

HIV treatment in 2013-Between Access and Cure or “Let’s become Political”

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Talking about HIV/AIDS in 2013 from the point of view of a developed country in the Western hemisphere enlightens the development of two decades of HIV treatment: The introduction of highly active antiretroviral therapies (ART) including dramatically decreased the mortality of AIDS since 1996 in the EU, USA and Japan. We have learned about possibilities and limitations of antiretroviral therapy. Sustained viral suppression depends on a number of factors, which have to be controlled by the patient and physician. (i) HIV therapy only is effective over a longer period of time, if taken continuously and adherently by the patient. (ii) The management of numerous side effects, such as haematological abnormalities, dyslipidemia, polyneuropathy, mitochondrial toxicities, insulin resistance, organ toxicities and lipodystrophy, to mention only a few, is a challenge for physicians. (iii) Viral resistance and cross resistance within all classes of antiretroviral drugs are complicating the situation and lead to therapy failures increasing with the duration of ART. Treatment response rates range from 70-90% in therapy naïve patients but decline to approximately 50% in patients who received several ART during treatment history. However, the life expectancy of a person infected with HIV in 2013 in Germany is expected to be only marginally decreased in comparison to HIV negative subjects.

The so-called Berlin patients even arouse hope amongst patients, physicians and scientists that HIV may be eradicated in humans in the medium term. Although this case is currently not reproducible it seems to have opened doors towards treatment to cure. We have learned that the approach of cure can only be a collaborative one: genetic and transplantation medicine meets pharmacological treatment and a number of different clinical specialisations, and finally we also ought to convince benefactors to pay for cure.

At the 2013 IAS congress in Kuala Lumpur these discussions encountered a new WHO approach for the early treatment of HIV in the less lucky parts of the world. At the 13th of July, “the United Nations launched a new “framework which seeks to give 15 million people with HIV/AIDS access to antiretroviral treatment by the year 2015. The framework, entitled Treatment 2015, offers countries and partner’s practical and innovative ways to increase the number of people accessing antiretroviral medicines that will enable those living with HIV to live longer and healthier lives, as well as help prevent new infections. Treatment 2015 takes into account the new consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection released last month by the World Health Organization, which recommend that people living with HIV start antiretroviral therapy (ART) much earlier” [1].

According to UNAIDS, 9.6 million people living with HIV had access to ART in 2012, and the target to reach 15 million is a push to achieve the Millennium Development Goal that seeks to stop and repel the spread of HIV/AIDS by the 2015 deadline.

If you take in account the new antiretroviral guidelines, a number of nearly 15.2 million additional children, women and men should be treated with ARVs in future. However, the report notes

that “30 countries account for 9 out of 10 people who are eligible for antiretroviral therapy but who do not have access”. The new guidelines say in brief that people should be tested more regularly, start treatment much earlier at CD4 cell counts <500 cells/ μ L and shall take newer HIV drugs such as tenofovir-DF/emtricitabine and raltegravir instead of zidovudin, stavudin or nevirapine. HI-viral load should be used as therapy success control rather than the CD4 cell count.

This certainly raises questions:

(1) Such a framework for diagnosis and treatment is sometimes even more expensive than treatment itself and due to its necessity of highly developed medical infrastructure much harder to implement than spreading the drugs.

(2) The WHO expects the cost for a year of treatment to drop down to 127 \$ per person. The WHO however bans substances who undoubtedly have side effects but are produced as generics by a number of countries, e.g. India, Thailand or Brazil, hotspots of the AIDS epidemic.

(3) What about access to treatment of HIV+ gay men in Eastern Europe, women in Islamic countries or i.v.-drug users in East Asia? The framework lacks a political statement and plan towards participation of all affected social populations. As Bertrand Audoin, secretary of the IAS, recently pointed out in the New York Times, “three decades of experience in responding to the H.I.V./AIDS epidemic has provided indisputable evidence that depriving those groups most at risk of H.I.V. infection of their human rights drives them to underground. The impact is twofold: Not only do sex workers, men who have sex with men, drug users and transgender people live in daily fear of reprisals, but precisely because of that they are considerable less likely to access basic health services (...) Education campaigns that reach the general population are unlikely to reach these populations, and it is no surprise that in many parts of the world H.I.V prevalence among (these groups) is much higher than in other and populations” [2].

In 2013, HIV has become a chronic, treatable disease for those who have access to treatment and medical resources through e.g. social and health insurances. Cure seems to be an option within the next two decades. In contradiction more than 60% of HIV infected

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who should be treated have no access to treatment today and certain populations will not have it in the next 20 years unless a debate about sexual orientation, poverty and discrimination can be implemented in various countries of the world.

Thus, HIV science can only be successful in treatment and eradication of HIV/AIDS unless we become political.

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