

PREVENTION ● on the Line

December 2014

HIV prevention is at a crucial moment. It is indispensable and advancing in leaps and bounds. Yet it is also in jeopardy. Here's what needs to happen next.

There are now more effective strategies to prevent acquisition and transmission of HIV than at any other point in the epidemic. The distinction between antiretroviral therapy (ART) for HIV-positive people as treatment (for clinical benefit) and prevention (for reducing risk of HIV transmission) is fading, as evidenced by the recent WHO *Consolidated Guidelines on the Use of Antiretrovirals*.

Some countries are starting to adopt these guidelines and implement ART programs that initiate treatment regardless of CD4 cell count for some or all populations. And UNAIDS has put forward the ambitious “90-90-90” target, which aims for 90 percent of people living with HIV to know their status, 90 percent of those to be on ART and 90 percent of those to be virologically suppressed by 2020.

These are terrific shifts in policy and rhetoric, and it is crucial to work to put them into practice.

The stakes for HIV prevention are as high as they have ever been. In this radically new environment, HIV prevention is “on the line” in two senses of the phrase. First, it is fundamental to achieving the profound changes in the epidemic that current modeling says are possible with sufficient investment and acceleration of delivery of key

services. In any figure charting hoped-for declines in HIV infections, prevention is quite literally causing the line to curve towards zero. But since most of today's models focus mainly on ART, prevention is also “on the line” in the sense of being inadequately and inaccurately defined, resourced and implemented.

The focus of the next 12 months—and beyond—must be on ensuring that *all* aspects of the HIV response are linked to specific, resourced strategies that turn talk into action. We know from experience that this can work (see page 4 for examples). To do this, there needs to be action at all levels—from delivery of proven tools, to demonstration of emerging strategies, and development of innovative technologies for the future. Right now, there aren't sufficient financial resources to fund this action. Filling this funding gap is absolutely essential.

AVAC has three key recommendations that—in addition to filling the resource gap—can keep prevention “on the line” that slopes to zero new infections and deaths from AIDS. As shown on the next page, these align with our “3-D” framework for existing, emerging and yet-to-be-identified strategies.



AVAC Report 2014/15: HIV Prevention on the Line

In early 2015, AVAC will publish **AVAC Report 2014/15: HIV Prevention on the Line**. The Report will provide a full analysis of the state of HIV prevention research and implementation, with a full exploration of the targets, strategies and resources needed across the research-to-rollout spectrum.

Key Recommendations

1 Align high-impact strategies with human rights and realities.

Today, there is a strong emphasis on linking investments and impact. Some of the strategies suggested include shifting from national coverage to focused services in specific “hotspots”, initiating treatment on the same day as diagnosis

and targeting “key populations” including MSM and sex workers with tailored strategies. The science suggests these strategies may have impact, but if civil society concerns go unaddressed, effective strategies won't work.

2 Invest in an oral PrEP-driven paradigm shift.

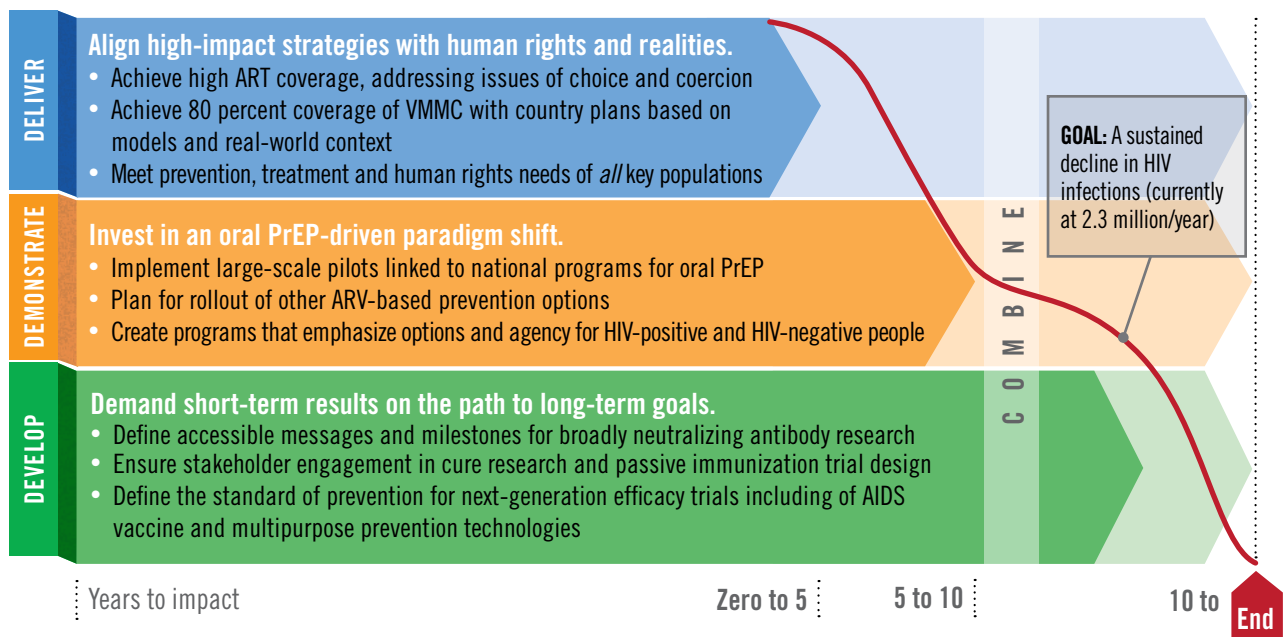
Daily oral PrEP for HIV prevention will never be for everyone. But the past 12 months have seen a groundswell of discussion, demand and data that upend several prevention paradigms. Many HIV-positive and HIV-negative individuals see oral PrEP as a powerful tool for sharing responsibility for HIV prevention. It turns out that people who have high rates of unprotected sex and

are using PrEP can be highly adherent. But scale-up isn't keeping up with this momentum. Investing in large-scale pilots, programs and policies is essential and will not only increase the impact that PrEP can have today but will also lay the groundwork for new prevention options, especially ARV-based microbicides, if and when they are demonstrated to be efficacious in clinical trials.

3 Demand short-term results on the path to long-term goals.

An AIDS vaccine is at least a decade away from public health delivery, but there are steps that need to happen in the coming year to stay on track. Targets and funding for research remain essential for a wide range of R&D including vaccines, long-

acting injectables, multipurpose prevention options and cure. To sustain support, it's critical to clearly identify next steps and craft messages that manage expectations, address the complexities of future efficacy trials and focus advocacy.



Taking Targets to Task

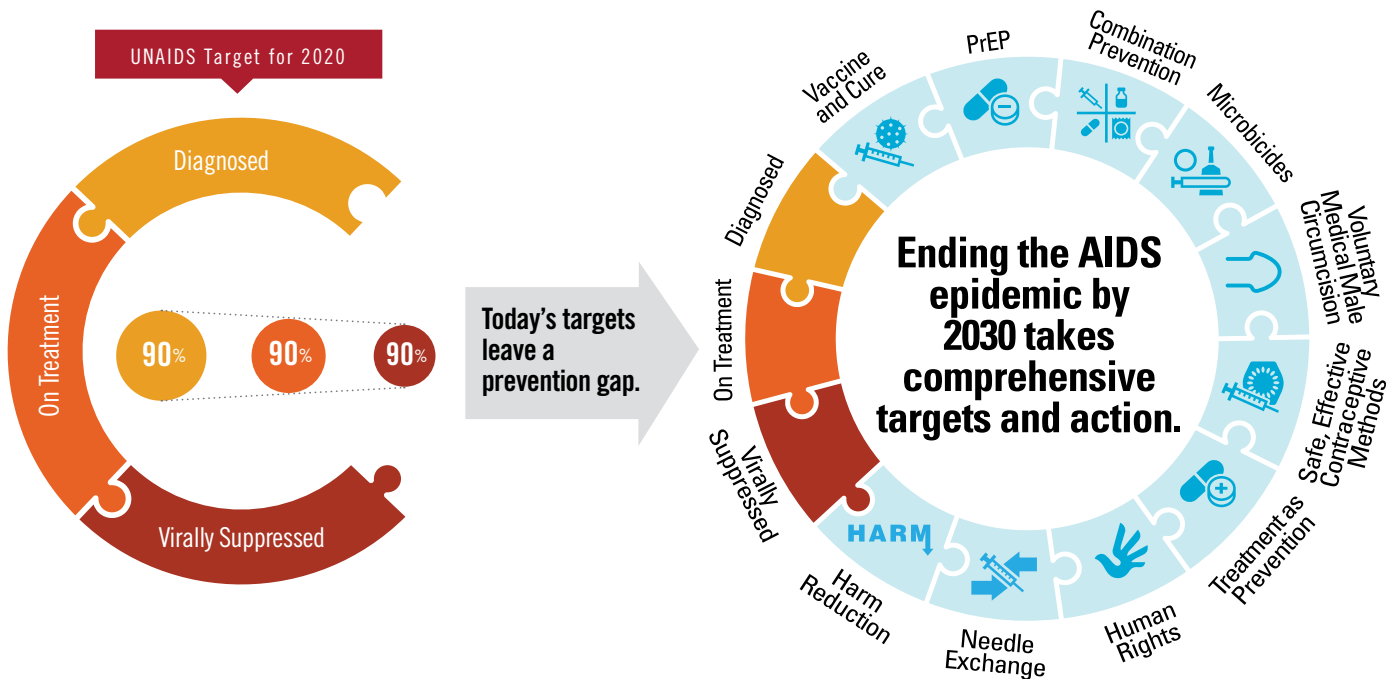
Mind the gap.

Targets are absolutely necessary to setting a course for an effective AIDS response. But they're far from sufficient. A slew of targets for separate interventions can be confusing and misleading, since such targets are often discussed in isolation, suggesting that a single strategy can accomplish all. The truth is no single strategy will end the AIDS epidemic. But a comprehensive response backed by

resources, fueled by evidence, political will and collective demand can achieve this goal.

Targets, particularly for prevention, lack precision and plans to turn them into reality. In these graphics, AVAC summarizes what's needed to ensure a comprehensive response driven by smart planning, sufficient resources and accountability. A full analysis is coming early next year in *AVAC Report 2014/15*.

These are urgent recommendations. UNAIDS is in the process of developing prevention and anti-discrimination targets to complement the 90-90-90 goal focused on testing and ART. It is critical that these targets are developed and launched with the same level of rigor and endorsement that accompanied 90-90-90.



We know an effective target can achieve results.

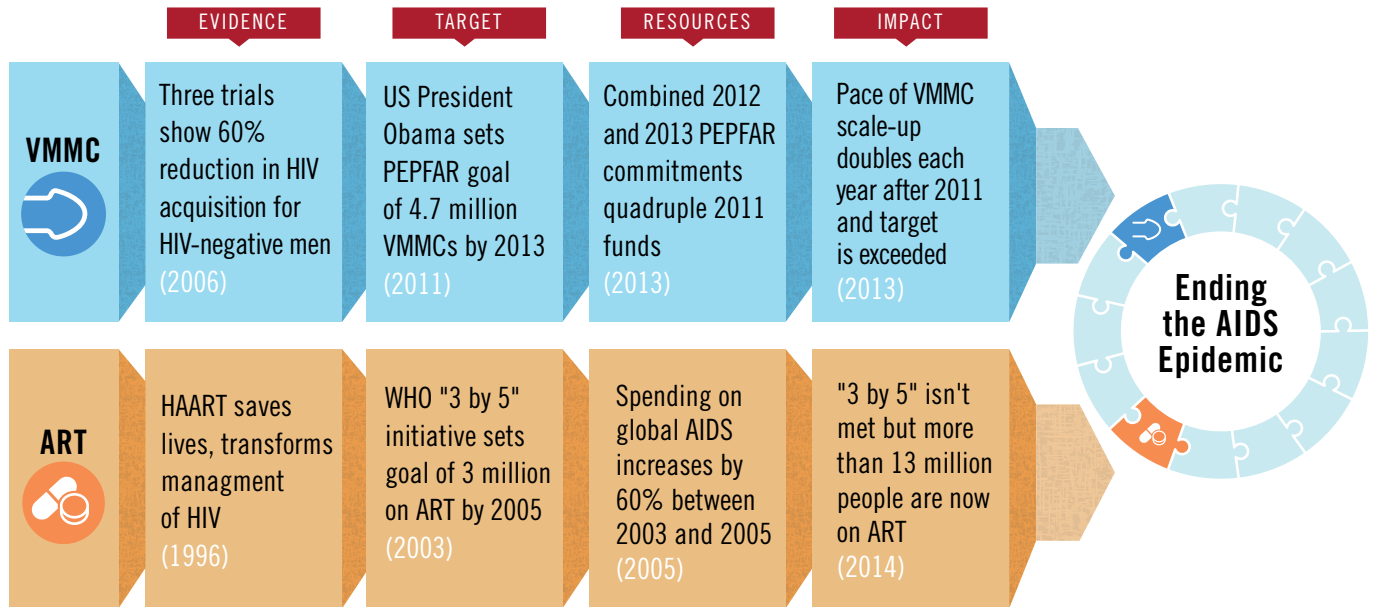
As the graphic on page 4 illustrates, there are clear examples of targets that have driven change that impacted the epidemic. The WHO “3 by 5” initiative for ART is one. More recently, the PEPFAR target of 4.7 million VMMC

procedures achieved by 2013 helped propel a surge in resources and innovative delivery.

These targets worked because they reflected evidence and were backed by resources. Their impact can be evaluated in terms of the

absolute numbers—people initiated on treatment, men undergoing VMMC—but also in the way that they changed the sense of what was possible as part of the global AIDS response. This is true even though 3 by 5 didn't meet its deadline.

Targets that Worked



For targets to have impact, they need to tick all the boxes. Right now, many targets don't—or don't exist at all.

Targets can turn from audacious to irrelevant without sufficient resources, real-time progress reports and buy-in from the grassroots to the political leaders. Targets that don't meet these criteria can turn from something aspirational to aim *for*, to something to aim *at*—a focal point for frustration, criticism and cynicism.

The first place this happens is at the country level in HIV-endemic countries in sub-Saharan Africa and elsewhere. In these resource-constrained contexts, stakeholders barraged by goals, models, guidelines and imperatives may have a hard time finding anything that matches their resource-constrained reality.

Here are the key attributes that turn a target into impact. *AVAC Report 2014/15* will use this framework to rate progress, precision and plans for biomedical prevention strategies at every stage of development for some examples across the biomedical prevention field.

