Tuesday!

Highlights and insights

What do girls want? This was the question posed by a panel-led discussion at AIDS2016 on Tuesday. The reality is that girls around the world face a host of cultural, political and economic barriers to good health and many suffer gender based violence (GBV) from both long term partners (and husbands) and in more casual relationships. In fact, women are 1.5 times more likely to acquire HIV if they experience gender based violence. Whilst there was of course talk of female empowerment, the panel encouragingly steered away from discussion what **girls** can do to combat the dual epidemic of HIV and GB - to what role the community and, specifically, men, play: "Don't tell us to raise our voices; some of us have been raising our voices for a very long time" exclaimed one female delegate.

Sweden's satellite pursued similar themes looking at male involvement for better access and equity in HIV. It confirmed an urgent need to engage and reach **men and adolescent boys** with evidence-informed HIV prevention and access to treatment and care services supported by age-, sex- and geographically disaggregated data. Dr Luiz Loures (UNAIDS deputy executive director) in his opening remarks, emphasised that male engagement is key to the gender gap in the region and also stressed that the dreams of the girls will not be realised if men are left behind in the HIV response. Khaya Mabuza (Swaziland, NERCHA) shared shared a graph illustrating the increasing incidence of new infections among adolescent girls as a result of intergenerational sex, which also emphasised the need of targeting and involving men in HIV response programmes. Rev Bafana Khumalo (Sonke) highlighted the importance of engaging faith based organisation to see improvement in HIV response.

There was high science and high excitement during the session on the **new evidence** explaining why young South African women have such high rates of infection. Presented by Caprisa in the style of a scientific detective story, it unravelled a set of interrelated pieces of research that throw light on the vexing situation of why 66.4% of 30-year old women in their northern KwaZulu Natal study were HIV-positive. The conclusion of the session was that only combination prevention will reduce HIV in young women – a combination of treatment-as-prevention, pre-exposure prophylaxis, male circumcision and programmes to change gender norms and empower women. Watch this space next week for a longer piece on this remarkable work…

South Africa is doing pretty well. **"Test and treat", or "test and start"** has become a reality - if reality is defined as a formal policy position. Clearly the scientific evidence of the benefits of early treatment have been seriously considered by policy makers. However, the implications of this massive roll-out or operationalisation of universal testing and treatment do not seem to be that clear. The financial

considerations are obviously a major concern, but importantly, a new set of demands are created as more and more people are put onto ART. Current modes of ARV dispensing and distribution need to be rethought - making it easier, quicker and cheaper for people to access their treatment. New innovative processes need to be put place to encourage adherence. Current good practices need to be considered for national scale-up – a prime example is perhaps the role of community health workers in the roll-out of test and treat, and then in supporting adherence in the long-term. Committing to international guidelines seems to be the simplest of action in the process of making test and start a reality. Operationalisation may, in the long-term, present the most challenges.

AIDS 2016 is also showcasing a lot of information about the provision **of PrEP to adolescents, youth and key populations** in southern and eastern Africa which simply was not available to most of us just a year ago. Similar to "test and treat", there is a mix of optimists and reluctant pessimists about the extent to which PrEP can protect our populations in the near future. However, it seems clear that PrEP can be a feasible and effective option for many people at risk, even if it is not appropriate technology for many others. As an activist reminded us, most of the pessimists point to factors which many thought would make ART impossible to introduce at scale in Africa. This gives us room for optimism. However, providers and users of PrEP are pointing again to obstacles in areas that have tripped up our treatment, prevention and SRH programs since the start of the family planning and HIV responses. So they re-emphasise factors such as the need to provide user friendly services, particularly for youth and key populations, that respond to their diverse needs and contexts. They also highlight the need to make sure that users and communities are well informed and adequately mobilised. There are promising signs that PrEP technology, such as longer acting injectables, may evolve relatively fast. But some of these other factors will require sustained, dogged strengthening of community and health systems.

Funders of programmes for key populations are increasingly relying on robust and credible size estimates in order to resource and programme appropriate HIV prevention interventions. Criminalization of MSM and sex workers, compounded by disabling legislation and human rights violations, seriously impacts on this task. Poor estimates have resulted in some countries reporting high coverage of HIV services, only to be skewed by poor sampling and extrapolation. PEPFAR has committed to invest significantly in size estimation in its new KP fund, in order to target interventions based on reliable data.

The 21st International AIDS conference is abuzz with best practices, new guidelines and policies. For **policy makers and practitioners** at country level, it is challenging to distil the overall body of knowledge and determine where the evidence scale stands. Do we implement the new model for test and treat from country X, or should we implement the learning from country Y on their national laboratory systems?

Budgets, policy cycles and political decision-making are less prominently present at the AID conference. From an early morning satellite session, organised by Pangaea, it became clear that evidence-informed decision making is high on the agenda of both researchers and policy makers. Policy makers and panellists indicated that in order to facilitate evidence into action, they need good quality evidence, which needs to be documented as best practices and disseminated within government decision-making structures. Furthermore, these best practices need to be costed to cater for financial planning and budgeting. Countries in the southern and eastern African region, present at the satellite show commitment to South-South cooperation, under the umbrella of the regional economic commissions, SADC and EAC. This learning can be amplified and accelerated through the organisation of study tours, with the aim to expose decision-makers to the context in which the best practice operates and the details of what makes the practice a best practice and how it can be replicated and scaled up in different context.