

# The Slippery Slope

## RECOMMENDATION

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**Make this your message:** *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 is 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.*

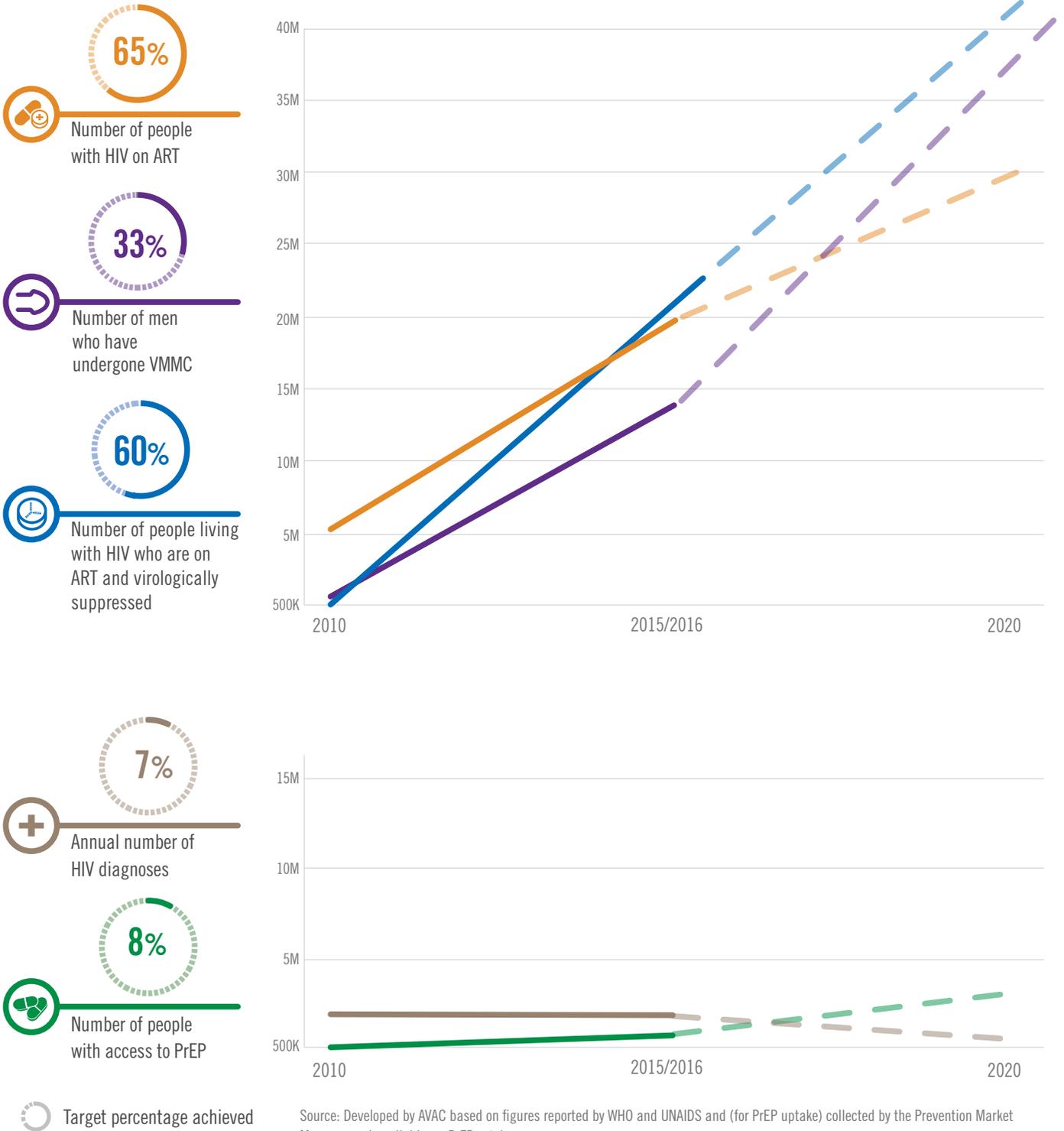
Today there are only a few countries that are even possibly on track to achieve epidemic control. This good news leaves raging epidemics elsewhere, particularly in places where human rights are in shambles and HIV is concentrated in key populations. This isn't the kind of partial progress we can settle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

When it comes to mixed messages, the fuzziest phrase of 2017 just might be “on the path to epidemic control”. PEPFAR used the phrase to identify 13 focus countries in its updated strategy, released in September 2017. UNAIDS has used it but more recently seems to be moving away from it. Whether you love it or want to lose it, it's hard to think of another handful of words that carries such a combination of promise and peril. The promise is that some countries have seen rates of new diagnoses plummet as antiretroviral treatment access has scaled up. PEPFAR funded detailed household surveys, known as the Population-based HIV Impact Assessments (PHIA), which provide data of unprecedented quality in mapping these declines. Based on these downward slopes, PEPFAR predicts that a select handful of countries can achieve epidemic control (which PEPFAR defines as a context in which there are fewer new cases of HIV than AIDS deaths) by 2020. It's a tantalizing possibility. It's also where the peril comes in.

Countries that have achieved dramatic incidence reductions are indeed “on a path” to epidemic control. That path, though, is all projection. In most places, the pace at which incidence must decline to meet a 2020 goal of “epidemic control” is faster than the pace at which new diagnoses have declined to date. (The technical term for this is an  $R_0$ , or basic reproductive ratio of less than one, meaning that the number of people that a single person with HIV would pass the virus on to is on average less than one.) Countries that are on the path to a place where  $R_0$  is less than 1 have to step up—and change—their game: reaching young people and men, mixing in more effective primary prevention and striving for

**Figure 16 Target Tracking, 2010–2020**

As the figures below show, progress has been made toward some, though by no means all, of the UNAIDS Fast Track Goals for 2020. Calculating progress is also complex: because rates of new HIV diagnoses aren't dropping, the overall number of people living with HIV is bigger than forecast when the Fast Track initiative launched. One reason: limited change related to discrimination, stigma and gender inequality. AVAC has long argued that ambitious targets are the best kind. They propel action even if they aren't met. But when it comes to achieving epidemic control, progress must be properly calculated, and can never be confused with success.



Source: Developed by AVAC based on figures reported by WHO and UNAIDS and (for PrEP uptake) collected by the Prevention Market Manager and available on [PrEPwatch.org](http://PrEPwatch.org).

saturation coverage of VMMC and ART, all in the context of true cultural and legal shifts that protect rights and undo sexism, homophobia and state violence. In other words, it's going to be at least as hard—if not harder—to cover that final kilometer than it was to arrive at the present state.

In every country that has provided sex and age disaggregated data, rates of HIV diagnosis, linkage to ART and virologic suppression among those on treatment are lower among young men and women aged 15 to 24 than the general population. This is the precise age group that has swelled in size over the past twenty years. As the figure on page 23 shows, the math behind the “youth bulge” is clear: even with decreases in incidence, there are more young people with and/or at high risk of HIV than there were 30 years ago. Today's best efforts are keeping rates of new HIV diagnoses from going up, but the steps that put countries on the path to epidemic control aren't enough to finish the job.

Perhaps paradoxically, hope for the future lies in the fact that, to date, most countries haven't thrown everything they've got at their epidemics.

The gains so far in countries like Swaziland and others with PHIA data are estimated by PEPFAR to be about 90 percent attributable to antiretroviral treatment leading to virologic suppression in people living with HIV. That's an extraordinary achievement. It's also an indictment of a slow global response that waited far too long to act on the evidence that immediate ART could preserve individual health and reduce onward transmission when the person with HIV was able to make an informed choice to begin.

The downward trends in countries “on the path” to epidemic control don't reflect fully scaled-up VMMC programs. These incidence slopes don't even reflect all of the benefit of the VMMCs performed during the period when incidence was declining, as many of the African males undergoing medical male circumcision are under age 24, so the benefits in terms of infections averted are in the future, when they reach the period in which they are at highest HIV risk, between 25 and 34.

The downward slopes also don't reflect the introduction of oral PrEP or meaningful progress towards addressing the structural factors that put adolescent girls, young women, men who have sex with men, transgender people and sex workers—among others—at such substantial risk. Work on these fronts is just getting underway—or hasn't started in earnest. So we can only imagine what might happen if these pieces of the prevention puzzle were put in place. Indeed, the dominant story coming from UNAIDS and some donors is the progress that's been made with ART. As Figure 16 shows, there is a reason for this: access is rising around the world. But new diagnoses are not falling. The goals for the protection of human rights and levels of discrimination are even further off track. And funding levels continue to move in the exact opposite direction of what is required to meet—and sustain—any or all of these targets for the long term.

The dotted lines that project paths towards epidemic control or global targets trace steep and, we would argue, slippery slopes. The spaces between those dots might as well be chasms, for all the ways that it's possible to fall off course. The resources that are currently invested in primary prevention (prevention for people at risk of acquiring HIV) remain paltry and siloed by strategy, rather than integrated into the kind of comprehensive approach articulated by MSMGF and the other authors of *Reconsidering Primary Prevention of HIV: New steps forward in the global response* (see Figure 2, p. 5).

Moreover, a framework for meaningfully implementing and measuring progress toward primary prevention goals has only just been released by UNAIDS, and it's not going to be simple to implement for many reasons: oral PrEP is a new strategy (see Section Two), young women and adult men are hard to reach with existing strategies and yet are among those at the highest risk and many testing programs have been urged to measure “yield” solely in terms of number of people with HIV diagnosed and linked to care. This is a missed opportunity, as testing programs that identify people

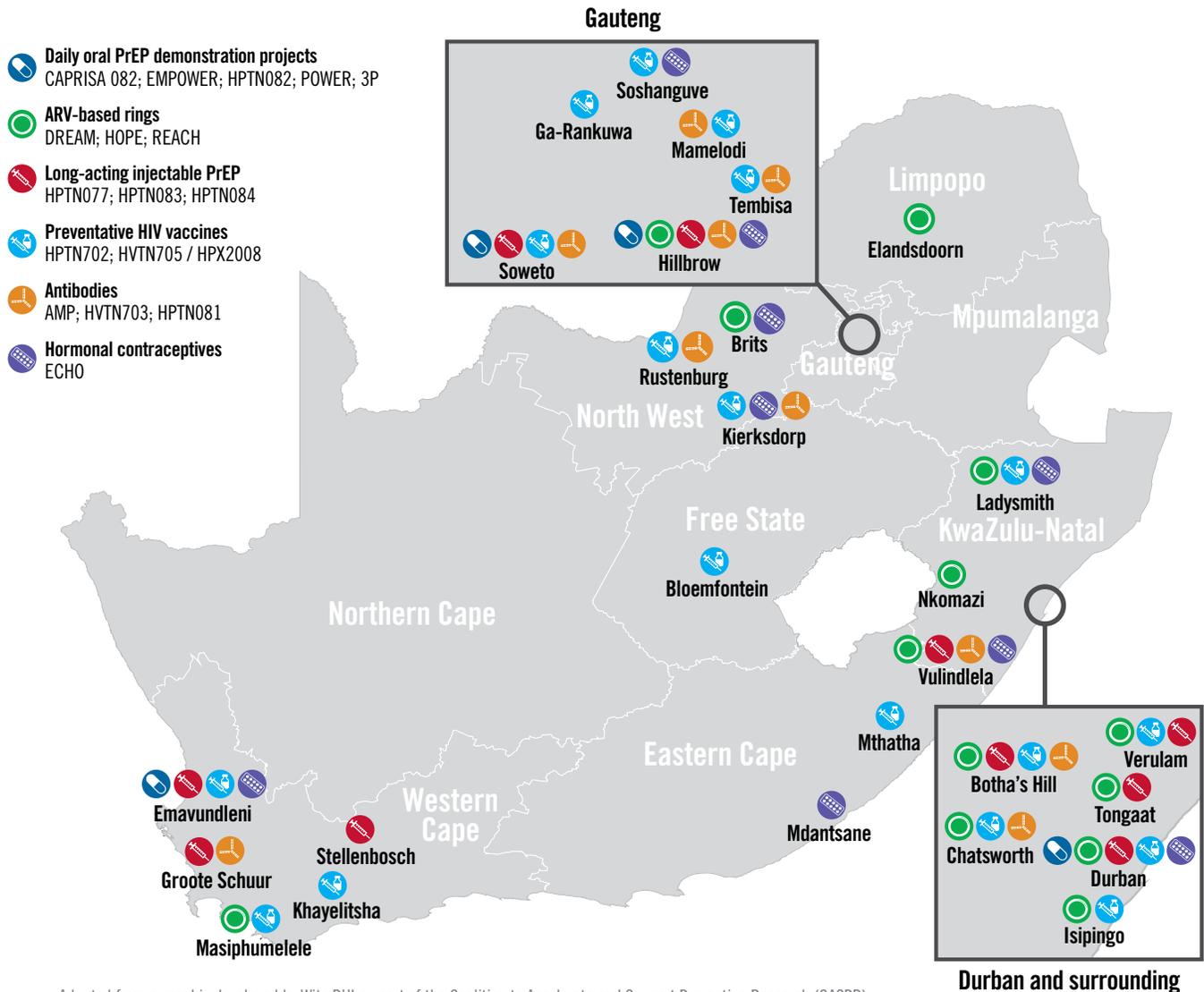
with HIV are also seeing many people at risk who should be linked to effective, tailored prevention. This is going to take resources, innovation and clear directives to redirect and reorganize testing programs so that they serve people with HIV and those at risk for HIV equally well.

At the same time, demographics, decisions about how to spend existing prevention dollars and optimistic graphics about countries on track to achieve epidemic control are a distraction from the core issue: there isn't enough money available for the global AIDS response to achieve the 2020 targets, and the money that is available is increasingly being allocated by PEPFAR to countries that have made progress. Struggling countries, countries whose economic status is shifting and countries where the epidemic is localized in marginalized groups are all going to be left behind. The world is not on a path to epidemic control—not even close. We need the stories of progress to make the case for why more resources are needed but to confuse progress with ultimate success is dangerous, if not irresponsible. The message that countries are on the path to epidemic control suggests that our work is close to done. It is not.

To get the job done, whether it's achieving  $R_0$  or an AIDS free generation or "control" there are five things that need to happen differently:

- ▶ **Increase the resources available for fighting HIV/AIDS.** The progress to date has been phenomenal in some countries—and it hasn't been achieved by accepting the rhetoric that "flat is the new normal." Low- and lower-middle-income countries must continue to increase contributions to health budgets and HIV spending, high-income countries must continue to ante up and the private sector must pitch in to a wholly achievable and high-return investment in existing and future tools, such as an effective preventive HIV vaccine, which have a crucial role to play in decisively ending the epidemic.
- ▶ **Take the funding that is presently available for primary prevention and spend it better.** *AVAC Report* makes this point every year. And every year it bears repeating: HIV testing that isn't linked to referrals and services for HIV-negative people should not be coded as an HIV prevention investment. Provision of an HIV test and a brochure about safe sex should not qualify a program for recurring, substantial investments of prevention dollars. PrEP programs that roll out without community partners and civil society buy-in are wasting some or all of their investments. New and exciting interventions should not displace core investments in VMMC and condom programs. There are efficiencies and shifts in policies that can help advance primary prevention even in today's constrained environment.
- ▶ **Model the impact of different strategies on the path to epidemic control—and then act on this information.** During the years when ART coverage soared and incidence plunged in Swaziland, funding for VMMC fluctuated, and the coverage crept up by a measly 16 percent. Even if it had been substantially higher, though, the impact in HIV infections wouldn't have showed up in the five-year window. VMMC prevention at the population level accrues over time; the cost of not having hit more ambitious targets will be seen in years to come. Countries, funders and civil society all need better information about the relative contribution of different strategies—and of different forms of inaction—if we are to have any hope of programming toward true epidemic control.
- ▶ **Leave no country, community or epidemic behind.** The most pernicious use of the "path to epidemic control" phrase is in the context of PEPFAR's current strategy, which highlights real progress in 13 countries while sidelining 37 other countries that receive PEPFAR funding. This includes countries like Ukraine, one of many countries with an epidemic related to injection drug use and driven by the absence of

Figure 17 HIV Prevention Research and Demonstration Sites in South Africa (December 2017)



Adapted from a graphic developed by Wits RHI as part of the Coalition to Accelerate and Support Prevention Research (CASPR).

comprehensive rights-based harm reduction. In the context of constrained resources, funders are using the category of “on the path to epidemic control” to allocate funding away from geographies with entrenched, key population-based epidemics—and to slash resources in middle-income countries where there is no evidence that governments plan to step up and fill the gap. We all want nothing more than for the world to be on the path to epidemic control. But this can’t happen without investment, honesty and clarity. Mixed messages won’t cover the final kilometer. They never have.

## Conclusion

By the time AVAC brings out our next annual report, we will be within 18 months of the deadline for the Fast Track goals. Today the world is only halfway to achieving its treatment target and less than half way to the 2021 VMMC target. Progress towards coverage of male and female condoms, and reductions in stigma and gender-based violence are all too slow. Daily oral PrEP is slowly gaining traction, and stigma and discrimination are more entrenched than ever. In the coming months we will track progress—stay connected on [www.avac.org](http://www.avac.org)—and will also work to influence outcomes via a range of advocacy efforts.

**Join us.**