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Treatment as Prevention: recognising the creative potential of antiretroviral medications

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On the 12th of June 2012 I attended a summit organised by The International Association of Physicians in AIDS Care (IAPAC) and the British HIV Association (BHIVA). It focused on implementation challenges and opportunities of biomedical prevention, TasP and pre-exposure prophylaxis (PrEP), and was titled “Controlling the HIV Epidemic with Antiretrovirals”. The conference facilitated discussion on the use of existing antiretroviral drugs for HIV prevention, an idea much encouraged by the success of the HIV Prevention Trials Network (HPTN) 052 Study in 2011. The HPTN 052 study was a randomized clinical trial that evaluated whether antiretrovirals can prevent the sexual transmission of HIV within heterosexual couples in which one partner is HIV-infected and the other is not. The trial was ended four years ahead of schedule due to evidence showing that initiation of antiretroviral therapy (ART) before the previous guideline of 350 CD4 cells/mm³ reduces the risk of an HIV-positive individual transmitting HIV to their negative partner.

As a result, HPTN 052 has brought a revival of hope for slowing rates of HIV infection (We CAN end the AIDS epidemic, June 2011). Although scientists have welcomed the data as opening the possibility of a significant shift in the global AIDS response, others have raised fears that that using antiretroviral medications to prevent HIV transmission, referred to as ‘treatment as prevention’ (TasP) may encourage the remedicalisation of HIV prevention. As Vinh-Kim Nguyen et al. (2010) defined it, remedicalisation is a paradigm shift in the battle against HIV and AIDS that signals a return to the early 1980s view of the epidemic as ‘a medical problem best addressed by purely technical, biomedical solutions whose management should be left to biomedical professionals and scientists’ (Nguyen et al. 2010:1).

Indeed, in light of new findings, the global response to the epidemic has been increasingly concerned with biomedical, structural and behavioural interventions aimed at scaling up HIV testing, clinical and laboratory monitoring and support of patient adherence. According to Nguyen et al., the growing emphasis on TasP is occurring at the expense of non-medical prevention efforts such as safe sex education or harm reduction

strategies. It also risks ignoring a broader discussion inclusive of local epidemiological and socio-historical contexts. Critics argue that debates emerging under TasP do not account for community orientated and context-sensitive prevention, which has often originated from high-risk populations. These include the practice of 'negotiated safety', which offers a possibility of risk avoidance other than using condoms in regular relationships as long as safe sex agreements are negotiated to cover sexual behaviour outside those regular relationships (Kippax and Race 2003: 3-4).

Although populations targeted by prevention strategies appear to actively change those strategies, the framework of remedicalised prevention draws attention away from that fact. As a part of the audience of the "Controlling the HIV Epidemic with Antiretrovirals" Summit, I observed how social actors appear in the discussion mostly in the context of patients' adherence to ART regimes. Yet I believe that the question of 'how to make them take pills' could be replaced with a much more imaginative debate on how investing in new ways of using antiretroviral drugs may alter an already rich environment in which HIV positive people live and access health care. As experience of living with HIV differs accordingly to geographical location (see for example, Rosengarten & Michael, 2009a; 2009b; Davis & Squire, 2010), we could ask if ART may produce different outcomes in various contexts. It is the role of social scientists to carefully attend to its conditions and potential trajectories.

Currently, more than 70 percent of people living with HIV lack full access to treatment (Rosengarten 2009: 3). Places where ART is available experience difficulties that challenge and/or alter the course of the disease and its treatment. These include HIV-related stigma, medication side effects that may increase uptake of alternative therapies, and heterogeneous ways in which people form relationships with their sexual partners and within their communities (see for example Race 2001, Rosengarten 2009, Tiruneh 2011). I argue here that understanding what informs patients' thinking around treatment requires us to engage with such complexities as well as with biomedical advances and their implications.

Pharmaceutical interventions have already been recognised as having profound ethical and social consequences. Studies have shown how they generate a new kind of a patient who can, and is expected to take responsibility for his or her well-being (Rosengarten et al. 2004). Indeed, the possibility of monitoring viral loads through blood tests allowed providers to 'see' a patient's adherence and discipline them accordingly. It also created the possibility for patients to adopt inventive and diverse styles of risk reduction. Research in Australia demonstrated how gay men spoke of being either the insertive or receptive partner in unprotected anal

intercourse depending upon their HIV antibody status. Respondents also described how low or undetectable viral loads lowered risk of infection (Rosengarten, Race, & Kippax 2000).

In HIV prevention the social and the biological are co-constitutive. Kane Race (2003) proposed that forming a response to HIV risk is a reflexive mediation between embodied practices and medical knowledge. Race shows how historical, diverse gay communities incorporate medical knowledges, prevention tools and varied ideas about the risk of HIV transmission in a way which sustains gay culture and recasts gay men's agency as creatively achieved. His argument revises the presumption of the target of prevention as a passive individual measured against behavioural models of adherence.

Neither biomedical advances nor the HIV-positive individuals that they act upon can be assumed to be passive or invariable. Acknowledging their agency opens up novel possibilities of approaching issues such as the ethics of TasP. According to medical ethics, one of the fundamental requirements that must be met by healthcare providers is that of patient autonomy. This implies that every patient has a fundamental right to autonomy in making informed decisions about their treatment, free from coercion. Such a position assumes that:

- doctors possess a complete knowledge about the virus as well as the drugs and their influence on the human organism
- such knowledge can be communicated to the patient in a straightforward way
- patients are able to make decisions independently of their healthcare providers and the people they are surrounded with.

Though I am far from suggesting that physicians are violating patients' rights in how they provide advice and prescribe medication, I argue that the principle of patient autonomy is often incommensurable with the conditions under which HIV care can be provided. Firstly, the knowledge of TasP and its effects on patients' health is still widely debated. Yet, in New York and San Francisco anybody diagnosed with HIV is offered ART regardless of their CD4 count (Krellenstein and Strub 2012). Critics assert that doctors pursue the implementation of TasP by describing the individual benefits of an early start to ART, even though the research on the benefits and risks of initiating the treatment before clinically indicated is far from conclusive (Krellenstein and Strub 2012). It is important to acknowledge that TasP policies are entering clinics that have a long history of discouraging an early start of therapies due to pharmaceuticals' toxicity and their side effects. Instead of witnessing a straightforward application of TasP policies, clinical spaces may become arenas where new ideas are negotiated alongside, and often in contradiction to, old

beliefs about ART.

Also, conversely to the principles of patient autonomy, the translation of knowledge during doctor-patient consultation is unlikely to be straightforward as patients often offer their own interpretations of medical recommendations (e.g. Coyle 2008, Gil et al. 2010). In some local contexts, for example, patients with full access to antiretroviral drugs may consider TasP a liberating tool that enables them to protect sexual partners. On the other hand, some individuals may lack confidence to discuss an early initiation of ART with their physicians and some may be discouraged by side-effects or difficulties in sustaining adherence regimes which add to the burden of illness. TasP may also introduce discussion about trust in a relationship and partners' responsibilities for each other's health.

Finally, it must be acknowledged that patients make decisions that incorporate the opinions of doctors they trust, fellow patients, or partners who they love (e.g. Kippax and Race 2003, Kippax 2010). A study of serodiscordant heterosexual couples in Kenya who were offered a choice of antiretroviral prevention methods found that not all participants were willing to use early treatment for prevention. Instead, a majority of HIV-negative participants expressed their readiness to share the responsibility for preventing HIV transmission through taking a daily dosage of antiretroviral drugs to reduce their risk of becoming infected (PrEP) (Heffron et al. 2012). This may indicate that sexual partners of people living with HIV are active actors in the decision making process.

The complexity of TasP cannot be assumed and should not be underestimated. Investigation into TasP, however, can only be done if efforts that present ARVs as a straightforward means of prevention are abandoned in favour of a richer debate on the potential trajectories of biomedicalised prevention. Both social and biomedical sciences have to recognise the creative potential of ART for creating new dynamics in clinic spaces as well as within the relationships people form outside it. The history of the epidemic shows how communities develop their response to HIV risk through incorporating medical knowledges, prevention tools and varied ideas about the risk of HIV transmission. In future, we might expect that consequences of biomedical interventions will also introduce varied phenomena, e.g. new ways of seeking trust and pleasure within relationships and new forms of safe sex negotiation.

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