José M. Zuniga – President & CEO, IAPAC

The days of siloed approaches to chronic conditions such as HIV are over

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First established in 1985 at the height of the AIDS pandemic, IAPAC is the world's oldest medical association dedicated to HIV. Today, the organisation brings together over 30,000 professional and paraprofessionals delivering services to people living with and affected by the disease. In an exclusive and wide-ranging interview, IAPAC President & CEO Dr José M. Zuniga outlines why there is no excuse for AIDS-related deaths in 2024, declares that HIV must not be left behind as global stakeholders increase spending on pandemic preparedness, and explains how the politicisation of HIV is deeply troubling, but nothing new. Dr Zuniga also highlights how IAPAC's 'Fast-Track Cities' initiative has helped reduce HIV incidence in major urban centres and why the association is rebranding to reflect a more integrated 'whole health' approach.

When did you first become aware of HIV/AIDS?

I first became aware of HIV in high school at a time when there was a tremendous amount of ignorance around the disease. Eventually, I followed the track of HIV largely because I had friends and mentors who had acquired HIV, some of whom, unfortunately, died of AIDS-related complications. At that point there was no available therapy, and the focus was largely on opportunistic infections and palliative care.

I came to this work shortly after serving in the US military. My first posting was at the AIDS Action Council and Foundation in Washington DC, where I was working with colleagues around health policy issues, ensuring sufficient domestic investment in the HIV response, and creating a safety net for medically indigent adults [people in the US who do not have health insurance and who are not eligible for other health care such as Medicaid, Medicare, or private health insurance – Ed.] living with HIV and falling through the cracks of the US health system.

I joined IAPAC in 1997 and I have been with the association for almost three decades. It has been an incredible experience; challenging in many respects but rewarding in terms of what we've been able to achieve. It is also a little scary to think about what we have left to do on this last mile to achieve our goals.

What is IAPAC and how does the association support its 30,000 clinician and HCP members globally?

Our association was launched in 1985 as the Physicians Association for AIDS Care (PAAC), making us the oldest medical association dedicated to HIV. We started out as domestically focused, supporting clinician education around opportunistic infections, palliative care, and nutrition, etc. and advocating for a social safety net. Our mission was to marshal the resources, moral and otherwise, of a growing number of physicians to speak out about and action the right to health that people living with HIV deserved – and that remains at the core of our mission today.

We eventually became the International Association of Physicians of AIDS Care (IAPAC) in 1995 before changing our name again to the International Association of Providers of AIDS Care (also IAPAC) in 2012 to reflect an expanded remit. While we have around 30,000 clinician members worldwide, we also represent a broad range of healthcare providers, both professional and paraprofessionals, delivering services to people living with and affected by HIV. Our membership now includes primary care physicians as well as specialists, but also pharmacists, nurses, and community health workers.

UNAIDS put out a report last year showing that AIDS can be ended as a public health threat by 2030. You have said elsewhere that this goal is not simply aspirational, it is achievable – what gives you such cause for optimism?

During my 26 years with IAPAC and several more years prior to that with other HIV-focused organisations, I have witnessed incredible progress. The HIV movement is truly unique and has made a massive contribution to the cause of HIV, as well as to other movements. We have been able to maintain amazing momentum over these many years, including through the COVID-19 pandemic.

Thinking about the history of HIV, in the early to mid-1980s, it was an automatic death sentence for anyone who was diagnosed. We then had a glimmer of hope in the early 90s, first with monotherapy, and then dual therapy that extended people's lives, and ultimately the advent of antiretroviral therapy (ART) in 1996. This was a gamechanger; anyone who has access to ART and maintains optimal adherence can be guaranteed a near normal lifespan. The transition from a death sentence to a chronic condition is remarkable and today, almost 30 million people globally are on ART. Properly supported to remain engaged in care and adhere to their ART regimens, people living with HIV who achieve an undetectable viral load pose no risk of transmitting HIV, which is an added preventative benefit known as treatment as prevention, or U=U (Undetectable equals Untransmittable).

However, the benefits of these scientific breakthroughs are only guaranteed for those who have access to the full HIV care continuum. This is not limited to ART alone, but more broadly to other health and social support services. In the past, only nominal numbers of people were able to access ART. Moreover, some policymakers and critics suggested that expanding access to ART in the Global South was impossible because people there allegedly did not have clocks or watches and would not be able to figure out when to take their medications. Those are the specious arguments that were being made at that time. Today, we have global consensus around the ability to curb new HIV infections and prevent AIDS-related deaths.

The terminology of "ending HIV" is challenging in that it sets an unrealistic goal. That in and of itself was aspirational. But when we speak to a more defined goal of ending AIDS as a public health threat as it has been defined, speaking to HIV epidemic control and elimination metrics; that is achievable. And in that respect, we can make new HIV infections exceedingly rare through treatment as prevention and through the amplification of pre-exposure prophylaxis (PrEP) as an adjunct to ART.

Quite frankly, there is no excuse to have AIDS-related deaths in 2024. We have a highly effective treatment that is keeping millions of people alive and thriving. We need to work to ensure access for all people living with HIV under a rapid-start protocol, and that treatment itself is wrapped in non-stigmatizing, culturally sensitive supportive services to maintain people's long-term

engagement in care, and that their rights to dignity, health and wellbeing are respected.

AIDS is a global threat that differs not just between countries but also within them. Could you outline why you decided to launch the 'Fast-Track Cities' initiative, whereby individual cities commit to eradicating HIV by 2030, and what the results have been so far?

On World AIDS Day 2014, along with our partners UNAIDS, UN-Habitat, and the City of Paris, we launched an initiative that aims to urbanise global goals. These include the AIDS-related Sustainable Development Goal (SDG) and the UNAIDS 95-95-95 targets [whereby 95 percent of all people living with HIV know their HIV status, 95 percent of all people with diagnosed HIV infection receive sustained antiretroviral therapy, and 95 percent of all people receiving antiretroviral therapy have viral suppression by 2025 – Ed.]. We saw this as a way for cities to have an impact on national HIV epidemics, notably in countries with a critical mass of Fast-Track Cities.

Given urbanisation trends, many of the people living with, or at risk of, HIV live in urban settings. Policymakers in these urban settings can be more nimble than national governments in their ability to implement innovations and elected officials are much closer to constituents. This means that they can be held to account for progress, or lack thereof.

This initiative, which started out with 26 initial cities, was really an experiment to see if, by having local impact, we could ultimately achieve national and global impact. Remarkably, we have indeed seen that type of progress, even through the COVID-19 pandemic. For example, in South Africa, which has 14 Fast-Track cities, PrEP use has increased from around 170,000 initiations in 2021 to 217,000 initiations in 2023. That is a result not only of national policy and the investment of donors such as the US President's Emergency Plan for AIDS Relief (PEPFAR), but also the capacity building and technical assistance provided through the Fast-Track Cities programme. Two of the cities – eThekwini (Durban) and Johannesburg – are directly supported by PEPFAR and USAID.

In HIV, the gold standard is reduction in incidence. Some cities within the Fast-Track Cities network have nearly halved HIV incidence in the span of a few years. Kingston, Jamaica, for example, had 98 new infections per 100,000 people in 2018 but saw that decrease to just 56 per 100,000 by 2021. The same thing happened in Lusaka, Zambia, where incidence dropped from 2,300 to 1,000 per 100,000 people in the same period. That is still far too many new HIV infections, but it signals the ability to have an impact, even in places in which we might have thought intractable challenges prevented achieving those reductions in incidence.

We have seen this achievement equally in cities in the Global North, but I wanted to highlight these particular cities as examples of impact in the Global South, which in some instances is even outperforming the Global North.

Building on this progress, what are the most important gaps that IAPAC is looking to fill over the next few years in terms of access, capacity building, medical education etc?

From a medical association perspective, there is a continued need for building health workforce capacity to address HIV within an integrated care model to facilitate whole-person health based on Universal Health Coverage principles. The days of siloed approaches to chronic conditions such as HIV are over, especially given the significant retrenchment in health financing we are witnessing not just from bilateral and multilateral governmental support funds, but also industry and even foundations.

There is always a shinier objective to fund and pandemic preparedness certainly represents that for many donors in the space currently. However, we must ensure that HIV does not get forgotten – there is a way of weaving HIV into a broader global health agenda, leveraging not just the significant lessons we have learned from HIV but also the infrastructure. In that way, we can ensure that HIV does not become a neglected disease, which is my nightmare scenario. During the COVID-19 pandemic, it was the HIV infrastructure and the HIV health workforce that was repurposed to avoid the worst of what we might have experienced. It is somewhat hypocritical to leverage an infrastructure and workforce that has enjoyed significant investment and then disinvest once the new global pandemic is over.

In addition to our integration focus, we will continue our work, in partnership with community partners, to address issues that (bio)medical institutions do not typically excel at by virtue of rigid solely p-value missions. One such issue is stigma, which persists as a challenge to accessing and utilising HIV and other health services. This stigma is not just HIV specific, but intersectional in nature, dehumanizing people living with and affected by HIV by nature of their race and ethnicity, sexual orientation, gender identity, migrant status, and other factors.

There is also the issue of ensuring equitable access to healthcare. For example, in the United States, 64 percent of HIV-negative people who could benefit from PrEP to avoid acquiring the virus have not received access to a prescription. That unacceptable percentage is largely due to racial disparities in access to care, primarily within the African American and Hispanic communities. Centres for Disease Control and Prevention (CDC) data show quite a significant disparity: 94

percent of white individuals who are clinically eligible for PrEP have access, compared to only 24 percent of Hispanic people and just 13 percent of African Americans. This is not unique to the United States – disparities in HIV prevalence among marginalised communities are stark in almost every country of the world. Evaluating the HIV response through an equity lens and advancing our work with an equity-focus is of critical importance to avoid a world with two standards of HIV care.

Did the speed at which the world tackled COVID frustrate you as a longtime participant in the HIV field?

Yes, there was a bit of frustration, although also relief as we all (those of us who believe in vaccines and are not duped by misinformation) benefited from that research. The frustration not only comes from the expedited 'warp speed' approach to COVID-19 vaccine development, but also the failures of vaccine and cure research outcomes over the years. We accept that HIV is a much more complex virus than COVID-19, making R&D challenging. However, in the absence of a vaccine or a cure, we already have two effective tools (PrEP and ART) that that could get us to a definition of HIV epidemic control, make new infections exceedingly rare, and make AIDS related deaths completely avoidable.

So, in that respect, there is a sense within the broader HIV medical community that we should adopt a dual focus: concentrate on scaling what we already have while also continuing to push for companies, such as those that developed mRNA COVID-19 vaccines, to prioritise HIV vaccine and cure research. Our message is that if you did it for COVID-19, you could do it for other disease areas as well. However, this requires courage, prioritisation, and investment.

Going back to the question of disparities and equity, ultimately when we have a vaccine or vaccines and cure, we need to be able to implement them, which is typically where we fall down. For example, we were able to roll out antiretroviral therapy in much of the Global North within just a couple of years of its advent in 1996. We did not see that same uptick in sub-Saharan Africa, for example, for five to 10 years. This issue is not exclusive to HIV; we also saw it with COVID-19 vaccines and treatments. Implementation requires capacity building and planning for how medications and vaccines can be rolled out. Sadly, that is typically not an area of focus for policymakers and needs to be addressed. Of course, expanding local capacity to manufacture drug and diagnostic technologies also requires a policy response, as well as investments to avoid the stark inequities laid bare by the COVID-19 pandemic. By fostering self-reliance, African and other countries can enhance resilience, reduce dependency on external actors, and ensure timely access

to essential medicines and technologies.

AIDS alleviation efforts are becoming increasingly politicised in the US with conservative thinktanks and lawmakers arguing that the Biden administration has "hijacked" PEPFAR to promote abortion instead of treating and preventing HIV. This has led to PEPFAR's funding up to 2028 coming under question. How badly does this risk exacerbating the global situation for AIDS patients?

HIV has always been politicised. In my early years at the AIDS Action Council and Foundation I remember, sitting in the US Senate gallery and listening to Senator Jesse Helms – one of our country's most infamous homophobes – rail against people living with HIV and those at risk of it. Against a backdrop of HIV being used as a political weapon, the creation of PEPFAR stands out even more. President George W. Bush, who signed PEPFAR into law back in 2003 really had no incentive to invest in the global HIV response and did so as a "compassionate conservative."

Because of that decision, millions of lives have been saved, millions of infections averted, and entire communities have been lifted up. It therefore saddens me greatly to see the re-politicisation of HIV and to see PEPFAR held hostage by political ideology around reproductive rights. This is an initiative that has enjoyed bipartisan support for over 20 years, even during the Trump administration.

PEPFAR was granted a one-year reauthorisation, which at least ensures that this important programme continues with Congressional approval, although it is sad to not have the standard five-year reauthorisation. All of this clearly signals that we must make the case to US taxpayers and taxpayers in other countries for continuing investment in HIV and the global health response more broadly. National health budgets around the world are being slashed to create opportunities for investments in other spaces. In some instances, these other spaces are critically important to the future of that country. Nevertheless, without health and wellbeing and ensuring that social programmes are not flooded by people who are uninsured or living in poverty, countries' futures will be jeopardised.

There is therefore a national security argument to be made for continued investment in programs like PEPFAR, as well as the Global Fund to Fight AIDS, Tuberculosis, and Malaria. I would hope that argument would prevail over ideological and intolerant discussions about reproductive rights and LGBTQ human rights, but I have been proven wrong in years past. We will have to wait and see, even as we mobilise as a social justice-loving community to defeat political and other forces

hellbent on passing draconian and/or odious laws.

And globally, these types of questions also seem to be causing ruptures – with anti-homosexuality laws in countries like Uganda stopping people from accessing lifesaving health services and seriously impeding progress on eliminating HIV. What dangers are you seeing on this front?

Recently, the Constitutional Court of Uganda refused to repeal this law but did strike down a few clauses, one of which was a clause that restricted the right to health for LGBTQ people. The right to health is interwoven with the right to life, liberty, and the pursuit of happiness. In that respect, the Court's desired outcome was clearly to ensure that Uganda does not lose funding from World Bank, PEPFAR, or other sources. We will see what happens with that; these institutions are not easily fooled.

These laws tend to drive epidemics underground. In addition to the human rights violations that they represent, they create a disabling environment for the type of HIV and other health outcomes that we desire. Therefore, there is a continued need for us to use every lever at our disposal so that these heinous laws do not live on the statute books for long. Lives are at stake, and not just the lives of people in Uganda or Ghana, whose parliament recently passed a similar anti-LGBTQ bill. An infection in Uganda should matter to all of us on human rights grounds, but also because it creates the space for the onward transmission of HIV and other, completely preventable, communicable diseases, in a world that is increasingly interconnected due to globalization.

What are IAPAC's key areas of focus in the next five and a half years up to 2030?

It is somewhat of an open secret to our friends and colleagues that IAPAC is currently undergoing a realignment to reflect our broader global public health goals, including those outlined in our memorandum of understanding (MoU) with WHO and a new MoU we are signing with the Africa CDC in the next several weeks.

In that respect, we will continue to leverage the experiences of a growing network of Fast-Track Cities – we are now at over 550 globally – and roll out our Fast-Track Country designation for countries with a critical mass of Fast-Track Cities, including Australia, Brazil, France, Kenya, South Africa, the United Kingdom, and the United States. Our aim is to enhance collaboration and coordination between municipal, sub-national, and national health authorities, along with other

affected communities, to push towards the 2030 health-related SDGs. We are at the midterm and although many cities around the world are on track, many countries are off track.

As such, and as part of our integrated whole health focus, IAPAC will rebrand as Fast-Track Health. We are not abandoning HIV, which will remain our top priority, but we are expanding our mission to reflect the intersection of HIV with other communicable and non-communicable diseases. People living with and affected by HIV do not exist in isolation of cardiovascular disease, diabetes, hypertension, mental health conditions, or substance use disorder. We will thus be placing our protocols for the integrated management of communicable and non-communicable diseases on steroids, within the context of person-centred care.

Our first partnership as Fast-Track Health, which we will formally announce during the upcoming World Health Assembly at the end of May 2024, is with the Commonwealth Secretariat to raise awareness about and facilitate the scale of HPV vaccination in Commonwealth countries. This partnership reflects the future of how we aim to move a global public health agenda forward. Of course, there is an intersection between HIV and HPV, in that women living with HIV are at higher risk for cervical cancer, but having said that, through Fast-Track Health there is an opportunity to leverage the HIV infrastructure, the Fast-Track Cities infrastructure, and the Fast-Track Countries infrastructure, to accelerate the pace of progress around other health-related goals.

HIV will remain our highest priority because we are committed to a mission we have been advancing since 1985. But we aim to also prioritize a whole health approach that underscores the imperative of equitable access to health services and promotes the highest attainable standard of health for all. Those are IAPAC’s (and Fast-Track Health’s) priorities. We are a little anxious about the fact we are at the midterm to the 2030 deadline for the health-related SDGs, but we are also thinking about what 2031 looks like. This involves asking very tough questions about what has worked, what has not, and taking an implementation science lens to dissect the HIV response so that we can make necessary adjustments before the clock runs out on the SDGs and we find ourselves flatfooted going into the next decade.

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