

RECONSIDERING PRIMARY PREVENTION OF HIV

NEW STEPS FORWARD IN THE GLOBAL RESPONSE

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RECONSIDERING PRIMARY PREVENTION OF HIV:

NEW STEPS FORWARD IN THE GLOBAL RESPONSE



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BACKGROUND

The uneven distribution of HIV risks and burdens across populations is a well-substantiated fact, though seldom publicly acknowledged.¹ 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 other reproductive aged adults (15 years old and older). Globally, new infections among these key populations account for 45% of all new HIV infections.² This figure is likely to be an underestimate, given the intense stigma associated with disclosing and reporting acquisition risks for HIV among gay men, people who use drugs, sex workers, and transgender people.³ In addition, HIV epidemics in the majority of low- and middle-income countries (90 of 120) have concentrated epidemics among key populations. In countries with more broadly generalized epidemics, risks are still not evenly distributed and key populations still shoulder disease burden that is markedly disproportionate.

Specific interrelated determinants converge to create the higher probability of HIV infection among key populations (biological, social, structural). For example, key populations are rendered vulnerable to HIV by discriminatory laws and politically driven policies, creating stressors that exacerbate risk for HIV acquisition and make the problem of HIV worse. In addition, the absence of protective laws and policies, and the failure of governments to uphold rights also enables the persistence of unchecked stigma and discrimination in healthcare and social service settings. These barriers to healthcare means untreated sexually transmitted infections and therefore heightened risk for HIV infection and transmission.⁴

“ When viewed more holistically, determinants to HIV incidence reduction will more likely be multi-factorial, involving various prevention strategies that are thoughtfully combined, tailored and delivered by communities most impacted by HIV.

Propelled by the introduction of powerful and life-saving antiretroviral medications, the increasingly bio-medicalized global HIV response challenges us to rigorously re-imagine prevention. While this is a welcome development in the global response to HIV, access to medical interventions is hampered by the costs of medicines, health-care, testing and monitoring, and the politics of funding.⁵ In addition, gay and bisexual men, people who use drugs, sex workers, and transgender people are not prioritized for antiretroviral treatment or are offered only a limited number of places in treatment programs because these groups are not seen as deserving.⁶ Moralistic decision-making about who should have access to treatment is common (e.g., the requirement of absolute abstinence from drug use as a condition for services).

External funding to address HIV in low and middle-income countries is being redirected and is shrinking.⁷ There is now a global scramble to do more with less. Motivated by the need to find cost savings, the HIV sector is now revisiting the viability and necessity of prevention but current global-level discussions center around the exclusive use of antiretroviral medications. And while there are important examples of successful HIV incidence reduction programs driven by bio-medical interventions, the success of those programs is largely situated in high-income countries or among general populations, where access to medications is relatively better because of strongly supported community mobilization efforts. For example, the introduction of targeted pre-exposure prophylaxis (PrEP) is beginning to gain momentum with some dramatic results, at least with men who have sex with men. However, there are concerns about the acceptability, accessibility, and affordability of PrEP. In addition, there are questions about the sustainability of comprehensive PrEP programs beyond demonstration initiatives in the Global South. Redirected funding is often at the cost of support to community-led programs, which are critical to the success of PrEP programs.

While access to antiretroviral medication used prophylactically or as treatment for HIV is an urgently needed human right, primary prevention should be conceptualized more broadly than expanded coverage of antiretroviral medications. **When viewed more holistically, determinants to HIV incidence reduction will more likely be multi-factorial, involving various prevention strategies that are thoughtfully combined, tailored and delivered by communities most impacted by HIV.** Recent reports of dramatic reductions in new HIV infections among men who have sex with men in New South Wales, Australia, corroborate these points.⁸ In New South Wales, gay men mobilized to educate their community, to insist on strong partnership with healthcare providers, clinics, and local government, and to demand that services are safe, community-led, and prejudice-free.

Taken together, the social shape of the HIV epidemic requires a reconsideration and reboot of primary prevention activities. A reimagined, modernized HIV primary prevention approach will:

1. Be community-led;
2. Address ‘upstream’ factors; and
3. Properly resource combination approaches chosen and led by communities for which prevention efforts are intended.

Finally, we need a next era in HIV prevention, one that marries the efficacy of biomedical interventions with the effectiveness of imbuing these tools with community control and ownership.

PRIMARY PREVENTION: REVISITING DEFINITIONS

Primary prevention should be thought of as **a network of strategically and necessarily combined community-led strategies** as opposed to stand-alone interventions that are imposed. Primary prevention strategies in the HIV sector are (or should be) qualitatively different than dominant public health practices, which tend to exclusively favor biomedical testing and treatment modalities. Given current trends in the HIV field, it is important that we emphasize a more balanced approach while laying bare what primary prevention is. Primary prevention:

1. **Proactively** seeks to build adaptive strengths, coping resources, and health in people – a focus on disease or correcting assumed deficits or vulnerabilities is not sufficient;
2. Concerns itself with **total populations** and **communities**, not necessarily the provision of services on a case-by-case basis;
3. Employs the main tools of **education** (including about the range of prevention options available) and **social/structural-level change** (including changes in laws, policies, and practices), not just medicines, although HIV requires the use of antiretroviral medications and the strategic use of diagnostic tools;
4. Assumes that we can only efficiently address problems before and if they happen when people have **resources** they need to thrive (including expanding the range of options people have when managing their health).

Primary prevention also asserts the view that stressful social conditions have a major negative influence on health by disrupting and damaging social relations in general. It acknowledges the devastating effects of alienation, depression, anxiety, and anger associated with upstream factors like poverty, institutionalized oppression, and discrimination.⁹ Upstream factors are therefore legitimate and necessary factors to address from a prevention perspective.

PRIMARY PREVENTION: REVISITING DEFINITIONS

Primary prevention of HIV in our current moment must encompass activities that are directed towards populations at elevated risk. These prevention efforts must be designed to promote sexual health as a strategy for averting new HIV infections. Several primary prevention strategies have evolved across different health sectors. Here, we stress four major dimensions that are sometimes missed in the chase for magic bullet solutions to preventing HIV acquisition and transmission:

1. Peer-delivered, voluntary education with the purpose to factually inform, so that individuals are best equipped to select the prevention options that are right for them;
2. Community organization/mobilization and systems change, to address resource inequities or disenfranchisement caused by harmful institutional and legal practices;
3. Opportunities for social support and belonging, because genuine, empathic, trusting, caring, and safe relationships have the power to build and sustain resiliency;
4. Competency promotion, which starts by building on the strengths of individuals and their communities rather than fixating on disease or inventing deficits. Being strength-based is important because in addition to the power of belonging, people require frequent opportunities to make meaningful contributions to their general welfare and that of their communities.

In 1985, psychologist George W. Albee developed a formula for incidence of mental health problems in society.¹⁰ Dr. Albee described incidence as the combination of organic factors and stressors that are moderated by coping skills, self-esteem and social support. His conceptualization of incidence is salient to contemporary challenges in the primary prevention of HIV. We have adapted Dr. Albee's formula to underscore the complexity of HIV incidence:

$$\text{HIV INCIDENCE} = \frac{\text{BIOLOGIC VULNERABILITY} + \text{SOCIAL/STRUCTURAL DISENFRANCHISEMENT}}{\text{RESOURCES (INDIVIDUAL, FINANCIAL \& COMMUNITY)} + \text{SOCIAL SUPPORT}}$$

It's clear to see in this equation that the bigger the numerator and smaller the denominator, the greater the incidence of HIV. Conversely, a smaller numerator and bigger denominator will result in reduced HIV incidence. Biologic vulnerability in this equation acknowledges the medical aspects of HIV disease, including acquisition and transmission routes. Resources refer to knowledge, expanded health options, funding, and the power to act and engage as one wishes. Albee's incidence formula is helpful in highlighting the multiple entry points necessary for the primary prevention of HIV. It also highlights the need for multiple strategies working in tandem.

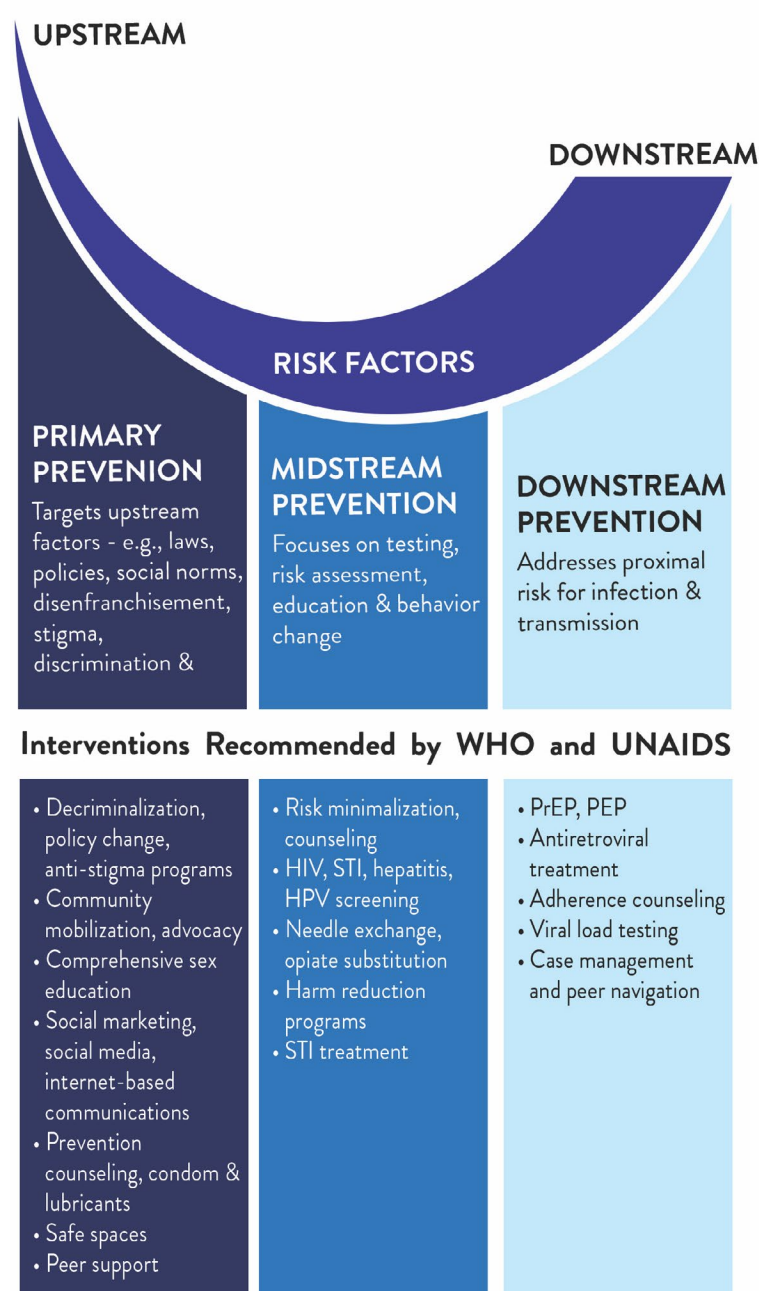
In the HIV sector, we have heard for years the maxim, ***"We cannot treat our way to the end of AIDS."*** This is because individual treatment will have no effect on population-level incidence, especially given that treatment is not equitably accessible, with stigma, discrimination, criminalization, and violence standing in the way. Treatment is a necessary component of prevention but not sufficient on its own. In the same way condom and lubricant availability and utilization are necessary but not sufficient as stand-alone tools to prevent all new HIV infections. While treatment is preventative, it is dependent on other interventions, including condom and lubricant use, to have an impact on incidence at the population level. Modeling conducted in the UK showed even with high treatment coverage, there would have been significantly more HIV infections among men who have sex with men in the period between 2006 to 2010, were it not for the use of condoms.¹¹ Only primary prevention can reduce the number of new HIV infections, especially when multi-pronged approaches (as implied by the incidence formula) are strategically implemented. Unfortunately, the sector has experienced great difficulty moving beyond a rush for the next slogan-driven, aspirational targets for HIV drug coverage. HIV is as much a complex social problem as it is a complicated bio-medical challenge. There are no simple or quick fixes or magic bullets. However, we can reduce HIV incidence with the tools we currently have, if those tools are strategically combined and placed in the hands of communities for which they are intended.

PRIMARY PREVENTION: A NETWORK OF STRATEGIES

Since 2007, UNAIDS has recommended multi-pronged or combination approaches to HIV prevention for gay men and other men who have sex with men, people who use drugs, sex workers, and transgender people, while addressing more broadly their human rights (see Figure 1). UNAIDS recommendations for a minimum standard package of prevention services for governments planning and developing HIV prevention programs begin by asserting the importance of human rights and the removal of legal barriers that undermine access to HIV-related services. This includes removing laws that criminalize non-heterosexual behavior, gender non-conformity and non-cisgender identity, sex work, and drug use. UNAIDS guidance for HIV prevention goes on to recommend: empowerment of key population communities to participate equally in social and political life (including non-tokenistic representation in national HIV planning and implementation processes); availability of safe physical and/or virtual spaces for members of marginalized communities to seek information and referrals for care and support; and access to medical and legal assistance for gay men and other men who have sex with men, people who use drugs, sex workers, and transgender people that experience sexual coercion and/or violence.^{12, 13, 14, 15}

The World Health Organization, in its 2016 Consolidated Guidelines for Key Populations discusses the importance of enacting ‘critical enablers’ that includes revising harmful laws and policies; implementing and enforcing anti-discrimination laws; and decriminalizing same-sex behaviors. These strategies are in addition to PEP, PrEP, needle and syringe programs, opiate substitution therapy, mental health services, risk minimization counseling, STI, HIV, hepatitis, HPV testing and treatment, as well as promotion of quality condoms and water-based lubricants at scale. These strategies were reaffirmed several times over the past decade, including in 2009, 2011, 2014, and 2016.³

FIGURE 1: Network of HIV Prevention Strategies



PRIMARY PREVENTION: A NETWORK OF STRATEGIES

The universal adoption of UN- and WHO-endorsed prevention strategies remains a serious challenge. For example, the 2011 Political Declaration included a target to halve HIV transmission among people who inject drugs by 2015, but this target was completely missed. Despite the absolute centrality of needle and syringe programs and opiate substitution therapy as primary prevention strategies for people who use drugs, these services are too few and vulnerable to the political currents regularly upsetting evidence-informed and rights-based responses to both substance use and HIV. Moreover, coverage for these services remains substantially below the minimum levels needed to sufficiently address HIV among people who inject drugs. Globally, it is estimated that only 8% of people who need harm reduction have access.¹⁶ Evidence shows that countries with well-supported needle and syringe programs have averted HIV epidemics among injecting drug users, but due to moralizing attitudes and political expediency, cutbacks and closures of harm reduction services are occurring at a time when scale up is critically needed.¹⁷

Contrary to applying a network of strategies approach, most countries in Asia have adopted antiretroviral treatment as a blanket HIV prevention strategy. Although efforts to expand treatment coverage are welcome, the HIV epidemic among men who have sex with men, people who inject drugs, sex workers, and transgender people remains unaffected. New data about the efficacy of a test-and-treat approach with men who have sex with men in the region reinforces doubt about the appropriateness of a one-size-fits-all, single-intervention approach to reducing HIV incidence among key populations. Investigators in the new study showed that the prevention potential of antiretroviral treatment is rendered null by the route and timing of HIV transmission in men who have sex with men, principally due to acute HIV infection. They write, “By the time antiretroviral treatment for prevention renders it effect, most new HIV infections in men who have sex with men will have already occurred.”¹⁸

With an estimated 1.9 million new HIV infections a year, a lop-sided proportion of which are among key populations,^{1,2} we urgently need a network of primary prevention strategies that are differentially and strategically deployed. The primary prevention of HIV can be strengthened by considering the acquisition and transmission dynamics that are specific to key populations. Communities can and should play a vital role in understanding and navigating those dynamics.

CENTERING COMMUNITY TO AMPLIFY OUTCOMES

It is vital that HIV community advocates become deeply engaged in ensuring that primary prevention programs are optimized. Gay men and other men who have sex with men, people who use drugs, sex workers, and transgender people, including people living with HIV, should be leading research, program, and policy efforts to address HIV in their communities. Moreover, community advocates should not become subordinate to repressive government policies or political agendas that result in deviation from evidence-informed and rights-based guidance. Nor should researchers, public health officials, or policy makers relinquish their responsibility to secure the genuine assent of communities most impacted by HIV. A reinvigoration of HIV prevention obliges policy makers and donors to ensure community control over **all** tools. Not doing so will lead to diminished or substandard programs and services. Research has shown no public health advantage to adopting top-down STI or HIV program and policy approaches (i.e., mandatory HIV or STI testing, prevention messages that are negatively framed as imperatives).^{19, 4}

Public health strategies have their biggest impact when: a) they are collaboratively designed and implemented by members of the community for which they are intended; and b) individuals and communities are self-motivated and given the freedom and resources to participate in health promoting behaviors they have worked to develop. HIV and other sexual health services done **with** or **led** by community members for which the services are intended are more likely to yield better health outcomes because they result in earlier, more frequent service engagement, and improved retention.²⁰ In addition, men who have sex with men, sex workers, people who use drugs, and transgender people are best equipped to help members of their own communities because they: 1) share experiences of stigma, discrimination, and/or violence; 2) have knowledge about and access to supportive networks of other men who have sex with men, sex workers, people who use drugs, and transgender people, who can sensitively inform outreach and service implementation; 3) are more likely to be comfortable discussing sensitive matters concerning the experiences of being part of socially marginalized (and in many instances, criminalized) groups; and therefore 4) can more easily establish trust with service recipients and gain their confidence. As such, the global HIV response should pivot its service direction from a **for community stance** to a **by community orientation**. Men who have sex with men, sex workers, people who use drugs, and transgender people, including those living with HIV, should be actively engaged to participate in all aspects of HIV program design, implementation, management, evaluation, resource mobilization, and governance. The GIPA principle (Greater Involvement of People Living with HIV) is the earliest expression of the importance of community involvement. Its importance is as central in today's global HIV response as it was when it was first formalized in 1994.²¹

FUNDING TO MAKE PRIMARY PREVENTION POSSIBLE

Primary prevention remains seriously undermined by low funding levels that are grossly misaligned with the number of estimated new infections worldwide. Underfunding exacerbates poor coverage of primary prevention for groups shouldering disproportionate acquisition risk for HIV including, gay men and other men who have sex with men, people who use drugs, sex workers, and transgender people. A recent study of budgets within new grants signed and approved over the 2014 and 2016 allocation period, conducted by the Global Fund to Fight AIDS, Tuberculosis, and Malaria (the Global Fund), confirms underinvestment in HIV programs targeting gay men and other men who have sex with men, people who use drugs, sex workers, and transgender people (see Table 1). Of the 5.9-billion-dollars approved in new grants over the 2014-2016 allocation period, \$724 million (12%) was specifically dedicated to programs intended for **all** key populations (4.16% for sex workers, 3.5% for people who inject drugs and 4.4% for men who have sex with men and transgender people problematically aggregated as a single group^a). Programs funded included costs for HIV testing services as well as expenses associated with research, training, and management. The study revealed that nearly 14% of the \$724 million supported behavioral interventions, approximately 13% supported condom and lubricant programming, 7% supported syringe exchange programs, 4% supported opioid substitution therapy, and 0.39% supported PrEP. Less than 10% of funding earmarked for key populations is used to support interventions targeting upstream factors like community organizing and mobilization, promoting supportive legislation, sensitizing against anti-stigma and discrimination, or mitigating violence.²² In other words, funding for primary prevention with key populations amounts to a slice of a slice of a slice of a bigger pie.

^a Men who have sex with men and transgender women are two distinct groups at higher risk for HIV infection. As such, their prevention, care, treatment, and support needs are different and should be treated as such. The highly problematic practice of combining these groups and conflating their needs should stop because it leads to weak, inappropriate, and harmful programming.

TABLE 1: 2014-2016 Global Fund Investment in HIV Programs for Key Populations

TOTAL GLOBAL FUND FUNDING 2014 - 2016	KEY POPULATIONS COMBINED	MEN WHO HAVE SEX WITH MEN AND TRANSGENDER PEOPLE	PEOPLE WHO INJECT DRUGS	SEX WORKERS
\$5,968,658,499	\$724,373,701	\$264,573,281	\$211,322,903	\$248,477,517
NATIONAL GRANTS	12.14%	4.44%	3.54%	4.16%

To grasp the fullness of the problem when it comes to investment in programs for key populations, one must understand how the Global Fund contribution fits within overall funding for HIV. Consider the following:

1. The total estimated investment needed to achieve global HIV targets by 2020 must increase to \$26.2 billion by 2020 – as of 2016, total investment from all sources was \$19.1 billion;
2. Per UNAIDS, 25% of the total investment should be devoted to prevention;²
3. The Global Fund's contribution to the total global HIV response is estimated to be 10%;
4. As the largest international donor evidence-driven prevention, U.S. PEPFAR program bilaterally contributes an additional 20% to the total (in addition to their contribution to the Global Fund), of which, 20%- 23% is directed towards prevention (when expenditures for the prevention of HIV infection in infants and HIV testing are excluded, the prevention share is 13-16%, including 4% for services focused on key populations);¹
5. Other bilateral contributions combined, add less than 10% to the total estimated HIV investment;
6. Approximately 63% of total HIV investment is now coming from domestic sources.⁷

While the Global Fund's recent study of its own budgets show incremental improvement in investment for key population programming, its investment is miniscule in comparison with overall funding and what is needed. And although domestic investment is modestly increasing and is now the main source of funding for the HIV response globally, domestic funding rarely includes consideration for the HIV prevention needs of key populations. In fact, governments' reluctance to fund evidence-informed and rights-based programs for key populations raises serious questions for international donors about their role as funders of last resort.

Community-based organizations that are led by key populations are best positioned to reach and support their own communities, yet these organizations remain inadequately resourced. Many organizations rely on volunteers and have trouble retaining staff. Erratic funding and inadequate support for core costs, undermine the stability of community-led organizations. Complicated grant requirements and subsequent compliance regulations can be overwhelming, deterring many innovative and effective community-led organizations from seeking funding. In addition, grants to community-led organizations may have limited impact unless they are accompanied by customized, community determined capacity building and sustainability plans from the outset. Bottlenecks within donor bureaucracies can also delay disbursement of funding to community-led organizations, resulting in stop-and-start programs. These issues are compounded for community-led organizations operating in hostile legal or policy environments that limit their opportunities to develop organizational capacity and donor accountability mechanisms. Because of under-developed capacities, many donors are reluctant to invest in smaller organizations. This has forced many community-based organizations led by men who have sex with men, people who use drugs, sex workers, and transgender people to operate at the margins or in the shadow of much larger, well-established and better-resourced, parastatal or international non-government organizations, many of which end up acting as gate-keepers to resources. These factors limit true community engagement and feed a self-perpetuating cycle of under-resourcing for community-led responses.²³

Exacerbating matters, community-led organizations delivering HIV services to men who have sex with men, sex workers, people who use drugs, and transgender people are often the targets of vandalism, harassment, and police raids. Under such conditions, men who have sex with men, sex workers, people who use drugs, and transgender people are significantly less likely to seek the services they may need. To scale up the primary prevention of HIV, community-based organizations led by and serving key populations should be well-supported with medium- to long-term funding and capacity development assistance (e.g., task-shifting, training, peer-delivered technical assistance, emergency assistance, and information exchange). In addition, we must support community-led organizations to work in partnership with local healthcare providers and law enforcement officials to address the structural barriers of misogyny, homophobia, transphobia, whorephobia, drug user phobia, HIV stigma, discrimination, blackmail, extortion, and violence. Finally, community-led organizations must be supported to more effectively and systematically collect, understand, and apply data in their day-to-day work. This is important to ensure reflexivity and course correction, allowing for greater efficiency in the implementation of HIV prevention strategies and the ability to react quickly in changing, often hostile conditions.

LET'S TALK ABOUT SEX AND DRUG USE

Advocates worldwide remain troubled by the inclination of policymakers to understate the problem of HIV. Political rhetoric often misrepresents HIV epidemiology, conveniently rendering gay men, people who use drugs, sex workers, and transgender people invisible. Country control (in international development jargon) to designate 'key populations' has not, does not, and will not change how people acquire HIV. In other words, the persistence of revisionist characterizations of HIV has never and will never change the biology of acquisition. Except for infant HIV acquisition that occurs during pregnancy, childbirth, or through breastfeeding, HIV is primarily transmitted sexually and via blood through the sharing of injecting equipment.

It is not possible to imagine an effective primary prevention response to HIV without openly acknowledging, addressing, and talking about sex and drug use. And yet, governments and mainstream program implementers continue to concoct national strategies and interventions that pathologize and problematize sex, without directly addressing how HIV is primarily acquired and transmitted. In fact, national AIDS strategies intended to blanket the 'general population' provides governments with a convenient reason for never addressing sex. Openly talking about sex, sexual orientation, gender identity, and drug use requires that we acknowledge and engage gay men, people who use drugs, sex workers, and transgender people. The only thing governments and mainstream program implementers loath more than addressing sex and drug use, is having to be accountable to the expressed needs of gay men, people who use drugs, sex workers, and transgender people. For primary prevention to stand a chance, the silence, denial, negativity, and moralism surrounding sex and drug use must end.

THE DANGERS OF TOKENIZING YOUTH RHETORIC

The acquisition and transmission routes for young people and adults are the same – HIV is transmitted sexually and via the use of non-sterile injecting equipment. And like adults, HIV risk among young people is exacerbated by a myriad of social and structural factors, such as sexism, homophobia, transphobia, whorephobia, drug user phobia, and criminalization. They also include factors like consent, emancipation, autonomy, and privacy laws, which are unique to young people.

THE DANGERS OF TOKENIZING YOUTH RHETORIC

The primary prevention of HIV therefore requires that specific consideration be given to young people. HIV prevention practice is dynamic and ongoing. It requires constant updating and iterative manoeuvring to respond to the specific needs of its target audiences. That includes their developmental needs. Primary prevention of HIV for school-aged youth should be qualitatively different from prevention efforts enacted for middle-aged adults. The primary prevention of HIV among young people needs constant renewal since there will always be a new cohort hungry for knowledge and information to reinforce their strengths and skills. This must include broad-based implementation of age-appropriate comprehensive sexuality education.²⁴

Rhetoric about young people and HIV often glaze over these facts and ignores the disproportionate vulnerability to HIV among young gay men, young people who use drugs, young sex workers, and young transgender people. Donors and policy makers often gloss over HIV acquisition and transmission risk among young key populations in favour of generic, sanitized discourse about youth. They also often speak in tokenizing ways about young people in the HIV response, never having consulted with or engaged organizations led by young people. Young people, including young gay men, young people who use drugs, young sex workers, and young transgender people, should be directly engaged when planning HIV prevention programs. Moreover, we must remain proactive in calling out tokenism and rhetoric that invisibilizes young key populations.

GENDER AS A KEY POPULATION ISSUE

Gay men and other men who have sex with men, people who use drugs, sex workers, and transgender people are the routine targets of gender-based violence. Stigma, discrimination, violence, and criminalization directed at LGBT people, people who use drugs, and sex workers are the consequences of deeply-held stereotypic beliefs and expectations about the hierarchical social roles men and women can take, in which men are considered superior to women. These beliefs underlie gender inequalities that are reinforced through social and cultural institutions and enshrined by public policy and law. Moreover, gender inequality is a main driver of homophobia, transphobia, whorephobia, and drug user phobia. For example, violence directed to gay men is correlated with societal misogyny. Gender equality is therefore central to a primary prevention agenda, especially for key populations. This position stands in stark contrast to mainstream HIV and international development responses that narrowly consider gender equality as predominantly focused on the needs and rights of heterosexual cisgender women and girls. HIV vulnerability is heightened by sexism, the circumstances of which must be made explicit. Narrow mainstream notions of gender equality sometimes lack a level of specificity about the circumstances that heighten risk for cisgender women and girls and tend to ignore the needs of both transgender and cisgender women and girls who use drugs, are sex workers, or are lesbians.

The HIV needs and rights of cisgender women and girls merit separate and dedicated attention, as do the HIV needs and rights of gay men and other men who have sex with men, people who use drugs, sex workers, and transgender people. Efforts to designate women and girls as key populations misses this point and is a disservice to both cisgender women and key population groups, of which women and girls are members.

MOVING FORWARD: CORE PRINCIPLES OF PRACTICE

Principles of practice have long been deliberated, published and advocated for by AIDS service providers and activists (e.g., the GIPA Principle, the Yogyakarta Principles).^{25, 26} However, they are often overlooked in policy discussions because of a public health focus on evidence or science in substantiating HIV-related interventions and program strategies. The global HIV response requires evidence, balanced by principles. The following are some important core principles of practice that can serve as broad guidelines in 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;
- 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, competencies, social connections, capacities, and resiliency that are already present in 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
- 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.

Broader adoption of these principles will provide a common foundation for the ongoing development and promotion of the primary prevention of HIV among gay men and other men who have sex with men, people who use drugs, sex workers, and transgender people.

CALL TO ACTION

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

Community-led prevention must be properly resourced. 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. The international development and HIV sectors must adopt a more nuanced understanding of gender. And we must collectively embrace the fact that even the best prevention tools, including antiretroviral medications, will not work without assent from communities most impacted by HIV.

Indeed, the most exciting developments in recent years happened when communities seized control over discourse and over the dispensation of new tools and technologies, to apply in ways and in combinations of their choosing. This paper is offered in that spirit – the spirit of community ownership and the power of partnership.

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

- Stop chasing magic bullet solutions to HIV and end sloganeering about HIV drug coverage – instead, invest in carefully tailored combination approaches;
- 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;
- Combine and tailor prevention approaches with consideration to acquisition and transmission dynamics that are specific to key populations – blanket approaches leave people behind;
- Imbue HIV primary prevention, care, and treatment with the power of community ownership and abandon top-down approaches;
- Remedy funding inequities by investing more substantively, strategically, and differentially in evidence-informed, rights-based, and community-led programs; and,
- Adopt community-endorsed, human rights-based principles of practice, starting with the GIPA principle.

Want to sign onto this call to action? Email us at contact@msmgf.org or visit www.msmgf.org



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ABOUT THE PARTNERING ORGANIZATIONS



Global Action
for Trans Equality

GATE's mission is to work internationally on gender identity, gender expression, and bodily issues by defending human rights, making available critical knowledge, and supporting political organizing worldwide. GATE envisions a world free of human right violations based on gender identity, gender expression, and bodily diversity, and transformed by the critical inclusion of those historically marginalized. GATE works to build powerful, expert, and well-resourced political movements, able to have meaningful participation in global processes and to transform the landscape of socioeconomic justice.



GNP+ works to improve the quality of life of all people living with HIV. GNP+ advocates for and supports fair and equal access to treatment, care, and support services for people living with HIV around the world. As a rights-based organization, emancipation and self-determination are GNP+'s core principles. GNP+ envisions a world where people living with HIV enjoy a better quality of life through a powerful and united worldwide social movement of people living with HIV.



ICW dedicates itself to strengthening networks of women living with HIV; advocating for improvements in the availability and accessibility of care and treatment services for HIV positive women; and communicating information across the ICW network that promotes the achievement of ICW's advocacy and networking goals. ICW is the only international network, which strives to share the experiences, views, and contributions of 19 million women worldwide who are HIV positive.



International Network of People who Use Drugs

INPUD is a global peer-based organization that seeks to promote the health and defend the rights of people who use drugs. INPUD exposes and challenges stigma, discrimination, and the criminalization of people who use drugs and their impact on the drug-using community's health and rights. INPUD achieves this through processes of empowerment and advocacy at the international level, while supporting empowerment and advocacy at community, national, and regional levels. INPUD is a movement of people who use drugs who support the Vancouver Declaration, which sets out their demands, emphasizing that their human rights must be respected and their health and wellbeing prioritized.



A GLOBAL NETWORK OF TRANS WOMEN AND HIV

IRGT works with trans organizations, communities, and advocates around the world to: promote a human rights framework in response to trans women's health; ensure public health responses meet the needs of trans women at risk for or living with HIV; assure equitable access to and distribution of resources; encourage a multidisciplinary trans-led and trans-specific research agenda; highlight the intersectionality of trans women's issues with other groups; empower and build capacity of trans women and trans organizations; and host the trans pre-conference at the International AIDS Conference every two years.



MSMGF was founded in 2006 at the Toronto International AIDS Conference by a group of activists concerned about the disproportional HIV disease burden being shouldered by men who have sex with men worldwide. MSMGF is an expanding network of advocates and experts in sexual health, human rights, research, and policy, working to ensure an effective response to HIV among gay men and other men who have sex with men. MSMGF watchdogs public health policies and funding trends; strengthens local advocacy capacity through program initiatives and supports more than 120 community-based organizations across 62 countries who are at the frontlines of the HIV response.



NSWP exists to uphold the voice of sex workers globally and connect regional networks advocating for the rights of female, male, and transgender sex workers. NSWP is a membership organization. Its members are local, national or regional sex worker-led organizations and networks across five regions: Africa, Asia and the Pacific, Europe, Latin America, North America, and the Caribbean. NSWP's work is based on three core values: 1) acceptance of sex work as work; 2) opposition to all forms of criminalization and other legal oppression of sex work (including sex workers, clients, third parties, families, partners, and friends); and 3) supporting self-organization and self-determination of sex workers.

The Platform works towards achieving UNAIDS 2020 and 2030 targets by advising UN agencies, the Global Fund, U.S. PEPFAR, bilateral donors, and international funders of the global HIV response. Convened by MSMGF and UNAIDS, the Platform, in partnership with grassroots advocates and their networks, takes an active role in elevating the sexual health and human rights concerns of gay and bisexual men in the context of the global HIV response.

UPSTREAM

DOWNSTREAM

RISK FACTORS

**PRIMARY
PREVENTION**

**MIDSTREAM
PREVENTION**

**DOWNSTREAM
PREVENTION**

