatment offers no hope to these tens of millions of human beings. In fact, it passes a death sentence on them. One international official, speaking anonymously to the *Washington Post*, put it bluntly: "We may have to sit by and just see these millions of people die."<sup>8</sup> Such a position may be seen as public health realism. Yet realism of this type contradicts the basic principles of equity and human rights and acquiesces to what has been called a system of "global medical apartheid."<sup>9</sup>

The apartheid analogy has been drawn by people who fully measure its resonances. Among them are leaders of South Africa's Treatment Action Campaign (TAC), many of them antiapartheid veterans, and South African Supreme Court judge Edwin Cameron, an HIV-positive man who also struggled publicly against apartheid and now stands in the front ranks of the AIDS fight. Cameron argues that "the moral choices of the 1980s," which pitted people of conscience against South Africa's apartheid government, are "replicating themselves in a different form in the 2000s" in the battle for equal access to AIDS treatment.<sup>10</sup>

A first step toward altering the existing injustice is for the voices of poor people with AIDS to be heard. Increasingly today, activists living with HIV/AIDS from the developing world are speaking out, claiming a role in shaping international AIDS policy. They demand that decisions about such issues as the apportioning of funds for prevention and treatment no longer be made without consulting the people most directly concerned: people living with the virus, the vast majority of whom are poor. People living with HIV/AIDS "are 40 million strong and growing, and they are not telling us to concentrate all of our AIDS activities on prevention. ... They are not arguing that costly therapeutic interventions are not 'sustainable' in poor settings, not 'appropriate technology' for low-tech areas of the globe."<sup>11</sup>

Matthew Damane, a 25-year-old South African man from the township of Khayelitsha, outside Cape Town, receives ARV medications through a pilot program run by Médecins Sans Frontières (MSF) and the Treatment Action Campaign (TAC). Damane has drawn national and

international attention as a spokesperson arguing from his own experience that AIDS treatment can be effectively implemented in resource-poor settings, and that poor Africans can indeed learn to comply with complex drug regimens:

Because I have been helped so much by this medication, I wish I could share it with all the others in South Africa who face the same problem. Recently I went with a delegation of people from MSF and TAC to Brazil. We imported some generic antiretroviral medicine in defiance of the drug company patents. ... In Brazil, I saw a country that is not rich, but everybody there has access to antiretrovirals. That has the effect of reducing the stigma and bringing down the rate of infection. South Africa could do the same. ... The MSF programme, which is a trial providing antiretrovirals to people in Khayelitsha, is working very well. It shows that people living in poor squatter communities can take the drugs properly and benefit from them. There are just millions more people waiting in the queue.<sup>12</sup>

Another resident of Khayelitsha receiving HAART through the MSF program echoed these sentiments: "People must know that a poor person like me living in a shack can take these drugs properly. They are my chance to live."<sup>13</sup>

Advocates of a prevention-only approach to HIV/AIDS in low-income countries argue that providing ARV treatment is not cost-effective in poor regions. A year of productive life can be gained in sub-Saharan Africa at a cost of about US\$1, using HIV prevention strategies such as condom distribution and blood product screening in hospitals.<sup>14</sup> To gain a year of life with adult antiretroviral therapy will cost hundreds of times more.<sup>15</sup> Yet cost-effectiveness is only one factor to be examined in weighing clinical strategies.<sup>16</sup> Ethical and humanitarian aspects also demand consideration.

Moreover, as a physician who administers HAART to patients in the MSF pilot program has argued: "Narrow cost-effectiveness analyses of AIDS treatment in developing countries promote a medical ethic that would never be considered in the developed world." Rich countries apply cost-effectiveness analyses only very selectively in evaluating health care options. For the privileged to advise those in less-developed countries to adopt cost-effectiveness as their exclusive criterion in HIV/AIDS control is iniquitous.<sup>17</sup>

In addition to the moral problems raised, a prevention-only strategy fails to take seriously the overwhelming social and economic costs for countries with high HIV prevalence. Many of these infected people will die of AIDS in the midst of their most productive years of work and

parenting, generating enormous losses not only for individuals and families, but for society as a whole.<sup>18</sup> Plummeting numbers of teachers, medical staff, and farmers have been already documented in the hardest-hit countries.<sup>19</sup> The generation of orphans to AIDS is growing exponentially, and four decades of gains in infant mortality and life expectancy have been lost to HIV in many African countries.<sup>20</sup> (For further discussion, see Myth 8.) Providing treatment to infected people, enabling them to continue fulfilling their parental responsibilities and contributing to society through work, will bring important social and economic payoffs. As Dr. Peter Piot, head of UNAIDS, has argued, prevention efforts will help save people from falling prey to infection in the future. But people, societies, economies, and whole countries are in urgent danger **now**, because of the threat of millions of premature deaths, and "only treatment can change that trajectory." The quality of the future that awaits numerous high-burden countries depends heavily on the quality of life they are able to provide to their HIV-infected citizens in the present.<sup>21</sup>

## The Limits of Prevention

The prevention of new HIV infections must be the cornerstone of a comprehensive global AIDS strategy. Yet there are limits to what prevention efforts can achieve. Notably, though AIDS education and prevention have been underway in many countries since the 1980s, the spread of HIV has not been halted, and indeed has worsened steadily in many areas. While numerous moderately effective prevention initiatives and some dramatic successes can be cited, such victories are exceptional.

Inadequate support for prevention programs explains a substantial part of this failure. In 2001, a prevention leadership forum sponsored by several major foundations pointed out that "less than \$1 billion is spent each year on HIV prevention programs in low- and middle-income countries," despite UNAIDS estimates that between \$4 and \$5 billion annually would be needed to sustain an effective global HIV prevention campaign.<sup>22</sup> Constrained budgets have meant that effective but relatively costly prevention measures -- e.g., voluntary testing and counseling, treatment for STDs, and prevention of mother-to-child transmission of HIV using maternal antiretroviral therapy -- have scarcely penetrated the poorest and most heavily burdened areas.<sup>23</sup> Yet, even where relatively vigorous prevention programs operate, structural obstacles often limit their effectiveness.

Early programs focusing on individual behavior change (for example, condom use) proved largely ineffectual in many settings. In recent years, some public health practitioners and scholars have shifted their attention

to structural and environmental factors influencing people's ability to implement prevention messages. Important gains in knowledge have been achieved, and a growing "structural-factors literature" has emerged.<sup>24</sup> Yet this effort is relatively new, and numerous gaps in the research remain. Moreover, understanding how social and economic factors determine individuals' vulnerability to infection does not necessarily mean public health officials will be able to alter these patterns. As discussed in Myth 2, prevention strategies continue to clash with relentless social and economic pressures, including the effects of poverty, class disparities, structural racism, and gendered power differentials.

On matters such as condom use, carefully crafted, culturally appropriate programs are needed both to empower women and to change attitudes among men. Yet even the best planned initiatives -- informed by social science research and relying on peer educators -- often meet with frustration.<sup>25</sup> Individual risk behaviors are framed by a predisposing social context whose mechanisms escape the control of at-risk individuals and AIDS educators alike. Social obstacles and economic constraints must be negotiated before ordinary people can translate prevention theory into practice.

In areas where the epidemic has already gained a powerful hold, with adult prevalence rates reaching five percent or higher, conventional prevention strategies, even good ones, bring limited success. Once the epidemic has moved out from relatively focused high-risk groups into the general population, fully containing the spread of infections becomes virtually impossible. This is the current situation in many high-prevalence countries. Most HIV-positive people remain asymptomatic for years, so they can unwittingly transmit the virus to numerous others before learning they are infected. Under such conditions, traditional education and prevention campaigns can bring new infection rates down, but will not reduce them to zero. Even where prevention scores victories, as in Uganda, the epidemic continues, and the question of treatment for infected people demands to be addressed.<sup>26</sup>

## **Treatment/Prevention Synergy**

HIV prevention and treatment for people with HIV and AIDS are not mutually exclusive options. On the contrary, a growing body of evidence suggests that the availability of treatment actually advances prevention goals. Prevention and treatment support each other.<sup>27</sup>

This synergy is clearest in the area of voluntary counseling and testing. Widespread HIV testing that gives people knowledge of their status is a

cornerstone of effective prevention programs. When HIV-positive people are aware they are infected and receive appropriate counseling, they are better able to cope with the disease and to take action to protect their partners from infection. Similarly, people who know they are HIV-negative, especially in a high-prevalence area, find encouragement to reduce risk behaviors and maintain their health. Thus, voluntary counseling and testing programs have been shown to be one of the most effective prevention tools.<sup>28</sup>

Voluntary counseling and testing has been a pillar of Uganda's widely admired AIDS control program, as a means of fostering a collective response to the epidemic and bringing both seropositive and seronegative people into the system for counseling and support.<sup>29</sup> The role of voluntary counseling and testing is expanding in the US through the CDC's new campaign: a Serostatus Approach to Fighting the Epidemic (SAFE).<sup>30</sup> Its efficacy and cost-effectiveness in promoting risk-reducing behaviors has been demonstrated in randomized control trials.<sup>31</sup> For example, testing women of reproductive age is a critical part of programs to prevent mother-to-child transmission.<sup>32</sup>

However, broad-based community participation in voluntary counseling and testing is often difficult to achieve. Discrimination against HIV-infected people discourages many from seeking testing and counseling services.<sup>33</sup> Fears of stigmatization and the possibilities of domestic violence and desertion by husbands and family are strong barriers to women.<sup>34</sup> Hopelessness and fear of dying also discourage participation. In a study in Zambia, many people who did not want testing said they were probably infected anyway, and since there was no medical help for them, it was better not to know.<sup>35</sup> Where a significant number of people in the community already have AIDS, fatalistic attitudes are easy to understand. Without access to medical treatment, people may have much to lose by knowing their status and very little to gain. The psychological stresses are high not only on people undergoing the test but also on counselors.<sup>36</sup> Emotional difficulties such as anxiety and depression have been reported among health care workers in AIDS-endemic regions where no therapy is available to offer patients.<sup>37</sup> In such contexts, both counselors and prospective HIV test subjects may feel that an HIV-positive diagnosis amounts to a death sentence.

New approaches are desperately needed to encourage acceptance of voluntary counseling and testing. Linking it with access to life-saving treatment offers real hope and provides a clear incentive for testing, greatly strengthening AIDS control programs. When ARVs are offered, people have something important to gain from voluntary counseling and testing, whatever their test results.

Research has also shown that access to AIDS treatment can help reduce

the stigma associated with HIV infection.<sup>38</sup> Over time, the availability of effective treatment modifies the social perception of the disease. This effect has been observed not only in the US and Europe, but also in rural Haiti. In the years before effective treatment, the uniformly fatal infection often inspired reactions of terror; people's fears of the virus spread to include individuals infected with it. In recent years, the availability of therapy has changed the situation by bringing about what has been called a "normalization" of HIV disease. Stigmatization and discrimination have been reduced, so HIV/AIDS can now be dealt with as a more straightforward, "normal," medical problem.<sup>39</sup> In wealthy countries, AIDS is now thought of by many as a chronic disease rather than as a death sentence. The greatly increased numbers of people seeking voluntary counseling and testing in low-income settings where treatment has been made available have confirmed the synergy between prevention and treatment. This effect has been observed in Brazil and in a pilot HAART programs in rural Haiti and in South Africa. At the Haitian clinic, use of free HIV counseling and testing services increased by more than 300 percent after the introduction of antiretroviral treatment for qualifying patients. An MSF program in South Africa saw a rise of over 1100 percent in the number of people voluntarily seeking testing after ARV therapy was introduced.<sup>40</sup>

Another public health consideration for expanding access to AIDS treatment is that ARV therapy may reduce the level of infectiousness. The evidence is mainly indirect, but convincing. Antiretrovirals act to suppress active replication of the virus and have been shown to reduce viral load in blood and semen.<sup>41</sup> Decreased viral load has been associated with lower risk for transmission of HIV infection.<sup>42</sup>

Unfortunately, easy access to ARVs in the absence of strong prevention programs can introduce new dangers, both for individuals and populations. While viral loads in patients undergoing treatment may fall below "detectable" levels, it does not necessarily fall to zero.<sup>43</sup> The risk of infection through sex with a person undergoing antiretroviral therapy treatment is reduced but **not** eliminated. This may not be fully appreciated by the wider population; alarming new trends in parts of the US and Europe show a decrease in the level of safer sex practiced among people living with HIV/AIDS and people at high risk for contracting the virus.<sup>44</sup> Studies among traditional high-risk groups suggest the availability of treatment may be reducing perceptions of risk. In the US, while many people living with HIV/AIDS are reaping the lifesaving benefits of improved treatment, prevention efforts remain inadequate and should be stepped up. Prevention and treatment must be strengthened together, in balance. A one-sided focus on either component reduces the efficacy of the overall program and hampers health authorities' capacity to control the pandemic.

## Treatment Programs Create Political Leverage

Health experts have noted that treatment for current victims of a disease is easier to "sell" politically than prevention programs whose beneficiaries are not identifiable men, women, and children but rather an abstract, faceless statistical population. "Politicians would usually prefer to point to living individuals whose lives they can claim to have saved, than to point to a line on a graph representing future deaths averted because of their support for prevention." This may be because those who benefit from prevention "cannot be sure that they in fact benefitted as individuals and are therefore less likely to be grateful (and to show their gratitude at the ballot box)."<sup>45</sup>

We should hear the warning that emotional appeals may introduce confusion into rational debates on AIDS control. However, supporters of strengthened prevention efforts are mistaken to view the political appeal of AIDS treatment as necessarily harmful to the cause of effective HIV prevention work. On the contrary, the rising political force of AIDS treatment activism is the best hope for mobilizing greater worldwide support for all aspects of the AIDS struggle, including prevention.

These debates would not be happening at all -- and they would not be generating the current level of international attention and concern -- if it were not for the emotional and moral intensity of campaigns led by treatment activists. Through the pathos of individual faces and stories, a decisive human truth emerges: the lives of people with HIV/AIDS matter. When policymakers and ordinary people respond to this truth and allow it to influence their decision-making, it is a sign that political and economic rationality can be informed by solidarity and compassion.<sup>46</sup>

The demand for treatment creates a degree of political leverage that prevention alone is unlikely to generate.<sup>47</sup> By forming a strategic alliance with the treatment community, HIV prevention advocates can add moral and political force to the analytic strength of their call for dramatically increased international investment in prevention. Just as prevention and treatment reinforce each other in AIDS control efforts, so they should join forces in the political arena to demand increased resources for balanced, multisectoral AIDS control programs.

## HIV/AIDS and Health Care in an Unequal World

At the dawn of the ARV era, observers like Dr. Jonathan Mann had discerned an evolving economic caste system within the global AIDS

struggle. The 1996 Vancouver AIDS conference at which HAART was introduced bore the title "One World, One Hope." Mann noted the title's unintended irony: "Today, there is not 'one world' against AIDS, and this reality of separatism ... threatens progress against AIDS and is the central reason why real leadership and coherent global action against [the pandemic] have become virtually impossible." Unfortunately, Mann's concern with "separatism" has lost little of its relevance in the years since he issued his warning.<sup>48</sup>

Fundamental considerations of equity demand that we organize to transform a system that assigns people with identical clinical conditions to life or death, based only on their ability or inability to pay. Of course, the determination of health outcomes by economic status is in no way unique to HIV/AIDS. Yet this fact increases, rather than reduces, the importance of confronting egregious injustices in the availability of AIDS treatment. AIDS crystallizes the biological and structural violence of a whole global system in which poverty kills by direct and indirect means. But breaking this cycle for AIDS would be a powerful step toward justice in health care and the sign of a renewed determination to foster solidarity in a deeply divided world. Thanks to the work of treatment activists, AIDS focuses public attention and concern; other deadly diseases that disproportionately affect poor people have not created similar constituencies. The charged character of HIV/AIDS debates should be used politically to maximum effect. AIDS can become the "wedge issue" that enables a new level of awareness, debate, and action to attack the full range of global health inequalities.

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