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Stellenbosch University Researchers Call for Shift in Thinking about Antiretroviral Treatment

Summary:

'Nobody Left Behind' is the title of the 'Melbourne Declaration', the signature high-level advocacy statement of the 2014 International AIDS Conference. As AIDS researchers and activists from around the world gather in Melbourne this week for AIDS 2014, researchers at the Stellenbosch-University-based South African Centre for Epidemiological Modelling and Analysis (SACEMA) have released a policy brief highlighting what they argue is a long overdue shift in thinking, on the question of antiretroviral treatment initiation for people living with HIV.

In short, they argue that the time is right for the scientific and activist community to cease debating who is 'eligible' or not for HIV treatment; instead HIV positive people should be empowered to make this decision for themselves in consultation with a supportive and well-trained health care worker. Then, they say, investigation and debate can shift to the many 'next questions' which arise in any case, whether they are dealt with head-on or not.

Contextual aside:

It has long been clear from many studies that no intervention for HIV-infected patients has anything like the health impact of antiretroviral drugs (ARVs). For the first decade or so of use, which is the timeframe over which we have amassed the most data, ARV Treatment (ART) appears to give people living with HIV almost the same health and survival as HIV negative people. Also, nothing besides abstinence or condoms (noting that the consistent resort to either is essentially unheard of) provides anything like the prevention effects of ARV. This is because antiretroviral treatment, while not currently able to cure HIV infection, dramatically reduces the rate of viral replication, making it extremely unlikely that a well-treated patient will spread HIV. And yet, debate continues about when to offer treatment, according to what might be 'optimal' criteria juggling a plethora of considerations from cost, short and long term benefits, pharmacological and psychological side effects, and systemic risks. This means that some people who feel they want the benefits for themselves and their loved ones, must wait until they become 'sufficiently' far advanced in the progression of the disease, to be 'eligible'.

What is at stake:

Scientists and activists are increasingly clear on the benefits and moral imperative of providing treatment. However, it is also clear that the most heavily affected countries, largely in sub-Saharan Africa, cannot overnight, even with the best of intentions or the greatest commitment of political will, actually guarantee the right to ART for every HIV infected person. Policy makers run the risk of appearing insincere or inept if promises appear to be disregarded, or targets are not even approximately met. Rapidly growing ART programmes, which are in any case ballooning under health departments' feet,

really are uncharted waters with few precedents to guide navigation. Caution, in the face of many uncertainties, maintains the debate on who is eligible for treatment.

Eventually, there will be many millions of people on ART, both in South Africa and beyond, though more here than in any other country, at least for the foreseeable future. They will need to be monitored and supported in an ever shifting landscape of treatment fatigue, adverse events, cumulative toxicity, and imperfect control of uneradicated virus. What appears avoidable today, in terms of burden on the health care system, through a delay in throwing wide the doors of treatment, will in any case soon be eclipsed by a rising tide of patients on treatment. New cases rapidly accrue into the system, even as the majority of those already on treatment are stabilized in near normal health, at least for a decade or more (much more, one hopes). Huge and rapid rises in the numbers of people on treatment are in any case inevitable – and effective treatment is arguably the best way to stem the flow.

Alex Welte, Director of SACEMA, a National Research Foundation Centre of Excellence, put it this way:

“For too long, the multi-faceted challenges to implementing an effective treatment programme have been cast as a central debate about how best to ration antiretroviral medication. Every good leader or manager knows that solutions for today sow the seeds for the challenges of tomorrow – and that this is no reason to delay critical initiatives. There is no universal formula that tells patients and clinicians when to start ART, and tells health departments what their targets and guidelines should be. When we stop obsessing over the ultimately unanswerable question of when ‘best’ to start treatment, we will have more time, money and energy to deal with the difficulties we will in any case eventually face: of safely maintaining an unprecedented number of patients on long term medication, and of dealing with the inevitable cost and limitations of such a massive, hopefully sustained, response to a single disease.”

Reflecting on the current state of debate as emerging in various AIDS 2014 affiliated initiatives, Wim Delva, Senior Research Fellow at SACEMA commented:

“The Melbourne declaration, as drafted, does not specifically deal with the matter of guaranteed access to treatment at any stage of HIV infection, but ‘Nobody Left Behind’ is a broad moral imperative, and we hope the dots are joined appropriately. People increasingly call for a vision for an end to AIDS, and this is appropriate. To get there, we must first have an end to dithering about treatment, and we should embrace the next round of difficulties and concerns as evidence that we are biting the bullet of facing the long term reality of millions of people taking critical, but not innocuous medication. This is their best bet for a healthy future and safe relationships.”

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