

Have we forgotten about HIV?

The AIDS conference in Montreal in July and August of this year was a welcome change from the ‘meetings’ of the past 2 years, with plenty of in-person attendance as a combination of changing epidemiology and vaccines lessened COVID-19’s impact. It was not without controversy though, with many important participants – all from the global south – denied visas to enter Canada, weakening potential impact and advocacy.

That aside – and this needs urgently to be addressed – as we approach World AIDS Day in December, I am wondering, have we forgotten about HIV? According to the latest UNAIDS report,^[1] progress in prevention and treatment is stalling around the world. Eastern Europe, central Asia, Latin America, the Middle East and North Africa have all seen annual increases in infections over several years. In Asia and the Pacific, new HIV infections are now rising, where they were falling. The chances of reaching the 2030 goal to end AIDS is slim. Every 2 minutes in 2021, an adolescent girl or young woman was newly infected with HIV. New infections are now hitting key populations particularly hard, with women and girls accounting for 49% of all new infections in 2021. And funding is falling, just when it is needed most – development assistance for HIV from donors, except the USA, has fallen by 57% over the last decade. As the current monkeypox epidemic is showing, the global north ignores what is happening elsewhere at its peril.

But probably the most important message from Montreal was around primary prevention of HIV – pre-exposure prophylaxis (PrEP). Oral PrEP is well-established, although not enough people use it, and there is now a vaginal ring available as well. However, the most exciting development in prevention is the long-acting intramuscular injection, cabotegravir. This is now part of the World Health Organization’s guidelines for PrEP, although currently likely to be too expensive for use in the global south – antiretrovirals all over again. I hope that price cuts will not take as long to reach us as they did with antiretrovirals. Already, South African researchers have produced models showing that the drug needs to cost no more than USD15 per injection in low-coverage conditions, and USD9 per injection in conditions of high coverage, if it is going to be cost-

effective compared with oral PrEP.^[2] A long-acting injection has major advantages over oral PrEP. People at high risk of HIV infection do not have to remember to take a pill every day, or women to insert a vaginal ring, which may lead to conflict with sexual partners. A long-acting injection is discreet and can be provided for vulnerable women easily as part of long-acting injectable contraceptive injections.

We need policies, programmes and investments by all governments to ensure that the available prevention options are equitably available and easily accessible. So far, too few have taken up oral PrEP, which has been around for 10 years.^[3] There is a lack of political and societal will to advocate for these options for HIV, which still carries enormous stigma. There is still unacceptable judgement around sexually transmitted infections, and many African countries’ draconian anti-gay and trans sexuality legislation simply reinforces this.

It is not enough to say that those living with HIV can go on treatment. Although more and more people in Africa can now access and remain on antiretrovirals, this is not a solution when there are proven biomedical solutions to preventing HIV infection, feasible choices for people who need and want them. We need to advocate for this choice.



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1. UNAIDS. UNAIDS Global AIDS Update 2022. <https://www.unaids.org/en/resources/documents/2022/in-danger-global-aids-update> (accessed 5 September 2022).
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3. AVAC. Message from Montreal: which way will we go? AVAC, 28 July 2022. <https://www.avac.org/blog/message-from-montreal> (accessed 5 September 2022).

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