ANNUAL LETTER 2017

STRONG SCIENCE, BOLD ACTIVISM

INTERNATIONAL **AIDS** SOCIETY

MAKING 2017 A YEAR OF ACTION

Dear IAS Members and Partners

As 2017 begins, our community is anxious and concerned. Political and societal changes continue to upend our expectations and generate uncertainty about what is ahead of us. We worry about human rights, the plight of refugees and migrants, progress towards gender equality, and the strength of our commitment to each other as human beings.

Deeply wrapped up in all of this is our fight against HIV – a disease that has shown itself adept at exploiting the very changes that seem to be dominating our world.

As corners of the planet shift towards nationalism and xenophobia, we wonder where the future of our global cause lies. Is the progress we have made against the greatest pandemic of our time slipping through our hands?

No, it's not – at least not yet.

In the midst of this anxiety and uncertainty, we've seen action and defiance against rolling back hard-won gains. The millions of people who participated in Women's Marches around the world in January are proof that apathy doesn't rule, that a collective determination is there to resist a new world order that demonizes and isolates those in need.

Our movement has shown that we know how to make history, not merely observe or survive it. That is our strength. We are not history's passengers. We are its conductors.

And let's remember: 2016 was a remarkable year for our work. In those 12 months: The Global Fund to Fight AIDS, Tuberculosis and Malaria was replenished; the world demonstrated its political commitment at all levels to fight AIDS at the United Nations General Assembly High-Level Meeting on Ending AIDS; and we returned to Durban for the 21st International AIDS Conference (AIDS 2016) for a, yet again, historic meeting on HIV and AIDS.

Continued progress can be seen across our work – in the development of long-acting antiretrovirals; the launch of the first large-scale HIV vaccine trial in southern Africa in nearly 10 years; the more than 18 million people receiving HIV treatment; and growing momentum for the scale-up of HIV self-testing, spurred in part by the World Health Organization's (WHO) recommendation.

The return to Durban reunited and rejuvenated the AIDS community, reminding us how far we have come from the birth of the treatment access movement in 2000. AIDS 2016 sparked

a revitalized union between science and activism led by a new generation of leaders as demonstrated by one of the largest youth participation levels ever seen at an AIDS conference.

But Durban was also a wake-up call. UNAIDS released an alarming report detailing how our prevention efforts have faltered.[1] And a separate report on funding trends gave rise to genuine fears that international donors are moving on from AIDS.[2] These signs of trouble came only weeks after the global community wavered in its commitment to address the needs of key populations at the UN High-Level Meeting.

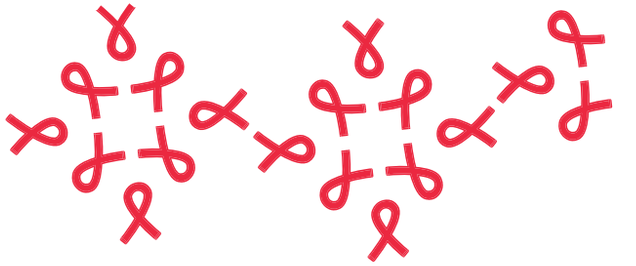
If 2016 served as a wake-up call from complacency and premature congratulations, 2017 must be the year when the HIV community confronts our challenges and renews our determination to grasp the historic opportunities that scientific research and community leadership have given us.

This must also be the year we truly join arms with our colleagues in other disciplines. We must align our cause with the TB community as it prepares for the first-ever High-Level Meeting on TB at the United Nations; with the sexual and reproductive health and rights community as it grapples with the reinstatement of the Global Gag Rule; with the hepatitis community as it works to increase access to affordable medicines and reduce mortality to preventable illness; and the cancer community as we together look for a cure to end HIV and cancer in our lifetimes. Finally, we must all as one global health community work to solidify and entrench human rights and social justice in the pursuit of health.

In July this year, we reconvene for the 9th IAS Conference on HIV Science (IAS 2017) in Paris, the home of some of the most important breakthroughs in HIV science. The meeting offers a critical opportunity for our community to resist a world turning inward, and to demand that at this pivotal moment – when we can actually see the light at the end of the tunnel – we must keep faith with the tens of millions of people living with and affected by HIV.

I hope to see you there.

OWEN RYAN
IAS Executive Director



LINDA-GAIL BEKKER	ANTON POZNIAK	CELIA CHRISTIE-SAMUELS	CHRIS BEYRER
PRESIDENT	PRESIDENT-ELECT	TREASURER	IMMEDIATE PAST PRESIDENT

THE THREE PRIORITIES

While redoubling our efforts to work in partnership with other health and human rights advocates, we need new, creative ways of achieving our goals against AIDS. Business as usual is a sure recipe for failure in our quest to drive down new infections and AIDS-related deaths.

In particular, reaching our goals requires sufficient, predictable and sustainable financing for the fight against HIV and AIDS. As the gap between the amount needed and what is actually available widens year by year, HIV stakeholders must unite to take three key actions:

1. Enhance the strategic impact of finite AIDS funding by prioritizing the scale-up of essential HIV strategies as we work to continue expanding access to HIV treatment and care

2. Redouble our efforts to generate the level of resources needed to combat HIV

3. Further reduce the cost of medicines and other essential HIV prevention care and treatment tools.

GETTING SERIOUS ABOUT HIV PREVENTION

To improve the impact of finite resources, we need to increase financing for proven HIV prevention strategies. UNAIDS reports that only about 20% of current AIDS spending is focused on primary prevention – short of the global target of 25% for prevention services.[1] As donors and countries have focused on scaling up HIV treatment, the commitment to HIV prevention has waned.

The deprioritization of HIV prevention has yielded predictably tragic results. Since 2010, there has been no decline in new HIV infections among adults, and there has been only a modest, if still important, 6% reduction in new infections among young women (aged 15-24).[3] From 2010 to 2015, UNAIDS reports that the number of new HIV infections among adults has increased in some of the world's most populous countries, such as South Africa, Egypt, Indonesia, Nigeria, Russia and Ukraine.[1]

Investing in increased access to testing, condoms and lubricants and in targeted HIV education is not only money well spent, but is also an ethical necessity. The same is true about our continuing work on eliminating new infections among children. Every person vulnerable to HIV infection, no matter where he or she lives, deserves access to the means of protecting against HIV acquisition. However, as the priority given to HIV prevention has fallen, gaps in

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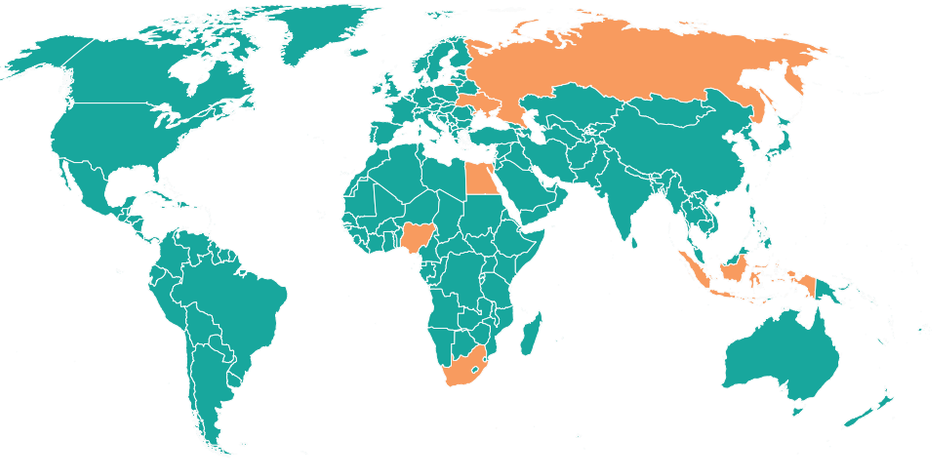

providing critical prevention services have widened in many countries.[1]

Prevention programmes are only successful if they reach those at greatest vulnerability. Too often, our efforts have not been sufficiently targeted and tailored to the groups most likely to become infected. In the past several years, we've seen an explosion of learning regarding optimal ways to target and focus prevention efforts, but we still often fail to put these lessons to use or to align our prevention efforts with the reality of the epidemic.

While taking immediate steps to ramp up spending and programming for HIV prevention, we need to invest in strategies that offer secondary protection to individuals who are vulnerable to HIV infection, regardless of whether they recognize their risk or take steps to reduce it.

Long-acting formulations of pre-exposure prophylaxis (PrEP) offer promise as a prevention strategy that does not require daily effort by the user. But, as the very slow uptake of oral PrEP in many countries shows, long-acting PrEP will only have a robust public health impact if countries, providers and communities are prepared to make this option readily available to those who need it. For key populations – sex workers, men who have sex with men, people who inject drugs, and transgender people – PrEP is a potential game-changer, but only if we translate the promise of PrEP into effectively targeted programmes. Smart, sustainable delivery strategies will be needed, and uptake will be most robust if people are offered a choice of PrEP options, including both pills and injections.

As part of a comprehensive prevention package, voluntary medical male circumcision offers men protection against HIV acquisition, and also provides indirect protection to women by reducing the number of men living with HIV. Here, too, however, our efforts are falling short of what is needed. For the first time since 2007 when the WHO began recommending voluntary medical male circumcision for HIV prevention, the number of men newly circumcised in 2015 was lower than in the previous year in 14 priority countries in sub-Saharan Africa.[1]

HIV treatment is another powerful form of secondary HIV prevention. But it is increasingly clear that HIV treatment alone is insufficient: the lack of progress on prevention over the past five years occurred at the very time that coverage for treatment was steadily rising. A case in point is Rwanda: though the country appears on track to reach the 90-90-90 treatment targets,[4] the annual number of new HIV infections was virtually unchanged from 2011 to 2015.[5] The same pattern of high treatment coverage and persistent HIV transmission is apparent in Australia.[6] The impact of secondary HIV prevention will take time.

We will only fully leverage the prevention benefits of treatment if we continue expanding access and improving outcomes across the treatment cascade. To put the world back on track towards lowering the annual number of new HIV infections, the reduction in HIV transmission risks associated with antiretroviral (ARV) therapy must be coupled with an equally strong prevention effort that decreases the risks of primary HIV acquisition.

Strategies that mitigate social or structural factors that increase HIV vulnerability function as a "social vaccine", reducing HIV risks by improving the lives of the most vulnerable. The evidence is now robust that cash transfers and expanded access to education reduce the vulnerability of adolescent girls and young women to HIV, but there is a yawning gap between what we know about structural interventions and what is happening in the real world.[7] Scaling up structural interventions for HIV prevention will require that the AIDS community collaborate with actors in other fields, such as education, social protection, human rights and law enforcement.

"Prevention is not just for HIV-negative people but for HIV-positive people as well. We need to use the awareness of expert patients to help people understand at a personal level the importance of HIV prevention."

Loyce Maturu, IAS Member, 24-year-old woman born with HIV, Zimbabwe

SPENDING NOW TO AVOID SPENDING MORE LATER

UNAIDS estimates that at least US$26.2 billion will be needed annually by 2020 to implement an optimally effective AIDS response.[5] In 2015, total HIV investments amounted to US$19.0 billion, and no meaningful increase in total resources for AIDS occurred within the past three years, raising concerns about our ability to sustain the gains we have made.[1] These trends leave us well short of what we need to drive further progress in reducing new HIV infections and AIDS-related deaths.

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Our community faces important challenges in working to mobilize essential new funding. The range of global health and development priorities is proliferating, as reflected in the nearly 200 targets of the Sustainable Development Goals. It will require nimble, steady advocacy to both make the case for new resources for AIDS and show how these investments improve multiple development priorities.

Activism by scientists, clients, healthcare workers and community members has sustained the AIDS response. But in traditional donor countries, the grassroots energy that helped propel funding increases has dissipated. If we hope to save the next generation from the health threats posed by the epidemic, we must get back to basics, uniting in an urgent effort to remind decision-makers that HIV isn't over, and that pulling out now risks losing all the gains we have made and effectively wasting the unprecedented resources that have already been spent.

"We very much appreciate the efforts by the government and other partners to make antiretroviral therapy available throughout our country. However, third-line regimens remain unavailable. We urgently need to make these available, as we already have patients who are failing on second-line regimens. Although viral load monitoring is now less costly than it was, it remains a luxury for some patients."

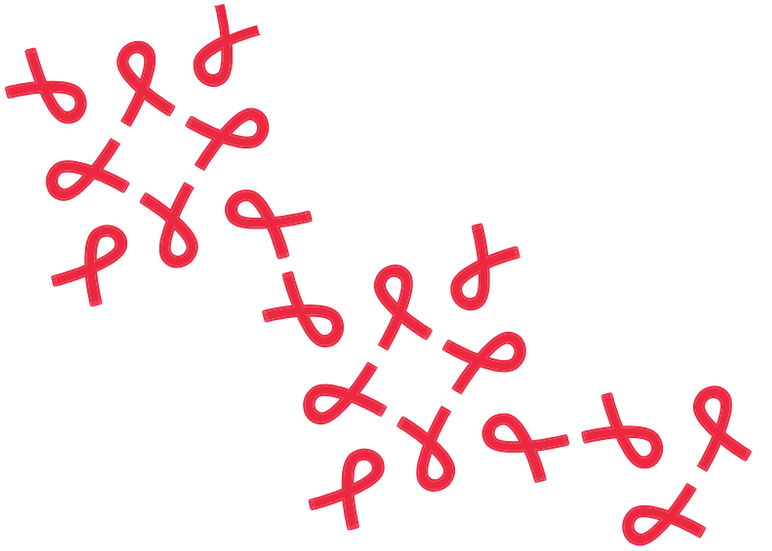
Dr Hermine Meli, IAS Member, Healthcare worker, Cameroon

Strengthening sources of predictable and sustainable financing

For several years, the most reliable funding for HIV prevention and treatment programmes has come from the Global Fund and the US President's Emergency Plan for AIDS Relief (PEPFAR). Funding pillars for HIV scientific research have included the US National Institutes of Health and the Bill & Melinda Gates Foundation. Moving forward, ensuring the continued strength of these funding sources will be pivotal to hopes for major progress on AIDS. The successful three-year replenishment of the Global Fund in 2016 offers encouragement that this essential funding vehicle will remain for the foreseeable future.

However, these seemingly solid sources of AIDS funding also confront potential threats to their viability. Many European governments have curtailed global health and development spending to accommodate new spending for other priorities. And in the US, historically the leading provider of AIDS financing, anticipated deficit reduction efforts and other factors could place sharp downward pressure on funding for the global HIV response. Strong, smart and sustained advocacy will be needed to meet these challenges.

Additionally, we need to push back against the growing notion that national income categories alone should determine eligibility for international support. Many of the key populations most heavily affected by HIV live in middle-income countries. Although some middle-income countries are addressing the HIV-related needs of key populations, many more are not. People, not national borders, should be the touchstone for how AIDS resources are allocated.



Increasing domestic investments in AIDS

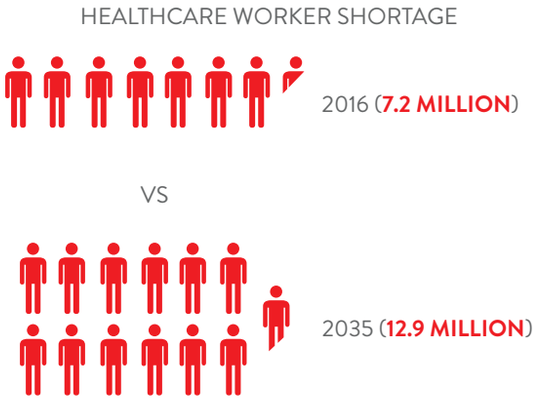
Even as overall spending on AIDS has begun to decline over the past two to three years, domestic spending on AIDS has continued to increase as more and more countries are allocating public financing towards HIV prevention, care and treatment programmes. Yet while domestic spending has been a recent bright spot, most countries are still spending far too little, especially on primary prevention.

Analyses indicate most countries have yet to dedicate public sector funds to the AIDS response to a degree that corresponds with their economic potential and national HIV burden. Even following the collapse of many commodity markets, most economies in sub-Saharan Africa continue to expand. Decision-makers in Africa and other parts of the world need to leverage this economic growth to support HIV prevention, care and treatment programmes, recognizing that these investments generate 15:1 economic returns by increasing labour productivity, averting future medical expenses, and improving outcomes for children.[9]

Reducing donor funding now would further disincentivize countries from increasing their spending, and waste previous investments – leaving many countries unable to sustain or build on the gains made in recent years. It would also punish countries that have increased domestic resources but cannot yet afford the full burden of their epidemic.

Investing in the health workforce

In the AIDS response, people are our most important resource. Health systems do not treat people living with HIV or prevent new HIV infections. People do. The healthcare workers who labour every day – often against considerable challenges – are the front line of our response to HIV, and the response is serving them insufficiently.

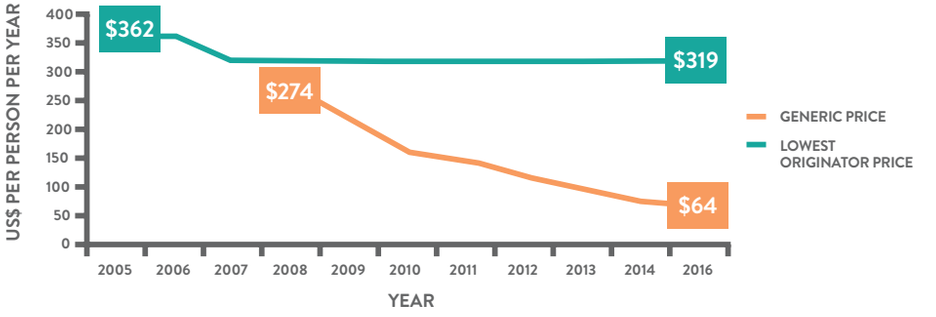


In many countries, healthcare workers are in extremely short supply. The workforce shortage, already estimated at 7.2 million, is projected to grow to 12.9 million by 2035.[10] In more than 80 countries, the population-level density of healthcare workers falls short of the minimum threshold recommended by WHO.

These shortages mean that we need to do everything possible to support and value the healthcare workers we have. Far too often, though, we fail the healthcare workers on whom we must rely if we hope to drive down new infections and AIDS-related deaths. Too many healthcare workers lack the tools they need, are underpaid, work in challenging environments, receive inadequate continuing education, and have few opportunities to advance in their field.

BRING DOWN THE COST OF DRUGS

While working to generate new funding for AIDS, we also must minimize the costs of key inputs into our programmes. Continuing our efforts to lower the prices of essential medicines must remain a priority. More than 18 million people worldwide had initiated ARV therapy as of June 2016,[11] and the lives of these and many more who will start treatment depend on future access to these life-saving medicines. In low- and middle-income countries, the average cost of first line ARV regimens has fallen by 90% over the past 15 years.[12]



Example price evolution of first line ARVs. Price reduction for the 2016 WHO Guidelines first-line recommended tenofovir disoproxil fumarate / emtricitabine (TDF/FTC) fixed dose combination (data shown for the 300/200 mg tablet over the period from 2005 until 2016) [13]

However, threats are now emerging that imperil the future affordability of HIV medicines, including the growing demand for more expensive, patented second- and third-line regimens, the spread of national patent regimes in compliance with requirements of the World Trade Organization, and the increasing concentration within the generics market for antiretroviral medicines. The world's ability to ensure that ARVs and other essential medicines are

readily available and affordable when and where they are needed is further undermined by the increasing efforts of some high-income countries to impose onerous and unwarranted intellectual property provisions through bilateral and multilateral trade agreements.

As new HIV medicines are developed, their makers are increasingly opting to enter into voluntary licensing agreements with generic manufacturers as a means of expanding access to these drugs in low- and middle-income countries. Although these voluntary licensing agreements represent progress over earlier practice when clients in resource-limited settings often had to wait many years to obtain new medical innovations, they also have important shortcomings. In addition to omitting many middle-income countries altogether, these licensing agreements frequently impose onerous reporting requirements on clinicians, limit the ability of generic manufacturers to find the least expensive source of active pharmaceutical ingredients, and include other measures that actually worsen consumers' access to drugs in some countries.

Leading health economists have analysed available data and determined that the costs of manufacturing many ARV medicines are minimal – roughly US$80 per person per year. When generic manufacturers are available to supply these medicines at such affordable prices, actions that undermine their ability to do so cannot be aligned with the commitments that every country has made to work towards ending the AIDS epidemic.

While the need to ensure access to affordable medicines is especially urgent in low- and middle-income countries, prices at which drugs are marketed in high-income countries inflict onerous burdens on health systems and inevitably limit access to life-saving therapies.

> *"My generics company can manufacture HIV antiretrovirals for a dollar per day."*
>
> *Yusuf Hamied, Cipla Chairman, 2000*

Although new challenges to access and affordability are emerging, the next few years also offer opportunities to further lower drug costs. Several ARV compounds will soon lose patent protection, affording possible relief to health consumers and systems, especially in middle-income countries that are now excluded from licensing agreements.

The HIV community should join together with advocates for other chronic diseases to demand a new global deal on drug pricing. Transparent voluntary licensing agreements that include no hidden restrictions or onerous reporting burdens are needed. Countries have the right under international law to maximum flexibility to adopt compulsory licensing. This should be in parallel to importation or using other strategies to make essential medicines available to those who need them.

STRONG SCIENCE, BOLD ACTIVISM

Understanding that "action" starts at home, the IAS has outlined specific priority commitments to address key challenges in 2017 in line with our core guiding principles: **Science. People. Progress.**

Science:

Promote and leverage scientific advances to accelerate progress in reducing new infections and AIDS deaths.

Urgent scientific breakthroughs must move out of plenary halls and into clinics and communities where they are needed most. We will continue to push for new methods to reach our members and partners with vital scientific information to ensure that knowledge is translated into best practice and effective policies.
In 2017, the IAS will....

Host at least six regional summits through the IAS Educational Fund with local scientific and community partners. Already scheduled for this year are meetings in Morocco, Brazil, Kenya and Canada – with other locations to follow. These meetings build on those hosted in Ukraine, Senegal, Turkey and Nigeria in 2016 – educating audiences about the latest science and tying that knowledge to policy change on a national and regional level.

Ensure IAS 2017 prioritizes the major challenges outlined above and emphasizes the importance of cross-discipline learning. The programme in Paris will feature essential discussions on HIV prevention, drug pricing and access, and the future of financing the response to the epidemic in addition to showcasing the important intersections between HIV cure and cancer research and new HIV and HCV breakthroughs.

Give our members the tools they need to translate science to action. Specifically, we will develop and distribute knowledge toolkits to our members that adapt all of the conference's best science into an easily-shared and adaptable presentation package. This series of resources, which was already developed from AIDS 2016 and is available exclusively to IAS Members, can be used for professional presentations and at-home briefings.

People:

Invest in professionalizing and promoting the HIV workforce – particularly the next generation of HIV professionals – to build the skills and resources that are needed to end the epidemic.

Healthcare workers are the linchpins of our hopes for a healthier future. With the collaboration of national governments, international donors, professional medical associations and civil society, we must ensure these frontline workers are adequately compensated, recognized for their contribution to the AIDS response, surrounded by the infrastructure and commodities they need, and provided with opportunities to grow and thrive in their careers. Healthcare workers must be involved from the beginning in setting policy and planning programmes, since they, along with the communities they serve, know how best to link life-saving services with the people who need them. **In 2017, the IAS will...**

Support an increasing number of educational fellowships for clinicians and other frontline healthcare workers that help them advance their skills in HIV care. Fellowships are currently available in paediatric HIV clinical science. More opportunities for specializing and professionalizing in HIV care will follow throughout the year.

Develop user-friendly global frameworks that support national planners, clinicians and community members to differentiate care for HIV clients. These resources will expand upon those created by the IAS in 2016 to ensure healthcare workers have an easy-to-use resource to guide their work across a wider array of populations and geographies.

Prominently recognize frontline healthcare workers who represent the gold-standard of working with key populations through Me & My Healthcare Provider – a community of best practice providers that establishes an international platform for celebrating their work and recognizing achievements in standard of care.

Progress:

Advocate for sustained global leadership and increased investment on AIDS while keeping the fight against stigma and discrimination at the heart of our work.

The history of the AIDS movement is a story of the collaboration between clients and healthcare workers, activists and policymakers, and researchers and communities. Working together in the face of seemingly undeniable odds is the only way to end stigma, discrimination and exclusion.
In 2017, the IAS will...

Facilitate an open, evidence-based conversation on the linked challenges of drug pricing and access to move beyond rhetoric and describe real solutions that lead to improved quality of care.

Co-develop a global scientific statement on the "science of criminalization" in order to accelerate investment, advocacy and action on a robust human rights and social justice agenda.

Reinforce the transformational impact of HIV investments across the world including the value of scientific research, programme implementation and community representation and advocacy. The IAS will work with partners to ensure that political decision-makers understand how much AIDS funding has positively impacted the world.

FOOTNOTES

[1] Joint United Nations Programme on HIV/AIDS. Prevention Gap Report. Geneva: UNAIDS; 2016.

[2] Kates J et al. Financing the Response to HIV in Low- and Middle-Income Countries: International Assistance from Donor Governments in 2015. Washington, DC and Geneva: Henry J Kaiser Family Foundation and UNAIDS; 2016.

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[10] World Health Organization. A Universal Truth: No Health Without a Workforce. Geneva: WHO; 2013.

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[13] Médecins Sans Frontières. Untangling the Web of Antiretroviral Price Reductions. Geneva: MSF; 2016.

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Produced by International AIDS Society |
Avenue de France 23, CH-1202 Geneva, Switzerland |
Tel: +41 22 710 08 00 | Fax: +41 22 710 08 99 |
info@iasociety.org | www.iasociety.org