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Editorial

World AIDS Day 2013: "Getting to Zero: Ending AIDS"

In 2010, when UNAIDS put forward its vision of "Zero new HIV infections. Zero discrimination. Zero AIDS-related deaths", the end of AIDS only existed in an aspirational future. Now people are talking concretely about it. In a report released in July 2013 outlining the United Nations Secretary-General's vision for the next global development agenda, Ban Ki-moon called on all countries to 'realize the vision of a future free of AIDS[1]. The post-2015 development agenda will replace the Millennium Development Goals (MDGs) when they expire and will likely set goals for 2030. Meanwhile, the US President unveiled last World AIDS Day (2012) PEPFAR's (President's Emergency Plan for AIDS Relief) Blueprint 'Creating an AIDS-free Generation'[2] which sets out a roadmap for US Government action to this end.

To bring to the debate a rigorous analysis of the evidence and recommendations for how to achieve the end of AIDS, UNAIDS and *The Lancet* are co-convening the global Commission: 'Defeating AIDS - Advancing global health'. Launched in May 2013, the Commission is co-chaired by President Joyce Banda of the Republic of Malawi, African Union Commission Chairperson Dr Nkosazana Dlamini Zuma and Professor Peter Piot, Director of the London School of Hygiene and Tropical Medicine and aims to generate high profile advocacy for ending AIDS as a shared triumph of the post-2015 development agenda.

We are convinced that recent rapid progress in the AIDS response indicates that ending AIDS is achievable in the next development era. However, getting to zero will only be possible with the kind of resolve that has marked the AIDS response to date, combined with bold new actions.

The notion that ending AIDS can be a tangible development goal demonstrates how far we have come. The Millennium Declaration and the MDGs recognize that reversing the global HIV epidemic is a key indicator of, and instrumental to, progress in development. Building on the strength of the AIDS movement, MDG 6 fuelled the scaling up of national AIDS responses, resulting in significant results. Since 2001, the number of people newly infected with HIV each year has been reduced by 20 per cent, thanks to a combination of biomedical, behavioural and structural prevention strategies. Access to antiretroviral therapy now reaches over 8 million people - more than half the people in low- and middle-income countries who are eligible for it, and 20 times greater than the number on treatment in 2003[3]. Resources mobilised for the AIDS response in low- and middle- income countries have increased more than tenfold since 2001[4].

Rapid advances in science over the last three years, including the development of microbicides for women and oral pre-exposure prophylaxis, combined with the scale-up of treatment have brought the vision of the end of AIDS from the realm of dreams, into the realm of reality. Such progress has been made possible by, for example, steady and smart investments, the removal of punitive laws, multi-sectoral action and the roll-out of new medicines and technologies.

India provides a case in point. The country reduced new infections by 57 per cent among adults between 2001 and 2011. India has achieved significant comprehensive programme coverage of key populations, including over 80 per cent among sex workers and over 60 per cent among men who have sex with men (MSM), supported by a sharp increase in the government's share of total spending

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on HIV in recent years[5]. On the global stage, India is pivotal in the scale-up of treatment with Indian generic pharmaceutical companies accounting for at least 80 per cent of antiretrovirals (ARVs) purchased by low- and middle-income countries and over 90 per cent of pediatric ARVs[6]. Despite rapid progress, opportunities for even greater change have been missed and barriers to progress persist.

While further rapid gains are possible, getting to zero the world over will require sustained efforts and innovative approaches. We think six priorities merit attention.

***First, target resources at those most in need, utilizing strategic investment thinking*:** The response must focus on the people and geographical areas in greatest need. A new map of the epidemic as a series of 'hotspots' is emerging. 'Hotspots' are location-specific pockets of transmission, for example, in urban centres or among key populations, where significantly higher prevalence levels are experienced than in the surrounding area or than among the general population. Moving forward, investments must match this new map of mini-epidemics. Morocco is already adjusting its thinking: the country analysed where new infections were occurring and increased its spending on key populations at higher risk accordingly, from 25 per cent to over 60 per cent of its AIDS budget between 2008 and the current plan[7]. The same can be said of India where the strategic targeting of investments to key populations in high priority districts has proven effective[8].

***Second, ensure widespread testing and early treatment*:** Under a third of people living with HIV in Asia know their HIV status. Stigma and discrimination prevent people from getting tested. When patients eventually get tested, their CD4 levels are often below 100, which impairs the efficacy of treatment and precludes any treatment as prevention benefit. Evidence is growing that wider, earlier initiation of ART could reduce population-level incidence of HIV[9] and have cost-saving implications.

***Third, strengthen and diversify financing for sustainable health*:** In the context of shifting global resource flows, financing the AIDS response and global health after 2015 must evolve. Moving beyond Official Development Assistance will require strengthening country ownership, sharing responsibility, ensuring accountability and leveraging innovative financing mechanisms. Shared responsibility and global solidarity, pioneered in the African Union's 2012 Roadmap on AIDS, TB and malaria[10], provides a bold new paradigm for increased domestic funding of the response with ongoing commitment from international partners. Investing in global health means investing in global public goods and as such should be a priority for governments. For the first time ever, in 2011, domestic resources exceeded international investments in the global AIDS response. Asia has substantially increased its funding for HIV in the past 10 years, with China, Malaysia and Thailand now using domestic sources to support over 85 per cent of their AIDS responses[11].

***Fourth, further strengthen monitoring and evaluation systems*:** Comprehensive and timely data are crucial to optimize the use of limited resources, to ensure effective programmes and to build accountability. Next generation M&E technology will enable us to better track in real time how the epidemic is evolving and where interventions are reaching affected communities. India provides an excellent example of how this can be done. It was one of the first countries to systematically use a risk and prevalence mapping approach to develop and sharpen its HIV response, steadily increasing the number of sentinel surveillance sites from around 200 in 2000 to more than 1300 a decade later. The improved data enabled India to focus its HIV response on the most affected areas and populations, with the States of Maharashtra, Tamil Nadu, Andhra Pradesh and Karnataka in the south and Manipur and Nagaland in the north east identified as "priority States"[12].

***Fifth, draw stronger linkages between the AIDS response and other relevant diseases and development issues*:** The recognition that AIDS programmes require multi-sectoral action was key to the creation of national AIDS councils and UNAIDS as a joint programme of several UN entities. But synergies across health and development must be further leveraged. The post-2015 agenda should be designed to build better linkages throughout the new development architecture in a more holistic way. The inter-sections between HIV and non-communicable diseases (NCDs), HIV-TB-diabetes and HIV and hepatitis C are set to become more pronounced in the years to come and, as such, integrated responses should be maximised in both policy and practice.

***Sixth, protect the principles of the AIDS response at the core of joined-up action*:** As the AIDS response is taken further out of isolation, its principles should inform new approaches to health and development. We must continue to promote human rights as both an entitlement and engine of development. People and affected communities should remain in the driving seat

and have a central place in governance arrangements. Hallmarks of the AIDS movement and catalysts for real progress, such as the strong commitment to social justice, human rights and gender equality, should be protected and extended. Lastly, the principle that action should be data-driven, evidence-informed and results-oriented must continue to underpin effective health responses.

In 2013, 32 years after AIDS first hit the headlines as it ravaged gay communities in the US, it is possible to talk about the end of AIDS. Although achievable, the road ahead is challenging and transformative approaches are called for. The UNAIDS and Lancet Commission was initiated to drive this further transformation and galvanise commitment to doing health and development differently. Building on the findings and recommendations of the Commission, ending AIDS provides both a vision around which we can rally and a goal for our collaborative efforts.

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