27 February 2014

Community consensus statement on the use of antiretroviral therapy in preventing HIV transmission

Introduction to the statement

1. This is a community consensus statement on the use of antiretroviral therapy (ART) to reduce the risk of HIV transmission from people living with HIV. It does not cover the provision of antiretroviral drugs to people who are HIV negative to reduce their risk of acquiring HIV (pre-exposure prophylaxis, PrEP). It is also not specifically about access to ART in general.

2. This statement is issued with the underlying principle in mind of safeguarding the health and wellbeing of people living with HIV, whether they choose to take ART or not. It supports the human rights, dignity and self-determination that enable people to make the choices that most benefit their health and wellbeing and that of their partners.

3. HIV prevention should not be viewed as an aim of ART that is separate from the overall health and wellbeing of the person taking it. The provision of ART for prevention purposes should never violate individuals' rights to health, self-determination, consent or confidentiality.

4. This statement is a specific community response to a number of HIV treatment guidelines and policies issued in the last few years that have addressed treatment as prevention as part of their remit. There has been divergence of recommendations and opinion in this area within guidelines, partly due to divergence of opinion about the implications for human rights, public and individual health, and resources, of providing ART for reasons of prevention.

5. This statement is not issued to supplant these guidelines and policies but to establish some guiding principles. It is issued within the broader framework of the Greater Involvement of People Living with AIDS (GIPA), the HIV Leadership through Accountability programme, and the Positive Health, Dignity and Prevention policy framework established by GNP+ and UNAIDS.

6. This statement was originated by the European AIDS Treatment Group in collaboration with NAM/Aidsmap.com. It was developed via an online consultation, a community meeting in September 2013, and further consultation with key opinion leaders in the HIV community. It is now offered for sign-on and endorsement by individuals and organisations in the community of people living with and affected by HIV.

Statement

7. There is conclusive evidence that effective ART considerably reduces an individual's risk of transmitting HIV through vaginal sex, and convincing epidemiological and limited direct evidence that this applies to anal sex and needle sharing as well. (See appendix two for a summary of our current state of knowledge.)

8. These findings strengthen the evidence base for previous declarations on the potential for prevention by ART. They present great opportunities but also challenges for individuals living with HIV.

9. ART has the potential to relieve people living with HIV of the burden of guilt, anxiety and fear of criminal liability at the prospect of transmitting HIV to others. A community manifesto issued in 2008 said that treatment as prevention "favours quality of life and – even more – social integration of people with HIV". A sign-on community statement issued in 2011 said that earlier initiation of ART "is a powerful, potentially cost-saving tool that can help end the AIDS epidemic." Some surveys have shown that people living with HIV rate no longer being able to transmit the virus as among the most important advantages of a hypothetical cure for HIV infection.

10. However, using ART as prevention also has implications for human rights, resource allocation, and the planning and integration of HIV care and treatment. The 2011 statement cited above added: "Biomedical, structural and behavioral interventions need to be delivered in the context of a community-centered mobilization for health and rights".

11. On an individual level, taking ART for life is a decision that most people will need time to consider and which they should not feel pressured into. ART for prevention has potential long-term side-effects, and once started will probably need to be taken for life. In addition, ART, unlike other methods including condoms, cannot prevent most other sexually transmitted infections (see endnote).

12. In many countries, the vulnerable populations that need ART most have the worst access to HIV services, in part due to criminalisation and stigma. The prevention benefits of ART cannot be realised until these are addressed.

13. The potential to use ART as a public health measure could potentially lead to people with HIV being or feeling coerced into taking an HIV test or ART. This is of particular importance to people belonging to stigmatised populations who may be, or fear being, exposed or endangered by such programmes. There must therefore be safeguards against pressure, coercion or legal threats, in the name of public health, being applied to people who do not yet wish to take ART. We oppose any public health measures, implemented or proposed, that are based on compulsory HIV testing or treatment.

14. On an individual level, providers should be alert to the possibility of coercion by partners or others and establish that the person living with HIV wishes to take ART of her/his own free choice. This may be a particular issue in situations of gender-based violence or coercion.

15. ART for people who test HIV positive should not be adopted as the sole component of HIV prevention programmes. It should not supplant, or weaken access to, existing methods of proven effectiveness. Scientific studies of biomedical HIV prevention methods have all integrated ART with other proven HIV prevention methods; treatment access programmes must be designed similarly. These methods include the provision and promotion of male and female condoms and lubricant, the provision of sterile injecting equipment, voluntary medical male circumcision, risk-reduction counselling and motivational programmes, and social support programmes to help people minimise their sexual risk.

16. The recognition of the efficacy of effective biomedical prevention methods, and their integration into existing programmes, may be an opportunity to refresh, rethink or challenge community norms that are not sufficiently protective, are difficult or impossible to sustain for some people, or are counterproductive. Typically these norms have required 100% adherence to a strategy such as condom use or sexual abstinence before marriage, or define condomless sex as unsafe in all contexts.

17. Equally, however, it is important that programmes that extend access to ART are carefully thought through and designed so that existing methods and community norms that safeguard people's sexual health and wellbeing are not negatively affected, especially in situations where populations maintain high adherence to existing methods that could be potentially eroded. Examples include high levels of sterile equipment use by people who inject drugs and condom use by sex workers.

18. The provision of ART cannot stand alone as a prevention method. Access to voluntary HIV counselling and testing, access to free or affordable HIV care, access to effective and tolerable ART and access to support for consistent adherence are necessary conditions for the effective use of ART as treatment or as prevention.

19. ART as prevention presents opportunities and challenges regarding the supply of drugs and healthcare system capacity and resource prioritisation. The cost of ART must decrease further if it is to be provided to all who fall within the 2013 WHO treatment guidelines and to those who may wish to use it for prevention outside those guidelines. As ART is associated with higher rates of retention in care and viral suppression, wider use, especially accompanied by falls in price, may be cost-effective, and even cost saving.

20. Providing ART for prevention must not in any way impede efforts to make ART available as treatment to anyone who needs it for clinical benefit. They must both be part of a general programme whose aim is to improve the physical and emotional health and social position of people with HIV and their partners.

21. Patient readiness is crucial to support the high levels of adherence necessary to suppress HIV. We recommend adoption of the patient readiness paradigm, as outlined in the EACS treatment guidelines. For people with high CD4 counts, readiness should be explored early and should not be deferred until CD4 criteria for clinical need are reached.

22. Many people with HIV remain unaware of the prevention benefits of ART. We recommend the adoption of the BHIVA/EAGA statement that healthcare providers should inform all patients of the potential prevention benefits of ART. We also recommend provision of patient materials suitable for different ages, knowledge levels and ethnicities explaining the prevention benefits of ART, and updating them on the latest research (*Appendix 1 lists unmet research needs*).

23. The prevention benefits of ART are even less well known among people who are HIV negative but vulnerable to HIV. The current partners and potential partners of people with HIV need accurate and clear information on the effect of ART in reducing the likelihood of HIV transmission and providers need training to give this. This needs to be done in a way that they can use to strengthen their ability to stay free of HIV infection rather than undermine it, and to take responsibility for their own and their partners' sexual health.

24. Most models predict that ART by itself will not end the HIV epidemic. Expanding access to ART as prevention must not endanger access to other proven prevention methods or to reduce investment in research into new methods. Providing ART to people with HIV, however, not only saves lives but may also be a necessary component of what it takes, ultimately, to end the HIV epidemic.