IFMSA Policy Document
HIV and AIDS response

Proposed by the Team of Officials
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Policy Statement

Introduction:
HIV is known as the human immunodeficiency virus, a virus that is transmitted through specific body fluids and dwells in the immune system which results in progressive degradation of the body's immune system. Without intervention, HIV can lead to a state known as acquired immunodeficiency syndrome (AIDS), characterised by opportunistic infections. To date, there is no cure for the infection, despite the outstanding life expectancy outcomes of antiretrovirals (ARTs), so public health efforts have been focusing on primary prevention and harm-reduction strategies. However, many socioeconomic and cultural barriers still limit access to ARTs and HIV screening, slowing down our fight against HIV and AIDS.

IFMSA position:
The IFMSA acknowledges the seriousness of the global HIV and AIDS pandemic and the necessity for a coordinated multisectoral response, in order to improve healthcare access and health outcomes of people living with HIV. The IFMSA believes that, in addition to medical, economical and logistical considerations, the response needs to adequately address sociocultural issues related to HIV, including discrimination and stigma.Moreover, the IFMSA has identified key populations, barriers and measures to emphasize on in order to work towards our common objective of eliminating HIV and AIDS in the foreseeable future.

Call to Action
IFMSA calls for Governments and Policy makers to:
• Invest the financial and human resources needed for research and development of national strategies to eradicate HIV and AIDS.
• Implement evidence-based prevention strategies, such as Pre-exposure prophylaxis and harm reduction, and empower existing ones including comprehensive sexuality education.
• Ensure equitable access to antiretroviral treatment for all people living with HIV and AIDS.
• Ensure basic legislation that outlaws discrimination in work and healthcare systems is in place.
• Assess the local and regional needs of people living with HIV and AIDS and ensure democratic participation of key populations and social minorities in the policy making process.

IFMSA calls for Non-governmental Organizations to:
• Organize workshops and projects to equip communities with the skills and capacity needed to empower, show support and interact with people living with HIV as well as ensure that every community remains a safe space for members living with HIV and AIDS.
• Engage in HIV health and rights populational and peer-to-peer education by collaborating with advocacy and community groups from a stigma-free, sex positive and human rights-based approach.
• Collaborate and advocate with stakeholders in government and non-state actors working on projects that promote the HIV and AIDS response as well as participate in the global health strategy envisioned by the 2030 Sustainable Development Agenda which includes ending AIDS as one of its targets.
• Advocate against laws that limit access to health services and workplace opportunities for people living with HIV and AIDS.
• Actively participate in World AIDS Day, and other HIV and AIDS-specific campaigns.

IFMSA calls for Healthcare providers to:

• Offer services free of stigma and discrimination towards people living with HIV and AIDS by avoiding discriminating behaviour both inside and outside the work environment.
• Be mindful of their attitude, approach and language regarding HIV, AIDS and people living with HIV in clinical settings and also in their personal lives to ensure that they do not have a negative influence on the layperson's mentality towards the subject
• Advocate against laws that limit access to health services and workplace opportunities for people living with HIV and AIDS.
• Include a multidisciplinary and intersectional approach when caring for people living with HIV and AIDS that adequately addresses their medical and social needs.

IFMSA calls for Medical schools to:
• Expand the medical curriculum to include HIV and AIDS science and sociology, including the social determinants of health, human rights-based approaches and patient centered care relating to people living with HIV and AIDS as well as assess students' competencies and attitudes in addressing issues related to HIV and AIDS stigma and discrimination.
• Provide teaching moments for both students and staff to advocate and educate peers on HIV and AIDS science and sociology.
• Ensure a safe on-campus environment for people living with HIV and AIDS by educating the academic community and/or affirming stigma-free strategies in codes of conduct, institutional bylaws and other internal policies.
• Provide faculty development programs that prepare current personnel of all work fields, including medical, teaching and logistical staff, to address issues relating to HIV and AIDS discrimination and stigma in a sensitive manner.
• Promote HIV community and advocacy groups by supporting lectures, seminars and activities related to the subject.

IFMSA calls for Medical students to:
• Deepen their understanding of medical and sociocultural issues relating to HIV and AIDS, including stigma and discrimination, key populations and UNAIDS (United Nations Programme on HIV and AIDS) Fast Track Targets that aim to end AIDS by 2030.
• Participate in HIV and AIDS research, including but not limited to HIV and AIDS prevention, treatment and addressing stigma.
• Dissipate misinformation related to HIV and AIDS in healthcare and education settings and play an active role in reducing and challenging discrimination related to HIV and AIDS.
• Advocate for comprehensive medical education on HIV and AIDS issues.
• Plan and engage in programs and campaigns that aim to, among other means of prevention measures, end stigma and discrimination towards people living with HIV at the local, national and international level.
• Empower and communicate respectfully, sensitively and without judgement with people living with HIV and AIDS at all times.

Position Papers

Background information

The HIV and AIDS pandemic represents one of the most important global health challenges in modern history. For over 30 years, progress has been made towards the prevention, treatment and design of strategies to eradicate the virus. When used optimally, combination antiretroviral therapy (ART) has proven to effectively control HIV replication, prevent the development of AIDS, prolong life and reduce transmission risk. Despite this undeniable success, the fight towards eradicating HIV continues to face many challenges, especially in terms of societal approach towards the issue.

One such challenge is stigma. HIV-related stigma encompasses negative beliefs attitudes towards people living with HIV, including their families and healthcare providers. Some of the key populations affected by HIV include MSM individuals, people who inject drugs, people in prisons and other closed settings, sex workers and transgender people, which are particularly vulnerable towards HIV discrimination in addition to the stigmas attached to their respective conditions [1]. These marginalized groups are less likely to seek medical attention which in turn leads to unfavorable outcomes in infection control at the individual and societal level [2].

HIV-related stigma has declined across the world since the beginning of the 21st century, but it remains high in several countries. Data from the Stigma Index research study that has been carried out in Germany, Greece, Portugal and the state of Michigan in the United States indicate that more than one in 10 people living with HIV have experienced at least one form of stigma and discrimination in healthcare [3]. Outside of healthcare settings, stigma is also prevalent - in several Latin American countries, for example, at least 33% of men and women (aged 15–49 years) said they would not buy vegetables from a shopkeeper who is living with HIV [4]. Consequently, bridging the gap in HIV detection and perception has to start with population education on the infection.

Some other barriers that are complicating the continuous battle against HIV and AIDS are economic and logistical challenges in delivering lifelong treatment for the over 35 million people currently living with HIV, with lifelong adherence remaining challenging for many individuals [5]. This warrants increased emphasis on public health measures as well as governmental involvement towards rendering treatment accessible.

According to the most current statistics of 2017, approximately 37 million people are living with HIV, with 1.8 million new cases reported in 2017. Moreover, 75% of all people living with HIV know their HIV status, while 79% of all people living with HIV who know their status have access to treatment, and 81% of all people on HIV antiretroviral treatment are virally suppressed [6].

In 2017, almost 22 million people living with HIV had access to antiretroviral therapy, up from 8 million in 2010, while some short of 1 million people died during the year from HIV and AIDS-related complications. 77 million people have become seropositive with HIV since the start of the epidemic and 35 millions of them have died from HIV and AIDS-related complications. 80% of seropositive pregnant women have access to antiretroviral medication to prevent mother-to-child transmission of HIV [6].

Discussion

Human Rights for HIV:
Stigma and discrimination related to HIV is still preventing millions to accessing the testing, prevention and treatment services [7]. Evidence suggests that this stigma and discrimination, especially in clinical settings, are limits towards accessing the HIV testing as well as limits to the serostatus disclosure, retention in care and uptake of and adherence to antiretroviral therapy (ART) [7].

The human rights principles of non-discrimination, equality, participation, access to justice and accountability play an important role towards achieving a significant response to HIV and AIDS [8]. In 2016 at the High-Level Meeting on ending AIDS by 2030 it was noted upon the call for member states that "Using the language and power of human rights, people living with HIV and human rights defenders have secured important legal and judicial victories against HIV-related discrimination and human rights violations" [9]. The statement additionally reaffirmed that access to medicines was increased as well as law changes and inclusion of human rights programs related to HIV as a result of the perseverance of the people living with HIV as well as human rights defenders. Moreover, it highlights the importance of the meaningful participation of both key populations and civil society advocates for human rights [9].

Identifying key populations:

According to the United Nations Program on HIV/AIDS (UNAIDS), key populations are understood as "groups who, due to specific higher-risk behaviours, are at increased risk of acquiring HIV" [2].

Half of all new HIV infections are among key populations and their partners because these groups often have legal and socio-economic barriers that increase their vulnerability to HIV in all countries and settings. It is important to note that many individuals can relate to more than one key population, increasing their vulnerability. Therefore, prevention strategies require putting key populations at the forefront of the discussions [2].

Key populations include but are not limited to:

- Men who have sex with men (MSM)

The term MSM refers to a man of any age who engages in sexual or romantic intercourse with other men. As the terms "men" and "sex" vary through time and cultures, the term MSM encompasses a wide variety of sexual orientations and gender identities, involving people who identify as homosexual, bisexual, transgender and heterosexual among others [10]. Globally, MSM are disproportionately impacted by HIV, with the global HIV prevalence among this group in major urban areas 13 times greater, on average, than in the general population. Furthermore, the incidence of HIV among MSM is rising in several parts of the world, accounting for 41% of new HIV infections in Western Europe in 2011 [11]. At-risk sexual behaviours such as unprotected receptive anal intercourse, high number of partners, sex on drugs and concomitant injection drug use are thought to explain these numbers but social and psychological aspects specific to this population also need to be taken into account [11].

- People who inject drugs

People who inject drugs are among the most susceptible to acquire HIV, accounting for 10% of new HIV infections globally and almost 30% outside of Sub-Saharan Africa, especially in Eastern Europe and Central Asia, highlighting the importance of regional prevention strategies in addressing HIV in this population [2]. This vulnerability is particularly due to factors such as needle and injection equipment sharing as well as criminalisation, marginalisation and poverty build up this risk and constitute barriers to proper care access [11]. Moreover, decriminalisation of drug use might be an effective approach, as

shown by the decline of HIV new infections in people who use drugs in Portugal after such a law was implemented [2].

- Sex workers

Sex workers are defined as “female, male and transgender adults (18 years of age and above) who receive money or goods in exchange for sexual services, either regularly or occasionally”. Sex work must be consensual and take place between adults, to differentiate it from “sexual exploitation” [12]. It is estimated that sex workers are 13 times more likely to acquire HIV than adults in the general population [13]. However, this rate varies significantly among regions, reaching a prevalence of almost 50% in some countries of eastern and southern Africa [11]. This vulnerability to HIV transmission is due to universal issues of stigma and discrimination, concomitant drug use, higher-risk sexual behaviours and mobility and human trafficking [11]. However, sex workers have been shown to be one of the groups to best respond to HIV prevention programs, especially when they are sex-worker-led and community-based, as seen in initiatives in countries like Cambodia, the Dominican Republic, India and Thailand [11].

- Transgender people

A systematic review and meta-analysis found a pooled HIV prevalence of 19% among transgender women in the 15 countries with available data, odds almost 50 times greater than the general population [14]. Many studies have demonstrated multiple co-occurring health problems among transgender women, including high rates of violence and victimization, substance use, sexual abuse and assault, and depression with impulsive behaviours. This is associated with structural and social inequalities including but not limited to stigma and discrimination, lack of access to identity documents that match gender expression, high prevalence of underemployment, street-based sex work with low pay and no legal protections, homelessness and lack of access to health services [15]. Moreover, transgender women who seek psychological affirmation of their gender from partners may be more willing to have unprotected sex [16]. According to World Health Organisation’s policy brief, “Respondents to a qualitative study on the values and preferences of transgender people with regard to HIV noted that many transgender people prioritize access to and use of hormone therapy over HIV care and treatment. Therefore, access to hormone therapy is an important entry point into HIV care and treatment for transgender people” [16].

- People in prisons and other closed settings

There are more than 30 million men and women in prisons worldwide and other closed settings, including those in pre-trial detention [17], and an estimated 3% of them live with HIV [18]. This risk is imputable to overcrowding, poor nutrition, limited access to health care and ARTs, unsafe injecting practices, unprotected sex and tattooing. Because of the illegality of sex work, drug use, and same-sex behaviour in many countries, many people from other key populations also populate prisons. In addition, settings with forced gender segregation are important contexts for sexual activity between males not linked to homosexual identification. Recommended HIV prevention and treatment services are usually unavailable in prison settings as about 5% of countries have syringe programs in prisons, as condoms are available in the prisons of only 28 countries [18].

- Migrants and mobile populations (MMPs)

The UNAIDS 2016-2021 Strategy: On the Fast-Track to Ending AIDS identifies the ever-rising number of migrants, refugees and crisis-affected populations for urgent action across the entire spectrum of human rights including civil, cultural, economic, political, social, sexual and reproductive rights [19]. While not all MMPs are at increased risk of HIV as a result of their mobility, in many contexts, they are highly exposed to a general lack of access to health services, information, employment opportunities and socioeconomic stability, often as a result of discrimination and social exclusion. Migrants may acquire HIV in their country of destination or while in transit and face specific vulnerability to HIV related

to their status as a migrant. In South-East Asia, it was noted that the HIV prevalence among the populations of migrants to Thailand from Cambodia, Myanmar, southern China and Vietnam is up to four times the HIV prevalence among the general population [5]. Moreover, in conflicts, emergencies and post-conflict periods, women and girls are at heightened vulnerability to HIV, particularly in settings where rape is used as a weapon of war [20].

- Adolescents and young people

The term adolescence refers to all people aged 10 to 19, and it is a period of physical, cognitive, emotional and psychosocial development of critical importance, as many adult-life health outcomes are determined during this stage of life [21]. Thus, adolescents are placed in a particularly vulnerable position when it comes to HIV acquisition, where according to UNAIDS, it is estimated that out of 36.7 million people living with HIV at the end of 2016, over 2 million belonged to this group [22]. This is due to unmet needs for comprehensive sexuality education, as well as the result of the lack of youth-friendly services in healthcare settings. Adolescents living with HIV require special support to stay linked to care and to ensure treatment adherence, but the lack of effective services has translated into an increase of 50% of the AIDS-related deaths among adolescents globally since 2000, which deeply contrasts with the broad decrease among the general population [22].

Identifying Barriers

- Socioeconomic barriers

On multiple levels HIV is an issue that is associated with social and economic inequity, as it affects those of lower socioeconomic status at a disproportionately high rate, oftentimes secondary to limited access to healthcare resources such as clinics and prevention programs [23]. Furthermore, socioeconomic status is a key factor in determining the quality of life for individuals after they are affected by the virus . A 2013 systematic review also showed that income, level of education, and employment/occupational status were significantly and positively associated with the level of adherence [24]. Of note, inversely, HIV status also has an effect on socioeconomic status with stigma often resulting in dismal employment perspectives [25].

- Cultural and religious barriers

Community-level stigma remains a very powerful vector towards increasing the vulnerability of marginalized social groups in the face of HIV. These groups are at risk for loss of income and livelihood, poor care within the health sector, withdrawal of caregiving at home, poor social and emotional health due to harassment and ill-treatment and high-risk behaviours [26]. As discussions about sex and sex education as a whole remain taboo in many countries, adequate platforms to learn about sexual health and gather information around STIs such as HIV are still out of reach, perpetuating the negative outcomes of the infection. As such, community leaders need to be involved in social initiatives raising awareness on HIV and AIDS as well as paving the way for a more open and welcoming community space.

- Legal barriers

According to a publication of HIV Justice Network, “In many instances, HIV criminalisation laws are exceedingly imprecise – either in their explicit wording, or in the way they have been interpreted and applied – making people living with HIV (and those perceived by authorities to be at risk of HIV) extremely vulnerable to a wide range of human rights violations” [27]. HIV criminalisation describes this unjust application of the criminal law to people living with HIV based solely on their HIV status. Since HIV infection is now a chronic, treatable health condition, it is inappropriate for criminal prosecution related to HIV non-disclosure, exposure or transmission to involve charges such as “murder”, “manslaughter”, “attempted murder”, “assault with a deadly weapon” or “aggravated assault”. Nonetheless, the HIV Justice Network analysis shows that a total of 72 countries have adopted laws that specifically allow for HIV criminalisation and prosecutions have now been reported in 61 countries, either under HIV criminalisation laws or general criminal or public health laws [27].

- Gender barriers

Gender inequalities and gender-based violence continue to exacerbate women and girls' vulnerability to HIV and block their access to HIV services. Intimate partner violence, inequitable laws and harmful traditional practices reinforce unequal gender power dynamics by limiting women's choices, opportunities and access to information, health, social services, education and employment. In 146 countries, laws allow girls under 18 to marry with the consent of their parents, while in 52 countries, the same applies to girls under 15 [28].

Directing the Global HIV Response

In response to the HIV pandemic, international and public health institutions have worked together in developing global and local strategies to tackle the issue. This position paper outlines the core objectives and recommendations from the WHO and UNAIDS to be implemented nationally and locally in a state-sensitive way to strengthen the global HIV and AIDS response and reduce the burden of the infection.

The 90-90-90 Strategy

The 90-90-90 targets was launched by stakeholders in 2014 to set measurable goals in the HIV and AIDS response. The aim was to achieve the following goals by 2020 [29]:

· 90% of all people living with HIV will know their HIV status.
· 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy
· 90% of all people receiving antiretroviral therapy will have viral suppression.

This is part of the UNAIDS Fast Track commitments to end AIDS by 2030 [30] Despite various stakeholders' actions, the year 2020 is very close, and there is a general lack of exigency. This coupled with other complex contributing factors such as weak health systems, lack of funding, and other governmental priorities could potentially stall these crucial milestones and eventually be detrimental to ending the AIDS epidemic.

90% diagnosed

This target is hinged on the basis of making testing services available to asymptomatic people in the general public who are not aware of their status. The WHO recommends that HIV testing services should adhere to the proposed "5 Cs"; Consent, Confidentiality, Counseling, Correct Status, and Connections [31]. In many low and middle countries, the likelihood of all these conditions being strictly implemented is very low. Research has shown diagnostic statistics that range from 87% in the Netherlands to 11% in Yemen [32].

90% treated

Antiretroviral therapy (ART) has contributed to a revolutionary way in increasing life expectancy and reducing new infections and AIDS-related deaths, allowing great financial gains. This target focuses on improving equity, access, speed and early initiation of HIV treatment in order to achieve a better control of the infection [28].

90% virally suppressed

Viral suppression not only helps monitor the infection and the response to ARTs but is a valuable prevention tool as it is virtually impossible for individuals with an undetectable viral load to spread the infection. Viral suppression is dependent on adherence to ARTs, reason why key populations need better healthcare access, support and follow up on their viral load and overall health. [33].

- **WHO and Public Health Recommendations**

In order to scale up the current deficit AIDS response, especially with regards to key populations, the WHO has established a Comprehensive Package of Interventions recommended to assist countries with programming for HIV prevention and treatment. It has also established to this end target primary health interventions with relative concrete measures and goals set out for members, known as the Fast-Track targets for primary prevention.

The Comprehensive Package of Interventions [2]**:**

a) Essential health sector interventions

1. Comprehensive condom and lubricant programming
2. Harm reduction interventions for substance use, in particular needle and syringe programmes and opioid substitution therapy.
3. Behavioural interventions
4. HIV testing and counselling
5. HIV treatment and care
6. Prevention and management of co-infections and other comorbidities, including viral hepatitis, TB and mental health conditions
7. Sexual and reproductive health interventions.

b) Essential strategies for an enabling environment

1. Supportive legislation, policy and financial commitment, including decriminalization of behaviours of key populations
2. Addressing stigma and discrimination.
3. Community empowerment.
4. Addressing violence against people from key populations.

Five combinations of HIV prevention [34]**:**

- Combination prevention for adolescent girls, young women and their male partners in high-prevalence locations
- Combination prevention with key populations
- Comprehensive condom programs
- Voluntary medical circumcision and sexual and reproductive health services for men and boys in 14 countries
- Rapid introduction of pre-exposure prophylaxis

UNAIDS 2020 framework goals for primary prevention [34]**:**

- 90% coverage of prevention service packages for female sex workers, men who have sex with men, transgender people and prisoners.
- 40% coverage of opioid substitution therapy for people who inject drugs.
- 90% condom use at last sex among people with multiple partners.
- 30% coverage of cash transfers for adolescent girls in hyper-epidemic settings with low rates of secondary school enrolment.
- 90% voluntary medical male circumcision (focused on 10-29-year-old men in 14 priority countries).
- 10% pre-exposure prophylaxis (PrEP) for female sex workers, men who have sex with men, serodiscordant couples (in generalized epidemic countries) and for 15-24-year-old girls and women (in areas with >3% incidence in hyper-epidemic countries).
- 80% coverage of post-exposure prophylaxis for accidental exposure and victims of rape.

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