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UNAIDS-Lancet Commission Working Group 1 Discussion Paper
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Discussion Paper

Envisioning “The end of AIDS”: Challenges and prospects

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[Please note that this is an annotated outline and not a full paper. The paper is provided in this form for consultation to provoke a meaningful discussion on content and avoid over-deliberation on word choice/‘word-smithing’]

ABSTRACT

The decline in HIV and AIDS has created the springboard for renewed impetus against all facets of this devastating global health problem. A unique opportunity exists at this time for the global community to harness the prevailing impetus to envision the end of AIDS. Unprecedented international political commitment, resource mobilisation, and civil society engagement have combined to effectively implement programmes and services using evidence-based technologies and approaches, such as the scale-up of antiretrovirals for therapy as well as for prevention of mother-to-child transmission. Complacency could rapidly reverse this trend. Further, new HIV infections continue to occur in key populations characterised by their marginalisation and vulnerability in society. Greater effort is needed at this point in the 32 year history of the AIDS epidemic. However, mathematical models demonstrate that combinations of available interventions have the potential to reduce the reproductive rate of infection to below 1, which is the level required to sustain the HIV epidemic.

Ending AIDS will not be a simple or easy task and will require much more than political commitment or biomedical tools. A more detailed understanding of HIV transmission at a local level needs to be combined with renewed effort to address ongoing HIV transmission. Concerted action at the local level should learn from past failures, build on local and global successes in implementing effective interventions to scale. Effective implementation will need reinvigorated effort to address stigma and discrimination, integration of AIDS into the broader social development agenda, and the strengthening of health systems and programmes. At the same time, research towards an effective HIV vaccine and a cure needs to continue apace. Now more than ever, we cannot afford to lose the momentum. With a renewed global effort, the end of AIDS is within our grasp.

1 Average number of secondary cases that arise from any new case of infection in wholly susceptible population
1. **Introduction: Is this the right time to talk about the end of AIDS?**

i. **Brief historical overview of the 32 year history of the HIV epidemic**

1.1. Describe the early epidemiology of the epidemic and the associated stigma and discrimination
1.2. Briefly highlight regional specificities
1.3. Capture how the discovery of antiretroviral therapy (ART) changed the epidemic from a death sentence to a chronic manageable disease in many developed countries when treatment first became available, and the role of the private industry in the development of ART
1.4. Highlight the inequities in treatment access between developed and developing countries and how the advocacy of community organisations, trade unions, activist groups, scientists and health care workers demanded that the injustice of global inequity in access to AIDS treatment be ended
1.5. Draw attention to the mobilisation of necessary resources, e.g. Global Fund and PEPFAR that made treatment access a reality in the developing world
1.6. Outline the historical achievements in prevention, scale up of condom use, e.g., Thailand 100% condom use, clean needles for people who inject drugs (PWID), antiretrovirals for mother-to-child transmission, the introduction of rapid HIV testing and later the successes of preventing sexually acquired HIV infection using medical male circumcision. Brief mention of the impact of AIDS prevention programs on reducing other STIs (e.g. syphilis) known to be major co-factors for HIV transmission
1.7. Highlight how HIV brought to light many key sexual and reproductive health issues
1.8. Note that HIV also facilitated programs by governments for marginalised and criminalised populations such as MSM, drug users, and sex workers

ii. **What is the state of the current epidemic?**

1.9. Describe the declining global HIV incidence over the past 10 years and declines in AIDS-related deaths
1.10. Emphasise that, despite the declines, we are still experiencing a significant epidemic. Include current estimates of HIV burden globally with a description of regional differences [Insert Figure of current global epidemic]
1.11. Note that new HIV infections are occurring mainly in “key” populations including young women in Africa, transgender and men who have sex with men (MSM), people who inject drugs (PWID), male and female sex workers, street children and prisoners in many parts of the world. Include brief descriptions of the severity of the HIV epidemic in each of these groups
1.12. Mention the close links between TB and HIV, showing how TB will remain a major threat as long as HIV is not controlled
2. Why “the end of AIDS”? Why now?

i. Progress in preventing sexual transmission of HIV

2.1. Provide a brief summary of the scientific progress over the last 3 years in using ART as both prevention and treatment, as well as challenges
2.2. Highlight the progress in implementing medical male circumcision and the population level impact

ii. Preventing vertical transmission

2.3. Brief description of scale-up, coverage and impact as well as challenges

iii. Preventing transmission in PWID

2.4. Access to clean needles and harm reduction
2.5. Law reform

iv. Progress in scaling up provision of ART

2.6. Progress in scaling up ART and impact on lives saved as well as challenges
2.7. Highlight that the progress would not have been possible without the leadership and commitment of national governments, unprecedented resource mobilisation, an ethos of shared responsibility, global solidarity and the passionate engagement of civil society, NGOs, and most notably people living with HIV themselves

3. Our unique opportunity to choose a future without AIDS

3.1. We have reached a juncture in the AIDS epidemic that enables us to paint a different vision for our future
3.2. This is an opportunity that was not available to us 10 years ago when the global HIV epidemic was increasing
3.3. The progress made in scaling up treatment and prevention provides hope that we can begin to tread the path to the end of AIDS
3.4. An unprecedented opportunity exists now to harness this momentum. Hence, we need to act now and indeed accelerate our efforts to combat this disease
3.5. Now is not the time for complacency – providing an example of how complacency in the TB field has led to the situation we have today of a virtually untreatable TB epidemic (XDR-TB) in some parts of the world
3.6. Provide an example of complacency in a developing country which has resulted in a reversal in past gains by a trend towards increased sexually risky behaviour and rising HIV incidence. Also, concerning trends in complacency among young people in developed countries (AIDS no longer a death threat because of the availability of treatment)
4. What does “the end of AIDS” mean?

4.1. Traditionally talk about eradicating or eliminating disease. At this point in time it is not possible to eliminate or eradicate HIV (as there are millions currently infected) but we can certainly bring down the incidence to a level where the reproductive rate of infection is below 1

4.2. The world needs a countdown on the journey towards the End of AIDS in each country – e.g.

- Point 7: A nationally co-ordinated comprehensive response, including human rights and a legal framework that is conducive to non-discrimination against AIDS
- Point 6: Detailed knowledge of the local epidemiology of HIV, including identifying hotspots, and application of that knowledge to guide investment and programming
- Point 5: Scaling up provision of ART (as part of a comprehensive package of optimum care + medicines + adherence support) to 90% of those qualifying for treatment with 90% annual retention
- Point 4: Elimination of mother-to-child transmission
- Point 3: Number of patients initiating ART exceeds the number of new infections
- Point 2: The incidence rate (number of new infections in the population) reaches a low point where the reproductive rate of infection is less than 1. Each country will need to calculate and define this target level
- Point 1: The number of new HIV infections reaches a point below the threshold established for each country (eg. incidence rate where the reproductive rate of infection is 0.25)

Once point 1 is reached, then at point 0, a new set of locally derived milestones are needed to get to zero new HIV infections along the path to the end of AIDS

4.3. The end of AIDS is an aspirational vision that we hope to achieve over the long term with a program for the next 10-15 years towards this vision

4.4. The end of AIDS encompasses reducing new HIV infections, providing ART to all who require treatment and reducing the stigma and discrimination that prevents people from accessing the care and treatment they need as well as maintaining them in care

5. Is the end of AIDS feasible without a vaccine or cure?

5.1. Ending AIDS will require more than a just biomedical solutions because AIDS is more than a biomedical problem

5.2. Ending MTCT in children is already achievable without a vaccine or cure

5.3. Ending HIV in everyone will require a cure but ending AIDS will not

5.4. We have existing interventions to address social drivers – with examples

5.5. We also have effective biomedical technologies, such as MTCT, male circumcision [Insert Figure]

5.6. Models show how we can set the global epidemic on the path to the end of the AIDS epidemic with current technologies noting that future new technologies are also needed to accelerate progress towards the end of AIDS [Insert Figure demonstrating how scale up of existing technologies can change the epidemic trajectory]
6. What will it take to get to the end of AIDS?

6.1. Achieving the goal of the end of AIDS will require the transformation of the HIV epidemic into low level endemic in most regions of the world over the next 10-15 years

6.2. To achieve the end of AIDS we need to build on successes, learn from failures and implement to scale

i. Know your epidemic – have detailed understanding of local epidemiology

6.3. The HIV epidemic varies considerably between regions and even within countries

6.4. An example is provided illustrating the variance in HIV prevalence between provinces and districts in South Africa

6.5. A detailed understanding of the local epidemiology will enable each country to develop appropriate interventions that respond specifically to their communities’ needs

6.6. The strong geographical variation in HIV prevalence within countries should be strategically used for commitment of resources for focused programmes in high prevalence zones

6.7. “Knowing your epidemic” is essential for all countries, even those with stable and declining epidemics to identify “hotspots”

ii. Scale up of HIV prevention

6.8. Several effective HIV prevention options are already available for reducing new HIV infections but are not being implemented at the necessary scale and magnitude to those who need it most

6.9. Examples will be provided from modelling of the potential impact of tackling individual HIV prevention options to scale

6.10. The gaps in current prevention options will be described, including

- HIV counselling and testing – how to reach those reluctant to test and the importance of HIV testing as a gateway to both prevention and treatment
- MTCT (breastfeeding transmission and reaching those mothers who do not attend antenatal care)
- Circumcision – providing circumcision scale up and creating demand
- Injecting drug use and the need to overcome stigma and discrimination
- Need to implement new technologies like Pre-Exposure Prophylaxis (PrEP) in a targeted manner as part of a comprehensive HIV prevention approach (condoms, needle exchange, risk reduction etc.)
- Importance on focusing resources that target key populations that have not been able to achieve low incidence, for example adolescents and young girls in particular
- Targeting young people, including comprehensive sexual and reproductive health education in schools before they become sexually active
iii. Scale up of HIV treatment

6.11. Have made significant progress but millions still in need of treatment
6.12. One key issue is to maintain people on ART
6.13. Improve treatment for children

iv. Key enablers that will allow us to implement a more effective AIDS response at scale

- Advocacy is not as strong as it was in the beginning of the epidemic. We need to change this and in particular we need young people to inspire a new wave of activism in the AIDS response
6.15. Engagement of civil society to assist governments in achieving their goals, adding depth to services, and reaching the key populations. Importance of embracing the NGOs and CBOs that are doing the work on the ground to help the key populations
6.16. New partnerships and alliances including private sector and religious groups.
6.17. Shared responsibility and global solidarity – need for developing countries to increase domestic investment in the AIDS response while, at the same time, there is a need for substantial and sustained international investment to tread the path to the End of AIDS

6.18. Need to take AIDS out of isolation and need to link it to other health issues
- HIV needs to be integrated with other health issues. e.g. TB, sexual and reproductive health services, maternal and child health, non-communicable diseases such as cardiovascular disease etc.
- By addressing the HIV issue we also have an opportunity to impact on other health issues and contribute to a healthy population
- Providing HIV treatment has led to innovations like task-shifting, rapid HIV tests, etc. Many lessons for health system strengthening that would benefit all health care
6.19. Health system strengthening
- Need to change concept of health system – expanding the “human family”
- AIDS has had huge impacts on so many health issues (other STIs, maternal and child mortality, TB) and non-health related issues (economy: marked reduction of destruction of the work force, the main reason for the massive support and worldwide solidarity, decrease gender and all forms of discrimination). AIDS has created new opportunities for tackling other major world problems
6.20. Sustained political will and incentives for political leadership - Political leaders need to keep up the momentum and fight complacency

v. Deal with underlying social drivers

6.21. Stigma and discrimination
- HIV is not just a biomedical problem – even if we did have a preventative vaccine or a functional cure, we will still have stigma. Stigma against people living with HIV and those at higher risk of infection remains a significant barrier in successfully controlling the AIDS epidemic
• HIV-related stigma and discrimination is a human rights violation that undermines prevention efforts by making people afraid to find out whether or not they are infected, to seek out information about how to reduce their risk of exposure to HIV, and to change their behaviour to more safe behaviour
• Necessary to address such discrimination and stigma in order to achieve public health goals and overcome the epidemic
• Although progress on eliminating stigma and discrimination is difficult to quantify, several projects, programmes and activities throughout the world have successfully challenged stigma and discrimination – with examples

6.22. Legal barriers to the HIV response
• Same sex relationships, sex work and sex outside of marriage is criminalised in many countries. These laws further entrench HIV-related stigma and human rights violations
• The criminalisation of HIV transmission by those HIV positive people who have unprotected sex is impacting on people wanting to know their HIV status
• Travel restrictions based on HIV status is a human rights violation
• Drug policies hinder access to HIV prevention
• Decriminalisation of sex work and drug use can have an impact on the epidemic – using New Zealand and Portugal as examples

6.23. Gender inequality and gender-based violence
• Gender equality and empowerment of women and girls is essential for reducing HIV incidence, for example in sub-Saharan Africa and the Caribbean

vi. Ending AIDS will also require innovation

6.24. Need innovative ways to reach key populations
6.25. Innovation in R&D in service delivery from supply to demand driven, greater use of community-based workers to increase quality, access, efficiency (with examples)
• Improve the retention in the treatment cascade to minimise ART resistance
• Task-shifting

6.26. Further scientific innovations and continued investments to develop:
• Better drugs for treatment (long acting formulations) and better treatment options for paediatric patients;
• Vaccines;
• Microbicides; and
• Cure

7. Conclusion

7.1. Ending AIDS is possible and desirable and is imperative to the post-2015 agenda.
7.2. Reaching the End of AIDS will depend on building on successes, learning from failures and implementing to scale. This applies to both biomedical and social/structural interventions
7.3. Need to also continue development of new diagnostics, including for early post-exposure infection, vaccines, prevention approaches for young women, long-acting/slow release antiretroviral drugs, and a cure
7.4. The end of AIDS will not be reached without continuing many of the current major efforts, continued strong leadership of world leaders, continued international support and continued responsibility and engagement of local governments
7.5. There are challenges but they should not deter us
7.6. Won’t end AIDS tomorrow but it has to be part of our long-term vision for the post-2015 development agenda

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