# Treatment 2.0

## What is Treatment 2.0?

Designed and developed by UNAIDS and the WHO in June 2010, Treatment 2.0 is an overarching HIV/AIDS strategy that aims to markedly improve access to, and optimize the prevention benefit of, antiretroviral therapy (ART) globally.[1] The 10-year initiative articulates the need for a coordinated plan of action across multilateral, bilateral, and country-level agencies to dramatically simplify and scale up efforts toward universal access to HIV care and treatment.[2-4]

## What is the context and history behind Treatment 2.0?

Treatment 2.0 represents the culmination of 10 years of programmatic experience and lessons learned from global HIV/AIDS care and treatment efforts. Treatment 2.0 builds upon:

- The 3 by 5 Initiative (3 million people on ART by 2005): On World AIDS Day in 2003, the UN General Assembly committed to putting 3 million people on ART by the end of 2005. At the time only 400 000 people in low- and middle-income countries (LMIC) had access to ART, while over 30 million were living with HIV. Although the ultimate goal of 3 by 5 was not achieved until 2007—2 years later than expected—the initiative successfully tripled the number of people on ART to approximately 1.3 million by the end of 2005.[5-6]
- The 15 by 15 Initiative: In 2011, the UN General Assembly recommitted to increasing access to ART by setting a target of 15 million people on treatment by 2015.[7] The WHO suggested that achieving this target could potentially avert an additional 12 million new HIV infections, but that it would require increased funding as well as a greater focus of HIV/AIDS investments in "only what works."[8]
- Findings from the HPTN 052 Study in 2011: A groundbreaking, randomized-control trial among heterosexual serodiscordent couples demonstrated a 96% reduction in transmission when the HIV-positive partner started ART early.[9] The study demonstrates that ART may have a substantial prevention benefit for HIV-negative sexual partners of heterosexual people living with HIV/AIDS (PLHIV).[10, I]

## What does Treatment 2.0 aim to accomplish?

- Proposed targets by 2015:
  - Elimination of new HIV infections in children[1,2,11]
  - Reduction of TB deaths among people living with HIV by 50%[1,2,11]
  - 15 million people on ART[1,2,11]
- Required investment:
  - Approximately $22 billion annually by 2015 (investment as of December 2011 was approximately $7 billion)[1,2,11]
- Proposed outcomes by 2020:[1,2,11]
  - Avert 12.2 million new infections[1,2,11]
  - Avert 7.4 million AIDS deaths[1,2,11]
  - Gain 20.4 million life years[1,2,11]

The following table outlines the 5 pillars of Treatment 2.0. These pillars are meant to guide progress toward achieving Treatment 2.0's ambitious goals and provide a framework for a more detailed implementation plan.

[I]Please see the MSMGF's fact sheet on Treatment as Prevention to learn more about the implications for MSM. http://www.msmgf.org/index.cfm/id/81/Publications/

| Pillar | Public health significance |
|---|---|
| **Creating a better pill and diagnostics** | Public and private partners should develop a 1-pill regimen that is low in toxicity and durable against drug resistance. Simple, cost-effective and technologically appropriate diagnostics for LMIC must be created and brought to market in order to reduce costs and burden on health systems.[1,2,4,5] |
| **Treatment as prevention** | Given that treatment lowers a person's viral load and decreases the risk of infecting others, treatment is a viable and evidence-based strategy for preventing the spread of HIV. In light of HPTN 052 and other studies that show ART may result in additional prevention benefits such as lower rates of tuberculosis, malaria, and maternal death, ART should be an integral component of HIV prevention efforts.[1,2,4,5] |
| **Stop cost from being an obstacle** | Decreasing the cost of medications will enable funds to support more patients and improve overall access. In turn, higher treatment coverage will lead to lower morbidity and mortality, as well as more economically productive life-years for those living with HIV/AIDS and for those who remain uninfected as a result.[1,2,4,5] |
| **Improve uptake of HIV testing and linkage to care** | Less than half of PLHIV globally know their HIV status, and programmatic experience has highlighted challenges to successfully linking and retaining PLHIV into care and treatment. Country-level efforts to decentralize and integrate HIV/AIDS services with other health services have produced promising results, including increased HIV testing rates and utilization of prevention and treatment services.[1,2,4,5] |
| **Strengthen community mobilization** | Engagement with local, community-based organizations and groups has proven effective at improving access to HIV prevention and treatment services for high-risk populations such as MSM, sex workers, and people who use drugs. A recent WHO evaluation found that local CBOs led by PLHIV are best positioned to target and reach high-risk populations.[1,2,4,5] |

## What are the foreseeable challenges and barriers to achieving the goals of Treatment 2.0?

There are many challenges and potential barriers to achieving the ambitious goals of Treatment 2.0. A few examples include:

- Resource limitations within the health sector: Lack of health sector funds and/or qualified, skilled health workers, insufficient supply of antiretroviral medications, and weak and/or disintegrating health infrastructure may hamper or slow scale-up of Treatment 2.0.
- HIV/AIDS stigma, homophobia, and lack of political will: AIDS stigma and homophobia impede health-seeking behavior and access to HIV/AIDS prevention and care. In order to eliminate these barriers, country-level governments and health ministries must first seriously engage in developing policies and practices that mitigate stigma, decriminalize homosexuality, and meet the needs of vulnerable, underserved populations most at risk for and disproportionately affected by HIV.
- Economic downturn: The global recession has constrained donor and country-level HIV/AIDS budgets worldwide. Mobilizing the necessary funds to increase the global envelope of HIV/AIDS funding from $7 billion to $22 billion will be a substantial challenge to realizing the goals of Treatment 2.0.[12]
- Potential priority shifting within pharmaceutical markets: In order to develop a better pill and diagnostics, the pharmaceutical industry must remain focused on research and development. However, the market signals that both pharmaceuticals and their generic counterparts are shifting their interest from HIV/AIDS toward non-communicable diseases (eg, cancer, diabetes, and/or cardiovascular disease).[12]
- Perceived conceptual divide between prevention and treatment: In light of the results of the HPTN 052 trial, prevention and treatment of HIV cannot be perceived as mutually exclusive concepts, but should instead be understood as highly interrelated and mutually reinforcing of one another.[12]
- Lack of mobilization efforts directed toward communities/groups most affected by HIV/AIDS: There is no "silver bullet" for ending the AIDS epidemic. However, any success or advancement toward the goals of Treatment 2.0 will be highly dependent on mobilizing communities most affected by HIV/AIDS through education and raising awareness.[4-5,12]

## What does Treatment 2.0 mean for gay men, other MSM, and relevant service providers?

Treatment 2.0 officially recognizes the need to both improve and expand access to HIV/AIDS services for key populations such as MSM, people who use drugs, sex workers, and transgendered people in LMIC. Furthermore, Treatment 2.0 acknowledges that expansion of services to gay men and other

MSM entails promoting and protecting their human rights, as well as working to mitigate stigma and homophobia.[1]

Previously, prioritization of outreach and provision of services to MSM was only perceived necessary in North America, Europe, and other regions with "concentrated epidemics."[II,13] However, current research highlights the importance of addressing MSM and other key populations within "generalized epidemics" such as those in sub-Saharan Africa as well.[III,13,14] Recent epidemic modeling exercises conducted in Kenya show that successful targeting of MSM could have a positive impact on overall infection rates.[15] While members of key populations may represent the majority of people contracting and transmitting HIV in concentrated epidemics, these populations may also be active in generalized epidemics and may actually drive a substantial proportion of the epidemic in some cases.[15]

Given guidance from Treatment 2.0 and recent research findings, efforts to improve and increase service access for MSM are essential to effective prevention and care strategies. Donors such as the US President's Emergency Plan for AIDS Relief (PEPFAR) are now, more than ever, encouraging targeted interventions and services for MSM and supporting policies that promote human rights.[16]

Unfortunately, the field of HIV/AIDS is still far from providing gay men and other MSM around the world with broad access to prevention and care. From June through August 2010, the Global Forum on MSM and HIV (MSMGF) conducted a global study of more than 5000 gay men, other MSM, and their health service providers regarding access to and knowledge of the spectrum of HIV prevention strategies.[17] Data from this study indicated that less than 30% (29.9%) of MSM believed that antiretroviral medications (ARVs) were easily accessible, particularly those who were residing outside of North America and Europe. More than half (53.9%) of MSM worldwide reported that ARVs were either hard to access or not accessible at all.[17]

These findings reveal that the generalized approach to Treatment 2.0 is not enough. In order to increase access to HIV treatment, more efforts are needed to combat homophobia and stigma—key barriers that impede access to prevention and care for MSM. More efforts are also needed to educate service providers about MSM and their specific needs. Providers must be committed to creating a stigma-free environment and understanding the concerns that gay men and other MSM may have in seeking HIV prevention and care services.[14]

## Conclusions

Treatment 2.0 has enormous potential to have a positive impact on the global HIV/AIDS epidemic and expanding prevention and care of HIV for gay men and other MSM. Given the rapid timeframe for implementation of Treatment 2.0, it may be tempting for some stakeholders to neglect the socio-cultural factors linked to HIV infection among MSM like stigma and discrimination. Therefore MSM advocates should be involved at all levels of addressing the epidemic and work to ensure that Treatment 2.0 supports the promotion and protection of human rights globally in order to improve and expand HIV prevention and care for gay men and other MSM.

[II]The term "concentrated epidemic" refers to scenarios where less than 1% of the general population is HIV positive, but more than 5% of any high-risk group is HIV positive.
[III]The term "generalized epidemic" refers to scenarios where more than 1% of the population is HIV positive.

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