

TWO YEARS AND COUNTING

A Letter from the Executive Director

In just about 24 months, the world will arrive at the deadline for the UNAIDS “Fast Track” goals for ending the epidemic. The primary fast-track goal for HIV prevention is a reduction in new diagnoses from roughly 2,000,000 a year, to less than 500,000. There’s no chance this goal will be achieved. In July 2018, days before the biennial International AIDS Conference, UNAIDS released its annual state-of-the-epidemic report and declared a “prevention crisis”.

That’s the bad news. There’s a lot of bad news around today though. Here at AVAC, we’re concerned that the true implications of this missed target haven’t sunk in. Simply put, the tremendous gains in

the fight against HIV made to date are all in peril due to failures in primary prevention. This is due, in no small part, to the demographic shift known as the “youth bulge” or “wave”. In many HIV-endemic countries, there are or soon will be twice as many young people as there were when the epidemic started. At the same time, epidemics driven by drug use in Eastern Europe and Central Asia are out of control. The US epidemic is disgracefully unchecked. This is not a theoretical coming storm. It is a landscape-altering hurricane, just off the shore.

FIG. 1 AVAC’s “3D” View of the World: 2018 and beyond

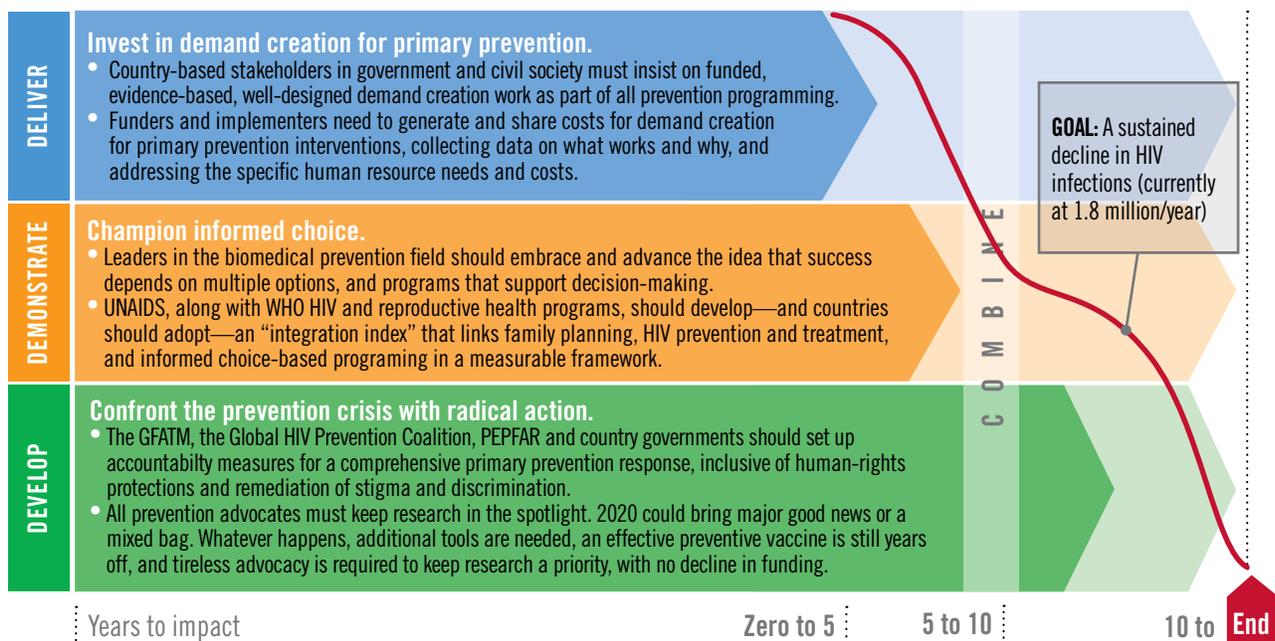
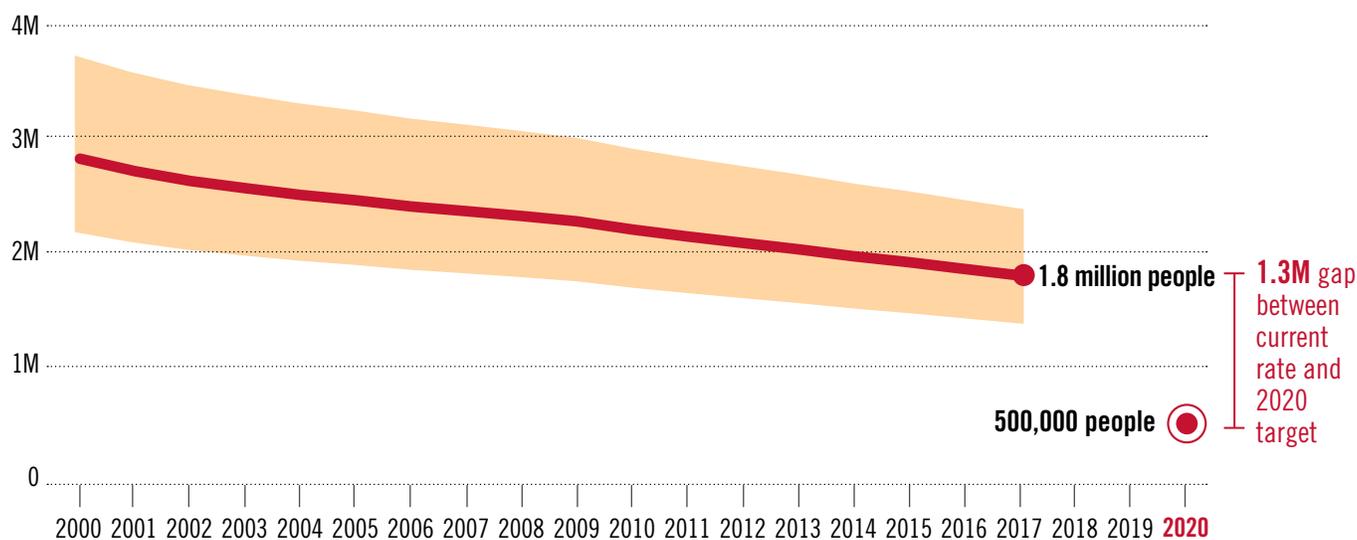


FIG. 2 Global Number of New HIV Infections, 2000-2017 and 2020 Target



Source: UNAIDS. *Miles to Go—Closing gaps, breaking barriers, righting injustices*. July 2018. Accessible at: www.unaids.org/en/resources/documents/2018/global-aids-update.

This is not the time for panic or denial. Action is a must. And here is where the good news lies: the reasons why the world is going to miss the target are obvious and can be tackled. This year's *AVAC Report* is dedicated to diagnosing the problem and proposing actionable solutions.

Hasn't AVAC done this before? Yes and no. As we discussed in 2014, in our report *Prevention on the Line*,¹ the primary prevention targets set by UNAIDS and adopted by countries the world over have, for several years, been buried pages into UNAIDS' annual reports. Even with the advent of the Global HIV Prevention Coalition,² which has revitalized primary prevention planning structures at the country level, there has been limited allocation of new resources to close persistent funding gaps. As we described in our 2017 report, *Mixed Messages*, there is a gap between rhetoric and practice, and between countries'

priorities and the possibilities given budget envelopes and funder priorities.

There is also a messaging gap. The true scope of the prevention crisis is hard to convey without also casting doubt on the significant progress to date in expanding access to treatment leading to virologic suppression, scaling up VMMC and more. US government investment in research and implementation related to HIV outpaces any other nation in the world and is essential to the global response. Historically, congressional support has been bipartisan and enthusiastic. A message that conveys the stakes as well as the successes is tough to find. A message that does this and also includes the need for research is even more complex.

With this year's Report, we don't waver from prior analysis. Instead we try to get specific and practical. The crisis is coming, the message is clear. Here's our proposal for exactly what to do and why.

¹ For this and all previous *AVAC Reports* visit www.avac.org/avac-report.

² For more information see: <https://hivpreventioncoalition.unaids.org/>.

AVAC Report 2018: No Prevention, No End—At-a-Glance

1: NO DEMAND CREATION, NO IMPACT



THE PROBLEM: Today's primary prevention and treatment strategies need new approaches to "demand creation". While there's innovation in this field, it's applied unevenly across interventions. Data gaps on the costs and cost-effectiveness of demand-side thinking are pervasive; the funding gap for primary prevention makes this necessary work seem like a luxury.



THE RISK: The perfect can become the enemy of the good. The risks in arguing for intentional and thoughtful introduction plans are that access gets slowed down in pursuit of an unattainable ideal and that expectations of the program design approach are overinflated.



THE PATH TO A SOLUTION: Understand not everyone can do demand creation. It's a science, not a set of slogans. This is true for treatment; it's the bedrock of primary prevention. Find the people who can do it, the programs that have done it before and work with them to do it consistently. Reaching the right people is more important than reaching all people. Limited resources should be allocated to tailored demand-side thinking.

2: NO CHOICE, NO PREVENTION



THE PROBLEM: Informed choice is easy to advocate for and hard to implement. Cost, provider time and public health priorities can all work against investment in services that offer and support choice in strategies.



THE RISK: Embracing informed choice in biomedical prevention is tricky. There isn't enough money for primary prevention basics like male and female condoms and VMMC. Advocating for more choices such as PrEP, multiple testing approaches, etc. means finding ways to do more with existing resources and also demanding additional funds.



THE PATH TO A SOLUTION: Identify, cost and adapt best practices in informed choice programming and monitoring from family planning and HIV programs as part of planning for new biomedical tools.

3. NO RADICAL ACTION, NO END



THE PROBLEM: There is a primary prevention crisis. The emphasis on ART-based programs to reduce incidence has drawn attention and funds from primary prevention for too long; the 2020 global target for incidence reduction will be missed.



THE RISK: So much has been accomplished in the fight against AIDS; so much is left to do. Emphasizing failure can hurt morale and momentum, yet so can over-promising and failing to deliver.



THE PATH TO A SOLUTION: Tailor today's prevention approaches to specific communities and contexts; sustain research and prepare for results. ART scaled up in the context of flat funding by finding efficiencies; biomedical prevention hasn't nearly done the same. Accountability mechanisms for implementing effective primary prevention must be built into GFATM, Global HIV Prevention Coalition activities and PEPFAR COPs and at the same time champions of primary prevention can prepare the world for research results and future trials.

First: fund real, rigorous demand creation for primary prevention strategies. In Section One, we assert that there is a science to ensuring that people who most need prevention or treatment are reached with messages that are accurate, resonate and prompt action. There are promising signs that this science is seen as valuable. The US government, the Bill & Melinda Gates Foundation and some additional country governments are prioritizing “demand-side thinking”, work that needs to be expanded and made routine; it’s the key to making primary prevention work.

Another focus this year is choice. In Section 2, we argue that without choice there is no end to the epidemic, and then go on to explain exactly what we mean, what is and isn’t known, where to spend money and time, and why.

Choice matters because of questions like these:

- ▶ How does a woman at risk of HIV choose between contraceptive methods when one or more of them have a possibility of increasing her risk of getting HIV?
- ▶ How does a woman living with HIV and of child-bearing age, who is struggling to adhere and wants an easier regimen, make a choice about using dolutegravir, a powerful, well-tolerated antiretroviral that may increase risk of a birth defect that occurs very early in pregnancy?
- ▶ How does an African man who has sex with other men decide whether to comply with the health provider’s request for the names and contact details of his or her sexual partners?
- ▶ How does a person at substantial risk of HIV decide between condoms, oral PrEP, and weigh the offer of assisted partner testing or couples counseling—or choose all three?

It is expensive to build, staff and supply programs that allow people to answer these questions. Events from the past year—discussed in Section Two—show that it is it is even more costly *not* to act.

The title of this letter, *Two Years and Counting*, is a nod to the titles of AVAC’s annual reports for the first several years of our existence. Taking inspiration from US President Bill Clinton’s 1997 speech that committed the US to developing an AIDS vaccine within 10 years, we called our annual reports “Nine years and counting...” and so on, stopping in 2003 with “Four years and counting...”.

We didn’t stop because we gave up, but because we felt it was important to calibrate expectations and lay out agendas that would maintain momentum for as long as needed. We still feel that way, and we’re excited that the “Two Years and Counting” deadline takes us close to the anticipated release date of the results of a major HIV vaccine efficacy trial, along with data from trials on long-acting injectable PrEP and antibody-mediated prevention. As we discuss in the final section of this Report, these data will emerge at almost the exact same time that the deadline for the 2020 Fast Track prevention targets (see Fig 14, p. 33) will pass with most unmet.

On the matter of titles, we chose *No Prevention, No End* for this year’s Report both because the message is true, and because of its link to the powerful activist chant, “No Justice, No Peace,” often heard in the US at rallies against police brutality. The same forces of racism and inequality that enable state-sanctioned violence against black and brown Americans also drive the US epidemic, especially amongst transgender women and same-gender loving men. This structural violence is at work in Africa, Europe—it is the global scourge of hate that we fight every day, with all the love and joy we can muster.



Mitchell Warren
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