



RECOMMENDATIONS

Make These Your Messages

1

Systemic prevention (such as long-acting injectable antiretrovirals or a vaccine) is a prevention priority—but not a standalone solution.

Stop saying: *Long-acting injectable options are what's needed because people can't or won't use other options.*

Funders and decision-makers involved in prevention research need to develop products that people will want and use. This means asking people—via well-designed, human-centered research—and acting on the answers. Who's accountable? Many groups—including the US NIH's Division of AIDS, which is reevaluating its trials network structure and scientific priorities. (See page 7 for more.)

2

Daily oral PrEP as a prevention tool is struggling in some contexts and soaring in others.

Stop saying: *Lots of people don't want to take oral PrEP, so it's failing.*

People using PrEP are the ones whose “non-adherence” is counted, but there are other defaulters to pay attention to, including governments and funders who are advancing disjointed programs without involving civil society, including the people most in need, such as young women and key populations. When these programs falter, it's not the user's fault.

When the people who need it feel ownership of the product and the program, any strategy—including PrEP—can work. Oral PrEP definitely isn't for everyone, but many people who might want it still need a chance to try. (See page 21 for more.)

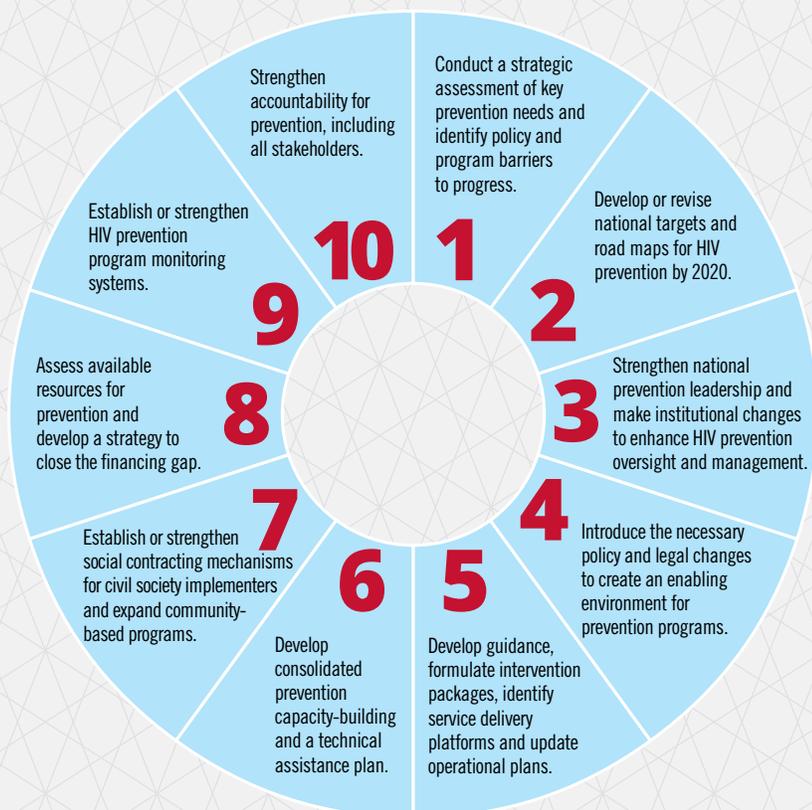
3

We're on track to epidemic control if and only if the funding gap is closed, rights infringements and violations are addressed, civil society is involved and comprehensive prevention and research are prioritized in a way that it has never been before.

Stop saying: *A country or community's progress to date is the same as its future path.*

Today there are only a few countries that are even possibly on track to achieve epidemic control. This good news leaves raging epidemics elsewhere, particularly in places where human rights are in shambles and HIV is concentrated in key populations. This isn't the kind of partial progress we can settle for. (See page 31 for more.)

Figure 1 The UNAIDS 10-Point Plan for Making Progress on Prevention



Source: UNAIDS. 2017. *HIV Prevention 2020 Roadmap*. <http://www.unaids.org/en/resources/documents/2017/hiv-prevention-2020-road-map>.

In the pages that follow, we delve deep into a vast, disparate range of topics. The commitment to clarity starts at home, so here's how we see it all fitting together:

First: It is a dynamic time for HIV prevention. There are more trials of new concepts, more programs for daily oral PrEP and more attention to HIV prevention in country plans than a year ago (or ever before). This is fertile ground for progress. Our Report focuses on challenges and proposed fixes, but the overall message is that science continues to deliver and needs to be sustained.

Second: Issues and themes recur across institutions, so sometimes the best way to see the big picture is

with a tight focus. In Section 1, we offer a deep dive into the decisions that the National Institutes of Health's Division of AIDS (DAIDS) will make about the future of its HIV clinical trials networks. While these decisions are happening in real time and affect many countries, communities and clinical trials, the DAIDS networks aren't even the sum total of US-funded research, let alone global research endeavors. However, the key recommendation we make is for all research stakeholders: don't make the mistake of thinking there are shortcuts in HIV prevention. No single shot (or series of shots) or implant will solve adherence issues and therefore make pills, gels and rings obsolete.

Third: The inconvenient truth about HIV funding and progress towards "Fast Track" targets is the most important truth today. There isn't enough money; the progress isn't sufficient or consistent, even though there are places where the context is promising. We must not confuse progress, however real, with a guarantee of success.

Since our last *AVAC Report*, we have seen an expansion of global efforts focused on prevention for HIV-negative individuals. This broad category of efforts to prevent HIV acquisition encompasses everything from daily oral PrEP to harm reduction to male and female condoms, and it has the public health moniker of "primary prevention". This sets it apart from ART for people living with HIV, a "secondary" prevention strategy with proven benefits for individual health.

The list of efforts is long and overlapping: A Global Prevention Coalition launched in October 2017 by UNAIDS and UNFPA and a new HIV Prevention 2020

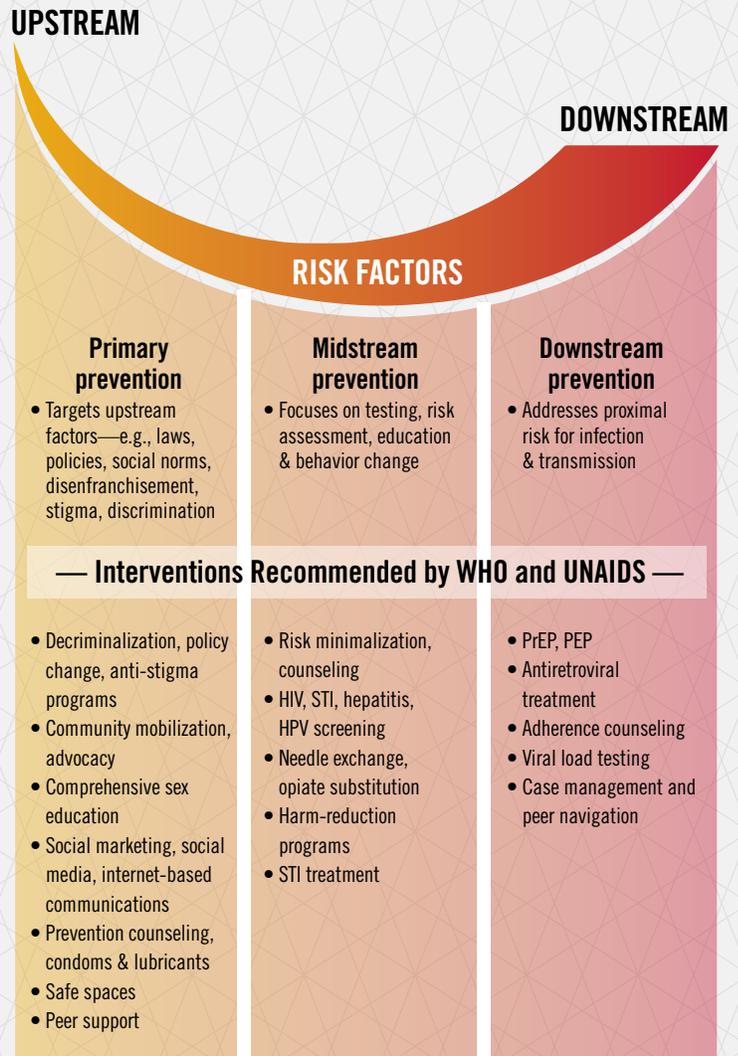
Road Map; a Global PrEP Working Group launched by WHO; and so on. Targets for primary HIV prevention are now understood to be as important as UNAIDS' "90-90-90" targets focused on HIV testing, linkage to ART and virologic suppression that have been the main focus for so many years. It's terrific that the binary seems to belong to bygone days.

But where, aside from shuffling through position papers and roadmaps, does that leave us? Quite simply, with a mixed message in which the policies say one thing and the situation for people living with and at risk of HIV says something else entirely. Primary and secondary prevention are essential and "epidemic control" is possible, but the funding is missing, and the commitment to comprehensive programming—including continued research for new strategies—is uneven.

These mixed messages are perhaps most pronounced in the context of prevention for women and girls, and all those who are collectively known as "key populations". The draft UNAIDS/UNFPA "scorecard" for its prevention roadmap¹ advances clear metrics for tracking VMMC and PrEP as part of general prevention, but when it comes to the urgent needs of key populations, it veers away from specifics. In a world where homosexuality and sex work are explicit or implicit grounds for surveillance, violence, imprisonment and intimidation, providing a condom and an HIV test is not effective prevention. Yet this is often what counting "prevention interventions offered" amounts to. It makes no sense. The real answer lies in highlighting the targets for structural change that UNAIDS set out in 2016—and then taking bold activist steps to achieve them.

The main thing that cuts across all of these issues is resources. The total estimated investment in global

Figure 2 **MSMGF's Model for Conceptualizing Prevention**



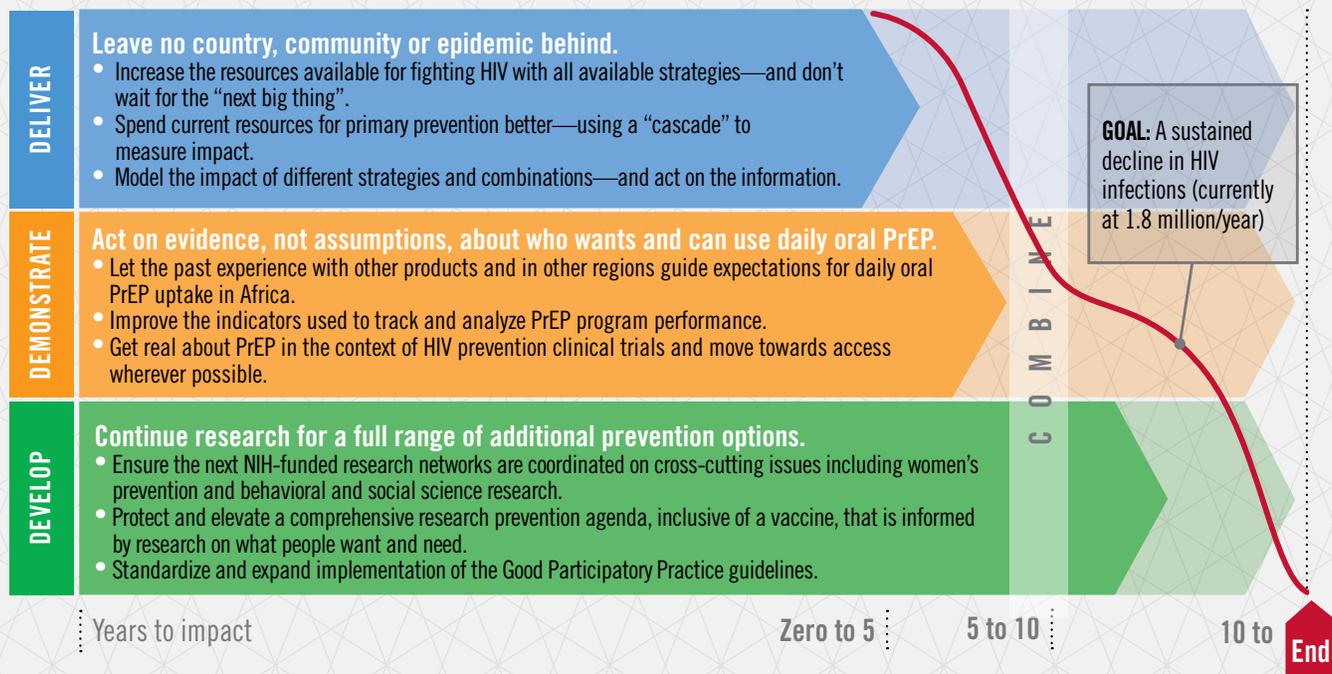
Source: Global Forum on MSM & HIV. 2017. *Reconsidering Primary HIV Prevention*.

AIDS must increase to US\$26.1 billion by 2020 if the Fast Track targets are to be met. The world was seven billion dollars short of this in 2016, and annual funding is already declining year-on-year. The rhetoric is that "flat is the new normal" and that efficiencies must be found to save money, which can then be reinvested. PEPFAR's updated strategic plan signals another shift in funder/implementer strategy.² The program says that it will now focus resources

¹ UNAIDS. 2017. *Towards a Global HIV Prevention Coalition and Roadmap*. http://www.unaids.org/sites/default/files/media_asset/towards-global-hiv-prevention-coalition-and-road-map_en.pdf.

² PEPFAR. 2017. *Strategy for Accelerating Epidemic Control*. <https://www.pepfar.gov/documents/organization/274400.pdf>.

Figure 3 **AVAC's "3D" View of the World: 2017 and beyond**



and attention in 13 countries that are on track to achieve epidemic control. Meanwhile, non-focus countries—among others—will receive less attention and money, even as their epidemics grow. Russia, for example, has the highest number of HIV cases in Europe, with incidence and AIDS deaths rising year on year. None of the interventions with known efficacy for HIV prevention, including harm reduction programs, ART on demand, PrEP, or tailored interventions for drug users, sex workers, and MSM are available to scale. Russia is not an exception, but a caution and a call to action for all.

At the country level, no amount of prioritization or boosting of political will can ever improve prevention if the resource envelope is consumed almost entirely by commodities (e.g., antiretroviral medications, HIV test kits etc.) and meeting the needs of a high-quality, rights-based ART program.

A final word on why this year's focus is on saying what you mean—and acting on it.

To work on the frontlines of HIV/AIDS is to defend freedom of speech to its fullest extent and to deplore all forms of violence—physical, psychological, structural—that are incited or permitted as a result of that speech. We know that often-silenced voices must guide the conversation—see page 36 for some of the ways that AVAC and our partners are working to speak truth to power. We may not always agree, but we're here, we're listening and we're ready to add our voices to those of our allies until this hard and necessary work is done.

Mitchell Warren
Executive Director, AVAC