An Action Agenda to End AIDS

Critical Actions from 2012-2016 to Begin to End the HIV/AIDS Pandemic

JULY 2012
ver the last year, the conversation about the AIDS epidemic has dramatically changed. We’re now beginning to talk about how to end it. The hope stems from research breakthroughs as well as an accretion of evidence on the potential impact of “combination prevention,” which the US government has defined as including voluntary medical male circumcision, the use of ART treatment in HIV-positive people to reduce risk of transmission prevention of pediatric infections and HIV testing.

To begin to end the epidemic, we need to be strategic and ambitious in what is available today. There is evidence on the impact some of these core strategies can have when combined with other interventions. And there is modeling that shows that these strategies, taken to scale and with attention to key populations, will reduce deaths, new infections and the price tag for the AIDS epidemic over the long term.

So there is agreement that the world can begin to end the epidemic. But there is an open and urgent question as to how.

This report lays out a plan for beginning to end the AIDS epidemic. It includes clear time-bound outcome targets, as to reduce deaths, new infections and the price tag for the epidemic. But there is an open and urgent question as to how.

This plan focuses on scaling up a limited number of core interventions that will have the greatest impact and offer the greatest value in epidemics driven by sexual transmission. We emphasize, too, that comprehensive harm reduction, decriminalization and human rights protections must be combined to effectively address the epidemics among injection drug users, men who have sex with men (MSM) and sex workers around the world. Failure to implement these strategies at scale remains a major missed opportunity of HIV prevention to date.

As the concept of combination prevention takes hold, there will inevitably be debates about which interventions to prioritize. We believe the test should be to identify the cost-effective approaches that will best reduce HIV incidence and AIDS-related morbidity and mortality. Thirty years into the epidemic, we cannot afford—literally—to choose any other criteria for prioritizing our efforts. Available evidence indicates that the following core interventions meet this test and deserve to serve as the backbone of efforts to begin to end the epidemic:

- **HIV Testing**—to dramatically increase the number of HIV-positive and -negative individuals who know their status early and access needed services.
- **HIV Treatment**—to move to global implementation of ART guidelines that optimize treatment and prevention benefits.
- **Voluntary Medical Male Circumcision**—to achieve 80 percent coverage among adult males (ages 15-49) in 14 priority countries.
- **Prevention of Vertical Transmission**—to virtually eliminate new infections in children by 2015.

To end the epidemic, we cannot do everything in every setting. Nor can we look to limited AIDS funding to address all the many ills that undermine health and development. Core interventions should be complemented, where indicated by local circumstances, by other strategies, such as condom promotion, harm reduction, behavior change strategies, demonstration projects for pre-exposure prophylaxis and programs to address underlying determinants of HIV risk. There are multiple agendas focused on protecting human rights, addressing structural drivers, rights and health of injection drug users, gay men and other men who have sex with men, sex workers and other key populations, and advancing reproductive health rights and justice. These and many others are not captured explicitly in this document. They underpin it nonetheless.

At this historic moment, all stakeholders need to commit to a common goal. We must focus and hold ourselves accountable. And while working to deliver core interventions to broad scale, let our actions and investments continue to support the search for a preventive vaccine and a cure for HIV/AIDS, which will make permanent the favorable changes that strategic action in the next five years will generate.

### If we do this...

- **Make hard choices by prioritizing rapid and comprehensive scale-up of core interventions along with specific, rights-based approaches to reach populations at greatest risk.**
- **Mobilize sufficient, sustainable resources to ensure the rapid and comprehensive scale-up of core interventions.**
- **Agree on clear roles and responsibilities and hold one another accountable for results through agreed timelines, target outcomes, transparent reporting and real-time assessment of results.**
- **Build the evidence base to end AIDS by prioritizing implementation research and the search for a preventive vaccine and a cure.**
- **Use every resource as effectively as possible by lowering the unit costs of core interventions, improving program management and strategically targeting services.**

### We can achieve this...

- **Focused, Evidence-Based Prevention Programs for Key Populations**—to ensure that drivers of the epidemic are addressed.

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"America’s combination prevention strategy focuses on a set of interventions that have been proven most effective — ending mother-to-child transmission, expanding voluntary medical male circumcision, and scaling up treatment for people living with HIV/AIDS. Now of course, interventions like these can’t be successful in isolation. They work best when combined with condoms, counseling and testing, and other effective prevention interventions. And they rely on strong systems and personnel, including trained community health workers. They depend on institutional and social changes like ending stigma; reducing discrimination against women and girls; stopping gender-based violence and exploitation, which continue to put women and girls at higher risk of HIV infection; and repealing laws that make people criminals simply because of their sexual orientation.”

— US Secretary of State Hillary Clinton

November 8, 2011
ENDING AIDS: Game changers

**YESTERDAY**

- **AGLUA DECLARATION**
  - African Union countries pledge to spend 15% of budgets on health

- **GLOBAL FUND**
  - For AIDS, Tuberculosis & Malaria formed

- **PEPFAR**
  - Launch of President’s Emergency Fund for AIDS Relief

- **CHAI**
  - Clinton Health Access Initiative negotiates affordable prices for generic ARVs

- **WHO 3 BY 5 INITIATIVE**
  - Launches as a global target to provide 3 million people living with HIV/AIDS in low- and middle-income countries with treatment by the end of 2005

- **NEW INVESTMENTS**
  - in HIV prevention research & development yield results throughout decade

**SOUTH AFRICA AIDS RESPONSE SCALE-UP**
- Government scales up provision of ART

**NEW WHO ART GUIDELINES**
- Earlier initiation of ART, starting at CD4 count of 350, up from 200

**CONSENSUS**
- on access to ART for all

**KANTANAN NATIONAL ART PROGRAM**
- National policy aims to provide access to ART for all

**ART COVERAGE**

- **$1.4 B** $1.6 B $3.2 B $5 B $6.1 B $8.3 B $11.3 B $13.7 B $16 B

**47%**

**95%**

**60%**

**73%**

**86%**

**ART COST/YEAR**

**ART VMMC COVERAGE**

- **1.5 M**
- **4.7 M**
- **15 M**
- **20 M**

**ABUJA DECLARATION TARGETS MET**
- Abuja Declaration achieved, yielding an additional $5 billion annually for AIDS

**Projected outcomes are estimated based on epidemiological and impact modeling from a range of sources. For more information and sources and for the most up-to-date version of this graphic as progress is tracked over time please visit www.endingaids.org**

**TOMORROW**

- **GLOBAL FUND RESTORED TO FINANCIAL HEALTH**
  - International donors replenish Global Fund

- **HUMAN RIGHTS**
  - 90% new countries commit to end same sex behavior

- **HARM REDUCTION**
  - Implemented in 75% of countries

- **NEW WHO ART GUIDELINES**
  - Full implementation of “AIDS-Free Generation” strategy

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**VMMC COVERED**

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**HIV VACCINE**

- First proof of concept

**MICROBICIDES**

- First proof of concept

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**END**

Build the evidence base to end AIDS

Make hard choices

Use every dollar of funding as effectively as possible
### Make hard choices by prioritizing the rapid and comprehensive scale-up of core interventions, along with specific, rights-based approaches to reach populations at greatest risk.

<table>
<thead>
<tr>
<th>Year</th>
<th>Target</th>
<th>Description</th>
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</table>
| 2012 | -      | National governments expedite planning and implementation of strategic scale-up of core interventions, with focus on bringing combined prevention to scale, and initiate processes to monitor implementation. National governments, supported by international donors and technical agencies, commit to end waiting lists for core interventions. National governments, UNAIDS, and PEPFAR coordinate national funding commitments for 2013 with core interventions and UNAIDS Investment Framework goals. 
| 2013 | -      | All national governments demonstrate steps to implement combination prevention focused on core interventions as outlined by epidemic profile including needs of key populations. 
| 2014 | -      | 80% of national governments improve alignment of spending in order to scale-up core interventions as outlined by epidemic profile including needs of key populations. 
<p>| 2015 | -      | All national governments have defined combination prevention roll-out plans focused on core interventions for their local epidemic. 60% of national governments improve alignment of spending in order to scale-up core interventions as outlined by epidemic profile including key populations. 100% of national governments improve alignment of spending to scale up core interventions consistent with epidemic profile including key populations. |</p>
<table>
<thead>
<tr>
<th>Year</th>
<th>Results</th>
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<tbody>
<tr>
<td>2000</td>
<td>• Durban International AIDS Conference generates new energy to expand ART in developing countries</td>
<td>2008</td>
<td>• For first time, a clinical trial finds experimental vaccine reduces HIV risk</td>
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<td>2001</td>
<td>• UN General Assembly Special Session on HIV/AIDS (UNAIDS) results in unanimous agreement on targets in the global response</td>
<td>2009</td>
<td>• India overturns penal code criminalizing homosexuality</td>
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<td>2002</td>
<td>• Doha agreement formally permits developing countries to use generic drugs and other trade flexibilities to address AIDS and other health crises</td>
<td>2010</td>
<td>• Multi-country trial finds daily oral PrEP using TDF/FTC reduces risk of HIV transmission in heterosexual men and women</td>
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<td>2003</td>
<td>• The Global Fund launched and issues first grants</td>
<td>2011</td>
<td>• UNAIDS launches new Investment Framework</td>
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<td>2004</td>
<td>• U.S. President George W. Bush creates PEPFAR</td>
<td>2006</td>
<td>• First FDA approval of a generic ARV</td>
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<td>2005</td>
<td>• Botswana becomes first African country to provide free ARVs through the public sector</td>
<td>2007</td>
<td>• WHO formally recommends scale-up of VMMC for HIV prevention</td>
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<td>2006</td>
<td>• U.S. launches expedited review for fixed-dose ART combinations for use by PEPFAR</td>
<td>2008</td>
<td>• WHO issues guidance recommending provider-initiated HIV testing</td>
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<td>2007</td>
<td>• WHO launches “3 by 5” initiative, with the goal of providing ART to at least 3 million people by December 2005</td>
<td>2009</td>
<td>• PEPFAR is reauthorized at $48 billion</td>
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<td>2008</td>
<td>• Clinton Foundation secures major reductions in prices of ARVs</td>
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<td>2009</td>
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<td>2011</td>
<td>• A study finds that ART reduces the risk of HIV transmission in serodiscordant couples by 96%</td>
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<td>2010</td>
<td>• Global community endorses universal access to HIV prevention, treatment, care and support</td>
<td>2001</td>
<td>• Five major pharmaceutical companies agree to lower prices for AIDS drugs</td>
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<td>2011</td>
<td>• Product (RED) launched</td>
<td>2002</td>
<td>• Millennium Development Goals call for action to halt HIV by 2015</td>
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<td>2002</td>
<td>• U.S. CDC recommends routine testing for all adults</td>
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<td>• More than 2 million AIDS deaths peak at 2.2 million</td>
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<td>• More-Skiers deaths occur (2+ million) in two periods: 2002-2003 and 2006-2007</td>
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<td>• Soviet countries commit to new debt relief for Africa</td>
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<td>2007</td>
<td>• VMMC shown to be effective in two additional clinical trials</td>
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<td>2008</td>
<td>• UNAIDS and WHO report ARV coverage increased by 36% in one year</td>
<td>2009</td>
<td>• New South African President Jacob Zuma commits to strengthen national response</td>
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**GLOBAL AIDS TIMELINE 2000-2011**

**PROGRESS IN RESPONSE**
amfAR, The Foundation for AIDS Research, is one of the world's leading nonprofit organizations dedicated to the support of AIDS research, HIV prevention, treatment education, and the advocacy of sound AIDS-related public policy. Since 1985, amfAR has invested more than $340 million in its programs and has awarded grants to more than 2,000 research teams worldwide.

amfAR’s research investments—made principally through grants and fellowships awarded to leading researchers worldwide—have led to major advances in HIV treatment and prevention. For example, amfAR-funded research has contributed to the development of four of the six main drug classes that are helping people with HIV/AIDS live longer, healthier lives. And amfAR pioneered the research that led to treatments that prevent mothers from passing HIV onto their newborn children.

For the past decade, amfAR’s research investments have been focused squarely on a cure. Through the amfAR Research Consortium on HIV Eradication (ARCHE), the Foundation has brought collaborative teams of researchers together to explore ways to overcome the barriers that stand in the way of eradicating HIV.

Since awarding its first international grant in 1986, amfAR has supported HIV research, prevention, education, and advocacy efforts in regions of world that have been particularly hard hit by AIDS. amfAR’s TREAT Asia program is widely regarded as a model of regional collaboration on HIV/AIDS. amfAR’s MSM Initiative provides financial and technical support to community organizations in developing countries working to reduce the spread and impact of HIV among gay men, other men who have sex with men (MSM), and transgender individuals.

One of the earliest and most respected advocates for people living with HIV/AIDS, amfAR galvanized national leadership on AIDS and was instrumental in securing the passage of key legislation that has formed the bedrock of the U.S. response to AIDS for more than two decades, including the Ryan White CARE Act. Through its public policy office, amfAR continues to educate policy makers, the media, and the public about evidence-based policies to address HIV in the U.S. and around the world.

For more information, visit www.amfar.org.

AVAC focuses in four priority areas:

• Develop and advocate for policy options to facilitate the implementation of available biomedical HIV prevention options as well as the expeditious and ethical development and evaluation of new ones.
• Ensure that rights and interests of trial participants, eventual users and communities are fully represented and respected in the scientific, product development, clinical trial and access processes.
• Monitor HIV prevention research and development and mobilize political, financial and community support for sustained research as part of a comprehensive response.
• Build an informed, action-oriented global coalition of civil society and community-based organizations that exchange information and experiences.

For more information on AVAC’s work and how to support it, please visit www.avac.org.