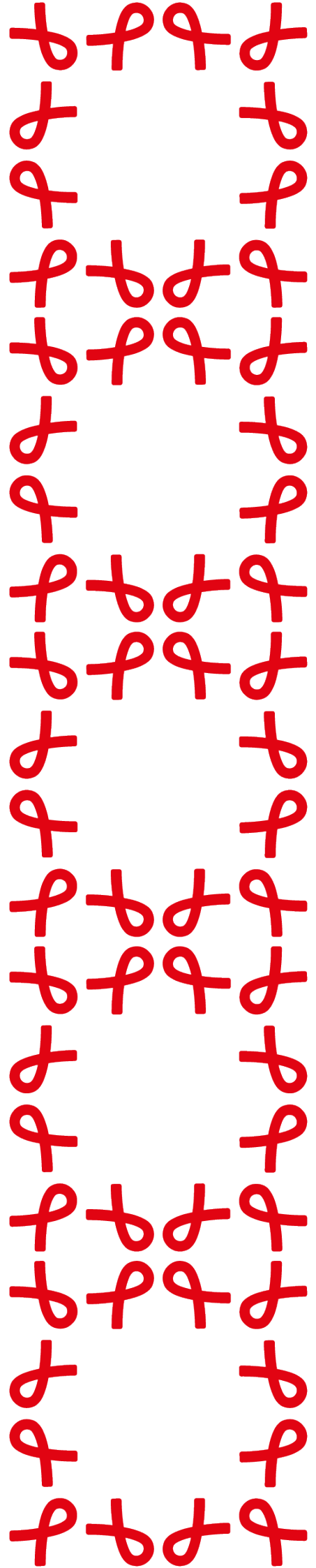


ENDING AIDS BY 2030:
SCIENCE, COMMUNITY AND
POLITICAL COMMITMENT
24 APRIL 2018, TOKYO, JAPAN

*A symposium co-organized by the International AIDS Society
and the Japan Center for International Exchange*



In collaboration with:



BACKGROUND

On 24 April 2018, the International AIDS Society and the Japan Center for International Exchange brought together leading scientists, policy makers, advocates and funders to review the state of the HIV epidemic in Japan and globally from a scientific, policy and human rights perspective. More than 100 participants joined the meeting to discuss what needs to be done, and by whom, to ensure that we do not miss the opportunity to end AIDS, once and for all.

SETTING THE SCENE

In opening the meeting, International AIDS Society Executive Director **Owen Ryan** pointed out that the great advancements made in understanding HIV and how to prevent and treat infection were a major global health achievement. However, with new infections continuing and almost half of infected people remaining untreated, the big challenges ahead include improving prevention, treating an ever-increasing number of people for longer, and securing the necessary resources to do so. The objective of the meeting was thus to identify what needs to be done, and by whom, to ensure that the opportunity to end the epidemic in our life time is not missed.

In Japan, annual numbers of newly reported HIV-infections and AIDS patients have remained flat, as **Chieko Ikeda**, Senior Assistant Minister for Global Health at the Ministry of Health, Labour and Welfare of Japan pointed out. It remains problematic, however, that around 30% of those infected were not aware of their HIV status until after the onset of AIDS. She stressed that the Japanese government is committed to addressing the HIV/AIDS epidemic, working hand in hand with medical institutions and non-governmental organizations while paying due attention to human rights and social circumstances, and also remains actively engaged in global HIV/AIDS responses.



Chieko Ikeda, Senior Assistant Minister for
Global Health, Ministry of Health, Labor and Welfare



Adeeba Kamarulzaman, *Dean, Faculty of Medicine, University of Malaya; Member, IAS Governing Council*

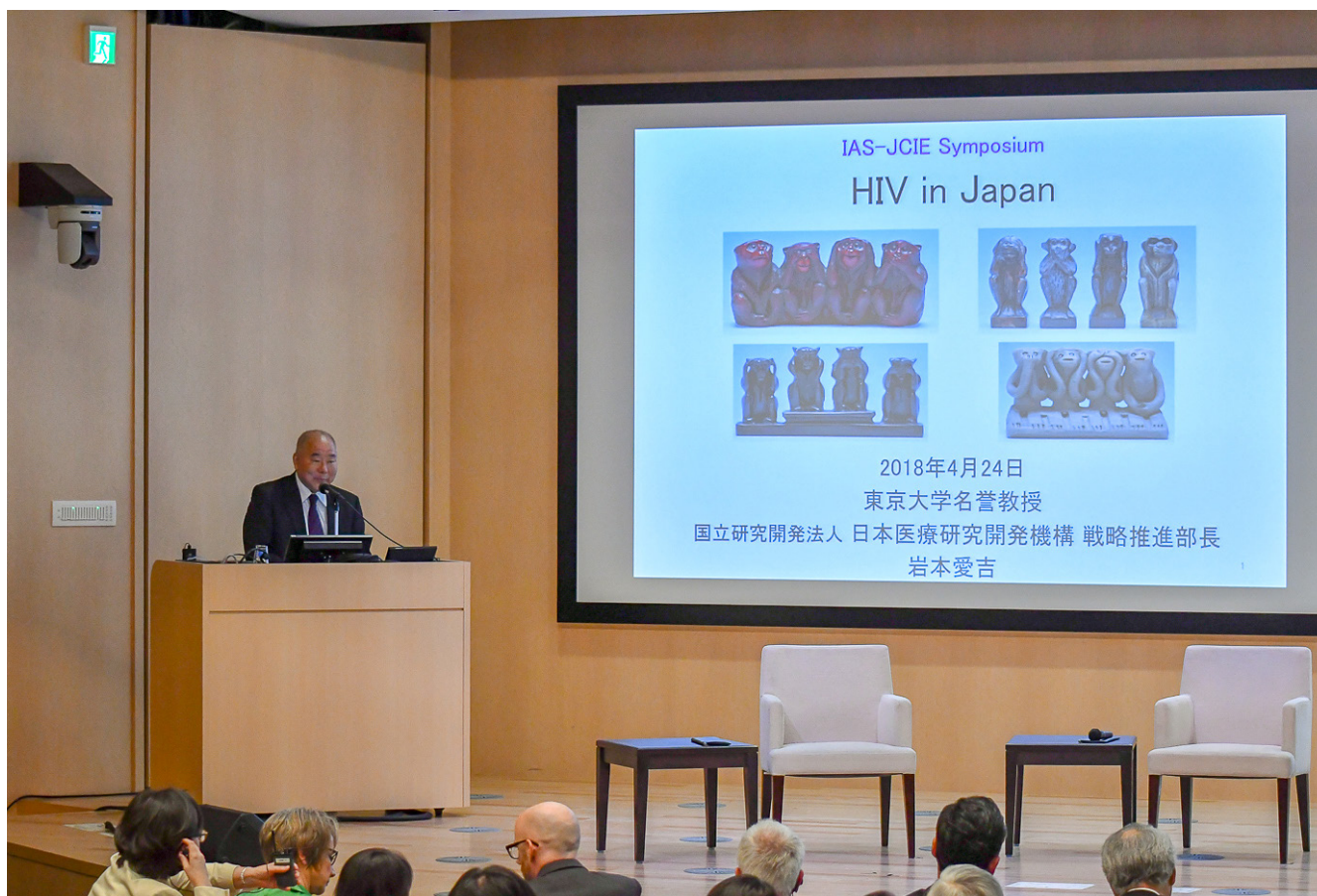
Adeeba Kamarulzaman, Dean of the Faculty of Medicine at the University of Malaya, reminded the audience that since the beginning of the HIV epidemic, 70 million people have become infected with the virus globally, and 35 million have lost their lives to the disease. We have, however, come a long way since first headlines appeared on a rare new disease in the early 1980ies: in 1984, Françoise Barré-Sinoussi and colleagues discovered the virus that causes what was termed the “Acquired Immune Deficiency Syndrome”, or AIDS, only two years earlier. In 1985, a test for HIV infection became available, and in 1987 the first antiretroviral drug was approved for treating AIDS. It took another nine years for highly active antiretroviral therapy (HAART) to arrive, however, by which time 22 million people were infected. While AIDS-related deaths now started to fall in developed countries, HAART became more widely available in developing countries only in the early 2000s. Today, more than half of all infected people globally are on treatment.

With improved treatment has come better prevention, including through more and better biomedical prevention options, more effective behavioural interventions, and, not least, due to the fact that effective treatment significantly decreases the risk of transmission. As a result, HIV incidence and mortality have been declining in most world regions between 2010 and 2016, with the exception of Eastern Europe and Central Asia.

Still, almost 38 million people were living with HIV in 2016. The same year saw 1 million deaths, and 1.8 million new infections – that are 5,000 new infections every day. At this rate, much remains to be done to attain the global goal of ending AIDS by 2030. The concerted effort required to achieve it has been translated into the 90-90-90 concept: The epidemic is under control if 90% of all infected people know their HIV status, 90% of these are receiving treatment, and for 90% of these people treatment is working effectively. Currently, very few countries in Europe have achieved this, while in many countries across the world – including the United States – treatment is available only to less than 60% of those who should receive it.

Looking at Asia and the Pacific, where 5.1 million people currently live with HIV, AIDS-related deaths were reduced by one third since 2000, to around 180,000 in 2016. India and China carry the highest burden of HIV infection, followed by Indonesia and Pakistan; together, these four countries account for more than 75% of infections in the region. In aggregate, 71% of those infected know their status, which means that almost one million do not. 47% of people living with HIV are on treatment, and 39% are virally suppressed – leaving gaps of 1.7 million between the numbers of people reached with effective treatment and those who should receive it according to the 90-90-90 formula. In Malaysia, while overall new infections rates have decreased due to a significant decline in infections among injecting drug users, new sexually transmitted infections have increased, with the share of heterosexual transmission at just under 46%. With an HIV prevalence of 18.9% among injecting drug users, the harm reduction programme in the country includes more than 700 needle exchange sites and over 800 methadone programme sites. Overall, 82% of people living with HIV know their status and 66% are linked to care. However, only 37% are retained in care, 34% received antiretroviral treatment, and 25% are virally suppressed. In Cambodia, a concerted effort comprising predictable government budgets for HIV services, treatment scale up, integration of HIV into broader health services, expansion of community engagement and a focus on targeted HIV prevention have turned the epidemic in the country from a generalized one into a concentrated epidemic among vulnerable populations.

Globally, significant challenges remain in reaching particularly vulnerable groups. At the core of these are stigma and discrimination which prevent key populations from accessing services – either because services are being denied to them outright or because they feel ashamed or want to avoid exposure to discriminatory behaviours. With the risk of infection between 10 and 24 times higher among these groups than among the general population, removal of such barriers is essential for reaching the goal of ending AIDS.



Aikichi Iwamoto, *Managing Director, Department of Research Promotion, Japan Agency for Medical Research and Development; Emeritus Professor, University of Tokyo*

Moving from the global overview to the situation of HIV and AIDS in Japan, **Aikichi Iwamoto**, Managing Director of the Department of Research Promotion at the Japan Agency for Medical Research and Development and until recently chairperson of the Ministry of Health, Labour and Welfare's AIDS Surveillance Committee, started by referencing the dramatically improved prognosis of people living with HIV since the first case of AIDS was reporting in North America in 1981: Thanks to the development of HAART around 1996, the life expectancy of persons infected with HIV at the age of 25 has increased from 7.6 years in 1995 to 32.5 years in 2005. There have been further breakthroughs in recent years, including treatment as prevention (TasP): We now know that if a patient's viral load remains consistently undetectable, the virus will not be transmitted. And we have also learned that individuals with a high number of CD4 cells (white blood cells that are an essential part of the human immune system) can expect better treatment outcomes if treatment is initiated immediately upon testing HIV-positive, rather than waiting for the CD4 count to decrease over time.

The AIDS Surveillance Committee analyzes changes in the numbers of newly reported HIV and AIDS cases. The Japanese reporting system treats new HIV infections separately from AIDS patients: Only those individuals are counted as AIDS patients whose infection was detected after their HIV infection had already developed into AIDS. Therefore, understanding recent infection trends requires focusing on the number of newly reported HIV infections. The annual number of those cases levelled off at 1,000-1,100 per year since 2008, and further declined to less than 1,000 in 2017 (preliminary data), for the first time in 11 years.

According to data provided by the University of Tokyo's Institute of Medical Science, it was about five years ago that the ratio of HIV patients undergoing treatment in Japan exceeded 80%. This means that the period in which treatment became more widely available coincides with the point in time at which the number of newly reported HIV cases began to level off.

Blood donor data and outpatient statistics from the AIDS core hospitals throughout Japan were used to analyse the HIV care cascade in the country. On this basis, it is estimated that of HIV-infected individuals in Japan, 86% know their status, 77% are retained in care, 71% are on treatment and 70% have an undetectable viral load. Applying the 90-90-90 formula, the current global goal for ending AIDS, Japan stands at 86-83-99. However, as a number of patients are being treated at clinics and other institutions that are not part of the network of AIDS core hospitals, it is considered highly likely that more than 83% of infected persons who know their HIV status are receiving treatment.

The current challenges in Japan are threefold: (1) how to increase the number of effective HIV tests being performed; (2) how to reduce the number of new infections; and (3) how to reduce the number of AIDS cases. Simply increasing the number of tests being performed would not, however do the trick: According to research conducted during the period 2006 to 2010, a higher number of HIV tests conducted at public health centres and other institutions did not translate into a greater number of people testing positive or a higher ratio of positive tests.

In light of advances in treatment, what is critical going forward is for clinicians and policymakers to create comprehensive HIV programmes that incorporate treatment and prevention in an integral way. Additionally, it is essential to assess why people do not get tested and delay seeking services until they experience symptoms of AIDS, and to enable all people living with HIV to receive treatment.



Owen Ryan, Executive Director, International AIDS Society, and
Peter Sands, Executive Director, The Global Fund to Fight AIDS, Tuberculosis and Malaria

The first session described that both globally and in Japan, great progress has been made in decreasing new infections among many populations; finding those that are infected and moving them into treatment; and in treatment outcomes with regard not only to life expectancy but also quality of life. The second session focused on ways to ensure that this progress can be maintained and expanded to the 17 Million people not currently on treatment, and to reach those groups with prevention services that continue to see stagnant or even increasing infection rates. Representatives of two large funders of global HIV programmes shared their thoughts: **Peter Sands**, the Executive Director of the Global Fund to Fight AIDS, Tuberculosis and Malaria, and **Tamaki Tsukada**, Deputy Director General of the International Cooperation Bureau of the Ministry of Foreign Affairs of Japan.

Asked about the actions required to end AIDS as a public health epidemic by 2030, Peter Sands focused on prevention: With 1.8 Million new infections in 2016 and almost 16 Million people that should be treated with antiretroviral drugs not yet receiving these, the world needs to seriously address the gaps that persist in prevention. Obviously, money is needed but also a stronger determination to remove stigma and discrimination that too often prevent vulnerable people from obtaining the services they need. More imaginative ways of reaching groups at high risk – notably young women and girls in sub-Saharan Africa – are also required that move out of the clinical realm and into society to address risky behaviours as well as sexual violence.

Tamaki Tsukada added that the shift in ambition from working towards reversing incidence, as had been one of the Millennium Development Goals, towards aiming for an end of the epidemic as part of the Sustainable Development Goal framework, illustrated the global optimism that such an end was indeed possible – if political leaders step up their will to implement the necessary policies and invest the required resources. In doing so, a careful balance should be struck between vertical approaches that channel investments into the fight against specific diseases, and horizontal ones that aim to strengthen national health systems. Neither key populations nor young women and girls can be left behind in the response, which also must deal with new challenges such as the spiralling risk of anti-microbial resistance.

UNAIDS estimates that to end the global HIV epidemic as a public health threat by 2030, an investment of more than US\$25 billion is needed in 2020, and that even in 2030, more than 20 billion must be invested each year to keep everyone on treatment and prevent new infections. According to Peter Sands, considering the significant and increasing investments made by national governments, such large funds are not out of reach; funding from donors, however, is unlikely to increase. Higher domestic spending will have to be coupled with much greater efficiency in the way money is spent, particularly with regard to improved treatment regimens and better logistics. Tamaki Tsukada stressed the need for a sustained level of support from donor countries, as global health security is indivisible: as long as a health threat exists in one country, all others cannot fully prosper. This notion must be communicated more clearly.

In many world regions, including in Asia, key populations including men having sex with men, injecting drug users, prison populations and sex workers are particularly vulnerable to infection. In other geographies, women and girls, too, experience high infection rates. To overcome the structural barriers – stigma and discrimination, gender inequalities etc. – that keep people from accessing vital services, funders such as the Global Fund work with civil society groups, globally and in each target country, to define the best ways to reach those in need. Such work, added Peter Sands, must be grounded in human rights and equity.

Tamaki Tsukada stressed that systematic approaches are important: the continuum of care from prevention through testing to treatment and adherence to drugs must be available to all; solid supply chains are required so that drugs are available when need; and properly trained health workers need to be able to provide integrated interventions that embed HIV prevention and care within broader health services. Eventually, we want to attain Universal Health Coverage (UHC) as the most effective way of ensuring a healthy population. Japan is working with other development partners to support countries in moving towards UHC, including through the UHC2030 platform that brings together approximately 60 countries, bilateral and multilateral donors, civil society organization and the private sector to accelerate progress towards UHC. Japan also contributes to the Global Financing Facility in Support of Every Woman Every Child with a view to incentivizing countries to move towards UHC.

How can the private sector be better leveraged in the fight against HIV? Peter Sands suggested to look toward the climate change community for ideas on motivating private sector investment, from steering operational interest – companies need a health workforce – through tapping into corporate expertise in logistics to upgrade health commodity supply chains, to drawing on corporate innovation capacity in areas such as better drugs, new employment models that could be adapted for health services, or marketing knowledge that could inform effective behaviour change communication. According to Tamaki Tsukada, considering that commercial viability drives private companies' decisions, it is important to create appropriate incentive structures for corporate investment in health. The GHIT Fund for collaborative research and development in health is one such example.

Are infectious diseases such as HIV and tuberculosis competing with non-communicable ones – cancer, diabetes, heart disease – for attention and resources? Both discussants urged not to discriminate between diseases. Investments made in HIV prevention today help avoid expenditure for treatment and significant loss of productivity later. Only a healthy, productive population guarantees economic growth and development. To achieve it, inequities in health care provision must be removed.

Shinichi Oka, Director of the National Center for Global Health and Medicine's AIDS Clinical Center and co-chair of this session, invited **Shuzo Matsushita**, Professor at the Center for AIDS Research at Kumamoto University, to provide an overview of recent developments in HIV treatment.

Advances in HAART have turned HIV infection into a controllable chronic disease, with treatment regimens evolving in tandem with the development of better drugs. The post-1981 era can be divided roughly into three phases: During the period between 1996 and around 2007, the primary goals were to prevent HIV infection from progressing to AIDS and to reduce AIDS mortality. Subsequently, earlier treatment initiation proved effective in preventing comorbidities as well, prompting medical institutions to promote earlier treatment initiation from 2008 onward. The confirmation in 2011 that proper treatment prevents HIV transmission in couples where one partner is infected and the other is not has underlined the importance of providing treatment for anyone who tests HIV positive (Treatment as Prevention/TasP). Thanks to these developments, people living with HIV today have nearly the same life expectancy as those who do not carry the virus, as long as they take their medication regularly, and can live a normal life, including marrying and having children—advancements that were unimaginable when ART started.

Long-term treatment, however, entails several challenges, one of which is drug resistance. In the past, as patients were required to take many different drugs on a regular basis, failing to take all the necessary drugs resulted in the emergence of drug-resistant HIV variants. Recently, on the other hand, there have been a number of reports on the discovery of resistance to drugs that were believed to hardly invite such resistance. A study published last year in *The Lancet* shows that resistance to non-nucleoside reverse transcriptase inhibitors (NNRTIs), which have been used frequently since the early days, has been increasing year by year. According to the study, the annual increase in the odds of pre-treatment NNRTI resistance reached 23% in southern Africa, 17% in the rest of Africa, and 11% in Asia. As an NNRTI-containing first-line regimen may thus simply result in more treatment failures, we are seeing a shift towards integrase inhibitor-based treatment.

Other challenges involved in long-term treatment include an increase in comorbidities associated with aging; coinfections with tuberculosis, hepatitis B or C, or other viruses; drug-drug interactions; and limitations in access to treatment.

Given that ART requires patients to maintain lifelong adherence, it will become even more important in the future to consistently secure funds that enable ART to be provided to all patients on an ongoing basis. This is because, while ART suppresses HIV replication, it does not eliminate HIV-infected cells from the body. For this reason, it is crucial to develop an HIV cure. A number of avenues are being pursued in parallel: One of them pertains to a patient who had been infected with HIV, developed acute myeloid leukaemia, underwent bone marrow transplantation using the cells of a donor with a special genetic background, and as a result saw his HIV infection become undetectable. Another line of study focuses on neutralizing antibody treatment, which has been shown to significantly reduce the viral reservoir in monkey models. Such studies are essential steps on the path towards achieving long-term HIV remission—a state that no longer requires ongoing treatment.

Regarding the situation of HIV treatment in Japan, one reason that the 90-90-90 goals have not yet been fully achieved is the low rate of HIV testing among people with a high risk of HIV infection. Efforts to raise awareness among young people are also still insufficient. Furthermore, we should move away from CD4 count thresholds as a condition for obtaining a disability certification, which again is required to qualify for subsidies for treatment.



Shuzo Matsushita, Professor, Center for AIDS Research, Kumamoto University and member of the IAS Governing Council, **Daisuke Mizushima**, AIDS Clinical Center, National Center for Global Health and Medicine, **Shinichi Oka**, Director, AIDS Clinical Center, National Center for Global Health and Medicine
Hiroyoshi Endo, Dean, St. Luke's International University Graduate School of Public Health

Introduced by **Hiroyoshi Endo**, Dean of St. Luke's International University Graduate School of Public Health, **Daisuke Mizushima** of the AIDS Clinical Center at the National Center for Global Health and Medicine in Tokyo provided an overview of latest developments in HIV prevention science.

Initially, preventing HIV infection relied exclusively on behavioural methods, such as promoting the use of condoms. These conventional methods, however, were not always effective, prompting the search for biomedical prevention methods. One of these is Treatment as Prevention (TasP), as mentioned by earlier presenters: If a person's HIV viral load is reduced to an undetectable level through anti-retroviral treatment, this not only minimizes the risk of transmission, but is also effective in controlling group-level transmission. Such findings have formed the basis of international prevention initiatives, most notably the Undetectable Equals Untransmittable (U=U) campaign and the 90-90-90 care cascade targets.

Other biomedical prevention methods include post-exposure prophylaxis (PEP) and pre-exposure prophylaxis (PrEP), both of which involve administering antiretroviral drugs to individuals uninfected with HIV for prevention purposes. Originally introduced as a measure to protect healthcare workers from hospital-acquired infections caused by needlesticks and other accidents, PEP is now used to address situations unrelated to medical accidents too, in particular to reduce the risk of sexual HIV transmission. This method requires ART to be initiated within 72 hours of a possible HIV exposure and continued for 28 days.

For individuals repeatedly exposed to situations with a high risk of infection, pre-exposure prophylaxis/PrEP offers an alternative solution. PrEP can involve the use of microbicides, vaginal rings, a long-acting, intramuscularly injectable drug that is currently under investigation, or the oral administration of Truvada (a fixed-dose combination containing emtricitabine and tenofovir disoproxil fumarate). Regarding the latter, consistently taking one tablet every day reduces the infection risk by more than 90%.

Studies have also shown that the risk of HIV infection can be reduced by approximately 85% by taking two tablets two to 24 hours before intercourse, followed by taking one tablet daily for two days after intercourse.

The efficacy and safety of PrEP have already been scientifically proven. In reality, however, PrEP still involves multiple challenges that have to be addressed in different ways in different local circumstances: How to identify those at high risk of infection? How to work ensure good adherence to preventive regimens? The International Antiviral Society considers as candidates for PrEP individuals from a population with an HIV incidence of at least 2% per year, as well as HIV-negative partners of HIV-infected persons who do not have viral suppression.

In Japan, PrEP has not been discussed proactively. This is in part due to a lack of data on HIV prevalence and incidence among men having sex with men (MSM). Three studies have been or are in the process of being undertaken to address this situation: Firstly, an HIV self-testing study to estimate incidence and establish the effectiveness of home-based testing, carried out in cooperation with a community centre in Tokyo's Shinjuku area, Japan's largest gay district, and a non-profit organization supporting people living with HIV. Between August 2015 and December 2016, among more than 1100 users, over 82% of tests were returned. 34 cases of HIV infection were detected, translating into a prevalence of 3.03%.

The second study works with an MSM-cohort at a sexual health clinic that operates within the National Center for Global Health and Medicine in Tokyo. Its main objective is to lay the ground for a future pilot study of PrEP in Japan. To do so, MSM and transgender women aged 16 years and older are recruited to visit the clinic once every 3 months to receive guidance and preventative information, and test and, if required, receive treatment for HIV, syphilis, and anorectal STIs. Just over 300 clients have been enrolled so far, with 30% testing positive for STIs and an HIV incidence rate of 4.1%.



Shuzo Matsushita, Professor, Center for AIDS Research, Kumamoto University and member of the IAS Governing Council

Finally, and linked to the previous study, a PrEP demonstration study was initiated in February 2018 with 120 adult MSM who are at substantial risk of acquiring HIV, with a time horizon of at least two years.

Although some of the data given above are preliminary, the prevalence rates obtained so far suggest that MSM in Japan are indeed candidates for PrEP. Whether PrEP will succeed in Japan ultimately depends on ensuring adherence (the patient takes drugs as prescribed) and retention (the patient continues to seek care).

A number of obstacles to introducing oral PrEP in Japan remain: Use of Truvada for prevention purposes has not yet been approved; the costs of the drug are high, so a generic version needs to be made widely available; and oral PrEP may result in an increased prevalence of condom-less intercourse which may lead to an increase in sexually transmitted infections other than HIV. Providing MSM with accurate PrEP information is also critical.

RIGHTS AND ACTIVISM FOR HEALTH FOR ALL



In introducing this session, **Satoko Itoh**, Managing Director of the Japan Center for International Exchange and Friends of the Global Fund, Japan, stressed that activism is one of the elements symbolizing the fight against AIDS. People from all walks of life—scientists, politicians, clergy, or those working with non-governmental organizations—have been working hand in hand with people living with HIV to urge governments to make medical services available to all those in need. This social movement has created a tidal wave, propelling national government and the global community into action to build a framework for actions against AIDS.

Commenting on the impact of his own advocacy, **Ryuhei Kawada**, a member of the House of Councillors of the National Diet of Japan, mentioned that it was 23 years ago that, at the age of 19, he was one of the plaintiffs in a lawsuit brought by victims of HIV infection through tainted blood products. The fact that he joined the lawsuit and disclosed his name made university students of the same age realize the relevance of the issue to themselves and inspired them to act. This led to 3,000 young people gathering from all over Japan to form a human chain around the Ministry of Health and Welfare building. This and other actions drew attention from the media, leading to a social movement that changed public perception as well as politics. As a result, the lawsuit was settled and all those in need received HIV treatment.

In the process, we also saw a reduction in stigma and discrimination of people living with HIV.

For **Yuzuru Ikushima**, the President of non-governmental organization PLACE Tokyo, international conferences were milestones in the involvement in decision-making of people living with HIV and their advocacy communities in Japan. The first such turning point came when the then representative of PLACE Tokyo was invited by the International AIDS Society to represent the community on the organizing committee of the 10th International AIDS Conference, held in Yokohama in 1994. Preparations for the International Congress on AIDS in Asia and the Pacific in Kobe triggered the establishment in 2002 of the Japanese Network of People Living with HIV/AIDS. However, the 1998 lawsuit mentioned by Ryuhei Kawada was crucial due to the fact that as a result, people living with HIV could access treatment irrespective of their income and the way in which they became infected. Previously, many people living with HIV had to file for personal bankruptcy due to their mounting medical bills.

Adeeba Kamarulzaman described Malaysia's experience in shifting towards a proactive harm reduction policy. The impetus came in 2007, when the Millennium Development Goals mid-term report showed that the country had not been able to stem the HIV epidemic – the only Millennium Development Goal not achieved in the country – and the government felt pushed into action. Scientists and activists, using scientific evidence, worked with moderate religious leaders as key actors in a society where drug use is considered a moral weakness, referring also to the Sharia's aim of preserving life as an argument for introducing methadone programmes and needle exchanges. Needle exchange programmes, although merely tolerated, remain in place today and have led to significant success in reducing infections.

Christoph Benn spoke about the impact his work as a doctor in East Africa had on his own awareness of the disease and the need for coordinated global investment to fight it. The global HIV movement is unique; it has been a game changer in the way in which it built on the notion of a human right to health to demand access to HIV treatment and prevention services for everyone, irrespective of where a person lives or how rich or poor she or he is. A movement that combined advocacy for policy change with public protest against the injustices in handling it has succeeded in turning a raging, deadly epidemic into a chronic disease.

Commenting on priorities for achieving an end to AIDS, **Yuzuru Ikushima** said that in Japan, it will be vital to raise the proportion of MSM in rural areas – where stigma and discrimination continue to be problematic – taking HIV tests. However, rather than allocating funds to stigma reduction the government's HIV/AIDS budget has been continuously reduced to now 4.7 billion yen per year. Also, whereas the number of newly reported HIV infections in Japan has been flat overall, those among non-Japanese living in Japan has been on the rise. With violence and discrimination against lesbian, gay, bisexual, and transgender persons and people living with HIV still strong in Japan and other Asian countries alike, joint action is needed. On a positive note, HIV policy in Japan has shifted from regarding people at high risk of infection as a group to be controlled to one that is part of the solution.

Ryuhei Kawada added that the HIV epidemic is not viewed as a serious concern in Japan and that better education on sexuality and human rights is required to reduce stigma and discrimination. To secure the necessary funds, the Japanese government could utilize an international solidarity levy, as some other countries have done: Current plans for an international tourism tax to be introduced in Japan from 2019 are for revenue to be used to fund tourism promotion, which should be expanded to also channel proceeds towards measures against infectious diseases.



Yuzuru Ikushima, President and Representative, PLACE Tokyo; Adeeba Kamarulzaman, Dean, Faculty of Medicine, University of Malaya; Member, IAS Governing Council Ryuhei Kawada, Member, House of Councillors, National Diet of Japan

Referring to the high levels of stigma and discrimination – and sometimes criminalization – that continue to prevent members of key and vulnerable populations from accessing appropriate health services, **Adeeba Kamarulzaman** called for closer attention to mental health issues associated with social exclusion, including self-stigma, depression, and suicidal tendencies. Education of health professionals, starting with students, is required, along with empowering members of key populations to circumvent health systems and seek support and services in their communities. She pointed out that innovation, such as shifting the tasks of prevention and care out of the health system into communities, and the notion of social determinants of health – e.g. poverty or inequality as drivers of disease – had been essential for the success of the HIV response to date and could be models for tackling chronic and non-communicable diseases as well.

Christoph Benn described three key requirements to end AIDS as a public health epidemic and establish Universal Health Coverage: community involvement to define and deliver services that work, further biomedical innovations – including an HIV cure – that are affordable to all, and finding a balance between domestic efforts and continuing international solidarity. Today, there is a movement growing to demand Universal Health Coverage. Advocates for this movement from the Asia Pacific region and they were active in the conference on UHC in Tokyo in December 2017. Only if this movement expands globally will we be able to attain the Sustainable Development Goals.

HIV/AIDS TIMELINE

ONE UNDER ZERO BY 2015

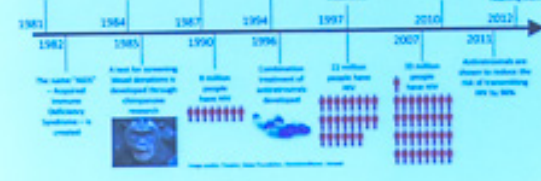
Global Health Strategy and the Millennium Development Goals on the issue of HIV and AIDS were set in the Action Plan



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