



**AIDS IS
(STILL)
POLITICAL**

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INTERNATIONAL AIDS SOCIETY

**HIV
IS NOT
A CRIME.**

AIDS IS (STILL) POLITICAL

Like you and the more than 6,000 colleagues who attended the 9th IAS Conference on HIV Science (IAS 2017) in Paris, we were in awe of the scientific data presented from Swaziland last July [1]. Sitting in the plenary hall, we learned that new HIV infections there were cut almost in half in only six years. That – in the country with the highest HIV prevalence in the world – is incredible.

And yet in the same room only a few days later, we learned of the explosive expansion of HIV in middle-income countries in Eastern Europe, where new infections have risen by 60% since 2010 [2].

Despite global scientific advancements and increased sharing of “best practices”, there are clearly two entirely different narratives of HIV unfolding across the world. What is at the core of this divergence, and why does it persist?

ONE REASON: POLITICS.

In resource-limited countries where strong national commitment is combined with robust international support, the prospect of minimizing the epidemic to the point where it is no longer a serious public health threat appears increasingly feasible. Where political commitment on AIDS is strong, we have allowed science to guide our response.

However, in many other settings, ideology seems to be outweighing science in the HIV response (and in much of public health in general). Harmful political choices, including rapid donor transitions, criminalization and unscientific public health programmes, have led to predictably bad health outcomes, leaving many countries and regions with no end to AIDS in sight.

This year marks 30 years since the creation of the International AIDS Society (IAS), an important moment of reflection for our organization. We were founded in 1988 by a group of scientist-activists desperate to share information to stop the pandemic spreading around them. When the IAS was first created, there was no treatment for HIV and no prevention of mother-to-child transmission. There was pervasive stigma and discrimination, limited understanding of HIV transmission and disease progression, a lack of awareness of the degree to which HIV was predominantly spreading in sub-Saharan Africa, and by and large only condoms for prevention. To overcome massive challenges, those scientist-activists had to address the politics that stood in the way of achieving an effective response to the epidemic.

Since that time, astonishing scientific advances helped transform the fight against HIV, shifting the discourse on HIV from an urgent, activism-led discussion to a more technocratic, biomedical one – obscuring the political dimensions along the way. But in this moment of truth – when talk of “ending AIDS” is proving increasingly disconnected from reality for much of the world – we must face some uncomfortable questions:

Who are we ending AIDS for? Much of our current efforts appear specifically focused on heterosexual people in Southern and Eastern Africa. Yet within this region and throughout the world, millions are being left behind, particularly in key populations. How do we build an AIDS response that is both effective and equitable?

Why is prevention falling behind? We have an ever-growing list of effective prevention interventions but few resources to implement them. National programme planners have little room to accommodate prevention within their budgets and political leaders often lack the courage to tackle the questions that effective HIV prevention raises. How do we follow through from rhetoric to implementation of HIV prevention?

How should donor nations support the response to HIV in low- and middle-income countries outside of Southern and Eastern Africa? Repeatedly, we see countries transitioning from donor funding without the support to sustain the accomplishments of the past decade. Community systems wither and clinical care falters. What does responsible transition look like?

How ready are we, as the HIV community, to embrace other approaches to managing the epidemic? The HIV response has rightly built unique funding models and service delivery systems to address what was understood as a health emergency.

To sustain this momentum in an increasingly integrated world, we will need to work more closely with other aspects of health and social service systems. What is the optimal relationship between the HIV community and the broader global health and development fields?

As we prepare for the 22nd International AIDS Conference (AIDS 2018), we are dedicating this year's IAS Annual Letter to begin working through those questions.

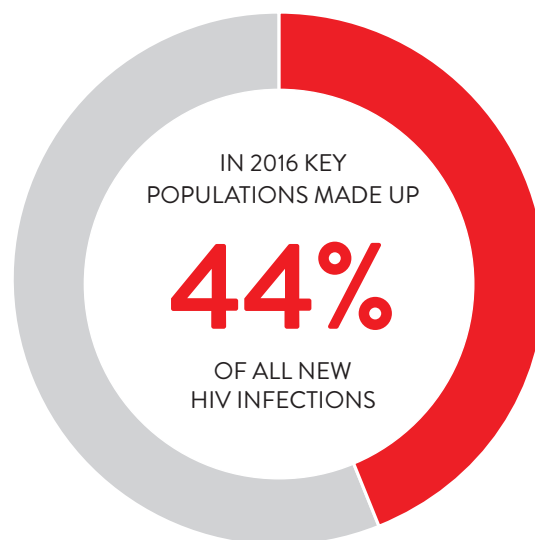


WHO ARE WE ENDING AIDS FOR?

The HIV community's insistence on equitable access to the fruits of scientific advances has forever changed the global health field for the better. Yet the truth is that we are not living up to our rhetoric. Increasingly, we are witnessing declines in new infections in many generalized epidemics, but also an alarming shift in disease burden towards key populations, including gay men and other men who have sex with men, people who inject drugs, sex workers and transgender people. In 2016, key populations made up 44% of all new HIV infections, including 80% of all new infections outside sub-Saharan Africa [3].

Even in epidemics that are declining overall, entire groups of people are being left behind. For example, while South Africa has made important gains in reducing new HIV infections, nearly 2,000 adolescent girls and young women (ages 15-24) become infected with HIV every week. Similarly, in the United States, new HIV infections overall have fallen, but new data released by the Centers for Disease Control and Prevention indicate that many black Americans are being left behind as they are least likely to learn their HIV status, receive antiretroviral therapy or achieve viral suppression [4].

Unless we act to reverse these trends, the future of the epidemic looks far more precarious than the global discourse of "ending AIDS" suggests. On the current course, we may be able to bring some measure of control to a handful of generalized epidemics that are primarily driven by heterosexual transmission. But without radically improved success in reaching all populations, HIV could well become endemic in marginalized populations across much of the world. Recent trends suggest that this is precisely what is happening as the share of new HIV infections among key populations continues to rise [5].



“BECAUSE OF BAD POLICIES THAT REFLECT IDEOLOGY AND BIAS RATHER THAN SCIENCE, THOSE MOST VULNERABLE TO HIV ARE DETERRED FROM ACCESSING THE SERVICES THEY NEED.”



FOUR IN 10 ADOLESCENT GIRLS (AGED 15-19) IN AFRICA HAVE EXPERIENCED PHYSICAL OR SEXUAL VIOLENCE FROM AN INTIMATE PARTNER

Though prevailing disparities are not just about politics (stigma is both intrinsic to and distinct from politics), it is hard to miss the political biases that undermine efforts to ensure that the gains of the AIDS response are equitably shared. Take as an example the epidemic's extraordinary impact on adolescent girls and young women. Four in 10 adolescent girls (aged 15-19) in Africa have experienced physical or sexual violence from an intimate partner [6], and the evidence is that gender-based violence is associated with a significantly greater risk of acquiring HIV[7]. Yet few countries have invested in comprehensive programmes to combat gender-based violence or to ensure ready access to adolescent-friendly sexual and reproductive health services.

Because of bad policies that reflect ideology and bias rather than science, those most vulnerable to HIV are deterred from accessing the services they need. For example, when known HIV infection itself can be criminalized or when the behaviours that are central to personal identity or one's way of life are prohibited by law, individuals understandably fear coming forward for HIV testing. Seventy-two countries specifically allow for the criminalization of HIV non-disclosure, exposure or transmission, with marginalized groups often at greatest risk of being prosecuted [8]. More than 70 countries criminalize same-sex relations [9], and the global war on drugs has created daunting barriers to ready access to essential harm-reduction services.

From the outset of our fight, the AIDS response was understood as part of a larger fight for social justice. We must demand the repeal of punitive laws, effectively support communities to reach those who are being left behind, and refuse to declare victory until AIDS is ended for all populations.



WHY IS PREVENTION FALLING BEHIND?

When the global community adopted the first declaration of commitment on HIV in 2001, it stressed that primary prevention was the “mainstay” of the response. In 2018, primary prevention is often an afterthought. As spending has rightly increased on programmes to deliver essential care and treatment to the growing number of people with an HIV diagnosis, investments in essential HIV prevention programmes have often been crowded out, especially as available funding for AIDS has stagnated.

Predictions that we can end AIDS are based primarily on the 90-90-90 approach, which aims to leverage the enormous prevention and therapeutic potential of HIV treatment. But it is increasingly clear that attaining 90-90-90 will not on its own end the epidemic. Even as steady gains have been made in increasing knowledge of HIV status, antiretroviral treatment coverage and rates of viral suppression, limited progress has been made over the past decade in reducing the number of new infections [10,11]. With the world’s largest-ever generation of young people aging towards adolescence and young adulthood, an increase in new infections is inevitable unless we sharply increase rates of viral suppression and substantially lower the rate of HIV transmission.

In both high-income countries and resource-limited settings, recent evidence demonstrates that the combination of scaled-up HIV treatment with strong investments in science-based primary HIV prevention can lead to sharp, rapid decreases in new infections [12,13,14,15,16]. Although we have long known that this “combination prevention” approach is what is required, we have seldom brought combination prevention to scale. The recent decline in the number of men in Africa seeking circumcision services is a perfect example of this [17]. Pre-exposure antiretroviral prophylaxis (PrEP) has, when combined with scaled-up HIV treatment, made possible the extraordinary reductions in new HIV infections reported in many cities in Europe and North America.

However, PrEP has achieved minimal coverage in low- and middle-income countries, and no clear plan is presently in place to guide or accelerate PrEP expansion.



There are also signs that global commitment to research on new prevention technologies is stagnating. Even as scientific developments have renewed optimism on the feasibility of HIV vaccines and other prevention breakthroughs, HIV research funding has effectively remained flat for the past decade [18]. Of even greater concern, there has been little planning on how we can ensure that future vaccine or cure candidates are rapidly taken up by the tens of millions of people living with or at risk of HIV infection worldwide.

HIV prevention is a long-term investment, one whose outcomes (that is, infections prevented), by definition, are invisible. HIV prevention inherently demands that we face difficult issues head-on; these include sexual diversity, adolescent sexuality and drug use. We devalue HIV prevention at our peril: it is essential if we hope to prevent a resurgence of the epidemic in coming years.

HOW SHOULD DONOR NATIONS SUPPORT THE RESPONSE TO HIV IN LOW- AND MIDDLE-INCOME COUNTRIES OUTSIDE OF SOUTHERN AND EASTERN AFRICA?

When international donors pledged more than 15 years ago to invest tens of billions of dollars towards reversing the global HIV epidemic, they made a political choice. The same can be said of many national governments that have allocated substantial domestic resources towards HIV programmes.

But the political commitment to AIDS is waning. From 2014 to 2016, total donor government disbursements for HIV fell by roughly 20%^[19]. Globally, resources available for HIV programmes in low- and middle-income countries from all sources declined by 7% in 2016 alone^[20]. While domestic investments in HIV continue to increase, the pace of growth is now far slower than it was five years ago ^[21].

Although few, if any, international donors use national income status as the sole criterion for eligibility for health assistance, the donor community is increasingly prioritizing aid to low-income and/or high-burden countries. This potentially leaves key populations in concentrated epidemics at growing risk of losing essential international funding for HIV programmes, as programmes for key populations in many countries are heavily dependent on external assistance^[22].

It has long been clear that stigma, discrimination, criminalization and social exclusion often prevent members of key populations from accessing services. Yet feasibility of access for these groups is rarely a factor that donors consider when transitioning countries off of assistance. This leaves behind a tremendous vacuum in settings where national governments have no intention of funding essential HIV programmes for key populations.

Don't misinterpret this observation. National leaders in middle-income countries must be held accountable for direct domestic funding to address their own epidemic. But there is evidence that some countries are transitioning out of international assistance too swiftly and without sufficient planning^[23].

As a community, we must always keep people at the centre of our efforts. National transitions from donor support must be undertaken with careful planning and over an extended period of time to ensure the continuation of essential services for marginalized populations. The international community as a whole must address the wide gap of coverage that is growing in middle income countries.





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HOW READY ARE WE, AS THE HIV COMMUNITY, TO EMBRACE OTHER APPROACHES TO MANAGING THE EPIDEMIC?

Recognizing AIDS as a global crisis that has demanded a unique response, the HIV movement has, when needed, often gone its own way. While we have always collaborated across sectors and with diverse partners, we were also willing to create HIV-specific systems and responses to get the job done. This willingness to “think outside the box” is one of our greatest strengths.

In planning for the long-term nature of the fight against HIV, we will need to embrace integration to sustain and build on our successes. As HIV has become a chronic, manageable condition, it is increasingly addressed within broader health systems like other chronic diseases. These systems need to be robust to sustain uninterrupted access to HIV treatment for tens of millions of people in the coming decades. Thus, the future of the HIV response will depend on the building blocks of health systems, including an adequate and well-trained health workforce, laboratory systems, and accessible systems for delivering care and treatment services.

Moreover, as people living with HIV age, they require – like other older populations – a broad array of health services, including screening and treatment for cardiovascular disease, diabetes and cancer. More integrated, co-located service models will be needed to manage and coordinate care for multiple health challenges, especially TB. HIV prevention will also need to work more collaboratively with other sectors; education, social protection systems and other sectors will have pivotal roles to play in addressing the social and structural factors that increase vulnerability to HIV.

But there are also risks to wholesale integration of HIV in broader health systems. In bringing HIV closer to other components of global health and development, we must ensure that we preserve the elements of the HIV response that have proven so transformative, including a commitment to human rights and gender equity, participatory and inclusive responses, community leadership and engagement, ambitious targets to inspire and guide our efforts, accountability and transparency.

**“THIS WILLINGNESS TO
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Regardless of how we integrate, we must stay vigilant against political and ideological boundaries that have negative impacts on health outcomes for everyone. An example of this is the US Government’s reimposition of the global gag rule. Its extension to the full breadth of global health programmes supported by US assistance merely compounds the challenges that clinics and other health projects face because of declining financing. Clinics face an excruciating choice – if they do what science, human rights (and, in some countries, the law) require and provide the full panoply of sexual and reproductive health services their clients need, they run the risk of going out of business due to a termination of essential funding[24].



We look forward to working with IAS members over the course of this year to achieve these commitments together.

1. Linking HIV with the broader global health agenda

To sustain the HIV response and to elevate health as a global priority, the HIV community needs to increasingly make common cause with the broader global health field. The IAS-Lancet Commission on the Future of Global Health and the HIV Response was convened to critically examine how best to integrate HIV with global health and to identify the unique attributes of the HIV response that must be preserved and mainstreamed across the health field. The commission aims to advance the vision of sustainable health for all. It will launch this year and is assessing where and how HIV should be integrated with broader health programmes; the aim is to identify synergies to benefit both HIV and non-HIV-related health outcomes. Modelling teams convened by the Commission will quantify the health and economic benefits of a more integrated, more accountable approach to HIV and health.

2. Pushing science to drive policy

This year, the IAS will join with partners to launch the Expert Consensus Statement on the Science of HIV in the Context of the Criminal Law authored by leading scientists around the world. The document outlines how the broad use of criminal law, often grounded in an exaggerated appreciation of risk, contributes to misinformation about HIV and undermines public health. It is our hope that the expert statement will become the gold standard reference for clarifying key issues of HIV science for the benefit of all actors involved in the criminal law, including police, prosecutors, lawyers, judges, expert witnesses, lawmakers and advocates. The ultimate test of this statement will be the degree to which harmful policies and practices are jettisoned. The IAS will work with country advocacy and human rights partners as watchdogs on this critical issue to ensure that science informs policy change and best practice.

3. *Uniting interdisciplinary scientists, community advocates and frontline healthcare workers at AIDS 2018*

Many of the populations experiencing some of the highest HIV burdens are also those whose well-being is at risk due to a persistent absence of comprehensive sexual and reproductive health services. These include men who have sex with men, transgender people, sex workers, people who inject drugs and young women and adolescent girls. At AIDS 2018, the IAS will embrace the spirit of interconnectedness and promote an interactive experience that advances the conversation on how efforts to bring an end to AIDS will directly contribute to realizing the full Sustainable Development Agenda. This includes our new partnership with Women Deliver, Generation Now. This is a two-year initiative uniting our global platforms – AIDS 2018 and Women Deliver 2019 – to support the protection of sexual and reproductive health and rights for adolescent girls and young women.

4. *Investing in prevention prioritization*

The IAS will now host the Global HIV Vaccine Enterprise, combining organizational efforts to increase support for researchers, scientists and advocates working to develop an effective preventive HIV vaccine. A vaccine, like other innovative prevention approaches in development, will not be a substitute for other forms of HIV prevention, but will provide a powerful new tool that can hasten reaching a genuine tipping point in the global epidemic. This commitment expands upon our ongoing work focused on developing and delivering an HIV cure and expanding research opportunities and treatment options to address paediatric HIV.

5. *Making groundbreaking HIV research available*

We will continue to freely disseminate, through the Journal of the International AIDS Society, ground breaking and important research findings from a range of disciplines in the HIV field. The specific focus is on operational and implementation science, which provides valuable information on various algorithms for monitoring and delivering comprehensive yet affordable and sustainable treatment, prevention and care programmes in different contexts. Similarly, the IAS Educational Fund will continue operating for the third year, offering interactive knowledge toolkits and dynamic regional fora based on the latest science presented at the IAS and AIDS conferences. Through these efforts, we are translating the most recent research from a global level to a local context to increase accessibility for clinicians and other healthcare providers.

6. *Making the money work for people-centred healthcare*

The IAS is committed to garnering political will and increasing the scale up of differentiated service delivery to improve access to and quality of services for people living with and most vulnerable to HIV. Differentiated service delivery is fundamentally client-centred, aiming to better serve the needs of people living with HIV while reducing unnecessary burdens on the health system. If this client-centred approach leads to cost-saving efficiency gains, then all stakeholders stand to benefit. Conversely, if investment in a client-centred approach requires additional resources to empower communities and ensure that no one is left behind, the IAS remains resolute on ensuring that these resources are available



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