By J. Stephen Morrison

THE ISSUE

Just recently, 16,000 gathered in Amsterdam for the International AIDS Conference—“AIDS2018.” Many leading figures painted a sobering picture: goals for global HIV/AIDS treatment and prevention goals are not likely to be attained, funding has declined, high-level political will is lacking, and there is the risk of a resurgent epidemic. All of which makes for considerable discomfort and uncertainty. We are at a turning point in thinking about what comes next in controlling HIV/AIDS in the coming years.

During the week of July 23, 16,000 advocates, persons living with HIV, scientists, clinicians, service providers, policymakers, and researchers convened in Amsterdam for the biannual International AIDS Conference—“AIDS2018.”

Collectively, a large number of the leading figures at Amsterdam painted a common, deeply sobering picture. In varying ways, each acknowledged that global HIV treatment and prevention goals are not likely to be attained, while there is little evidence or hope of major new funding to meet outstanding needs in the global response (indeed, the likelier prospect is continued decline). That is matched by a conspicuous deficit of high-level political will, and intensified competition for attention and resources. Several voiced the fear of losing ground, and several pointed to the real risk of a resurgent epidemic.

This is the new prevailing consensus, the new realism. It is what you heard in listening in Amsterdam to the individual public remarks of Michel Sidibé, head of UNAIDS, Peter Sands, head of the Global Fund to Fight AIDS, Tuberculosis and Malaria, Peter Piot, former head of UNAIDS and now Dean of the London School of Hygiene and Tropical Medicine, and Mark Dybul, former head of the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund and now at Georgetown University.


Interestingly, this pronounced shift in tone and substance does not jettison pride and optimism. Rather, what you often encounter is an awkward back and forth between hope and pessimism. The result: HIV/AIDS has come to occupy an uncomfortable, unstable, and murky middle ground. It is a place of decidedly mixed sentiment, that frankly can be confusing and fragile, that feeds fear and uncertainty, and that begs for answers that remain elusive.
THE DILEMMA

Today the AIDS world faces a confounding dilemma.

We are nearly two decades into realizing historic achievements—22 million of 38 million persons living with HIV are on life-sustaining antiretroviral treatment. In the past 20 years, those treatments have become more powerful, more convenient to take (from dozens of pills a day to single-tablet daily regimens), with fewer side effects, and at costs that are 1/100th of what they once were in lower- and middle-income countries. Especially in southern and eastern Africa, heavy investment by the United States (exceeding $80 billion since 2004), the Global Fund, and others has propelled countries toward achieving UNAIDS’ 90-90-90 goals of 90% who know their status, 90% of those who are on antiretroviral treatment, and 90% of those who have successfully suppressed the virus and ceased to transmit infections. That investment has created an impressive new public health infrastructure. PEPFAR in particular has demonstrated in a limited group of focal countries, that if there is real focus, commitment, resources, and partnerships, remarkable results are indeed possible. New data presented by PEPFAR at Amsterdam demonstrated the impressive progress achieved in Namibia.

More than 15 million individuals living with HIV are not on treatment, most of whom do not know their status. New infections—1.8 million per year—are not declining and are primarily among young adults and members of marginalized populations. Each year, the baseline, unserved population living with HIV steadily expands.

Each of the 22 million persons now on treatment will, it is hoped, live fruitfully on treatment for decades, yet at considerable cost and requiring much care to ensure unbroken continuity and evolution of services into old age.

There is still no vaccine or cure, and no hope of seeing either in the near to medium term. That fundamentally sets HIV/AIDS apart from other dangerous infectious disease epidemics. And it makes for a very uncomfortable reality when thinking about truly controlling the arc of this dangerous, infectious disease pandemic, truly sustaining the response over the long-haul, and managing the inherent risk of a rebound of the epidemic if there is not accelerated expansion of investments.

We are witnessing the steady erosion of high-level political commitments, combined with the erosion of a reliable and predictable financial base. Both deficits may widen into the future.

The Institute of Health Metrics and Evaluation (IHME) at the University of Washington has documented how donor...
commitments dropped by $3 billion between 2012 and 2017. Kaiser Family Foundation and UNAIDS in their report released ahead of the Amsterdam documents how 8 of 14 major donors decreased their commitments in 2017. At the same time, national governments have failed to offset this decline with increased commitments.

At Amsterdam, the Dutch government succeeded in enlisting ten health ministers from Eastern Europe and Central Asia to join a closed-door dialogue that even included the Russians in the same room with Ukrainians: that was a very promising political step engineered through careful diplomatic finesse and commitment. But absent from Amsterdam were any heads of state, with the exception of former President Bill Clinton, now 18 years out of power. South Africa raised hope that it would fill the void with the appearance of the deputy president, but he was diverted to other priorities, just prior to the conference.

WHAT HAPPENED?

Many factors account for where we are today.

Gone is the threat of HIV/AIDS that seized the global community in the 1980s and 1990s, as the death toll climbed and infection rates grew, with new treatments out of the reach of the millions who lived in countries with generalized epidemics, where life expectancy began to fall precipitously, wiping out gains from decades of development. This dire situation fueled the sense of urgency that was such a powerful motivator when President George W. Bush launched PEPFAR and the major Western donors launched the Global Fund early in the 2000s.

There is instead today a widespread complacency, a function of success, hubris, and our own rhetoric. The convenient optimistic, rallying cries of just a few years ago—the declaration that we are near an “End to AIDS”—may have bolstered and sustained commitments in the short term, but such claims were premature and demobilized and desensitized opinion leaders. State leaders, legislators, and senior policymakers do not today see an acute threat from HIV/AIDS in the same way that it was understood to be a politically and destabilizing force around the turn of the millennium. Nor do they today understand the possibility of a resurgent HIV/AIDS epidemic, even though a case can be made that we do indeed face that threat, especially with the doubling of the youth population in sub-Saharan Africa in the next decades and persistent HIV infection rates. Nor do they see the full scope of the unfinished business, the 15 million living with HIV and the urgent need to expand prevention efforts. How to restore high-level attention is altogether unclear.

Confidence has waned. As many countries creep closer to the 90-90-90 goals, we have had to grapple with the discovery that we remain still very distant from success and have had to recalibrate expectations accordingly. Even if these goals are achieved, 27 percent of all people living with HIV still would not be virally suppressed and hence be capable of continuing to pass on the virus. Aggressive action is needed to stay at or above those goals by continuing to put more people on treatment and stop new infections that would increase the overall number of people living with HIV.

Moreover, reaching the final “10-10-10” is proving to be hugely problematic—politically, operationally, programmatically, and financially. It is that population that includes the most marginal, criminalized, stigmatized, vulnerable, and difficult to reach: men who have sex with men, injecting drug users, sex workers, young men between 15-35 years, and adolescent girls and young women. These are the populations that account for half of new infections and experience bewilderingly high rates of new infection. They are the populations likely to be living in the deepest poverty, with the least economic power and legal protections, and the greatest vulnerability to sexual violence.

The geography of the epidemic itself has changed. Eastern and southern Africa are doing reasonably well, but there are pockets of hyperepidemics where upwards of 70 percent of adolescent girls are living with HIV, such as KwaZulu-Natal Province in South Africa. And there is reason for alarm when looking at Eastern Europe, Central Asia, and West and Central Africa. Each region has its own special needs, dynamics, and demands, which have not yet been parsed out carefully enough.

And then there is Russia. It falls altogether outside the frame of reference of PEPFAR and the Global Fund, it has an estimated 1 million persons living with HIV, and new infections are running at 100,000 per year: this represents a doubling in the past decade, making Russia the largest epidemic in Europe.

Though Russia’s epidemic is driven overwhelmingly by injection-drug use, the Putin government continues to defy public health science and practice by outlawing proven methods of prevention and treatment (e.g., methadone, syringe exchanges) and continuing to criminalize and abuse key populations. At the same time, it actively pressures Kazakhstan and Ukraine at high levels to desist from their efforts to introduce expanded harm reduction programs.

Elsewhere, Russia’s menacing actions impede any international dialogue on reform of Russia’s errant and costly HIV/AIDS approaches: e.g. its occupation of Crimea,
destabilization of eastern Ukraine, and interference in democratic elections – that in turn have triggered international sanctions.

The shadow of Russia's malevolence was in evidence at the opening of "AIDS2018," which featured a memorial to the five AIDS experts who were among the almost 300 victims of the shoot-down of Malaysia Flight 17 over Ukraine in July 2014, as it was heading for Melbourne, site of "AIDS2014." Investigators have subsequently tied that incident back to Moscow.

**THE WORLD HAS CHANGED**

Four shifts have also fundamentally changed the larger context for deliberations over the future of HIV/AIDS, making it far more difficult, not less, to command focus and commitment.

First, the entire parameters of global health changed with the advent of the Sustainable Development Goals. AIDS exceptionalism is a diminished currency, as the drive to establish Universal Health (UHC) Coverage gains steam and as HIV/AIDS shares the stage and competes for resources with chronic disorders (diabetes, cancer, hypertension, respiratory disease), hepatitis, and tuberculosis.

Amsterdam revisited with new intensity the fissure between the push to keep HIV siloed, to reach key populations that face stigma and discrimination in health systems most effectively, versus the push to create integrated primary care as envisioned under UHC. It is a debate over both strategy and money. It will likely stretch out for some time and is already consuming considerable energy. Whether it will be a fruitful debate that results in new concrete innovations is an open question.

Second, the demographic accelerations in Africa are changing the equation fundamentally, creating a youth tsunami that threatens to swamp the gains of the past 15 years.

Third, in today’s disordered world, marked by enduring crises on several continents and an estimated 68.5 million refugees and displaced persons (and growing), political and financial attention are diverted to acute demands. And HIV/AIDS is getting lost. New crises, such as in Venezuela, have added 2 million refugees in the space of less than two years, with the real, near-term prospect of doubling.

Fourth, and perhaps the biggest change we grapple with—that particularly feeds uncertainty, anxiety, and fragility—is the ascent of populist nationalism in the United States, the United Kingdom, and across Europe.

That historic, geopolitical shift is built on a shared discontent, anger, and intolerance within multiple electorates. It features a contempt for democratic norms and human rights, and a deep skepticism of science, foreign aid, and diplomatic engagement outside sovereign borders. It is contributing to the steady, deliberate dissolution of the postwar liberal internationalist order. In many places there is flagrant disregard of fact and brazen racism and misogyny. It is wishful thinking to assume this shift is a temporary, short-term phenomenon.

Thus far, priority targets for populist nationalists in the United States and elsewhere have been Western establishment political alliances, security pacts, and global trade relations, along with longstanding normative commitments on human rights and multilateralism.

Luckily, HIV/AIDS up to now has not been expressly in the firing line. But neither has it been entirely spared: witness the expansion by the United States of the Mexico

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Activists place white crosses with red ribbons at the Museumplein in Amsterdam on December 1, 2009.

Source: ROBERT VOS/AFP/Getty Images
City Policy, known colloquially as the “global gag rule” that applies now to an estimated 470 international NGOs managing and estimated $900 million in programs. At the same time, the deteriorating respect for human rights and protections in many countries is directly threatening to the ability of HIV/AIDS programs to reach key populations.

The two capitals who were the stalwart foundations of the decade-long steep ascent of HIV/AIDS and global health writ large—Washington and London—have flipped into the populist nationalist camps, creating an enormous new leadership vacuum. A resilient U.S. Congress has held the line against repeated Trump administration budgetary assaults, leveraging the realization that millions of lives are at stake and reflecting the continued influence of advocates, former presidents, foundations, the faith community, and business. No less important, Ambassador Deborah Birx has retained leadership of PEPFAR.

Paradoxically, the fragile continuity of U.S. commitments in the Trump era was (and remains) the single most important, quiet news coming out of Amsterdam.

The United States accounts today for $6 billion of the $8.1 billion of donor dollars committed to HIV/AIDS. As other donors have exited, the United States has stood its ground. That means that the United States looms ever larger and conspicuous as the lynchpin of global engagement on HIV. That unstable equilibrium is hardly a comfortable position to be in.

**WHAT NOW?**

Where does this all leave us? Though there are no easy answers, a few options come to mind.

Some things do not need to change. There is no choice but to take the long view and continue with those proven prevention, treatment, and care interventions that we know to be highly effective, achieve higher efficiencies and cost savings, incentivize governments to do more with their own national resources, press ahead in reaching key populations and young women and men, advance promising new innovations like PreP, and make continued critical investments in R&D.

The fight against criminalization of HIV, which Amsterdam demonstrated remains truly alive, will continue, bolstered by the vibrant community of grassroots HIV advocates.

But it will also be important to reach outside the confines of the HIV/AIDS world, take new risks and innovate, update outlooks and behavior, erect new concrete alliances, and cultivate new leadership—including youth, the next generation of AIDS leaders, a refreshingly high priority at Amsterdam (thanks to the determined leadership of Linda-Gail Bekker and others).

Inside the central institutions governing much of the HIV/AIDS response—PEPFAR, the Global Fund, and UNAIDS—it can and should be possible to build on successful models of how to use HIV/AIDS interventions to build the primary care infrastructure that enables integration of care and treatment for other chronic conditions as countries set out on the path to UHC.

It is within reach to bridge key populations with progress in advancing UHC goals, as countries implement strategies to provide health for all by 2030. Confronting stigma, discrimination, and disempowerment is not inherently in conflict with integration of services. That change will however rest on determined reform and no doubt stir active resistance, but it will be essential in this next phase.

WHO under Dr. Tedros’ leadership is potentially poised to do far more to move this agenda forward. The same is true for Jim Kim at the World Bank.

There is the need to capture systematically—and make real to policymakers—the true threat of a resurgent epidemic: where exactly the most serious risks lie, and how grave the costs of inaction will be. As noted above, even if countries reach the 90-90-90 goals, they have still not established the conditions for “U=U” (undetectable = untransmittable), since nearly one-third of HIV-positive individuals would not have achieved viral suppression.

The single most important priority is protecting the vital U.S. program from populist assault. That will rest on reinvigorating and updating congressional interest in both PEPFAR and the Global Fund to preserve strong bipartisan support.

In this next phase, Chancellor Merkel of Germany, President Macron of France, and Prime Minister Trudeau of Canada will carry added weight globally. Each has the potential, along with Prime Minister Abe of Japan and President Ramaphosa of South Africa, to step forward at key moments to revitalize the discussion of global HIV/AIDS in the larger context of global health, whether it is at the September UN High Level Meeting on TB, the Munich Security Conference,
the G-7 and G-20, the IMF/World Bank meetings, or next year’s UN High-Level Meeting on UHC.

Russia will likely remain isolated and recalcitrant. But it may also be approaching a moment of existential reckoning, as the true costs of its AIDS epidemic become more visible and undeniable. Russia’s activism on TB and its progress in recent years in NCDs (alcohol, smoking, diet) may also create new opportunities for diplomatic engagement. That proposition should be tested.

It is similarly worth testing what new forms of engagement with China may be fruitful: perhaps centered on One Belt/One Road, embedded in discussions over how to achieve UHC in partner states; perhaps centered on its new foreign aid institutions; or perhaps shaped by its strategy to fill the space created by the U.S. retreat geopolitically, especially in Africa, where China has been active and where most of the HIV population globally reside.

The single most important priority is protecting the vital U.S. program from populist assault. That will rest on reinvigorating and updating congressional interest in both PEPFAR and the Global Fund to preserve strong bipartisan support. Knowledge and familiarity in Congress are rapidly thinning, and a big new crop of freshly elected members will arrive in January.

Holding “AIDS2020” in San Francisco and Oakland, a source of controversy and debate in Amsterdam, will carry clear risks, in the degraded and polarized political and media environment in the United States. But it can also be an opportunity, if seized and managed correctly, in mobilizing bipartisan congressional participation and galvanizing support from the faith, advocacy, foundations, and business communities. “AIDS2020” can potentially help stir a new national debate over HIV/AIDS, at home and abroad.

LAST THOUGHT

President Clinton declared on the closing day of the Amsterdam gathering that “There can be no Brexit for AIDS.” That remarkably astute and succinct statement captures where we are today: at the edge of real danger, but still able to resist and fight back. Realism has moved to center stage but not vanquished hope and optimism.

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ENDNOTES


12. Peter Piot, “Global health and the HIV response,” (speech, Amsterdam, Netherlands, July 26, 2018), AIDS 2018; Achieving 90-90-90 means 90 percent of PLHIV know their status, 81 percent (90x90) of all PLHIV are on ART, and 73 percent (81x90) of all PLHIV are virally suppressed. Hence 27 percent of all PLHIV would not be virally suppressed if 90-90-90 is achieved.