The time window of the Millennium Development Goals (MDGs) will close at the end of next year, and the world is assessing progress. Meanwhile, behind the scenes, the future of human development is being shaped by a variety of stakeholders with a diversity of interests and goals. Separate priorities are scrambling for position – climate change and environment, poverty, food insecurity, conflict and violence, water and sanitation, youth empowerment, gender and LGBT justice – and there is growing concern that health is not being prioritised. This is a shortcoming we cannot afford and an opportunity we cannot miss.

It is not a matter of health ‘winning’ the race to the top of the post-2015 agenda. Essentially, development is not possible without healthy societies. Health cuts across every challenge facing human development and every challenge is fuelled by social inequities. By focusing on improving health and longevity, we can make inroads into all of them.

Thirty-plus years of the global AIDS response has demonstrated that health is an entry point to dealing with larger issues affecting society – like human rights, social justice, equitable opportunity, universal access to services and more. AIDS brought sensitive issues into the light and started the debate on solutions. Without these discussions, we could not have introduced successful harm reduction programmes for intravenous drug users in places like Australia and Malaysia. Countries like India may not have been emboldened to break patents and produce badly needed generic drugs. Violence against women and girls became a community health issue as well as a UN Security Council resolution. The AIDS movement turned marginalised communities of people into powerful civil society organisations that demanded universal access to services, challenged stigma, and battled discriminatory laws and damaging social practices.

With its proven track record of breaking through political gridlock; mobilising people, resources and innovation; and delivering results, the AIDS response will be a powerful lever in the post-2015 era to achieving unprecedented progress across human rights, health and development.

As we look to shaping a new development agenda, we must not pack the health MDGs into a box of expired initiatives and start anew. We have made incredible progress – against killer diseases like malaria, tuberculosis and HIV, and towards improving health outcomes for women, children and babies. But these trends are not self-sustaining. It will take continuing hard work to stay on this trajectory and not slip back.

Ending AIDS is essential

AIDS is not over and that is a major barrier to the future of development. Inequities and marginalisation drive the AIDS pandemic; meanwhile, the impact of AIDS deepens poverty and increases inequalities at every level, from household to global. It dilutes economic growth, especially in Africa, but also among marginalised communities in high-, middle- and low-income countries alike. The Commonwealth countries comprise 64 per cent of the global HIV epidemic. The countries with the highest number of people living with HIV are South Africa, Nigeria, Kenya, Mozambique, Uganda, Tanzania, Malawi and Zambia.

Ending AIDS must have a prime position on the post-2015 agenda. There is a growing call to help the world define a bold vision for ending the AIDS epidemic as a distinct Sustainable Development Goal in the post-2015 framework. Without this, I fear that AIDS will get lost or relegated to a sub-goal for health.

Keeping focused on ending AIDS will hold the international community accountable to build on progress, while also creating global demand for breaking down social, legal and political obstacles to progress.

But how? First, ending AIDS will signal a significant global achievement for the entire human family. Its transformative power will drive and deliver wins on gender equality, human rights, and the determinants of poverty and exclusion. Second, a prominent position for AIDS in the post-2015 development framework is in the interest of all countries – as a public health priority and as a pathfinder for inclusive and rights-based development action everywhere.

Finally, advancing the contributions of the AIDS response to human rights is central to the post-2015 framework. It will show that ending AIDS demands that we also protect the civil, cultural, economic, political and social rights of everyone, everywhere.

A new world

It is important to recognise that we do not live in the same world where the MDGs were conceived 15 years ago. There have been seismic shifts. Global politics and policy-making have become more complex and integrated, with unprecedented challenges in bringing all the players together around a single agreed agenda. One thing is clear: the old approaches to global relationships are obsolete. The previous paradigm was simple, if not necessarily
operative: one part of the world had money and the other part of the world had problems. But today, due to the economic rise of countries like India and the many countries of Africa whose GDP is growing dramatically, some three-quarters of the world’s poor (those who live on less than US$1.25 a day) live in what have become middle-income countries.

Fifteen years ago, we did not have the real-time communications technology to monitor and demand government accountability and the democratisation of society. We did not have an active private sector interested in building and leading development partnerships separate from the bureaucracy of multilateral organisations. All of these initiatives are critical, now and in the future, for innovation and for the transfer of competencies and knowledge. We must pay attention to these changes in economic groupings and political shifts if we are to create a new narrative for global health.

The old paradigm was also designed around treating and curing single diseases. This is massively inefficient and leaves too many people behind. Addressing the social determinants of health more broadly – poverty, discrimination, gender violence and inequity, sexual and reproductive health and education – brings progress to other development challenges as well. The new global health paradigm must bring all people – sick and healthy, safe and at risk – to the centre of health care. This is the only way we can leverage health care as an entry point to improving human lives on all fronts.

**Governance is the glue**

The achievements of the AIDS response have been the result of a convergence of civic, public and private efforts to protect and promote the fundamental values of inclusiveness, justice, human rights and gender equality. Governance was the glue that held these principles and values in place.

But the global health governance structure we have today is not efficient or sustainable. Current arrangements are unwieldy, don’t deliver enough accountability, don’t give sufficient prominence to the voices of the southern hemisphere and aren’t progressive or ambitious enough in their agendas. These arrangements need a shake-up.

For example, the way essential medicines reach the poor people of the world is inefficient and unsustainable. Yet the demand for affordable medicines is increasing exponentially. Faced with the fact that non-communicable diseases are now the leading cause of morbidity and mortality around the world, the challenge has become how to provide medicines, often over a lifetime, to billions of people.

The AIDS movement has been a leading force in addressing the drivers of pharmaceutical costs. Activists, in partnership with key sympathetic countries, demanded innovation in drug development and registration, and that intellectual property and trade laws support people’s struggle to survive. The Doha Declaration reaffirmed flexibilities in the Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS) in circumventing patent rights, leading to generic competition and ultimately to a dramatic increase in the number of people on HIV treatment – and very significant cost savings.

However, only 11 countries have managed to produce their own generic versions of patented essential medicines. Africa has become overly dependent on Indian generics, particularly in relation to HIV treatment. Although political commitments to regulatory harmonisation and enhancing local production have been made, progress is slow. In this context, new models to stimulate innovation on research, development and commercialisation are needed.

**Accountability mechanisms**

Global governance should also be more accountable to people directly. New technologies, such as ‘mobile money’ and social media, present opportunities to equip citizens with data, enhance their participation in the public sphere and extend their agency over development-related decision-making.

Many are calling for a ‘data revolution’, where better and more open data can be utilised to reduce corruption, improve decision-making and the allocation of resources, empower citizens, reach people with services, facilitate organisation and support good governance.

**Social protection**

Today, only 20 per cent of the world’s population has adequate social security coverage while more than half lack any coverage at all. As a result, billions of people are vulnerable to a vicious cycle of unemployment, catastrophic medical costs, insecure access to food, low levels of education, low personal agency, poverty and poor health.

Despite growing recognition of the importance of social protection, many low-income countries are unable to finance social protection programmes and lack the institutional capacity to bring coherence to a multitude of internationally supported interventions. Social protection programmes are often under-funded in middle- and high-income countries as well, where political will and the disempowerment of poor and marginalised communities, rather than lack of available resources, are the greatest obstacles.

The establishment of permanent social protection systems requires the development of a politically sustainable social contract. Public discourse is critical in determining who deserves support and in what form in order for countries to move from temporary, usually externally financed, social assistance programmes to domestically financed, sustainable programmes that are part of a clear social contract.

**Unprecedented opportunity**

The global focus on what comes after the MDGs presents an unprecedented opportunity to rethink not only the way we deliver health, but to think beyond coverage towards total quality and impact. It sets up an obligation to stop just talking about integration and to begin to expect it.

The ongoing work of the UNAIDS/Lancet Commission: Defeating AIDS – Advancing Global Health is advocating for what it calls a ‘grand convergence’, where infectious disease and maternal and child mortality rates in most low- and middle-income countries converge with the levels presently seen in the best-performing middle-income countries.
Such convergence, which will be achieved through transforming health systems, would prevent ten million deaths by 2035. The estimated economic benefits would exceed costs by a factor of between nine and 20 over the period 2015–35. This will be a remarkable achievement, but it will require AIDS, health and development actors to invest in realising an even broader ‘convergence agenda’ – bringing together efforts to address the political, economic and social determinants of HIV and impoverishment.

We can no longer be fragmented and working in isolation. We must combine our resources and strategies across sectors, because the challenges for ending extreme poverty and ending the AIDS pandemic are deeply interconnected. Together, we need to confront the social drivers that produce and perpetuate disparities and inequities – in health, income, power and opportunity. If we fail to do this, we will never be able to reach people on the margins in a sustainable manner.

I am not talking about feel-good projects – I am talking about the sort of transformation that will be owned by people and will create a new dynamic, a new discussion and a new paradigm. In today’s world, all the problems are shared and all are affected. So the responsibility for solutions must be shared as well.

When governments and stakeholders learn to think in terms of shared responsibility, then people will begin to build sustainable transition plans in their respective places and they will completely change the paradigm of health and development that has operated for a century. To me, this people-led transformation is the cornerstone of the debate that will shape the future health and well-being of all people.

Endnote

1 Top ten countries with the highest HIV prevalence rates among adults (aged 15 to 49), highest first: Swaziland, Botswana, Lesotho, South Africa, Zimbabwe, Namibia, Zambia, Mozambique, Malawi and Uganda (World Health Organization).

MICHEL SIDIBÉ was appointed Executive Director of UNAIDS and Under-Secretary-General of the United Nations in 2009. Since then, his vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths has echoed around the world.

Under his leadership, UNAIDS works to ensure that no one is left behind in the response to HIV and that everyone in need has access to lifesaving HIV services. He initiated the global call to eliminate HIV infections among children and his global advocacy has firmly secured HIV’s place at the top of political agendas. His idea of shared responsibility and global solidarity has been embraced by the international community and has encouraged increased ownership of their epidemics by countries most affected.

Sidibé has spent more than 30 years in public service. He has been awarded honorary doctorates from Tuskegee University and Clark University, as well as an honorary professorship by Stellenbosch University. In 2012 he was named one of the 50 most influential Africans by the Africa Report and one of 50 personalities of the year by the French newspaper Le Monde in 2009.