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# RECONSIDERING PRIMARY PREVENTION: CALL TO ACTION FOR THE GLOBAL HIV RESPONSE

## SIGN THE CALL TO ACTION

The world needs [a new phase in the evolution of the HIV response](#)—one that reinvigorates prevention by seamlessly combining the efficacy of upstream, midstream, and downstream interventions with the powerful effectiveness of community action.

Gay men and other men who have sex with men, people who inject drugs, sex workers, and transgender women are 24, 24, 13.5, and 49 times more likely to acquire HIV, respectively, than adults in the general population (15 years old and older). Globally, these “key populations” disproportionately bear the burden of new infections, as gay men and other men who have sex with men, people who inject drugs, sex workers, and transgender women accounted for 45% of all new HIV infections in 2015.

Key populations are rendered vulnerable to HIV by upstream factors like punitive and discriminatory laws and politically driven policies, creating stressors that exacerbate risk for acquisition. Moreover, the absence of protective laws and policies enable unchecked stigma and discrimination in healthcare settings. These barriers mean people delay or skip seeking the services they may need, making the problem of HIV even worse.

The persistence of revisionist characterizations of HIV has never and will never change the biology of acquisition: HIV is primarily transmitted sexually and via blood through the sharing of injecting equipment. For primary prevention to stand a chance, the silence, denial, negativity, and moralism surrounding sex and drug use must end. Policy makers and donors, including governments, must shed their reluctance to openly and positively address sex and drug use in their public health discourse and responses to HIV.

Propelled by the introduction of powerful and life-saving antiretroviral medications, the increasingly bio-medicalized global HIV response challenges us to rigorously reimagine prevention. The prevention toolbox is getting bigger, but the application of the tools is getting smaller. Bio-medicalized interventions, which have been lauded as successes in the HIV response, must be strategically combined with other interventions and delivered by communities for which interventions are intended. Community-led prevention must be properly resourced.

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Primary prevention remains seriously undermined by low funding levels that are grossly misaligned with the disproportionate impact HIV is having on key populations worldwide. For example, in the Global Fund to Fight AIDS, Tuberculosis, and Malaria's 2014-2016 funding period, only \$648 million of the \$5.9 billion (or 12%) was specifically dedicated to programs intended for all key populations, and less than half of this was dedicated to the primary prevention of HIV.

The social shape of the HIV epidemic requires a return to a primary prevention strategy that is proactive, addresses upstream factors, re-centers communities most impacted by HIV, and properly resources combination approaches chosen and led by communities for which prevention efforts are intended. HIV and other sexual health services done with or led by community members for which the services are intended are more likely to result in earlier, comprehensive, and more frequent service engagement, and improved retention, yielding better health outcomes.

We the undersigned endorse the below core principles of practice to serve as broad guidelines for the design, implementation, and evaluation of primary prevention programs for gay men and other men who have sex with men, people who use drugs, sex workers, and transgender people:

- The imperative to reduce new sexually transmitted infections, including HIV, should not impinge on personal freedoms;
- All people, including gay men and other men who have sex with men, people who use drugs, sex workers, and transgender people, have the right to self-determination;
- All people, including gay men and other men who have sex with men, people who use drugs, sex workers, and transgender people, deserve the same level of support, health, access to services, and political rights as anyone else;
- All people, including gay men and other men who have sex with men, people who use drugs, sex workers, and transgender people, have the right to privacy and are entitled to a fulfilling and satisfying sex life;
- Gay men and other men who have sex with men, people who use drugs, sex workers, and transgender people, should be actively and meaningfully engaged at all stages and levels in research, program and policy development, implementation and evaluation—participatory processes should be utilized throughout;
- Young people, including young gay men, young sex workers, young people who use drugs, and young transgender people should be directly engaged when planning HIV prevention programs, in a non-tokenistic way that recognizes unique factors like consent, emancipation, autonomy, and privacy laws;

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- The primary prevention of HIV should not be risk or deficit oriented—instead, successful HIV prevention efforts should leverage and be rooted in the strengths, resources, individuals and communities;
  - Pleasure, gender, satisfaction, intimacy, love, and desire are key concepts in a fuller understanding of sex and sexuality among gay men and other men who have sex with men, sex workers, transgender people, and of drug use among people who use drugs, and therefore in formulating more meaningful research, programmatic, and policy responses; and finally,
  - Researchers, prevention practitioners, healthcare professionals, and policymakers should consider structural, situational, and contextual factors in understanding HIV acquisition and transmission risk and in developing sexual health interventions tailored to the specific needs of gay men and other men who have sex with men, people who use drugs, sex workers, and transgender people.

We therefore call upon advocates, healthcare providers, researchers, public health officials, and donors to:

1. Stop chasing magic bullet solutions to HIV and end sloganeering about HIV drug coverage—instead, invest in carefully tailored combination approaches;
2. Evolve primary prevention in a manner that seamlessly stitches together bio-medical, behavioral, community, and structural interventions, because these interventions lose their effectiveness without the others;
3. Combine and tailor prevention approaches with consideration to acquisition and transmission dynamics that are specific to key populations—blanket approaches leave people behind;
4. Imbue HIV primary prevention, care, and treatment with the power of community ownership and abandon top-down approaches;
5. Remedy funding inequities by investing more substantively, strategically, and differentially in evidence-informed, rights-based, and community-led programs;
6. Adopt a more nuanced understanding of gender that recognizes the complexity of identities and sexualities; and,
7. Adopt community-endorsed, human rights-based principles of practice, starting with the Greater Involvement of People Living with AIDS/HIV (GIPA) principle.

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**SIGNED:**

Global Action for Trans Equality (GATE)

IRGT: A Global Network of Transgender Women and HIV

The Global Advocacy Platform to Fast-track the HIV and Human Rights Responses with Gay and Bisexual Men (The Platform)

The Global Forum on MSM & HIV (MSMGF)

The Global Network of People Living with HIV (GNP+)

The Global Network of Sex Work Projects (NSWP)

The International Community of Women Living with HIV (ICW)

The International Network of People Who Use Drugs (INPUD)