AVAC
25 Years and Counting

December 1, 2020

Dear World,

Last year, AVAC gave its annual report on the state of the field a simple title: “Now What?” We never could have imagined the answer.

COVID-19 began to dominate the news cycle and daily life during the first quarter of 2020. In the United States, it continues to have a devastating and disproportionate impact on Black, Latino and Indigenous people, the elderly and on front-line workers. Epidemiological patterns around the world are less clear, although there is evidence that people living with HIV whose viral load is not controlled are more susceptible to serious disease. In many setttings, COVID-19 casts a harsh light on health disparities and the structural violence of white supremacy that drives them. In the United States, the COVID-19 epidemic is unfolding alongside a national reckoning with the brutality and violence directed at BIPOC Americans every day. Racism, environmental degradation and inequities are all inextricably interlinked and 2020 has been a time of pain, loss and reckoning.

The COVID-19 pandemic highlights disparities that people living with and working on HIV/AIDS—and many other health and rights issues—have known about for years. The grief, fear and trauma of living through a new pandemic while still fighting for ongoing progress in addressing AIDS is, for many of us, a daily reality.

But what’s also real and necessary is our collective strength, wisdom and resolve as activists and advocates.

This has been a time when truths about global pandemics—and global, national and local disparities—have been revealed to people who, because of geography, class or privilege, had not seen them before. But they have been there all along—as have the solutions.

As UNAIDS, PEPFAR and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) move forward with multi-year strategic planning processes, these key players along with governments and for all who care about public health and controlling the pandemic, have the chance to change the public health paradigm in ways that are long overdue bring current ones under control and prevent new ones. These steps are essential to preventing future pandemics, and to recovering from the ground that’s been lost in childhood vaccinations, HIV and tuberculosis testing, prevention as a result of COVID-19. To act on these recommendations is to take concrete steps that will also restore faith in science, evidence and institutions like the World Health Organization and the US and African Centers for Disease Control among many others, all of which serve as stewards of evidence-based action on global health.

At AVAC, we know that there are no simple solutions. We also know that progress depends on bold, visionary activist leadership and smart, strategic advocacy. We are proud to be in the fight with so many determined, dedicated colleagues and comrades. Together, we commit to working to catalyze action on these three priorities—and more:

1. **Program for choice.** Biomedical primary prevention is at a historic turning point, but only if countries and funders heed evidence-based demands that programs must emphasize choice, not individual products, and that research and development of new choices (both user-dependent and long-acting) continue.
2. **Pay for the workforce needed to achieve health equity.** From COVID-19 contact tracing to trusted community-based workers supporting HIV testing, treatment and prevention, TB programs and much more, health care workers are critical in controlling pandemics and achieving universal health coverage.
3. **Pursue just, equitable access for COVID-19 vaccines, therapeutics and community-led prevention.** HIV prevention advocates who've tracked everything from voluntary medical male circumcision (VMMC) to PrEP rollout know that you can't wait for the product to plan. It is essential to take steps now, before a vaccine is available, to build trust through transparent science, fair pricing and the prioritization of those who are most often left behind.

1 Program for choice.

Biomedical primary prevention is at a historic turning point, but only if countries and funders heed evidence-based demands that programs must emphasize choice, not individual products, and that research and development of new choices (both user-dependent and long-acting) continue. In the midst of the COVID-19 pandemic, 2020 has brought important milestones in biomedical HIV prevention:

- In July, the European Medicines Association (EMA) issued a favorable opinion on the Dapivirine Vaginal Ring (DVR), and, in November, World Health Organization (WHO) pre-qualified it.
- In May and November, trials of long-acting injectable cabotegravir (CAB-LA) showed high levels of protection in gay men and other men who have sex with men, transgender women who have sex with men, and cisgender women.

The EMA opinion has not yet turned into national regulatory approvals, WHO guidance or country-level policy. ViiV, the pharmaceutical company behind CAB-LA, has said that it will seek regulatory approval in 2021. This brings the HIV prevention field to the brink of a major milestone.

For the first time in the history of the HIV epidemic, it is possible to build a choice-based prevention program that offers people a range of options with information in plain language about risks and benefits, as well as supportive counseling about choices that meet an individual's needs.

This model has worked for years in the contraceptive field. A client-centered, choice-based approach asks people to think about their lives and choose what works for them, and it supports them in switching methods as often as they need to. This major development could revolutionize HIV prevention, but only if the people who will use the products lead the way. Here's what this means:

- **Choice is key.** Product developers, funders, policy makers and program implementers working on product introduction must design—and civil society must demand—a choice-centered approach to talking about, programming for and procuring new biomedical strategies. No strategy should be presented as "preferred" or "better".
- **Ability to adhere should not be used as the sole criterion in deciding who is offered or told about a product.** The EMA opinion states that "DVR is intended for use by cisgender women as a complementary prevention approach in addition to safer sex practices when women cannot use or do not have access to oral PrEP." It's essential to interpret 'cannot use' in terms of personal choice, and not as a provider assessment of ability to adhere. The only criterion necessary to choose DVR or oral PrEP or condoms or other strategies as they become available should be preference.
- **Strategize, staff, plan, budget and procure for choice-based HIV prevention.**

  Strategize: PEPFAR, UNAIDS and GFATM are all three entities are moving towards a "people-centered" approach, an emphasis on primary HIV prevention, integration of HIV with sexual and reproductive health, and attention to human rights. Right now the words are there—the strategies and budgets need to match.

  Staff: The GFATM should ensure that its Technical Review Panels for primary prevention are staffed with experts from civil society and relevant fields (e.g., contraceptive programming) in order to make this a reality. Countries that convened ECHO task forces in 2019 to look at contraception and HIV programming should use these or other interdisciplinary bodies to plan for client-centered HIV prevention embedded in comprehensive and integrated sexual and reproductive health offerings. PEPFAR should fund health cadres that can support client- and choice-centered primary prevention and should use its robust data collection system to inform health worker training and deployment strategies.

  Plan, budget and procure: Oral PrEP should be available in all settings where DVR is introduced; CAB-LA should be as well, when approved. All three methods, in addition to male and female condoms and VMMC, should be offered in all programs. The costs of providing multiple methods will almost certainly be offset by reductions in new infections if—and only if—these are client-centered, choice-based programs. A program that pits options against one another or emphasizes a single option will not gain trust and may undermine prevention gains.

- **Implement "language justice".** Communities of people who will be using, advocating for and talking about these products must guide how they are described, positioned and compared to one another, so that the full extent of benefits, risks and primary characteristics is apparent in plain language that resonates with local culture, history and modes of understanding.

2 Pay for the workforce needed to achieve health equity.

From COVID-19 contact tracing to trusted community-based workers supporting HIV testing, treatment and prevention to TB programs and much more, health care workers are critical in controlling pandemics and achieving universal health coverage.

The World Health Organization has recently proposed the use of a Universal Health Care (UHC) Service Coverage Index, which would assess country coverage of UHC by measuring specific services. A group led by former PEPFAR Ambassador Eric Goosby surveyed 183 countries, categorized by level of income, to understand which indicators were most "important" in predicting UHC coverage. Health care workforce density was the top-ranked indicator in lower-middle income countries and the third and fifth ranked in upper-middle and low-income countries, respectively. Notably, in high-income countries, coverage of HIV antiretroviral treatment among people living with HIV was the dominant indicator linked to achievement of UHC. This is a potent reminder that "basic" health care and HIV care are inextricably linked in all parts of the world as the HIV epidemic persists worldwide.

Countries must strive for—and donors must support—progress on all universal health coverage indicators. However, a health care workforce that includes trusted community-based cadres who can support contact tracing, home-based care, differentiated service delivery models and so much more, is critical to ending current pandemics and preventing new ones.

In the US, the People's Pandemic Prevention Plan calls for a "Public Health Corps" of 300,000 unionized jobs paid a living wage. As AVAC has recently reported in its collaboration with Amref Health Africa and Friends of the Global Fight, the State of Massachusetts is modeling its COVID-19 contact tracing on a community health worker model originated in Rwanda in response to Ebola. The "Public Health Corps" must be funded and deployed to support similar work in other communities, along with other critical services, including HIV testing and linkage to ART and PrEP, adherence support, trauma and violence prevention and counseling and more.

For UNAIDS, PEPFAR and GFATM specifically:

- PEPFAR should continue to support innovation in differentiated service delivery models, funding community-based, indigenous groups to provide key services and using its regular data reviews to map the impact of health care worker (HCW) investments on key indicators.

- UNAIDS can play a leading role in articulating the ways that an expanded HCW investment will advance both HIV and UHC goals.
- GFATM must continue to lead in funding health care workers and programs that provide integrated HIV and sexual and reproductive health and rights services, including funding the procurement of contraception (which PEPFAR is not permitted to do, even when the Mexico City Policy/Global Gag Rule has been lifted).
- The US government should adopt the Public Health Corps approach as a model for both domestic and global health programs and policies.
- Low- and lower-middle income countries should set and meet ambitious health care worker targets that link staffing to progress in meeting primary, HIV, TB and sexual and reproductive health needs of all people.

3 Pursue just, equitable access to COVID-19 vaccines, therapeutics and community-led prevention.

HIV prevention advocates who've tracked everything from VMMC to PrEP rollout know that you can't wait for the product to plan. It is essential to take steps now, before a vaccine is available, to build trust through transparent science, fair pricing and the prioritization of those who are most often left behind.

In recent months, AVAC has produced a "checklist" for data-sharing and regulatory decision-making in advance of any vaccine licensure as well as an advocate's guide to access. These documents lay out the critical components of just and equitable access and include these essential actions:

- **When results are announced, make comprehensive data sets publicly available for peer review.** Publication via press release or political podiums is not scientifically rigorous, promotes mistrust and fuels public concerns around the politicization of science.
- **Fully fund financing mechanisms supporting access.** International development agencies should prioritize funding the COVAX Advance Market Commitment (AMC) to secure vaccine access for low- and middle-income countries (LMICs). GAVI's critical role in leading this effort and coordinating multiple stakeholders must be supported and sustained.
- **Demand equity in vaccine purchasing.** When wealthy countries enter into direct agreements with vaccine developers to secure millions of doses for the exclusive use of their own citizens, they limit the supply of vaccines available for LMICs. There still is a US $5 billion gap in funding to procure approved vaccines for countries eligible for supplies via advance market commitments. Allowing immediate generic production of licensed products and setting

benchmarks for prepurchase commitments that meet national and global need are all interventions to ensure equity. The World Trade Organization should immediately agree to the request, put forward by India and South Africa, for a temporary waiver on the Trade Related Intellectual Property Rights (TRIPS) provisions for all commodities needed for the COVID-19 response.

- **Ensure pricing at low or no cost to all who need it.** Fair pricing depends on pharmaceutical companies and other investors in research and development valuing people over profits. To ensure accountability, product developers must disclose development costs, both their own investments and the amounts received from public sector sources. If a pharmaceutical company refuses to agree to a fair price, the US President should make use of their existing powers to license a generic producer.
- **Plan equitable distribution.** Criteria for administering initial supplies of effective vaccines must be clear, ethical, rights-based and include metrics for ensuring vaccine access for prioritized populations.

In a year of profound losses, freedom fighters the world over have mourned the passing of civil rights leaders and US Congressmen John Lewis and Elijah Cummings. In a posthumously-published essay, Lewis provided this reminder:

The truth does not change, and that is why the answers worked out long ago can help you find solutions to the challenges of our time. Continue to build union between movements stretching across the globe because we must put away our willingness to profit from the exploitation of others.

When AVAC asked "Now What?" in late 2019, we did not know what was coming—no one did. Amidst the trauma and pain, there is the comfort of knowing that we and the activists, advocates and allies from all corners of the fight for health justice have the answers for what remains to do and what must be done.

We look forward to doing it together,

AVAC