

Treatment as Prevention (TasP)
and Governing Human Immunodeficiency Virus (HIV)
in British Columbia

by

Ashley Mollison
BA, University of Calgary, 2007

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Supervisory Committee

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Dr. Susan Boyd, Studies in Policy and Practice
Supervisor

Dr. Michael Prince, Studies in Policy and Practice
Committee Member

Abstract

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Committee member

In 2010, the government of British Columbia (B.C.) dedicated \$48 million to stop the spread of HIV. The *STOP HIV/AIDS* pilot project promotes the uptake of HIV testing in the general population, and the use of antiretroviral therapy amongst those living with HIV/AIDS. This project operates with the rationale of ‘treatment as prevention’ (TasP), meaning that antiretroviral therapy is beneficial for the person living with HIV/AIDS, and has the secondary benefit of reducing the spread of HIV in the general population. Public health discourses are constructed via particular worldviews and involve the creation and delineation of societal problems. Undertaking a discourse analysis, I identify eight dominant discourses of TasP and STOP HIV/AIDS that include: provincial and international support for TasP and lack of federal leadership in HIV/AIDS; TasP, a ‘paradigm shift’ and a ‘game changer;’ TasP as beneficial to the individual and society; human rights and harm reduction; proof and certainty; failure of current prevention efforts; risk discourses; and, finally, universal treatment. I also identify five alternative discourses: holistic understanding/social determinants of health; stigma and discrimination; rights discourse: GIPA, informed consent and self-determination; coercion/criminalization and alternative risk discourse.

Through a lens of governmentality, I explicate two overarching and simultaneous discursive strategies in realizing the objective of decreasing the spread of HIV in B.C. The first strategy acts on individuals living with HIV/AIDS, encouraging individuals to take up antiretroviral therapy. The second strategy acts on the general population, informing the population that HIV is a problem, and that treating people living with HIV/AIDS is the best way to protect society as a whole. There are various techniques within these two strategies.

These discursive events have immense consequences for the uptake of health policies and programs by the public. The dominant and alternative discourses of TasP impact HIV policy and practice and specifically the individuals living with HIV and AIDS who are the subjects and targets of these initiatives.

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Chapter 1: Introduction

In February 2010, the Honourable Kevin Falcon, Minister of Health Services for British Columbia (B.C.), Canada, announced a commitment of \$48 million over four years to halt the spread of Human Immunodeficiency Virus (HIV) infection in B.C. The initiative is known as *Seek and Treat to Optimally Prevent HIV/AIDS (STOP HIV/AIDS)*, earlier referred to as *Seek and Treat*.¹ It is through this pilot project that efforts to halt HIV are now underway in downtown Vancouver and in Prince George, B.C. The initial title of this project outlines a two-fold objective, and that is to *seek* out populations deemed at risk for contracting HIV and to *treat* those who are living with HIV not yet accessing Highly Active Antiretroviral Therapy (HAART).² Dr. Julio Montaner of the B.C. Centre for Excellence in HIV/AIDS (BC-CfE) leads the *STOP HIV/AIDS* initiative and sends a message to the world that B.C. is a leader in proactive HIV prevention and management. The B.C. Ministry of Health Services (MoH), the Ministry of Healthy Living and Sport (MHLS) and the BC-CfE (2010), released a joint media statement where Montaner was quoted as saying that, “through Premier Campbell’s commitment to HIV treatment, care and research, we will reduce AIDS-related deaths and HIV infections in B.C., and we will show the world how to do it” (n.p.).³

The public framing of the *STOP HIV/AIDS* initiative sees a ‘paradigm shift’ in HIV policy and practice. The shift is from conceptualizing treatment and prevention as two separate domains to a move towards ‘treatment as prevention’ (TasP). The idea is

¹ For the purpose of this paper, the *STOP Project* and *STOP HIV/AIDS* are used interchangeably.

² HAART (Highly Active Antiretroviral Therapy) is the treatment for HIV. Throughout the paper I use the term ‘antiretroviral therapy’ or ‘antiretrovirals’ as a short form for HAART.

³ Gordon Campbell was premier of B.C. at the time of data collection.

that treating people with HIV is not only beneficial for the individual but has a secondary benefit of decreasing the spread of HIV in the general population.

The *STOP HIV/AIDS* pilot project tests the hypothesis that TasP is an innovative way in which the spread of HIV can be managed and stopped in B.C. The project is represented in provincial and national newspaper headlines such as, “B.C. researchers on right track in the fight against HIV” (Ivens, 2010a), “B.C.-made therapy the cornerstone of world’s AIDS fight” (Chai, 2010) and “Taking the fight against AIDS to a new level” (Mickleburgh, 2010). B.C. is positioned as a leader in the global AIDS fight with the *STOP HIV/AIDS* initiative.

In this thesis, I conduct a discourse analysis, informed by critical theory, of TasP as a notion introduced to the public in 2009, and then, further developed through the *STOP HIV/AIDS* pilot project beginning in 2010. In the first Chapter, I provide a background of *STOP HIV/AIDS* and describe my research focus. Chapter 2 offers a literature review of TasP as the knowledge-base that underlies the *STOP HIV/AIDS* project. In Chapter 3, I position myself as a researcher and describe the theoretical approach, methodology and research design of the thesis project. I discuss ethical considerations and the limitations and significance of this research for policy and practice. Chapter 4 outlines the dominant and alternative discourses surrounding TasP and *STOP HIV/AIDS*. Chapter 5 concludes the thesis with a preliminary discussion, reflection of the topic and possibilities for further research.

Background

In Canada, there are approximately 65,000 people living with HIV or AIDS⁴ (Public Health Agency of Canada [PHAC]b, 2012). The province of B.C. is home to approximately 12,000 people living with HIV/AIDS (MoH et al., 2010).⁵ In B.C., HIV is not a generalized epidemic⁶ (AVERT, 2011) as greater numbers of HIV appear among specific populations. Therefore, HIV is considered a concentrated epidemic⁷ among specific populations such as those who use injection drugs and men who have sex with men (Lima, Hogg & Montaner, 2010). The incidence of new HIV infections in B.C. is decreasing. According to the B.C. Centre for Disease Control (BC CDC, 2009), in 2009, 338 people tested positive for HIV in B.C., as compared to 349 in the previous year. However, the total number of people living with HIV in B.C., as in the world, continues to rise.⁸

STOP HIV/AIDS is a pilot project created and led by the BC-CfE. The *STOP Project* is carried out by three B.C. health authorities of Northern Health, Vancouver Coastal Health and the Provincial Health Services Authority as well as Providence Health Care, a faith-based health care organization with several sites across B.C. (MoH et al., 2010). The program is funded by the B.C. government with contributions from the

⁴ In Canada, HIV becomes AIDS when a person living with HIV acquires opportunistic or AIDS-related illnesses at later stages of the disease (Canadian AIDS Treatment Information Exchange [CATIE], 2011)

⁵ Although it is suggested that approximately one quarter of people living with HIV in B.C. do not know their status (MOH et al., 2010).

⁶ Generalized epidemics are defined by an HIV incidence of above 1% in the general population (AVERT, 2011).

⁷ Concentrated epidemics are defined as HIV incidence of above 5% in a specific group but under 1% in the general population (AVERT, 2011).

⁸ HIV is a communicable disease that is transmitted from person to person. While new infections are decreasing, the number of people *in total* living with HIV increases from year to year. People are living significantly longer with the advent of antiretrovirals.

international pharmaceutical company, Merck,⁹ and the U.S. National Institute on Drug Abuse (NIDA) (MoH et al.). *STOP HIV/AIDS* began in 2010. The project is to be carried out over four years, until April 2013, inclusively. The project is directed by a steering committee made up of experts to oversee the implementation.¹⁰ The STOP Project has a leadership committee made up of members of the BC-CfE, the three health authorities, Providence Health Care, the MoH, the Provincial, Aboriginal Physician Advisor and an Aboriginal community member (BC-CfE, 2011c).¹¹

One of the strongest knowledge claims that underlies *STOP HIV/AIDS* is that the worldwide spread of HIV is being advanced by those who are in the ‘acute’ or early stages of the HIV infection (Gay & Cohen, 2008). It is estimated that approximately one quarter of the people who are living with HIV in B.C. are not aware of their status (MoH et al., 2010). A person who is unaware of their HIV status is thought to contribute to the spread of HIV for two reasons: the first is that the individual may not know to practice harm reduction¹² behaviour, which can reduce the risk of transmission of HIV to others (Gay & Cohen), and the second is that acute HIV infection is a period characterized by a spike in HIV viral load,¹³ where there is a higher risk that HIV will transmit to others (Gay & Cohen). A person who does not know their HIV status may be in the acute stage of HIV, creating a ‘high risk’ environment for the transmission of the virus.

⁹ Merck is one of many pharmaceutical companies that produce antiretroviral medication.

¹⁰ It is not public knowledge who is on this committee

¹¹ The name of the one aboriginal community member on the leadership committee is not public knowledge.

¹² Harm Reduction, as used in this paper, is an approach to health policy, programming and services which minimizing harms associated with behaviours which increase the risk of infectious diseases (such as HIV). Harm reduction approaches include, but are not limited to: the distribution and use of clean needles, safer crack kits, condoms, etc.

¹³ Viral load is a measure of the amount of HIV in the blood, measured in copies per millilitre (copies/ml). Less than 50 copies/ml is classified as an “undetectable” viral load (CATIE, 2011).

STOP HIV/AIDS has made it a priority to increase HIV case findings in B.C. (BC-CfE, 2011b). *STOP HIV/AIDS* aims to link those living with HIV, and particularly, the early stages of HIV, to primary and specialized HIV care, and increase the uptake of and adherence to antiretroviral medication (BC-CfE, 2010b).¹⁴ Evident in the concept of TasP is the belief that HIV transmission will decrease (or stop) if people living with HIV/AIDS know their status and begin treatment. This belief is based on evidence that antiretroviral therapy decreases a person's HIV viral load and that the uptake of antiretroviral therapy has the secondary benefit of decreasing the transmissibility of the virus (Challacombe, 2010; Gay & Cohen, 2008; Montaner, 2008; Montaner et al., 2006, 2010a).

STOP HIV/AIDS is being piloted in downtown Vancouver and in Prince George, B.C.¹⁵ Downtown Vancouver and the city of Prince George are two identified sites as home to the majority of B.C.'s HIV population and growing numbers of new HIV infections (BC-CfE, 2011a). *STOP HIV/AIDS* aims to engage the 'hard to reach' populations in these target areas. The project focuses on such groups as "Aboriginal people, youth, people with mental illness and/or addiction, immigrants and refugees, marginalized populations of men who have sex with men, homeless persons and injection drug users" (Tolson, 2010, p. 4). *STOP HIV/AIDS* was created and is being led by Dr. Julio Montaner, a physician, the Director of the BC-CfE, the Chair in AIDS Research, and the Head of the Division of AIDS in the Faculty of Medicine at UBC (UBC) (BC-CfE, 2011a). Montaner is the past president of the International AIDS Society (IAS), the

¹⁴ For a full list of the project aims see Appendix 1

¹⁵ Downtown Vancouver includes a poor, inner city neighbourhood, the Downtown Eastside and Prince George is a mid-sized city in Northern B.C. Both areas have been highlighted as a high number of HIV cases and new infections (BC-CfE, 2011a).

leading organization in setting antiretroviral treatment guidelines for people living with HIV/AIDS. Montaner has a long history of HIV advocacy, research and service and is a strong advocate for Insite, a supervised injection service in the Vancouver's Downtown Eastside (BC-CfE, 2011a). Montaner is well established in the networks of the international and national AIDS communities, as well as heavily sponsored by international pharmaceutical companies.¹⁶

The *STOP HIV/AIDS* project has had a tremendous impact on health and human service delivery in Vancouver and Prince George, B.C. One such impact is the establishment of new healthcare positions to the two pilot areas. In Vancouver, for instance, the *STOP HIV/AIDS* outreach team, responsible for testing at various venues, and the Vancouver Coastal Health (VCH) outreach team, responsible for linking those 'lost to care' with the healthcare system, are newly established teams consisting of nurses, outreach workers, administrative staff, nurse educators, clinical practice managers, clinical analysis managers and physicians (Tu, 2011).

STOP HIV/AIDS has rolled out strategies to increase testing, care and treatment services in these two pilot areas. Two specific strategies have unfolded to increase testing in the population. The first strategy is mass testing in target populations where the *STOP HIV/AIDS* outreach team in Vancouver has held health fairs and testing events in the West End, at bath houses, at World AIDS Day events, and at other organizations that serve target populations such as men who have sex with men, people who use injection

¹⁶ Montaner's articles declare conflicts of interest resulting from funding relationships with Merck, Gilead and ViiV Healthcare, pharmaceutical companies working in the area of HIV who support TasP (see for example, Montaner et al., 2010).

drugs, youth and female sex workers (Tu, 2011). Rapid point-of-care testing services¹⁷ are now offered at single room occupancy hotels and shelters in the DTES (BC-CfE, 2010b). The second strategy is routine testing in the general population, where physicians are now offering HIV testing to all people going for regular blood work at major hospitals in Vancouver (Vancouver Coastal Health, 2012).¹⁸

STOP HIV/AIDS has involved the creation of peer support groups, and social housing for people who are HIV positive in recognizing the broader, systemic factors that underlie access and adherence to treatment for marginalized populations. The intensive case management associated with the *STOP HIV/AIDS* outreach teams links people who are HIV positive to housing, mental health and addiction services, and assists individuals to apply for disability benefits (Tu, 2011).

The impact of the STOP Project has moved beyond the pilot areas to other areas in B.C. An example of this is a Structured Learning Collaborative, whereby twenty-five care teams came together with the goal to improve and create a standardized level of HIV testing, treatment and care in the province of B.C. The Learning Collaborative operated for one year to provide opportunities for health practitioners to engage in face-to-face meetings, monthly teleconferences and a “virtual community of practice” (“STOP HIV/AIDS structured learning collaborative,” 2012).

The impact of this project has also moved beyond B.C. Once the pilot is completed in B.C., the U.S. National Institute on Drug Abuse (NIDA) has dedicated \$50

¹⁷ Rapid, point-of-care testing is relatively new technology that provides healthcare workers with the ability to test for HIV and provide results to clients immediately. This is the technology that allows STOP outreach teams to have ‘health fairs’ in various venues with testing services at each one. The blood work will still be sent to the lab. A standard test will be conducted if the point-of-care test is positive in order to confirm results.

¹⁸ The BC Civil Liberties Association has brought up concerns regarding informed consent around routine HIV testing (see <http://bccla.org/> for more information).

million for the evaluation of the Vancouver HIV prevention model to be conducted in the US criminal justice system under the name of “Seek, Test and Treat” (BC-CfE, October, 2009). The Joint United Nations Program on HIV/AIDS (UNAIDS, 2011) announced a new initiative called *Treatment 2.0* with a TasP component based on the results of BC-CfE research. More recently, the BC-CfE announced its plans to work with China to implement the TasP model as China’s official HIV/AIDS strategy (BC-CfE, UBC, & Providence Health Care, 2011). The B.C. model is put forth globally as a successful and proven method to prevent and stop the spread of HIV. The impact of *STOP HIV/AIDS* is not localized, but reaches far and wide, influencing policy and practice throughout the world.

Research Focus

Treatment as prevention is presented by the BC-CfE as a ‘paradigm shift’ away from conceptualizing prevention and treatment as two different aspects of HIV policy and practice. The shift is in conceptualizing the use of treatment as a preventative measure to halt the spread of HIV in a population. *STOP HIV/AIDS* is a unique project to examine this paradigm shift, as it is the first project putting TasP into practice. I conducted a discourse analysis informed by Foucault’s conceptualizations of power and governing in my research to examine *STOP HIV/AIDS* and TasP. I analyzed print and electronic news articles about *STOP HIV/AIDS*; texts created by the BC-CfE that were available to the public about *STOP HIV/AIDS*, including monthly/quarterly newsletters, and web pages from the BC-CfE website. I analyzed responses to the dominant¹⁹ TasP and *STOP*

¹⁹ Dominant discourse is a broad term that refers to prevailing and pervasive discourses in society that do not stem from an identifiable claims-maker or source.

HIV/AIDS discourses in publications produced by people living with HIV/AIDS,²⁰ and by community-based HIV advocacy and service organizations, such as the Canadian AIDS Society. The data collection period was from February 2009 to September 2011.

There are a range of strategies and techniques used to encourage people to take up treatment and testing practices, ranging from those that could be described as coercive to more subtle, within the *STOP HIV/AIDS* initiative. An example, of a technique that could be considered coercive is where people are offered Tim Horton's gift certificates as incentives for testing in some parts of the DTES in Vancouver. In this thesis, I concentrate on the discursive strategies and techniques to mobilize populations towards the governing objective of decreasing the spread of HIV in B.C. My focus is not on the strategies and techniques used on the front line to encourage testing and treatment. I am interested in the knowledges underlying TasP and the subjects that are created through TasP and the *STOP HIV/AIDS* initiative. The questions that guide this research are:

1. What knowledges (rationalities) are constructing and constructed by the discourses of *STOP HIV/AIDS*? How are these discourses informing and being informed by testing and treatment policy and practice?
2. What techniques are employed by *STOP HIV/AIDS* to mobilize populations toward governing objectives? Are there distinct techniques used for different target populations?
3. What subjects are created through the discourses of the *STOP HIV/AIDS* initiative?

In the next chapter, I present some of the key knowledges underlying TasP as well as some alternative discourses that arise in the body of literature surrounding TasP.

²⁰ For example, *PositiveLite* which is an independent online publication for people living with HIV and allies.

Chapter 2: Literature Review

Treatment as prevention is a large, multi-disciplinary, body of knowledge that underlies the *STOP HIV/AIDS* initiative. I begin the literature review by describing the emergence of TasP through a brief, socio-historical account of HIV prevention initiatives. Next, I describe the scientific, economic and mathematic discourses underlying TasP that ‘claims-makers’ use to rationalize the roll out of *STOP HIV/AIDS* in B.C. Finally, I describe some alternative discourses in the literature that have emerged as key concerns and considerations of TasP.

A Short History of HIV Prevention

The first cases of AIDS were reported in the United States in 1980 and in Canada in 1982 (Oppenheimer, 1992). Rare pneumonia and cancers emerging among homosexual men in the United States prompted studies into this “Gay Related Immune Disorder” or GRID by the Center of Disease Control (CDC) (Oppenheimer). The initial hypothesis by the CDC was that AIDS was caused by the homosexual ‘lifestyle’ and linked with the consumption of ‘poppers’ or amyl nitrate, and promiscuity (Oppenheimer). False beliefs were perpetuated about AIDS in the general population through research focusing on gay men and heightened fear of the disease in the media. Merson, O’Malley, Serwadda and Apisuk (2008) state that, “Because of the association of disease with marginalized populations, sexual transmission, and death, the initial years of the pandemic were characterized by widespread stigma, discrimination and denial” (p. 477). The CDC continued to do studies exclusively with homosexual men until 1983, blinded by the assumption of AIDS as a ‘gay disease.’

In the mid 1980s, the CDC shifted from a lifestyle hypothesis to one that considered a biological agent as the cause of AIDS (Oppenheimer, 1992). People with haemophilia, people who used injection drugs and Haitians began to report AIDS-like symptoms. In 1983, the term ‘high risk’ group was first used in the CDC’s Morbidity & Mortality Weekly Report (MMWR) naming the four high risk groups to contract AIDS as homosexual men, intravenous drug users, Haitians and haemophiliacs (Canadian Broadcasting Corporation [CBC], 1983; Oppenheimer). It was in 1984, one year after the naming of high risk groups, that HIV was isolated and named the virus to cause AIDS (Oppenheimer). The biological hypothesis was now a theory.

In the early years of AIDS, gay-rights activists and allies, in community-based organizations, responded to the lack of government funding for AIDS services by promoting prevention and education (Merson et al., 2008; Oppenheimer, 1992). The purpose was to dissolve misconceptions about AIDS, to alleviate fear and respond to the discrimination directed towards those who were targeted as having the disease (Merson et al.; Oppenheimer). Grassroots organizations in Canada, such as the AIDS Committee of Toronto (ACT), made up of people living with AIDS and their allies, distributed information about AIDS and prevention methods in order to counteract myths about AIDS and discriminatory targeting of homosexual men (CBC, 1983). Pamphlets distributed in the United States and Canada, such as “Play Fair!” or “How to Have Safe Sex in an Epidemic: One approach,” advocated the use of condoms and harm reduction through sex positivity (Merson et al.). The first Canadian conference on AIDS was held in Montreal, in 1985. A steering committee for the formation of a national society

emerged from this conference, and the Canadian AIDS Society (CAS) was officially formed after the second National Conference in 1986 (CAS, 2012).

Near the end of the 1980s, AIDS research and services became a recognized part of medical institutions and public health in Canada (Fee & Fox, 1992). It was not until the 1988 conference in Toronto that the Federal Centre for AIDS (FCA) and the Canadian Public Health Association (CPHA) were brought into the work of the AIDS organizations (Fee & Fox). Phase I of the first National AIDS Strategy of Canada was launched in 1990, initially supporting grassroots and community-based organizations who were already involved in information and prevention dissemination with the public (PHACa, 2012). CAS and the partner organizations coordinated the first National AIDS Awareness campaign called, “Our Challenge for Life” (CAS, 2012).

In 1993, the federal government launched Phase II of the National AIDS Strategy, which resulted in a greater amount of funds and partnership development across several levels of society between community-based and non-profit organizations, private and public stakeholders and international partners. This era of AIDS prevention signalled the beginning of an institutionalization²¹ of prevention, taking prevention out of the realm of community-based organizations and people living with HIV/AIDS (Fee & Fox, 1992). Strategies for HIV prevention since the mid 1980s have been diverse and politically-charged, ranging from abstinence-based approaches, advocating lifestyle change, such as abstinence and sobriety, to harm reduction approaches advocating the use of condoms, using safer drug use supplies and reducing ‘risk’ behaviours.

²¹ Institutionalization or the formalization of HIV prevention had benefits for the AIDS movement including increasing funding, awareness and education for HIV prevention and services. However, it also moved decision-making away from the people who were closest and most impacted by the epidemic.

Biomedical Developments and the Emergence of TasP

The antiretroviral drugs for HIV treatment (HAART) were revealed at the Vancouver International AIDS Conference in 1996 (Gulick, 2010). Antiretroviral therapy was and continues to be successful in averting deaths, and profoundly improving the everyday health and well-being of people living with HIV/AIDS, which has changed the face of the AIDS epidemic. The discovery of antiretroviral therapy propelled the development of biomedical interventions to prevent the spread of HIV.²² Since then, much funding and hope has gone into these biomedical interventions, including post-exposure prophylaxis and pre-exposure prophylaxis, such as topical microbicides²³ (Merson et al., 2008). Studies to test the efficacy of pre-exposure prophylaxis have had small successes. These studies include the iPrex study (Grant et al., 2010), the Caprisa 004 study (Karim et al., 2010) and the Partners PrEP study (Baeten et al., 2012). The outcome of the studies has shown, however, that there is a benefit of antiretrovirals in the prevention of HIV transmission.

TasP is presented as a new concept after thirty years into the HIV epidemic. It emerges in an environment where there is still no cure or vaccine available for HIV. There are some successes in pre and post exposure prophylaxis (though diminishing hope in microbicides that do not contain antiretrovirals), a global disparity in access to antiretroviral therapy, and HIV rates that continue to increase on a global scale. Prior to

²² Compared to non-medical approaches to HIV prevention such as harm reduction interventions as condoms, safer crack kits and clean needles.

²³ Post-Exposure Prophylaxis (PeP) refers to the use of antiretrovirals for prevention of HIV in situations where a person knows they have been exposed to HIV and begins an immediate antiretroviral regimen (Cohen, Gay, Kashuba, Blower & Paxton, 2007). Occupational PeP is for, for example, health care workers. Non-occupational PeP refers to non-occupational exposures, for instance when a person has been exposed to HIV through sexual assault. Microbicides refer to a type of pre-exposure prophylaxis which when taken by a person who is HIV negative, in pill or topical form, reduces the ability for HIV to infect the person who is HIV negative (Gay and Cohen, 2008).

TasP, treatment and prevention have been conceptualized and funded as two different activities. The claim of TasP is that antiretroviral medication is not only effective for improving the lives of people living with HIV/AIDS but also effective in decreasing the transmission of HIV and preventing the spread in a population. Scientists concur that lowering viral load, through medical intervention and virus suppression, is effective in decreasing HIV transmission (see for example Cohen, 2012b). Communities of people living with HIV/AIDS have, for years, understood the secondary benefit of antiretroviral therapy and have aptly used antiretroviral therapy alongside other harm reduction approaches in the prevention of HIV. The BC-CfE has introduced TasP to the world as a novel approach to HIV treatment and prevention.

The Science behind TasP²⁴

TasP makes the claim that antiretroviral treatment should be used as an integral component of HIV prevention approaches. Dominant discourses appeal to a series of viral and epidemiological facts about HIV, to promote HIV testing and treatment in B.C. through the *STOP HIV/AIDS* pilot project. Studies have shown that antiretroviral therapy is successful in preventing the replication of HIV in the body and has the ability to reduce the plasma HIV viral load of an individual to undetectable levels (Challacombe, 2010; Gay & Cohen, 2008). The lowering of the plasma viral load can reduce the spread of HIV through the blood. Secondly, there is evidence that the risk of HIV transmission through sexual contact is significantly lowered when a person's plasma viral load is at undetectable levels (Montaner et al., 2006, 2010a).²⁵ This is due to evidence that

²⁴ See Appendix 2 for definition of terms

²⁵ Random controlled trial studies are currently underway to test the transmissibility of HIV at different viral loads (Gay & Cohen, 2008).

suggests that the HIV viral load in the blood correlates (though not perfectly) with viral load in the genital tract and the sexual transmission of HIV (Gay & Cohen). The chance of transmitting the virus through sexual transmission is reduced if the plasma viral load is also reduced. A final piece of evidence to suggest the efficacy of antiretroviral therapy for prevention is that antiretrovirals have been successfully used in the prevention of mother to child transmission,²⁶ and occupational and non-occupational post-exposure prophylaxis (PeP) (Gay & Cohen; Lima et al., 2010; Montaner et al., 2006, 2010a, 2010b).

The Modelling and the Benefits of TasP

Several mathematical and population-based studies suggest that wide-scale treatment of people living with HIV/AIDS, within current treatment guidelines,²⁷ is successful in decreasing the spread and incidence of HIV in a population (Lima et al., 2010; Montaner, 2008; Montaner et al., 2010a).²⁸ A key driver of the TasP and the *STOP HIV/AIDS* pilot project in B.C. is a population (ecological) study done through the BC-CfE. Using evidence from B.C., Montaner et al. (2010a) found that, since the onset of HAART in 1996, antiretroviral therapy uptake by people living with HIV/AIDS has averted as much as 30% of potential infections per year. The latest modelling by Lima et al. (2010), suggests that if the number of people accessing antiretroviral therapy in B.C. increases by 50%, over 1300 infections can be averted within five years.

²⁶ In Canada, the risk of transmitting HIV from mother-to-child is almost entirely eliminated.

²⁷ To those with CD4 counts of below 350 cells/mm³. See Appendix 2 for definition of terms.

²⁸ To date there have been eight studies that examine the secondary effect of antiretroviral use for population benefits with mixed results. See Cohen, Muessig, Smith, Powers and Kashuba (2012d) for a summary of these studies.

The use of antiretroviral therapy for preventative purposes has been proposed as a cost effective intervention in the HIV epidemic (Granich, Gilks, Dye, De Cock & Williams, 2008; Johnston et al., 2010; Lima et al., 2010). Lima et al., suggest that if the number of people on antiretroviral therapy increases by 50% in B.C., after five years the government could save as much as \$3.4 billion on healthcare costs. This prediction can be seen as a driving force behind the government's investment in the *STOP HIV/AIDS* initiative in B.C. For instance, if the number of individuals in B.C. starting treatment increases from coverage of 50% to 75%, the net costs avoided by the B.C. government could be as much as \$900 US million (Johnston et al.). A TasP model in B.C. has the potential to become cost-effective in as little as four years even though there are significant initial costs associated with wide scale treatment (Johnston et al.). TasP has been heralded for its potential to decrease the burden on the health care system and save lives (Granich et al.; Lima et al.). Lima et al., propose that a TasP strategy in B.C. could prevent as much as 4,155 years lost to disability and mortality within five years.

Antiretroviral therapy has the ability to decrease viral loads in individuals to undetectable levels, decreasing and nearly eliminating the risk that an individual can transmit the HIV virus. There is potential for antiretroviral therapy to make an even larger improvement in the lives of people living with HIV/AIDS if it can be shown that undetectable viral loads create a zero risk environment for transmitting HIV. This may alleviate some of the stigma and discrimination faced by people living with HIV/AIDS if HIV is no longer transmissible (Conseil National du CIDA [CNS], 2009; Gay & Cohen, 2008). Additionally, the fear associated with passing HIV to others may be alleviated

and the rights of people living with HIV/AIDS to uninhibited intimacy, sexual pleasure and having children can be achieved (CNS; Gay & Cohen).

HIV Prevention Trials Network (HPTN) 052 is the first randomized control trial to assess the efficacy of TasP by studying the effects of early versus delayed antiretroviral treatment on the transmission of HIV. This study enrolled 1750 heterosexual men and women, in serodiscordant relationships (one partner is living with HIV while the other is not), in 13 sites around the world.²⁹ This study began in a pilot phase in 2005 and was more broadly implemented in 2007 with results showing that the earlier initiation of antiretroviral therapy decreased the risk of heterosexual HIV transmission by 96% (Cohen et al., 2011; 2012b). This study gave evidence to the benefits of antiretroviral therapy for prevention limited to the study group of heterosexual couples. The proponents of the *STOP HIV/AIDS* model deploy scientific, economic and mathematical evidence to promote the benefit of TasP. The following section provides some considerations and concerns that have been raised about TasP.

Considerations and Concerns about TasP

There were few public critiques of the *STOP HIV/AIDS* project in the time period that I conducted my data collection. However, since TasP was presented as a novel concept to the public in 2009, and the *STOP HIV/AIDS* pilot project was announced in February 2010, concerns and considerations have emerged about TasP. These concerns range from questioning the most appropriate and feasible way to implement a TasP

²⁹ Ninety seven percent of the couples were heterosexual. Half of the couples began antiretroviral therapy with CD4 counts were below 250 cells/mm³, while the other half began antiretroviral therapy at an earlier stage of HIV illness with CD4 counts between 350-500 cells/mm³. All were given access to comprehensive harm reduction supplies and information. Twenty seven transmissions occurred in the delayed treatment group, while only one occurred in the early treatment group.

project, questioning how the population and individuals might respond to the increased promotion of testing and treatment and considering the ethical and human rights dimensions of the TasP paradigm. Kippax, Reis & de Wit (2011) frame the discussion in terms of efficacy versus effectiveness. The former refers to the success of TasP in controlled conditions (such as the HPTN 052 study), and the latter refers to how a TasP model would operate in 'real world' conditions.

In terms of efficacy, the TasP model depends on how antiretroviral medication moves through and affects the body at the cellular level. TasP depends on the ability of the antiretroviral therapy to not only reduce the viral load in the blood but to reduce the viral load in the genital tract (Gay & Cohen, 2008; Velasco-Hernandez, Gershengom & Blower, 2002) which will enable HIV to become less transmissible (Granich et al., 2008). There is evidence that the viral load in the blood does not always correlate with the viral load in the genital tract (Cohen et al., 2012b). Most evidence for TasP comes from studies done with heterosexual couples. There is uncertainty about whether the success seen in preventing transmission of HIV among heterosexual couples in serodiscordant relationships, as in HPTN 052 study, will be realized among populations of men who have sex with men (Muessig et al., 2012).³⁰ Another key consideration is in how the body responds to the earlier initiation of antiretroviral therapy, with new treatment guidelines that promote the preventative value, and the long term effects on the body (CNS, 2009; World Health Organization [WHO], 2009). Other concerns exist around the emergence of drug resistance and transmission of drug resistant strains with earlier and wide-scale

³⁰ This is due to higher risk of transmission in anal intercourse as opposed to vaginal intercourse, differences in how antiretroviral medications reduce viral loads in the GI tract (anal intercourse) and urogenital tract (vaginal intercourse) and the mixed study results on changing risk behaviour with increasing availability of antiretroviral therapy among men who have sex with men (Muessig et al., 2012).

initiation of antiretroviral therapy (Blower & Gershengom, 2000; De Cock, Crowley, Lo, Granich & Williams, 2009; Gay & Cohen; Granich et al.; Velasco-Hernandez et al.; WHO), including the emergence of drug sensitivities in a population (Blower and Gershengom; Blower, Achenbach, Gershengom & Kahn, 2001). However, there is evidence that drug resistance is not as much as a concern in the B.C. context which is based on modelling specific to the B.C. environment (Lima et al., 2010). Blower et al., highlight the need to develop more therapies to suppress drug resistance and to decrease the amount of time that a person with drug-resistance is receiving ineffective treatment.

Achievements in TasP depend on the optimal approach for governments to identify those who are living with HIV and not yet accessing antiretroviral therapy (CNS, 2009; Gay & Cohen, 2008; Lima et al., 2010; WHO, 2009). Kippax et al. (2011), state that effectiveness includes considerations related to the provision of testing and treatment services, the acceptability and adoption of more frequent testing of those who do not consider themselves at risk and uptake of treatment by those living with HIV. This involves an immediate scale up of outreach to those who do not know they are HIV positive and the implementation of testing sites where high quality, rapid-testing is offered (Granich et al., 2008). Success will depend on identifying those with the highest viral loads (when the person is the most infectious) as well as encouraging routine testing as opposed to client-initiated testing (Padian et al., 2011).³¹ There are challenges encouraging testing in the general population where the technology may not be available to detect HIV at early stages and convincing those who are not experiencing any symptoms to be routinely tested (Nguyen, Bajos, Dubois-Archer, O'Malley & Pirkle,

³¹ See Cohen, Dye, Fraser, Miller, Powers and Williams (2012a) for a full discussion on early detection of HIV and TASP strategies.

2011; Padian et al.). This will involve de-stigmatizing and normalizing HIV testing in a population (Padian et al.). The BC-CfE has started a provincial campaign to de-stigmatize HIV testing.³²

Other considerations for TasP relate to how individuals living with HIV/AIDS will respond to this concept. Decreasing the spread of HIV will depend on the proportion of people in a population that are treated because success of TasP is based on large, population coverage (Gay and Cohen, 2008; Nguyen et al., 2011). Success of the TasP model depends not only on identifying those who are HIV positive, through testing, but promoting treatment to people living with HIV/AIDS and improving adherence rates for those who have interrupted their treatment regimes (CNS, 2009; Lima et al., 2010; Padian et al., 2011; WHO, 2009). Adequate adherence is a challenge and an on-going issue while depending on a range of biological, social and cultural factors that go into individual decision-making. For instance, the *STOP Project* community focus groups found stigma as a key barrier to unfolding the *STOP Project* and for people accessing testing and treatment services in B.C. (Tolson, 2010).

Another concern about TasP relates to the feasibility of the TasP strategies to improve all stages of HIV care beyond testing and treatment. The continuum of HIV care refers to the stages that are believed to lead a person living with HIV, from not knowing their status to having a suppressed or undetectable viral load. The continuum of care includes HIV infected, HIV diagnosed, linked to HIV care, retained in HIV care, on antiretroviral therapy and ends with suppressed viral load (CDC, 2011). According to the

³² The Treatment as Prevention (Together we can stop HIV/AIDS) website launched in early 2012. Although this is outside my time frame for data collection, this website provides information to the public about the concept of TasP, encourages individuals to 'take action' to end HIV by 'pledging' to get an HIV test. For more information see <http://treatmentasprevention.ca/>

CDC, due to ‘leaks’ in the continuum of care of the 1.2 million people in the United States who are living with HIV, only 28% have an undetectable viral load. Similarly, Gardner, McLees, Steiner, del Rio and Burman (2011) report that even in a scenario where each stage of the continuum of care is increased by 90% (for example, diagnosis of 90% of people living with HIV/AIDS and treatment of 90% of the individuals found to be HIV positive), there would still be approximately 34% of individuals with an unsuppressed viral load and ability to transmit the HIV virus.

A major concern is that TasP will have a significant financial and economic impact on governments (Challacombe, 2010; De Cock et al., 2009; Gay & Cohen, 2008; Granich et al., 2008; WHO, 2009). An important consideration for the unfolding of a TasP project is how it will be offered in partnership with community-based organizations. Scaling up testing services, outreach, treatment and counselling through community-based organizations will depend on the ability for organizations to integrate treatment and prevention programming which has typically been funded and developed as two separate entities (Challacombe). For instance, the *STOP Project* community focus groups found funding cuts to community-based organizations as a potential barrier to the *STOP Project* in B.C. (Tolson, 2010). Kippax et al. (2011) postulate the impact that TasP could have on current prevention efforts such as needle exchange programs that are offered through community-based organizations. Their concern is that the implementation of needle exchanges and other politically charged prevention strategies could prove more difficult if treatment is understood as the paramount prevention strategy.

TasP projects involve the negotiation of HIV treatments between the needs of the population and the individual. Uncertainties exist about the optimum time to start

antiretroviral therapy and which antiretroviral treatments and combinations to use that are both beneficial to the individual and that can serve the secondary benefit of preventing the spread of HIV in a population (CNS, 2009; WHO, 2009). Treatments have side effects and are expensive.³³ If treatment is becoming more useful for its secondary benefits, then there is a need for simpler treatments that are less expensive, easier to consume and that result in fewer side effects for the individual (Granich et al., 2008; Lima et al., 2010). It is noted that the messaging around individual versus population prevention must be carefully negotiated by governments and service providers (Challacombe, 2010). There is concern about the secondary effects of messaging that suggests that treatment reduces a person's viral load to undetectable levels which eliminates the risk of transmission (Challacombe). The concern is that this messaging can lead to behavioural disinhibition, where an individual who is living with HIV uses antiretrovirals, exclusively, which can lead to an increase in antiretroviral resistance and the spread of other infectious diseases in a population (Blower and Gershengom, 2000; Granich et al.; "Round-Up," 2008; Solomon et al., 2005; Velasco-Hernandez et al., 2002; WHO). However, behavioural disinhibition is a concept that is contested by some researchers (Gay & Cohen, 2008). Adams (2011) highlights the need to understand the processes through which messages of individual risk are perceived and interpreted by communities that are targeted with behavioural interventions.

Ethical and human rights are interests that emerge in promoting wide scale testing and treatment in a TasP project (De Cock et al., 2009; WHO, 2009). Questions arise as to the best way to promote testing and treatment without digressing into coercive

³³ Antiretroviral therapy is offered free of charge in B.C.

approaches (Challacombe, 2010; WHO). Researchers suggest that the choice of an individual to access testing and treatment needs to be respected and that voluntary testing and treatment must always be maintained (Challacombe; Velasco-Hernandez et al., 2002; WHO). There is the concern that a TasP model will lead to a re-medicalization³⁴ of the HIV epidemic, and that the human rights and socioeconomic factors that drive HIV, and prevent individuals from accessing treatment, need to be addressed (Nguyen et al., 2011). The focus on biomedical interventions and the lack of discussion of socioeconomic factors that drive the epidemic can result in reversing the over 30 years of prevention work that has been done (Nguyen et al.). Patton (2011) contrasts the understanding of human rights in TasP initiatives between public health officials who are ‘witnessing disease’ as numbers and costs, and people living with HIV/AIDS and community-based organizations who ‘witness illness’ through lived experience with HIV/AIDS.

The ethics of providing treatment for preventative purposes is under question when a person is not necessarily ill or showing symptoms related to HIV or when there are millions of people, globally, who do not have access to treatment despite living with high viral loads and/or HIV-related illnesses (WHO, 2009). According to Padian et al., (2011), research needs to be done to examine the balance between efficiency and equity in new biomedical prevention strategies. Treatment would need to be offered in a strategic way in terms of a public health imperative balanced with making accessible treatment to those who need it the most.

The literature review reveals that there were uncertainties, concerns and critiques about the efficacy, effectiveness and ethical and human rights issues surrounding TasP.

³⁴ Re-medicalization of the HIV epidemic refers to returning to the time of the emergence of antiretrovirals (mid to late nineties) where HIV resources, funding and interests looked to biomedical answers to stopping the spread of HIV, overlooking broader socioeconomic and cultural factors that drive the epidemic.

It appears that less attention has been paid to the function of TasP in governing people who are at risk for, or living with, HIV/AIDS. In the next chapter, I present a positioning of myself as a researcher and a theoretical framing for which to analyze the discourses of *STOP HIV/AIDS* and TasP.

Chapter 3: Theoretical and Methodological Lens

Positioning of the Researcher

My experience in coming to write about and research *STOP HIV/AIDS* is not an experience of someone who lives with HIV. My involvement in prevention, awareness and service within university-based HIV/AIDS initiatives, community AIDS service organizations, and research has contributed to my passion and interest in the area of HIV/AIDS for the last nine years. I continue to be passionate about the many dimensions of HIV/AIDS and the intersections with politics, economics, religion, criminal justice, medicine, moral regulation, business and human rights. In working and studying in the area of HIV/AIDS, I am most passionate about the people who live with HIV/AIDS and who are not *only* this disease. I am conscious of the tendency for people living with HIV/AIDS to be reduced to an acronym, to a risk group and to a category. Through my work, I aim to alleviate the reductionist and dehumanizing tendency, and acknowledge the diversity within HIV/AIDS work and communities.

In this chapter, I describe my theoretical framing and methodological lens in coming to explore the discourses of TasP and the *STOP HIV/AIDS* initiative. I discuss the theoretical framing of governmentality as introduced by Michael Foucault and elaborated on by governmentality theorists. I begin by providing a brief history of Foucault's interest in the study of government. I divide the discussion of governmentality into five sections: an interest in government, governmentality and public health, governing rationalities or systems of thought, governing technologies or systems of action and governing through freedom and the creation of the subject. I thread key components of a Foucauldian conceptualization of power and links to the *STOP*

HIV/AIDS project throughout each sub-section. I describe my methodological lens in the sections of: discourse analysis, data selection and limitations and significance of the research.

An Interest in Government

Governmentality provides a framework for which to analyze the discourses of TasP and the *STOP HIV/AIDS* initiative. Foucault (1991) first introduced the term governmentality during a prominent lecture in the early 1980s. In this lecture, Foucault described the emergence of a new form of power called the ‘art of government’ during the late 18th and early 19th centuries. At this time, European nations had increasing populations which presented with new and unique problems associated with this growth. The emergence of issues at the level of the population, as in new diseases associated with rapidly growing cities, for example, provoked those in power to find the necessary tools to measure, understand and manage their populations (Foucault; Rose, O’Malley & Valverde, 2006). The need to understand and manage new population phenomena led to the development of a new governing ‘mentality’ around questions of the “peculiar intensity of how to be ruled, how strictly, by whom, to what ends, by what methods [...]” (Foucault, p. 88). The art of government came to mean the exercise of new forms of coordinated power as institutions and professions became increasingly consolidated in the project of population governance (Foucault; Rabinow, 1984).

While Foucault set the backdrop for studies of government, Nikolas Rose, Peter Miller and others have developed this study further (Gordon, 1991; Miller & Rose, 2008; Rose et al., 2006; Rose & Miller, 1992). Since then, several scholars have applied a governmentality analysis to a variety of topics including social insurance, health and

medicine, accounting and risk, and unemployment and poverty (Miller & Rose).

Governmentality theorists have moved studies of governing beyond the political state and have described an analysis of governmentalities³⁵ as exploring thought and strategy aimed at directing the 'conduct of conduct' (Foucault, 1991; Fullagar, 2002; Miller & Rose). The sovereign state is but one aspect of governance. Those who use this analysis propose that government is made up of a variety of social actors including professions, regulating bodies, institutions and individuals (Foucault; Miller & Rose). It is through the social relations between these entities that governing happens. The result is the exercise of power on knowledge and subjects.

Governmentality and Public Health

It is important to describe the function of public health in population governance in order to situate *STOP HIV/AIDS* as a public health initiative. Lupton (1995) describes public health and health promotion as a governmental apparatus constituted by a variety of actors. According to Lupton:

The imperatives explicit in health promotion activities initiated and carried out by state bodies are supported by a proliferation of agencies and institutions, including commodity culture, the commercial mass media, the family, the educational system, advocacy groups and community organizations. (p. 11)

Public health interventions are not simply created by the state and aimed at the public body. Rather, public health interventions are realized through coordinated relationships between multiple actors in society including people who take up, use and resist these

³⁵ Miller & Rose (2008) prefer to pluralize governmentality to highlight that many governmentalities may happen simultaneously.

interventions. For instance, *STOP HIV/AIDS* may stem from the work of the BC-CfE, and be supported by the B.C. government, with an underlying rationalization that the spread of HIV is a problem. However, *STOP HIV/AIDS* is carried out through partnerships with community-based organizations. The way in which the project happens then, depends on how community groups, activists, and the media take-up, use, resist and shape this project.

Modern public health, as we know it, first emerged with Edwin Chadwick and the *Poor Law Commission of England* in attempts to reduce the reliance of poor people on the state through, “the use of state power to prevent illness and disorder by altering social conditions or behaviours seen as promoting ill-health” (Sears, 1992, p. 66). Lupton (1995) identifies the Enlightenment period as a time where significant shifts occurred in public health strategies. Public health strategies emerging at this time fulfilled governing objectives to monitor, to order and control their populations. The emergence of statistics in the 17th century aided the public health movement in its contribution to population and epidemiological surveillance. Statistics made it possible to track and predict disease growth and movement in the population, as well as develop concepts of normal and abnormal (Lupton; Sears). The ‘social medicine’ movement in 18th century Europe put forth the notion that good health was a right of all citizens, and the state was responsible for facilitating citizens’ access to resources for realizing good health. With the rise of industrialization and urbanization, public health became necessary for monitoring, surveying and maintaining a healthy productive workforce (Sears). At this time, the focus of public health was on the environment and social conditions as a cause for

disease spread through miasmatic and contagion³⁶ theories of disease. Issues of morality and social order were also tied into the public health movements of the 18th century as immigration threatened both the individual (disease) and social body (productivity) (Lupton; Armstrong, 1983).

The discovery of the microbe at the end of the 19th century served to make disease 'invisible,' putting all people at risk (Lupton, 1995). While disease could be attributed to an invisible agent, the contagion and miasmatic theories of disease continued with visible signs of dirtiness, poverty, and 'otherness' being associated with the spread of disease. Sears (1992) describes how public health strategies to combat disease spread in the 19th century in Canada, shifted from a focus on creating sanitary public conditions to a focus on personal and home-based hygiene in the early 20th century. This signified an outsourcing of the responsibility of the state to provide a sanitary environment for its citizens in favour of having the family, and primarily women, responsible for keeping their families healthy.

Armstrong (1983) describes how the late 19th century enacted the movement of health into the community by using the concept of the Dispensary. The Dispensary was originally developed as a response to addressing tuberculosis (TB) in Edinburgh. The Dispensary was a way to move health care out of the hospital, to decentralize and shift from providing healthcare to those who were very ill, to surveying and monitoring the entire population including those who were not only living with TB but who were at 'at risk' for TB infection. According to Armstrong:

³⁶ Competing disease theories before the Enlightenment were the Miasmatic theory, the theory that disease spread through 'bad air,' and the Contagion theory, the theory that diseases were spread through physical contact. The Miasmatic theory associated dirt and odor with disease spread. The Contagion theory led to the belief that the 'ill' needed to be separated from the 'healthy' (e.g. Quarantine) and relied on identifying groups as responsible for spreading diseases (Lupton, 1995).

The new gaze, however, identified disease in the spaces between people, in the interstices of relationships, in the social body itself. In this new conceptualisation, pathology was not an essentially static phenomenon to be localized to a specific point, but was seen to travel throughout the social body, appearing only intermittently. (p. 8)

Armstrong alludes to a major shift that speaks to the focus of public health in seeing individuals as vectors of disease as opposed to individuals living with an illness. Lupton (1995) points out that while strategies of public health continue to shift overtime:

The discourses and practices of public health have carried with them moralistic and discriminatory meanings disguised under their utilitarian logic. When disease threatens to rage out of human control and science and medicine appear to be ineffective in containing it, notions of blame draw upon fears which can be traced back to medieval notions of sinfulness and punishment, purity and contagion, cleanliness and dirtiness.(p. 46)

Sears (1991) frames the contrasting features of public health and community-based organizations in terms of 'health from above' and 'health from below.' These two positions are not mutually exclusive and do overlap (especially true, since funding from government sources increasingly limits advocacy activities of community-based AIDS organizations). According to Sears, a major difference between the two approaches is in how the state fits into the lives of the individuals and conceptualizations of what 'community' means. As discussed previously, public health recognizes the state as being heavily involved in the health of the individual with the constant monitoring, surveillance and reporting of disease for the purpose of understanding and limiting disease spread.

Sears points out that, since their inception, community-based AIDS service organizations have sat in a precarious and contradicting position with regards to the state by asserting people's rights to autonomy from state intervention, right to privacy, information and informed decision-making, while simultaneously demanding resources from the state. The community-based organizations have carried out prevention at the standpoint of people affected by HIV/AIDS rather than waiting for the state to act.

Governing Rationalities or Systems of Thought

Miller and Rose (2008) distinguish between two components of governmentality: governing rationalities or 'systems of thought' and governing technologies or 'systems of action.' Rose and Miller (1992) suggest that an interest in government is in the interest of the "systems of thought through which authorities have posed and specified the problems for government, but also the systems of action through which they have sought to give effect of government" (p. 177). These systems of thought, or rationalities, put answers to questions of what issues are problematized in populations, who is allowed to govern, who can be governed and what is considered to fall in the realm of the governable. The *STOP HIV/AIDS* project problematizes the spread of HIV in B.C. and the people who are most at risk for spreading the disease. A variety of rationalities, embedded in the notion of TasP, underlie this problematization. A key focus in my thesis is identifying and exploring these rationalities as put forth through the discourses of the TasP and the *STOP HIV/AIDS* initiative.

It is important to understand how Foucault links knowledge and power in further understanding governing rationalities. According to Foucault (2007), "for knowledge to function as knowledge it must exercise a power" (p. 71). Foucault recognizes the

importance of understanding the production of knowledge rather than understanding knowledge as something that exists prior to human intervention. Foucault (1977) describes the production and maintenance of ‘regimes of truth’ by those who have access to certain forms of knowledge and are given the credibility to create true and false statements. According to Foucault, the production of knowledge includes, “the production of effective instruments for the formation and accumulation of knowledge- methods of observation, techniques of registration, procedures for investigation and research, apparatuses of control” (p. 102).

Dominant discourses of *STOP HIV/AIDS* operate by appealing to particular mathematical and epidemiological knowledges based on instruments, such as quantitative data collection and modelling that show the benefit of scaling up treatment for the populations of people who are living with HIV in B.C. These knowledges are a product of particular understandings about the world, measurement tools and power relations. What is important is not that these forms of knowledge exist, but that they enter into social relations with other knowledges and bodies to create a truth. Knowledge and truth claims emerge from the way they are sought, the instruments used and a variety of coordinated and uncoordinated practices and social relations. These knowledges or rationalities determine the types of interventions and actions directed towards those who are the target of the *STOP HIV/AIDS* initiative.

Governing Technologies or Systems of Action

Miller and Rose (2008) describe systems of action or technologies as “assemblages of persons, techniques, institutions, instruments for the conducting of conduct” (p. 16). Technologies refer to the mechanisms for carrying out governing

objectives and the ways in which governing rationalities are realized. *STOP HIV/AIDS* can be seen as a technology that uses a range of strategies and techniques to ‘conduct the conduct’ or manage the behaviours of individuals who live with, or are at risk of contracting, HIV.

The Foucauldian conceptualization of power as network-like is essential to further understand the ways in which governing technologies may work. For Foucault, power is not stagnant or a single entity that can be transferred from one place to another. Rather, power is understood as an outcome of the diverse relations among knowledges and subjects. Power exists in “networks and circuits of power that traverse different spheres of life” (Saukko & Reed, 2010, p. 3). According to Foucault (1977), power is “something which circulates, or rather as something which only functions in the form of a chain [...] and exercised through a net-like organization” (p. 98). It is useful to think of power as not one thing that moves in a unidirectional way but as enacted in and through specific relations in a network-like organization. To further understand *STOP HIV/AIDS* as a governing technology, it can be observed how the B.C. provincial government, pharmaceutical companies, media, AIDS service organizations and individuals become involved in population governance by participating in the strategies and techniques of *STOP HIV/AIDS*.

Governing through Freedom and Creation of the Subject

The exercise of a governing mode of power relies on individuals that freely take up, and act, power (Foucault, 1982). In this process, individuals are made subjects. According to Hekman (2010), “subjects are both the point of power’s inscription and the vehicle of its articulation” (p. 57). Individuals are shaped by and exercise power,

simultaneously. Foucault's understanding of power as productive and positive is important to understand the process of governing through freedom. Power does not only coerce, force or dominate individuals to behave in a certain way. Power is both enabling and constraining as power "engages with a subject or a person who acts" (Saukko and Reed, 2010, p. 7) which can bring about a variety of responses. According to Foucault (1977):

And not only do individuals circulate between its threads; they are always in the position of simultaneously undergoing and exercising this power. They are not only its inert or consenting target; they are always also the elements of its articulation. In other words, individuals are the vehicles of power, not its points of application [...]. (p. 98)

It is through action that individuals enter into power relations.

The notion that individuals carry out governing technologies through freedom is relevant to the *STOP HIV/AIDS* initiative. People living with HIV/AIDS and those who are identified as at risk, may take up testing and treatment for the 'good' of the population.³⁷ The connection for people to access testing and treatment is through physicians, nurses or clinicians, and community-based organizations. In the *STOP HIV/AIDS* initiative, individuals are the vehicle through which governing technologies move and work. At the same time, the individual becomes a subject by carrying out or resisting governing objectives. According to Foucault (1982):

³⁷ Fears emerge that TASP projects may become coercive programs, as in mandatory testing and treatment. Coercion may align more closely with Foucault's conceptualizations of 'disciplinary' rather than 'governmental' mode of power. Disciplinary power is associated with coercive techniques (such as mandated treatment) and governmental power is associated with governing techniques that are exercised through freedom of choice (such as making the decision to start treatment to be a responsible citizen).

[...] power applies itself to immediate everyday life which categorizes the individual, marks him by his own individuality, attaches him to his own identity, imposes a law of truth on him which he must recognize and which others have to recognize in him. It is a form of power which makes individuals subjects. (p. 781)

STOP HIV/AIDS puts forth particular understandings of the individual at risk for, or living with, HIV/AIDS that result in creating particular subjectivities. Individuals who are targeted for testing and treatment live the discourses of *STOP HIV/AIDS* and act the governing objectives through their responses to the project. There is an opportunity for strategic reversibility, in governing technologies and relations, as individuals have varying degrees of freedom and capability to respond to the *STOP Project* (Rose & Miller, 1992). In analyzing public responses to TasP and the *STOP HIV/AIDS* initiative, I explore how organizations and individuals respond to particular modes of subject creation as put forth through the discourses of these initiatives.

Discourse Analysis

In this thesis, through the lens of governmentality, I critically analyze the discourses of TasP and the *STOP HIV/AIDS* initiative. The *STOP HIV/AIDS* initiative can be seen as a technology enacting particular governing rationalities and strategies. It is by analyzing the discourses of the *STOP HIV/AIDS* initiative that governing rationalities, strategies and techniques are identified. Foucault (1981) explained his take on discourse, in *The Order of Discourse*, a lecture held at the College of France between 1979 and 1980. Foucault's notion of discourse is more than just language and encompasses both language and practice (Hall, 1997a). Hook (2001) echoes Foucault's notion of discourse when he writes, "...one should approach discourse less as a language

or as textuality, than as an active ‘occurring,’ as something that implements power and action, and that also is power and action” (p. 532). The interest for Foucault was to understand how discourses produce knowledge and subjects. According to Hall (1997a), a Foucauldian notion of discourse:

[...] constructs the topic. It defines and produces the object of our knowledge. It governs the way that a topic can be meaningful and talked about and reasoned about. It also influences how ideas are put into practice and used to regulate the conduct of others. Just as a discourse ‘rules in’ certain ways of talking about a topic, defining an acceptable and intelligible way to talk, write, or conduct oneself, so also, by definition, it ‘rules out’, limits and restricts other ways of talking, or conducting ourselves in relation to the topic or constructing knowledge about it. (p. 44)

Discourse comes with rules for thinking, speaking and acting, and constructs the environment in which individuals can freely act. In constructing this environment, discourse turns bodies into subjects. According to Hekman (2010), “in order to be a subject, to have an ontological existence at all, one must be recognized as a subject in the discourses of one’s society [...] the discursive enables the material in a way that does not apply to other beings” (p. 57). For instance, according to Hook (2001):

Once we consider the discursive utterance (the diagnosis of someone as a ‘pervert’ for example) as an action, as a practice or an event, then this utterance seems to start verging on the territory of materiality, and becomes more easily linked to the array of physical activities through which such a diagnosis may be made in the first place. (p. 537)

Individuals, while realized in particular discursive environments, are not, knowingly, controlled by discourse. Rather, individuals may take on and use discourses by taking up and acting on available discourses. Bacchi (2005) describes a ‘dual focus’ concentration on the ways in which discourses constrain and enable, but also on how discourses are used and ‘deployed.’ The discourses of TasP and *STOP HIV/AIDS* construct the ‘good’ and ‘responsible’ citizen with HIV (or at risk for HIV) as one that gets tested regularly, begins and adheres to treatment regimes. A person with or at risk for HIV makes decisions about their own health in a discursive environment that is permeated by these constructions. However, the person can use and resist these discourses. The importance of analyzing the discourses of *STOP HIV/AIDS* lies in the unintended consequences of a large-scale testing and treatment initiative.

Data Selection

In this thesis, I prepare a discourse analysis informed by critical theory of TasP and *STOP HIV/AIDS*. There is more than one way to do a Foucauldian, discourse analysis. My aim is to understand the function of TasP in the *STOP HIV/AIDS* initiative through an exploration of texts and visual materials. According to Hall (1997a), intertextuality refers to the process by which texts “...accumulate meanings, or play off their meanings against one another, against a variety of texts and media” (p. 232). Governing rationalities, strategies and techniques are identified by examining discourses in written and visual materials. *STOP HIV/AIDS* was a new initiative and there were few public texts about this program during the time of my data collection. I analyzed public materials of TasP and *STOP HIV/AIDS* from February 2009 to September 2011, from the following sources:

- 1) Print and electronic news stories about TasP and *STOP HIV/AIDS* from the following provincial and national newspapers: *The Vancouver Sun*, *The Province*, *The Globe and Mail* and *The National Post*;
- 2) A monthly newsletter produced for the public by the BC-CfE called *Forecast Newsletter* and a quarterly publication called *STOP HIV/AIDS Update*;
- 3) Links related to TasP and *STOP HIV/AIDS* from pages on the BC-CfE website called “Our News,” “In the News” and “News Releases”³⁸;
- 4) Public responses to, and statements about, the *STOP HIV/AIDS* initiative from online publications, such as *PositiveLite*, and organizations, such as the Canadian AIDS Society, led by and for people living with HIV/AIDS and allies.

I began the data analysis by reading and viewing the texts to identify emerging key discourses and extracting dominant messages. Stuart Hall (1997b, p. 46) uses examples from Foucault’s work to create a list of elements necessary for the study of discourse such as statements, rules, subjects and knowledges that emerge in texts and other visual materials (see Appendix 3). The examples are from Foucault’s earlier work of madness and sexuality. Drawing from and modifying Hall’s template for studies in discourse, I read and viewed the texts to identify:

- 1) Statements about *STOP HIV/AIDS* and TasP which give us a certain kind of knowledge about them;
- 2) The rules which prescribe certain ways of talking about *STOP HIV/AIDS* and TasP and exclude other ways which govern what is ‘sayable’ or ‘thinkable’ about treatment and prevention;

³⁸ Links from these web pages included coverage of TASP and *STOP HIV/AIDS* from You Tube clips as well as online articles and print newspaper articles from *Science Daily*, *The Toronto Star*, *The Economist* and *The New York Times*.

- 3) 'Subjects' (e.g. people living with HIV/AIDS, those at risk for HIV) who personify the discourse with the attributes we would expect these subjects to have, given the way knowledge about the topic was constructed at the time;
- 4) How this knowledge about the topic acquires authority, a sense of embodying the 'truth' about it; constituting the 'truth of the matter' (e.g. the disciplinary knowledge of TasP, the instruments of measure, the endorsements of TasP and *STOP HIV/AIDS*);
- 5) The practices within institutions for dealing with the subjects whose conduct is being regulated and organized according to those ideas (e.g. the practices for the individual who tests positive for HIV, the individual who is HIV positive and not on antiretroviral therapy);
- 6) Acknowledgement that a different discourse or episteme will arise at a later historical moment, supplanting the existing one, opening up a new discursive formation, and producing, in its turn, new conceptions of treatment and prevention (e.g. alternative conceptualizations of risk, prevention and treatment).

I applied a governmentality lens in the analysis with particular attention to discourses that have been identified as strategies and techniques of governing such as moral regulation, risk, criminalization and responsabilization. I linked the discourses into processes of governing including governing rationalities and techniques. I discovered where and who the subjects were in these texts, and explored the statements and truth claims made about these subjects. I examined how people living with HIV/AIDS were included and not included in the texts and identified the practices or actions (governing techniques) that emerged in, and were suggested by, the texts. I focused attention on alternative

discourses that emerged about *STOP HIV/AIDS* in the texts mentioned above, which opens space for new conceptualizations of treatment and prevention.

Ethical Considerations

I consulted front line workers who were involved in AIDS service organizations and community-based organizations, to get feedback on the relevancy of this topic while developing my proposal. I continued to seek advice from people throughout the research and writing process, in an advisory capacity, and this guided my research project. I bring a critical reflexivity to this research. My intention is to forefront the people who are living with HIV/AIDS, in my research. I sought the input of people living with HIV/AIDS and their allies. This data is used in an advisory capacity as human subjects are not included in my project. I have both “insider” and “outsider” status. I am not living with HIV, so I am an outsider to the experiences of those who are. However, my work, community organizing, and consultation with AIDS service organization workers and others who live with and work in the field of HIV/AIDS allows me to gain some inside knowledge about the diverse experiences of people living with HIV/AIDS.

Limitations and Significance of the Research

In this research, I rely on secondary data. This information is constantly being updated through further research which re-shapes the discourses. My data comes from the introduction of TasP to the public through to the implementation of the *STOP HIV/AIDS* pilot project (February 2009- September 2011). This research is significant because it presents the discourses from the initial years of the project and how the discourses contributed to the framing of *STOP HIV/AIDS* by the leading project

spokespeople, and were taken up in the general population. Through the lens of governmentality, I describe the discourses that are influential, and perhaps unintentional, in constructing new (or re-created) prevention and treatment knowledges and subjectivities.

Chapter 4: The Discourses

A key aim of this research project is to identify dominant and alternative discourses of *STOP HIV/AIDS* and TasP. Foucault described how discourses embody and exercise power and knowledge and how the social relations between multiple actors shape and are shaped by discourses (Foucault, 1981). The way that discourses are taken up, responded to and resisted contribute to the forming of these discourses and also the creation of the subject. In this Chapter, I identify the key dominant and alternative discourses.

Dominant Discourses

STOP HIV/AIDS, the first pilot project to test the effectiveness of treatment as prevention, appeals to the ‘knowns’ about how HIV functions and behaves, and the actions and spread of HIV in the population. The TasP model is reported to have great benefits to both population health and the health of people living with HIV/AIDS. The proponents of *STOP HIV/AIDS* predict that scaling up testing and treatment in B.C. will have many positive effects, including decreasing the number of new infections. The dominant discourses speak to the ease of introducing and implementing a wide-scale testing and treatment program in B.C.

Dominant discourses analyzed for this thesis include those produced by the BC-CfE about TasP and *STOP HIV/AIDS*, and include news stories, monthly and quarterly publications such as the *Forecast Newsletter*, and links to web pages on the BC-CfE website. Dr. Julio Montaner is the primary knowledge producer for TasP and *STOP HIV/AIDS*. Montaner is the spokesperson for *STOP HIV/AIDS* in his role as a practicing

physician, the director of the BC-CfE, head of the STOP Project, and as the academic researcher responsible for publicizing the concept of TasP. There is overlap between the discourses produced by the BC-CfE and those of the media. The BC-CfE is diligent at putting out press releases about developments in *STOP HIV/AIDS* and TasP, and the news media reference Montaner continually. For instance, news media articles look to the BC-CfE to frame stories about TasP and *STOP HIV/AIDS*, similar to the description used by the BC-CfE, with Montaner as the key spokesperson. In turn, the BC-CfE provides links to media articles to reinforce and build support for this project. There is a circularity of claims among discourses produced within and outside the BC-CfE about TasP and *STOP HIV/AIDS*.

In this next section, I divide the dominant discourses of TasP and *STOP HIV/AIDS* into eight headings which include: provincial and international support for TasP and lack of federal leadership in HIV/AIDS; TasP: a ‘paradigm shift’ and a ‘game changer;’ TasP as beneficial to the individual and society; human rights and harm reduction; proof and certainty; failure of current prevention efforts; risk discourses and, finally, universal treatment.

Provincial and international support for TasP and lack of federal leadership in HIV/AIDS

The BC-CfE received critical support for TasP in February 2010 when the provincial government funnelled \$48 million into B.C. health authorities for the *STOP HIV/AIDS* pilot project (MoH et al., 2010). However, prior to the *STOP HIV/AIDS* funding announcement, the BC-CfE effectively publicized key events related to support and endorsement of TasP through their monthly publication, *Forecast Newsletter*, and

media releases. These highly publicized endorsements are important in both problematizing the spread of HIV and providing TasP as the solution. The first major endorsement of TasP is described as happening at the 5th IAS conference in South Africa in 2009. According to BC-CfE's *Forecast Newsletter* (October, 2009), "[...] at this year's International AIDS Society (IAS) Conference in South Africa, the strategy was hailed as the 'topic of the year.' This prevention and containment strategy is now widely accepted by experts worldwide" (p. 1). The BC-CfE publicized this endorsement despite the fact that mathematical models and observational data were the only evidence to suggest the benefit of antiretroviral therapy for prevention (Montaner et al., 2006).

The next publicized endorsement is described as WHO's endorsement of TasP in 2009. According to the BC-CfE's *Forecast Newsletter* (July/August, 2009), "An important boost for the treatment as prevention approach came from the World Health Organization (WHO), which had resisted this concept for years" (p. 2). Again, in another issue of *Forecast Newsletter* (BC-CfE, December, 2009), "Earlier this year WHO researchers independently validated the BC-CfE's claim with the publication of the results of a separate mathematical model predicting that global universal treatment with antiretroviral drugs would reduce HIV infections [...]" (p. 3). International endorsements moved closer to home with the United States endorsing and financially supporting the BC-CfE's work later in 2009. In December 2009, the BC-CfE announced through their *Forecast Newsletter* that U.S. health officials, using the BC-CfE's TasP model, were to launch 'seek and treat'³⁹ in the Bronx and in Washington, D.C. (BC-CfE, December, 2009). In that same month, the BC-CfE sent out a press release indicating that NIDA had

³⁹ This is not the current BC-CfE's pilot project. U.S. health officials used the same language to develop their project in the Bronx and in Washington, D.C.

committed \$50 million over five years to evaluate the *STOP HIV/AIDS* project in B.C. (BC-CfE, 2009b).

Canadian financial support came in October 2009, when the BC-CfE published press releases indicating grants received from the Bank of Montreal (BMO) and the Canadian Institutes of Health Research (CIHR) (BC-CfE, 2009a; BMO Financial Group, 2009). Montaner, as the lead spokesperson, worked to have TasP endorsed in the international scene prior to national and provincial endorsements. In addition, the BC-CfE publicized international and U.S. support for TasP to pressure national and provincial governments. This chronology of endorsements speaks to a particular strategy in building momentum for TasP and *STOP HIV/AIDS*. In February, 2010, the B.C., government made the official funding announcement for *STOP HIV/AIDS* (MoH et al., 2010).

The publishing of endorsements illuminates political tensions between federal and provincial governments. It is stated in an issue of BC-CfE's *Forecast Newsletter* (January, 2010), "While Montaner lauded the contribution made by the U.S. in the fight against HIV/AIDS, he was critical of the lack of support from Canada's federal leadership [...]" (p. 2). In the same issue of the *Newsletter*, Montaner is shown as deeply thankful to the B.C. government for leading the way on the project. According to the *Newsletter*:

Reflecting on the growing global acceptance of the treatment-as-prevention strategy, Dr. Montaner noted that it was tremendously gratifying for him to see that this approach has secured endorsement at the highest possible levels provincially and is also increasingly shaping public policy abroad. (p. 2)

The provincial government is aligned with progressive international public policy while the federal government is not mentioned. In this *Vancouver Sun* article, Pemberton (2010) quotes Montaner as saying:

At the end of the day, this is a key strategy to control the epidemic, said Montaner, who added he is disappointed the Canadian government has not made a statement in support of treatment. He said he has invited Prime Minister Stephen Harper to the International AIDS Society World AIDS Conference in Vienna in July but has yet to receive a reply. “That tells you the story. The feds don’t want to talk to us,” he said. (n.p.)

Montaner critiques the federal government’s lack of support for HIV/AIDS treatment and prevention. In an article in *The Province* (Ivens, 2010a), Montaner is quoted as saying:

We begged, asked and implored for [HIV/AIDS] issues to be made part of the agenda for the G8 [conference last month]. We were met with total silence on their part. [...] This is sad. We cannot have British Columbia leading the world and Canada watching from the side. (n.p.)

The lack of recognition of TasP is generalized to become a symbol for the lack of commitment and leadership in the federal government for HIV/AIDS.

The next major publicized support for TasP comes with the endorsement from the Joint UN Programme on HIV/AIDS (UNAIDS). According to the BC-CfE’s *Forecast Newsletter* (May, 2010), “This strategy has also been [...] embraced by Michel Sidibe, Executive Director of UNAIDS, who publicly hailed Seek and Treat as an ‘aggressive form of prevention’” (p. 3). UNAIDS acted on their endorsement of TasP when they introduced *Treatment 2.0*, a treatment initiative involving simpler treatments with a focus

on a public health, prevention goal. According to the BC-CfE's *Forecast Newsletter* (July/August, 2010), "Mr. Sidibe cited the groundbreaking work coming out of B.C. as evidence supporting the UNAIDS' push for Treatment 2.0 – a global HIV treatment revolution" (p. 1).

The UNAIDS endorsement of TasP is again used, through a press release put out by the BC-CfE (2010a), to address the Canadian federal government's lack of commitment to HIV/AIDS:

As UNAIDS leads countries around the world to deepen their commitment to the made-in-B.C. concept of treatment as prevention, the government of Canada is standing on the sidelines," said Montaner. "We need Canada to reflect the global commitment to treatment as prevention, and take a leadership role in this important initiative." (n.p.)

The 'made-in-B.C.' term comes to be a catch phrase used throughout the provincial media outlets. The use of the 'made-in-B.C.' as opposed to 'made-in-Canada' term, speaks to the framing of TasP as a provincial rather than federal initiative. In an issue of *Forecast Newsletter* (BC-CfE, January, 2011), former B.C. Premier Gordon Campbell is quoted as saying, "I can tell you the voices that we hear from across the province, and the voices we hear from around the world, are saying that British Columbia is on the leading edge of dealing with this issue" (p. 1). China's endorsement of TasP was publicized by the BC-CfE's *Forecast Newsletter* (March, 2011) when the "world's most populous nation embraces treatment as prevention" (p. 1).

The results of the HPTN 052 study, released in May 2011, showed a 96% reduction in transmissions of HIV with the earlier initiation of antiretroviral therapy

(Cohen et al., 2011). The results were publicized by the BC-CfE as the ultimate legitimacy to the efficacy of TasP. According to the BC-CfE's *Forecast Newsletter* (May, 2011), "International support for the BC-CfE- pioneered concept of Treatment as Prevention continued to build this month with the release of a landmark study demonstrating the overwhelming effectiveness of antiretroviral therapy in reducing HIV transmission" (p. 2). Dominant discourses produced by the BC-CfE and re-produced by the media, through use of the BC-CfE's press releases, served to show the growing momentum of TasP as a legitimate prevention strategy on a global scale. International endorsements are used strategically to distinguish TasP and *STOP HIV/AIDS* as a provincial rather than a federal initiative. International and provincial support for TasP is set in contrast to the federal government's lack of commitment to HIV/AIDS. TasP is presented by the BC-CfE as a politically charged issue highlighting a tension between federal and provincial governments.

TasP: A 'paradigm shift' and a 'game changer'

The news media effectively publicizes international endorsements of TasP. TasP is treated like an invention, novel or new approach to preventing the spread of HIV. *The Globe and Mail* (York, 2009) tells a simple story of a decade's worth of work from a scientist with a dream, a dream of seeing the end of AIDS. The narrative begins with Montaner and other scientists from the BC-CfE working tirelessly for over 10 years to prove that treatment is effective for prevention. The media highlights how the BC-CfE's team of researchers persevered despite not always being taken seriously. Finally, the controversial idea of TasP becomes finally accepted by the medical and political community. According to *The Globe and Mail* (York), "A lot of people thought Julio

Montaner was a little crazy when he first suggested that the best way to eliminate the AIDS epidemic would be a massive scheme to give AIDS medicine to every infected person” (n.p). And further on the article quotes Montaner, “The more you treat, the more you reduce the cases. ...When we first suggested this in 2006, people thought we were a little loonie. But it’s now fully accepted. We just need to get started” (n.p.). A benevolent ‘underdog’ story about a physician not taken seriously culminates in a paradigm shift that transforms global conceptualizations of treatment and prevention. The AIDS 2010 conference opened with a panel called, “Toward a Paradigm Shift in Treatment and Prevention,” with the argument that treatment and prevention are no longer two separate domains, with newfound evidence that treatment is effective for prevention (“AIDS 2010: Towards a paradigm shift,” 2010). Here it is that claims of TasP as a ‘paradigm shift’ were made long before the HPTN 052 results were announced. HPTN 052 was seen as the study proving what had been said all along: antiretroviral therapy is highly effective in preventing the transmission of HIV.

Foundational results of the HPTN 052 study were announced in May 2011, and reinforced the idea of TasP as a transformative discovery. The international *Economist* (“End of AIDS”, 2012) followed up on the results of the HPTN 052 study and stated, “this is the sort of area where a single scientific breakthrough might, like the invention of AIDS-suppressing drugs and the discovery that those drugs could be used to break the chain of transmission, change everything” (n.p.). TasP is paralleled to the discovery of antiretroviral drugs in this article. A discursive shift occurs with the results of HPTN 052 study where the ‘paradigm shift’ in understanding the use of antiretrovirals for prevention becomes a ‘game changer’ in July 2011. This shift implants the notion of TasP in its

ability to change the face of the AIDS epidemic. In *The Globe and Mail* (Itan & Picard, 2011), Montaner is quoted at the IAS conference as stating, “The notion that treating HIV can reduce the chances of the disease spreading – and therefore is also an effective means for prevention – ‘is a true game changer’” (n.p.). Language such as ‘paradigm shift’ and ‘game-changer’ serves to situate TasP as prompting a new era of HIV prevention. TasP is described as a new and novel concept to the benefit of individuals living with HIV/AIDS, and society, as a whole.

TasP as beneficial to the individual and society

There are two major justifications for the introduction of a population wide HIV prevention program in the dominant discourses of *STOP HIV/AIDS* and TasP. These are the benefit to the individual and the benefit to society. It is predicted through mathematical modelling that TasP will, drastically, decrease the spread of HIV in a population (Lima et al., 2010; Montaner, 2008; Montaner et al., 2010a) as well as be a cost effective solution to decreasing the spread of HIV (Granich et al., 2008; Johnston et al., 2010; Lima et al., 2010). The results of a random controlled trial are used to support the use of treatment for prevention among serodiscordant heterosexual couples (Cohen et al., 2011).⁴⁰ The dominant discourses speak to the benefits of TasP for, both, society and the individual living with HIV/AIDS. In the BC-CfE’s *Forecast Newsletter* (June, 2011), Dr. Cutler, Director of HIV prevention programs at Centres for Disease Control and Prevention in New York, is quoted as saying, “The evidence increasingly suggests that early antiretroviral treatment is a classic ‘win-win,’ meaning that it benefits both the

⁴⁰ There are other studies that have since come out to test the efficacy of TASP (see Cohen et al., 2012d for details).

individual patient and contributes significantly to a reduction of secondary HIV transmissions” (p. 1). The idea that TasP is a ‘win-win,’ or a solution that benefits both the individual living with HIV and society, is pervasive in the discourses. The discourses of individual and societal benefits of TasP are now examined.

A) Benefits to the individual

TasP is a public health initiative aimed at reducing the spread of HIV in the population. The ecological and mathematical modelling used to justify TasP is primarily focused on the benefits for public health. From the start of the STOP Project, however, the BC-CfE has produced knowledge testifying to the benefit of TasP and *STOP HIV/AIDS* for people living with HIV/AIDS, as the primary goal. *STOP HIV/AIDS* has been framed as a political, as well as medical project, that has as much to do with advocating for access to antiretroviral medication as increasing uptake of medication for those living with HIV. A *CTV National News* story (“CTV National News,” 2010) about *STOP HIV/AIDS* commences with AIDS activists marching at the international AIDS conference to demand global access to antiretroviral medications. Next, Montaner is shown sitting at his desk and *STOP HIV/AIDS* is described. In this, and other media reports from the AIDS 2010 conference, the link is made between the right to individuals’ access to antiretroviral treatment and TasP and other biomedical prevention initiatives (BC-CfE, 2010a; July/Aug, 2010; “AIDS 2010: Official Press Release,” 2010). Nguyen et al. (2011), discuss how AIDS 2010, with the theme, “Rights Here; Right Now,” was co-opted by Montaner and the TasP agenda, where the political message of the need for individuals to access antiretroviral therapy for their *own* good, came second to access to treatment for prevention purposes.

In another example, a representative from the AIDS community is frequently situated alongside researchers from the BC-CfE. Mr. Kerr, the representative, is featured on both the front cover of an issue of the *Forecast Newsletter* (BC-CfE, February, 2010) and in the press release (MoH et al., 2010) announcing the *STOP HIV/AIDS* project. When the funding for *STOP HIV/AIDS* was announced, the February 2010 issue of *Forecast Newsletter* reported:

Mr. Kerr, who has been HIV positive for 25 years, said that he began taking the new drugs in 2006, he feels “like I’ve been given my life back” [...] The *Globe and Mail*, which dubbed Seek and Treat a “street-smart ambitious” strategy, noted that Mr. Kerr, supported by several other patients and Dr. Montaner, has waged a high-profile battle with Canadian health regulators to obtain access to experimental HIV drugs. (p. 2)

In both texts, the link is made between *STOP HIV/AIDS* and Kerr’s political battle for access to experimental, ‘life-saving’ HIV drugs, not covered by Medicare. The *STOP HIV/AIDS* initiative is linked to antiretrovirals giving Mr. Kerr’s ‘life back.’ The press release is the first of many texts to describe the life-saving properties of antiretrovirals for use in the STOP Project. After that, in almost every description of *STOP HIV/AIDS*, the term ‘life-saving’ is used to describe the use of antiretrovirals for prevention. In the *Vancouver Sun* (Ivens, 2010b), Montaner is quoted as saying, “So, while treatment is highly cost-effective on its own merits because it is a life-saving, disease preventing intervention, it has a multiplier effect on the prevention axis” (p. A3).

The repetitive use of the term ‘life-saving’ has two effects: one, TasP is linked to the right to medication, an ongoing, long term battle fought by AIDS activists – making

TasP a human rights issue; and two, TasP becomes associated with antiretroviral therapy for the benefit of the individuals' well-being, distancing TASP from a population prevention initiative. The STOP Project becomes the mechanism by which specific groups of people get access to medications, which are represented as having the potential to save their life. In an issue of BC-CfE's *Forecast Newsletter* (October, 2009) it is clear who needs this access:

The seek-and-treat strategy, known as "Seek and Treat for Optimal Prevention of HIV/AIDS" (STOP HIV/AIDS) aims to drastically increase access to the life-saving HAART treatment among groups that are at risk of HIV infection. This includes injection drug users, sex-trade workers, prisoners, aboriginals and those with other underlying health conditions such as mental illness. (p. 1)

The subjects in this dominant discourse are people living with HIV/AIDS who belong to key risk groups. Subsequent *Forecast Newsletters* provide snapshots of information on the benefit of antiretroviral therapy for people who use drugs (BC-CfE, March, 2010; October, 2010), children (April, 2010), Aboriginal people (July/August, 2010) and mothers (November, 2010). As mentioned in the literature review, there are concerns about the adverse effects of medications for individuals living with HIV/AIDS including building drug resistance, the transmission of drug resistant strains, the emergence of drug sensitivities and the long term effects associated with starting antiretroviral therapy earlier in the course of the disease (Blower & Gershengom, 2000; Blower et al., 2001; De Cock et al., 2009; Gay & Cohen, 2008; Granich et al., 2008; Velasco-Hernandez et al., 2002; WHO, 2009). The dominant discourses, by far, speak only to the benefits of TasP

for people living with HIV/AIDS by linking it to issues of access to the life-saving properties of antiretrovirals.

B) Benefits to society

A major discourse paralleling the ‘life-saving’ properties of antiretrovirals for the individual is the secondary benefit of antiretrovirals for the population not living with HIV. *The Province* (Ivens, 2010a) quoting Montaner states, “We expanded the use of antiretroviral therapy coverage because we had some preliminary evidence that this is not just good for the patient, but it’s also able to decrease the likelihood of people transmitting HIV” (n.p.). The benefit to the individual is assumed rather than overtly described in discourses pertaining to the benefit to society. A *Globe and Mail* article (Mickleburgh, 2010) describes the function of antiretrovirals in the *STOP HIV/AIDS* project as, “the powerful, anti-HIV drug cocktail that has transformed the once-lethal disease into a chronic, manageable condition not only works, it does double duty” (n. p.). In this article, antiretrovirals are personified. Antiretrovirals are described as a productive entity, transforming HIV/AIDS into a manageable condition, and further, protecting society. According to Montaner, quoted in an article in the *Vancouver Sun* (Hall, 2010), “For patients, HAART treatment prevents virus replication, slows disease progression, extends life expectancy and significantly reduces the number of new HIV-related diseases and AIDS-related deaths” (n.p.). Antiretrovirals are represented as multiple in their positive effects and good for everyone. The benefits to the individual are not separated from the population, but instead, what is good for the population is good for the individual.

Human rights and harm reduction

A prevalent discourse that emerges is the link between *STOP HIV/AIDS*, human rights and harm reduction. *STOP HIV/AIDS* is described as a human rights approach in this *New York Times* article (McNeil, 2011):

By offering clean needles and aggressively testing and treating those who may be infected with H.I.V., Vancouver is offering proof that an idea that was once controversial actually works: Widespread treatment, while expensive, protects not just individuals but the whole community. (n.p.)

In this article, *STOP HIV/AIDS* is portrayed as a controversial approach in line with other harm reduction approaches, such as Insite in Vancouver, B.C. Harm reduction initiatives, such as distributing clean supplies and ‘aggressively testing and treating’ are seen as two components of the same strategy. In the BC-CfE’s *Forecast Newsletter* (February, 2011), the connection is again made between harm reduction and TasP:

Their [City of Vancouver and Province of B.C.] support has enabled us to prove that harm reduction and treatment as prevention are effective health policies that save money and save lives, and now we need the world to hear these messages and implement these programs (p. 1).

The link that is made between harm reduction and TasP blurs the line between two, very different rationales for health interaction with the individual living with HIV/AIDS.

Harm reduction aims to alleviate harms associated with risk behaviours for the secondary benefit of preventing the spread of HIV in a population. TasP, as a public health initiative, advocates interventions for the individual for the purpose of preventing the spread of HIV in the population.

STOP HIV/AIDS is also discursively linked to human rights through global access to essential health care services. TasP becomes the mechanism for which people get access to ‘lifesaving’ antiretroviral therapy. In a *Globe and Mail* article, Picard (2010) quotes Montaner, “you cannot access appropriate health care if you are stigmatized against, persecuted, criminalized, prosecuted, silenced [...] if we discriminate, people won’t be tested and they won’t be treated” (n.p.). And further in this same article, Montaner is quoted as saying:

We hope that Vienna will have, as its crowning moment, the adoption of Treatment 2.0, the recognition that treatment is prevention and the recognition that we need to ameliorate the human-rights deficit to open the door to more effective treatment. (n.p.)

HIV is recognized as a human rights issue with multiple factors impacting testing and treatment access, but interestingly, treatment is framed as the outcome of working to alleviate human rights abuses. The benefit of antiretroviral therapy for society is extended beyond the spread of HIV. In an issue of BC-CfE’s *Forecast Newsletter* (July/August, 2010), Michael Sidibe, the executive director of UNAIDS, is quoted as saying, “Dr. Montaner stated that expanding HAART coverage will have multiple benefits including decreasing tuberculosis, decreasing the number of orphans and preserving and strengthening health systems in affected countries around the world” (p. 2). And in another issue of *Forecast Newsletter* (BC-CfE, May, 2010):

A recent Ugandan study found HAART treatments helped reduce the number of orphans by 93% and decreased mortality among uninfected children – who are

often left motherless and more likely to die within two years of their mother's death – by 81 per cent. (p. 2)

These affirmations firmly implant the notion that antiretroviral therapy is beneficial to others beyond the person living with HIV/AIDS by appealing to the societal fears of motherless children and orphans. Also, internationally recognized supporters such as Stephen Lewis have endorsed the projects potential to reduce suffering to others. In the BC-CfE's *Forecast Newsletter* (May, 2011), Lewis is quoted as saying, "The validity of Treatment as Prevention seems to be to be proven by Julio and others beyond a reasonable doubt, and to delay the implementation any further is frankly unconscionable" (p. 1). Stephen Lewis, who is internationally recognized for his work on human rights issues, is paralleled with TasP, further aligning the project with a human rights discourse in the societal benefit of access to medications.

Proof and certainty

Proof and certainty is a discourse related to the benefit of *STOP HIV/AIDS* for society. In the literature review, it is described how there are uncertainties surrounding TasP, such as the feasibility of unfolding a wide scale prevention initiative and how it will work in practice. The uncertainties do not emerge in the materials produced by the BC-CfE or in the media but do emerge in small academic circles and in alternative discourses. The BC-CfE, in 2009, declared the proof and certainty of treatment for prevention purposes with only evidence from mathematical modelling and population observation. The BC-CfE (July/August, 2009) refers to Dr. Pedro Cahn, past president of IAS and states, "Considering the remarkable success of AIDS medicine so far, Dr. Cahn emphasized that the concept of HAART as prevention has to be redefined as HAART is

prevention” (p. 5). A shift in language from Treatment *as* Prevention, to Treatment *is* Prevention secured the benefit of treatment for the prevention of secondary infections and the spread of HIV in a population.

Disbelief in the efficacy of TasP is framed as incomprehensible by the time the HPTN 052 study announcement, in May 2011. At the July 2011, IAS Conference, Montaner tells a reporter for the conference (“Interview with Julio Montaner,” 2011), “We now have definitive proof that when you treat a serodiscordant couple the treatment of the person infected by HIV is not only good for his or her health but decreases transmission by 96%” (n.p.). The HPTN 052 study provides the ‘definitive proof’ for the efficacy of TasP. Later in this interview, Montaner is quoted, “We are at the point that we can start talking about the end of AIDS” (n.p.).

In an issue of the *Forecast Newsletter*, the BC-CfE (July/August, 2011) quotes the director of the U. S. National Institute of Allergy and Infectious Diseases (NIAID), as saying, “Julio has been talking about Treatment as Prevention for a very long period of time,” said Dr. Anthony Fauci, “Now we have absolute confirmed data that he was right all along” (p. 1). The occasional news article provides a one-sentence disclaimer about the results of HPTN 052 amidst these claims of proof and certainty, “While the study shows a correlation between use of HAART and HIV diagnosis, researchers said the results are not conclusive proof of causality” (Iltan & Picard, 2011, n.p.). This disclaimer does not seem to impact the dominant claims of definitive proof and ‘absolute confirmed data’ for the prevention of HIV through treatment.

Again, a political discourse appears. The dominant discourse supports the proof and certainty of TasP while it quells the voices of those who speak about the uncertainty

or the need for more evidence. The dominant discourses present resistance to TasP as a case of *political will* rather than lack of evidence with the framing of TasP as proven, and as a human rights issue. According to Montaner et al. (2010b):

A decision that all HIV medical providers, researchers, public health advocates, and policymakers must face, therefore, is do we know enough now to expand HAART to those in need or should we wait until we have more evidence on its impact and effectiveness? We argue for the former; there is a public health and humanitarian imperative to expand HAART coverage to all those in medical need according to current medical guidelines. (p. S8)

The calls for more evidence that emerge in the alternative discourses are downplayed in the dominant discourses, in light of the creation of a ‘public health and humanitarian imperative’ for treatment access.

Failure of current prevention efforts

The benefit of antiretroviral therapy over and above other prevention strategies is one more emerging dominant discourse. This discourse encompasses a variety of claims stating that the current strategies are unsustainable, that antiretroviral therapy is the leading prevention initiative, and there is a failure in current prevention efforts. Early on in the TasP discourse, the use of condoms and other harm reduction efforts are rendered unsustainable in light of the return on investment of antiretroviral therapy for HIV prevention. According to Montaner et al. (2006), “The present approach to the management of HIV/AIDS is clearly unsustainable” (p. 534). The BC-CfE set the stage for the use of antiretrovirals as the most effective prevention strategy after rendering the current approaches to prevention as unsustainable. In a 2010 news article (“Updated HIV

therapy,” 2010), Montaner is quoted as saying, “[...] individual and societal benefits of starting earlier HIV treatment provide further momentum for treatment as prevention, which – in the absence of a vaccine or cure – remains the best way to contain and halt the spread of HIV” (n.p.). Prevention initiatives, such as the distribution of condoms and promotion of safer sex, are portrayed as stagnant. As well, previous prevention initiatives are understood to have failed. Bernard Hirschel, head of the HIV/AIDS unit at Geneva University Hospital, tells a reporter at the 16th Conference on Retroviruses in Montreal, Quebec (“HIV treatment as prevention,” 2009), “The situation with prevention is that we are back to square one, because condoms, behavioural change, the hopes in microbicides are dashed, we need all the help we can get in prevention [...]” (n.p.). *The Globe and Mail* (York, 2009) quotes Montaner as saying, “After initial progress in reducing AIDS in the developed world, the condom strategy has failed to make further progress in recent years, he said. I’m not happy with a plateau. We can’t accept just a stabilization of the problem” (n.p.).

The current prevention strategies are portrayed as unsustainable, stagnant or failed in the dominant discourses. Treatment as prevention comes forward as the solution to the problem of ineffective prevention strategies. This discourse does not recognize the reality that current prevention strategies have been extremely successful in curbing the spread of HIV. These dominant claims have also resulted in backlash from the AIDS community (discussed further in the alternative discourses section below). One diminutive contrast, about current prevention efforts, is found in this article in *The Toronto Star* (Black, 2010), where Montaner is quoted as saying, and “what we’re saying is if you treat everyone who is eligible for antiretroviral therapy, we will have a

significant effect on prevention. But it won't entirely stop the epidemic. Other prevention tools are still important" (n.p.). The quote in this article is, by far, an exception to the dominant discourse, with a measured and understated portrayal of the benefits of treatment for prevention. This statement could have been made as a response to the reaction from the AIDS community about failures of current prevention methods.

TasP is presented as an economically sustainable initiative. Montaner tells a reporter, in a 2011 interview at the IAS conference ("Interview with Montaner," 2011), "We have many tools that we can use to stop the epidemic, but the most important tool, the one that gives you the greatest return for your investment is antiretroviral therapy" (n.p.). This quote provides a glimpse into how the term, 'failure' is defined by the BC-CfE. Current prevention strategies are deemed to be economically unsustainable which sets the stage for TasP as an effective economic strategy.

Risk discourses

Risk discourses pertain to the risk of HIV transmission for society and include: HIV/AIDS as a threat to society, the use of militaristic and war metaphors to describe HIV and AIDS and the economic risk of HIV transmission. In this section, I describe each risk discourse in detail.

A) Threat to society

A discourse which overlaps with the benefit of TasP for society is the risk of transmission of HIV for society. It is in this discourse that AIDS is most clearly re-problematized as a public health imperative. Embedded in public health initiatives is a problematization of the spread of disease and an impetus to monitor, survey and regulate those living with the disease. An underlying impetus for TasP is the estimated

percentage of the population who is living with HIV, who do not know they have it and who, unknowingly, spread HIV in the population. *The Globe and Mail* (Mickleburgh, 2010), reporting on Vancouver's health authorities' call for universal testing, writes, "Identifying this 'hidden iceberg' of unsuspecting HIV-infected individuals will enable them to receive earlier treatment, thus significantly reducing the spread of AIDS, according to health authorities here" (n.p.). The goal of the project is presented as identifying individuals who pose a threat to society despite the article's focus on the potential for *STOP HIV/AIDS* to reduce stigma through universal testing. The BC-CfE's *Forecast Newsletter* (January, 2011) makes this a comprehensible objective:

An estimated 25 per cent of the approximately 13, 000 British Columbians living with HIV are unaware of their infection. "This is not only bad for the individual because they are unable to access treatment and its significant health benefits sooner, but it's also bad for the community because undiagnosed individuals pose a significant risk of transmitting the virus to others," said Dr. Julio Montaner, Director, BC-CfE. (p 2)

A blanket statement about people living with HIV/AIDS posing 'significant risk' is made without acknowledgement of the risk behaviour. The dangerous assumption is made that all people living with HIV/AIDS pose a significant risk to society.

B) Militaristic and war metaphors

The use of militaristic language and war metaphors is yet another risk discourse evoking fear of the virus and people living with HIV/AIDS. The STOP pilot project was first referred to by its abbreviated title, 'Seek and Treat' but later called *STOP HIV/AIDS* due to the strong, adverse response from the AIDS community. The war metaphors

continue to be used in the dominant discourses about the project, although the project is no longer referred to as ‘seeking’ and ‘treating.’ There are several times when the media uses war metaphors to conjure up images of the AIDS attack on society. According to *The Vancouver Sun* (“Revolutionary drugs,” 2009):

Indeed, Dr. Julio Montaner and the medical research team at the B.C. Centre for Excellence in HIV/AIDS have increased the scale of the battlefield. This time Montaner is preparing to launch his most ambitious AIDS-fighting effort yet with the proposed expansion of life-saving antiretroviral therapy in two of B.C.’s hardest-hit communities. (n.p.)

The terms ‘battlefield,’ ‘launch,’ and ‘AIDS-fighting effort’ all speak to a war against AIDS. Antiretrovirals are portrayed as the life-saving source for the ‘hardest hit’ communities on the AIDS battlefield. AIDS is imagined as the enemy and antiretrovirals are the weaponry against AIDS. According to an issue of *Forecast Newsletter* (BC-CfE, June, 2011), “Over the years, Dr. Montaner has avidly advocated expanded access to HAART to all medically-eligible HIV-positive individuals as a potent weapon in the fight against HIV/AIDS” (p. 2). War metaphors are used to describe the fight against AIDS at a population level as well as within the body of the person living with HIV. According to an article in *The Globe and Mail* (York, 2009):

The notion of treatment as prevention ‘creates a powerful new rationale’ for the expanded use of anti-retrovirals and other AIDS drugs, he said. ‘We have transformed treatment from being merely a life-saving tool. Now it means we are protecting society, we are protecting our children.’” (n.p.)

This transformed status of treatment as prevention moves antiretroviral therapy outside the realm of the individual allowing it to protect society at large. In another *Globe and Mail* article (Picard, 2010), Montaner is quoted as saying, “Through methodic research and with evidence-based decision-making we have transformed a devastating set of circumstances into something we have the tools to control” (n.p.). Antiretrovirals are ‘transformed’ into a tool for ameliorating a ‘devastating set of circumstances’ and are now regarded as, both, the tools to control HIV, and the weaponry to rid HIV in protecting society. And in an issue of *Forecast Newsletter* (BC-CfE, June, 2011), “We have the therapies to effectively conquer this epidemic, said Montaner.” (p. 1). In another article in the *New York Times* (McNeil, 2011), B.C. doctors are portrayed as heroes putting people on treatment for the benefit of society as a whole:

Doctors often feel a greater commitment to each patient’s comfort than to the abstract idea of fewer infections in a given city. But Vancouver is a different story. Canadian medical care is free for the poor, doctors are expected to pursue public health goals and Vancouver’s provincial health department aggressively hunts for people to test. (n.p.)

This article conjures up images of valiant doctors, ‘aggressively’ seeking out people living with HIV/AIDS for the benefit of the population. In an issue of *Forecast Newsletter* (BC-CfE, June, 2011) the consequence of not controlling the epidemic is described: “Any further delay in implementing treatments worldwide will result in millions of preventable HIV infections, incalculable misery and death, and jeopardize the health of future generations” (p. 1). In an interview with the CBC (2011), Montaner

describes treatment as prevention as the “Dramatic turning point in the war on AIDS” (n.p.). Thus, the containment of HIV is perceived as a battle and a battle that can be won.

An economic theme interweaves through the war and militaristic discourses. In *The Economist* (“30 Years War,” 2011) the statement is made that, “The armory, in other words, is getting fuller. But war costs money, and money is in short supply at the moment” (n.p.). Further, in *The Economist* (“End of AIDS,” 2011), the article reads, “The question for the world will no longer be whether it can wipe out the plague, but whether it is prepared to pay the price” (n.p.). Here, again, TasP is framed as a political and economic issue while the concerns of TasP itself are left, unquestioned. The question becomes: are countries willing to pay the price to combat AIDS?

A discursive connection between Tuberculosis (TB) and HIV sheds light on how talking about AIDS as a battle, can quickly become a coercive treatment discourse. Montaner discusses the benefits of TasP and the results of the HPTN 052 study at the 2011 IAS conference (“Interview with Montaner,” 2011) where he makes the comment:

What this means is that not unlike other diseases, like tuberculosis [...] My dad was a TB doctor and he always taught me when you treat a person with TB, that individual, virtually the moment they start treatment from a public health perspective, it’s no longer a problem...the best thing you can do for the epidemic is to find the cases, offer them treatment, help them to take the treatment and you can solve the problem – where HIV becomes the same thing. (n.p.)

In reality, TB is a very different disease than HIV, far more infectious and easy to contract. A connection is made between HIV and TB, which could open up the

possibility for a public health approach to HIV treatment, including mandatory treatment, as in the case of treatment for active TB in the current TB prevention strategy in Canada.

TasP is simplified and described in *The Economist* ("End of AIDS," 2011), with an example of vaccination:

Now it seems that treatment and prevention will come in the same pill. If you can stop the virus reproducing in someone's body, you not only save his life, you also reduce the number of viruses for him to pass on. Get enough people on drugs and it would be like vaccinating them: the chain of transmission would be broken.

(n.p.)

The ultimate goal, breaking the chain of transmission, is described as a win for both the individual and population. Vaccination, meaning providing probable immunity to a person and preventing the contracting of a disease, is used by *The Economist* to mean preventing the spread of HIV in the population, which further highlights the focus on the health of the population over the individual.

C) Economic risk

A dominant discourse about *STOP HIV/AIDS* and TasP is the strong economic rationale for implementing treatment as prevention. Antiretroviral therapy is described as cost-effective and cost-saving for society, in the present and in the future, throughout the dominant discourses. In an opinion piece by Lima et al. (2010), the abstract reflects a positive view about the new guidelines promoting earlier treatment of HIV, despite the fact that there are limitations brought out in the article:

The individual and health benefits of these new guidelines are immense. The results show that by decreasing the number of individuals on HAART saves lives,

it is cost averting, and it positively impacts society by decreasing the number of new HIV infections. (p.1)

Montaner has phrased a quote, frequently used by the news media, referring to the benefits of treatment for society, “It’s good for the patient, it’s good for public health and it’s good for the public purse” (Ivens, 2010a, n.p.). Michael Sidibe is quoted by the BC-CfE (July/August, 2010) as using an alternative to these three P’s: “Thanks to the support of British Columbia Premier Gordon Campbell, and the dedication of Julio Montaner, the world now knows that treatment as prevention is a reality that works for the three Ps: It works for the patient, it works for the people and it works for the pocket” (p. 1). In the title of the article, “New HIV prevention strategy to benefit sufferers by cutting costs” (2010), *STOP HIV/AIDS* is portrayed as benefiting people living with HIV/AIDS *because* there is the potential to reduce the economic cost that HIV has on society.

Antiretroviral therapy is portrayed as a good economic investment for the future beyond the cost savings in the present day. Even when not speaking about money, the term ‘return on investment’ is used to describe the benefit to society for treating the individual earlier as opposed to in the future. According to *The Globe and Mail* (Iltan & Picard, 2010), “The findings dramatically enhance the return on investment for the therapy, and bolster the campaign for treating people earlier and more broadly because they will be less likely to infect others, Dr. Montaner said” (n.p.). Clearly, the message is that investing in the cost of treating people now will prevent new infections in the future. The economic cost to society is further described in this *Globe and Mail* article, by Picard (2010). Quoting Montaner, he writes:

Everyone with HIV-AIDS needs treatment – we can do it today, tomorrow or in three to five years when they are sicker. You don't save money by delaying treatment; later treatment is more expensive and less effective, and that person can also be spreading the virus. You're shooting yourself in the foot by waiting. [...] Any way you look at it, investing in antiretroviral therapy, investing in universal access is not only the right thing to do, it's the smart thing to do. (n.p.)

A simple, economic reasoning is used to describe why everyone living with HIV should be on treatment. Picard quotes Montaner as stating, “with treatment, you make an individual 90-per-cent less likely to transmit HIV, you are dramatically reducing the risk of AIDS in the next generation. By treating more you are actually putting a higher down payment on the AIDS mortgage” (n.p.). In the dominant discourses, HIV is understood as an economic risk and *STOP HIV/AIDS* and TasP is recognized as the smart financial decision that is beneficial for the present and future. A *New York Times* article (McNeil, 2010) provides some insight into why *STOP HIV/AIDS* may have emerged as an economic solution to the spread of HIV. McNeil quotes Montaner as saying:

In 2004, I rebelled when the government people started to say, ‘we need to get control over the budget for your program’ [...] I went to the ministries of finance and health and told them: the best-kept secret in this field is that treatment *is* prevention.” (n.p.)

Universal treatment

Universal treatment of people living with HIV/AIDS is one more dominant discourse which relates to discourses pertaining to decreasing and eliminating the spread of HIV in the population. This is an important discourse as it has provoked response

from the AIDS community. This discourse first emerged in mathematical modelling which considered the possibility of treating 100% of individuals living with HIV/AIDS. For instance, Granich et al. (2008) mathematically modelled the effects of treating 100% of people living with HIV/AIDS. Lima et al. (2010) modelled the scenario of increasing antiretroviral expansion to 50%, 60%, 75% and 100% coverage. It is important to note the claim that underlies the theory of TasP is that most transmissions occur during acute HIV infection. For TasP to work the most effectively, individuals must be diagnosed prior to seroconversion, the point at which the body starts to produce antibodies for HIV, which can be difficult to detect (Nguyen et al., 2011). There are concerns about the ability for such early detection and there is a need for further research in this area (see Cohen et al., 2012d for an in-depth debate on the topic).

Montaner initially acknowledged the challenges to the concept of treating all people living with HIV/AIDS in practice, “Although treating 100% of HIV-infected individuals worldwide might not be feasible or even ethically acceptable at this time, given the state of the pandemic, consideration of this possibility is worthwhile” (Montaner et al., 2006, p. 533). However, documents produced by the BC-CfE for the public, including *Forecast Newsletters* and news reports, revealed different language of antiretroviral expansion with goals of more aggressive and earlier treatment for people living with HIV/AIDS.

Claims of treating everyone living with HIV became very strong when the concept of TasP first emerged in the public sphere. According to the BC-CfE’s *Forecast Newsletter* (December, 2009), “The philosophy is, if you could test everybody, and treat everybody who has HIV, you could use treatment as prevention” (p. 3). The discourse of

universal treatment is taken up and streamlined by the media in this high-profile article in *The National Post* (Seeman, 2009):

Dr. Montaner feels we need to reach out and try to treat everyone who is HIV-positive –“Whether you are a chairman of a company, a cleaning lady or a prostitute, it doesn’t matter” [...] He calls the approach “treatment as prevention.” (p. A12)

This strong wording was met with resistance by epidemiologists, economists, and others who questioned the feasibility of unleashing a wide scale treatment program. The pointed statements were also met with critique by some in the AIDS community, further discussed in the section on alternative discourses. In an issue of *Forecast Newsletter* (January, 2011), it states, “If you could find everyone with the AIDS virus and give them the treatment, you could eliminate the HIV epidemic” (p. 2).

In addition to the statements supporting the treatment of everyone living with HIV, the BC-CfE’s *Forecast Newsletter* (May, 2010) provides more subtle suggestions by providing examples of other cities that have adopted aggressive treatment strategies. According to this issue, “San Francisco has followed suit, with public health doctors advising patients to start taking antiretroviral medicines once they are found to be infected with HIV” (p. 3). And in the same *Newsletter*:

A group of Harvard scientists in Botswana have launched a similar ‘Test and Treat’ program in the village of Mochudi [...] Hoping to reduce or prevent the spread of infection, local health workers will go door-to-door testing villagers for the virus. Villagers found to be infected will immediately receive HAART. (p. 3)

The statements of full treatment coverage became less aggressive, with caveats to the feasibility of such an endeavour, by the end of the two and a half year time-frame that I looked at the discourses. According to Montaner, in an interview at the 2011 IAS conference (“Interview with Julio Montaner,” 2011):

As soon as we recognize that HIV is actually not good for you at any stage of HIV...now we have new guidelines that are more progressive and more encouraging of people to consider treatment at much earlier stages. Not ready to say everybody all the time but we are getting pretty close. (n.p.)

While the possibility to treat everyone living with HIV is opened up, less aggressive wording is used by the BC-CfE. However, coercive themes still emerge in the media discourse. Noted in *The Economist* (“30 Years War,” 2011):

People do not like taking medicine, particularly if they have no symptoms [...] Not only would anti-AIDS drugs have to be made available to everyone infected [...] but all those people, or, at least, the vast majority of them, would have to be persuaded to take them. That is difficult enough when someone is ill. (n.p.)

Montaner’s quote sees ignorance or ‘realizing that HIV is not good for you’ as a barrier to treating everyone, while *The Economist* poses persuasion as an acceptable solution to this problem. In this quote, from *The Economist* (“30 Years War,” 2011), more detail is provided on how the individual might be persuaded to take antiretroviral therapy:

It will be even harder to persuade the asymptomatic to pop a daily pill or two for the public good. They might do so for love, of course. More selfishly, one result of HPTN052 in those receiving drugs was less tuberculosis, a disease that is a

common consequence [of] AIDS. So people now thought symptomless may not be quite as symptomless as they seem. (n.p.)

In this article, taking antiretroviral therapy for the benefit of the individual is portrayed as a selfish act, implying that individuals should easily accept taking a ‘pill or two for the public good.’ Again, HIV is linked to TB through the HPTN 052 study showing decreased incidents of TB as one benefit of antiretroviral therapy. While Montaner uses TB to suggest a public health approach to treatment, *The Economist* makes the direct correlation between HIV and TB. As discussed in the following section, the fear of coercive treatment measures is a prevalent theme running through the alternative discourses.

Alternative Discourses

There are ongoing concerns regarding TasP since its emergence as a model in the field of HIV/AIDS. The questions arise about how this model will operate in practice, the most effective way to implement this model and the most effective way to use treatment for preventative purposes. In the time frame of my data collection (February 2009 to September 2011), public alternative discourses responded to the rationalities of TasP and not, specifically, to *STOP HIV/AIDS*. As *STOP HIV/AIDS* represents the first ‘in practice’ pilot project of TasP, I understand these alternative discourses to be responding to the underlying rationales of *STOP HIV/AIDS*. Four organizations in Canada released position statements or background papers on TasP between 2006⁴¹ and

⁴¹ I included one document outside my data collection period due to a limited number of texts presenting alternative positions to the dominant discourses.

2011. These organizations are community-based and include Positive Living B.C.,⁴² the Canadian AIDS Society (CAS), the Toronto People with AIDS Foundation (Toronto PWA) and the AIDS Committee of Toronto (ACT).

In addition to these organizations, writers from two online magazines called *PositiveLite*⁴³ and *Poz Blogs*,⁴⁴ regularly contributed to TasP alternative discourses. Alternative discourses from people living with HIV/AIDS and community-based organizations, and blogs, created multi-layered discourses that bound the experiential knowledge of those living with HIV/AIDS. In this chapter, I identify the main alternative discourses while recognizing the inherent connectivity between these counter discourses. The alternative discourses are listed under the five headings of: holistic understanding/social determinants of health; stigma and discrimination; rights discourse: GIPA, informed consent and self-determination; coercion/criminalization and alternative risk discourse.

Holistic understanding/ social determinates of health

The alternative discourses speak to the need for a multi-faceted approach to control the HIV epidemic and to understand HIV/AIDS treatment as only one aspect of the strategy to eradicate HIV. According to Positive Living B.C. (2006), "...we believe that the eradication of the HIV epidemic requires a complex, multi-faceted approach. To maximize the effectiveness of treatments, various related strategies must simultaneously be in place and other issues should be addressed" (p. 1). According to CAS (2009):

⁴² At the time of data collection, this organization was called the British Columbia Persons with AIDS Society (BCPWA). In the text, I will refer to Positive Living B.C.

⁴³ *PositiveLite* is a Canadian Online HIV magazine founded by Brian Finch, an AIDS Activist for over 25 years, who has operated a blog since 2005. With approximately 35 contributors, this magazine is a lifestyle magazine covering a variety of topics.

⁴⁴ *Poz Blogs* is the online portion of Poz magazine, a U.S. based online and print magazine operating since 1994.

While CAS supports and advocates for access to and the provision of ART to all who want it and would benefit from its use, managing, responding to, and eliminating HIV requires an adaptable, multi-faceted, layered, approach to address the complexities and nuances of the epidemic. (p. 7)

The alternative discourses contrast with the straight-forward, streamlined message embedded in the dominant discourses that testify to the benefit and superiority of treatment over other prevention strategies.

Alternative discourses recognize antiretroviral therapy as part of prevention but are careful to highlight the efficacy and legitimacy of other prevention methods. ACT responds to the claim by proponents of TasP that current prevention approaches are not working and that condoms and other prevention strategies have reached a plateau. According to ACT (2011), “ACT supports treatment as part of prevention but also includes condoms and other barriers, microbicides, pre and post exposure prophylaxis, voluntary and confidential testing, needle exchange and harm reduction initiatives” (n.p.). ACT is careful to describe a spectrum of prevention strategies with one being antiretroviral therapy.

Alternative discourses highlight the need to see beyond the transmission of HIV and to understand the holistic nature of health for people living with HIV/AIDS. CAS (2009) in a published background paper on TasP, based on consultation with 91 people living with HIV/AIDS in Canada states, “They [people living with HIV/AIDS] argue that there is more to living with HIV than concerns about intimate partnering” (p. 3). Instead, it must be recognized how socio-economic and cultural environments impact people’s decisions about taking up and remaining on treatment. The Toronto PWA (2010), an

organization with a member base of 8000 people, released a position paper on TasP that stated, “The expectation for widely consistent human behaviour in a ‘treatment as prevention’ model is unrealistic. There are many barriers affecting adherence capacity, from mental/emotional and nutritional status to social issues such as housing and access to medical care” (p. 2). These discourses speak to the complex factors influencing treatment decisions, moving away from assumptions of consistent or uniform human behaviour, which is embedded in the knowledge base underlying population health.

The recognition of diversity within the communities of people living with HIV/AIDS is illuminated in alternative discourses. These discourses speak to differences between people living with HIV/AIDS in terms of medication needs and experience, viral load, age and gender, in considering TasP. The Toronto PWA (2010) writes, “While providing PHAs [people living with HIV/AIDS] with up to date and accurate information is essential to this issue it’s equally important to acknowledge that specific racialized communities have their own individual and problematic relationships with western medical science” (p. 3). Alternative discourses recognize the connectivity between individuals with HIV/AIDS while, also, recognizing the differences of the individuals. The alternative discourses raise differences in terms of ethnicity, gender, socio-economic status and viral load count.⁴⁵ The alternative discourses contrast with the dominant discourses when referring to the unified group called ‘people living with HIV/AIDS’ without acknowledging diversity within this group. In an article in *Poz Blogs*, Sonnabend (2010b) reminds the reader of the differences between those with high and low CD4 count: “Should we not be concerned that the expense of treating a person with

⁴⁵ It is important to recognize that viral load count is also used to differentiate, divide and regulate individuals living with HIV and AIDS in terms of who has a ‘detectable’ and ‘undetectable’ viral load. In this thesis, I strive not to glorify a potentially stigmatizing distinction.

500 CD4s could make it more difficult for a person with 50 CD4s to receive medications?” (n.p.). The troubling concern revealed in this quote is treating all people living with HIV/AIDS in the same way. The other issue raised is the possibility that one person’s access could impact another person’s access to antiretroviral therapy. This contrasts the dominant discourses in asserting TasP’s role as being the mechanism through which people get access to antiretroviral therapy.

Stigma and discrimination

Stigma and discrimination are significant alternative discourses that emerge. In line with the broader factors that affect people’s decision-making about their own health, organizations and individuals discuss the effects of stigma and discrimination on testing and treatment practices. According to Positive Living B.C. (2006), “HIV related stigma and discrimination continue to prevent people from being tested and from seeking treatment and support services” (p. 2). Alternative discourses reveal the opportunities for both increasing and decreasing stigma through the implementation of TasP initiatives. According to Strubs (2011b) in *Poz Blogs*, “This strategy has the potential of reinforcing stigma, especially of those who refuse to start treatment, and classify people in two categories, the ‘good’ and the ‘bad’ PHA [person with HIV]” (n.p.). This contrasts with the dominant discourses which portray TasP as an opportunity to decrease stigma by normalizing HIV testing through routine testing, and through the potential to make those living with HIV less ‘infectious.’ Toronto PWA utilizes the dominant discourses of risk and dangerousness to imagine a situation in which people living with HIV/AIDS through TasP are de-stigmatized. Toronto PWA (2010) asks the following question, “Would public stigma commonly associated with HIV be positively affected by widespread belief

that HIV+ people are ‘less dangerous’ than previously thought, and do we think there might be an impact on criminalization trends if this were to occur” (p. 2). Stigma discourses are closely aligned with discourses of criminalization, which are discussed further on in this chapter.

Rights discourse: GIPA, informed consent and self-determination

The Greater Involvement of People with HIV/AIDS (GIPA) was a principle created in 1983 by early AIDS activists in Denver and asserts the rights and involvement of people living with HIV/AIDS in policy, programming and decisions that affect their lives. GIPA was declared at the Paris Declaration in 1994, and formally adopted by UNAIDS in 1999 (IAS, 2012). GIPA carves out the rights and responsibilities of people living with HIV/AIDS in decision-making that affects their lives, advocating for self-determination and informed consent while condemning coercion in HIV testing and treatment. In the alternative discourses, discussions surrounding TasP focus on ethics and rights of people living with HIV/AIDS. Discourses including those of informed consent, coercion, autonomy and free choice are historicized in the experiences and recollection, by people living with HIV/AIDS, of side effects, experiments and prevention strategies of the past. For instance, according to Toronto PWA (2010), “it is everyone’s fundamental human right to be fully informed, engaged, and self-determined in their treatment choices, and that these rights do not change based on health or HIV status” (p. 1).

In line with GIPA principles, people speak to the need for ongoing informed consent at all stages of testing and treatment processes, self-determination in treatment choices and condemn any form of testing and treatment coercion. A key aspect of GIPA

is the involvement of people living with HIV/AIDS in decision-making related to their own health programming and individual choices. According to CAS (2009), “[People living with HIV/AIDS] are in the best position to speak to the lived experience of ART and make recommendations for treatment delivery and considerations as part of their ongoing Greater Involvement of People living with HIV/AIDS – GIPA practice” (p. 1). Alternative discourses recognize the lack of involvement of people living with HIV/AIDS in TasP and advocate for that involvement. Leahy (2011a) writes, “arguments for HIV treatment as prevention are being driven by physicians and a lesser extent by prevention experts. The collective voice of HIVers is missing in action (again)...” (n.p.).

AIDS organizations assert the rights of people living with HIV/AIDS to make the ultimate decisions about their own health with regards to treatment. According to CAS (2009), “Population-wide HIV prevention possibilities – no matter how compelling – cannot supersede an individual’s right to choose if and when to start or continue ART or any other treatment” (p. 2). In a statement from ACT (2011), “universal application of treatment violates the human rights of people with HIV/AIDS by removing the choice of when to begin anti-retroviral therapy” (n.p.). This is in response to TasP as a recommended universal treatment.

Alternative discourses highlight that individuals need to be more engaged in their treatment decisions, including knowing the evidence behind new treatment and prevention strategies, as education and social factors are crucial for making truly informed choices. According to an article in *PositiveLite*, Leahy (2011a) writes, “I’d like to see the education of newly diagnosed HIVers become more sophisticated so that they are truly able to make informed decisions rather than submit to the will of their

physician” (n.p.). Monteith (2011) uses his experience to highlight the biological impact on such things as informed consent, “I remember that feeling of toxicity that followed my diagnosis. That is not the time to make an irrevocable decision to be treated earlier than indicated by the treatment guidelines” (n.p.). Monteith highlights the factors that may play into the timing of informed treatment decisions.

Other people recount historical events, programs and strategies throughout the epidemic to relay the importance of accurate information and informed individuals.

According to a comment on a blog on *PositiveLite* (Tim, 2011):

Shooting the HIV+ would end the epidemic, too. I am worried about the ethical issues in “test & treat.” Since AZT, AIDS care has been marked by a cycle of strategies that have ultimately been proven to be bad theory: two that come to mind are the eradication of the virus from the body or treatment interruptions.”
(n.p.)

This blog commenter reminds readers of the HIV treatment strategies in the past that failed to benefit people living with HIV/AIDS. The START (Strategic Timing for Antiretroviral Treatment) study, a multi-site study aimed at determining the benefit to people living with HIV/AIDS, of starting treatment earlier with a viral load count of 500 cells/mm³ as opposed to 350 cells/mm³, is due to come out with results in 2016 (“START Study,” 2011). The START study is the first random-controlled trial to test the benefit to the individual of taking treatment earlier.

Coercion/ Criminalization

The potential for coercion in testing and treatment programs emerges as a major concern in the alternative discourses. Community-based organizations illustrate an

awareness of the potential for coercive measures in their discussions about TasP. One of the first statements from ACT (2011) on treatment as prevention states: “The AIDS Committee of Toronto (ACT) believes that HIV testing and treatment should be offered to all people living with HIV/AIDS, but no one should be forced to undergo either” (p. 1). CAS statements (2009) also cite: “Free and informed consent, without coercion, by individuals seeking treatment is the bottom line in ART-related research. This means that despite medical advice, individuals reserve the right to start, delay, discontinue or outright refuse to accept treatment” (p. 5). As part of resisting coercion, organizations highlight the need for a range of acceptable responses to treatment including the decision not to start treatment. A blog commenter on the *PositiveLite* (Viral Load Warrior, 2011) writes:

Ultimately the patient has say about what goes into his/her body. If he/she is not comfortable with taking meds, how could the policy-makers and medical community go about challenging that in people who have decided that they'd rather wait until they need treatment, or that they'd rather not take any treatment at all? (n.p.)

It is reiterated that treatment is a personal decision about the individual's wellbeing and is not about transmission in the population. This blog commenter opens up the possibility, again, for the individual to decide not to take treatment. In contrast, in the dominant discourses, there exists no range of possible responses to a positive HIV status beyond starting treatment. The only acceptable response to an HIV positive status is uptake of antiretroviral therapy because the notion is that TasP fundamentally depends on people starting antiretroviral therapy.

A major discourse that is revealed in responses to TasP is fear of, and warning against, coercion. In the alternative discourses, coercion is defined in a range from subtle coercion, found in misleading information about TasP, to the potential for criminal persecution of those who do not participate in the program. According to Sonnabend (2010a), “It is important that we are careful not to exert even subtle coercion on healthier HIV positive people” (n.p.), and further (Sonnabend, 2011), “providing misleading information is a form of coercion; withholding information may also be coercive” (n.p.). In a *PositiveLite* article, reiterating a speech given at a New York AIDS Treatment rally, Strubs writes (2011a), “Defining those of us with HIV as a threat to society and manipulating or coercing us into treatment, rather than empowering us to access healthcare and make well-informed treatment decisions for ourselves, is a dangerous threat to our rights” (n.p.). Additionally, a blog commenter responding to an article by Leahy (Viral Load Warrior, 2011) writes, “A cynical part of me thinks that in order to do [TasP] successfully, HIV positive patients would need to be required by law to take meds...Urghhh imagine? That would be so wrong” (n.p.). The fear about being coerced into treatment is alive and well in the alternative discourses. The fear of coercive treatment measures emerges in an environment where the lives of people living with HIV/AIDS intersect with the criminal justice system. Strubs (2011a) asks the question, “Do those of us with HIV present enough of a public health danger to trigger the use of legal mechanisms to intervene and force us to take treatment against our will?” (n.p.).

Alternative risk discourse

As seen in the dominant discourses, ‘risk’ is used to delineate those who are at risk of contracting HIV or at risk of transmitting to others. Risk is also used to describe the

economic risk of delaying inevitable treatment in favour of offering treatment to people with HIV/AIDS earlier in the course of their illness. The alternative discourses, on the other hand, highlight the risk to the person living with HIV/AIDS who is asked to take-up antiretroviral medications for the public 'good.' Alternative risk discourses negotiate risk and benefit to the person living with HIV/AIDS in light of potential population benefits. There is the concern that people living with HIV/AIDS are being asked to take up medication where there is a lack of evidence for the benefit to the individual and potentially an even greater risk to the person with HIV/AIDS. According to Sonnabend, in an article on *Poz Blogs* (2010a), "Some will be included who may not themselves derive any benefit from the intervention, but will only be exposed to its risks" (n.p.). And later in this same article, Sonnabend writes, "Before undertaking any intervention, its benefits and risks must be described as best as possible and then weighed. We want to come out ahead" (n.p.). Recall the HPTN 052 study, which tested the efficacy of delaying antiretroviral therapy as opposed to immediately offering antiretroviral therapy in serodiscordant couples being heralded for the evidence of the efficacy of TasP. However, there was little difference between the deaths in the immediate and delayed antiretroviral therapy groups. Ten deaths occurred in the immediate antiretroviral therapy group compared to thirteen deaths in the delayed antiretroviral therapy group (Cohen et al., 2011). Though touted as the ultimate evidence of the efficacy of treatment for prevention, studies beyond HPTN 052 are needed to prove the benefit of immediate antiretroviral therapy for people living with HIV/AIDS.

Alternative risk discourses overlap with discourses of criminalization. One blogger highlights the overburden of risk associated with people living with HIV/AIDS. According to Monteith (2011):

You can't trumpet the necessity of treating everyone with HIV all the time to put an end to this pandemic and then slink away and refuse to insist on the same level of lack of risk in the context of these prosecutions [criminalization of the spread of HIV]. We're getting the burden of your policies and none of the benefit. (n.p.)

Monteith refers to the criminalization of people living with HIV/AIDS related to HIV non-disclosure.⁴⁶ He makes the point that while proponents of TasP insist on individuals knowing their HIV status, the actual "knowing" of HIV status is criminalized.

Alternative discourses include strong statements opposing taking treatment for the sake of others as opposed to one's own health. According to Monteith in an article on *Poz Blogs* (2011):

I take these treatments for my own health, not yours. If you get some secondary benefit from my adherence to effective treatment, then bonus for all of us. Just don't expect me to put your interests ahead of my own and embark on a lifetime of treatment before the treatment guidelines indicate it's necessary for controlling the impacts of HIV on me. (n.p.)

A key concern in the counter discourses is the proposal represented in dominant discourses that individuals with HIV/AIDS should take up treatment earlier in the progression of the illness. The concern is the potential for long term side effects of earlier

⁴⁶ Canada, currently, has a very high rate of criminal prosecution of people living with HIV who do not disclose their status before engaging in an activity, such as sexual relations, deemed to pose a 'significant risk' to another person (CHALN, 2012). Monteith highlights that the criminalization of HIV is a huge barrier to individuals getting tested and knowing their status,

treatment and the immediate need for further evidence and information. According to the Toronto PWA (2010), “Advocacy for treatment supposes that long-term damage from untreated HIV is more severe than the potential damage caused by long-term use of anti-retroviral medications” (p. 2). People living with HIV/AIDS describe their own experience with a history of antiretroviral medications to discuss issues of risk with proposed earlier initiation of antiretrovirals. According to Leahy in an article in *PositiveLite* (2011b), side effects from medications can seriously affect mobility. For example:

The problems with lifetime meds really worries me too. I’ve been on ART since the beginning – 15 years. The side effects I am experiencing now – peripheral neuropathy which is seriously affecting my mobility – cropped up in year 14, a result of the meds taken in those early days. We just don’t know the long term risk profile of the drugs that are being prescribed now. (n.p.)

Not all discussions of risk by people living with HIV/AIDS, however, are opposed to treatment for the sake of prevention. According to Sonnabend (2011), “Given adequate information, a person with greater than 500 CD4 lymphocytes may reasonably decide to take antiretroviral drugs to lessen the risk of infecting a partner even knowing that there may be no personal benefit or that there is possibly harm” (n.p.). The main point here is not whether people living with HIV/AIDS should or should not take medications, but that it is the decision of the person living with HIV, if and when, they want to start treatment.

Chapter 5: Discussion and Conclusion

Treatment as prevention (TasP), the assertion that antiretroviral therapy is beneficial for the individual on treatment, as well as society as a whole, is a claim that has caught the world by storm. The Government of B.C. strongly endorsed this claim when it dedicated \$48 million over four years (2010 to 2013, inclusive), to stopping the spread of HIV through the *STOP HIV/AIDS* pilot project. My objective in conducting a discourse analysis of *STOP HIV/AIDS* is to better understand the rationalities of TasP as the foundation of the pilot project. I have, first, identified the dominant and alternative discourses of *STOP HIV/AIDS* and TasP. To do this, I looked at the dominant discourses about *STOP HIV/AIDS* and TasP, and how individuals and community-based organizations in the larger AIDS movement responded publicly to these discourses. In this chapter, I identify the underlying discursive strategies and techniques that are used by proponents of TasP to meet governing objectives. As noted in the introduction, the questions that guide this thesis are:

1. What knowledges (rationalities) are constructing and constructed by the discourses of *STOP HIV/AIDS*? How are these discourses informing and being informed by testing and treatment, policy and practice?
2. What techniques are employed by *STOP HIV/AIDS* to mobilize populations toward governing objectives? Are there distinct techniques used for different target populations?
3. What subjects are created through the discourses of the *STOP HIV/AIDS* initiative?

Social theorists that are influenced by Foucauldian notions of power and that apply a governmentality lens, understand government to be constituted by a multiplicity of actors in society. The power that government enacts is an outcome of complex social relations between these actors, and also of individuals who freely take up and act out governing technologies. Public health, for instance, is constituted by public health officials, but the relations between many ‘bodies’ including health care workers, statisticians, politicians, researchers, the media, the educational system and others, make up the apparatus of public health (Lupton, 1995). The public health apparatus determines what and who is in the realm of the governable through the processes of developing and enacting population health initiatives. Current public health rationalities problematize the spread of HIV and determine who, and by what mechanisms, the problem of the spread of HIV will be solved.

My research identifies three rationalities of TasP: First, that HIV transmission is a problem and the spread must be managed; second, that HIV transmission is propelled by people living with HIV/AIDS who do not know they have it, or who know they are HIV positive but are not on antiretroviral therapy; and third, that the best way to decrease or stop the transmission of HIV is to increase testing to identify those who are HIV positive, and increase uptake of antiretroviral therapy among people living with HIV/AIDS. Through TasP, a person’s treated body is recognized for its utility in stopping the spread of HIV.

STOP HIV/AIDS is a technology to realize the governing rationalities of TasP. The lens of governmentality describes technologies as “assemblages of persons, techniques, institutions, instruments for the conducting of conduct” (Miller & Rose,

2008, p. 16). Various strategies and techniques have been implemented on the front line to encourage testing and treatment uptake in B.C. since the onset of the *STOP HIV/AIDS* project. Strategies have ranged from providing Tim Horton's gift cards for testing incentives, to providing housing supports for those who are HIV positive (Tu, 2011). These strategies employed by *STOP HIV/AIDS* recognize that getting tested, initiating and staying on antiretroviral therapy, depends on a range of socio-economic and cultural factors. My interest in looking at the discourses of *STOP HIV/AIDS* and TasP is on the *discursive* strategies and techniques used to encourage testing and treatment practices. I found that these discursive strategies moved beyond encouraging testing and treatment. An important part of my research is how the spread of HIV is re-problematized as a public health imperative, and how TasP is put forth as the most sustainable and viable solution to further reduce the spread. I identified discursive strategies, employed to *both* encourage individuals to take up testing and treatment practices, but also, to convince the general population that TasP is the ultimate solution to the problem of HIV transmission.

I identified dominant discourses about *STOP HIV/AIDS* and TasP in print and online newspapers, monthly and quarterly publications produced by the BC-CfE, and other electronic sources linked to the BC-CfE website. Dominant discourses included provincial and international support for TasP and lack of federal leadership in HIV/AIDS; TasP: a 'paradigm shift' and a 'game changer;' TasP as beneficial to the individual and society; human rights and harm reduction; proof and certainty; failure of current prevention efforts; risk discourses and, finally, universal treatment.

I identified responses to the dominant discourses in publications by people living with HIV/AIDS and allies in online publications and in public responses from

community-based organizations. I identified alternative discourses about TasP related to holistic understanding/social determinants of health; stigma and discrimination; rights discourse: GIPA, informed consent and self-determination; coercion/criminalization and alternative risk discourse.

The tension between individual and population health arises in the discourses of *STOP HIV/AIDS* and TasP. Embedded in the distinction between them are the historical roots in what Foucault describes as an emerging governing ‘mentality’ in the mid-eighteenth century. European governments of the time needed to find ways to understand and manage their growing populations. The modern public health movement of the early twentieth century saw the medical gaze shift from that of the individual to the entire population, the potentially at risk, and to the interactions in the spaces between individuals in the social body (Lupton, 1995; Armstrong, 1983). TasP acts on the bodies and spaces between individuals in the population, asking individuals to assess and self-regulate risk behaviours, and routinely, get tested for HIV. TasP asks individuals who test positive for HIV to take up treatment for their own benefit, and also for the benefit of the ‘social body.’

The conceptualization of the population as a ‘social body’ is evident in the creation of an indicator called ‘community viral load’ (Wood, Milloy and Montaner, 2012). Community viral load is a new measure of HIV in a population identified as the mean viral load within a fixed population and location. These researchers observed the changes overtime in community viral load from a data set of people who use injection drugs in Vancouver’s DTES. These researchers observed the effect of antiretroviral therapy on an entire community’s viral load through access to centralized information

pertaining to whether or not these individuals were on antiretroviral therapy. This observational data became a rationale in the body of evidence for treatment as effective prevention. The community viral load is a new target for HIV interventions that removes the focus from the individual living with HIV. Individuals are the nodes where HIV emerges and where HIV can be observed. In the dominant discourses, treatment decision-making based on the individualized experience of the person living with HIV/AIDS is constructed as second to the objective of lowering the viral load of the social body.

TasP holds a distinct space between the individual and public health. TasP initiatives depend on individuals not only changing their behaviours, but altering the chemistry of their bodies for a larger public health imperative. According to Jaffe and Hope (2010), there are two competing ethics that emerge within the rationalities of TasP. The ethical standards of clinical practice dictate that medical professionals must act in the best interests of patients and maximize benefits and reduce harms to the individual (in this case, the person living with HIV). Public health interventions, on the other hand, seek to maximize the benefit and reduce the harm to *both* the individual and the population (in this case, the uninfected public). A problem occurs in cases where sufficient harm to the population is shown while benefits to the individual are either not proven or at worst cause harm (Jaffe & Hope). In such cases, the benefits to the population may outweigh the harm to the individual, leading to the enactment of coercive treatment measures and punitive approaches (Jaffe & Hope). Such is the case with active TB, where it is mandatory for individuals to go on treatment should they contract this communicable disease.

The success of *STOP HIV/AIDS* depends on the population coming to know HIV transmission as a problem and acting in line with public health objectives. What is missing in the description by Jaffe and Hope (2010) is the process by which an individual health issue comes to be understood as an issue of public health, and further, of significant harm to the population so as to prompt action. *STOP HIV/AIDS* presents a unique opportunity to observe the path through which the spread of HIV is re-problematized in B.C. and is the first major intervention to test the effectiveness of TasP. Proponents of *STOP HIV/AIDS* use discursive strategies and techniques that are distinct for different members of the population. Rose (1996) describes the concept of ‘dividing practices’ as a way to understand how governing techniques differ for different target groups.

The underlying rationalities of TasP are that HIV is a problem and must be controlled by identifying those who do not know they are living with HIV, and treating those who are living with HIV. I argue that there are two overarching and simultaneous discursive strategies used to realize these governing rationales. The first strategy acts on individuals living with HIV/AIDS, encouraging individuals to take up antiretroviral therapy. The second strategy acts on the general population, informing the population that HIV is a problem, and that treating people living with HIV/AIDS is the best way to protect society as a whole.⁴⁷ I discuss the two strategies in more detail in the following pages.

⁴⁷ I am aware of the potential to re-create the binary between the individual living with HIV and the ‘general population.’ I am aware of the diversity within each side of the binary, despite using the distinction for the purpose of this paper.

Strategy 1: Individuals living with HIV/AIDS should start antiretroviral therapy

The first discursive strategy that emerges in the dominant discourses is to assert TasP, and initiatives such as *STOP HIV/AIDS*, as unquestionably beneficial to the individual living with HIV/AIDS. This is carried out through two techniques: one, TasP is likened to antiretroviral therapy and presented as beneficial to the individual. Two, TasP is framed as a human rights issue linked to global access to antiretroviral therapy for people living with HIV/AIDS.

In the first technique, proponents of TasP conflate the benefits of antiretroviral therapy with the concept of TasP. The underlying knowledge of TasP recognizes people living with acute HIV as those who are most likely to transmit the virus. According to this argument, the success of TasP is therefore dependent on identifying and increasing treatment uptake among those in the acute stages. The real issue at hand is whether or not it is ethical or feasible to reach individuals who are in the acute stages of HIV, and whether it is beneficial for the individual to take antiretroviral therapy at earlier stages of the illness, and for a longer period of time without knowing the potential adverse effects of early treatment. The dominant discourses, however, position the *decision* to take antiretrovirals, as the key issue. Dominant discourses appeal to the benefits of antiretroviral therapy for people living with HIV/AIDS. In addition to masking the real issue at hand, dominant discourses leave out the potential adverse effects and the lived experience of HIV treatment regimes.

The development of antiretroviral therapy has undeniably had an enormous impact on the health of people living with HIV/AIDS, and in many cases, allowed individuals to live longer and healthier lives. However, the alternative discourses speak

to the potential harms/harmful experiences for the individual, with medication and adverse effects. Alternative discourses address the underlying knowledge that TasP is most effective when individuals begin treatment immediately. The alternative discourses express concern about the potential risk of initiating antiretroviral therapy at earlier times, at higher viral loads and for longer periods of time. The alternative discourses question the evidence for earlier initiation of antiretroviral therapy for the benefit to individuals living with HIV/AIDS. In the HPTN 052 study results, there was no significant difference in the deaths between the test and control groups despite showing the success of treatment for prevention (Cohen et al., 2011). This fact is unnerving considering that HPTN 052 is used within the dominant discourses as the primary evidence to support individuals to take up antiretroviral therapy for prevention.

The alternative discourses point out that the decision to be on antiretroviral medication is an individualized decision consisting of considerable deliberation and personal assessment of treatment readiness. Alternative discourses point to the risk inherent in a person getting tested and knowing their HIV status. In Canada, there are very high prosecution rates against people living with HIV/AIDS who do not disclose their HIV status, and who put another person at ‘significant risk’ of HIV transmission (Canadian HIV/AIDS Legal Network [CHALN], 2012). A person who knows their status and has an unprotected sexual encounter puts themselves at risk for a prison sentence with a potential charge of aggravated sexual assault. Alternative discourses state the importance of decreasing stigma and addressing the criminalization of people living with HIV/AIDS, before asking the population to get tested and identify themselves as HIV positive.

Another issue that arises in the alternative discourses is whether people who need treatment the most have access to treatment. If TasP contributes to an environment of competition between people living with HIV/AIDS, who need access to medication, and if there is a push to increase treatment uptake, who will have access? Kippax et al. (2011) discuss the balance that needs to be struck between efficacy and equity in promoting treatment to those that need it the most and to those who are the strategic beneficiaries from a public health perspective.

A second technique in the strategy of asserting TasP as unquestioningly beneficial to the individual is the framing of TasP as a human rights issue. In this technique, TasP becomes a fundamental, political issue about access to treatment for people living with HIV/AIDS. It is seen in the dominant discourses that 'access' to treatment is one way speak about TasP. In the first official year of *STOP HIV/AIDS*, TasP was discursively linked to the right to treatment, at the AIDS 2010 conference with the theme: 'Rights Here; Rights Now.' According to Nguyen et al. (2011), Montaner worked to have 'new prevention technologies' (NPTs), of which TasP is one, emerge as a key theme from the international conference, and in some cases, this elevated the issue of treatment as prevention above the issue of human rights. In the dominant discourses, the federal government's lack of commitment to HIV/AIDS is used to highlight B.C.'s dedication to TasP, as though TasP is the only public health approach to decreasing the spread of HIV. Patton (2011) discusses the differences, and in some cases contradictions, between the *rights* language used in the dominant discourses of *STOP HIV/AIDS*, and those in the alternative discourses that emerge from people living with HIV/AIDS. Patton argues that TasP, 'witnessing disease,' as economic cost analysis and cases, conflates rights of access

to treatment with goals of stopping HIV in the population. Human rights retreat from the individual that is wronged and the result is the erasure of the rights belonging to the voices of the people who need to be protected. In addition, Patton highlights how *STOP HIV/AIDS* has the potential to violate these rights through mandatory testing and treatment. The framing of TasP as a human rights issue has silenced the debates about TasP and its effectiveness that need to happen (Nguyen et al.). TasP is presented as a political decision about whether or not governments are committed to the project, rather than a decision of the effectiveness and benefit to people living with HIV/AIDS. The premises of TasP are put forth as uncontested while those who question the assumptions and motivations of TasP are considered to be unscientific or ignorant to the benefits of antiretroviral therapy for people living with HIV/AIDS.

Strategy 2: TasP is beneficial for the protection of the population

The second discursive strategy is the framing of the benefit to society of treating the individual living with HIV/AIDS. Four techniques are used to realize this strategy. First, TasP is presented as a new and novel approach and a discovery to end AIDS, compared to the discovery of antiretrovirals. Second, HPTN 052 is positioned as the final piece of evidence needed to move forward with TasP initiatives. Third, antiretroviral therapy is presented as the most feasible and sustainable prevention method, over and above current prevention approaches. Four, risk discourse is used through war metaphors, militaristic language, and economic risk, to understand AIDS and people living with HIV/AIDS as a threat to society.

The first technique that emerges is to portray TasP and *STOP HIV/AIDS* as a ‘paradigm shift’ or ‘game changer’ at the population-level control of HIV. The story

emerges in the dominant discourses that understands TasP as an invention, a discovery and novel approach to combating AIDS. This is then endorsed by a variety of stakeholders from individuals such as Stephen Lewis, to organizations such as WHO and UNAIDS, and to entire countries such as China. The reality is that TasP is not a new concept. Cohen et al. (2012b), describe the research that has been conducted since 1997 to test the efficacy of antiretroviral therapy for preventing HIV transmission. According to Cohen et al.:

In 1997, in a study from our group on this matter, we stated, "...antiretroviral therapy, by decreasing levels of HIV-1 in semen, may lower the infectious inoculum of treated men and possibly reduce the likelihood of sexual transmission to uninfected partners." (p. 99-100)

Since 2000, trials have been ongoing to study the use of antiretroviral therapy for prevention. Alternative discourses reiterate the knowledge that the AIDS community holds in understanding the prevention benefits of antiretroviral therapy. According to Adams (2011), "much of the first decades of HIV have been characterized by a certain 'techno-eschatology', that is, a tendency to wait for a definitive answer or historical turning point to be delivered by science and medicine" (p. 6). The language of 'turning point,' 'game-changer,' and 'paradigm shift,' legitimizes TasP as a definitive, scientific solution to the spread of HIV – the answer the world has been waiting for.

A second technique to show the benefit of TasP for society is to use the results of HPTN 052 to demonstrate the efficacy of TasP. The results of this study are used in the dominant discourses to rationalize antiretroviral therapy as the paramount approach to decreasing the spread of HIV. In the dominant discourses, HPTN 052 is declared as an

endpoint, and as proof of the efficacy of TasP. However, there is much more research to do. The proponents of TasP use the *preliminary* results of the HPTN 052 study to show the efficacy of TasP. However, the study will be ongoing until 2015 (Cohen et al., 2012c) and further studies are needed to assess the long term impact of earlier initiation of antiretroviral therapy for people living with HIV/AIDS. Secondly, the study population of HPTN 052 is serodiscordant heterosexual couples and there are mixed results about the benefits of antiretroviral therapy for prevention of HIV transmission for other populations (Cohen et al., 2012d). Thirdly, the HPTN study shows the efficacy of TasP, but does not speak to the effectiveness of TasP in ‘real-world’ conditions. According to the research team who oversaw the implementation of HPTN 052, “The goal is now to determine whether ART can be used so broadly and so effectively as to reduce the spread of HIV within a population” (Cohen et al., 2012b).

A third technique to show the benefit of TasP for society is to assert the success of TasP over and above current HIV prevention approaches, such as condoms, and other harm reduction methods. In the dominant discourses, current prevention efforts are, predominantly, rendered ineffective, unsustainable and cost inhibitive. Antiretroviral therapy is portrayed as effective, a ‘good investment,’ and heavily endorsed by individuals, organizations and governments around the world. Kippax et al. (2011), suggest that the ‘failure’ of current prevention strategies has less to do with the efficacy of the strategy and more to do with the effectiveness of these strategies in the social, political and cultural landscape where they are promoted. The alternative discourses highlight the factors that influence testing and treatment practices that include the criminalization of HIV, stigma and discrimination and other social determinants of

health. The dominant discourses about the failure of current prevention approaches leave out the contextual factors that impact testing and treatment practices. Another dominant discourse, noted in the *New York Times* article (McNeil, 2011), connects TasP to other approaches to prevent the spread of HIV, such as Insite's supervised injection facilities. In this case, harm reduction initiatives are understood as within the scope of TasP, due to Insite's proximity to the home of the *STOP HIV/AIDS* pilot project.

A fourth major technique to show the benefit of TasP for society is to assert AIDS as a threat to the general public, rationalizing the need to prevent its spread. The dominant discourses of *STOP HIV/AIDS* and TasP describe a society that is protected from the individual whose viral load is effectively suppressed through antiretroviral medication. The physical risk to society is created through the use of militaristic and war metaphors to show AIDS as the enemy and antiretroviral therapy as the weaponry. Social, cultural and emotional risk is created through the impact of lives lost to AIDS on innocent victims, such as women and children. Dominant discourses create a sense of fear that HIV will grow, unabated, due to the failure of current prevention efforts. Economic risk is portrayed by considering the economic benefit of treating everyone living with HIV.

The potential for TasP to be a coercive treatment measure emerges in the fourth technique. The belief that people living with HIV/AIDS should be treated is prompted by describing AIDS as a risk to the general population. In addition to the use of militaristic and war metaphors, TB is discursively and conceptually linked to HIV. In the dominant discourses, TB is described by Montaner as 'like' HIV. There is, also, evidence that antiretroviral therapy prevents TB in those living with HIV (Cohen et al., 2011). This

connection is significant considering that, in Canada, there are coercive TB treatment measures to mandate those living with active TB to initiate treatment.

The subjects

Another key objective of this research is to identify the subjects created through the discourses of TasP. Of key importance to the study of discourse is the process through which individuals are made subjects (Foucault, 1982; Hekman, 2011). In the dominant discourses, I see both AIDS and people living with HIV/AIDS positioned as subject. AIDS is the subject in terms of the threat that AIDS poses to society, of which antiretroviral therapy is the answer. The war and militaristic discourses refer to the threat of AIDS or the battle against AIDS as a target for public health initiatives. The conceptualization of the 'social body' allows dominant discourses to speak about AIDS as something that exists outside the individual and antiretroviral therapy as the weaponry to defeat the AIDS virus.

In the dominant discourses, people living with HIV/AIDS are one category or one of the many at risk categories. People living with HIV/AIDS are named in relation to the benefits of antiretroviral therapy. Discourses centre on the economic benefit of treating people living with HIV/AIDS now, rather than in the future when more individuals are potentially affected. The individualized body that facilitates treatment as prevention is largely left out of the dominant discourses. There are two exceptions, however, where the individual living with HIV becomes the subject. The first is in the funding announcement of the *STOP Project* (MoH et al., 2010), where Mr. Kerr is situated as the spokesperson for the AIDS community. Another exception is in *The Economist*, where

the realities of TasP are personalized to center the person living with HIV/AIDS.

According to 2011 article in *The Economist* (“End of AIDS, 2011”):

To prevent transmission, treatment would in theory need to be expanded to all the 34m people infected with the disease. That would mean more effective screening (which is planned already), and also a willingness by those without the symptoms to be treated. That willingness might be there, though, if it would protect people’s uninfected lovers. (n.p.)

This quote highlights concepts such as ‘willingness’ and ‘choice,’ not often found in the dominant discourses. This article moves TasP from the level of population health to the level of individual decision-making despite the paternalistic tone of the article.

The alternative discourses centre on the subject who is actually the person living with HIV/AIDS. These discourses situate *STOP HIV/AIDS* and TasP in historical experiences of public health initiatives and their impact on people living with HIV/AIDS. The words of people living with HIV/AIDS emerge and the diversity within the community is highlighted. The alternative discourses highlight the GIPA principles and the need for people living with HIV/AIDS to autonomous decision-making, free from coercion.

Conclusion

STOP HIV/AIDS is more than a biomedical prevention project. This pilot project connects many people living with HIV/AIDS to housing and other social supports recognizing the factors that influence the ability for individuals to initiate and stay on antiretroviral therapy. The proponents of *STOP HIV/AIDS* and TASP focus dominant messaging on testing and treatment components despite attempting to increase the

percentage of people engaged in all stages of the continuum of HIV care. The BC-CfE, with Montaner as their spokesperson, works hard to justify and build the impetus for *STOP HIV/AIDS* and TasP. The *STOP HIV/AIDS* initiative presents a unique opportunity to examine the process through which the spread of HIV is re-problematized in B.C. and antiretroviral therapy is positioned as the solution. Critically undertaking a discourse analysis in February 2009, I observed the foundation being laid for the project in the path taken by the BC-CfE to publicize endorsements from international bodies such as the IAS, WHO, U.S. health organizations, Canadian granting agencies, and finally, the B.C. government. The BC-CfE publicized support for TasP through their own publications and press releases building up to the funding announcement in February 2010. TasP is presented as a novel approach, the ‘hero’ that has come to win the war on AIDS. I have described various strategies and techniques that encourage and reinforce the acceptance of antiretroviral therapy for prevention. I have identified techniques in this thesis that are discursive and speak both to people living with HIV/AIDS and not living with HIV/AIDS.

A discourse analysis, with a governmentality lens, is beneficial in identifying governing strategies and techniques that may be subtle and difficult to recognize. These discursive happenings have immense consequences for how health policies and programs work and are accepted by the public. Discourses can encourage uptake of testing and treatment practices. Discourses can also remove options for acting in ways contrary to the ‘known’ benefit for society. Initiating my research, I expected to find more instances where dominant discourses spoke exclusively to individuals living with HIV/AIDS in encouraging treatment practices. I observed that the dominant discourses speak more

frequently to the general population than to those living with HIV/AIDS. Addressing the general population involves encouraging uptake of testing practices,⁴⁸ but more often involves compelling the audience to see antiretroviral therapy as the answer to halt the spread of HIV. This compelling argument includes the use of war and militaristic metaphors that present AIDS as an attack on society and as a threat to physical and economic wellbeing. The social body is threatened in the battlefield that is the fight against HIV causing “incalculable misery and death” (McNeil, 2011, n.p.). The original term for the pilot project, ‘Seek and Treat,’ set the stage for the use of these war and militaristic metaphors.

A discourse analysis, using a governmentality lens, tells us that dominant discourses are not just words. Rather, public health discourses are constructed by particular world views and involve the creation and delineation of societal problems. As Lupton (1995) points out, public health discourses carry with them the problems of social order, morality, cleanliness and fear of the ‘other’ from ages past. Discourses are not objective nor are they stagnant. Discourses have effects. Discourses turn individuals into subjects. Studies of governmentality are interested in how individuals carry out governing strategies through freedom and governing of the self. Discourses have effects because individuals act in line with (and resist) governing objectives.

The alternative discourses illustrate the effects of the dominant discourses. Alternative discourses respond to something happening through dominant discourses, which may or may not be immediately obvious. For instance, a fear that emerges in the alternative discourses is the fear of TasP as a potentially coercive treatment measure.

⁴⁸ A broad-based testing campaign began in 2012 to target the general population in B.C.

While I did not identify situations where proponents of *STOP HIV/AIDS* and TasP referred to mandatory treatment as a goal of the project, the language alluded to such a possibility. For example, mathematical models that predicted the economic feasibility and outcome of treating up to 100% of people living with HIV/AIDS.

War and militaristic metaphors position HIV as a threat to society and antiretroviral therapy as weaponry against the impending attack. War metaphors in public health are not new. Sontag (1988) in “AIDS and its Metaphors,” wrote about the military metaphors used to describe AIDS in the first decades of the epidemic. According to Sontag, war metaphors emerged around the time of World War I to educate the public about syphilis. In her book, Sontag describes the impact of military metaphors on people living with HIV/AIDS. According to Sontag:

the metaphor implements the way particularly dreaded diseases are envisaged as an alien ‘other,’ as enemies are in modern war; and the move from the demonization of the illness to the attribution of fault to the patient is an inevitable one, no matter if patients are thought of as victims. (p. 11)

These metaphors have the potential to exacerbate current criminalization of, and stigma against, people living with HIV/AIDS. These metaphors also allow for action on the part of the sovereign state to remove the perceived threat. For example, Canada currently has a very high rate of criminal prosecution of people living with HIV/AIDS who do not disclose their status before engaging in an activity deemed to pose a ‘significant risk’ to another person (CHALN, 2012). This contributes to “a climate of anxiety, fear, stigma and misinformation that undermines HIV counseling, education and prevention efforts [...]” (CHALN, n.p.). The dominant discourse pertaining to the ‘significant risk’ of HIV

transmission as a justification for TasP, and other metaphors, have the potential for increasing fear of people living with HIV/AIDS in the public and exacerbating the criminalization of HIV. They may also prevent people from being tested for fear of knowing their status. A contradictory message arises when the public is asked to both fear HIV and identify themselves as living with HIV.

A major challenge from the beginning of TasP and *STOP HIV/AIDS* is developing messaging for the population and the individual. This tension is seen highlighted in messaging about the failure of current prevention methods. The claim is made that TasP works at the level of the population and not at the level of the individual. Medical professionals and researchers were initially concerned with ‘behavioural disinhibition,’ which is the concept that individuals will replace necessary harm reduction methods with the exclusive use of antiretroviral therapy for prevention purposes.⁴⁹ However when TasP was first made public, messaging about the failure of current approaches to prevention were prevalent.⁵⁰ Current approaches were described as unsustainable and stagnant, and this failure was used as a justification for a new approach to prevention. A second confusing message appears. The general population is asked to believe that current approaches to prevention have failed, and at the same time asked to continue to use current prevention approaches uninterrupted. For people living with HIV/AIDS, individuals are asked to take-up antiretroviral therapy for the purpose of the public good,

⁴⁹ Antiretroviral treatment use has been known in the AIDS community for many years for its secondary benefit of preventing the transmission of HIV. However, the fear of behavioural disinhibition came out with the publicization of TASP.

⁵⁰ The language of ‘failure’ of current prevention strategies was beginning to shift during the end of my data collection period. This is, most likely, due to backlash and concern about the effects of using a sweeping statement to describe all current approaches to prevention. Interestingly, in some data, *STOP HIV/AIDS* is described as, or as including, harm reduction initiatives.

while continuing to use other prevention methods. People living with HIV/AIDS receive little additional personal benefit of antiretroviral therapy for prevention purposes.

Proponents of TasP make the claim that antiretroviral therapy is, undoubtedly, effective for prevention. Embedded in this claim is the belief that antiretroviral medication is effective for individuals when taken at higher CD4 counts. Alternative discourses respond and question the evidence for such a claim. Alternative discourses remind the public of the START study (2011), which aims to test the benefits of treatment at earlier stages of the illness. Individuals living with HIV/AIDS question the risk they are asked to take for society's benefit, such as the long term exposure to antiretroviral therapy. The results of the HPTN 052 study became the evidence needed to prove the efficacy of TasP in the dominant discourses. The results of this study, however, were influenced by the dominant discourses testifying to the proof and certainty of TasP. For instance, one of the reasons why this study was halted was due to popular medical opinion shifting antiretroviral recommendations to earlier initiation and making it redundant to test the efficacy of such a claim. According to the leading researchers of HPTN 052 (Cohen et al., 2012c), "by 2009, the belief about the ideal time to start treatment had evolved so much as to jeopardize the continuation of the trial, although no high-level evidence to support his position had yet surfaced." (p. 345). The dominant discourses shifted medical opinion as to the best time for individuals to start antiretroviral treatment, which affected the study's research design and outcome.

There are many benefits to a discourse analysis. This research project prompts an exploration into the discursive strategies used by the proponents of TasP and *STOP HIV/AIDS*. There are also some limitations related to the scope of this discourse analysis.

I focus this analysis on the dominant discourses stemming from the BC-CfE and taken up by the media, and on the alternative discourses stemming from community-based organizations and their publications, responding to the underlying knowledges and rationales of TasP. I identify dominant discourses that, predominantly, address the population, problematizing the spread of HIV and providing a compelling solution in the form of antiretroviral therapy for prevention. A governmentality lens understands that the operation of governing rationales and techniques rely on diffuse relationships between the state (and, in this case, multiple sovereign states), the media, community-based organizations and individuals. At the time of data collection, community-based organizations were at the initial stages of putting this project into motion. Further research is needed to explore the ways that community-based organizations carry-out, resist and negotiate the underlying rationales of TasP. Sears (1991) frames this discussion as ‘health from above’ and ‘health from below’ in how community-based organizations negotiate the interests of the clients and the objectives of the sovereign state. Further research is needed in how TasP shapes policy and practice within community organizations that carry out TasP on the front line. This practice includes texts, materials and campaigns developed by community-based organizations for the public and people living with HIV/AIDS to encourage uptake of testing and treatment practices, to observe how community organizations negotiate individual and population messaging and interests.

The dominant and alternative discourses of TasP impact HIV policy and practice, and specifically, the individuals living with HIV/AIDS who are the subjects and targets of these initiatives. Foucault (1982) discusses “struggles against subjection” as the most

important struggle of our time, against those technologies that fix individuals into particular subjectivities. This thesis is a starting point to explore technologies that contribute to the creation and fixing of subjectivities. Further research is needed to understand how the discourses of *STOP HIV/AIDS* and TasP construct the individual who is living with HIV, from the standpoint of the person living with HIV.

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Appendix I: Aims of STOP HIV/AIDS

All of the Aims for the *STOP HIV/AIDS* Research Program represent a natural extension of work already being done by the BC-CfE.

Primary Aims

- Aim 1: To enhance HIV case finding in BC
- Aim 2: To increase the number of HIV-positive people accessing care
- Aim 3: To increase the number of HIV-positive people on HAART, consistent with the 2008 Therapeutic Guidelines
- Aim 4: To monitor HIV/AIDS related morbidity and mortality and HIV incidence in BC

Secondary Aims

- Aim 5: To monitor drug adherence, resistance, and adverse events
- Aim 6: To expand health care capacity to support HAART
- Aim 7: To monitor population impact, resource utilization and cost-effectiveness associated with expansion of HAART access
- Aim 8: To model the potential impacts of further HAART expansion in BC

Appendix II: Defining Terms

CD4 cell count refers to the count of a specific type of T-cell in the immune system. HIV targets CD4 cells which are an integral part of the immune defence against viruses. A normal CD4 count is between 500-1500 cells per cubic millimetre (cells/mm³). A count between 200-500 cells is a bit concerning and below 200 cells means that the immune system is very weak (CATIE, 2011)

Viral load is a measure of the amount of HIV in the blood measured in copies per millimetre (copies/ml). Less than 50 copies/ml is classified as an “undetectable” viral load (CATIE, 2011).

How HIV works in the body- HIV tricks the CD4 cell with a fake CD4 receptor. It binds to the cell. Once inside the cell, HIV converts its RNA into DNA using a molecule called reverse transcriptase, which allows the genetic material of HIV to match that of the CD4 cell. The HIV inserts its DNA into the CD4 cell with an enzyme called integrase.

Finally, HIV tricks the cell into making copies of itself which spreads and continues to process of invading other CD4 cells in the body (CATIE, 2011).

HAART (or ART) - Combinations of anti-HIV drugs that prevent HIV from invading the host CD4 cell at several points in the process. First line treatment- usually consists of a 3 ART drugs (2 NRTIs with a NNRTI or a protease inhibitor) (Gulick, 2010). The other classes are generally used when people become resistant to the NRTIs or NNRTIs (CATIE, 2011).

Appendix III: Hall's Template for Studies in Discourse

Hall (1997b) uses examples from Foucault's work to create a list of elements necessary for the study of discourse such as statements, rules, subjects and knowledges that emerge in texts and other visual materials. The examples are from Foucault's earlier work of madness and sexuality. I adapted Hall's template to apply to my research to identify knowledges, subjects, rules and ways of speaking in the discourses of *STOP HIV/AIDS* and TasP.

- 7) Statements about 'madness', 'punishment' or 'sexuality' which give us a certain kind of knowledge about them;
- 8) The rules which prescribe certain ways of talking about these topics and exclude other ways- which govern what is 'sayable' or 'thinkable' about 'insanity, punishment or sexuality, at a particular historical moment;
- 9) 'Subjects' who in some ways personify the discourse- the madman, the hysterical woman, the criminal, the deviant, the sexually perverse person; with the attributes we would expect these subjects to have, given the way knowledge about the topic was constructed at the time;
- 10) How this knowledge about the topic acquires authority, a sense of embodying the 'truth' about it; constituting the 'truth of the matter', at a historical moment;
- 11) The practices within institutions for dealing with the subjects- medical treatment for the insane, punishment regimes for the guilty, moral discipline for the sexually deviant- whose conduct is being regulated and organized according to those ideas;

12) Acknowledgement that a different discourse or episteme will arise at a later historical moment, supplanting the existing one, opening up a new discursive formation, and producing, in its turn, new conceptions of 'madness' or 'punishment' or 'sexuality' new discourses with the power and authority, the 'truth', to regulate social practices in a new way. (p. 46).