HM Government

Achieving Universal Access –

the UK's strategy for halting and reversing the spread of HIV in the developing world

Cover Pictures

Top left:
A health educator in Ghana demonstrates the correct use of condoms for an audience of young people. Condom use is an effective HIV prevention method. Unless more is done on HIV prevention, the number of new infections will continue to increase.

Top right:
An AIDS patient shows his antiretroviral medication as he is about to take his second-ever dose. There has been a tenfold increase in access to AIDS treatment over the last five years. An estimated 3 million people in Low- and Middle-Income Countries were receiving treatment by the end of 2007.

Bottom left:
Indian volunteer home care worker, Mary Iruthaya, travels on foot to see her patients in surrounding villages. She is providing care for people living with HIV and AIDS. 'I am very proud to be working for people living with HIV and AIDS', she says, 'proud and happy'.

Bottom right:
Two months after starting his antiretroviral treatment, HIV-positive orphan Zamokuhle Mdingwe from South Africa, travels to the World AIDS Day event at which he will be speaking about his experiences. Travelling with him in the bus are his school classmates, who are coming to support him.

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Foreword by the Secretary of State

In 2004, the UK Government launched a strategy, called *Taking Action, the UK strategy for tackling HIV and AIDS in developing countries*. This set out our commitment to lead the global response to AIDS through promoting the needs and rights of those most affected by the epidemic, increasing funding, strengthening political leadership, and supporting international and national responses.

Much has happened since then. The UK has spent some £1.5 billion on AIDS programmes. Through our Presidencies of the G8 and the European Union in 2005, we led the world in a commitment to the historic goal of Universal Access to comprehensive HIV prevention, treatment, care and support. We have taken action to promote the needs and rights of women, young people, children, and vulnerable groups. And we have supported stronger, co-ordinated responses at the national level through, for example, the International Health Partnership and UN reform.

Great progress has been made as a result of global efforts, including lower HIV prevalence in some countries, more access to HIV treatment and marked increases in resources. But the epidemic continues to outstrip our efforts. Prevention programmes are still only available to one in five people who need them, and for every two new persons on treatment, another five get newly infected.

The impact of AIDS on individuals, families and communities, particularly in southern Africa, is devastating. In some settings, AIDS is reversing progress towards better health, education and economic prosperity: for example, life expectancy in Swaziland has fallen from 57.8 in 1993 to 31.1 in 2006, largely due to the impact of AIDS. Tackling AIDS removes a barrier to economic growth, leading not only to countries improving their own health and education services but also to more stable and prosperous nations who will trade with the UK and who are better able to respond to global threats like climate change. It encourages peace, democracy, good government and international security.

The international community has invested billions of pounds to improve education and health in developing countries, and reduce poverty. We must tackle AIDS in order to protect these investments, now and in the future. But most importantly, it comes down to saving lives. We have a duty to tackle AIDS – it knows no boundaries, there is no known cure, and it has the ability to devastate the lives of individuals, families and communities.

This strategy sets out the UK's response to these challenges, based on a detailed evaluation of *Taking Action* and recommendations from large numbers of partners in the UK and elsewhere in the world. It takes into account feedback from a 12-week public consultation in mid-2007, co-ordinated by the UK Consortium on AIDS and International Development. This received more than 90 submissions from domestic and international NGOs, the private sector, academic institutions, and multilateral agencies.

Our updated strategy:

- Makes clear our commitment to continue to play a leadership role, assisting developing countries to reach the goals of Universal Access and halting and reversing the spread of HIV
- Makes comprehensive HIV prevention a priority – only through effective prevention can we hope to minimise the impact of the disease decades from now
- Shows how we will continue to promote the needs and rights of women, young people, children, and vulnerable groups, and how we will support countries in providing stronger health, education and other basic services
- Prioritises UK support for an international system involving strong partnerships, from community to international level
- Includes commitments on prevention, the 'sustainability of treatment', social protection for those made vulnerable by the disease, and stronger health systems.

Building on the success of *Taking Action* – galvanised international support, increased funding, improved results – this strategy focuses on addressing the latest challenges. If we are to achieve Universal Access, and to halt and reverse the spread of AIDS, the evidence demonstrates we require a long term approach, across a range of health systems and services.Our new commitment to spend £6 billion on health systems and services up to 2015 demonstrates the UK's determination to remain at the forefront of global efforts to achieve Universal Access. This is in addition to the unprecedented long-term commitment by the UK, announced in September 2007, to provide £1 billion to the Global Fund between 2008 and 2015.

This strategy places people at the heart of the response. HIV is an infection that can affect any man, woman or child – rich or poor. We need to enable individuals, families and communities to have the ability and knowledge to protect themselves from infection, and provide support for those individuals and families living with HIV to lead healthy lives. The UK is committed to implementing this strategy, and we will work tirelessly with our partners to see it realised.

Secretary of State for International Development

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Executive summary

A sightseeing bus in Shanghai, China, displays the slogan 'Stop AIDS. Keep the promise'. This refers to the goal of Universal Access to comprehensive HIV prevention, treatment, care and support. To achieve Universal Access, there is an urgent need to ensure that new and existing resources result in increased access to services for those who need them.

Significant progress has been made since *Taking Action* was published in 2004:

- The percentage of the world's adult population living with HIV has levelled off
- 20 times more people have access to life-saving treatment
- The price of first line AIDS drugs has fallen considerably.

But the human cost of the epidemic remains immense:

- There are still more than 33 million people living with HIV – there is still no cure in sight
- Around 15 million children have been orphaned
- Access to AIDS services remains unacceptably low – for example, most prevention strategies are available to fewer than one in five people who could benefit from them
- In some countries, AIDS has reversed decades of progress towards better health, education and wealth.

What do we want to achieve?

Our common international goal is to halt and reverse the spread of HIV by 2015[1]. To achieve this we need to provide Universal Access to comprehensive HIV prevention programmes, treatment, care and support. We believe that greater focus and effort on HIV prevention is our best hope, and that effective strategies must be built on a detailed knowledge of the current epidemic – including what drives it – and its likely future progression. But we also need to sustain the momentum in AIDS treatment and do more to support the needs of adults and children living with and affected by HIV. This strategy paper describes the UK's policy and contribution to achieving these goals, with the supporting evidence set out in *Achieving Universal Access – evidence for action*.

Responding to the needs and protecting the rights of those most affected

Achieving Universal Access requires change in human attitudes and behaviour and requires us to ensure that HIV prevention, treatment, care and support services reach all who need them. HIV can affect anyone, but certain groups are more affected, including women, young people, children, sex workers, Men who have Sex with Men (MSM), Injecting Drug Users (IDUs), prisoners and migrants. These groups are often most neglected in the AIDS response. We must ensure that those most affected by HIV can access quality services.

But providing services, by itself, is not enough. Women and girls cannot always decide if, when, how and with whom they have sex. This has contributed to a 'feminisation' of the epidemic, especially in sub-Saharan Africa. Addressing gender inequality and harmful gender norms is therefore vital for reversing the spread of HIV.

Stigma and discrimination towards People Living With HIV (PLWH) and vulnerable groups also present major barriers to achieving Universal Access. Acts of discrimination deny people's rights to information, services, care and support. And fear of stigma and discrimination can discourage people from getting tested and, when they know they have HIV, from disclosing their status or accessing treatment and care. But we can challenge these barriers by empowering vulnerable groups to act on their own behalf and in their own interests.

Supporting more effective and integrated service delivery

Providing quality services that respond to the realities of people's lives is essential if we are to halt and reverse the spread of HIV. It requires:

- Effective national leadership on HIV and AIDS and support for human rights.
- Strong, inclusive planning and budgeting – with the involvement of PLWH and other vulnerable groups.

[1] Millennium Development Goal 6

- Stronger, more effective health services to tackle AIDS, sexually transmitted infections, family planning, Maternal, Newborn and Child Health (MNCH), Tuberculosis (TB) and malaria in an integrated way. These in turn require an adequate supply of capable, motivated health workers.
- Action across a range of sectors, including education, justice and social welfare.

As the second largest bilateral donor on AIDS, the UK has provided significant funds to support the global AIDS response. This has helped to galvanise international action, increase funding and deliver significant results. However, coverage of key services remains unacceptably low. If we are to achieve Universal Access, and to halt and reverse the spread of AIDS, there is an urgent need to ensure that new and existing resources result in increased access to services for those who need them. This requires us to focus on what services we deliver, how, where and to whom.

Evidence demonstrates that to achieve this we need to take a long term approach, across a range of health interventions and services: Sexual and Reproductive Health and Rights (SRHR), including maternal health services, can directly prevent transmission of HIV; MNCH services can also reduce the vulnerability of women, their children and families to HIV; tackling other diseases, such as TB and malaria, can reduce the impact of AIDS, including through reducing maternal mortality. These interventions and other elements of Universal Access, such as testing and treatment, require capable, effective health workers, systems to ensure distribution of services and supplies, and plans that provide for everyone – women, young people, children, vulnerable groups. The £6 billion announcement that accompanies this strategy reflects the emerging evidence that long term funding for health systems and services is the surest foundation for the achievement of the global effort to secure Universal Access.

We are also committed to strengthening action in other sectors. We have committed to spend up to £8.5 billion on education in the 10 years up to 2015. And this strategy commits £200 million over three years to expand social protection programmes, which will help ensure that more Orphans and Vulnerable Children have access to better child nutrition, health and education. The UK remains committed to meeting the needs of Orphans and Vulnerable Children (OVC). *Taking Action* helped increase global funding for OVCs. But we now need to ensure the needs of OVCs are systematically met. Evidence shows that this can best be achieved through integrating OVCs' needs into health, education and social protection plans. We will regularly review this approach, by publishing a report following the biennial Global Partners Forum on Children Affected by HIV and AIDS, to ensure that the approach outlined here supports the most effective ways of meeting the needs and rights of OVCs.

Making money work harder through effective partnerships

Providing Universal Access to AIDS services also requires adequate, long-term resources, especially as no vaccine or cure is in sight. Global financing for AIDS has increased, but it is still not sufficient to implement all the interventions needed over the coming years. We need to make the money work harder by preventing more infections and saving more lives with the resources that we have. We need to use economic growth to enhance the sustainability of AIDS services and we must build capacity at all levels – from community to national level.

All of this requires deep, broad partnerships between national governments, international partners and civil society, including networks of PLWH, as well as the private sector. National governments have responsibility for resourcing, co-ordinating and delivering effective AIDS responses, but they have to be supported by a wide range of other key AIDS or development actors:

- International partners, including the US Government President's Emergency Plan for AIDS Relief (PEPFAR), the UN, particularly UNAIDS, The Global Fund to fight AIDS, Tuberculosis and Malaria, the European Commission and the World Bank, need to support country-led AIDS responses and make them the basis for co-ordinated, effective action. This will have a positive impact in all countries, including fragile states and Middle-Income Countries.
- Civil society has a key role to play in advocating and providing services, in particular for vulnerable populations, in strengthening accountability, and in building social movements. Ultimately, success relies on enabling people to change their behaviour, and civil society, including PLWH, can play a crucial role in achieving that.
- The private sector can reach many people through effective workplace programmes and adjusting their core business.

Our actions on AIDS

This strategy commits us to support progress towards a number of specific targets. But these do not represent the sum of our work. The UK supports evidence-informed, rights-based and country-led efforts to provide Universal Access to integrated AIDS and SRHR services that meet the needs and rights of those most affected.

We will:

- Spend £6 billion on health systems and services to 2015. This will help maximise progress on AIDS through closer integration of AIDS, TB, malaria, and SRHR, including maternal and child health services.
- Focus our efforts on comprehensive HIV prevention. In the health sector, we will work with others to intensify international efforts to increase to 80% by 2010 the percentage of HIV-infected pregnant women who receive anti-retroviral treatments (ARVs) to reduce the risk of mother to child transmission, both in low income and high prevalence countries.

- Work with international partners to support countries with health worker shortages to provide at least 2.3 doctors, nurses and midwives per 1,000 people, supporting national plans that identify the appropriate mix of health workers.
- Work with others to intensify international efforts to halve unmet demand for family planning (including male and female condoms) by 2010, to achieve Universal Access to family planning by 2015.

An effective AIDS response requires action across a range of relevant sectors. We will:

- Spend over £200 million to support social protection programmes over the next 3 years. DFID will work with governments and civil society in eight African countries to develop social protection policies and programmes that will provide effective and predictable support for the most vulnerable households, including those with children affected by AIDS.
- Intensify efforts to increase the coverage of HIV and AIDS services for IDUs in countries where they are most affected. Work in partnership with governments, multilateral agencies, civil society and through nine bilateral programmes to improve the international environment on harm reduction.
- Increase by at least 50% funding for research and development of AIDS vaccines and microbicides over 2008-13, to reduce the impact of the disease on women and girls.

And we will focus our efforts to ensure that new and existing resources have the greatest impact. We will:

- Work with others to reduce drug prices and increase access to more affordable and sustainable treatment over the long term. This could yield efficiency savings of at least £50 million per annum – enough to cover the cost of ARV drugs for an additional one million people every year.
- Ensure the Global Fund to fight AIDS, Tuberculosis and Malaria implements the Paris Declaration target on use of common arrangements and procedures, including programme-based approaches.
- Work with development partners, both within and outside of the International Health Partnership (IHP), to ensure that sector-wide approaches to health strengthen the AIDS response and that targeted AIDS programmes also strengthen the wider health system.

DFID will continue to lead the UK's AIDS response internationally, and we will continue to work closely with other UK Government departments to implement this strategy. We will support and manage our staff to respond effectively in the context of AIDS, and we will manage and structure our business systems to ensure we deliver our programme and policy commitments on AIDS. Most importantly, we will continue to put people at the heart of our strategy, including strengthening the engagement of PLWH in our work.

Introduction – the focus of this strategy

This document sets out the UK's commitment to the goal of Universal Access to comprehensive HIV[2] prevention programmes, treatment, care and support, and describes the need for special attention on HIV prevention and care in order to achieve Universal Access and Millennium Development Goal 6. It details the UK's vision for achieving this goal and our role in supporting the international community. It places at its heart the needs and rights of women, young people, children and vulnerable groups. With the supporting evidence set out in *Achieving Universal Access – evidence for action*, this document sets out the evidence-informed policies and commitments for DFID and other government departments that we believe are required to accelerate progress towards the goal of Universal Access and to build a long-term, sustainable response in these three key areas:

- Responding to the needs and protecting the rights of those most affected
- Supporting more effective and integrated service delivery
- Making money work harder through effective partnerships.

It is based on an understanding of the UK's comparative advantage. We believe that we, like other countries and like national and international agencies, should focus our efforts where we are strongest.

The UK's comparative advantage on AIDS

The UK Government's evaluation of its 2004 strategy, *Taking Action*, describes a number of areas in which the UK has a comparative advantage on AIDS and can offer leadership[3]. Many of these areas of the UK's comparative strength were also identified among those who took part in our public consultation. The UK is best placed to:

- Support AIDS responses within a broader development context, focusing on supporting country-led responses, building sustainable national systems to respond to AIDS over the long term, and providing flexible resources directly to countries and through international NGOs and multilateral agencies
- Promote political leadership, including through global advocacy on critical and often contentious issues such as comprehensive HIV prevention, Sexual and Reproductive Health and Rights (SRHR), the rights of vulnerable populations and effective use of resources
- Promote aid effectiveness in line with the Paris principles[4], Global Task Team recommendations (see below) and the 'Three Ones'[5].

[2] Universal Access should include comprehensive prevention packages, treatment, care and support that address and integrate Sexual and Reproductive Health and Rights.

[3] Interim Evaluation of Taking Action: the UK Government's strategy for tackling HIV and AIDS in the developing world; p138.

[4] Countries, multilateral organisations and civil society organisations agreed the Paris Declaration on Aid Effectiveness in March 2005. It was anticipated that implementation of its five interlinked principles (Ownership, Alignment, Harmonisation, Managing for Results and Mutual Accountability) would together "increase the impact aid has in reducing poverty and inequality, increasing growth, building capacity and accelerating achievement of the MDGs".

[5] Agreed on 25 April 2004 at a UNAIDS meeting in Washington. One agreed HIV/AIDS Action Framework that provides the basis for co-ordinating the work of all partners; One National AIDS Co-ordinating Authority, with a broad-based multi-sectoral mandate; One agreed country-level Monitoring and Evaluation System.

1 Defining the challenge

Lerato Chakalane from Lesotho found out she was HIV-positive when three months pregnant. She was immediately enrolled in a programme preventing mother to child transmission of HIV, which included HIV counselling, antiretroviral treatment, and giving her new born baby girl a dose of the drug nevirapine shortly after birth.

Key messages

- Significant gains have been made in responding to the AIDS epidemic since *Taking Action* was published in 2004
- But much more remains to be done to halt and reverse the spread of HIV, particularly in southern Africa and central Asia and eastern Europe
- The AIDS responses of different countries need to be built on a detailed understanding of the epidemic, its drivers, impact and trends
- The UK is committed to the goal of Universal Access as a means to halting and reversing the spread of HIV
- Universal Access must include comprehensive HIV prevention programmes, treatment, care and support that meet the needs of all – including women, children and vulnerable groups
- Achieving Universal Access will depend on a stronger, more effective focus on prevention, care and support, while sustaining momentum for treatment
- Expanded access to Sexual and Reproductive Health and Rights (SRHR), including family planning, is a key part of an effective AIDS response.

The AIDS epidemic

Global efforts to tackle AIDS have accelerated significantly since *Taking Action* was published in 2004, and we have seen real progress:

- The percentage of the world's adult population living with HIV has levelled off, and some countries have achieved reductions
- The number of people with access to ARVs has risen from 100,000 in 2001 to three million in 2007, resulting in a reduction of HIV-associated deaths
- In 2007, the price of life-saving first line drugs fell below US$100 per person per year for the first time (a reduction by half since 2003)
- We have seen encouraging progress in the implementation of integrated HIV and Tuberculosis (TB) interventions in Africa
- Strong political leadership has resulted in an international commitment to the ambitious goal of Universal Access to comprehensive HIV prevention programmes, treatment, care and support by 2010.

Yet, in spite of such progress, the human cost of the epidemic remains immense:

- The number of People Living With HIV (PLWH) is increasing, because of new infections and the fact that people are surviving longer once they are infected
- There are now more than 33 million people living with HIV, with nearly 7,000 more becoming infected every day – 40% of them young people aged 15-25
- Each day nearly 6,000 people die from AIDS, and 15.2 million children are estimated to have been orphaned as a result of AIDS.

The number of new infections continues to outpace prevention and treatment efforts. Access to quality AIDS and Sexual and Reproductive Health and Rights (SRHR) services remains low:

- On average, a man in Africa uses only three condoms each year
- HIV prevention services reach only 53% of prisoners, 9% of Men who have Sex with Men (MSM) and less than 20% of Injecting Drug Users (IDUs), while just 60% of sex workers worldwide have access to HIV testing and condoms
- Anti-retroviral drugs to help pregnant women avoid passing on HIV to their babies are only reaching an estimated 34% of pregnant women with HIV
- It is estimated that 80% of African people who have HIV have not tested and so do not know their status
- Less than a third of those in need have access to ARVs.

Vulnerable groups

Vulnerable groups are those groups of people that are more likely to be severely affected by the impact of AIDS. They may be less able to access services, in some cases due to the greater discrimination and exclusion they face. These groups vary by country and over time, but generally include women, young people, children, sex workers, IDUs, MSM and prisoners. Other vulnerable groups include migrants and mobile populations (including mineworkers and truck drivers), clients of sex workers and their partners, partners of IDUs or MSM, people with a disability, elderly people and indigenous populations. The UK is committed to protecting their rights and meeting their needs.

Owing to biological, social, cultural and economic factors, women and girls are less able to control their risk of HIV infection than men and boys – in other words, they are disproportionately susceptible to HIV infection. A study from Uganda shows that pregnancy may increase the risk of acquiring HIV. Data from some high prevalence areas in sub-Saharan Africa areas has shown that women living with HIV are four times more likely to die during childbirth than women who do not have the virus. Young women, especially, are increasingly susceptible to infection. This drives a growing 'feminisation' of the epidemic, particularly in sub-Saharan Africa, where in 2007 almost 61% of PLWH were women. In some age groups, the differences are even more extreme: in South Africa's 15-29 age group, there are six women infected for every man. Young people, children, sex workers, IDUs, MSM and prisoners are also both more susceptible and vulnerable to HIV and AIDS.

Sub-Saharan Africa

Some regions are much harder hit by AIDS than others. More than two-thirds of all PLWH and nearly 90% of all HIV-positive children live in sub-Saharan Africa, and three-quarters of all AIDS-related deaths in the world in 2007 occurred there. Southern Africa is the hardest hit of all, accounting for over a third of all new infections and AIDS deaths, and in most countries in that region more than one in five of the adult population is HIV-positive. Southern African countries are struggling to provide care and treatment to PLWH, and to devise sustainable strategies to cope with its long-term impact. Preventing the further spread of HIV in the region is a priority.

Southern Africa requires an emergency response

AIDS is a humanitarian catastrophe in southern Africa, where HIV prevalence rates are hyper-endemic (affecting more than 15% of people) in eight countries: Botswana, Lesotho, Namibia, Swaziland, South Africa, Mozambique, Zambia, and Zimbabwe. Of the 12 million children orphaned by AIDS in sub-Saharan Africa, nearly four million live in these countries. Their epidemics are linked to each other by regional migration.

South Africa has the worst AIDS epidemic in the world, with one in six of the world's HIV-positive population living there. HIV mostly affects the poor, with the highest rates among black women in informal settlements. Despite the efforts of many of the world's best scientists and researchers, the epidemic continues to grow. It is estimated that 800 people die from AIDS every day in South Africa, and more than 1,000 become infected with HIV.

Across southern Africa as a whole, the highest rates of illness and death are among those who are most economically productive and at their reproductive peak. There have been substantial increases in death rates among mothers and children. Nearly three-quarters of deaths among young South Africans (aged 15-49) are caused by AIDS, and the majority of these young people are mothers. Children whose mothers die from AIDS are themselves four times more likely to die – whether or not they are HIV-positive.

Support for orphans and vulnerable children in southern Africa

Miriam Madzinga lives with her six younger siblings in Buhera, Zimbabwe. Although just 16, Miriam is head of her household because her father died in 1998, and her mother four years later. Miriam is one of the 1.3 million children in Zimbabwe who have lost one or both parents. Enforced parenthood is an unreasonable burden to place on her teenage shoulders, yet one that is repeated with terrible regularity across southern Africa. However, through the joint efforts of DFID and other donors, Miriam and thousands like her are receiving essential support.

Extremely high rates of HIV have serious consequences for households and communities. As families are impoverished by the loss of the most economically active members, large numbers of older people are left caring for orphans. Life expectancy for a person in many southern African countries is now shockingly low – between 30 and 40 years. In the worst affected countries – such as Botswana and Swaziland – where more than 20% of people of working age are infected, AIDS can reduce economic growth by 1.5% each year. The disease undermines the productivity and profitability of the workforce, including the private sector, and devastates the health and education of whole populations.

Asia, Latin America, Europe and the Caribbean

The fastest growing epidemics are in the former Soviet Union, eastern Europe and central Asia. Epidemics there are primarily concentrated among vulnerable populations, such as MSM, IDUs, prisoners, sex workers and their sexual partners. Injecting drug use is estimated to account for nearly one-third of new infections outside sub-Saharan Africa, and for more than 80% of all HIV infections in eastern Europe and central Asia. It is a key driver of epidemics in the Middle East, North Africa, South and South-East Asia and Latin America.

Working with vulnerable groups in India

In India, there is encouraging evidence of a significant reduction in new HIV infections in young women in four southern states, which are home to three-quarters of the country's HIV-positive population. This reduction is linked to the high coverage and quality of targeted interventions for sex workers and MSM. These interventions need to be sustained and replicated elsewhere in the country, and those for IDUs must be scaled up. The most recent estimates, based on data from a 2005-06 household survey, show that overall HIV prevalence remains low, at 0.36%. DFID has been supporting prevention interventions for over ten years, and currently funds India's National AIDS Control Programme.

In these regions, as elsewhere around the world, there are distinct differences in the type of epidemic, so different responses are required to tackle HIV and AIDS.

The importance of 'knowing your epidemic'

UNAIDS has four classifications of AIDS epidemic:

- **Low-level** – where HIV prevalence levels are below 1% and where HIV has not spread to significant levels within any particular group
- **Concentrated** – where HIV prevalence is high in one or more sub-populations such as MSM, IDUs, sex workers and their clients and prisoners, but the virus is not widely circulating in the general population
- **Generalised** – where HIV prevalence is between 1-15%, indicating that HIV prevalence is present among the general population at sufficient levels for HIV to spread through sexual networking
- **Hyper-endemic** – where HIV prevalence exceeds 15% and extensive heterosexual multiple concurrent partner relations with low and inconsistent condom use significantly contribute to the spread of HIV.

These classifications do not tell the whole story about epidemics, nor do they show what interventions are needed among different groups. For example, Ghana has a 2% HIV prevalence rate amongst the general population, and is classified as having a generalised epidemic. But the HIV prevalence rate among its commercial sex workers is 78%, showing the need to target interventions particularly at this group and their clients.

The importance of 'knowing your epidemic' (continued)

While AIDS presents a global challenge, epidemics within and across countries and regions can have different characteristics. So countries should strive to understand how HIV is transmitted at a local level and tailor an appropriate response. This means 'knowing your epidemic'. By understanding where the next 1,000 infections are likely to occur, how many people are becoming infected, which groups are most affected and why, the trajectory of the epidemic can be identified and a response can be designed that most effectively addresses it.

In Uganda, for example, DFID supported an analysis of current and projected AIDS data, which demonstrated an increasing number of new HIV infections. It also identified the groups of people most at risk and the drivers of the epidemic. It showed that new infections are occurring in older age groups, often among those in stable sexual partnerships, as a result of discordance (where only one partner is infected with HIV). DFID's support has helped the Government of Uganda develop a national strategy that focuses on prevention, and calls for the alignment of all resources according to where the greatest impact can be achieved. This includes targeting married couples and older age groups and promoting couple counselling, testing and disclosure.

Challenges of the current response

The international community has increased resources to support the global response to AIDS – from US$6 billion in 2004 to US$9 billion in 2006 and US$10 billion in 2007. Also, more organisations than ever before are joining global efforts to tackle AIDS. However, in many countries this has led to an inefficient response, with one survey showing that Cambodia and Vietnam each received 400 donor missions[6] in one year. This extent of un-coordinated donor support can lead to fragmentation, gaps and duplication of efforts, which in turn can erode national capacity to manage the AIDS response. This underlines the scale of the challenge, and the importance of continued support for co-ordinated action through the 'Three Ones'.

Much of the increased funding for AIDS programmes has been spent on initiatives that are dedicated only to that disease, with mixed results. On the positive side, these resources have improved the health of millions of people and have made a major difference, especially in countries with concentrated epidemics or hyper-endemics – where, without such disease-specific initiatives, the response would be far weaker. However, concentrating so many resources only on tackling AIDS can weaken a country's ability to provide other health services that are just as important.

[6] This includes all donor missions, not just those related to AIDS.

The commitments made on AIDS are important and valuable, but they do also need to be viewed in the context of wider and related development needs. There are finite resources and tough choices have to be made on where and how to spend these. In sub-Saharan Africa, health spending can be as low as £5 per person per year, well below the World Health Organisation's recommended £17. This means that, even with substantial price reductions, the cost of ARV therapy is likely to be unaffordable both for individuals and the state, and that those countries have to rely on donor funding for larger and larger outlays. This degree of dependence may not be sustainable in the long term.

Action is now urgently needed to address all these challenges. One projection, using 2005 data, suggested that, by 2015, Africa will see 1.5 million new HIV infections and 2.4 million deaths each year. Up to that point, 20 million children are expected to be orphaned[9]. These figures demonstrate the sheer momentum of the epidemic, with new infections today having an impact decades later.

Prevention of HIV infections is critical to halt and reverse the spread of the disease. A determined global response is needed now so that future generations do not suffer the consequences of our inaction.

Achieving Universal Access – our common goal

The UK is committed to reversing the spread of HIV[10]. To achieve this, we are committed, along with the entire international community, to intensify our work towards achieving the goal of Universal Access to comprehensive HIV prevention programmes, treatment, care and support by 2010.

UK efforts to secure commitment to Universal Access

At the Gleneagles Summit in 2005, the UK led efforts to secure the commitment of the G8 to the goal of Universal Access to treatment by 2010. Through our EU Presidency we pushed for international commitment to this goal at the Millennium Summit in 2005. We also led efforts to broaden this goal to include prevention, treatment, care and support at the UN General Assembly High Level Meeting in June 2006.

Universal Access implies a commitment to equity, inclusion and human rights. This means a response to AIDS that: ensures equitable reach and coverage of services; includes all according to their needs and rights; seeks to overcome discrimination, disadvantage and exclusion; and is clearly accountable.

[9] These figures mask huge variations in prevalence between countries, and within countries.
[10] Millennium Development Goal 6.

An estimated 200,000 people marched through Edinburgh in July 2005 to demand that G8 leaders address global poverty at the forthcoming summit in Gleneagles on July 6, 2005. The demands of the "Make Poverty History" campaigners included providing access to HIV and AIDS care and treatment for all who need it. The UK led efforts to secure the commitment of the G8 to the goal of Universal Access to treatment by 2010.

Universal Access responses must include quality HIV prevention, treatment, care and support interventions. These must address and integrate Sexual and Reproductive Health and Rights (SRHR) services, information, supplies and skills to respond to people's needs and rights. The balance of this package must be determined at the country level. It must be based on a detailed knowledge of the epidemic along with targets for coverage and timeframes to ensure a response that is appropriate, ambitious and realistic. Globally, the challenge is to:

(i) increase effort on comprehensive HIV prevention

(ii) sustain momentum with regard to treatment

(iii) increase effort for care and support

(i) Increase effort on comprehensive HIV prevention

Unless more is done on prevention, significant numbers of new infections will continue to occur, and the costs of treatment, care and support will escalate. There is strong evidence for the effectiveness of many approaches to prevention, including condom use, family planning and harm reduction services (discussed further below). But prevention initiatives often tend to attract less attention, be less comprehensive and receive less funding than treatment initiatives. Most prevention strategies are accessible to fewer than one in five people who could benefit from them and this number is even lower for marginalised groups like drug users and MSM. Prevention initiatives are not always carried out well, and are often not based on sound epidemiological data or the realities of people's lives.

> "We don't have a prevention mind set. Prevention is in some ways the quintessential non-event. When prevention occurs, nobody realises it."
>
> **Dr Helene Gayle**, a member of the Global HIV Prevention Working Group

Successful HIV prevention is about enabling individuals, couples and communities to make healthy choices about personal aspects of their lives – particularly sexual behaviour. These are not just based on information and rational choice; they are also influenced by complicated drivers of human action, including gender roles, inequality, norms around sexuality, economic need and status.

Legal considerations can also influence behaviour. For example, in countries where sex between men is illegal, condoms may

> "At times men test positive and get treatment privately and they won't inform their wives. Even if the wife notices signs and symptoms of the husband being positive and asks for condom use, men still refuse to use condoms with women they have married. Men claim they only use condoms on girlfriends."
>
> A woman from Rusape, Zimbabwe

A counsellor displays a condom and talks to a young woman about safer sex at a NGO health clinic in Kenya. It is important to increase the availability of condoms for young people as they become sexually active.

not be provided in prisons. Prevention must involve a variety of interventions that address both individual risk and behaviour and the social, cultural, economic and political drivers of the epidemic. Such interventions need to work at several levels (individual, community, social and legal), involve PLWH and other partners (such as the media) and mobilise a range of government sectors. This also shows why much of what constitutes HIV prevention lies outside the health sector.

Medical approaches to biological transmission of the virus cannot be fully effective without behavioural change and action to address social norms and inequality. For example, pregnant women who fear violence in the home are unlikely to test for HIV in a Prevention of Mother To Child Transmission[11] (PMTCT) programme. Interventions that encourage men and boys to oppose sexual violence and coercion are therefore vital to the success of prevention efforts. In general, more research is needed on the structural drivers of the epidemic, and on how to prevent HIV transmission in settings where prevalence is high. Furthermore, we need to focus more on 'prevention for positives', supporting couples where only one partner is living with HIV.

Promotion of male and female condom use, and integrating condom promotion into Sexual and Reproductive Health and Rights (SRHR) services, will continue to have a vital role in HIV prevention, especially in concentrated epidemics. It is important to increase the availability of condoms for young people as they become sexually active.

[11] PMTCT is defined by the World Health Organisation (WHO) as a four pronged approach comprising: 1) primary prevention of HIV infection; 2) prevention of unintended pregnancies among women living with HIV; 3) prevention of HIV transmission from mothers living with HIV to their infants; 4) care, treatment and support for mothers living with HIV, their children and families.

Getting condoms to sex workers in Indonesia

Although Indonesia's AIDS epidemic is currently concentrated in a few high-risk groups, it is vital that infection rates do not escalate within these groups and the wider population. DFID is providing £25 million between 2005 and 2008 to get condoms and other essential HIV services to one at-risk group: sex workers in Malang, East Java.

After two years, the results were promising. More sex workers were using condoms consistently, and there had been a decline in Sexually Transmitted Infections (STIs). In 2005, 6.4% of female sex workers in Suko, Malang district, were classed as "always using" condoms, with STI prevalence in this community at 31.3%. In 2007, 49.6% were always using condoms, and STI prevalence had reduced to 20.9%.

PMTCT is important. There is strong evidence for the effectiveness of PMTCT interventions, both to prevent HIV transmission to the child, and to prevent maternal death, which further protects children. Increased coverage could significantly reduce children's and mothers' susceptibility and vulnerability. Yet, only 34% of women currently have access to PMTCT services. This is why the UK will intensify international efforts to increase coverage of PMTCT.

When integrated with other services, PMTCT provides the opportunity to maximise health outcomes. Maternal, Newborn and Child Health (MNCH) services that include PMTCT are important entry points for women, their children and families to access broader health and AIDS services. But these programmes must recognise that women might not be free to act independently or have the resources to access testing, counselling, pre- and post-natal care and alternatives to breastfeeding. These programmes must be scaled up where they are most needed. Of the 21 countries on track to reach Universal Access targets for PMTCT by 2010, only four are from the eight hyper-endemic southern African countries.

Evidence indicates that, where there is no safe and affordable alternative to breast milk available, exclusive breastfeeding for the first six months of life is the safest, most cost-effective way to reduce HIV transmission from mother to child, especially where the mother also insists upon condom use. Exclusive breast-feeding results in lower transmission rates in the post-natal period for up to six months and is more likely to keep infants healthy. A key challenge is to ensure that health workers have the skills, knowledge and commitment to support mothers with HIV to feed their infants safely.

Family planning enables women (and men) to realise their right to choose if and when to have a baby. When HIV-positive women are given choice and opportunity to prevent unwanted pregnancies, it is a highly successful and cost-effective way of reducing mother-to-child transmission of AIDS and reducing maternal deaths. Evidence suggests that effective contraception in sub-Saharan Africa prevents over

twice as many cases of maternal-to-child transmission of HIV than the cumulative total of cases prevented by anti-retroviral therapies. The rapid scale-up of Universal Access to family planning is possible through an effective, equitable primary healthcare system. For this reason, the UK will intensify efforts to increase access to family planning.

The health benefits of family planning

Every year an estimated 80 million women have unplanned or unwanted pregnancies and 46 million seek an abortion. Twenty million of these abortions are unsafe and 65,000 - 70,000 women die. UNFPA (the United Nations Population Fund) has estimated that every US$1 million spent on family planning can avert 360,000 unwanted pregnancies, prevent 150,000 induced abortions and save the lives of 800 mothers and 11,000 children.

People who receive high-quality HIV counselling and testing are able to make informed choices based on knowledge of their HIV status. This can enable people to avoid high-risk behaviour and, when living with HIV, to live positively – but poor provision can have the reverse effect. Counselling and testing can also provide a critical entry point for key health interventions including HIV and TB treatment, care and support. Irrespective of whether counselling and testing are 'provider-initiated' or voluntary, these services must protect the rights and respect the decisions of individuals who 'opt out' of testing. They must always ensure informed consent and non–coercion, and must protect client confidentiality.

For people who inject drugs, it is essential to increase coverage and availability of comprehensive harm reduction services, particularly needle and syringe exchange and drug treatment programmes, including non-injectable substitutes. The effectiveness of these harm reduction programmes has been well demonstrated in reducing heroin use, drug associated deaths, HIV risk behaviours and criminal activity. Despite their effectiveness, less than 20% of injecting drug users worldwide receive HIV prevention services. The UK set out its position on harm reduction in 2005, and we are committing to continue to support greater access to such programmes in this strategy.

Continued investment is needed to ensure a safe blood supply, to protect healthcare workers and to achieve effective infection control in healthcare settings.

With the exception of recent knowledge about the benefits of medical male circumcision (see box below), there have been few developments on medical HIV prevention technology. Existing prevention methods appropriate to each context must be scaled up in parallel with the ongoing search for new ways to prevent HIV. Continued efforts are particularly required to find prevention methods that are female led or controlled, such as microbicides (see box below).

The potential of microbicides

The UK has been at the forefront of support to microbicides[12] since 1999. We have made significant investments – DFID's cumulative funding for microbicides now totals £50 million, and includes funding the world's largest microbicide clinical trial.

Microbicides could provide a female-controlled method to prevent infection where other methods are unfeasible, unreliable, or both – for example where a woman is unable to persuade her partner to wear a condom. While microbicides have so far proved unsuccessful in large trials, their potential means that they warrant further investment. Research suggests that even a partially effective microbicide has the potential to prevent two to three million new HIV infections each year.

DFID currently contributes over £9 million each year. We will increase by at least 50% our funding for research and development of AIDS vaccines and microbicides over 2008-2013.

There is strong evidence that circumcising men reduces their risk of becoming infected with HIV during heterosexual sex, but does not directly reduce HIV transmission to women or other men. UNAIDS recommended in 2007 that medical male circumcision should be offered as part of a comprehensive HIV prevention programme.

Male circumcision

An analysis of data from UNAIDS and a study in South Africa estimates that scaling up male circumcision in high prevalence areas could avert three million HIV infections in Africa by 2026.

To increase the safe provision of male circumcision, more training for healthcare workers and more public education about the benefits and limitations are needed.

Circumcision programmes will need to be monitored carefully for their impact on other prevention activities and for any negative impact on the provision of other key health services. For example, decreased risk for circumcised men may result in a decline in condom use, which could increase the risk of HIV transmission. Women must also not lose the ability to negotiate safer sex with circumcised partners.

Increasing access to male circumcision will need to take into account local practices. Female genital mutilation, which is a gross violation of women's rights, does not have similar protective benefits. Indeed, there are concerns that it may increase risk of HIV transmission. It must not be linked to, or confused with, male circumcision.

(ii) Sustain momentum for treatment

Significant achievements have been made in scaling up treatment, but coverage still varies widely between countries and population groups. Access to treatment for children remains inadequate. This is due in part to poor capacity to diagnose HIV infection in infants and the difficulty of tailoring dosage and formulations to meet their specific needs. IDUs are also less likely to receive ARV treatment, mostly as a

[12] Microbicides are being developed as gels, creams or rings that can be inserted into the vagina (or rectum) to reduce or prevent the transmission of HIV during sex.

result of misconceptions about the impact of drug use on treatment adherence, stigma in healthcare settings, and denial of care and support. In addition, while prices for first-line ARVs have been falling, second-line drug treatments are still very expensive and more effort is needed to reduce these costs.

To maximise the full potential of ARVs, we need to promote adherence to ARVs and contain the spread of resistant virus. The solution is to equip health systems to provide a continuous supply of drugs (anti-retrovirals and treatment of opportunistic infections) and improve people's access to health services, including counselling services and care. As we move forward, we will need to make more treatment regimens appropriate for resource-poor settings. Strategies are also needed to reduce the transmission of HIV in those on treatment, who may have drug resistance. This should be part of a wider strategy of HIV prevention for positive people.

The World Health Organisation (WHO) provide standard treatment guidelines to encourage countries to use evidence-based ARV treatment protocols. However, even in the most recent guidelines (2008), there are 24 first-line and 42 second-line recommended ARV treatment regimens. When there are so many products, and when few people are on second-line regimens, it is difficult to consolidate demand, and give countries a stronger basis for negotiating price reductions on drugs. The international community must push for further prioritisation of treatment regimens by WHO, and improved procurement practices, to ensure that countries get value for money. We will support action in this area, which could yield enough efficiency savings to fund medicines for an additional one million people every year. These issues are covered in more detail in Chapter 4.

(iii) Increase effort on care and support

In addition to improving access to treatment, more efforts are needed to scale up care and support for adults and children living with HIV. This includes a package of services, such as prevention of and treatment for opportunistic infections, nutrition, and palliative and home-based care. Quality care is important to maintain the health of a person living with HIV before they require treatment, and to secure the benefits of ARVs (including minimising resistance).

The affordable antibiotic cotrimoxazole can help prevent opportunistic infections and maintain the health of adults and children living with HIV. But its routine use in developing countries – particularly sub-Saharan Africa – has remained limited. Further efforts are required to ensure that this drug is better utilised.

DFID support to cotrimoxazole

The CHAP study in Zambia, sponsored by DFID, was particularly influential in promoting stronger guidance about cotrimoxazole prophylaxis. In 2004, the study showed that infants with symptomatic HIV infection who received daily cotrimoxazole were 43% less likely to die during a 19-month follow-up period, and 23% less likely to require hospitalisation. This was chiefly due to the drug's protective effect against bacterial lung infections.

It is important to improve rates of TB diagnosis among PLWH – and to improve HIV diagnosis among people with TB – in places where both diseases are endemic. For instance, in southern Africa, TB is the leading cause of death among people living with HIV, and transmission of (sometimes untreatable) drug resistant strains of TB are increasing rapidly. Preventative treatment needs to be made more available, and greater attention must be paid to infection control.

Pain is one of the most common symptoms of people living with AIDS. Many countries have minimal palliative and home based care services, which are often not well integrated into broader health systems. Good quality palliative and home based care must be made more available as part of a comprehensive approach to AIDS services. Oral opiates, including oral morphine, must be made routinely available for pain management. Public health and human rights concerns must influence policies as well as the need to control illicit trade in opiates and other drugs.

AIDS is having an enormous impact on women and children, particularly in sub-Saharan Africa. Women and girls are often more likely to be HIV-positive than men and boys and also provide the bulk of the care for PLWH and orphans and vulnerable children. Sections 4 and 5 set out how the international community, with help from the UK, can increase its efforts providing support for those affected by the epidemic, including orphans and vulnerable children.

PRIORITIES FOR ACTION

- Supporting countries to develop and implement evidence-informed prevention strategies that promote and protect human rights; that are relevant to the local epidemic context; and that promote comprehensive approaches to HIV prevention based on the realities of people's lives
- Supporting international, national and community-level strategies for care, including palliative care, that promote and protect human rights and that are relevant to the local epidemic context
- Pushing for further prioritisation of treatment regimens by the World health Organisation, and improved procurement practices, to ensure that countries get value for money on medicines.

The UK will:

Work with others to intensify international efforts to halve unmet demand for family planning (including male and female condoms) by 2010, to achieve Universal Access to family planning by 2015.

Work with others to intensify international efforts to increase to 80% by 2010 the percentage of HIV-infected pregnant women who receive ARVs, to reduce the risk of mother to child transmission, both in low income and high prevalence countries.

2 Responding to the needs and protecting the rights of those most affected

The picture shows a NGO worker talking to a young injecting drug user about HIV prevention at a mobile needle exchange point in the Ukraine. It is essential that comprehensive harm reduction services, particularly needle and syringe exchange and drug treatment programmes, including non-injectable substitutes, are available to people who inject drugs.

Key messages

- Greater efforts are needed to reach those most affected by the epidemic – including People Living With HIV (PLWH), women, young people, children and vulnerable groups, such as Men who have Sex with Men (MSM), Injecting Drug Users (IDUs), sex workers and prisoners
- AIDS responses must tackle the underlying drivers of the epidemic, including gender inequality, harmful sexual norms, stigma and discrimination and economic need
- Stigma and discrimination remain major barriers to achieving Universal Access and require urgent attention
- National responses must enable those most affected to participate in the design, implementation, monitoring and evaluation of services.

HIV is an infection that can affect any man, woman or child, rich or poor. It affects ordinary people, many of whom see themselves as being at low risk of infection. However, some people are more affected than others by the epidemic. 'Knowing your epidemic' and applying a rights-based approach can ensure AIDS responses reach those most in need to tackle the spread of the disease most effectively.

Globally, women, young people, children, Men who have Sex with Men (MSM), Injecting Drug Users (IDUs), sex workers and prisoners are most affected by AIDS[13]. They are more likely to be living with HIV than the general population, are less able to deal with the impact of the epidemic and are most likely to be failed by existing policies, programmes, support and services. This is a direct result of their unequal position in society and the negative effects of gender inequality, harmful sexual norms, stigma and discrimination, and economic need and status. We will collectively fail to address the epidemic if we fail to reach these groups with appropriate services – which take into account the realities of their lives – and address the underlying drivers of their susceptibility and vulnerability. Thus, tackling AIDS means addressing social exclusion and safeguarding human rights.

IDUs, sex workers, MSM, other sexual minorities[14], and prisoners are among the most marginalised and discriminated against in society, and they often face the greatest need. In many cases, national authorities deny the sexuality and existence of these groups, or make their behaviour illegal when they do recognise it. As a result, it is often difficult to reach these groups with effective interventions, such as condom promotion and harm reduction measures for IDUs. More action is required to respond to the needs and protect the rights of these vulnerable groups and People Living With HIV (PLWH). The UK will play its part and work with its partners to increase the coverage of HIV prevention and AIDS services for IDUs in countries where they are most affected. The Home Office, the Foreign and Commonwealth Office (FCO) and DFID will work together to improve the international environment for harm reduction.

[13] Examples of other groups that may be disproportionately affected by the epidemic include migrants and mobile populations (including mineworkers and truck drivers), clients of sex workers and their partners, partners of IDUs or MSM, people with a disability, elderly people, and indigenous populations.

[14] Sexual minorities is a phrase used to describe people who are not exclusively heterosexual or who do not define themselves as male or female. In some parts of the world, the terms 'lesbian', 'gay', 'bisexual', or 'transgender' are preferred. Certain sexual minorities, especially MSM and transgender persons, are almost always disproportionately affected by HIV.

Peer educators talk to sex workers about HIV and AIDS and other sexually transmitted infections. Such targeted programmes have helped to keep the HIV prevalence in most-at-risk populations, including sex workers, below 1% in Bangladesh.

Working with vulnerable populations in Bangladesh

In Bangladesh, HIV prevalence continues to be very low, and the main focus of national prevention efforts is on reducing the susceptibility and vulnerability in the most-at-risk populations, i.e. sex workers, IDUs and MSM. DFID has supported HIV prevention efforts in Bangladesh for more than 10 years. The prevalence of HIV in these at-risk groups overall remains below 1%, and surveillance has shown changes in key risk behaviours. These include a rise in use of condoms by brothel-based sex workers with new clients from 39% to 70% between 2004 and 2007, and a reduction in the same period from 86% to 55% in sharing of needles and syringes by IDUs in the capital city Dhaka.

Women and men face different risks and barriers in relation to the AIDS epidemic and in accessing services. Gender inequalities mean that women and girls cannot always decide if, when, how and with whom they have sex, or when to access basic services. Violence against women and girls significantly increases their risk of HIV infection. Women and girls report increased violence for refusing sex, requesting condom use, accessing HIV counselling and testing, and for testing HIV-positive. Women and girls also bear the greatest burden of care, including caring for orphans and those who are sick.

Women need greater control over HIV prevention through the promotion of female condoms and eventually through access to microbicides (see box on page 19). But effective action on AIDS also requires long-term changes in deep-rooted human attitudes and behaviours. It is important to work more with men and boys, and with the justice and education sectors, to change attitudes towards violence against women, harmful traditional practices (such as child marriage and female genital mutilation) and other structural inequalities.

Effective national responses should ensure that gender analysis is integrated into national AIDS strategies and plans. It is also important to track targets and indicators to measure outcomes for men, women and sexual minorities. People involved in the AIDS response may require training to better understand the importance of gender issues.

DFID's commitment to gender equality

" I believe we have a moral duty to help women break free from discrimination and lift themselves out of poverty. Indeed, we know that if we succeed, the benefits will not only be felt by women, but also their families and communities."

Douglas Alexander, Secretary of State, at the Gender and Development Network, March 2008

Gender equality is a goal in its own right, and has a vital role to play in achievement of the Millennium Development Goals (MDGs). Progress on gender equality is a critical factor in achieving all the Goals. MDG 3 specifically commits the international community to promote gender equality and the empowerment of women. In 2006, DFID published a White Paper, called *Eliminating World Poverty: making governance work for the poor*, which committed us to making our work on gender equality and women's rights more of a priority.

DFID explains how it will help developing countries to achieve gender equality and women's empowerment in the *Gender Equality Action Plan* (2007).

Two participants at a workshop organised by the International HIV/AIDS Alliance and Photovoice to empower people living with HIV in Ecuador. During the workshop the participants receive cameras and training, to allow them to portray the story of their lives and make their voices heard. Empowering people living with HIV and vulnerable groups is one of the most affective ways to reduce the stigma and discrimination related to HIV.

Sex between men is thought to account for at least 5-10% of HIV infections globally. One review found that MSM were 14 to 58 times more likely to be living with HIV in countries with low HIV prevalence, when compared to the general population. For many MSM, particularly in south Asia, sexual identities are complex. Many consider themselves to be heterosexual and also have sex with women. In order to meet the needs of MSM and transgender individuals, it is important to tackle the human rights violations that impede them from accessing the information, resources and support necessary to prevent HIV. The same applies for sex workers, IDUs and prisoners.

Young people face particular risks from HIV and AIDS, but the realities of young people's lives are often overlooked in national responses. Young people are frequently unable to access comprehensive information about Sexual and Reproductive Health and Rights (SRHR) or to use youth-friendly services that have been designed with them in mind – often because society denies that they are sexually active. Young men often face peer pressure to use drugs and alcohol and to demonstrate their sexual experience. This increases their risk of HIV infection as well as that of their partners. Targeted programmes are needed to work with young men to change these attitudes and this behaviour. The vulnerability of adolescent girls, particularly in the younger age group (10-14 years) and those who

> "You have to prove you're a man by hitting your girlfriend in front of your friends. They say: "You're not a real man unless you can control your chick." If you can't control her, they say she's given you some muti [traditional medicine]. After I went to the workshops I started to change my mindset."
>
> 21-year-old man, South Africa

are married, is also neglected. They need initiatives that help them overcome their isolation, create 'safe' spaces for girls to meet, and give them opportunities to learn life-skills and earn money. Young people represent a significant resource that can make a vital contribution to halting the spread of AIDS.

The AIDS epidemic has placed a huge burden on children affected by the disease, particularly in sub-Saharan Africa. When parents die, the stress of bereavement for their children is often compounded by the threat of poverty, abuse and dropping out of school. These factors put Orphans and Vulnerable Children (OVCs) at higher risk of HIV infection. Countries therefore need integrated programmes to respond to children's psychological, livelihood, health and education needs and to ensure protection from all forms of abuse. An effective response should also involve the carers, who are often elderly female relatives, and the wider community support systems.

Responding to these needs will require long-term commitments both within and outside of existing AIDS budgets. The UK remains firmly committed to meeting the needs and rights of OVCs and taking action to reduce their vulnerability to HIV, including through Prevention of Mother To Child Transmission (PMTCT) and social protection programmes.

Social protection programmes, described below, can reduce suffering and destitution faced by children and their carers, ensuring improved nutrition and access to health and education. This in turn can reduce susceptibility to future HIV infections. Accelerating action for children, including in Middle-Income Countries and fragile states, will require continued partnering with others, such as the United Nations Children's Fund (UNICEF) and civil society organisations. National plans of action for OVCs provide opportunities for scaling up the response and should be supported in a long-term, predictable manner.

It is also important to ensure that other neglected groups, such as older people and people with a disability, can access prevention, treatment and care programmes. Disabled women, in particular, are very vulnerable to sexual abuse and need appropriate targeted interventions.

Helping a forgotten minority: disability and HIV in Zambia

Susan Mshoka is in her early 30s and has been deaf since childhood. A widowed mother of two, she has publicly declared herself to be HIV-positive. Through the DFID-supported Zambian Federation of the Disabled (ZAFOD), Susan provides AIDS services for people with disabilities. In her own case, this has meant anti-retroviral therapy, which helps to slow the progression of HIV, and has made her healthy enough to work.

People who are geographically mobile can be more susceptible to infection, but are often overlooked in the AIDS response. For instance, economic migrants or truck drivers who spend long periods away from home are more likely to engage in casual or commercial sex and may have less access to services. Female migrants and

women and children caught up in conflict face increased risk of abuse, violence and trafficking and are at higher risk of HIV infection. Men also suffer from sexual abuse, particularly during armed conflict and when in prisons. Responses for groups like these need to be scaled up. Areas of focus include livelihood programmes to reduce harmful migration, appropriate AIDS and reproductive health services for mobile groups and better integration of AIDS within humanitarian responses.

People associated with HIV and AIDS often face stigma and discrimination. Even in hyper-endemics where a large proportion of the population is affected, PLWH may be rejected in their community, lose their jobs or property, be denied schooling or healthcare, and face abuse and lack of support. As a result, people may be afraid to ask for information about HIV and AIDS, get tested, disclose their status, or access treatment and care. Urgent action is required to reduce HIV stigma and discrimination. One of the best ways to do this is to empower PLWH and vulnerable groups to act on their own behalf and in their own interests. Furthermore, strong leadership from politicians, faith groups, community leaders, the media and others is crucial to create a supportive and open environment and to foster respect.

Defeating the stigma around HIV and AIDS in Kyrgyzstan

Although the UN estimates that there are up to 10,000 PLWH in Kyrgyzstan, only 1,479 have been officially recorded. As the epidemic is mostly concentrated among IDUs, many HIV-positive people face stigma and discrimination due to their association with AIDS as well as with drug use. This prevents more people from getting tested, and forces those who are HIV-positive to isolate themselves from services that can improve their health and reduce transmission. Furthermore, rollout of critical HIV prevention methods, such as clean needles, was hampered by laws that made a prison sentence mandatory for anyone caught in possession of even small amounts of drugs. In 2007, this legislation was changed – a real progressive leap in Kyrgyzstan.

DFID is currently funding a £6.4 million programme in Kyrgyzstan and other central Asian countries to scale up harm reduction programmes for IDUs and to change societal attitudes towards PLWH. Working both with governments and NGOs, it uses educational initiatives and counselling sessions to get essential healthcare to those who need it, while reducing stigma.

The international community needs to work with governments and civil society to ensure that the needs and rights of women, young people, children and vulnerable groups are fully integrated in the AIDS response. Providing targeted HIV prevention and AIDS services is important, but is not enough by itself. Increased efforts are needed to create social, legal and political environments to allow these groups to receive the support and services they need. Providing support for networks of PLWH and vulnerable groups (e.g. IDUs) can be an effective way of creating supportive environments, sharing best practice and improving accountability.

In fact, organisations and networks of PLWH and vulnerable groups, such as sex workers, IDUs, and MSM, are key actors in the AIDS response. Their meaningful involvement is critical for ensuring effective responses to AIDS. They also have a particular role to play in promoting positive prevention and treatment literacy, and providing (psychosocial) support for PLWH. However, their capacity is often limited and should be strengthened to ensure their full and active role in the responses.

Supporting the involvement of People Living With HIV and other vulnerable groups

Being HIV-positive has a dramatic effect on your life – nobody understands that better than those living with or directly affected by the disease. And nobody understands the needs of PLWH and other vulnerable groups better than they do. These groups should therefore be involved in all aspects of the AIDS response. This is not just their right; it is an essential part of effective responses to the epidemic.

DFID supports global and national networks of PLWH and affected communities, such as the Global Network of People Living With HIV (GNP+), the International Community of Women Living with HIV (ICW) and the International Harm Reduction Association (IHRA). This has helped to strengthen their leadership and meaningful involvement in the AIDS response.

PRIORITIES FOR ACTION

- Supporting the empowerment of People Living With HIV (PLWH) and vulnerable groups to act on their own behalf and in their own interest, and partcipate in all aspects of the AIDS response
- Ensuring that gender analysis is integrated within national AIDS plans, and that targets and indicators are developed to measure the impact of AIDS programmes on women and girls
- Promoting and taking action on neglected and sensitive issues – including adolescents' Sexual and Reproductive Health and Rights (SRHR); the needs and rights of Men who have Sex with Men (MSM); and harm reduction
- Working with our partners to ensure increased action against HIV-related stigma and discrimination.

The UK will:

Intensify efforts to increase the coverage of HIV and AIDS services for Injecting Drug Users (IDUs) in countries where they are most affected. Work in partnership with governments, multilateral agencies, civil society and through nine bilateral programmes, to improve the international environment on harm reduction.

Increase by at least 50% its funding for research and development of AIDS vaccines and microbicides over 2008-13.

3 Supporting more effective and integrated service delivery

A young couple receives family planning advice at a clinic in Botswana. HIV is closely connected to sexual and reproductive health and rights and other health issues. Integrating services and strengthening the wider health system will help to improve service delivery and people's health.

Key messages

- National governments need to provide strong political leadership, to own and co-ordinate their response to AIDS
- Stronger national systems are required to improve service delivery – including planning, budgeting and monitoring
- Health services are essential and require strengthening, particularly through stronger health workforces
- AIDS services need to be integrated with Tuberculosis (TB), malaria, Sexual and Reproductive Health and Rights (SRHR), including Maternal, Newborn and Child Health (MNCH) services
- Scaled up responses are needed outside of the health sector in order to ensure Universal Access – education, social protection, justice and livelihoods sectors all have important parts to play in the response

The impact the epidemic has on individuals, families and communities is worsened by the fact that basic services for health, education, social protection, livelihoods and legal protection are not reaching all those in need. Many communities, and in particular vulnerable groups, in both Low- and Middle-Income Countries are under-served, leaving them susceptible to HIV and vulnerable to the impact of AIDS. Delivering these basic services and achieving Universal Access requires:

(i) An effective country-led response based on stronger national systems of planning, budgeting and monitoring

(ii) Stronger, more effective systems for improved health service delivery

(iii) A more effective multi-sectoral response that addresses AIDS and gender issues.

All these aspects are dependent on effective partnerships between government, civil society – including People Living With HIV (PLWH) – and the private sector (which is further discussed in Chapter 4).

(i) Stronger national systems of planning, budgeting and monitoring

To ensure an effective country-led AIDS response, governments and local leaders (including faith and community leaders) must show leadership and build coalitions of support to tackle AIDS. These coalitions can act as catalysts for social movements that put people at the centre and enable communities to shape the course of the epidemic rather than merely respond to it. They also have a vital role in addressing the political and social factors that impede progress in achieving Universal Access.

The importance of strong political leadership

International political leadership has markedly increased since *Taking Action* was launched. Through the *UK's Call for Action on HIV/AIDS* (2003), and *Taking Action*, the UK has taken the lead on promoting the needs and rights of vulnerable groups, and on closing the funding gap – the UK is the second largest bilateral funder of AIDS, providing £1.5 billion over the period 2005-08. And other governments have followed suit. The amount pledged to the Global Fund to fight AIDS, Tuberculosis and Malaria has increased from US$1.5 billion in 2004 to US$3.1 billion in 2008. And the international community has committed to the goal of Universal Access.

National political leadership has also strengthened in some countries, leading to falls in HIV prevalence in countries such as Kenya, Cambodia and Thailand. But progress has not been consistent, and ideological positions have stood in the way of evidence-based, effective responses. Leaders all over the world need to recognise the social norms that drive the epidemic, and acknowledge that people, including young people, have sex – sometimes for money or with same-sex partners – and may use drugs.

And leaders need to match words with the right actions. All countries have made high level commitments, but the real proof of leadership is to turn commitment into action. Leaders at all levels (from international to community) and in all sectors (faith, sports, media) need to support effective AIDS responses. Where political leadership is poor or misguided, effective responses are stalled or blocked; finances are not allocated or are misapplied; and misinformation from high levels of society can lead, at community level, to substantial confusion and disbelief of the real facts. Antagonism to evidence-based approaches can stall effective responses, and lead to time-consuming legal challenges and unnecessary conflict.

Robust policies, systems and services within countries must include effective planning to provide a foundation for ensuring that services reach people in need. Credible, costed national AIDS plans should be based on 'knowing your epidemic' and should address contextual constraints to scaling up the AIDS response.

Poverty Reduction Strategy Papers and other national development plans should reflect AIDS plans. They should be consistent with the harmonisation principles in the Paris Declaration and in the International Health Partnership (IHP), and should promote action within different sectors. More work is needed to define what constitutes a credible costed plan and to articulate a process to ensure that credible plans receive funding. PLWH and civil society have a critical role to work closely with planners and implementers, ensuring the development and rollout of responsive national AIDS plans, as well as monitoring of their impact.

The International Health Partnership

The UK Prime Minister launched the IHP in September 2007 to put the health Millennium Development Goals (MDGs) back on track by building stronger health systems and making health aid more effective. It is a partnership of donors, developing countries and multilateral agencies[15], which is guided by two principles: 1) Developing countries should prepare robust National Health Strategies that reflect National AIDS Plans that highlight the need for stronger health systems; and 2) Donors should co-ordinate their funding around these strategies.

DFID is supporting the IHP at global level through its ongoing work with international health agencies and other development partners. At country[16] level it supports the development of national strategies and engagement with other partners in-country.

Early signs of progress include: eliminating user-fees (in Nepal, the IHP gave momentum to a new policy of free healthcare); and more health workers (in Mozambique, a central part of the IHP will be developing and implementing a co-ordinated strategy to increase the number of health workers).

Better collection, monitoring and use of data are needed to improve outcomes. Research, information and programme monitoring should be used strategically to facilitate better use of resources, secure stronger political and financial commitment for tackling AIDS and demonstrate improved accountability for results.

Rani Jayakodi, an HIV positive health worker in India, pays a routine visit to the family of a woman living with HIV. In many countries, AIDS has focused attention on the need to recruit and train more health workers.

[15] The UK, Norway, Germany, Canada, Italy, The Netherlands, France, Portugal, WHO, the EC, the World Bank, UNAIDS, UNFPA, GAVI Alliance, UNICEF, the Bill and Melinda Gates Foundation, the African Development Bank, The Global Fund to fight AIDS, Tuberculosis and Malaria, the UN Development Group.

[16] The IHP is initially being implemented in 8 first-wave countries: Burundi, Cambodia, Ethiopia, Kenya, Mali, Mozambique, Nepal and Zambia.

(ii) Stronger, more effective systems for improved health service delivery

Major, sustained efforts to strengthen health systems are critical to achieving Universal Access. This is why this strategy sets an overall target for health spending. Focusing on the health sector provides an incentive for stronger and closer integration of health services and helps tackle constraints that effect their delivery – including staff shortages and limited infrastructure. Effective partnerships between state and non-state providers are needed to increase access and improve the impact of health services. The DFID strategy for health is covered in the document *Working together for better health*, 2007.

AIDS is closely connected to other diseases and health issues, such as Sexual and Reproductive Health and Rights (SRHR) – including Maternal, Newborn and Child Health (MNCH) – and Tuberculosis (TB) and malaria. And health systems for delivering Universal Access are also responsible for delivering wider health and development goals, such as the MDGs on gender equality, child mortality, maternal health and communicable diseases. It is therefore important to focus on integrating services and strengthening the wider health system to improve service delivery and people's health.

Improving the links between AIDS and other health services

Where existing health services, especially primary care services, are not well organised to deliver comprehensive HIV prevention, treatment and care, governments and agencies are missing opportunities to deliver more effective services. An important opportunity is appropriately linking AIDS services with SRHR, including MNCH and sexually transmitted infection services, and other infectious diseases, such as TB and malaria.

HIV increases the risk of maternal death, for example by exacerbating malaria and TB during pregnancy, with subsequent serious impact on the child and the wider family. As women often first encounter the health system when they use maternal health services (especially antenatal clinic services), integration of AIDS services offers an opportunity to engage women, their partners and children in HIV prevention, treatment and care services. The World Health Organisation (WHO) recommends that maternal health services should provide a platform for scaling up Prevention of Mother To Child Transmission (PMTCT) efforts.

Integrating SRHR with HIV and AIDS

" *Men and women should be able to enjoy a satisfying and safe sex life, have the capability to reproduce and the freedom to decide if, when and how often to do so. This requires informed choice and access to safe, effective, affordable and acceptable healthcare services."*

DFID Position Paper on SRHR (July 2004).

Almost nine out of ten people with HIV were infected through sex or mother to child transmission. Sexual and reproductive ill health and HIV are influenced by the same underlying factors – and can usually be tackled through the same channels. DFID supports the integration of SRHR with AIDS services as an effective way of achieving Universal Access. However, integration needs to recognise the stage of the epidemic and the needs of specific groups.

In Nigeria, DFID is providing £52.8 million over seven years (2002-09) to promote SRHR for preventing HIV. DFID will also provide £5 million for a complementary public awareness campaign.

Stronger links must also be forged between TB, malaria and HIV services. In particular, in hyper-endemic countries, TB and HIV are fuelling each other, and the need for integration is made more urgent by the steep rise in drug resistant TB infections. In places where the TB burden is high, progress has been made on screening for TB and HIV and on treating both diseases, but more needs to be done to make these services more accessible.

Strengthening the wider health system

Despite being under-funded, AIDS is seen as one of the most generously resourced of all the communicable diseases. Indeed, successful advocacy has brought about a large jump in resources (see also Chapter 4). But some countries are struggling to ensure a balanced response across the health sector due to the volume of funding provided for AIDS. When this competes with other more scarce health resources, it can undermine efforts to strengthen national health systems and the response for other health priorities.

Support for the AIDS response can, and should, have wider benefits for the health sector. AIDS funding and funding for health systems are mutually reinforcing, because increased funding for AIDS can help to build stronger health systems, and investments in systems can support a sustainable AIDS response. UNAIDS estimates that 25% of the resources needed to scale up to Universal Access should go to strengthen health systems, to help them cope with the additional burden of delivering AIDS services. More efforts need to be made to:

- Strengthen the national and local stewardship of health systems by governments, which would lead to improved co-ordination of resources, and better strategic planning
- Strengthen partnerships between government and non-government providers of health services

- Improve financial management
- Ensure the availability of sufficient numbers of trained and motivated health workers, who are adequately paid and located where they are most needed
- Ensure equitable access to safe, affordable, essential drugs and commodities for all in need
- Address barriers that prevent people from accessing health services such as financial barriers, e.g. user-fees and cost of transport for people to reach clinics
- Improve the quality of data from routine monitoring, analytical work and research and the way it is used
- Ensure that systems are accountable and responsive to users.

A major challenge, especially in high prevalence countries, is to maintain the quality of healthcare delivery when faced with strong demand for services – in particular, when human resources for health are scarce.

The importance of health workers

" AIDS … has thrown a spotlight on the urgent need to strengthen human resources for health, for three reasons. Firstly, AIDS represents a significant burden on health systems. In some countries, half of all hospital beds are occupied with patients with AIDS-related illnesses. Secondly, to expand ART (Anti-Retroviral Therapy), and to make ART sustainable, we need strong health systems. Thirdly, being a health worker does not protect you from becoming infected. Botswana, for example lost approximately 17% of its healthcare workforce to AIDS between 1999 and 2005."

Peter Piot, UNAIDS, at the Global Health Workforce Alliance Global Forum on Human Resources for Health, Kampala, Uganda, 5 March 2008

In many countries, AIDS has focused attention on the need to recruit and train more health workers. These countries require an ample supply of trained and motivated health workers, who are adequately paid and supported, and located where the need is greatest. Without a quality workforce, health systems and services will continue to be weak, which will continue to affect our ability to provide access to AIDS services for all who need them. According to WHO, a country needs at least 2.3 health professionals (doctors, nurses and midwives) per 1,000 including people to enable 80% of deliveries to be attended by someone with the right skills. WHO has also proposed a comprehensive effort to shift tasks within the health system towards health professionals who are most plentiful and easiest to train and mobilise, such as nursing auxiliaries.

The health system should ensure that services reach those who need them. But significant barriers to access still exist – including the poor quality of services, the distances people must travel to access them, and social and cultural barriers. The cost of accessing health services is also a major barrier to uptake.

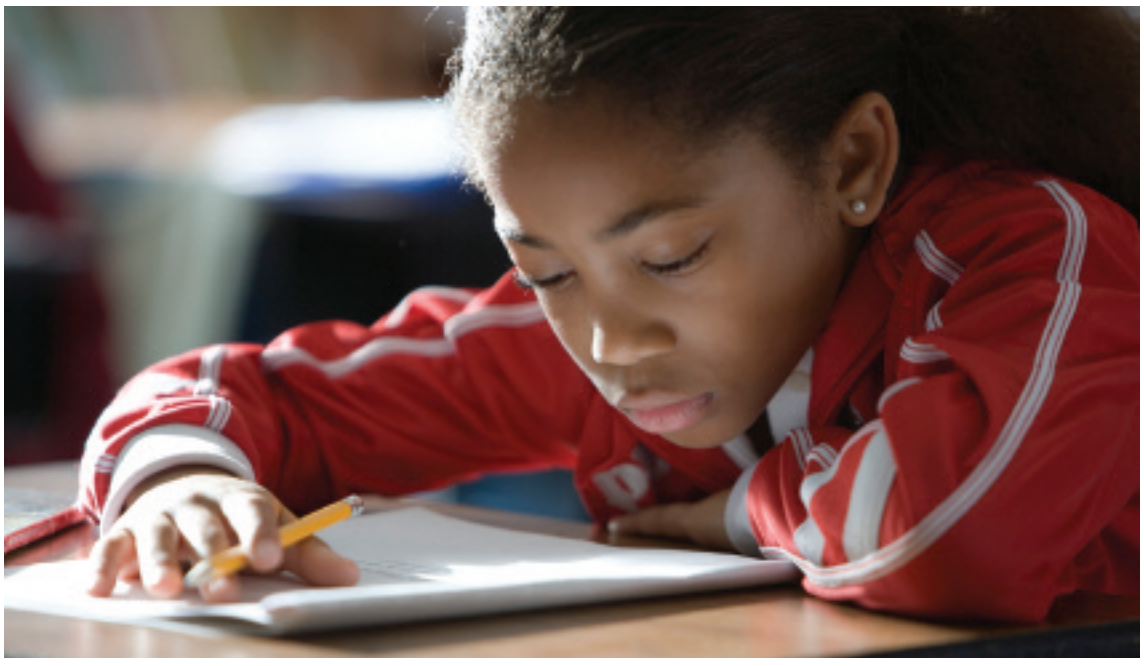
> "My 22-year-old daughter is on ARVs (anti-retrovirals) and gets her supplies from Mpilo hospital. Her main problem is that we can't always get her the drugs because transport is expensive. In February 2006 she went for five days without (treatment) since we could not raise the bus fare. Since then, my daughter has been bed-ridden and there is no hope that she will make it."
>
> Mother, Esigodini, Zimbabwe

For example, even where free anti-retroviral drugs are available, people may be prevented from taking them by the expense of getting a diagnosis or of travelling to get treatment. The stigma and discrimination people face in healthcare settings may also discourage them from accessing services, or may result in their being subject to prohibitive charges or being denied care. Reducing the cost of treatment and care for poor households and monitoring access to AIDS services remain high priorities.

Accountability is important. Community members – including PLWH – must participate in setting priorities, designing programmes as well as monitoring the quality of services and their access to them. This can help ensure that basic services are responsive to the people who use them, reaching those in need, and will help to reduce wastage and corruption in service delivery.

(iii) A more effective multisectoral response

AIDS is not only a health issue. AIDS is influenced by, and itself affects, a range of sectors in addition to health, including education, justice and social welfare. To be fully effective, an AIDS response, in particular in high prevalence countries, needs well functioning systems within these sectors, as well as strengthened community capacity to respond to the epidemic.



AIDS is not only a health issue, but is influenced by and itself affects a range of sectors, including education. Education can improve knowledge about sexual and reproductive health and help challenge some of the underlying factors that fuel the spread of HIV such as harmful norms around sexuality, gender and stigma.

In hyper-endemic communities, high rates of AIDS-related illness and death have undermined the capacity of sectors to deliver. For instance, the number of teachers who died in service in Mozambique due to AIDS increased by about 70% between 2000 and 2004, with associated reductions in the quality of education. AIDS is hindering development, so all sectors need to address not only how their work reduces the spread of HIV and mitigates the impact of AIDS, but also how AIDS itself affects each sector's ability to deliver results. This means addressing the causes and effects of AIDS through each sector's work and within the workplace.

The education sector plays an important role in producing HIV prevention for young people and support to OVCs. It can provide essential knowledge about HIV and SRHR and help to challenge some of the underlying factors that fuel the spread of HIV, such as harmful norms around gender, sexuality and stigma. The UK has committed to spend £8.5 billion by 2015 to fund long-term education plans.

Girls who complete secondary education are less likely to become infected with HIV, while boys are more likely to practise safer sex. For girls, school attendance leads to multiple benefits, including a reduced risk of unwanted pregnancies and a decline in rates of early marriage, particularly in sub-Saharan Africa. Furthermore, adolescents who do become sexually active while still in school are more likely to use contraception than their same-age peers who are no longer in school, which reduces their risk of infection. However, many girls and boys, including those orphaned by AIDS, are not in school. And many others do not reach the middle and secondary levels where education on sexuality and HIV is typically offered. Support for non-school-based programmes is therefore vital.

Education programmes can help to challenge attitudes around masculinity and gender-based violence. Children need to be reached at primary level, when their attitudes and behaviours are still forming and before they reach adolescence. Programmes should address social relationships, ideas of equity and rights, gender, and negotiating skills. These skills can help children to absorb more sensitive information about sex, sexuality, contraception and protection when they are older. When civil society organisations become involved they can help increase national capacity and provide more effective approaches than traditional curriculum-based programmes.

Education provides effective HIV prevention, but it requires schools that are safe for children. This includes having appropriate toilet facilities for girls and an appropriate number of female teachers. Schools should provide safe and supportive environments in which sexual violence and sexual relations between teachers and students are not tolerated.

Legal systems can be critical for tackling gender inequality, as well as stigma and discrimination. Of countries that reported to UNAIDS in 2008, 63% state that their policies hinder access of vulnerable groups to HIV and AIDS service. One-third indicates they have no laws to protect people living with HIV from discrimination. Lack of legal protection also means people are unable to hold to account those that discriminate against them.

7 year old Annasurya plays with a classmate at an NGO funded school for orphans and former child labourers in Andhra Pradesh, India. She is HIV-positive and has lost her mother to AIDS.

Communities and families provide crucial care and support for the chronically ill and children affected by AIDS. But capacities are limited. There is good evidence to show that well planned social protection programmes, targeted at the most vulnerable households, bring great benefits to children and their families.

Regular and predictable cash transfers can mitigate the impact of AIDS on children and their carers, who are often elderly women. Ministries of Social Welfare should be supported to ensure that appropriate and well-targeted social assistance programmes (such as old-age pensions or child support grants) are in place. And cash transfers must be part of a comprehensive system of care and support that includes family support services, accessible and affordable healthcare and education, psychosocial support, and broad livelihood support.

Reducing the vulnerability of children and their carers through social protection

The UK remains committed to meeting the needs of Orphans and Vulnerable Children (OVCs). We set a spending target for OVCs in Taking Action, which helped increase global funding for OVCs. UK spending on OVCs increased to over £150 million (2005-08) and other donors also earmarked funds for OVCs.

Existing support to OVCs – including planned President's Emergency Plan for AIDS Relief (PEPFAR) announcements – indicate that funding is likely to increase in the coming years. It is therefore right that the UK, working with agencies such as UNICEF, systematically addresses a key remaining policy challenge: ensuring that National Plans of Action (NPAs) for OVCs are integrated into health,

Reducing the vulnerability of children and their carers through social protection (continued)

education and social protection plans. This approach, endorsed by OVC experts[18], will help ensure that more OVCs are guaranteed long-term access to essential basic services and protection from abuse.

Focusing on integrating NPAs within social protection strategies is important because social protection programmes can particularly improve welfare for children affected by AIDS[19] and their families. Over the next 3 years, the UK will expand its social protection programmes and increase spending to over £200 million. DFID will work in at least 8 African countries to develop social protection policies and programmes, with governments and NGOs that provide effective predictable support for the most vulnerable households.

This will significantly increase the number of OVCs who have access to better nutrition, health and education. In Zimbabwe alone, we aim to reach 400,000 OVCs by 2010, up from 184,000 who are currently reached.

DFID has already supported these approaches. In Zambia, the UK is helping provide regular cash transfers to 13,000 people. In Ghana, the UK is supporting 2,000 households, including OVCs with predictable cash grants.

In South Africa, cash grants have resulted in increased height-for-age in children under 3 years – indicating that the impact of AIDS can be mitigated through these approaches. In Zambia, cash transfers to households have helped reduce overall school absenteeism by 16% – also important as education can reduce the risk of HIV infection.

We will work with UNICEF and NGOs to review the impact of social protection, particularly cash transfers, on vulnerable children through a 6-country study. We will regularly review our approach, including by publishing a report following the biennial Global Partners Forum on Children Affected by HIV and AIDS, to ensure that the approach outlined here supports the most effective ways of meeting the needs and rights of OVCs.

Social protection is only part of the response to the needs of OVCs. We also need to ensure that resources get down to communities, provide better diagnostics of children infected with HIV and greater access to paediatric treatment. The UK has committed £90 million to UNITAID, from 2008-11, which will help increase access to paediatric treatment. The UK will also support efforts to prevent transmission of HIV from mothers to their children. This can reduce the chances of children's infection from 40% to as low as 2%.

[17] Including by the Inter Agency Task Team (IATT) on Children and HIV and AIDS, and the Joint Learning Initiative on Children and HIV/AIDS (JLICA).

[18] A recent study of seven diverse cash transfer programmes across southern Africa revealed that between 50-70% of all recipients were HIV-affected.

PRIORITIES FOR ACTION

- Supporting efforts to better understand the drivers and impact of the epidemic at national and sub-national levels, as well as efforts to ensure that this information is used as a basis for national plans and strategies
- Supporting public and private sector efforts to strengthen health systems (human resources, drugs and supplies, infrastructure) to enable better access to, and coverage of, prevention, treatment, care and support services
- Supporting the integration of HIV and AIDS with TB, malaria and SRHR, including MNCH, services
- Strengthening multi-sectoral prevention, care and mitigation strategies based on knowledge of the local epidemic
- Promoting the implementation of education programmes that help young people, both those in and out of school, to have safe and healthy sexual relationships, free from stereotyping, violence and exploitation
- Supporting the development, implementation and review of credible, comprehensive and costed national AIDS plans that are linked to national health and other sector delivery plans

The UK will:

Spend £6 billion on health systems and services to 2015.

Spend over £200 million to support social protection programmes over the next 3 years. DFID will work with governments and civil society in eight African countries to develop social protection policies and programmes that will provide effective and predictable support for the most vulnerable households, including those with children affected by AIDS.

Work with international partners to support countries with health worker shortages to provide at least 2.3 doctors, nurses and midwives per 1,000 people, through supporting plans that identify the appropriate mix of health workers.

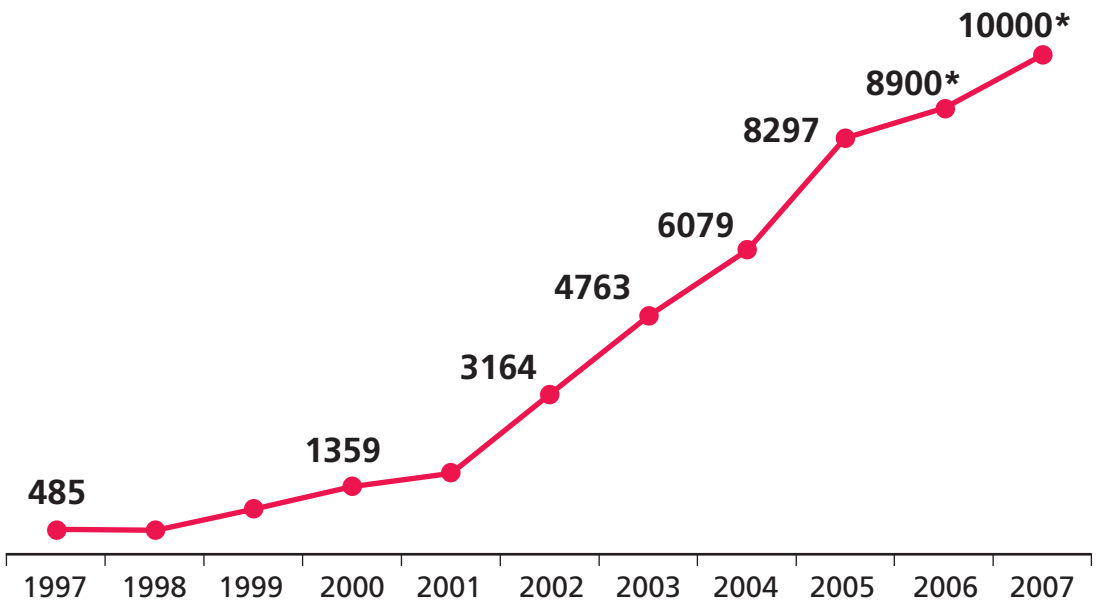
4 Making money work harder through an effective and co-ordinated response

Nozamile Ndarah has just had her medication changed, and has been given the generic fixed-dose combination drug Triomune instead of three separate pills. This makes it easier to take the medication, so she was pleased to make the change. (CORBIS)

Key messages

- The UK is committing significant resources to the global response to AIDS and we are focused on ensuring that new and existing resources have the greatest impact on the epidemic – now and in the future
- This depends on getting value for money, ensuring sustainability of the response, and strengthening partnerships and co-ordination
- Resources need to be channelled to where they are most needed – including to communities and community-based organisations
- Effective partnerships, including between governments, bilateral and multilateral agencies, civil society and the private sector, are essential in order to achieve Universal Access
- International partners need to support country-led AIDS responses and align behind national plans
- Multilateral agencies have a key role to play, particularly in fragile states and Middle-Income Countries
- The US Government President's Emergency Plan for AIDS Relief (PEPFAR), as the world's largest AIDS funder, is a key partner

Total AIDS Funding Worldwide ($ millions)



* Spending figures in 2006 and 2007 are estimates

Global financing for AIDS has increased 20-fold between 1997 and 2007, and has been growing at around US$1 billion a year since 2004. Total development assistance came to US$103 billion in 2007, and on current estimates, some 10% was allocated for HIV and AIDS. But need still outstrips funding, and the resource gap will remain significant in the future. By 2010, around five times the US$10 billion allocated for HIV and AIDS in 2007 may be needed. On current projections, this is unlikely to materialise, despite many promising signs of leadership elsewhere.

The critical challenge is not only to mobilise more money, but also to use the available funding to maximum effect, to benefit those most in need. To achieve Universal Access, all those involved in responding to AIDS will need to make the money work harder, both now and in the long term, to avert more infections and save more lives with the available resources. This depends on:

(i) getting value for money

(ii) ensuring that the response to AIDS is sustainable and affordable in the long term

(iii) strengthening partnerships and co-ordination in support of country-led AIDS responses.

(i) Getting value for money

As described in Chapter 1, the basic building block for an effective response is to 'know your epidemic', because when interventions are tailored to local circumstances, the money will have a greater impact. It can help to identify effectively the most cost-effective way to achieve prevention, care, support or treatment objectives.

Evidence demonstrates that prevention is far more cost effective than treatment, largely because of the high price of medicines, but also because the disease is not curable – so treatment is for life. We know that without more effective approaches to prevention, many countries simply won't be able to afford treatment in the future, as the number of people requiring treatment could grow explosively. A study of Thailand's AIDS programmes suggests that every US$1 spent in the 1990s on HIV prevention generated US$43 of savings a decade later by avoiding the need for expensive AIDS treatment services. To contain costs and reach the maximum number of people possible, the international community must step up prevention efforts.

But cost effectiveness needs to be considered alongside arguments for human rights and equity and commitments to Universal Access, and the momentum on treatment needs to be sustained. The prices of anti-retroviral (ARV) drugs have been falling steadily, but second-line drugs are still very expensive. Drug resistance, which forces people to move from first-line to second-line therapies, escalates costs. We must minimise drug resistance while also investing in new drugs, more affordable drugs and better access to medicines. Reducing the costs of drugs could enable savings that could fund access to life-saving treatment for an additional one million people every year, even without new resources. The UK will work with others to help make this happen.

Improving access to AIDS treatment

The private sector must continue to receive incentives to keep investing in new AIDS treatments. Further investment in research is necessary to identify better and more cost-effective drugs, including for the treatment of children.

More people will be able to receive existing treatments if ways can be found to make them cheaper. The cost of first-line treatments declined dramatically after 2000, as a result of brand name companies reducing prices, as generic producers became more competitive. However, new recommendations by the World Health Organisation (WHO) have now resulted in an increase in the costs of the recommended first-line treatment. And second-line treatments, composed of newer drugs with limited or no generic competition, cost far more and are needed by more people who do not respond well to first-line treatment.

Improving access to AIDS treatment (continued)

Research into the prices, procurement, production and organisation of ARV drug regimens suggests there is scope for over £50 million of efficiency savings every year. Drugs can be obtained at lower cost if countries co-ordinate and promote better practice in procurement, and give their procurement agencies reliable information about the best prices that are achievable. Protocols recommended by WHO should take account of the need to increase the cost-effectiveness of regimens. As newer drugs that face no generic competition come onto the market, countries have the option of utilising the Trade Related Intellectual Property System (TRIPS) to allow local manufacturers to license local production, which will help make AIDS medicines more widely available. Companies also need to price their medicines differently in different countries, in relation to people's ability to pay.

The Medicines Transparency Alliance (MeTA) will bring together international institutions, governments, industry and civil society to disclose information on the price, quality and availability of medicines. By making information publicly available, MeTA will help to increase public accountability and improve access to medicines, including those for AIDS. DFID plans to spend up to £20 million on MeTA over the next 10 years.

A new DFID Southern African regional programme on Access to Medicines will start in 2008. This will spend over £10million (in the first 3 year phase) to improve availability and affordability of quality essential medicines and diagnostics in Southern Africa Development Community (SADC) Member States. The new programme works with the SADC Secretariat, and SADC Member States, as well as civil society, to implement the SADC Pharmaceutical Business Plan and other initiatives – including regional activities to advance MeTA – in Southern Africa.

(ii) Making a lasting impact on AIDS: three faces of sustainability

The sustainability of the AIDS response ultimately depends on whether countries are able to afford the delivery of a comprehensive package of HIV prevention, treatment, care and support; provide the political leadership to prioritise resources; and have the capacity to co-ordinate and implement the AIDS response.

Economic sustainability: being able to afford the AIDS response

Economic sustainability rests on whether in the long term a government can afford the drugs, staff and other costs associated with delivering the AIDS response, without receiving donor support.

AIDS programmes that begin today will become long-term financial and political obligations for national governments and for the wider international community. Many of the countries worst affected by HIV and AIDS are poor and depend on aid. If donors ignore the spending liabilities that will continue beyond the end of their own time-bound investments, future services in these countries will be threatened.

This is why effective prevention activities are so important. Timely investment in AIDS can avert the large future costs of inaction and free up public funds for other priorities, such as boosting economic growth. In practice, financial sustainability is rarely factored into the global response.

No Low-Income Country (LIC) with a hyper-endemic or generalised epidemic has yet come close to achieving self-sufficiency in delivering an effective AIDS response, even in the medium term. The conclusion is stark – Universal Access cannot be achieved in these countries without sustained donor assistance. The international community must therefore maintain its commitment to supporting AIDS responses in the long term.

DFID has made long-term commitments (to the Global Fund to fight AIDS, Tuberculosis and Malaria, and to UNITAID, for example) and continues to encourage others to do so. Our long-term view is being extended to an integrated package of health and AIDS commitments. We are committing to spend £6 billion on health systems and services over seven years to 2015.

The real long-term solution relies on increased domestic wealth – through economic growth – which will help countries afford their own AIDS responses. But in high prevalence countries, AIDS is increasingly choking off growth. For instance, Swaziland's growth has turned negative since the 1990s as HIV prevalence has increased. This two-way interaction between HIV and growth must be taken seriously as part of a national growth and poverty reduction strategy.

Political leadership: prioritising resources for the AIDS response

Sustainability is not just a question of resources. Several Middle-Income Countries have, or are approaching, the ability to deliver Universal Access with domestic funding, but some lack the political will to do so. As discussed in Chapter 3, weak or misguided political leadership can lead to poor allocation of resources and stall effective, evidence-based responses.

National capacity: being able to implement the AIDS response

Chapter 3 also highlights the importance of strong national systems of planning, coordination, budgeting and monitoring. These are crucial elements of the national capacity to deliver basic services and implement the AIDS response. Other elements, also discussed above, include ample supply of human resources – including human resources for health – effective information and management systems and strong infrastructure. A lack of national capacity has resulted in an *implementation* gap.

A critical element of national capacity is the ability to allocate resources according to need and where they will achieve the greatest impact. This depends to a great extent on 'knowing your epidemic', strong planning and budgeting systems, but it also depends on the type of aid a country receives. When donors place earmarks and restrictions on aid, it limits countries' ability to allocate resources according to local needs and contexts. The international community should place fewer earmarks and restrictions on aid, and align behind national plans.[19] Funding given to partners will be monitored for the impact it has on programmes and how effectively institutions are able to use it to ensure our resources deliver the best results and value for money.

The international community and national governments must also eliminate bottlenecks that obstruct money and resources being channelled to where it can make the greatest difference to the epidemic. Civil society plays a crucial role in countries' responses to the epidemic, through delivering services and creating demand, challenging inequality, advocacy and strengthening accountability. Money and opportunities must be made available to community-based organisations and networks of those most affected by AIDS, to maximise their contribution to the response.

The international community should support the efforts of national stakeholders to track the flow of funding from national to community level, and address bottlenecks where possible. Expenditure tracking – part of a strong financial management system – is fundamental to ensuring that resources are used effectively and accountably.

This elderly woman in Malawi cares for children that have lost their parents to AIDS. Community based organisations play a vital role in providing support to households affected by AIDS, but are often under funded and unable to meet the demands for help. More efforts are needed to ensure that funding reaches community groups.

[19] The International Health Partnership (IHP) – as detailed in Chapter 3 – provides a framework for co-ordinating aid effectiveness and building on countries' national health plans

Ensuring funding reaches communities most affected by AIDS

Community Based Organisations (CBOs) play a crucial role in supporting community AIDS responses – they are facing increasing demand for their services, especially in hyper-endemic contexts.

Many CBOs are small, under-funded groups formed in response to the essential needs of their members' communities. It is vital that funding reaches these organisations, in order to support community capacity to respond to the AIDS epidemic.

In a number of countries, DFID has supported efforts to track how AIDS funding is used, such as National AIDS Spending Assessments (NASAs), which monitor funding for specific HIV services and interventions, at national and local levels.

(iii) Supporting an effective co-ordinated response

Universal Access is a goal for the entire international community. One agency or government alone cannot achieve it. National governments have responsibility for resourcing, co-ordinating and delivering effective AIDS responses, but they need support from a wide range of other stakeholders.

However, it is not always clear on the ground which agencies lead on which aspects of the response to AIDS. This can result in duplication of effort and gaps in support to national AIDS responses, and can lead to counter-productive competition among organisations. This makes extra work for national governments and detracts from their efforts in shaping and implementing programmes. At the same time, support from international partners does not always build the long-term capacity of government systems.

It is critical to strengthen co-ordination, alignment and harmonisation of responses. This has been well supported, not least by the 'Three Ones' principles, the OECD/DAC Paris Declaration on Aid Effectiveness, the Global Task Team[20] (GTT) (see below), and by UN reform. These efforts must be strengthened within the framework of the Millennium Development Goals (MDGs) and the goal of Universal Access. They can be measured using approaches such as the UNAIDS Country Harmonisation and Alignment Tool (CHAT).

The GTT provides a framework for co-ordinating and improving the effectiveness of aid in the AIDS response. It has made important progress in clarifying roles and responsibilities amongst international partners, although so far implementation has mainly focused on the UN. All those involved in the AIDS response should apply the principles of the GTT. This is particularly important given the significant increases in resources provided by the US Government President's Emergency Plan for AIDS Relief (PEPFAR), and by some philanthropic Foundations (in particular the Bill and Melinda Gates Foundation, and the Clinton Foundation HIV/AIDS Initiative).

[20] The Global Task Team on improving AIDS co-ordination among multilateral donors and international donors

PEPFAR warrants special attention, as the world's largest financer of the AIDS response, and the impact this has had on increasing access to services. Since 2003, PEPFAR has provided around $19 billion (2004-08) to support national AIDS responses. This has included support for counselling and testing for more than 33 million people, and supporting ARV treatment for around 1.45 million people. DFID works closely with PEPFAR and will continue to do so. The priorities for the UK in its work with PEPFAR will include:

- ARV sustainability
- Health system strengthening and human resource constraints
- Prevention; especially family planning and harm reduction
- Maximising multilateral performance and results.

President Bush has called for a reauthorisation of the PEPFAR programme at $30 billion over five years, and the Congress is currently considering legislation with funding totaling $50 billion for AIDS and the associated diseases of tuberculosis and malaria, including through contributions to the Global Fund. The legislation would affirm PEPFAR's focus on prevention and strengthening of health systems. It would however also maintain the requirement that PEPFAR grantees certify that they have policies opposing prostitution and sex trafficking (which has led to some programmes turning down U.S. funding).

Multilateralism with edge

The UK AIDS response uses a variety of delivery mechanisms depending on the epidemic and development context. Our bilateral programme has a number of specific benefits, which include:

- Enabling engagement in political dialogue with stakeholders in-country
- Flexibility and speed of reaction
- Closer links and coherence between aid and non-aid policies.

Our work with multilateral agencies, such as UNAIDS and the Global Fund to fight AIDS, Tuberculosis and Malaria, helps the UK support AIDS responses in different ways. Benefits of this approach include:

- Reduced administration costs
- Greater geographical reach
- Funding that is less dependent on national budget cycles
- Fewer political allocation mechanisms
- The ability to work at both the regional and global level.

Potentially, multilateral agencies can offer greater harmonisation of aid and better in-country alignment, and can co-ordinate the work of others. They also have broader and deeper technical knowledge to offer.

As set out in the Prime Minister's initiative on reforming the international system, the UK will use its funding and influence to maximise the performance of the whole multilateral system. This will become increasingly important as we withdraw from some Middle-Income Countries (MICs) and instead rely on multilaterals to deliver our aid there. Our vision for working with key partners is set out below.

Tackling AIDS in Middle-Income Countries (MICs)

Responding to AIDS in MICs is increasingly important. Five MICs in southern Africa[21] have HIV prevalence over 15%, while many countries in eastern Europe and central Asia, where the epidemic is growing fastest, are middle-income. Countries with large populations, such as India, China, Indonesia and Vietnam, are either already middle-income or will be within a few years.

MICs have substantial national resources to support AIDS responses, so international support needs to focus more on transferring knowledge and expertise, helping ensure policies address inequality and have a pro-poor focus, and providing technical assistance and human resources. However, in southern Africa the role of large AIDS funders will remain key.

Given DFID's commitment to spend 90% of its bilateral resources in LICs, we have limited capacity to support work in MICs. Our approach for MICs relies on working with the UK Foreign and Commonwealth Office (FCO), bilateral and multilateral partners, and civil society and private sector organisations.

Multilaterals can support efforts to scale up services in MICs where the governments are committed to tackling AIDS, and have appropriate policies in place. And where governments do not have the commitment or policies in place, the UN has the mandate to engage with them politically and technically on difficult areas to uphold globally agreed conventions – this is very important on human rights issues. The UK will press for effective multilateral support to AIDS responses in MICs.

DFID's regional office in southern Africa currently allocates 1/3 of its budget to provide technical assistance and support to tackle AIDS in the hyper-endemic countries and throughout the Southern African Development Community (SADC).

United Nations

The UN is a critical partner in taking forward the UK's response to AIDS, because it has the legitimacy to lead on policy and to monitor international efforts. It can also work in emergency situations where we are less effective. The UN plays an

[21] Botswana, Lesotho, Namibia, Swaziland, South Africa

important role in setting policy standards and instilling universal values of human rights and gender equality. UNAIDS, the United Nations joint programme for AIDS, plays an important advocacy and leadership role and is responsible for co-ordinating the UN response to the AIDS epidemic.

Internationally backed processes, such as the High Level Panel on UN reform, have called on the UN to work coherently around country priorities. They have also urged it to increase efficiency through joint programming, and to be more accountable on results to national stakeholders. We will fund the UN in a way that rewards results, supports reform and strengthens mutual accountability. Centrally, DFID is seeking to provide the majority of its funding through predictable core funding arrangements. We hope to channel additional funding for AIDS to the UN through the UNAIDS Unified Budget and Work plan. At country level, we seek to increasingly fund the UN through a One UN budget mechanism (in UN reform pilot countries) or through a Joint UN programme on AIDS at country level. We will no longer fund the UN in a way that leads to inter-agency competition for resources and to fragmentation and inefficiencies.

AIDS responses in fragile states and humanitarian contexts

The UK sets out its commitment on fragile states in DFID's White Paper *Making governance work for the poor*. The proportion of People Living With HIV (PLWH) is four times higher in fragile states than in other LICs, and the capacity of these states to respond is lower. More research is needed on the link between conflict and HIV, but there is currently some evidence to suggest that conflict can increase rates of HIV transmission. Post-conflict states should ensure due attention is paid to HIV in both humanitarian relief settings and during longer-term development processes.

We can make an impact on the epidemic in fragile states. Donors can support AIDS responses in fragile states in various ways, such as supporting non-state actors and multilaterals. For example, the UN can help ensure a co-ordinated donor response and promote prevention, treatment and care programmes. Through its role on the Inter- Agency Standing Committee, the UN is helping to bring AIDS issues into the mainstream of emergency-response work. But it is important to ensure that these efforts build systems and capacity for the long term, ensuring the AIDS response is sustainable and helping national governments to set the agenda.

Global Fund to fight AIDS, Tuberculosis and Malaria

DFID has committed up to £1 billion to the Global Fund to fight AIDS, Tuberculosis and Malaria (the Global Fund) up to 2015. The Global Fund has been a key driver of the growth in funding for AIDS since 2003. It now provides over one-fifth of all international resources for AIDS. This volume of resources can cause problems for

countries to manage effectively, so the UK will work with the Global Fund to ensure that its support is provided in ways that meet countries' needs.

In scaling up its portfolio over the next three years, the Global Fund should:

- Work more effectively with implementing partners and donors
- Ensure maximum value for its investment
- Support the international health architecture and national health systems to achieve better health outcomes for MDGs 4, 5 and 6.

Improved performance in these areas should include:

- Developing a simple validation process for comprehensive national plans
- More alignment and harmonisation efforts
- Maximising the number of good quality programmes that can be financed
- Ensuring value for money in procurement
- Targeting poorer developing countries
- Providing clear guidance for funding to strengthen health systems.

In addition, the Global Fund should build on its recent commitment to greater gender focus to improve outcomes for sexual and reproductive health and rights.

UNITAID – an international drug purchase facility

UNITAID's mission is to intervene in markets to lower the cost of drugs and speed up the rate at which they are made available. For such a new organisation with a small secretariat, it has contributed to some impressive outcomes. For example its support to the Clinton HIV/AIDS Initiative has led to a reported 40% reduction in the price of the paediatric anti-retrovirals (ARVs) it has sourced. As UNITAID develops further, we expect more positive outcomes. At UNITAID's launch in 2006, the UK made a 20-year commitment to UNITAID. Over the period 2008-11, we will provide up to £90 million.

European Commission

The European Commission (EC) has put in place a useful framework for taking action on HIV and Sexual and Reproductive Health and Rights (SRHR), strengthening health systems and improving aid effectiveness. Currently, around 20% of DFID's budget is channelled through the EC, and the UK is keen for the EC to focus more strongly on accelerating progress on HIV and AIDS at global and country level, including through supporting stronger health systems. At the global level, the UK and the EC can work together at the Global Fund board, and the EC should continue its active engagement with, and funding of, the Global Fund. At the country level, the EC should continue to ensure that EC Country Strategy Papers adequately address HIV and SRHR. EC targets and funding mechanisms should complement those of developing countries and other donors.

The EC's 'MDG contracts' have potential to provide longer-term predictable financing to countries with a strong track record of using additional resources to deliver better MDG outcomes, including strengthening health systems. The EC should use its convening power with European Union (EU) member states to support the effective translation of the EU HIV Prevention Statement at country level.

World Bank

The UK is the largest donor to IDA15 – the International Development Association[22] replenishment announced in December 2007 – and will provide £2.134 billion over three years (2008-11). We want the World Bank to continue to focus on strengthening health systems, which should include providing advice on fiscal space[23] and health financing, and capacity for monitoring results. We also want the Bank to continue its support for strengthening government policies and institutions, to enable the most effective and efficient use of government and partner funds. The Bank should lead by example and also use its convening power to encourage greater country ownership, and alignment and co-ordination of all donors' AIDS assistance strategies.

The challenge now is to maximise the impact of these different funding streams to achieve the health MDGs, which is why the UK initiated the development of the International Health Partnership (IHP), which is now being led by a consortium of international players. The IHP – which brings together the global health agencies, bilateral donors and developing countries – aims to accelerate the implementation of the Paris principles on aid effectiveness in the health sector. By strengthening the co-ordination of different funding channels, eliminating overlaps and reducing administrative burdens, the IHP also aims to maximise the effectiveness of current resources for AIDS and health, while opening the door to new resources. And by helping to build stronger health systems, the IHP will play a critical role in delivering sustainable HIV prevention, treatment and care services.

[22] International Development Association (IDA) is the part of the World Bank that helps the world's poorest countries.
[23] The International Monetary Fund (IMF) also has an important role here.

Activists take part in a march, calling for access to HIV prevention services and treatment, before the opening of the XV International AIDS Conference in Bangkok, Thailand, in 2004.

Civil society and the private sector

Civil society organisations (CSOs) play vital roles in tackling AIDS, and complement the work of governments and the private sector. CSOs have been crucial in both providing AIDS services (in particular for vulnerable populations) and creating demand for them by raising awareness, tackling stigma and discrimination, and promoting rights. CSOs often represent the voices of people most affected by AIDS when policies are being developed and decisions being made. And they play a critical role in holding governments and international agencies to account.

Organisations and networks of people living with or affected by HIV and AIDS are particularly important stakeholders. Their meaningful involvement is critical for ensuring effective responses to AIDS. They also have a particular role to play in promoting positive prevention and treatment literacy, providing (psychosocial) support for People Living With HIV (PLWH), and advocating for the rights of PLWH. However, their capacity is often limited and should be strengthened to ensure their full and active role in the responses.

Faith-based organisations (FBOs) form a distinctive part of civil society. As 70% of the world's people identify themselves as members of a faith community, FBOs can reach many people. They often provide a significant number of basic services in developing countries; in 2004, the World Bank estimated that faith groups account for half the education and health care provision in sub-Saharan Africa. They also have the potential to shape social norms that influence people's behaviour and attitudes towards someone living with HIV. However, some preach unhelpful messages around sex, condom use, homosexuality, and women's rights. Those that foster respect and understanding can have significant impact and should be supported.

The influence of Foundations and the level of funding they provide have grown markedly since *Taking Action* was published. We need to work more closely with key Foundations, particularly the Bill and Melinda Gates Foundation and the Clinton Foundation HIV/AIDS Initiative (CHAI), making best use of complementary strengths. This should include building on, and developing similar arrangements to, the Product Development Partnerships (PDPs), where the Gates Foundation is the dominant funder, and UNITAID, where CHAI is a major partner.

The private sector plays a significant role in the provision of services, through funding and research and by influencing governments. Workplace programmes that focus on prevention and treatment and tackling stigma and discrimination against PLWH can have valuable benefits for staff, their families and the community. Large companies are often well equipped to run these programmes, but small and medium sized enterprises also need to develop them within their own financial constraints, particularly in the informal sector. Trade Unions can also play an important role in some countries.

Private sector responses to AIDS

Mining company Anglo American is implementing the largest directly delivered, private sector ARV therapy programme in the world. Drinks company Diageo has a workplace programme for employees and their families that includes counselling, clinical management of opportunistic infections, palliative care and access to ARVs for life, even after the employee has left the business. Standard Chartered Bank's 'Living with HIV' peer education programme has been extended to young people, to the community at large and to the employees of other companies and organisations. In partnership with pharmaceuticals company Merck and Co, the Bill and Melinda Gates Foundation and the Government of Botswana are rolling out ARVs in Botswana.

In July 2007, the UK launched the *MDG Call To Action*, which seeks to accelerate progress towards the MDGs. This emphasises the need to work with civil society as well as the private sector.

DFID is investing £2.5 million (2006-09) in a joint programme with KfW to accelerate the private sector response to HIV and AIDS in the Caribbean. And in Kenya, DFID is investing £40 million (2007-11) to support the Kenya National HIV/AIDS Strategic Plan. Part of this will help build the capacity of the private sector to design and implement high quality HIV programmes.

PRIORITIES FOR ACTION

- Providing long-term, performance-based and predictable resources to countries and partners in support of a sustainable global response to AIDS beyond 2010
- Supporting and promoting innovative approaches, including through ensuring that all DFID's new AIDS programmes support operational research and using our central research budget to fund cutting-edge research to stimulate innovation
- Promoting efforts to track the flow of funds from national to community level and alleviate bottlenecks
- Funding multilaterals in a way that contributes to coherent implementation of national plans at country level, promotes institutional effectiveness and delivers results
- Making the money work harder to accelerate progress towards MDG 6, in line with the Paris principles of aid effectiveness, including through the IHP
- Working with partners to deliver an effective AIDS response in MICs.

The UK will:

Work with others to reduce drug prices and increase access to more affordable and sustainable treatment over the long term. This could yield efficiency savings of at least £50 million per annum, enough to cover the cost of anti-retroviral drugs for an additional one million people every year.

Ensure the Global Fund to fight AIDS, Tuberculosis and Malaria implements the Paris Declaration target on use of common arrangements and procedures, including programme-based approaches.

Work with development partners, both within and outside of the IHP, to ensure that sector-wide approaches to health strengthen the AIDS response and that targeted AIDS programmes also strengthen the wider health system.

5 How we will turn our strategy into action

Siphiwe Hlophe, founder of Swaziland Positive Living, came to London in November 2007 to raise awareness of AIDS and meet Douglas Alexander, Secretary of State for International Development.

Key messages

- DFID will invest significant resources in research to support an effective AIDS response
- We will work with other UK Government departments to support the global response to AIDS
- We are committed to the principle of Greater Involvement of People living with HIV and AIDS (GIPA), and will seek to strengthen the involvement of People Living With HIV (PLWH) in our work
- We will create an HIV-friendly work environment, strengthen our skills, knowledge and motivation and structure our business systems to best deliver the AIDS policy and programme commitments

Through the work of DFID, the Foreign and Commonwealth Office (FCO) and other government departments, the UK is able to support and influence the response to AIDS at all levels – from community to international level. DFID has more than 60 overseas offices, which enable us to support individual countries and regions, and inform international policy and advocacy with our experience of working within and across countries and sectors. Our core functions include political advocacy, policy development and the financing of bilateral and multilateral programmes and public goods.

Through our regional and country programmes, delivered directly by governments and through contracts with UN agencies, civil society and others, we support a range of AIDS and broader development programmes, ensuring that responses are owned and managed by the countries in question and that they are tailored to their needs. We take funding decisions in support of country priorities at a country level.

In countries with strong commitments to development, good governance and improving capability, we tend to focus on supporting the development and implementation of comprehensive country-led HIV and AIDS strategies, directly funding governments, as well as working with civil society and international donors and agencies. In more fragile states, where governments may be unable or unwilling to respond effectively, we tend to provide technical support to strengthen government capacity alongside direct support for service delivery via the UN or civil society. About half of our support reaches countries through international agencies like UNAIDS, the Global Fund to fight AIDS, Tuberculosis and Malaria, the World Bank and the European Commission.

The world's ability to respond effectively to the ever-changing AIDS epidemic relies on the strength of its research. DFID will spend up to £1 billion on development research over the next five years. Our support to research on AIDS will, in particular, help to:

- Make HIV prevention programmes more effective, by increasing our understanding on how to tackle the social, cultural and economic factors that influence people's behaviour and choices
- Fill the gaps in our knowledge about HIV stigma and discrimination, gender and inequality in relation to HIV and AIDS
- As an urgent priority, improve prevention strategies that can be controlled by women, by increasing by at least 50% our funding for AIDS vaccines and microbicides research
- Monitor the expansion of key AIDS services on their quality and impact, by supporting operational research.

We remain committed to improving what we do by linking the findings of this research with policy and practice, and we will work closely with other funders to provide a well-prioritised and co-ordinated approach.

A cross-government priority

FCO, Department of Health and Home Office will work with DFID to ensure broad and effective UK support to international and national AIDS responses.

The FCO will work with DFID to ensure broad and effective UK support to international and national AIDS responses that promote and protect human rights.

Specifically, the FCO will:

- Through representation in multilateral institutions, provide and advocate for leadership on comprehensive HIV prevention, treatment and care and support programming incorporating Sexual and Reproductive Health and Rights (SRHR)
- Using their network of overseas posts as a platform, support advocacy at national level where commitment to provide Universal Access is weak
- In DFID's Public Service Agreement countries, help engage in national political dialogue to ensure involvement of civil society and PLWH in national accountability mechanisms (e.g. Poverty Reduction Strategy Paper processes, national AIDS and health planning and review processes)
- At priority overseas posts, continue to place HIV prevention and AIDS treatment as a key issue for their engagement with host governments and international institutions and, where possible, look for targeted interventions that add value to DFID's work and that of international mechanisms such as The Global Fund and UNAIDS, drawing on the various funding sources available
- In Middle-Income Countries, support us in encouraging multilateral agencies where appropriate, at country level and board level, to take a greater leadership role in promoting, protecting and upholding the rights of vulnerable groups
- At their overseas posts consider lobbying the private sector in pressing for business to make anti-retrovirals (ARVs) available free to their employees.

The Department of Health is primarily responsible for ensuring an effective response to HIV within the UK. Working with the National Health Service (NHS), the Health Protection Agency, NGOs specialising in HIV, professional groups, the Sexual Health Independent Advisory Group (SHIAG) and local authorities, the Department of Health takes the lead on HIV policy and prevention, and treatment and care services in England. Health Departments in Scotland, Wales and Northern Ireland play a similar role.

The UK has a relatively low estimated prevalence of HIV and AIDS at around 0.2% in 15-49 year olds. Like many other European countries it is not insulated from the global impact of AIDS. All four of the UK health departments keep up-to-date information on new and emerging scientific developments, both nationally and internationally, through the advice given by the Expert Advisory Group on AIDS to Chief Medical Officers. In England, the SHIAG is currently reviewing the National Strategy for Sexual Health and HIV (2001) and will report its findings to the Department of Health in the summer of 2008.

The Government of Scotland recently reviewed its sexual health strategy *Respect and Responsibility*. It has reported to the National Sexual Health Advisory Committee, outlining new priority outcomes for the next three years. The strategy will re-focus effort on comprehensive HIV prevention, and seek to reduce the number of people who are HIV-positive but go undiagnosed. Interventions will be targeted at groups most at risk of HIV transmission.

The Department of Health will support the international AIDS response through the commitments set out in the Global Health Strategy[24]. The Department of Health also leads the UK delegation to the World Health Assembly, working towards more effective WHO action on:

- Sexual and Reproductive Health and Rights
- Strengthening health systems and the International Health Partnership (IHP)
- A clear division of labour with other multilateral agencies, in line with the Global Task Team recommendations.

Action by the Department of Health to strengthen the Code of Practice on Recruitment of Healthcare Workers from Overseas has helped to deter recruitment in the UK away from developing countries where human resources for health are under great pressure, sometimes because of AIDS. Good practice and learning from a review of the UK's Code of Practice will help inform work by WHO on developing a framework for a global Code of Practice.

The Home Office leads the UK's delegation to the UN Commission on Narcotic Drugs. In order to support the international AIDS response, it will press for strong international leadership and consensus on the importance and improved coverage of harm reduction interventions, such as needle exchange and substitution therapy.

The cross-Whitehall working group on tackling AIDS in the developing world will monitor the implementation of all these actions.

In addition to the priorities for international action and the commitments set out above, we will focus action on the following three areas:

Supporting our staff. DFID and the FCO will work to provide an environment where staff are able to protect themselves from HIV infection, and where they feel able to be open about their HIV status. DFID will seek to put the principle of Greater Involvement of People living with HIV and AIDS (GIPA) into action and work with PLWH in designing and implementing our policy. We will also explore the possibility of establishing a DFID+ network for those of our staff who are living with or personally affected by HIV. Finally, with the close involvement of the FCO and the British Council, we will review our existing HIV workplace policy and implement the findings of the review as appropriate.

Skills and competence. DFID will strengthen the skills, knowledge and motivation of our staff to best deliver our AIDS policy and programme commitments, work with others to support national plans and integrate a focus on HIV and AIDS within other sectoral responses. In addition, we will strengthen our skills and competence to address gender inequality and promote women's rights in the context of AIDS, in line with the Gender Equality Action Plan.

[24] The Global Health Strategy, to be launched in 2008, is a cross-government strategy to improve global health through coherent action across all government departments.

Business systems. DFID will structure and manage its business systems to best deliver our programme and policy commitments. We will do this by ensuring our commitments are incorporated in our planning processes and monitoring systems, and by promoting leadership and capability among our partners. We will use all the instruments at our disposal to make sure that support reaches a range of partners and stakeholders in the AIDS response, and we will commission an independent review of the implementation of this strategy in 3 years.

PRIORITIES FOR ACTION

The UK will:

- Manage and support our staff as individuals in the context of AIDS
- Develop the AIDS skills and competence of our staff so they can best deliver our policy and programme commitments
- Structure and manage our business systems to ensure we deliver our programme and policy commitments on AIDS
- Commission an independent review of the implementation of this strategy in 3 years time
- Work through the cross-Whitehall working group on tackling AIDS to monitor the implementation of the actions across DFID and other government departments.

Conclusion

This strategy sets out the actions that the international community must prioritise in order to achieve Universal Access to comprehensive HIV prevention, treatment, care and support, and to meet Millennium Development Goal 6. It also sets out the UK's commitment in these areas. There has been unprecedented progress since the publication of the UK's first strategy on AIDS in 2004. But there remains much more to do to increase access to AIDS services, and turn the tide of HIV infection across the globe. There is no time to lose. Millions of people's lives are at stake.

The strategy recognises the need to increase efforts on comprehensive HIV prevention and on improving the quality of care for people living with HIV. It emphasises the importance of meeting the rights and needs of those most affected, supporting effective and integrated systems, making the money work better, and supporting an effective, co-ordinated response. We will work with our partners – national governments, bilateral and multilateral agencies, civil society and the private sector – to place people at the heart of the global response. The UK will continue to offer leadership and vision to ensure progress in these areas. We will focus on the outcomes of our efforts. And we will focus on action that will save lives.

UK priorities for action

This section summarises and restates the areas where the UK believes priority action is needed to achieve the goal of halting and reversing the spread of HIV. Where appropriate, based on detailed contextual analysis of the epidemic, its trends and impacts, we will support countries' efforts to take action in these areas.

The UK commits to support progress towards a number of specific targets, which are also restated below. These targets do not represent the sum of our work. To enable us to reflect on the impact of our full work, we will commission an independent review of the implementation of this strategy in 3 years.

Priority 1:

Increase effort on HIV prevention; sustain momentum for treatment; increase effort on care and support

- Supporting countries to develop and implement evidence-informed prevention strategies that promote and protect human rights; that are relevant to the local epidemic context; and that promote comprehensive approaches to HIV prevention based on the realities of people's lives
- Supporting international, national and community-level strategies for care, including palliative care, that promote and protect human rights and are relevant to the local epidemic context
- Pushing for further prioritisation of treatment regimens by WHO, and improved procurement practices, to ensure that countries get value for money on medicines.

The UK will:

Work with others to intensify international efforts to halve unmet demand for family planning (including male and female condoms) by 2010, to achieve Universal Access to family planning by 2015.

Work with others to intensify international efforts to increase to 80% by 2010 the percentage of HIV-infected pregnant women who receive anti-retroviral treatments (ARVs) to reduce the risk of mother to child transmission, both in low income and high prevalence countries.

Priority 2:

Respond to the needs and protect the rights of those most affected

- Supporting the empowerment of People Living With HIV (PLWH) and vulnerable groups to act on their own behalf and in their own interest, and partcipate in all aspects of the AIDS response
- Ensuring that gender analysis is integrated within national AIDS plans, and that targets and indicators are developed to measure the impact of AIDS programmes on women and girls
- Promoting and taking action on neglected and sensitive issues – including adolescents' Sexual and Reproductive Health and Rights (SRHR); the needs and rights of Men who have Sex with Men (MSM); and harm reduction
- Working with our partners to ensure increased action against HIV-related stigma and discrimination.

The UK will:

Intensify efforts to increase the coverage of HIV and AIDS services for Injecting Drug Users (IDUs) in countries where they are most affected. Work in partnership with governments, multilateral agencies, civil society and through nine bilateral programmes, to improve the international environment on harm reduction.

Increase by at least 50% its funding for research and development of AIDS vaccines and microbicides over 2008-13.

Priority 3:

Support more effective and integrated service delivery

- Supporting efforts to better understand the drivers and impact of the epidemic at national and sub-national levels, as well as efforts to ensure that this information is used as a basis for national plans and strategies
- Supporting public and private sector efforts to strengthen health systems (human resources, drugs and supplies, and infrastructure) to enable better access to, and coverage of, prevention, treatment, care and support services
- Supporting the integration of HIV and AIDS with tuberculosis, malaria, and SRHR including maternal, newborn and child health services
- Strengthening multi-sectoral prevention, care and mitigation strategies based on knowledge of the local epidemic
- Promoting the implementation of education programmes that help young people, both those in and out of school, to have safe and healthy sexual relationships, free from stereotyping, violence and exploitation
- Supporting the development, implementation and review of credible, comprehensive and costed national AIDS plans, which are linked to national health and other sector delivery plans.

The UK will:

Spend £6 billion on health systems and services to 2015.

Spend over £200 million to support social protection programmes over the next 3 years. Work with governments and civil society in eight African countries to develop social protection policies and programmes that will provide effective and predictable support for the most vulnerable households, including those with children affected by AIDS.

Work with international partners to support countries with health worker shortages to provide at least 2.3 doctors, nurses and midwifes per 1,000 people, through supporting plans that identify the appropriate mix of health workers.

Priority 4:

Making money work harder through an effective and co-ordinated response

- Providing long-term, performance-based and predictable resources to countries and partners in support of a sustainable global response to AIDS beyond 2010
- Supporting and promoting innovative approaches, including through ensuring that all DFID's new AIDS programmes support operational research and using our central research budget to fund cutting-edge research to stimulate innovation
- Promoting efforts to track the flow of funds from national to community level and alleviate bottlenecks
- Funding multilaterals in a way that contributes to coherent implementation of national plans at country level, promotes institutional effectiveness and delivers results
- Making the money work harder to accelerate progress towards Millennium Development Goal 6, in line with the Paris principles of aid effectiveness, including through the International Health Partnership (IHP)
- Working with partners to deliver an effective AIDS response in Middle-Income Countries (MICs).

The UK will:

Work with others to reduce drug prices and increase access to more affordable and sustainable treatment over the long term. This could yield efficiency savings of at least £50 million per annum, enough to cover the cost of anti-retrovirals for an additional one million people every year.

Ensure The Global Fund to fight AIDS, Tuberculosis and Malaria implements the Paris Declaration target on use of common arrangements and procedures, including programme based approaches.

Work with development partners, both within and outside of the IHP, to ensure that sector-wide approaches to health strengthen the AIDS response and that targeted AIDS programmes also strengthen the wider health system.

Priority 5

How we will turn our strategy into action

The UK will:

- Manage and support our staff as individuals in the context of AIDS
- Develop the AIDS skills and competence of our staff so they can best deliver our policy and programme commitments
- Structure and manage our business systems to ensure we deliver our programme and policy commitments on AIDS
- Commission an independent review of the implementation of this strategy in 3 years time
- Work through the cross-Whitehall working group on tackling AIDS to monitor the implementation of the actions across DFID and other government departments.

List of abbreviations

AIDS acquired immune deficiency syndrome
ART antiretroviral therapy
ARVs antiretroviral treatment
CBO Community Based Organisations
CHAI Clinton Foundation HIV/AIDS Initiative
CHAT UNAIDS Country Harmonisation and Alignment Tool
CSO Civil Society Organisation
DFID Department for International Development
EC European Commission
EU European Union
FBO Faith Based Organisation
FCO Foreign and Commonwealth Office
G8 A group of eight countries representing the most powerful economies in the developed world. G8 members are USA, UK, Canada, France, Russia, Italy, Germany and Japan.
Global Fund Global Fund to Fight AIDS, Tuberculosis and Malaria
GIPA greater involvement of people living with or affected by HIV/AIDS
GNP+ Global network of People Living with HIV/AIDS
GTT Global Task Team on improving AIDS co-ordination among multilateral donors and international donors
HIV human immunodeficiency virus
ICW International Community of Women Living with HIV/AIDS
IDA International Development Association
IDUs Injecting Drug Users
IHP International Health Partnership
IHRA International Harm Reduction Association
IMF International Monetary Fund
LIC Low-Income Country
MDG Millennium Development Goal
MeTA the Medicines Transparency Alliance
MIC Middle-Income Country
MNCH Maternal, Newborn and Child Health
MSM Men who have Sex with Men
NASAs National AIDS Spending Assessments
NGO non-governmental organisation
NHS National Health Service
NPAs National Plans of Action
OVC orphans and vulnerable children
PDP Product Development Partnership
PEPFAR US Government President's Emergency Plan for AIDS Relief

PLWH People Living with HIV
PMTCT Prevention of Mother to Child Transmission
SADC Southern African Development Community
SHIAG Sexual Health Independent Advisory Group
SRHR Sexual and Reproductive Health and Rights
STI sexually transmitted infection
Three Ones One agreed HIV and AIDS action framework, one national AIDS coordinating authority, one agreed country-level monitoring and evaluation system
TRIPS Trade-related Intellectual Property System
TB Tuberculosis
UN United Nations
UNAIDS joint United Nations programme on HIV/AIDS
UNFPA United Nations Population Fund
UNICEF United Nations Children's Fund
UNITAID International drug purchase facility
WHO World Health Organisation
ZAFOD Zambian Federation of the Disabled

What is Development?
Why is the UK Government involved?
What is DFID?

International development is about helping people fight poverty.

This means people in rich and poor countries working together to settle conflicts, increase opportunities for trade, tackle climate change, improve people's health and their chance to get an education.

It means helping governments in developing countries put their own plans into action. It means agreeing debt relief, working with international institutions that co-ordinate support, and working with non-government organisations and charities to give communities a chance to find their own ways out of poverty.

Getting rid of poverty will make for a better world for everybody.

Nearly a billion people, one in six of the world's population, live in extreme poverty. This means they live on less than $1 a day. Ten million children die before their fifth birthday, most of them from preventable diseases. More than 113 million children in developing countries do not go to school.

In a world of growing wealth, such levels of human suffering and wasted potential are not only morally wrong, they are also against our own interests.

We are closer to people in developing countries than ever before. We trade more and more with people in poor countries, and many of the problems which affect us – conflict, international crime, refugees, the trade in illegal drugs and the spread of diseases – are caused or made worse by poverty in developing countries.

In the last 10 years, Britain has more than trebled its spending on aid to nearly £7 billion a year. We are now the fourth largest donor in the world.

DFID, the Department for International Development, is the part of the UK Government that manages Britain's aid to poor countries and works to get rid of extreme poverty.

We work towards achieving the Millennium Development Goals – a set of targets agreed by the United Nations to halve global poverty by 2015.

DFID works in partnership with governments, civil society, the private sector and others. It also works with multilateral institutions, including the World Bank, United Nations agencies and the European Commission.

DFID works directly in over 150 countries worldwide. Its headquarters are in London and East Kilbride, near Glasgow.

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