

amounts of assistance have been funnelled through programmes established for quick results outside of country systems, often prompting governments to reduce their spending on health. This approach is no longer tenable. Development assistance for health has to be better coordinated among partners than at present, flow increasingly through country systems, and be linked to increases in government spending on health. The recent slowdown in development assistance for health growth also highlights the need to prioritise institutional capacity building and to develop plans that help countries ease the transition from grant to concessional and eventually self-financing. The *Global Financing Facility in Support of Every Woman Every Child*<sup>11</sup> will spearhead these changes with its focus on national leadership, alignment of financing behind strategic investments, and improvements in local health financing systems.

While the challenge is daunting, attaining UHC and its sustainable financing by 2030 is feasible for most countries. Success will depend on governments and partners aligning their objectives into a coordinated strategic effort. Together, we can rise to this challenge and shape a new era of global health financing.

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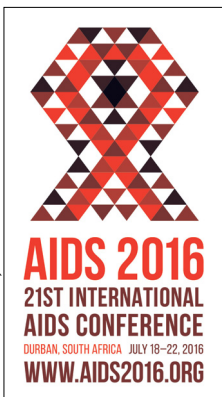
## AIDS 2016: from aspiration to implementation

Since AIDS was first recognised in 1981, more than 75 million HIV infections and more than 36 million deaths have occurred.<sup>1</sup> HIV infection is no longer an inexorable death sentence but a chronic manageable infection. Key factors responsible for this transformation have been an understanding of the modes of HIV transmission,<sup>2</sup> the development of effective combination antiretroviral therapy,<sup>3</sup> and the validation of surrogate markers to monitor the response to treatment.<sup>4</sup> But currently less than half of all people living with HIV worldwide have access to life-saving antiretroviral therapy,<sup>5</sup> at a time when donor interest is uncertain and global funding flattening.

The upcoming 21st International AIDS Conference (AIDS 2016) in Durban, South Africa, on July 18–22, 2016, must take on the challenge of expanding access to HIV treatment. HIV incidence is not declining fast enough to reduce the global burden of the epidemic. In some populations, including young women in sub-Saharan

Africa, young gay men and transgender women worldwide, and people who inject drugs in eastern Europe and central Asia, HIV infection rates are rising in 2016.<sup>1</sup> The basics of HIV prevention have not been delivered for these populations (ie, condoms, clean needles, opiate substitution therapy),<sup>6</sup> let alone provision of newer prevention methods such as antiretroviral pre-exposure prophylaxis (PrEP).<sup>7</sup> Human rights and social justice protections required for safe implementation of evidence-based HIV prevention have not been established in many countries. Some nations have enacted harmful laws and policies that undermine effective HIV responses, including laws further marginalising lesbian, gay, bisexual, and transgender people. A highly effective HIV vaccine, or a cure,<sup>8</sup> remains elusive. As the HIV world gathers in Durban this July, we face enormous challenges.

The last International AIDS Society (IAS) meeting in Durban in 2000 was a transformative event. It was



the first major AIDS conference held in the epicentre of the epidemic—and as we return, the host province of Kwa-Zulu Natal still has among the highest rates of new HIV infections among girls and women seen anywhere.<sup>9</sup> In 2000, attendees had to grapple with differential access to HIV treatment based on income, country, and region. Since then, we have learned a great deal. Rigorous studies have proven that antiretroviral treatment is most beneficial if initiated as soon as people are diagnosed with HIV,<sup>10</sup> and that early treatment can prevent new infections.<sup>11</sup> The use of PrEP can substantially reduce HIV incidence for those at greatest risk<sup>12</sup>—although only a few countries worldwide have implemented PrEP.

But so much remains to be achieved. More than 17 million people are on treatment worldwide but this means that about 20 million HIV-infected people are still untreated.<sup>13</sup> How will the global commitment necessary to ensure access to routine HIV testing, linkage to care, access to medication and treatment, as well as preventive services, be maintained? How will civil society partners remain supported in an increasingly medicalised response to HIV? How will programmes to support behavioural health issues (eg, risk reduction, medication adherence, treatment of concomitant psychosocial issues) be sufficiently scaled up? The Durban AIDS 2016 conference will be an opportunity to share best practices from across the globe and to take on these challenges. The impetus to develop successful programmes was the legacy of the 2000 Durban meeting, but in 2016, we need to move from models to mainstream if we are to take control of the epidemic. HIV cure and vaccines are essential goals, but while we investigate them, we can create a world in which no one with HIV has to die of tuberculosis or immunodeficiency. AIDS 2016 will highlight how those at risk can protect themselves against HIV using evidence-based bio-behavioural interventions, provided that governments do not suppress sexuality, nor gender expression, or deny substance users harm reduction services. Over the past 16 years, many best practice programmes have been developed. AIDS 2016 will be the forum for their presentation, dissemination, and replication, which can bend the

epidemic curve. We hope that this Durban conference will point the way towards the ultimate control of the devastation of AIDS.

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