

to reconcile with a mere confounding effect of tobacco smoking, while the relative risk for colorectal cancer, for which no infectious cause is known, is of similar magnitude in transplant recipients as the one seen for *Helicobacter*-related stomach cancer in both groups.

A weakness of today's knowledge on immunodeficiency and cancer, however, is that most data derive from North America, Australia, and northern Europe. Fortunately, new studies on cancer risk in people with HIV^{11,12} and transplant recipients⁶ are becoming available from southern Europe and low-resource countries, where the prevalence of cancer-related infections, including HIV, is generally greater than in the populations represented in the meta-analysis by Grulich and colleagues.

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We declare that we have no conflict of interest.

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The Sydney Declaration: a call to scale up research



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The evolution of HIV prevention, treatment, and care over the past quarter century is one of the great successes of medical science. Committed and sustained research efforts have provided the evidence on which approaches to programming are based. These same scientific efforts are now resulting in new prevention technologies and drugs, and new strategies to manage and deliver both. Good research drives good policy.

In recent years resources have dramatically increased for delivery of existing interventions in resource-limited settings. Although funding remains insufficient to meet the increasing need for services, it is imperative that the global community does not lose sight of the future while responding to the immediate crisis. An effective response to HIV/AIDS requires a sustained commitment to ensure that interventions and approaches to service delivery are continuously improved over time. For example, as current first-line antiretroviral regimens become increasingly available in resource-limited settings, there is an urgent need to identify optimum, durable, and well-tolerated

standardised first-line and second-line regimens, and to monitor and respond to resistance patterns as they emerge. Outcomes will not necessarily be the same in diverse settings across the globe.

Operations research is critical, in addition to basic, clinical, prevention, social, and policy research. We must identify which approaches are effective in the field, which are not, and why. We must also learn how to integrate HIV-specific services with primary, tuberculosis, malaria, prenatal and postnatal, and sexual and reproductive health services. None of these services have been as effectively linked to scale-up of HIV programming as is possible or necessary. Furthermore, greater understanding of the social, political, and cultural barriers that perpetuate stigma and discrimination can contribute to ensuring that governments act in the interests of public health.

Operations research will enable rapid implementation of new technologies to prevent, diagnose, and treat HIV infection, and can help to ensure that health systems are

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strengthened as a result of scaling-up HIV prevention, treatment, and care. Unfortunately, few granting agencies or national health budgets commit designated funds to operations research, and where such funding is available, it is often underused. The Global Fund to Fight AIDS, Tuberculosis and Malaria, for example, allows up to 10% of each grant to be allocated for operations research, but this provision is rarely used by countries and the research community is rarely represented on Country Coordinating Mechanisms (CCMs). The lack of participation on CCMs further reduces the likelihood that operations research will be a priority in funding applications.

An ancillary benefit of integrating research into the overall approach to scale-up in the developing world will be an expanding cadre of health-care workers trained in research methodologies and practice. Such research

should not be seen as an additional burden on the various funding bodies or ministries of health but, on the contrary, as the only means by which we can refine our understanding of what is and is not effective.

Last but not least, all areas of research can further strengthen the efforts of the global AIDS community to confront the absurd theories of AIDS denialists as well as the “magic” cures that continue to confuse policymakers, health-care professionals, and communities of people at risk of and living with HIV/AIDS throughout the world. HIV professionals must continuously build on the evidence base to ensure sound and effective policies and practices in HIV/AIDS prevention, treatment, and care.

The undersigned individuals and organisations call on national governments and bilateral, multilateral, and private donors to allocate 10% of all resources for HIV programming to research. We believe that without such funding we will fail to maintain a sustained and effective response to the AIDS pandemic.

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A webappendix lists signatories to this declaration, up until June 25; signatories after then can be found at the website of the International Aids Society (<http://www.iasociety.org/Default.aspx?pagelid=63>). PC has received consultancy fees, honoraria, and speakers’ fees from Abbott, Avexa, BMS, GlaxoSmithKline, Roche, and Tibotec. JK has received research funding, pharmaceutical drugs, and diagnostic equipment from Roche. MB has been paid as a consultant for Roche and Tibotec, and has received funding for conference attendance from Roche and Merck & Co. DC, SL, CM, and RK declare that they have no conflict of interest.

See Online for webappendix

HIV treatment, injection drug use, and illicit drug policies

The global over-reliance on criminal justice approaches to illicit drug use is putting the lives of injection drug users (IDUs) at risk. This policy approach severely undermines HIV-prevention efforts,¹ and the effects may be even worse for HIV-infected IDUs, because criminal justice strategies interfere with IDUs’ ability to access and remain successfully engaged in HIV-treatment programmes.

The HIV crisis has transitioned from an epidemic driven mainly by sexual transmission to one in which syringe-sharing by IDUs contributes to a substantial

proportion of new infections. UNAIDS estimates that a third of new HIV infections outside sub-Saharan Africa are attributable to IDUs.² In North America, IDUs account for about one in four cases of HIV, and in some areas where HIV is spreading most rapidly, such as eastern Europe and central Asia, more than 80% of all HIV cases occur in IDUs.² As this epidemic matures, increasing numbers of IDUs need highly active antiretroviral therapy (HAART).³ Whilst ongoing illicit drug use can create substantial challenges in the delivery of care,