



International Association
of Physicians in AIDS Care

January 5, 2009

Obama-Biden Presidential Transition Team
VIA EMAIL TO MR. PARAG V. MEHTA
Office of the Public Liaison
Presidential Transition Team

Dear Members of the Obama-Biden Presidential Transition Team:

The International Association of Physicians in AIDS Care (IAPAC) represents more than 12,000 physicians and allied health care providers in over 100 countries who are daily caring for and providing support to men, women, and children living with HIV/AIDS. In addition, IAPAC advances advocacy, education, and technical assistance activities in the United States and abroad with the aim of improving the quality of care and treatment our global membership provides to a wide range of HIV-positive patients.

IAPAC is pleased the “Obama-Biden Plan to Combat Global HIV/AIDS” is a robust response to the heretofore largely ignored U.S. HIV epidemic, as well as a commitment to expanding the U.S. response to HIV/AIDS globally. We are thus grateful to be included in dialogue with the Obama-Biden Presidential Transition Team around this matter of national and global security. In that spirit, we wish to offer additional and/or complimentary top-line recommendations to the Obama-Biden Presidential Transition Team, abbreviated in format here but which can easily be elaborated upon should you require additional information and/or context. Prior to stating these more specific top-line recommendations, IAPAC respectfully submits the following macro-level suggestions:

- Considering that the main route of HIV transmission worldwide is unprotected sexual intercourse, it is critical to foster open, objective, and evidence-based discussions about human sexuality and the promotion and care of sexual health. Efforts must be made to ensure that HIV prevention programs are developed and implemented according to up-to-date scientific knowledge on human sexuality and research on the effectiveness of methods and approaches to reducing the risk of exposure and in lowering the efficiency of viral transmission.
- Funding and programming decisions for HIV prevention, care, and treatment must be based on the principles of human rights and all other values of a democratic and pluralistic society – including regard for scientific evidence – not on the ideological viewpoints of donors or program developers. Imposing narrow views is a violation of human rights.
- To be effective, HIV prevention, care, and treatment programs must address social inequalities related to sexual orientation, gender, and ethnicity. These determinants of vulnerability must be placed higher among national and international priorities as issues to be urgently addressed with sound policies, visible political commitment, and sufficient funds to implement effective programs.



- The most effective responses to curb the growth of the HIV pandemic and provide care and treatment for those already living with HIV/AIDS must be multisectoral in nature. In the implementation of HIV prevention, care, and treatment programs the role of both the education sector and civil society is of paramount importance. International cooperation efforts will be more effective if these two sectors are fully engaged.
- At present time, the most conspicuous international targets in dealing with the HIV pandemic are focused only on efforts to slow its growth, and provide care and treatment on a universal scale to clinically eligible people living with HIV/AIDS. While these targets are praiseworthy, it is regrettable that there is neither enough emphasis in reducing the mortality caused by HIV-related conditions (e.g., hepatitis, tuberculosis) nor in improving the quality of life of those already living with HIV/AIDS who may also be co-infected with hepatitis and/or tuberculosis. The clear definition of such targets should lead to the development of systematic strategies to scale-up treatment for these conditions and to undertake other initiatives conducive to lessening stigma and discrimination and to improving overall quality of life.
- The U.S. Government may wish to take a careful look at the “division of labor” proposed within the United Nations system (particularly by the Joint United Nations Programme on HIV/AIDS [UNAIDS] co-sponsoring agencies) to ascertain whether it reflects their competencies, mandates, and resources, as well as whether it is conducive to fostering intersectoral cooperation. The same review is warranted for all other U.S.-funded/-supported bi- and multilateral development assistance programming, including the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund), as well as institutions and organizations with which it is partnered to advance HIV prevention, care, and treatment activities in the United States and abroad.

United States

- **HIV Care and Treatment.** Universal access to health care is an urgent priority, and we applaud the “Obama-Biden Health Care Plan” for its commitment to advocating Congressional passage of and ultimately to signing into law universal health care legislation. In the interim, however, there is an important measure that can be taken to ensure that individuals who are most affected by a lack of adequate health care coverage – currently relying on a patchwork of under-funded safety net programs (e.g., Ryan White CARE Act) – do not continue to fall through the cracks in our health care system.

Ryan White CARE Act. Since its original authorization in 1990, the Ryan White CARE Act has functioned both as payor of last resort and as a safety net program for medically indigent Americans living with HIV/AIDS. One of the most important components of the Ryan White CARE Act is the AIDS Drug Assistance Program (ADAP), which provides antiretroviral drugs to tens of thousands of Americans living with HIV/AIDS – about 50% of whom have incomes below the federal poverty level, and almost 30% of whom were uninsured at the time of their HIV diagnosis. Yet, a conservative estimate is that almost 100,000 additional Americans who are clinically eligible for antiretroviral therapy are unable to access it through the Ryan White CARE Act because state ADAPs are financially overstretched, necessitating waiting lists and restricted drug formularies.



Medicaid/Medicare. People living with HIV/AIDS are today not progressing to disabling conditions as rapidly, if at all. Yet this is the usual pathway to eligibility for the Medicaid and Medicare programs. Because these are entitlement programs, funding must increase to meet the demand unless the criteria for eligibility are changed. As states face serious budget crises, they are cutting back on eligibility and benefits under the Medicaid program, which they co-fund with the federal government. Thus, an increasing number of individuals remain dependent on the services funded through the Ryan White CARE Act, which do not automatically receive additional money based on demand but require increased appropriations from Congress.

RECOMMENDATION: IAPAC endorses and supports an Institute of Medicine (IOM) proposal to establish a new entitlement program that would group most current state and federal HIV/AIDS care programs into one national entity with streamlined rules and a larger budget. A single public financing arrangement – including consistent nationwide eligibility requirements and a federally defined list of services – would address gaps and a lack of coordination in the current system. While the specifics of such an arrangement would require negotiation, they would need to facilitate the provision of antiretroviral therapy to a growing number of clinically eligible Americans living with HIV/AIDS; offer uniform reimbursement to health care providers throughout the country; and be available to all HIV-positive U.S. citizens with incomes at or below 250% of the federal poverty level. People living with HIV/AIDS who earn more than 250% of the federal poverty level but do not have access to private health insurance would be allowed to participate in the program by paying a monthly premium based on their income levels.

- **HIV Prevention.** In the third decade of the U.S. HIV epidemic, the health system faces several challenges to HIV prevention, which include a difficulty in implementing HIV prevention interventions that have already been proven effective. For example, although there have been ample studies in a variety of settings that demonstrate the merits of needle exchange programs (NEPs), the federal government has since 1988 banned funding for their implementation, which if reversed could help to reduce the burden of HIV infection among intravenous drug users (IDUs). Intentional and unintentional barriers also exist to the delivery of HIV prevention interventions among other vulnerable populations – including men who have sex with men (MSM), commercial sex workers, and incarcerated individuals.

It should be recognized that an integrated approach is needed to HIV prevention; no single intervention operating in isolation is likely to have a significant impact on HIV incidence in a population. The constantly changing dynamic of the HIV epidemic reflects the need to revisit and revise existing interventions so that they are culturally appropriate and sensitive to the needs of local communities. For these reasons, ongoing evaluations and operational research are needed to help inform both programs and policies.

A challenging scientific agenda also remains for HIV prevention strategies. This should garner a greater portion of the attention and resources of the AIDS scientific establishment, given the maturity of HIV care and treatment in the United States. Recent promising advances in circumcision, microbicides, and HIV vaccine research suggest that real progress is coming in the near future. Moreover, antiretroviral therapy itself has made a substantial contribution to HIV prevention. Although it is an imperfect prevention tool that should always be accompanied by traditional methods of HIV prevention, it is encouraging to have



learned that with every log decline in plasma viral load due to antiretroviral therapy, the risk of HIV transmission declines by 2.45 times.

Finally, while current law already allows for the delivery and financing of most HIV prevention services through Medicaid and Ryan White CARE Act programs, available data suggest that, in practice, neither program is currently delivering a significant amount of HIV prevention services to their beneficiaries/clients. Encouraging such an arrangement would serve to increase the volume of HIV prevention services delivered in the United States, in addition to reinforcing the inextricable link between HIV prevention, care, and treatment.

RECOMMENDATION: IAPAC advocates increased political courage around how best to adjust policies and programs to take into account issues such as sexuality, gender, drug use, and harm reduction. We further encourage evaluations of and operational research around existing policies and programs, as well as an investment in novel interdisciplinary approaches to implementing behavioral interventions and biomedical technologies. IAPAC also supports a better balance between financial investments in HIV prevention research and HIV care and treatment research by encouraging a scientific agenda that focuses more of the AIDS scientific establishment's work on the development of HIV prevention strategies. And, we support measures to strengthen linkages between HIV prevention and HIV care and treatment from the policy, funding, and program perspectives.

- **HIV Testing.** Nearly 60,000 Americans were infected with HIV last year, and some 250,000 people nationwide are unaware of their infection. While initial successes show the potentially powerful impact of routine HIV testing, two years after the US Centers for Disease Control and Prevention (CDC) recommended opt-out HIV testing for Americans aged 13 to 64, major barriers stand in the way of making HIV testing the nationwide norm. Thus, more than one in five people HIV-infected Americans remain unaware of their status, fail to get life-extending antiretroviral therapy, and many unwittingly spread the virus, contributing to more than one-half of all sexually transmitted infections. Barriers to broader uptake of the CDC recommendations include lack of or minimal training about the CDC recommendations in primary health care settings, and state laws/regulations that either prohibit routine testing or limit/prohibit Medicaid and/or Medicare reimbursement for such testing.

RECOMMENDATION: IAPAC recommends taking to scale model programs that have demonstrated a meaningful impact in uptake of opt-out HIV testing, as well as linkages to HIV prevention, care, and treatment services. In addition, while respecting the constitutional divide between state and federal mandates, IAPAC supports increased dialogue between the US Department of Health and Human Services (DHHS), the CDC, state Departments of Health and other relevant state agencies with the aim of addressing both laws/regulations that prohibit implementation of opt-out HIV testing and/or limit or deny reimbursement for opt-out HIV testing services.

- **Human Resources.** People aged 85 and older make up the fastest-growing age group in the United States. Today, there are 3 million men and women in this category; by 2030, there will be more than 8 million. These demographic changes warn of a coming crisis in the health care labor force: As the population ages, demand for health care services will rise dramatically, but there will be fewer workers aged 16 to 64 to meet that demand. The field of HIV medicine is no exception with a large population of “graying” HIV care and treatment providers. As the U.S. HIV epidemic increases at a rate of 56,300 new infections per year,



there will be a steady increase in demand for HIV care and treatment services – coupled with care and treatment for HIV coinfection with the hepatitis B virus (HBV) and/or the hepatitis C virus (HCV).

One ongoing solution to the U.S. health worker shortage has been to encourage immigration of health workers from lower-income countries, thus introducing brain drain and subsequent health care delivery challenges in those countries with their own existing health worker shortages. In addition, task shifting (or the redistribution of specific clinical and non-clinical tasks from professional to non-professional cadres of health workers) has regrettably not been implemented to its full effect as a strategy for both addressing stresses on the health care labor force or containing costs. Community health workers (CHWs) carried out many Great Society programs in the United States in the 1960s and 1970s. Volunteer and paid CHWs worked as lay home visitors or health guides in programs with target populations, such as pregnant women or parenting families. Other CHW programs in the United States targeted Navajo communities, urban health centers, and rural communities. Since then, only a handful of states have successfully implemented state-wide CHW programs; yet the potential for nationwide scale-up of CHW programs could help to alleviate some of the strain on the health care labor force as well as help to contain costs.

RECOMMENDATION: IAPAC advocates a federally funded mandate to significantly increase the number of U.S. citizens attending/graduating from medical, nursing, allied, and vocational health profession schools, and encourages incentives for clinicians to specialize in critical fields of medicine, including HIV medicine, with perhaps additional incentive for establishing and/or practicing HIV medicine in inner-city or rural settings. Within the context of respecting the human right to migration, IAPAC also supports a national moratorium on active recruitment of health workers from countries already suffering health labor force shortages – of which the World Health Organization has listed 38 countries saddled with such shortages and burdened with public health emergencies (e.g., HIV/AIDS, tuberculosis, malaria) – until such time as a global resolution is negotiated between recipient nations and those nations most negatively affected by outward migration of highly skilled labor, including health care labor. In addition, IAPAC encourages a national investment in a CHW Corps to address gaps in health literacy and promotion, as well as health care delivery ranging from prevention to care and treatment services – both HIV- and non-HIV-related.

- **Reinventing “Community.”** Alongside the U.S. government’s response, the community response to HIV/AIDS must increase, stimulated by the work of local and national nongovernmental organizations (NGOs), faith-based organizations (FBOs), and community-based organizations (CBOs). Many of these organizations – which have historically played an important, and often catalyzing role – in addressing the needs of people living with HIV/AIDS, are squeezed by financial constraints while attempting to offer services to a growing number of clients. They require revitalization, resources, and as important a renewed sense that they are a part of the solution.

Beyond strengthening these organizations, however, a national sense of community must be instilled so that HIV/AIDS, by virtue of its changed face (mostly medically indigent, disenfranchised people of color), does not once more become a disease that affects “others.” President Barack Obama has a unique opportunity, just having completed one of the most inclusive campaigns in history, to embrace our nation’s most vulnerable individuals and



foster in the broader U.S. population a sense of camaraderie with people living with and at risk for HIV/AIDS.

RECOMMENDATION: IAPAC encourages an increased role for NGOs, FBOs, and CBOs in addressing the myriad challenges the United States faces in addressing its HIV epidemic, thus ensuring the country's response is not government-centered/focused. We support "revitalization grants" directed toward these non-profit institutions, albeit with accountability safeguards, so that they may remain both viable and responsive to the growing needs of both HIV-affected and at-risk communities. In addition, IAPAC advises President Obama consider broadcasting a "fire-side chat" with the American people, during which he may address some of the many health care-related challenges facing the United States, including that of HIV/AIDS, and issue a national call to action in support of universal access to health care, and related health care-related plans, including one to combat global HIV/AIDS.

International

- **Universal Access.** The United States – through its many years of targeted development and humanitarian assistance to middle- and low-income countries and its most recent investment of \$15 billion through the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) – is a recognized leader in the global battle against HIV/AIDS. Yet, despite its leadership and significant financial and human resource investments, the world remains considerably shy of the United Nation's goal of achieving universal access to HIV prevention, care, and treatment by 2010 (hereafter referred to as Universal Access). Weak health systems and, in particular, a critical shortage of health care personnel are among numerous factors threatening efforts to achieve Universal Access, as well as broader targets such as the health-related Millennium Development Goals (MDGs).

What persists in most low-income countries, but especially in sub-Saharan Africa, and is worsening as a consequence of the impact of HIV/AIDS, are constraints relating to organizational and human resource capacity. These are evident in the various evaluations of existing activities, and from other reports that exist on progress with national responses to HIV epidemics. Their conclusions can be summarized as follows:

- problems with implementing national plans due to human resource constraints which have unduly delayed national responses;
- the need to transform public services so as to improve performance at all levels, through systemic reforms that include action to raise the quality of human resources which are seen as limiting policy development and program implementation; and
- a lack of capacity in implementing agencies for national responses to HIV/AIDS (e.g., NGOs, CBOs) where many necessary skills and capabilities need to be strengthened if targets are to be attained.

While U.S.-led/-sponsored/-funded attempts have been made to strengthen health systems in many low-income countries – including those benefiting from PEPFAR funding – these attempts have unfolded in ways that, at worse, compromised already stretched health systems and, at best, served to strengthen health systems in the process. There subsequently exist incredible tensions as, for instance, the delivery of antiretroviral therapy inevitably emphasizes a medical model focus instead of an approach that embraces broader determinants of health as envisaged by primary health care.



With respect to health labor force shortages, herein lies perhaps one of the biggest roadblocks to ensuring that even if Universal Access is not achieved by 2010, many more of the currently estimated 6.9 million people living with HIV/AIDS in middle- and low-income countries who are clinically eligible may gain access to antiretroviral therapy. There are too few physicians, too few nurses, and too few allied health workers to scale-up access to HIV prevention, care, and treatment immediately, much less Universal Access by 2010. In addition, most low-income countries governments facing human resource shortages have neglected to implement evidence-based solutions, including that of task shifting from professional health workers to non-professional health workers (e.g., CHWs) – the implementation of which would immediately help to facilitate scale-up of HIV prevention, care, and treatment services.

Potential solutions to the health labor force shortage crisis can be thus categorized:

- Expansion of human resource capacity
 - Invest in training greater numbers of health and social service workers
 - Introduce pre-service training and expand in-service training to replenish, empower, and better equip service providers
 - Accept task shifting from more to less-specialized health workers
- Retention/recruitment of human resources
 - Institute policy changes, codes of practice, and ethical guidelines to minimize migration of health workers from low- to high-income countries, and from public health systems to private sector programs, including HIV programs
 - Improve the workplace environment (e.g., occupational health safeguards), and support staff and families living with HIV/AIDS through access to treatment, job security, protection against discrimination, and social benefits
 - Offer financial and non-financial incentives (e.g., housing and education allowances, career development and training opportunities) for service in public health and social systems or in underserved areas

RECOMMENDATION: IAPAC advocates a more strategic U.S. engagement in health systems strengthening to include cognizance of health system targets. We further propose a proactive approach through which national HIV/AIDS programs and global health initiatives (e.g., PEPFAR) would be held accountable for not only minimizing harm to health systems, but also for health system frameworks. With respect to human resources, IAPAC encourages adoption of the potential solutions outlined above with an aim toward expanding human resource capacity, as well retaining existing and recruiting additional human resources.

- **PEPFAR.** Since 2003, the United States has achieved notable HIV prevention, care, and treatment objectives in 15 African and two Latin American countries through PEPFAR – including placing 2.1 million people living with HIV/AIDS on antiretroviral therapy. Its reauthorization in 2008 presents a unique opportunity to consider important revisions to



PEPFAR so that deficiencies noted during the past five years, as well as “best practices” learned through in-country implementation of PEPFAR-funded HIV prevention, care, and treatment programs, inform PEPFAR’s future direction and thus favorably contributes to achieving HIV-related objectives/targets (its own, Universal Access, and the MDGs), as well as national HIV/AIDS plans which include, among other priorities, increased outreach to vulnerable individuals (e.g., women and children) and marginalized populations (e.g., injection drug users, commercial sex workers, men who have sex with men).

In addition, with its reauthorization and subsequent setting of even more ambitious HIV prevention, care, and treatment objectives/targets, many PEPFAR prime partners as well as sub-partners have reached or are close to reaching capacity for delivering existing (funded) levels of HIV prevention, care, and treatment delivery. This may necessitate a review by the Office of the Global AIDS Coordinator (OGAC) to determine whether existing prime partners and sub-partners are capable of absorbing additional government funding and/or expanding their scopes of work to accommodate more ambitious HIV prevention, care, and treatment objectives/targets, or whether additional academic institutions, non-profit and faith-based organizations, and commercial companies may need to be folded into the existing mix of PEPFAR partners.

RECOMMENDATION: IAPAC endorses three IOM recommendations to realign PEPFAR so that it better reflects its current/needed role: 1) execute a transition from emergency relief to long-term strategic planning and capacity building for a sustainable response; 2) address long-term factors that underlie the HIV epidemics in each beneficiary country (e.g., emphasizing and enhancing prevention, empowering women and girls by supporting improvements in their legal, economic, educational, and social status); 3) expand, improve, and integrate HIV prevention, care, and treatment as well as orphan and vulnerable children services, and increase attention to marginalized populations including commercial sex workers, IDUs, MSM, and incarcerated individuals. In addition, IAPAC recommends OGAC conduct a review of its current roster of prime partners and sub-partners to ensure their capacity to deliver upon existing (funded) and future PEPFAR-funded programs, and a concurrent review of additional academic institutions, non-profit and faith-based organizations, and commercial companies that could be called upon to serve as PEPFAR partners.

- **Antiretroviral Therapy.** While scale-up of access to antiretroviral therapy in the developing world is certainly to be applauded, it is important to note that the daunting challenges of lifetime antiretroviral therapy in the developed world (e.g., prolonged treatment adherence, co-morbidities, rising mortality from non-HIV health problems) are also of paramount importance to the future of HIV in the developing world, and an important dimension of strategies for their successful management in the developed world will be their potential applicability to the same problems in developing countries.

One issue that merits mention is the ubiquity of thymidine analogues, and stavudine (d4T) in particular, in first-line antiretroviral regimens in the developing world. The inevitable rise in peripheral neuropathy and peripheral lipoatrophy is already being described, thus rapid access to second-line drugs that lack these toxicities is a growing priority. Of note, with a steady rise in treatment failure due to clinical or immunological failure and toxicity, access to second-line treatments is an even more enormous challenge to lifetime antiretroviral therapy in the developing world. At present, access to one or more ritonavir-boosted protease



inhibitors and second-line nucleoside analogues is the first priority, but in future, access to other new antiretroviral classes and drugs will also be needed.

First among the unique obstacles facing people living with HIV/AIDS and their physicians in the developing world are HIV stigma and discrimination. An environment of tolerance in which to take an HIV test and live with an HIV diagnosis is of paramount importance to effective national and local HIV prevention, care, and treatment programs. Similarly, health professionals bear the responsibility of ensuring compassionate and non-judgmental care from health workers.

Access to simple, basic information for HIV prevention and HIV testing is another important challenge for lifetime antiretroviral therapy. It is estimated that only 20% of the world's population has access to needed HIV prevention information and voluntary counseling and testing (VCT). There is clear evidence that more people seek VCT when it is more accessible and convenient, and when care and treatment are available to people whom test HIV positive.

Unfortunately, the evolution of care and treatment for women and children in the developing world has mirrored the inequities in the North. Less than one-quarter of clinically eligible pregnant women and children have access to antiretroviral therapy. Several programmatic obstacles must be overcome to address this problem, including access to pediatric formulations, rapid HIV testing for all pregnant women, training for clinicians in pediatric care and pediatric dosing of antiretroviral therapy, DNA testing for infants born to HIV-positive women, and reproductive counseling, including breast-feeding counseling, for HIV-positive women.

Although 10% of HIV in the world is acquired through injection drug use, less than 1% of people living with HIV/AIDS who are on antiretroviral therapy in the world are IDUs. It is nearly impossible for a single clinician to effectively manage HIV infection in an IDU without a supportive local and national environment that includes harm reduction, counseling and treatment for chemical dependency and non-judgmental care for the individual and his or her family. Stigma reduction efforts in countries with high rates of injection drug use must include improved tolerance toward drug use and support for harm reduction strategies, as well as HIV stigma reduction efforts.

Although morbidity and mortality from non-HIV conditions are rising in the developing world, the main causes of death continue to be related to opportunistic infections, and tuberculosis is the most common among them. While first-year mortality on antiretroviral therapy in the developed world is 2% to 3%, it is 5% to 15% in the developing world. Among the many reasons for the greater mortality in the developing world are the higher prevalence of diseases such as tuberculosis, malaria, and infectious diarrhea; the greater prevalence of malnutrition and anemia; and limitations in the individual health care systems.

Finally, it is likely that a higher incidence of immune reconstitution disease also contributes to the greater mortality: the average CD4 count at which antiretroviral therapy is started is below 100 cells/mm³ in many sub-Saharan African countries, and immune reconstitution inflammatory syndrome (IRIS) is more common when ART is started at CD4 counts below 100 cells/mm³. Earlier diagnosis of HIV is one key strategy to reducing this early mortality. Others include greater access to primary and preventive health care, improved nutrition and maternal-child health and better tuberculosis detection and treatment.



RECOMMENDATION: IAPAC encourages an immediate transition from a public health emergency approach to a long-term clinical management approach (or a combination thereof) in countries where large numbers of HIV-positive individuals are currently on antiretroviral therapy. The long-term clinical management approach must take into consideration treatment-associated clinical, social, and other challenges related to lifetime antiretroviral therapy, and be predicated on a human rights platform that demands all individuals, including those most vulnerable (e.g., children) and the marginalized (e.g., IDUs), benefit from equitable access to antiretroviral therapy and supportive services. Among the many ways to address the existing inequitable access to antiretroviral therapy, IAPAC thus advocates mandated investments in the development of pediatric formulations of antiretroviral drugs, full inclusion of harm reduction interventions in antiretroviral therapy programs, resources in addition to not in lieu of HIV/AIDS-specific funding to address co-morbidities (e.g., tuberculosis), and an even greater financial and programmatic emphasis on early diagnosis of HIV infection with appropriate linkages to HIV care and treatment.

- **HIV Prevention.** On a societal level, HIV care and treatment cannot succeed separately from prevention. Because the success or failure of HIV prevention efforts will be a critical determinant of future treatment needs, universal access to effective HIV prevention must be a core element of a global response to HIV/AIDS, meaning that HIV prevention and HIV care and treatment must be scaled up simultaneously and together. Greater access to antiretroviral therapy reinforces prevention through increased testing, which can contribute to a reduction in stigma and discrimination. Many countries have made laudable progress in expanding treatment access continue to lag in their HIV prevention efforts, however, in large part because prevention requires dealing with subjects such as homosexuality, sex work, and illicit drugs. Far greater investment in prevention programs and commodities, informed by evidence, will be key to closing the antiretroviral therapy access gap and, as important, to stemming the tide of new HIV infections.

RECOMMENDATION: IAPAC recommends a significant investment of human and financial resources to scale up HIV prevention activities in the developing world, based upon scientific evidence, as well as internationally agreed upon policy statements, including UNAIDS's "Intensifying HIV Prevention." In addition, and as stated in the PEPFAR section above, PEPFAR must expand, improve, and integrate HIV prevention, care, and treatment among marginalized populations including commercial sex workers, IDUs, MSM, and incarcerated individuals.

Global

- **Global HIV/AIDS Summit Meeting.** As the most powerful democratic country in the world, the United States should try to convince all other democratic countries, both developed and developing, to pay increased attention to and allocate larger budgets to address HIV/AIDS in their own countries and around the world. For example, countries such as China, Japan, and Singapore should invest more money in HIV research, and should provide greater financial support for HIV prevention, care, and treatment in the developing world. At the same time, the governments of low- and middle-income countries should allocate more of their internal resources to fund HIV prevention, care, and treatment in their own countries so as to lessen their long-term dependency upon development and humanitarian assistance mechanisms such as PEPFAR and the Global Fund.



RECOMMENDATION: IAPAC recommends the Obama-Biden Administration host a Global HIV/AIDS Summit meeting, during which President Obama may call for action from all Heads of State, since political commitment and will has in the past proven to be key to achieving any meaningful and sustainable progress (e.g., PEPFAR). In addition, IAPAC requests that with every state visit he makes, President Obama enquire about HIV/AIDS in that country so that he reinforces a mutual commitment shared by the United States and the country in question to stemming the tide of new HIV infections, providing HIV care and treatment to those already infected, and investing resources toward health system improvements, human resource capacity, and other national and international priorities deemed necessary to achieve Universal Access, the MDGs, and, ultimately, a cure for and the eventual eradication of HIV/AIDS.

In closing, I wish to acknowledge the members of the IAPAC Public Policy Advisory Board who contributed invaluable elements to this document (all IAPAC physician-members): Drs. John G. Bartlett (United States), Bernard Hirschel (Switzerland), Rafael Mazin (United States), Jean Nachega (South Africa), Renslow Sherer (United States), and Praphan Phanuphak (Thailand). And, I wish to reiterate my gratitude to the Obama-Biden Presidential Transition Team for inviting IAPAC to engage in dialogue with you regarding domestic and international recommendations for the U.S. response to the global HIV pandemic.

Warmest regards,

José M. Zuniga
President/CEO