

DAVID WILSON - KAMPALA PLENARY TALK

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GOOD MORNING

I've chosen to speak without slides because I believe our central challenge in HIV prevention today is not to revisit familiar data in a context where there have been few new prevention insights for two years, but rather to integrate diverse data strands into a coherent overall analysis of what it means to "know our epidemics".

Our quest to know our epidemics must begin with the assertion there is no global HIV epidemic, but rather a multitude of epidemics - no single prescriptions can be relevant in, say, South Africa, Egypt, Russia, Thailand and PNG. The era of global guidance is truly over.

The most central and enduring distinction globally is between concentrated and generalized epidemics, which are fundamentally different – NOT because of prevalence but different in WHO gets infected and HOW. For too long, we've pursued generalized responses in concentrated epidemics, concentrated ones in generalized epidemics, or just hedged our bets and done a bit of everything everywhere.

At the extremes, the differences are stark. Latin America, the Middle East, Europe and Asia – most of the world – are and always will be - concentrated. Southern and Eastern Africa are generalized. Swathes in between are unresolved. Are the Caribbean, West Africa and the Pacific concentrated, low grade generalized or mixed? This matters – unless we understand, we can't respond optimally.

The global move to know our epidemics is welcome – it enables us to debate HIV prevention with greater vigor and freedom than ever before. Yet, there are pitfalls we must avoid.

First and above all: we must understand, but not overcomplicate. We could spend years painstakingly characterizing our epidemics, but broad brushstrokes are sufficient for action. Galvanized into intelligent action, we can

build and bolster our ships as we sail. And act we must, without endless analysis, guided by an overarching question – are our epidemics concentrated, generalized or mixed? And where in BROAD categories, are NEW infections – (our last 1,000 infections) occurring – among SW, MSM, IDU or adults with multiple partners? More specific answers can be distilled from and alongside well evaluated programs.

Second and related: modeling incident infections to know our epidemics has an important role but must be used cautiously and triangulated – seductive graphs offer spurious precision – and the prospect of protracted disputes that may impede and deflect energy from action.

Third: inclusive, participatory, consensual approaches to know our epidemics are laudable, but may compromise rigour if they reintroduce discredited orthodoxies, It took us three decades to accept there is no simple, direct association between income, education, gender and HIV. Numerous DHS+ and other studies show more educated, upper income people in richer African countries with greater gender equality have more, not less, HIV. What we know for certain is that we can curb HIV by tackling its **IMMEDIATE, DIRECT** cause – multiple, unprotected sexual partnerships.

Fourth: in the crucible of Southern Africa's epidemics, epitomized by Botswana, Swaziland and Lesotho, with uniformly high HIV prevalence, our greatest challenge is not knowing our epidemics – but knowing how to effect profound, fundamental normative, social and cultural change.

Once we know our epidemics in broad strokes, we can move to knowing our responses. But can we respond with proven approaches? Experience to date is often dispiriting.

Simply consider concentrated epidemics, driven by three familiar sources – sex work, MSM and IDU.

If we face concentrated epidemics fueled by sex work, we know what to do in the real world and at scale – targeted interventions

promoting education, condoms, sexual health, solidarity, empowerment and rights, supported by education for men in the general population, do WORK and have checked HIV in Asia's three sexually ignited epidemics – Thailand, Cambodia and South India. Our guiding mantra here is clear - focus, quality, coverage.

If MSM plays a major part in our epidemics, the real world picture in developing countries is less encouraging. We know that education, condoms, solidarity, empowerment and rights approaches may work in contexts open to MSM, such as India where the national AIDS authority has petitioned the high court to legalize homosexuality, Nepal (where the third gender – transgender - is an legal gender classification), and parts of South East Asia. Yet effective action is FAR harder in coercive contexts – simply consider Egypt, where a groundbreaking sero-survey merely hastened the imprisonment of MSM.

Which leads to the third category – IDU. We can't keep saying needle-syringe and substitution programs work in, say, the former Soviet Union or Asia, when we are scarcely closer to convincing the real authorities – presidents, parliaments, law ministries – they are preferable to coercion. Veteran drug expert Nic Croft fittingly concluded his Goa harm reduction plenary by confessing that after decades of effort, he no longer knew how to convince Asian governments to endorse harm reduction. And as a senior Indonesian Bureau of Narcotics official told us with exquisite Javanese subtlety, he was sure Indonesia would heed harm reduction advice if only it emanated from the United States Drug Enforcement Agency.

Turning to generalized epidemics, we face three overarching challenges.

First: many of our most trusted interventions – mass media, school and youth programs, condom social marketing, VCT and STI care – are at best unproven, at worst, disproven.

Second: the best preventive intervention in the history of the epidemic, male circumcision, is barely advancing.

Since the three trials ended two years ago, how many more

men have received this remarkable partial vaccine - lamentably few – and this will not improve without a step change in our resolve and resources. Yet the potential for action is immense – 7 of the 8 highest prevalence countries globally – all in Southern Africa – have male circumcision rates below 20%.

Third: the major contributor to reduced HIV transmission in generalized epidemics has been partner reduction – we have seen this in country after country. Yet, except in early Uganda, partner reduction appears to have occurred despite not because of formal programs. Consequently, we know far too little about how best to effect partner reduction. But this is no excuse not to radically increase our commitment and investment in well evaluated programs - and **ALONGSIDE NOT BEFORE** such programs, rigorous studies, to better understand how to reduce multiple concurrent partnerships.

Turning to the undetermined character of the epidemics of the Caribbean, West Africa and the Pacific, we must first resolve whether they are concentrated, low intensity generalized or mixed. If concentrated, we face the achievable challenge of refocusing to make sex work safe. If low grade generalized, we face a far greater challenge – how to convince countries with a 1% prevalence and numerous competing health and social priorities, such as the Congo, to invest in the fundamental social change required for partner reduction.

And this question poses a related challenge we can defer no longer. What is a proportionate AIDS response? Global AIDS resources, while vast, are largely concentrated in 15-20 countries, mainly in Southern and Eastern Africa. In the 10 or so highest prevalence countries, all in Southern Africa, epitomized by Botswana, Swaziland, Lesotho, the question is not whether we are distorting efforts too much, but whether we are distorting enough? In Francistown, Botswana, where 70% of women aged 30-34 have HIV, how can we possibly focus too much on AIDS? Yet, in much of East and West Africa, where HIV is lower than previously believed, and where AIDS is amongst the top 5 causes of disease burden, yet receives more funding than greater sources of disease burden, we need to re-position and integrate AIDS in genuine, effective support

of other pressing health challenges. And conversely, counter-intuitively even, in many countries in Latin America, the Middle East and Asia, AIDS may be proportionately under-financed. In Thailand, a feted success story, AIDS constitutes 14% of disease burden and only 2% of recurrent health spending. In Indonesia, which faces Asia's fastest growing epidemic, and in West Papua, the world's highest HIV rates outside Africa, HIV funding may fall, compromising vital programs.

In conclusion:

First, the move to know our epidemics is welcome, but must not be overcomplicated – broad but sturdy brushstrokes are sufficient for decisive, intelligent action.

Second, concentrated epidemics driven by sex work are eminently preventable, but protecting MSM and IDU will require novel evidence, arguments, advocacy and allies – our existing arguments and approaches simply aren't succeeding.

Third, in generalized epidemics, our core challenge is to reallocate effort and resources from the unproven or disproven approaches that currently dominate to the two proven but admittedly sensitive approaches we already have – male circumcision and partner reduction.

Will we, in conclusion, collectively have the courage to abandon orthodoxies and entrenched interests and not only accept the evidence but the remorseless, unrelenting FOCUS needed to apply proven solutions AT SCALE? Because that is what knowing both our epidemics and our responses must entail.

THANK YOU