



Imagining the End of AIDS

From Control to Elimination

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Since the presentation of the first case in 1985, HIV/AIDS has wreaked havoc in countries around the world. The estimated death toll is 36 million people, and counting. The disease and its impacts have highlighted the complex nature of HIV/AIDS as a public health issue and the required infrastructure for its response. More gravely, HIV/AIDS has illuminated the deep-rooted social injustices and prejudices that allowed the epidemic to grow in the first place.

Of the estimated 34 million people around the world who are infected with HIV, the virus that causes AIDS, currently there are about 17 million receiving treatment, and there are about 1.5 million new infections occurring each year. Notably, discussion of the “end of AIDS” has begun despite the absence of a cure for people living with the disease, a highly effective vaccine to prevent people from getting infected, or even a model of the disease trajectory that is bending to a plateau or an end.

The end of AIDS was promoted and marketed primarily to sustain interest and commitment to funding programs and research. In fact we do, indeed, have many of the tools and technologies required to control and begin to reverse the epidemic. The challenge is for us to improve implementation efficiency by making best use of the prevention and treatment tools we have in hand, and continue work toward developing new ones — including a cure.

The United Nations General Assembly in June 2016 adopted the 2016 Political Declaration on the Fast-Track to End AIDS. It outlines all the elements of a comprehensive AIDS response, including strengthening the research and development

agenda, and tackling stigma and discrimination related to HIV/AIDS.

This political declaration followed the UNAIDS (the Joint United Nations Programme on HIV and AIDS, the main advocate for accelerated, comprehensive and coordinated global action on the HIV/AIDS epidemic) launch of the “90-90-90” goals for 2020: 90 percent of all people living with HIV will know their HIV status; 90 percent of all people with diagnosed HIV infection will receive sustained antiretroviral therapy; and 90 percent of all people receiving antiretroviral therapy will have viral suppression.

This is the path outlined to achieve the elimination of HIV/AIDS as a “public health issue” by 2030. In the context of 90-90-90 goals, however, “elimination as a public health issue” has yet to be defined and elaborated upon.

OBSERVATIONS, TRENDS AND IMAGINATION

I was involved in discussions to create an alliance to end AIDS — a platform with the specific purpose of working collectively and intentionally toward the end of AIDS by 2030. As a technical adviser on the strategy, I had the opportunity to speak at the principal level with many of the part-



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ner organizations. Based on things I heard and trends I saw, I came to believe eliminating AIDS begins with imagining what that means. It is a different goal, not one of treating HIV/AIDS or preventing its spread, but *ending* AIDS. Here are some possibilities that might reorient our thinking toward eliminating the disease:

Developing a focused intention and changing the *modus operandi* to center on eliminating HIV/AIDS. The current prevention and treatment technologies, when implemented effectively, have the potential to control the HIV/AIDS epidemic. An elimination agenda, however, must move from the general to the specific, with obsessive drive and surgical precision.

To work toward elimination, focus should be shifted from the routine, widespread, generalized application of interventions to targeted, specific, customized interventions, working in concert with a plan to eliminate HIV/AIDS. It means getting to every “hot spot” priority area, mapped down to the district level, with fastidious tracking and follow-up. If elimination of the specter of HIV/AIDS is to be our goal, we must change our mindset and the way in which we plan and implement programs.

A helpful approach is to examine strategies adopted by programs that have achieved elimination of such diseases as smallpox or that are on the path to eliminating diseases such as lymphatic filariasis (elephantiasis), onchocerciasis (river blindness), guinea worm and polio. The approaches and strategies may be different, as are the tools to fight the diseases, but they have yielded good lessons in process, convening, institutional structures and modeling.

The high “attention-to-detail” nature of the shift toward elimination is not limited to a re-orientation in the HIV/AIDS response, but it needs a structural evaluation of how we fight AIDS. The last significant shift in the AIDS response was moving from an emergency response to one in which HIV/AIDS is regarded as a non-life-threatening, chronic disease. The AIDS epidemic has, in a sense, “grown up” and brought with it an associated shift in the *ad hoc* and “fire drill” response of a community in crisis to creating large institutions for financing, policy and advocacy, research

and clinical trials.

Such a coordinated and deliberate approach is, of course, a good thing. Perhaps the only downside of this “institutionalization” of HIV/AIDS is the settling in of a natural, business-as-usual approach that brings with it a bureaucratic, politicized and territorial culture through established and monolithic silos. The AIDS response superstructure thus requires re-evaluation, and some organizations have undergone a strategic rethink of their role and function.

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As is so often the case in global health and development, the availability of resources necessitates — and often forces — restructuring or re-invigorating the HIV/AIDS response. Though the global budget for global health and development has plateaued in the past few years, it still remains at the highest level of funding.

The tendency in the AIDS community (as in the greater development community) is to keep doing what we are doing, to build and add to the response by creating new institutions and developing new programs and interventions. This tendency to preserve what is being done, without examination, can result in continuation of programs that are obsolete, that don’t add any value or are not keeping up with changing contexts. They come at the cost of re-orienting and working toward an elimination agenda for HIV/AIDS, in the absence of an injection of new money.

Overcoming false choices. Various factions within the AIDS community believed (and some continue to do so) that some interventions should be given priority over others. For example, for cost reasons there was a strong push for prevention over treatment; others viewed testing as the critical nexus between prevention and treatment, thus more important.

There is a growing understanding and acceptance, however, that HIV/AIDS programs need



to be comprehensive and include sound nondiscriminatory policies; prevention education and awareness, testing and counseling; care, support and treatment; and a monitoring and evaluation function. These interventions reinforce each other, and the continuum of the public health response can lead to greater impact and behavior change in communities.

For example, good nondiscriminatory policies towards HIV/AIDS patients and tackling stigma can increase acceptance of testing. Effective testing can lead to an individual's behavior change in order to remain negative or, if someone is HIV-positive, to improve adherence and compliance to treatment. Assured and confidential access to treatment ensures continued viral suppression, reinforcing the concept that treatment can be a form of prevention.

Similarly, there has been much division between the research community and people involved in program implementation. It is increasingly understood, and it is good scientific and medical practice, that even if we have effective drugs, we should always maintain a strong pipeline to research new therapeutic and curative technologies for HIV/AIDS. That approach is particularly important to change the paradigm from disease control to disease elimination. New therapeutic classes of drugs and vaccines — even if partially effective — can change the trajectory of the epidemic.

Tailored responses: The HIV/AIDS pandemic is a series of micro-epidemics. While the pandemic aggregates and refers to magnitude of the global disease in numbers and distribution, the HIV/AIDS pandemic is not homogenous. The programming, therefore, needs to be commensurate to and appropriate for the local conditions of transmission and treatment, accommodating for the cultural, social and infrastructural considerations. For example, programs designed to address commercial sex workers are very different from dealing with migrant labor systems; or preventing mother-to-child transmission; or addressing gay men in New York or Nigeria. Furthermore, some of the tailored programs require dealing with systems that legally or socially marginalize, incarcerate and discriminate against the intended program beneficiaries such as sexual minorities, people who use drugs and

prison populations. The major AIDS funders are moving in the direction of pinpointing and tailoring needs rather than using broad-based messaging on awareness and education and more general facility- or community-based interventions. With the deliberate focus on these hot-spot communities and customizing the response to their needs, we can achieve better control on the path to elimination and track progress at a very local level.

Balancing good public health with good HIV health: Another tension in global health is the question of disease-specific responses versus a horizontal, platform-strengthening approach to health services and access. Around the world, the mining industry, whose workers had some of the highest prevalence of HIV/AIDS, aggressively instituted policies and programs on HIV/AIDS prevention and treatment. Subsequently, the HIV/AIDS programs transitioned into broader programs to ensure overall healthy lifestyle promotion and medical care, of which HIV/AIDS was a component. This form of integration also may have an impact on stigma associated with HIV/AIDS. Large institutions also have moved toward

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an agenda of strengthening health systems in addition to supporting interventions that are HIV/AIDS-specific.

There may be opportunity to make HIV/AIDS interventions a routine part of good public health and healthy habits. For example, condom use is an integral part of public health programs, even in communities not affected by HIV/AIDS, although from a Catholic perspective there is a risk of confusing contraceptive use of condoms with acceptable prophylactic use.

Socioeconomic and legal issues like the status of women, land ownership rights, economic opportunities and access to financing influence the risk and vulnerability of women, and interventions that address the empowerment of women

need to continue whether HIV/AIDS is present or not in communities.

Thus many aspects of the HIV/AIDS response can be integrated and linked to broader public health and development agenda. This would go further in supporting the sustainability of the HIV/AIDS response and create the conditions to support an elimination agenda.

PLANS AND STRATEGIES

The public health world is well experienced in creating audacious plans and programs to tackle

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global health and development issues, the scale of which often requires the creation of partnerships and platforms to move forward a plan and strategy. Such platforms include, for example, Uniting to Combat NTDs (Neglected Tropical Diseases) (<http://unitingtocombatntds.org/>); Roll Back Malaria (www.rollbackmalaria.org/); the Stop TB Partnership (<http://stoptb.org/>); and the Partnership for Maternal, Newborn and Child Health (www.who.int/pmnch/en/).

The HIV/AIDS community has well-established institutions that specialize in specific areas such as vaccine research, clinical trials, resource mobilization, private sector engagement, advocacy and communications. The depth of these institutions is remarkable, and any effort to coordinate such a universe of “subspecialties” within the AIDS community requires very clear focus, and most importantly, added value.

The elimination agenda could be the next big thing in AIDS response, and it certainly could be spurred by the advent of a new vaccine (even if partially effective) or a new class of drugs able to penetrate viral reservoirs that have been evading current treatment. Yet we have at our disposal a wide variety of existing tools, technologies and

resources — intellectual and financial — to start truly reversing the AIDS epidemic.

Behavior change, however, is the critical element that determines the success, effectiveness and impact of HIV/AIDS interventions. Behavior change requires a nuanced, subtle and sensitive understanding of local populations and culture. It determines whether people come forward to take a test, practice safe sex, take their medication on time and change their lifestyle and habits. Often, these are not rational decisions that comply with logistics, distribution and top-down programming, yet they are critical in order to improve implementation efficiency.

But, re-orienting HIV/AIDS response to a path of eliminating it is not only about behavior change in local communities. The challenge is the top-down behavior change of the institutions involved in the response — getting partners in the AIDS response to adopt:

- A deliberate focus to end the HIV/AIDS epidemic, including a clear concept of what elimination of the disease means

- Working from the bottom up, tracking at the community level

- Working to make HIV/AIDS interventions routine, as healthy lifestyle choices

- Re-examining their roles to be more efficient and focused on the end of AIDS

With greater self-examination and understanding of our own behaviors as healers, policymakers and public health proponents, we can achieve greater impact in the communities we serve. We can work together to end AIDS.

The goal draws on all of us to overcome complacency, reach beyond our comfort zones, tear down old structures to make way for the new, and strive toward what could be the next triumph in global health and the human spirit. It starts with imagination.

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