AIDS, health and human rights: Toward the end of AIDS in the Post-2015 Development Era

UNAIDS contribution to the Post-2015 Global Thematic Consultation on Health

— The international community has delivered remarkable results in its efforts to achieve Millennium Development Goal 6.

— The global AIDS response has won unprecedented health, human rights and development gains in all countries through principles and practices that can inform other work in global health and sustainable development.

— The AIDS response has been about people and not simply a disease.

— The global AIDS response has pioneered an innovative approach to global health governance through its principles of inclusion, accountability, shared responsibility and global solidarity.

— Ending AIDS can be a distinctive, shared triumph in the coming decades that shows what is possible through mobilized communities and global solidarity.
Introduction

Over the last 30 years the AIDS epidemic has claimed more than 35 million lives—devastating families, communities and countries. In response, a global movement emerged focused on getting results for people. It has transformed the way we approach health and development. Inspired by the remarkable progress, world leaders are daring now to speak about the end of AIDS.

While AIDS is far from over, the strategy has been set for the “end game”. AIDS can be ended through renewed and sustained commitment, by ensuring that resources are invested as efficiently and effectively as possible and by ensuring that evidence and human rights inform all efforts.

This paper explains how the global AIDS response can influence the post-2015 development agenda in two ways. First, HIV remains one of the world’s most serious health and human rights challenges. Second, the principles and practices forged in the global AIDS response can make valuable contributions to carrying out development differently across all dimensions of sustainable development: social, environmental and economic.

This paper represents a joint effort of the UNAIDS Cosponsors: ILO, UNDP, UNESCO, UNFPA, UNHCR, UNICEF, UNODC, UN Women, WFP, WHO and the World Bank—and the UNAIDS Secretariat.

The AIDS response

The Millennium Declaration and the Millennium Development Goals recognize that reversing the global HIV epidemic is a key indicator of progress in development. Meeting the goals fuelled the scaling up of national AIDS responses. The movement was driven by a novel coalition of people living with HIV, civil society (including women’s organizations, youth groups, academe, faith-based organizations, key populations and human rights advocates) national governments, the private sector and development partners. This global coalition made the call for universal access to life-saving HIV prevention, treatment, care and support that has resonated throughout the world.

This political mobilization reached the level of the Group of 8 (1) and continued to marshal significant resources not just for health but also for the systems that underpin it. Since the 1990s, the global AIDS community has mobilized a more than 50-fold increase in the resources for HIV responses in low- and middle-income countries (2). These investments are delivering results for people. The number of people newly infected with HIV in 2012 was down 20% from 2001 (3), reflecting a combination of biomedical, behavioural and structural prevention strategies. Access to antiretroviral therapy has been extended to more than 8 million people—more than half the people in low- and middle-income countries who are eligible for it (3). Achieving zero new HIV infections in children increasingly appears possible: between 2009 and 2011, 24% fewer children acquired HIV (3). Recent scientific advances show that quality-assured antiretroviral therapy prevents transmission of HIV (4,5), adding it to the established prevention toolkit.
In the post-2015 development agenda, an expanded, strategic and sustainable AIDS response is needed to reach a global vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths.

**Significant challenges remain ahead**

While the significant achievements in the AIDS response are encouraging, the epidemic is far from over (Table 1). Globally, HIV remains the fifth leading cause of adults dying and the largest killer among women aged 15–49 years (6). In 2011, 34 million people were living with HIV. Despite the overall decline in the number of people newly infected with HIV, 2.5 million people acquired HIV in 2011, including 890 000 young people (7).

Although 8 million people living with HIV are now receiving treatment, nearly 8 million more people are eligible for treatment but unable to access it. People living with HIV face many barriers that interfere with their ability to initiate and adhere to their treatment regimens (8). In some countries treatment drop-out rates exceed 25%. Fear, stigma and discrimination, health system failings as well as poverty and gender inequality have been cited as obstacles.

### Table 1

**Global summary of the HIV epidemic, 2011**

<table>
<thead>
<tr>
<th>People living with HIV</th>
<th>Total</th>
<th>34.2 million</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
<td>30.7 million</td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>16.7 million</td>
<td></td>
</tr>
<tr>
<td>Children (0–14 years)</td>
<td>3.4 million</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>People newly infected with HIV</th>
<th>Total</th>
<th>2.5 million</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
<td>2.2 million</td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>1.1 million</td>
<td></td>
</tr>
<tr>
<td>Children (0–14 years)</td>
<td>0.33 million</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>AIDS-related deaths</th>
<th>Total</th>
<th>1.7 million</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
<td>1.5 million</td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>0.70 million</td>
<td></td>
</tr>
<tr>
<td>Children (0–14 years)</td>
<td>0.23 million</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>People receiving antiretroviral therapy</th>
<th>Total</th>
<th>8.0 million</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women</td>
<td>4.3 million</td>
<td></td>
</tr>
<tr>
<td>Children (0–14 years)</td>
<td>0.57 million</td>
<td></td>
</tr>
</tbody>
</table>

*Source: Global report: UNAIDS report on the global AIDS epidemic 2012 (3).*
Although the numbers of new HIV infections and the AIDS-related deaths are declining in most regions, global and regional statistics mask differences between and within countries in access to HIV services. Compared with urban populations, people in rural areas are more likely to lack access to HIV-specific and general education and health services. Expanding access to services to eliminate new HIV infections among children and keep their mothers alive has lagged for adolescent girls, slowed by factors ranging from inadequate sex and health education and information to legal requirements for parental or spousal consent. Care and support for children affected by HIV, including children living with HIV, are still limited and often rely heavily on private, faith-based and other nongovernmental groups (9).

Despite widespread endorsement of the principle of know your epidemic and know your response, coverage of HIV prevention and treatment remains totally inadequate for key populations at higher risk, such as sex workers, men who have sex with men, people who use drugs and transgender people, and especially for young people in these and other affected groups (10). Female sex workers and men who have sex with men are estimated to be more than 13 times more likely to be living with HIV than the general population, with people who inject drugs being up to 22 times more likely (11). In 2010–2011, however, domestic funding accounted for less than 10% of total spending on HIV programmes for sex workers, men who have sex with men and people who inject drugs (Fig. 1), representing a lack of political will to provide services where they are most urgently required.

Figure 1
HIV spending on most-at-risk populations, low and middle-income countries with available data, 2010 or 2011

Source: 2012 country progress reports [web site] (11).
**Pay now or pay forever**

The onset of the global economic downturn has shaken the hopes of the mid-2000s of mobilizing the full funding needed for universal access. Since 2008, international investment for the global AIDS response has stalled. Domestic investment in HIV by low- and middle-income countries rose by 15% from 2010 to 2011 (3), indicating increased country ownership, but many countries still rely heavily on international assistance. Sixty-one countries receive more than half their HIV funding from abroad and 38 rely on international sources for 75% or more (11).

Regional leadership toward sustained and country-led responses has led to a new paradigm of shared responsibility and global solidarity. The African Union, for example, has adopted a Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria (12) that outlines practical steps by which African countries, together with development partners, can deliver sustainable results across the continent. Shared responsibility and global solidarity move away from traditional donor–recipient relationships towards novel forms of development cooperation and governance as exemplified by South–South and triangular cooperation.

International solidarity, political advocacy, technical support and funding must be intensified if progress is to be maintained and accelerated. A decline in international support would not only be a retreat from an ethical obligation but would also imperil returns on the significant investment made to date and push ending AIDS further off into the future. As UNAIDS Executive Director Michel Sidibé has stated, “It is not a question of paying now or paying later. Either we pay now or we pay forever.”

**Maximizing value from scarce resources through accountability**

A key feature of the AIDS response has been its practical commitment to mutual accountability and to achieving value for money (13,14). More than a decade of investment in harmonized national planning and HIV monitoring and evaluation systems (15) has enabled countries to track their HIV resources, basic HIV services and key epidemiological indicators. Civil society participation has been critical to progress reporting based on the decisions of the 2001 United Nations General Assembly Special Session on HIV/AIDS (later called Global AIDS Response Progress Reporting) on a range of indicators from clinical services delivered to political commitment demonstrated (16).

The global AIDS response’s unprecedented investment in transparent national oversight mechanisms, from advocacy groups to country coordinating mechanisms—in which people living with HIV and other affected communities sit with technical experts and policy-makers—have enhanced the relevance, ownership and coordination among stakeholders in HIV programmes.

The emphasis on monitoring and evaluation has strengthened traditions of evidence-informed policy dialogue and sparked social debate. As a result programmes are more efficient and accountable to people. In 2012, 186 United Nations Member States submitted comprehensive reports on progress in their national AIDS response (3). The Global AIDS Response Progress Reporting system has among the highest response rates of any international health and development monitoring mechanism, reflecting the engagement and mutual accountability of government, civil society and development partners.
Progress in the AIDS response has driven and benefited from progress across the health spectrum

Each national HIV epidemic and response interacts with a range of health and social issues. The AIDS epidemic is integrally linked to sexual and reproductive health, maternal and child health, family planning, sexually transmitted infections and gender-based violence. The vast majority of the people newly infected worldwide acquire HIV through sexual transmission or in connection with pregnancy, childbirth and breastfeeding. The HIV epidemic and poor sexual and reproductive health are driven by common root causes, such as poverty, lack of education including sexuality education, gender inequality, inadequate health services, social marginalization of the most vulnerable people and lack of protection for human rights (17–19).

According to one global analysis (20), each additional percentage point in HIV prevalence is associated with 8% higher infant mortality and 9% higher mortality among children younger than 5 years. In the absence of HIV, the estimated number of maternal deaths worldwide would have been 18% lower in 2008 (21). Family planning can reduce maternal mortality by one third and contributes to preventing children from acquiring HIV infection (22).

The HIV and tuberculosis (TB) epidemics are intertwined. The risk of developing TB is estimated to be between 20 to 37 times greater among people living with HIV than among those without HIV, and TB is the primary cause of death among people living with HIV (23). WHO estimates that scaling up collaborative HIV and TB activities prevented 1.3 million people from dying of AIDS-related causes between 2005 and 2011 (3).

Traditionally, diseases have been classified as either infectious diseases or chronic, noncommunicable diseases. The need for lifelong HIV treatment challenges that dichotomy. HIV and noncommunicable diseases have become the major chronic diseases of public health concern in low- and middle-income countries (24). As millions of people living with HIV age, they face a higher risk of noncommunicable diseases than the general population. Some antiretroviral drugs may also increase the risk of heart disease and diabetes, and HIV infection itself increases the risk of some types of cancer (25).

Although some health risks may interact with the HIV epidemic in harmful ways, their intersection also presents opportunities for integrating HIV services and other health and social development services. Examples include the following.

- Expanding the links across health services (drug-dependence treatment programmes, sexual and reproductive health services and community-based delivery) is key to providing services for adolescents at higher risk (26).

- Integrated health and human rights education and communication can be more efficient and sustained than disease-specific campaigns and can be integrated with comprehensive sexuality education, disseminating new, HIV-sensitive labour standards (27) and education for global citizenship (28).

- Increasingly, HIV treatment is being initiated and delivered through maternal health systems through task-shifting to midwives and nurses (29). Integrated platforms with strong community outreach can offer a range of services to reduce maternal and child mortality,
including empowering women and men to fully realize their sexual and reproductive health and rights.

**Health systems**

The remarkable mobilization of resources for the global AIDS response and the increasingly integrated and holistic approach of the response in many countries have served as a platform to drive progress across health systems. The Global Fund to Fight AIDS, Tuberculosis and Malaria estimates that nearly one third of its approved investments have been designed to strengthen health systems (30).

Key examples of HIV investments strengthening health systems include:

- stronger maternal and child health services, especially by massively scaling up services to prevent children from becoming newly infected and to keep their mothers alive (31);
- improved and expedited access to public goods such as pharmaceuticals and medical devices (32);
- scaling up and improving chronic care systems, strengthening laboratory and blood safety services and improving efficiency through task-shifting (31,33);
- expanding investment in nutritional support, recognizing the vicious cycle between poverty, food insecurity, treatment adherence and malnutrition (34);
- reinforcing health information systems with HIV monitoring and evaluation guidance and national spending assessments spanning health, education, labour, justice and social welfare (35); and
- building the capacity of human resources, especially by training health and community workers (30).

**Science and research**

The global AIDS response has driven extraordinary progress in basic, clinical and social science. It has brought renewed focus on implementation science and operations research (36). HIV research funding has expanded South–South and North–South collaboration in the health sciences and focused new energy on the social, cultural, economic and political context of health, vulnerability and risk.

The global AIDS response has brought concerted focus on the interface between biomedical and social strategies. Examples include work in harm reduction among people who inject drugs, HIV testing and counselling for couples. It also includes social marketing of condoms and other health commodities. Efforts in the area of human rights sensitization and training of police, judges, prison authorities and health care workers have enabled key populations at higher risk and young people to access HIV and health services.

HIV research has led to broadening the definition of scientific evidence to address the social and biomedical complexity of HIV risk and vulnerability. It has established a global consensus on good participatory practice and ethics in AIDS research—with lessons for research in other complex and sensitive areas (37,38). HIV research is rendering obsolete the dichotomies between biomedical and social-behavioural approaches as well as between treatment and prevention (39,40).
The AIDS community’s confidence in science, new technologies and strategic planning have helped world narrow the gap between innovation and implementation. In relation to pharmaceuticals, the AIDS response has been at the forefront of driving innovation. It has changed the face of clinical trials globally and improved the entire drug registration process in the global North, for example, through the fast tracking of registration and through community participation in national drug regulatory authorities (41–43). The quest for a cure and an HIV vaccine has played a key role in shaping 21st-century immunology and virology (44).

Pushing for positive social change: addressing health, human rights, vulnerability, equity and access

HIV infection rates have persistently aligned with various forms of social disparity. People have been discriminated against or stigmatized on the basis of issues such as age, gender, economic status, residence, education, mobility and citizenship, disability, occupation, marginalized sexual orientation and drug use behaviour, over and beyond their HIV status. This has made the movement for social justice, participation, equality and security central to the global AIDS response (45,46).

The AIDS movement broke the silence around sexuality, around gender and sexual norms that can oppress women and girls and lesbian, gay, bisexual and transgender people and around sexuality among young people. The movement has worked to overcome stigma and discrimination against people living with HIV and hold men and boys accountable for actual or threatened gender-based violence.

Although research on social factors has been underemphasized (32), AIDS programmes have revealed that harmful social norms can be changed (47) through education, strategic, social and behaviour change communication and removing punitive laws and policies.

Asserting leadership and resisting discrimination or neglect, people living with and vulnerable to HIV have formed networks of activism. Global networks of sex workers, men who have sex with men, transgender people and people who use drugs, women and girls, young people and other vulnerable groups have redefined community mobilization and strategic advocacy and won major improvements in policies and programmes (48,49) in both the public and private sectors.

In 2010, advocates secured a landmark common agenda to meet the HIV needs and rights of women and girls (50). More than 100 national programmes committed themselves accountable to a set of concrete actions to secure better evidence, end gender-based violence, engage men and boys,
empower and build the capacity of women and girls and provide universal access to sexual and reproductive health, including comprehensive sexuality education. These gender-transformative strategies are fundamental, not only to achieving HIV goals but to broader health, rights and economic and social development.

Gender equality, community ownership, inclusion of the most vulnerable people and recognition of the social determinants of health are themes in all efforts to confront and correct health disparities (51,52). Engaging young people in HIV responses builds on and aligns with global efforts to promote and protect the rights of children and young people and to leverage the experience and energy of youth in working for social justice.

Social protection is increasingly recognized as a holistic framework for promoting capacity and access to the health, social, educational and economic resources for health for all. HIV and human rights advocates promote HIV-sensitive social protection—policies that address the needs of key populations at higher risk and marginalized groups (53). For many countries, expanded social protection is an important enabler of progress on other development goals. For example, conditional cash transfers have played a significant role in achieving Millennium Development Goals related to health and education; social safety nets contribute to reducing poverty (54).

Innovations for more relevant and effective health and development governance

With a global movement behind it, the AIDS response has been an innovator in health governance.

The AIDS movement established the expectation that people living with and affected by HIV should help drive all policy-making that affects their interests. Adoption and enforcement of this norm by HIV advocates has improved the quality and focus of HIV programmes and has energized health oversight bodies, from WHO scientific and technical advisory boards to the governance mechanisms of international organizations (such as UNAIDS and the Global Fund) and national entities (such as Global Fund country coordination mechanisms (CCMs)).

AIDS activists have elevated HIV to an issue of high politics and global solidarity. Policy tools such as the “three ones” principles (one agreed HIV action framework, one national AIDS coordinating authority and one country-level monitoring and evaluation system) have raised expectations for multisectoral and multi-partner coordination for country-owned health and development priorities. Regional economic and political entities such as the African Union, the Economic and Social Commission for Asia and the Pacific, the Caribbean Community and development banks have stepped up their roles in global health through their action on AIDS. Using platforms ranging from the United Nations Security Council to social media, new political spaces have been created where governments and civil society come together to hold each other accountable for commitments made—and to demand further action.

Innovating governance mechanisms

A six country study compared existing models of national coordination of AIDS responses in Belize, El Salvador, India, Indonesia, Malawi and Tanzania. Some countries looked to integrate National AIDS Councils and Global Fund CCMs to streamline governance structures and avoid costly duplication. In Tanzania, the government replaced the CCM with the Tanzania National Coordinating Mechanism (TNCM), with the expanded role of coordinating all international resources for HIV, TB and malaria. The TNCM now provides a unified forum for sharing information amongst all stakeholders, enabling development partners to minimize duplication and reinforce synergies with improved information sharing.

UNDP 2013. National Coordination of AIDS Responses: An Issues Brief
The new paradigm of shared responsibility and global solidarity has enabled the AIDS movement to confront and overcome market forces and obstacles in global governance to improve access to affordable, quality-assured medicines. AIDS activists joined forces with governments in countries such as Brazil and Thailand to ensure that the flexibilities inherent in the TRIPS (Trade-Related Aspects of Intellectual Property Rights) Agreement would facilitate international trade in generic medicines – giving concrete expression to the principle that international human rights law and the right to essential medicines should supersede intellectual property protection.

The structures governing the AIDS response are increasingly country-owned and responsive to country contexts while preserving established principles, including engagement of sectors outside of health. Areas such as education, labour, social welfare, justice and finance are especially important. Structures are also increasingly decentralized, aligned to broader national priorities, and ensuring the meaningful engagement of civil society and affected populations (49).

Moving forward: five considerations for the post-2015 development agenda

As countries and communities reflect on the past and work towards a shared vision of the future, UNAIDS offers five overarching considerations:

1. The international community has delivered remarkable results in its efforts to achieve Millennium Development Goal 6; however, progress remains uneven and insufficient. Intensified efforts in the AIDS response will accelerate the achievement of other health goals—from strengthening health systems to addressing non-communicable diseases to improving maternal and child health and sexual and reproductive health and rights.

2. The global AIDS response has won unprecedented health, human rights and development gains in countries of all income levels through principles and practices that can inform other work in global health and sustainable development. Future development investment to strengthen the promotion of human rights and gender equality can ensure that no one is left behind.

3. The AIDS response has been about people and not simply a disease. Similarly, a more people-centred approach to development that addresses people’s opportunities and needs in a holistic way and gives priority to the engagement of communities in decision-making, including young people, marginalized groups and key populations at higher risk, will deliver more sustainable progress.

4. The global AIDS response has pioneered an innovative approach to global health governance through its principles of inclusion, accountability, shared responsibility and global solidarity. This transformative partnership agenda enables authentic country ownership, manifested in political leadership, active communities and local voices.

5. Ending AIDS can be a distinctive, shared triumph in the coming decades that shows what is possible through mobilized communities and global solidarity. A world that remains united to end AIDS will inspire civil society, governments and global development partners to tackle other complex 21st-century challenges that are shared by all countries.
References


