EDITORIAL

Moving past the 'pre-treatment' era of HIV care

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In 2003, the World Health Organization (WHO) first published human immunodeficiency virus (HIV) antiretroviral therapy (ART) guidelines, recommending treatment for persons with a CD4 count ≤ 200 cells/mm³. Shortly thereafter, the Global Fund and the President's Emergency Plan for AIDS Relief took the first steps towards what has become a massive scale-up of ART to over 12 million people worldwide, arguably the greatest public health achievement of our generation. These events ushered in a welcomed new phase of the epidemic in low-income countries, with significant reductions in HIV-related mortality and increased life expectancy for those infected.¹ However, whereas provision of ART to those who met the criteria provided demonstrable benefits, these same criteria necessarily dichotomized HIV treatment services between those who got it and those who watched, waited, and, more often than not, wandered away. Countless studies have documented staggering rates of attrition from HIV care between HIV testing and ART eligibility across the African continent, and beyond.²

In this issue of *Public Health Action*, Shankar and colleagues present rare programmatic data on pre-treatment loss to follow-up from India.³ Among a cohort of approximately 700 patients who did not meet the criteria for ART initiation at the time of initial presentation, only approximately 60% were retained in HIV care at 12 months. Perhaps not surprisingly, unmarried patients, those residing in rural areas, and those with Stage III or IV disease but who did not meet national treatment criteria (presumably with tuberculosis coinfection) were more likely to be lost from care. Future studies from the Indian sub-continent should build upon these findings by elucidating outcomes and reasons for loss among those not retained. Prior reports describing the costs of transportation and ancillary services, persistent stigmatizing attitudes towards HIV, overburdened clinics and health care professionals who provide heroic but limited pre-treatment care, have taught us that the pre-therapy period is one of the most vulnerable for people living with HIV.

These data add to an ongoing debate within the global HIV community about whether to eradicate thresholds for ART initiation. The benefits of early therapy are indisputable. Numerous studies have demonstrated both improved AIDS-related and non-AIDS-related morbidity and mortality with earlier initiation of ART.⁴ As of 2013, the US guidelines adopted a 'treatment for all' strategy, and both the European guidelines and updated WHO guidelines now recommend therapy for all patients with a CD4 count ≤ 500 cells/mm³. While we await the results of the START study to learn more about the risks and benefits of very early therapy, as well as results from numerous community-based 'test and treat' studies, it is increasingly clear that a significant proportion of patients cannot afford to wait any longer after arriving at an HIV clinic with a diagnosis in hand. Even with point-of-care CD4 count testing, numerous barriers to expedited therapy continue, and the cascade of HIV care remains dangerously steep.^{5,6} Removing all steps between testing and treatment will serve as a crucial life raft to millions at risk for this fall, and bring us closer to the next phase of the epidemic, one with exceedingly rare pre-treatment losses from care.

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