Analysis and recommendations for EC/EU actions on "Accelerating HIV Prevention"

Introduction:

The global commitments to scaling up access to HIV treatment were not equally followed by equal commitments to accelerate HIV prevention. Our global efforts on HIV prevention remain insufficient. For every two HIV positive people accessing antiretroviral treatment in 2007, five new HIV infections took place[1]. Furthermore, only 3 out of 5 young people do not have adequate information about HIV and just 1/3 of HIV positive pregnant women receive antiretroviral treatment to prevent HIV transmission to their babies2. In countries with concentrated epidemics less than 1/2 have implemented prevention strategies to reduce HIV infection among populations at higher risk such as injecting drug users or men who have sex with men[3].It is imperative to **increase efforts to accelerate HIV prevention**: there is clear evidence of the type of interventions that prove to work and it is urgent to make them more widely available.

The AIDS crisis requires a comprehensive and integrated response that balances the expansion and strengthening of current programmes with also **targeted long-term and sustainable investments in New Preventive Technologies** (NPT) such as vaccines and microbicides. Without these NPTs, HIV incidence will place increasing demands on resources, making treatment programmes unsustainable. Investment in research and development of NPTs today will provide dividends in the future.

A renewed emphasis on prevention is an important opportunity for the EU to take an approach to prevention which takes also local realities into consideration based on the 'know your epidemic' principle'. There is now strong consensus that **combination prevention** works. This involves behavioural change such as comprehensive sexuality education and using condoms; biomedical strategies such as circumcision and the prevention of mother-to-child transmission; treatment of HIV, other viruses and sexually transmitted infections; and social justice and human rights such as reform of discriminatory laws or those which undermine/criminalise HIV prevention efforts.

It is crucial that the EU ensures that its HIV & AIDS response links with **other human rights and development priorities** that will make HIV prevention possible: universal access to quality education, economic opportunities for women, an empowered citizenry that can hold governments to account, and human rights for the most marginalised.

This paper will highlight the following key prevention strategies that need to be scaled up:

1. **Prevention of mother to child transmission (PMTCT)**
2. **Male and female condoms**
3. **Addressing sexual and reproductive health (SRH) needs of people living with HIV and positive prevention**
4. **Male circumcision**
5. **New Preventive Technologies and R&D**
6. **Re-emphasis on comprehensive sexuality education**

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[1] Lay PD. AIDS remains an exceptional issue. *BMJ* 2008
[2] Horton R, Das P. Putting prevention at the forefront of HIV/AIDS. *Lancet*. August 2008
[3] UNAIDS. 2008 UNGASS Country progress reports.

1. Prevention of mother-to-child transmission (PMTCT):

Pregnant women are at higher risk of acquiring HIV and they can pass the infection to their children during pregnancy, labour and delivery or during breastfeeding. Providing pregnant women living with HIV with a full range of PMTCT services, including antiretroviral, can reduce the risk of transmission from around 35% to less than 2%. But in 2007, only 34% of pregnant women living with HIV in low and middle-income countries had access to PMTCT services, well short of the international target of 80% by 2010.

Reducing the risk of HIV transmission from mother-to-child is only one aspect of PMTCT programmes. A comprehensive PMTCT strategy includes four key elements[4]:

- Primary prevention of HIV for women of childbearing age
- Preventing unintended pregnancies among women living with HIV
- Preventing HIV transmission from a woman living with HIV to their infants; and
- Providing appropriate treatment, care and support to mothers living with HIV, their children and families

Women of reproductive age, especially pregnant women, and their partners need to receive information and services for HIV prevention. This should include access to safer sex information and counselling, condoms, voluntary counselling and testing (VCT), sexually transmitted infection (STI) management services, family planning, as well as access to antiretroviral (ARV) prophylaxis and treatment for HIV positive women, their partners and any children as required.

It is important to include indicators that capture *all four elements* of PMTCT programmes, a comprehensive and family-centred approach must be prioritised and scaled up to avoid the negative impacts of HIV on women and children.

2. Male and Female Condoms:

The correct and consistent use of condoms (both male and female) is an effective HIV prevention strategy.[5] In particular, female condoms provide women with a successful alternatives (the only existing female-controlled prevention method), with increased independence regarding their sexual relationships. It is a useful and cost-effective supplement to the male condom. Yet, most women do not know it and cannot access it. Condoms are essential to dual protection against STIs (including HIV) and against unwanted pregnancy. But the current supply of condoms in low and middle income countries falls 40% short of the number required (the condom gap)[6]. Unmet demand for female condoms[7] is even higher.

It is important to ensure that appropriate policies and programmes are in place to ensure that both male and female condoms are accessible, available and affordable to women, men and young people. An increase in its supplies to fulfil demand is a critical component in providing universal access to comprehensive prevention. Supporting people in negotiating condom use, including demystifying the unknown female condom, should also be a key part of programmes. Male and female condoms should be available to all regardless of social status or background in all health facilities as well as the workplace and centres of education where appropriate. Their availability should be linked to information and awareness programmes to ensure their correct and consistent use.

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[4] WHO, UNICEF with the Interagency Task Team (IATT) on PMTCT. Guidance on Global Scale-up of the prevention of mother to child transmission of HIV. Towards universal access for women, infants and young children and eliminating HIV and AIDS among children. 2007

[5] Position Statement on Condoms and HIV Prevention July 2004, UNFPA/WHO/UNAIDS, available at http://www.unfpa.org/upload/lib_pub_file/343_filename_Condom_statement.pdf

[6] Ibid.

[7] in 2007, roughly 423 male condoms were produced for just 1 female condom.

3. Addressing the sexual and reproductive health of people living with HIV (PLHIV) and positive prevention:

Many PLHIV are denied their right to sexual and reproductive health. Millions of women and men lack access to contraception and to the sexual and reproductive health information and services they need in order to choose their family size and improve their own and their children's life chances. The sexual and reproductive health desires of people living with HIV are as varied as the epidemic itself. The issues facing young people living with HIV as they embark on new relationships (repeated disclosure; potential sexual rejection because of HIV status, etc) are very different to the issues facing an HIV positive couple who may wish to conceive (health care provider attitudes; accessibility of appropriate services). Prioritizing the sexual and reproductive health needs of people living with HIV will necessitate a shift in donor priorities.

Prevention for and with PLHIV encompasses a set of actions that help PLHIV protect their sexual health, avoid other STIs, delay HIV disease progression, and avoid passing HIV infection on to others.[8] PLHIV play an essential role in preventing new HIV infections. Strategies for prevention for and with PLHIV include individual health promotion, scaling-up of HIV and SRH services, community participation and advocacy and policy change. Positive prevention strategies – aimed at PLHIV – need to be based on accepted human rights principles and be included as a mandatory component of a comprehensive HIV prevention strategy. At the programme level, positive prevention is at best often a separate approach that has no link to national HIV prevention strategies. Scaling up positive prevention approaches is an integral part of ensuring that 'treatment as prevention'[9] becomes an accepted part of the re-alligned approach towards HIV prevention.

4. Male circumcision

Male circumcision may prove to be an important part of a comprehensive package of HIV prevention services. Evidence is promising,[10] yet more information is needed on the social and cultural implications of male circumcision. The possibility of sexual disinhibition linked to a perception that circumcision offers complete protection against HIV is one area that must be further explored. More research is needed into the acceptability and feasibility of male circumcision as an HIV prevention strategy. Programmes that are aimed at scaling up access to male circumcision services should consider carefully the implications in terms of local community perceptions and the impact on wider prevention strategies. Although male circumcision has been shown to contribute to reducing HIV risk in men, there is less positive evidence on the impact it has on risk levels for women. Male circumcision should therefore be seen as an additional strategy rather than as a substitute for current prevention measures.

5. New Preventive Technologies and R&D

In the 25 years, the HIV community has gathered evidence that HIV vaccines and Microbicides are possible. While the R&D process for both has experienced setbacks, recent advances opened new avenues for research and new concepts are being developed. The EU and Member states have an important role to play in defining the R&D agenda. They can provide new approaches to stimulate needs-driven medical research such as milestones payments for R&D progress, fast track review procedures, new IP incentives and market guarantees. There is also a need for social research around new prevention technologies such as issues like use and access. The EC could play a valuable role in highlighting and addressing these neglected areas.

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[8] WHO, UNFPA, UNAIDS and IPPF (October 2005). *Sexual and Reproductive Health & HIV/AIDS: A Framework for Priority Linkages*

[9] Vernazza P et al. (2008), *Positive People on Effective HIV Meds Aren't Sexually Infectious* (Swiss Report) bulletin de Médecins Suisses 85(5)

[10] *New Data on Male Circumcision and HIV prevention: Policy and Programme implications*, WHO and UNAIDS, March 2007.

Focusing on long-term, flexible financing mechanisms to meet the needs of product focused research is key. Translating research into innovative products lies mainly within the private sector. Supporting not-for-profit Product Development public private partnership (PDPs) are thus essential. PDPs combine low capital costs and a commitment to global public goods with an industry like R&D model, working in partnerships with local researchers, building on long term sustainable capacity which prevents brain-drain and contribute to the shift from "donorship to ownership".

6. Comprehensive sexuality education

Whereas it is key to increase focus on the above far too neglected prevention measures and to focus on the importance of combining them to achieve the best results, it is crucial at the same time to further scale up efforts in providing an evidence based, comprehensive approach to sexuality education – and this globally. It has been shown to delay sexual activity, not increase the number of sexual partners, and to improve the utilization of condoms and contraception when sex does occur.[11]

Though 9 in 10 young Africans have heard of HIV, fewer than 40% of 15-19-year-olds can both correctly identify ways of preventing the virus and reject common myths about HIV. This lack of knowledge can lead to risky behaviours[12]. Today, over 50% of young people worldwide are sexually active by the age of 17. A worldwide earlier age of puberty's onset, a delayed age of marriage and liberal attitudes of a new global youth culture, combined with not acknowledging young people's sexuality, lead to unprepared premarital sex. Today's young people are therefore increasingly affected with sexual health problems such as teenage pregnancy, early motherhood, unsafe abortions, STIs including HIV and sexual abuse. In addition, young people's lower sexual health status is fuelled by gender inequality, exclusion for being HIV positive and discrimination based on sexual orientation. Sexuality education at a young age, covering all those issues, is therefore urgently needed.[13]

Link to the *Programme for Action*

HIV prevention is a key part of the existing *Programme for Action.* The key elements highlighted in this document should become part of various components of the *Programme for Action* as they have gender; rights, research and policy components.

References, sources of information – not exhaustive – info used for this submission

1. UNAIDS ((2005) *Intensifying HIV prevention.* UNAIDS Policy paper
2. WHO (2007). *Guidance on Global Scale-up of the PMTCT of HIV*
3. UNFPA, WHO, PATH (2005) *Condom programming for HIV prevention*
4. GNP+ (2007) *Global Consultation on the Sexual and Reproductive Health and Rights (SRHR) of People Living with HIV.* Consultation report
5. The Lancet (August 2008) *HIV prevention*
6. Would Council of Churches (August 2006) *Positive Prevention.* Contact No. 182
7. Protecting the next generation in Sub-Saharan Africa, Guttmacher Institute 2007
8. Comprehensive Sex Education as HIV Prevention, Caucus for Evidence-Based Prevention, August6, 2008 Issue 11

EU added value and comparative advantages

The above prevention strategies would collectively guarantee that the contribution made by the EU/EC would be both proactive in terms of programmatic advancement on the issues and instrumental in adding to the body of evidence that is required to maintain a comprehensive and rights-based approach towards HIV prevention. While many donors and partners are interested in prevention, work is focused on specific areas (condom supply and PMTCT – but in an insufficient way) and emerging areas of HIV prevention (positive

[11] Comprehensive Sex Education as HIV Prevention, Caucus for Evidence-Based Prevention, August6, 2008 Issue 11
[12] Protecting the Next Generation in Sub-Saharan Africa, Guttmacher Institute, 2007
[13] Comprehensive, rights-based Sexuality education for in- and outside school youth, Jo Reinders et al, World Population Foundation, 2008

prevention; SRH of PLHIV) remain unsupported. Also the progress in research is likely to result in a diverse clinical pipeline of promising candidates in coming years. Briefly the comparative advantage for the EU/EC would include:

1. *Prevention of mother to child transmission (PMTCT):* Ensuring that a comprehensive PMTCT approach is rapidly scaled up and that global indicators reflect all elements of this approach.
2. *Male and female condoms:* Addressing the condom gap; dual protection approaches, incl. global leadership to tap the potential of the female condom
3. *Addressing sexual and reproductive health (SRH) needs of People living with HIV and positive prevention:* Leadership on linking SRH and HIV responses. Ensuring that 'treatment as prevention' becomes a reality; addressing laws and policies that conflict (e.g. Criminalisation of HIV transmission and exposure) with comprehensive HIV prevention approaches.
4. *Male circumcision:* Ensuring that the research keeps pace with rights based programming principles and actions.
5. *New preventive technologies*: Stimulating R&D and long-term, flexible, predictable financing mechanisms, supporting the innovative Product Development Model as well as partnerships and capacity building with the South
6. Global leadership in promoting a combined approach to proven prevention methods and the 'know your epidemic' principle
7. Scale up at a global level evidence-based and comprehensive sexuality education

Objectives, potential outputs, areas of interventions and levels of EU/EC action
Please see attached table

Resource requirements, challenges and opportunities
Key resource requirements, challenges and opportunities include:
1. Political commitment and endorsement of a comprehensive evidence –informed approach towards HIV prevention
2. Commitment to ensure that 'cherry-picking' approaches towards HIV prevention are not supported by individual actors
3. Active engagement of networks of PLHIV and of key populations
4. Financial support for operations research/grants on selected areas of HIV prevention
5. Opportunity to link current research with accepted HIV prevention approaches
6. Act on lessons and current research from the latest International HIV Conference including the importance of addressing HIV related stigma and discrimination
7. Develop new indicators of political commitment to HIV, esp to HIV prevention
8. Engagement of GFATM on HIV prevention – so sustained funding for selected prevention areas becomes a reality in CCM proposals
9. Promote evidence informed programming – especially for programmes aimed at young people (both HIV positive and negative)
10. Act on and link sexual and reproductive and HIV responses and synergies
11. Promote female condom in gender and health policies
12. Act on the capacity for researchers from the south in order to engage a new generation of young scientists. Incentives are needed to offer a rewarding career in the developing country itself.
13. Play a leading role in promoting comprehensive sexuality education

Division of labour, external partners
EU MS: Policy & advocacy on HIV prevention; revised political commitment indicators on HIV
EC: Development of core grants for HIV prevention in selected areas of the world
External partners: GNP+; ICW; IPPF; London School of Health and Tropical Medicine, GCM, IAVI, IPM

Conclusions and recommendations

1. *Prevention of mother-to-child transmission (PMTCT):*Ensuring that a comprehensive PMTCT approach is rapidly scaled up and that global indicators reflect all elements of this approach.
2. *Male and female condoms:* Address the current condom gap and ensure that appropriate policies and programmes are in place to ensure that both male and female condoms are accessible, available and affordable to women, men and young people. Make the female condom a normal commodity and support research and development to create choice and lower prices.
3. *Addressing sexual and reproductive health (SRH) needs of people living with HIV and positive prevention:* Develop revised indicators of stigma and discrimination and ensure that funding supports the engagement of both the HIV and SRH communities. Scale up of positive prevention approaches is an integral part of ensuring that 'treatment as prevention' becomes an accepted part of the re-aligned approach towards HIV prevention.
4. *Male circumcision*: More research is needed into the efficacy and feasibility of male circumcision as an effective part of a comprehensive HIV prevention strategy.
5. *New Preventive Technologies:* Support long term, flexible and predictable funding; support not for profit product development public private partnerships, focus on capacity building and partnerships with the south.
6. *A combined approach to prevention:* The EU must lead international efforts to promote a combination approach to prevention based on the 'know your epidemic' principle. The EU must support national governments and partners to address the social and cultural factors that make individuals vulnerable to HIV.
7. Further scaling-up of *evidence based and comprehensive sexuality education*

Questions for discussion

1. What are the key elements of a comprehensive HIV prevention response? (Please think of the following elements in your answer: gender; human rights; involvement of key populations most vulnerable to HIV infection)
2. How and why should people living with HIV and people from key populations be involved in HIV prevention?
3. What are the prevention needs of PLHIV and how would you say they are currently being addressed?
4. How do some policies (for example those on the criminalisation of HIV transmission; on provider-initiated testing and counselling; etc) undermine all HIV prevention efforts and what should be done to address this?
5. Is the European Commission willing to take up global leadership on the female condom?
6. Is the European Union willing to support research and development and female condom programming with funding these components? Why is so little R&D done for an existing product providing huge potential in a world with a feminised pandemic?