DFID Department for International Development

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Achieving Universal Access –

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

A 2008 Baseline

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List of abbreviations

AIDS acquired immune deficiency syndrome
ART antiretroviral therapy
ARVs antiretroviral treatment
CSO Civil Society Organisation
FCO Foreign and Commo nwealth Office
G8 A group of eight countries representing the most powerful economies in the developed world: 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 and AIDS
HIV human immunodeficiency virus
IDUs Injecting Drug Users
IHP International Health Partnership
IHRA International Harm Reduction Association
LGBT Lesbian, Gay, Bisexual and Transgender
MDG Millennium Development Goal
MeTA the Medicines Transparency Alliance
MNCH Maternal, Newborn and Child Health
MSM Men who have Sex with Men
NGO non–governmental organisation
OVC orphans and vulnerable children
PEPFAR US Government President's Emergency Plan for AIDS Relief
PLWH People Living with HIV
PMTCT Prevention of Mother to Child Transmission
SRHR Sexual and Reproductive Health and Rights
TB Tuberculosis
UN United Nations
UNAIDS joint United Nations programme on HIV and AIDS
UNFPA United Nations Population Fund
UNICEF United Nations Children's Fund
UNITAID International drug purchase facility
WHO World Health Organisation

Contents

Introduction

This report provides a snapshot of the AIDS epidemic globally in mid–2008; when the UK's AIDS strategy *Achieving Universal Access* was launched. More specifically, it gives a picture of the situation in the main areas of UK focus and support.

This report should be read in the context of the UK's AIDS strategy and its specific commitments, subsequently reiterated in the Government's new White Paper *Eliminating World Poverty: Building our Common Future*. This report records the baseline situation under each of these commitments. And it is against these commitments that we will be held to account through future biennial reporting. An independent mid–term review will be commissioned to review implementation, including assessment against the more qualitative priorities for action.

DFID structure and business model

This report should be read in the context of DFID's business model; particularly the differing roles of headquarters and individual country offices, and of the four Directorates (Country Programmes; International; Policy and Research; and Corporate Performance) in delivering the UK's AIDS Strategy.

Delivering globally: International Directorate leads the cross–DFID work on strengthening the international institutions, to increase the impact of key multilateral agencies and international partners in reducing poverty. The directorate also leads on donor relations, driving aid effectiveness across the whole international system – both bilateral and multilateral; and on cross–border international issues such as corruption, conflict, humanitarian response, security and justice. Policy and Research Directorate meets DFID's demand for top class analysis and advice, grounded in real world evidence, and works to quickly capitalise on influencing opportunities and rapidly evolving policy initiatives. The UK government believes that research is essential for understanding and tackling world poverty. The role of research is to provide evidence that can shape development policies and programmes – not just ours, but across the world. Using evidence in policy and practice means that the decisions we make, and the work we do, will have a greater impact in the fight against poverty and in achieving the Millennium Development Goals (MDGs).

Delivering locally: The Country Programmes Directorate consists of three Regional Divisions – Africa; South Asia; and Middle East, Caribbean, Asia (North, Central and East) and the British Overseas Territories Division. The regional divisions provide oversight and support DFID country offices to reduce poverty and identify the priority policy areas and actions for DFID in helping to overcome them. DFID country offices have direct responsibility for programming. Country plans set out how DFID aims to contribute to poverty reduction and to achieving the Millennium Development Goals in individual countries. They are created for every country where DFID spends £20 million or more a year.

Part 1 of the report focuses on the global situation, our support to multilateral institutions, our work with global partners and our policy and research work;

Part 2 of the report focuses on the situation in key countries where we work.

The report provides data and examples of work we were doing at the time of the Strategy's launch. These examples are illustrative and will not necessarily form part of reporting for future years.

A cross–Government Strategy

Tackling AIDS is a priority for the UK Government as a whole and *Achieving Universal Access* is a UK Government–wide strategy. Much of this document focuses on the contribution made by DFID, but other Government Departments have a key delivery role too – through individual contributions and through membership of the Cross–Whitehall Group on HIV and AIDS, established to monitor the implementation of the Strategy. The report also presents data from across DFID and other Government Departments, for example from the Foreign and Commonwealth Office (FCO).

The countries and the data

Wherever possible, this report is based on internationally agreed targets and indicators, to monitor the impact of *Achieving Universal Access.* This is in line with the Paris Declaration principles of aid effectiveness and donor harmonisation[1].

Data have been principally collected for DFID's 22 Public Service Agreement (PSA) countries[2], but also in Burma, the Caribbean, China, Central Asia and Southern Africa (Angola, Botswana, Lesotho, Namibia, South Africa, and Swaziland). Information from country and regional programmes has been supplemented with data from DFID corporate performance systems and monitoring of internationally agreed targets and indicators[3]. The data reflect the situation at the strategy's publication in June 2008, or the latest data available at that time.[4] Although the quality of HIV surveillance data and methodologies has improved, many countries still have weak surveillance systems. And there is more work to be done in implementing the second generation of WHO/UNAIDS surveillance systems at national level. Through our core funding to UNAIDS, DFID is supporting progress in this important area.

1 Endorsed in 2005, the Paris Declaration is an international agreement to which over one hundred Ministers, Heads of Agencies and other Senior Officials adhered and committed their countries and organisations to continue to increase efforts in harmonisation, alignment and managing aid for results with a set of monitorable actions and indicators. High Level Forum, Paris, Feb 28 to March 2, 2005

2 Current PSA countries are: Afghanistan, Bangladesh, Cambodia, Democratic Republic of the Congo, Ethiopia, Ghana, India, Kenya, Malawi, Mozambique, Nepal, Nigeria, Pakistan, Rwanda, Sierra Leone, Sudan, Uganda, United Republic of Tanzania, Vietnam, Yemen, Zambia and Zimbabwe.

3 Eg UNAIDS data, Millennium Development Goal indicators, indicators agreed for the United Nations General Assembly Special Session (UNGASS) on HIV AIDS

4 For example, the epidemiological data published by UNAIDS in August 2008 relate to the year 2007; the financial year data relate to the period April 2007–March 2008.

Summary table of baselines for strategy commitments

UK AIDS Strategy "we wills":	2008 Baseline
Priority 1: Increase effort on HIV prevention; sustain momentum for treatment; increase effort on care and support	
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.	In 2007, unmet need for family planning in the developing world was estimated to be 29%.[5]
Work with others to intensify international efforts to increase to 80% by 2010 the percentage of HIV–positive pregnant women who receive ARVs, to reduce the risk of mother to child transmission, both in low income and high prevalence countries.	In 2007, coverage of services to prevent transmission of HIV from mother to child in low and middle income countries was 34%[6].
Priority 2: Respond to the needs and protect the rights of those most affected	
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.	In 2007 only 8% of people who inject drugs in low and middle income countries were thought to have access to any kind of HIV prevention service[7].
Increase by at least 50% its funding for research and development of AIDS vaccines and microbicides over 2008–13.	DFID provided £67.1 million for research and development of AIDS vaccines and microbicides from 2003/04 to 2007/08.
Priority 3: Support more effective and integrated service delivery	
Spend £6 billion on health systems and services to 2015.	For a comparator, DFID spent £776m on health systems in 2007/8.
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.	For a comparator, DFID's bilateral expenditure on social protection activities in 2007/08 was £45.5 million. As of 2008, work had begun in 7 African 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, through supporting plans that identify the appropriate mix of health workers.	WHO identified 57 countries that had less than 2.3 workers per 1,000 population in 2008

5 UNFPA/PATH, 2006

6 UNGASS Secretary General Report, 2008

7 Global State of Harm Reduction, IHRA 2008

Summary table of baselines for strategy commitments *(Continued)*

UK AIDS Strategy "we wills":	2008 Baseline
Priority 4: Making money work harder through an effective and co–ordinated response	
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.	In 2007, the price of a first line anti–retroviral drug regimen was around US$100 per person per 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.	The Global Fund result under the Paris Declaration 2007 Survey for programme based approaches was 76% – exceeding the Paris target of 66%.
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.	This will be measured partly through the quantity and quality of IHP country compacts. No compacts had been signed by June 2008; also, by the quality of national AIDS strategies and their integration into national plans. In 2008 only 100 countries out of 147 reporting to UNAIDS have national strategies been translated into costed operational plans. In sub–Saharan Africa, only about half of national HIV strategies meet UNAIDS quality criteria.

1. The global state of the epidemic and our policy response, 2008

Priority One: HIV prevention; treatment, care and support

Data from UNAIDS suggest, at the launch of the UK's strategy in June 2008, that:

- The percentage of the world's population living with HIV had levelled off
- The number of people accessing anti–retrovirals (ARVs) had r eached 3 million;
- There were 2 million AIDS deaths – compared to 2.2 million in 2005
- The price of first line AIDS drugs had fallen considerably to around US$100 per person per year
- UNAIDS report that 95% of countries had national policies to provide free access to HIV prevention services, although not always of the highest quality
- Over 33 million people were living with HIV, 22 million in sub–Saharan Africa.
- An estimated 2.7 million people had been newly infected in 2007
- Globally, around 15 million children were orphaned due to AIDS; around 2 million were living with HIV and 370,000 became infected during 2007
- Most prevention strategies were available to less than 1 in 5 people who need them; Globally only 30% of people in need of ARV treatment could access it.
- 63% of countries have laws or polices that present obstacles to providing HIV services, including accurate and comprehensive information for young people.

UK Commitments

Achieving Universal Access makes two specific commitments under this priority:

- 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–positive pregnant women who receive ARVs, to reduce the risk of mother to child transmission, both in low income and high prevalence countries.

Meeting the unmet need for family planning

Globally 201 million couples who want to space or limit their family size do not have access to effective contraception. Of these 137 million couples are not using any contraception and a further 64 million rely on less effective traditional methods. In 2007 unmet need for family planning[8] in the developing world was estimated to be 29%.[9] Evidence suggests that effective contraception in sub–Saharan Africa prevents more than twice as many cases of mother to child transmission of HIV than the cumulative total of cases prevented by anti–retroviral therapies[10]. In Africa, 90% of all HIV infections are sexually transmitted with young people and women disproportionately affected. Sufficient and reliable supplies of male and female condoms are key, but in Africa in 2004, it was estimated that donor supplies were only sufficient to provide 8.4 male condoms per man of reproductive age (15–49) and 1 female condom per 20 women of reproductive age each year.

In 2007/08 the total number of condoms distributed through DFID programmes in PSA countries was over 500 million. In 2008 the UK committed an additional £100m (over the period 2008/09 to 2012/13) to UNFPA's Global Programme for Reproductive Health Commodity Security. The programme goal is to provide universal access to reproductive health by 2015 and universal access to comprehensive HIV prevention by 2010.

In 2008 DFID made a commitment of £42.5m (over the period 2008/09 to 2012/13) to the International Planned Parenthood Federation to provide vital reproductive health information, services and supplies to the poorest and most marginalised people in 182 countries worldwide. See box below for further details.

8 The tool most commonly used for capturing this data is DHS surveys. The data represents women aged 15 to 49 who are sexually active, can become pregnant, and do not wish to have a child ever or in the next two years—but they are not using a modern contraceptive. Unmarried youth who are sexually active represent a large and growing segment of the population in many countries but their needs are not captured in all surveys. Consequently, unmet need is likely to be higher, and in some settings will be substantially higher, than the figures reflect.

9 Meeting the Need – Strengthening Family Planning Programmes, UNFPA/PATH, 2006.

10 Reynolds HW, Janowitz B, Wilcher R, Cates W. Contraception to prevent HIV–positive births: current contribution and potential cost savings in PEPFAR countries. *Sex Transm Inf* 2008;84 (suppl 2); ii49–ii53.

DFID support to the International Planned Parenthood Federation (IPPF)

DFID's funding to IPPF will support their five core areas of work (the five A's): Adolescents and Young People; HIV and AIDS; Abortion; Access and Advocacy. IPPF will report to DFID on a number of their global indicators. In relation to HIV and AIDS these global indicators and targets are:

- the proportion of member associations with written HIV workplace policies (2009 target – 70%);
- number of member associations with strategies to reach people particularly vulnerable to HIV; (2009 target – 85%)
- Number of HIV–related services provided by type of service (2009 target – 1,452,659 services – a 10% increase on their 2005 baseline);
- Number of condoms distributed (2009 target – 107,641,206 condoms – a 10% increase on their 2005 baseline).

Preventing Mother to Child Transmission (PMTCT) of HIV

The international commitment is to provide ARV treatment to 80% of HIV positive pregnant women by 2010. In 2007, coverage of PMTCT services in low and middle–income countries was 34%.[11] Some countries have made more significant progress, For data on the 2008 situation, by country, see Annex 2.

In developed countries, HIV transmission from mothers to children has virtually been eliminated because women have access to quality health services in which HIV services have been integrated into maternal, newborn and child health services. Effective, stronger health systems are needed to scale up access to PMTCT in developing countries, which is why in *Achieving Universal Access* we have made a commitment to spending up to £6 billion for improved health and AIDS services. Financing for health systems strengthening, increasing access to basic services, addressing human resource constraints, and integrating MCH and HIV services are the key to increasing coverage of PMTCT. Our work addressing the unmet need for contraception and safe abortion also contributes, as part of the comprehensive prevention package of PMTCT services recommended by WHO.

[11] Source: UNAIDS; Unicef & WHO 2008 (data provided by countries)/UNGASS Secretary General Report

Priority Two: Needs and rights of those most affected.

At the launch of the Strategy:

- Over 15 million women were living with HIV
- In high prevalence areas, an HIV positive woman was 4 times more likely to die in pregnancy or childbirth than a woman not infected.
- Women who experience violence were up to 3 times more likely to acquire HIV
- 40% of new HIV infections occurred in young people aged 15–24.
- On average, 80% of unprotected sexual encounters among adolescent girls took place within marriage
- In the few countries reporting to UNAIDS on populations most at risk, HIV prevention programmes reached 60% of sex workers, 46% of injecting drug users, and 40% of men who have sex with men in 2007.
- Sex between men accounted for between 5 and 10% of global HIV infections. It was one of 2 drivers of transmission in many emerging epidemics in Eastern Europe and Asia
- 84 countries had legislation that prohibits same sex sexual behaviour: in Asia, sex between men was illegal in 14 out of 19 countries.
- 63% of countries reporting to UNAIDS in 2008 said their policies hinder access of vulnerable groups to HIV and AIDS services. One third reported they had no laws to protect people living with HIV (PWLH) from discrimination.

UK Commitments

Achieving Universal Access makes two specific commitments under this priority:

- 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.

Providing Services for Injecting Drug Users

It is difficult to make an accurate assessment of the global prevalence of injecting drug use in 2008. As the Reference Group to the UN on HIV and Injecting Drug Use said: *"Data on the extent of injecting drug use are absent in many countries. In addition, recent and scientifically rigorous data are needed to better understand the level and nature of injecting drug use …. A greater investment in data collection is required to inform … programmes to … reduce the spread of HIV…Injecting drug use is illegal stigmatised behaviour and consequently IDUs are a hidden population making measurement of the extent of the behaviour difficult".*

But it is estimated there were just under 16 million IDUs around the world in 2008[12]. In 2007, over 3 million IDUs were estimated to be living with HIV. Drug injection with contaminated needles and syringes continues to be one of the major means of transmission of HIV and hepatitis C in Eastern Europe and Central Asia, where it accounts for 80% of all HIV cases. Drug use is also the entry point for HIV transmission in North Africa, Latin America and South and South–East Asia. In total, injecting drug use is estimated to account for just under one–third of new infections outside sub–Saharan Africa and up to 10% of all new HIV infections globally.

In 2003, the estimated coverage of basic HIV services for IDUs was just 5%. In 2007 only 8% of IDUs in low and middle income countries were thought to have access to any kind of HIV prevention service.[13] In those developed countries where harm reduction initiatives are long established, HIV prevalence among IDUs remains below 5%. Estimated HIV prevalence among IDUs was reported to be between 20% and 40% in 5 countries including – Russian Federation (37%), Cambodia (23%) and Vietnam (34%) and is greater than 40% in a further 9 countries, including – Estonia (72%), Brazil (48%), Kenya (43%), Ukraine (42%) and Nepal (41%).

We are supporting the International Harm Reduction Association (IHRA) to strengthen the engagement of civil society in the formulation of drug policy at international and national levels. We will provide over £1.5m to IHRA up to March 2010, to promote and share evidence and best practice across regional harm reduction networks, and to hold multilateral agencies to account for their work on harm reduction. This will contribute to improved UN coherence on this issue.

Funding for research and development of AIDS vaccines and microbicides

Global investment in HIV vaccines and microbicides was estimated to be in excess of $1 billion in 2007. A 2008 report of the HIV Vaccines and Microbicides Resource Tracking Working Group put spending at $961 million for HIV vaccines, $226.5 million for microbicides, and $59.4 million for other prevention options14. DFID provided £67.1 m funding for research and development of AIDS vaccines and microbicides over the 5 year period 2003/04 to 2007/08. The funding was provided through our support to three programmes:

- International AIDS Vaccine Initiative (IAVI) – £31.75m;
- International Partnership for Microbicides (IPM) – £8.4m;
- Microbicide Development Programme (MDP) – £26.9m.

HIV prevention is a rapidly developing field. Traditionally microbicides and vaccines have been the main focus of attention, but there is growing interest in other technologies (e.g. pre–exposure prophylaxis and the possible use of ARV treatment for prevention). DFID is not currently funding this type of research but, depending on scientific progress and global consensus, may support some of this work in the future. We will therefore keep this area under review, in future reports, to ensure that our spending is in line with the evolving evidence base.

[12] Reference Group to the United Nations on HIV and Injecting Drug Use (2008) The global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review. The Lancet, vol 372. Cited at http://www.ihra.net/GlobalStateofHarmReduction

[13] Global State of harm reduction, IHRA 2008

[14] Sustaining the HIV Prevention Research Agenda: Funding for Research and Development of HIV Vaccines, Microbicides and Other New Prevention options 2000 to 2007 *August 2008* HIV Vaccines and Microbicides Resource Tracking Working Group (AIDS Vaccine Advocacy Coalition AVAC, Alliance for Microbicide Development AMD, International AIDS Vaccine Initiative IAVI, Joint United Nations Programme on HIV/AIDS UNAIDS).

Priority Three: effective and integrated service delivery.

At the launch of the Strategy:

- 147 of 192 countries had submitted reports to UNAIDS regarding progress towards achieving universal access as of March 2008.
- Global financing for AIDS programmes (in low and middle income countries) in 2008 was $13.8 billion – the highest it has ever been.
- UNAIDS estimate that of the total global financing for AIDS, around 85% of resources were spent on health services related to HIV, including health systems strengthening.
- out of pocket spending by affected people and families amounted to nearly $1bn.
- In 2006 only 58% of girls in the developing world were enrolled in secondary school.

UK Commitments

Achieving Universal Access makes three specific commitments under this priority:

- 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.

Increasing financing for health systems and services

It is estimated that total development assistance for health has grown from $5.6 billion in 1990 to $21.8 billion in 2007[15]. In 2007/08, DFID spent £776m on health systems and services.

We have also pledged £1 billion to the Global Fund to fight AIDS TB and Malaria (the Global Fund) by 2015. In 2007/8 we contributed £100 million. UNAIDS calculate overall commitments in AIDS funding from the developed world totalled US$8.7 billion in 2008, up from US$6.6 billion the previous year.

[15] Lancet (2009) : 373: 2113–24.

Disbursements rose 56 percent to reach US$7.7 billion in 2008.[16] The UK contribution ($968.7m) made us the second largest donor, providing a greater share of total AIDS resources (5.7%) than our share of world GDP (4.4%).

Supporting social protection programmes

In 2007, an estimated 15 million children had lost one or both parents to AIDS. Of these children, 11.6 million live in sub–Saharan Africa. In some parts of Africa more than 25% of children have been orphaned. 98% of orphans and vulnerable children (OVCs) live within families or households. UNICEF estimates that only 12% of households with OVCs are getting external assistance – due to the vast numbers involved and funding bottlenecks. These families and households face underlying problems of poverty, few assets, low nutritional status, limited access to education and health services.

DFID's bilateral expenditure on social protection activities in 2007/08 was £45.5 million.[17] Countries in which DFID supports social protection may change over the 3 year period in response to national priorities and reflecting other donor actions. As of 2008, the UK was supporting social protection programmes through our bilateral programme in countries most affected by the epidemic, including Zimbabwe, Kenya, Zambia, Malawi, South Africa, Sierra Leone and Rwanda.

Meeting the health worker crisis

The world faces a chronic shortage of 4.2 million health workers, with 1.5 million needed in Africa alone. The critical shortage is recognized as one of the most fundamental constraints to achieving progress in the health–related MDGs. WHO recommends at least 2.3 health workers (doctors, nurses and midwives) per 1,000 people in each country to deliver basic health services. WHO identified 57 countries that had less than 2.3 health workers per 1,000 population in 2008 (of which 36 are in Africa). None of DFID's 22 PSA countries had met the target. See Annex 3 for data for PSA and other priority countries.

[16] UNAIDS: Financing the response to AIDS in low– and middle income countries: International assistance from the G8, European Commission and other donor Governments in 2008

[17] This target and baseline figure is based on a narrow definition of social protection which includes social assistance, social insurance and labour standards.

In April 2008, Prime Minister Brown and President Bush committed the UK and the USA to work together, alongside other partners, to fight diseases and support stronger health systems, public and private–sector health institutions, and health workers. The commitment will be demonstrated in Ethiopia, Kenya, Mozambique, and Zambia — four countries that the United Kingdom is supporting through the International Health Partnership (IHP+) and the United States is supporting through the President's Emergency Plan for AIDS Relief (PEPFAR) and other activities. In these four countries, the United Kingdom is planning to spend at least $420 million on health, including the health workforce, over the next three years (2008/09 to 2010/11), and the United States is planning to invest at least $1.2 billion over five years on health workforce development. At the same meeting the leaders called on G8 members to support partner countries to increase health workforce coverage levels towards WHO goal of at least 2.3 health workers per 1,000 by 2015.

At its Summit in Toyako in July 2008, the G8 made a commitment to "work towards increasing health workforce coverage towards the WHO threshold of 2.3 health workers per 1,000 people, initially in partnership with the African countries where we are currently engaged and that are experiencing a critical shortage of health workers. We will also support efforts by partner countries and relevant stakeholders, such as Global Health Workforce Alliance, in developing robust health workforce plans and establishing specific, country–led milestones as well as for enhanced monitoring and evaluation, especially for formulating effective health policies."

Priority Four: making money work harder through an effective and co–ordinated response

UK Commitments

Achieving Universal Access makes three specific commitments under this priority:

- 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.

Increasing access to medicines

The challenge of making expensive antiretrovirals (ARVs) available to millions of PLWH in developing countries catalysed global action on access to medicines. From 2000, there has been significant progress, including getting more than 3 million people in developing countries on ARV treatment by 2008, and at much lower prices – only 1% of the cost per head at that time. In 2007, the price of first–line anti–retroviral treatment in low–income countries started at around US$100 per person per year. But improved first line treatments recommended by WHO are now over twice the price of the most common treatment used to date. The cheapest second line treatments are over 6 times that price. For average prices for regimes recommended under 2006 WHO guidelines see Annex 4.

In 2008, DFID provided support to Boston University to create and maintain a comprehensive procurement database for HIV drugs that tracks prices, volumes and other market dynamics over time.[18] The database also records key changes in policies and can track their impact on the market. DFID is working with partners to establish a publicly available database that can support more efficient country procurements, inform strategic planning for market interventions and monitor the impact of such interventions over time.

Through the support of DFID and others, 1.4 million people were receiving AIDS treatment through the Global Fund at the end of 2007. The Global Fund has a target to double this number to 2.9 million by 2010.

[18] Waning, B et al. 'Global strategies to reduce the price of antiretroviral medicines: evidence from transactional databases.' Bulletin of the World Health Organisation. July 2009

As of 2008 there was no voluntary pooled procurement scheme for ARVs. So we will also work with the Global Fund and others – not only to support the establishment of an effective mechanism that will help manage drug costs but also to ensure long term commodity security and quality in the ARV market.

DFID has been working with the Commission on Narcotic Drugs and the International Narcotics Control Board to apply pressure through the multilateral system to ensure that access to essential medicines is given greater priority at the political level.

The Global Fund to fight AIDS, Tuberculosis and Malaria and the Paris Declaration

The Paris Declaration survey in 2007 shows that the Global Fund exceeded the Paris target of 66% by achieving 76% for Programme Based Approaches. However, the average gap in meeting all the Paris targets was 19%. The Fund has set itself targets of 10% for 2009, and 0% (i.e. full compliance) by 2010.

We have used our position on the Board of the Global Fund to support reforms to improve the way the Fund works, including in encouraging the Fund to measure its own performance against the full range of Paris indicators, now included in the Fund's Key Performance Indicators.

For Global Fund performance against Paris monitoring targets see Annex 5.

Strengthening health systems and sector wide approaches

In 2008 UNAIDS reported: "97% of countries have a multisectoral HIV strategy, 92% have a national HIV coordinating body, 92% have a national monitoring and evaluation plan in place or in development, and all low– and middle–income countries have integrated HIV into national development plans." But "only 69% of countries have national strategies been translated into costed operational plans with programme goals, detailed programme costing, and identified funding sources. In sub–Saharan Africa, only about half of national HIV strategies meet UNAIDS quality criteria." We are committed to work with country partners to help build a more integrated response, through our in–country programmes described in Part Two of this report.

The UK also seeks to strengthen health systems and sector wide approaches through the International Health Partnership (IHP+). This aims to strengthen aid effectiveness in the health sector through coordinated support to national health plans with a focus on strong health systems. The initiative was launched in 2007 by Prime Minister Gordon Brown, and is now implemented by the World Bank, WHO, UNICEF, UNFPA, UNAIDS, GFATM, GAVI and the Bill and Melinda Gates Foundation (known collectively as the Health8 or H8), with joint leadership from the World Bank and World Health Organisation. The IHP+ aims to achieve better health results by mobilizing donor countries and other development partners around a single country–led national health strategy, guided by the principles of the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action.

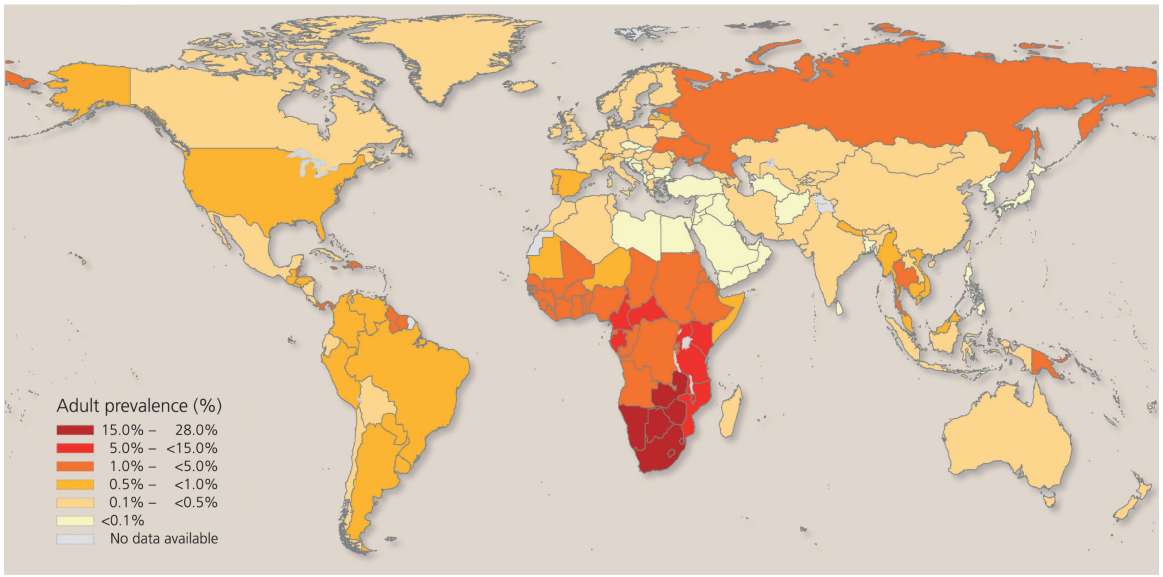
No IHP+ country compacts had been signed at the time of the strategy's launch in June 08, although a target of 8 by end 2009 had been set. 10 developing and 12 donor countries had signed up to the IHP+ process – as had the eight international organisations above, plus the European Commission.

2. Our Bilateral response in 2008

The remainder of this report sets out our country–level response to the epidemic in 2008.

DFID Country Offices are responsible for the design and delivery of HIV and AIDS responses within the guiding principles of the strategy as agreed in negotiation with host governments and other key stakeholders and take into account the local context of the epidemic. In line with best development practice, the strategy emphasises a country–led approach to HIV and AIDS. Financing mechanisms include: general budget support, sector budget support (e.g. health or education), along with support to multilateral and civil society stakeholders.

It is important to note DFID's bilateral efforts must be seen in the context of both our broader development support and of other government and donor investments in AIDS. Although future spending on health and AIDS is set to increase over the next 3 years, much of this will be through general budget support, and pooled funding arrangements (and via multilateral/global funding streams). Our efforts to ensure that this global response is coordinated and effective are described in the previous section.



Adult HIV prevalence: 2007. Source: 2008 Report on the global AIDS epidemic.

The epidemic and our response in Africa

The nature of the epidemic in Africa

Sub–Saharan Africa remains the region of the world most seriously affected by HIV and AIDS, accounting for 67% of all people living with HIV (about 20.3 million adults) and with 75% of AIDS deaths in 2007. Nearly 1.8 million children (90% of the global burden) living with HIV are in sub–Saharan Africa.

Many of DFID's African PSA countries have generalised epidemics (i.e. HIV prevalence > 5%) with hyper–endemic countries (prevalence >15%) across Southern Africa accounting for 35% of HIV infections and 38% of AIDS deaths in 2007. Altogether, sub–Saharan Africa has 67% of all people living with HIV[19].

It is a feminised epidemic. Women, especially young women, are disproportionately affected, accounting for half of all people living with HIV worldwide, and nearly 60% of HIV infections in sub–Saharan Africa. In Malawi four times as many women as men in the 15 to 24 year age group are infected.

Forward projections suggest significant social and economic impact. Several hyper–endemic countries are facing state collapse and severe economic decline (e.g. Swaziland, Lesotho).

In a number of heavily affected countries such as Kenya, Rwanda, Uganda, and Zimbabwe, there have been declines in HIV prevalence due to dramatic changes in sexual behaviour combined with AIDS deaths, and outward migration. While evidence on the specific linkages between interventions and behaviour change is still unclear there is better understanding of how behaviour change interventions can be effective (e.g. DFID funded research of the "Stepping Stones" programme has shown that working with men and women to improve gender relationships and behaviour reduced violence, STIs and HIV risk practices.) There is new evidence that medical male circumcision is effective in HIV prevention.

DFID approach and programmes

DFID's focus in Africa is the PSA countries (DRC, Ethiopia, Ghana, Kenya, Lesotho, Malawi, Mozambique, Nigeria, Rwanda, Sierra Leone, South Africa, Sudan, Tanzania, Uganda, Zambia and Zimbabwe) and Southern Africa hyper–endemic countries (South Africa, Botswana, Lesotho and Swaziland), financing through a mix of aid instruments and organisations.

[19] UNAIDS. 2008 Report on the Global Epidemic.

DFID Bilateral programmes vary according to context, nature of the epidemic and the donor mix within PSA countries. In stable countries, DFID tends to focus on development and implementation of country–led HIV and AIDS strategies, working with governments, civil society and international donors and agencies (e.g. in Ghana, Ethiopia, Uganda, Zambia, Mozambique). In fragile states, programmes focus on strengthening government capacity as well as supporting direct service delivery via the UN or civil society (e.g. Nigeria, DRC, Zimbabwe). In hyper–endemic middle income countries the approach is to provide technical support to unblock political and technical barriers to scale up. Technical support covers a range of treatment, care, prevention and mitigation interventions, working with state and non state actors and vulnerable groups.

In the spirit of the Paris Declaration to promote country–led responses with harmonised donor support, DFID continues to be a major advocate of the '**Three ones'** principles: country leadership for all sectors and stakeholders, one comprehensive national plan for all stakeholders and one robust monitoring and evaluation framework to measure progress. We also focus on:

- *HIV Prevention:* Reduction in the number of new infections is a priority. Countries and regions need to better understand the nature and drivers of their specific epidemics, including more accurate data on the rate of new infections (i.e. incidence) which is limited. The evidence base for effective interventions is still poor despite improved understanding of gender and behaviour change and emerging areas such as medical male circumcision.
- *AIDS Treatment:* DFID does not usually fund treatment directly, given that a large proportion of GFATM and PEPFAR funds focus on this. However, DFID often provides technical support to ensure that national systems are strengthened to deliver more effective treatment programmes. For example DFID Southern Africa has supported national and local planning and capacity building to integrate TB programmes with HIV services.
- *Sustainability of AIDS treatment* is a major challenge and will remain unaffordable for most African countries for the foreseeable future. Vertical programmes (e.g. PEPFAR, GFATM) have made a major contribution and will need to continue. However, efforts need to be made to ensure these investments are harmonised and aligned to national AIDS strategies, and help strengthen countries' health systems to deliver treatment over the longer term (i.e. integrated into primary health care, TB and sexual and reproductive health services).
- *Significant support is given to* programmes targeting key vulnerable groups for advocacy, prevention and treatment (e.g. PLWH, OVC, SEX WORKERS). NGOs are the main recipients of funds for work with vulnerable populations.

Programme Examples

Ethiopia: DKT social marketing programme:

Condoms distributed (between 2005 and end Aug 2007):	1.32 million
Mobile video unit performances (First 6 months of 2007):	551
People reached with mobile video unit performances:	160,000 (35% women)
BCC/IEC materials distributed to date:	Over 4 million
Bars and hotels signed up to the 'Wise up' BCC campaign for SW:	650

Kenya: PSI Condom social marketing:

Proportion of 15–24 yr old men reporting condom use at last sex with a casual partner:	Increase: 54.2 to 68.7% (between (2001 –2007)
Growth in sales of PSI condoms (per annum from 2002): (between 2002–2008)	12%

Lesotho: ALAFA programme: responding to HIV and AIDS in the textile industry:

2 years after inception, in 2006

- 60% of the (over 45,000) textile industry employees have access to prevention services
- 40% also have access to care and treatment.
- Nearly 4600 employees have been tested,
- Over 1500 patients are on treatment;
- 8 factories have an HIV policy in place or are in the process of customizing a policy by means of an HIV committee.

Nigeria: Promoting Sexual and Reproductive Health for HIV & AIDS Reduction Programme Between 2002–2008:

Proportion of condoms in Nigeria provided by DFID:	75%
Willingness to undergo HIV testing:	Increase: 40 to 54%
Increased condom use at last sex:	Increase: 64 to 75%

Baseline for key indicators

Centrally, DFID reports on the MDG indicators, using UNAIDS data on HIV prevalence among 15–49 year olds. For the Africa Division preferred reporting on PSA countries is HIV prevalence among 15–24 year olds, where country data are available on this indicator. Specifically, the indicator states that:

- 8 of the 14 PSA countries are expected to reduce their HIV prevalence rate among either 15 to 24 year olds (preferred data source) or 15 to 49 year by 2011.
- the number of condoms distributed.

The epidemic and our response in South Asia

Nature of the epidemics in South Asia

Between 2 and 3.5 million people in South Asia are living with HIV. Epidemics across the region are concentrated (under 1 % of the population is infected with HIV) and primarily driven by high risk practices, such as sex work and injecting drug use. India has a highly varied HIV epidemic and is the country with the largest number of people living with HIV in the region – approximately 2.5 million. The majority of reported HIV infections are concentrated in six states where HIV prevalence is, on average, 4–5 times higher than in other states. In Bangladesh, Nepal, and Pakistan, HIV prevalence is low among the general population but significantly higher in high–risk groups (e.g. sex workers, injecting drug users). For a breakdown of prevalence by country see Annex 1.

DFID approach and programmes

DFID South Asia Division's direct bilateral programme focuses on five priority countries: Bangladesh, India, Nepal, Pakistan and Afghanistan. These represent a complex mix of fragile, conflict, post conflict and large federal states. We also work indirectly in these countries via core funding to multilateral agencies and global funds as well as through our humanitarian programme which also operates in Sri Lanka.

DFID's response to the concentrated epidemics in South Asia varies according to context, nature of the epidemics and the donor mix in each country. See table below.

Targeted HIV and AIDS programmes: A key priority is to support countries in the region to accelerate the expansion of evidence–based interventions for vulnerable and at risk groups to between 60% and 80% coverage to prevent transmission of HIV infection and maximise impact. DFID is well placed to do this, backed by clear policies and positions on harm–reduction for injecting drug users, and on the need to provide comprehensive sexual and reproductive health services for sex workers, men who have sex with men and others, including condom promotion.

In India, Pakistan and Nepal, DFID focuses on the development and implementation of country–led HIV and AIDS strategies. Generally, the focus of these strategies is on scaling up services for the most at risk groups (i.e. MSM, IDUs, sex workers) given the concentrated nature of the epidemics. This is done working with governments, civil society and international donors and agencies. Within the context of country strategic frameworks, DFID supports core elements of the AIDS response:

- Prevention – encouraging and supporting governments to implement and scale up harm reduction, including provision of oral substitution therapy.
- Treatment: Whilst there are smaller numbers requiring treatment in South Asia, compared to Sub Saharan Africa, DFID supports national strategies and indirectly DFID via GFATM helps provide treatment to those in need.

- Care & Support: DFID supports care and support activities primarily through budget support to national AIDS programmes. This includes support to PLWH networks and the establishment of care and support homes or community care centres.
- Implementing the Three Ones and harmonising donor support**.** DFID has helped harmonise international efforts to support agreed country priorities in all countries. Harmonisation is important, but less problematic than in many aid–dependent, high–prevalence countries in Africa with large numbers of donors.

Programme Examples

- India, under the third phase of the National AIDS Control Programme (NACP III), is rapidly scaling up prevention, treatment, care and support services for vulnerable groups as well as prevention programmes for the general population, and programmes to support the needs of children affected by AIDS. DFID is also providing technical assistance (£5 million) to help scale up targeted interventions for MSM and IDUs, including social mobilisation efforts, innovative pilots and research.
- DFID support to Pakistan will contribute to up to 12 treatment and care centres by the end of 2009, with free drugs and services made available to all PLWH.
- DFID has supported the training of doctors in ARV administration and research on issues around the introduction of second line drugs in India.
- In Nepal, DFID has helped more than 5,500 PLWH receive care and support There are also plans underway to broaden support to social protection schemes.
- DFID Nepal has also funded approximately 70% of services for IDUs, and in India we have played a significant role in encouraging the National AIDS Control Organisation to fund and expand oral substitution therapy services.

Baseline for key indicators

1. South Asia's Division performance framework is the main accountability mechanism for DFID's bilateral programme in the region. The regional performance indicator for South Asia Division – divisional level (DSO) is: *MDG6– Decline in HIV Prevalence in High risk groups where trend available, in at least 3 countries*. Specific AIDS performance indicators and milestones are also included in the country performance frameworks for India, Nepal and Pakistan along with performance indicators for health systems strengthening and sexual and reproductive health in India, Nepal, Pakistan, Bangladesh and Afghanistan.

See Annex 6 for details of baseline indicators.

The epidemic and our response elsewhere in the world

Nature of the epidemic outside Sub–Saharan Africa and South Asia

Outside of Africa and South Asia, we work in several countries and regions that have concentrated epidemics and where our efforts are focused on working with *most at risk populations:*

- **South East Asia** has several diverse epidemics and the highest prevalence levels in Asia, where injecting drug use, commercial sex and unprotected sex between men who have sex with men are some of the main drivers. The epidemics in Cambodia, Burma and Thailand all show declines in HIV prevalence, with national HIV prevalence in Cambodia falling from 2% in 1998 to an estimated 0.9% in 2006[20]. However, epidemics in Indonesia (particularly in Papua province) and Vietnam are growing rapidly. In Vietnam, the estimated number of people living with HIV more than doubled between 2000 and 2005.
- **Central Asia and Eastern Europe** has a concentrated epidemic with highest rates amongst injecting drug users**.** The HIV epidemic in the region continues to grow, especially in Ukraine, where annual new HIV diagnoses have more than doubled since 2001[21]. [The numbers of newly reported HIV diagnoses are also rising in Azerbaijan, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Tajikistan, and Uzbekistan, which now has the largest epidemic in Central Asia.]
- **Burma** and **China** have epidemics which are also largely driven by injecting drug use. In China, where infections are increasing steadily, almost half the people living with HIV in 2006 are believed to have been infected through use of contaminated injecting equipment[22].

We also work in the **Caribbean**, which is the region with the second highest HIV prevalence globally. However, available information indicates that most of the epidemics in the region appear to have stabilized, while a few have declined in urban areas (e.g. in the Dominican Republic and Haiti). The main mode of HIV transmission in the Caribbean is unprotected heterosexual intercourse, paid or otherwise. Sex between men, although generally denied by society, is also a significant factor in several national epidemics.

[20] Source: National Center for HIV/AIDS, Dermatology and STIs, 2007

[21] (UNAIDS Reference Group on Estimates, Modelling and Projections, 2006; EuroHIV, 2007).

[22] Source: Lu et al., 2006; Ministry of Health

DFID approach and programmes

In many countries outside Africa and South Asia, DFID's focus is on improving the performance of the international effort and lesson–learning. Programmes are designed to fit the country context taking into account the status of the epidemic, the work being done by others and key barriers to success. Our programmes in these parts of the world have a strong component of advocacy for changes in legislation and policy addressing rights and ensuring access to prevention for high risk groups.

In **China, South East and Central Asia** we have pioneered harm reduction programmes for IDUs. The approaches and lessons from these programmes have been embedded into national programmes which are in many cases being expanded widely. Some countries in the region are liberalising laws and policies on access to methadone substitution. In China, DFID is supporting the government's HIV programme by transferring knowledge and best–practice on harm reduction.

In the **Caribbean**, a newly approved project supports anti–stigma and discrimination efforts. We will report on this in our 2010 report.

Improving harmonisation and alignment is an important part of our work. In China DFID blends financing with the GFATM thereby simplifying reporting requirements. DFID also led on preparation of a joint review of all China's HIV and AIDS programmes including all rounds of the GFATM, representing the GFATM in this process. In Cambodia DFID committed to a new 5 year health programme in partnership with 6 other donors. Our funding will be channelled through a World Bank Trust Fund to a country pooled account.

Programme Examples

Prevention:

Burma: In 2006 six donors set up the $100 million Three Diseases Fund – which provides a harmonised approach to HIV funding for six donors. The UK Ambassador was Chair of the Fund from November 2007 to December 2008. Through the Fund we supported condom promotion in high risk groups. In 2008 over 22 million condoms were distributed.

Cambodia: Achievements and challenges

The 100% condom use programme, scaled up nationally has been the mainstay of Cambodia's HIV prevention response. The condom social marketing programme supported by DFID and USAID has been the corner stone of this. Total condom sales over the period Oct 2006–Sept 2007 were 26.5 million. This has gone up steadily from 5 million in 1995.

Efforts to achieve Universal Access Targets for HIV prevention are on track; condom coverage and use rates with sex workers and their clients continues to be consistently high at 82–99% as evidenced by the 2007 national behavioural sentinel surveillance.

However, these achievements are at risk. The 2007–08 Suppression of Trafficking Campaign and the promulgation of the Suppression of Trafficking and Sexual Exploitation Law (February 2008) has had unintended but serious consequences for reaching sex workers/entertainment workers and their clients with HIV services. 50% of brothels have been closed and entertainment establishments have closed their doors to HIV prevention. Sex workers have been driven underground and are not accessing HIV services. In addition drug users have been increasingly targeted by law enforcement authorities for arrest and detention.

Protecting the rights of those most affected. There have been some notable successes to **scaling up prevention services for high risk groups**. For example, there is pioneering work on harm reduction for injecting drug users in China, Vietnam and Central Asia.

In **China,** increasing coverage of services to IDUs is currently the highest priority at this stage of the epidemic**.** DFID has supported work amongst the most at risk populations including IDUs. Targets to be achieved by 2011 include:_69,300 IDUs on methadone maintenance against a 2008 baseline of 25,000; 159,780 IDUs receive peer education and needle exchange services The 2008 baseline was 68,000.

In Vietnam: Scaling up of harm reduction services including provision of clean needles and syringes to IDUs is a key part of our support. Successes include:

- increased access to free needles and syringes from zero in 2004 to 15 million in 2008, accounting for 75% of all free needles distributed in the country,
- start up of a long resisted methadone treatment programme in 2008 for 800 patients and
- a new law on HIV and AIDS prevention and control that gives a clear legal basis for harm reduction activities

FCO approach and comparative advantage

The part played by FCO in delivering Achieving Universal Access is outlined in the Strategy. Its role in the multilateral system is covered at page 6 above. In addition, FCO has an important role to play as an advocate for Universal Access – particularly in those countries outside Sub–Saharan Africa and South Asia where DFID has little or no presence. FCO is especially strong in supporting the human rights of vulnerable groups and in advocating against stigma and discrimination.

In the run up to the strategy launch, FCO posts around the world argued:

- **for resources for Universal Access.** The UK Ambassador in Burma held meetings with Ministry of Health and media engagement to advocate for more resources for health in particular HIV and AIDS, TB and malaria
- **for HIV awareness and access.** In December 2006 the FCO supported a local NGO's biannual AIDS conference in Singapore, providing an expert British speaker to explain the benefits of subsidising HIV medication. Shortly after the NGO's next conference in December 2008 the Minister for Health agreed for the first time that HIV should be 'treated like any chronic disease' and HIV medication subsidised. In China, the FCO funded a project that raised HIV awareness among isolated ethnic minority communities by making materials available in the Tibetan language.
- **against stigma and for human rights.** The FCO worked with AUSAID to lobby the Solomon Islands Government on HIV prevention by ensuring greater confidentiality of Voluntary Counselling and Testing processes. WHO estimate there may be between 350–500 PLWH in the Solomon Islands, where homosexuality is illegal and there are cultural and religious barriers to prevention strategies.
- FCO and DFID also developed a joint human rights strategy in Nigeria. This includes targeted interventions on several issues that have an impact on national AIDS responses. Examples include work with NGOs on female genital mutilation, and lobbying with EU colleagues on the same sex marriage bill, which will increase risk of HIV transmission by restricting LGBT rights in Nigeria.

See Annex 6 for details of baseline indicators.

3. Delivery and next steps

Chapter Five of Achieving Universal Access sets out how we will turn the Strategy into action, by supporting and developing our staff and putting in place systems for delivery.

In 2008 DFID employed 2,671 employees, of whom 1,277 were based overseas.[23] These staff – and their colleagues in other Government Departments – are crucial to the delivery of the Strategy. But they are also individuals, who may be affected by HIV in their own right, to whom we have duty of care. To make the Strategy happen, these staff also need robust business systems for delivery, monitoring and evaluation. Annual regional and international professional retreats are held to ensure the health cadre is up to date with new developments in the international health agenda. Skills are also kept up to date through field visits, mentoring by more senior members of staff and other professional training.

Supporting and developing our staff

UK Government staff and their dependents, in the UK and around the world, have been covered by a joint HIV workplace policy (between FCO, DFID and the British Council) since 2002**.** This policy covers all our FCO posts including locally engaged staff in DFID country offices overseas. DFID offices throughout the world have taken specific action to evaluate and improve HIV workplace policies and access to confidential voluntary counselling and testing (VCT) and medical provision, including ARVs.

For example, DFID–**Zimbabwe** and the British Embassy in Harare have run sessions for staff to tackle some of the fears that may prevent staff from accessing treatment. In **Tanzania** a joint British High Commission, British Council and DFID arrangement enables staff and their dependants to receive confidential testing, counselling and treatment at a local Hospital in Dar es Salaam;. In **Vietnam**: DFID with the British Embassy and British Council developed guidance for FCO, DFID and BC staff on the HIV and AIDS policy specific to the country context in English and Vietnamese.

DFID, FCO and the British Council are currently reviewing their workplace policy. This will lead to updated information for staff and produce practical guidance material for Managers on how to implement best practice in all our offices in the UK and overseas. Over the period of the strategy DFID, The FCO and the British Council will continue to work towards:

[23] DFID annual report 2008 p194

- providing an environment where staff are able to protect themselves from HIV infection, and where they feel able to be open about their HIV status;
- putting the principle of Greater Involvement of People living with HIV and AIDS (GIPA) into action and work with people living with HIV (PLWH) in designing and implementing our policy;
- exploring the possibility of establishing networks for those of our staff who are living with or are personally affected by HIV.

Systems for delivery, monitoring and evaluation

Various parts of DFID are responsible for the monitoring and evaluation of the Strategy, but the AIDS and Reproductive Health Team and colleagues working on regional and country programmes take the leading roles. Following recent reviews of the quality of DFID M&E systems, we have initiated a major programme of work to improve the quality of logframes and ensure we have better means to monitor, measure and evaluate results. Data from these logframes will feed into future reports

The Informal Cross–Whitehall Working Group on AIDS meets regularly to discuss cross–government working on AIDS in developing countries – 3 times in the last 9 months. The group has revised the terms of reference for the group since the updated Strategy was launched, and will continue to review the strategy at these meetings to ensure coherence with other related HMG policies and strategies and seek opportunities to exploit synergies between them.

This document has set out the baseline situation for Strategy priorities as of June 2008. We will publish the first progress report against this baseline for World AIDS Day in 2010.

Annex 1

Baseline data for the strategy commitments: Part One: the global state of the epidemic and our policy response

1. HIV prevalence and mortality in DFID priority countries 2007/8

Table 1: Number of people living with HIV, adult prevalence rate and deaths due to AIDS, 2007

DFID Priority country	No of people living with HIV (thousands)	No of women (15+) living with HIV (thousands)	Adult (15–49 years) prevalence (per cent)	Young women (15–24 years) prevalence (per cent)	Young men (15–24 years) prevalence (per cent)	Deaths due to AIDS (thousands)
Afghanistan	n/a	n/a	n/a	n/a	n/a	n/a [<100]
Bangladesh	12 [7.7 –19]	2 [1.2–3.4]	n/a [<0.1]	n/a [<0.1]	n/a [<0.1]	<0.5 [<1]
Burma	240 [160 – 370]	100 [63 – 150]	0.7 [0.4 – 1.1]	0.6 [0.3 – 1.0]	0.7 [0.3 – 1.2]	25 [19 – 34]
Cambodia	75 [67–84]	20 [17 –23]	0.8 [0.7 – 0.9]	0.3 [0.1 – 0.6]	0.8 [0.3 – 1.2]	6.9 [4.3 –8.2]
China	700 [450 –1000]	200 [120 –310]	0.1 [<0.1 – 0.2]	0.1 [<0.1 – 0.2]	0.1 [<0.1–0.2]	39 [23 –62]
Democratic Republic of Congo	n/a [400 – 500]	n/a [210 – 270]	n/a [1.2 – 1.5]	n/a [0.7 – 1.2]	n/a [0.1 – 0.4]	n/a [24 – 34]

Table 1: Number of people living with HIV, adult prevalence rate and deaths due to AIDS, 2007 *(Continued)*

DFID Priority country	No of people living with HIV (thousands)	No of women (15+) living with HIV (thousands)	Adult (15–49 years) prevalence (per cent)	Young women (15–24 years) prevalence (per cent)	Young men (15–24 years) prevalence (per cent)	Deaths due to AIDS (thousands)
Ethiopia	980 [880 – 1,100]	530 [470 – 580]	2.1 [1.8 – 2.2]	1.5 [1.1 – 1.9]	0.5 [0.2 – 0.7]	67 [57 – 77]
Ghana	260 [230 – 290]	150 [130 – 160]	1.9 [1.7 – 2.2]	1.3 [0.9 – 1.7]	0.4 [0.2 – 0.6]	21 [18 – 24]
India	2,400 [1,800 – 3,200]	880 [670–1,200]	0.3 [0.2–0.5]	0.3 [<0.1–0.5]	0.3 [<0.1 –0.5]	n/a
Kazakhstan	12 [7 – 29]	3.3 [1.8 – 7.7]	0.1 [<0.1 – 0.3]	0.1 [<0.1 – 0.2]	0.2 [0.1 – 0.4]	<0.5 [<1]
Kenya	n/a [1,500 – 2,000]	n/a [800 – 1,100]	n/a [7.1 – 8.5]	n/a [4.6 – 8.4]	n/a [0.8 – 2.5]	n/a [85 – 130]
Kyrgyz Republic (Kyrgyzstan)	4.2 [2.3 – 7.7]	1.1 [<1 – 2]	0.1 [<0.1 –0.3]	0.1 [<0.1 –0.2]	0.2 [0.1 –0.3]	<0.2 [<0.5]
Malawi	930 [860 – 1,000]	490 [450 – 530]	11.9 [11.0 – 12.9]	8.4 [6.7 – 10.4]	2.4 [0.9 – 3.8]	68 [59 – 77]
Mozambique	1,500 [1,300 – 1,700]	810 [690 – 960]	12.5 [10.9 – 14.7]	8.5 [5.9 – 11.1]	2.9 [1.2 – 4.2]	81 [67 – 98]
Nepal	70 [50 – 99]	17 [12–25]	0.5 [0.4–0.7]	0.3 [0.2 –0.4]	0.5 [0.3 –0.9]	5 [3.5–7.5]
Nigeria	2,600 [2,000 – 3,200]	1,400 [980 – 1,700]	3.1 [2.3 – 3.8]	2.3 [1.2 – 3.3]	0.8 [0.3 – 1.2]	170 [130 – 270]

Table 1: Number of people living with HIV, adult prevalence rate and deaths due to AIDS, 2007 *(Continued)*

DFID Priority country	No of people living with HIV (thousands)	No of women (15+) living with HIV (thousands)	Adult (15–49 years) prevalence (per cent)	Young women (15–24 years) prevalence (per cent)	Young men (15–24 years) prevalence (per cent)	Deaths due to AIDS (thousands)
Pakistan	96 [69 – 150]	27 [19–42]	0.1 [<0.1–0.2]	0.1 [<0.1 – 0.2]	0.1 [<0.1 – 0.2]	5.1 [3.5 – 8.2]
Rwanda	150 [130 – 170]	78 [69 – 88]	2.8 [2.4 – 3.2]	1.4 [0.9 – 1.9]	0.5 [0.3 – 0.7]	7.8 [5.7 – 10]
Sierra Leone	55 [42 – 76]	30 [23 – 43]	1.7 [1.3 – 2.4]	1.3 [0.7 – 1.9]	0.4 [0.2 – 0.7]	3.3 [2.3 – 4.7]
South Africa	5,700 [4,900 – 6,600]	3,200 [2,800 – 3,700]	18.1 [15.4 – 20.9]	12.7 [9.1 – 17.0]	4.0 [1.7 – 6.0]	350 [270 – 420]
Sudan	320 [220 – 440]	170 [120 – 250]	1.4 [1.0 – 2.0]	1.0 [0.6 – 1.5]	0.3 [0.2 – 0.5]	25 [17 – 32]
Tanzania	1,400 [1,300 – 1,500]	760 [710 – 810]	6.2 [5.8 – 6.6]	0.9 [0.5 – 1.3]	0.5 [0.4 – 0.7]	96 [86 – 110]
Tajikistan	10 [5 – 23]	2.1 [<1 – 5]	0.3 [0.1 – 0.6]	0.1 [<0.1 – 0.4]	0.4 [0.2 – 1.2]	<0.5 [<1]
Uganda	940 [870 – 1,000]	480 [440 – 540]	5.4 [5.0 – 6.1]	3.9 [2.7 – 5.2]	1.3 [0.6 – 1.9]	77 [68 – 89]

Table 1: Number of people living with HIV, adult prevalence rate and deaths due to AIDS, 2007 *(Continued)*

DFID Priority country	No of people living with HIV (thousands)	No of women (15+) living with HIV (thousands)	Adult (15–49 years) prevalence (per cent)	Young women (15–24 years) prevalence (per cent)	Young men (15–24 years) prevalence (per cent)	Deaths due to AIDS (thousands)
Uzbekistan	10.9	4.6 [2.1 – 12]	0.1 [<0.1 – 0.3]	0.1 [<0.1 – 0.2]	0.1 [<0.1 –0.3]	<0.5 [<1]
Vietnam	290 [180 – 470]	76 [46 –120]	0.5 [0.3 –0.9]	0.3 [0.1 –0.5]	0.6 [0.3 – 1.1]	24 [14 –39]
Yemen	n/a	n/a	[<0.2]	n/a	n/a	n/a
Zambia	1,100 [1,000 – 1,200]	560 [520 – 610]	15.2 [14.3 – 16.4]	11.3 [8.5 – 14.2]	3.6 [1.6 – 5.2]	56 [47 – 66]
Zimbabwe	1,300 [1,200 – 1,400]	680 [650 – 720]	15.3 [14.6 – 16.1]	7.7 [3.8 – 11.7]	2.9 [1.2 – 4.4]	140 [130 – 150]

Source: 2008 Report on the Global AIDS Epidemic, UNAIDS, 2008

Annex 2

2. Prevention data

The table below provides data on the unmet need for family planning and PMTCT coverage in DFID PSA and other priority countries against which future progress will be monitored. We have also included data on the contraceptive prevalence rate (CPR) because the level of unmet need for family planning makes more sense when set within the context of the overall level of contraceptive utilisation. The table also includes data on the numbers of people receiving ARV and the numbers of condoms distributed in countries where data is available.

Country	% unmet need	Year	% CPR	PMTCT coverage % (2007)[25]	Reported number of people living with HIV receiving ARVs 2007/08[26]
Low and Middle income countries				34	
Afghanistan	n/a	n/a	n/a	n/a	
Angola	n/a	n/a	6	9	11,540
Bangladesh	11.3	2004	58	2.5	178
Botswana	26.9	1988	48	>95	92,932
Burma	19.1	2001	34	30.5	11,100
Cambodia	25.1	2005	24	33	26,664
China	2.3	2001	87	9	35,112
Democratic Republic of Congo	24.4	2007	31	5	17,561 (2006)
Ethiopia	33.8	2005	15	7	90,212
Ghana	34.0	2003	25	21	13,357
India	12.8	2006	47	17	158,020
Kazakhstan	8.7	1999	66	62.5	442
Kyrgyz Republic (Kyrgyzstan)	11.6	1997	60	5	87
Kenya	24.5	2003	39	69	177,000
Lesotho	30.9	2004	37	32	21,710
Malawi	27.6	2004	33	32	100,649
Mozambique	18.4	2004	17	46	85,822
Namibia	6.7	2007	44	64	52,316
Nepal	24.6	2006	38	3	1,240

[24] Towards Universal Access – Scaling up HIV services for Women and Children in the Health sector, Progress Report 2008: WHO, UNAIDS, UNICEF

[25] Towards Universal Access progress report, 2008: WHO, UNAIDS, UNICEF

Country	% unmet need	Year	% CPR	PMTCT coverage % (2007)[25]	Reported number of people living with HIV receiving ARVs 2007/08[26]
Nigeria	16.9	2003	13	7	145,392
Pakistan	24.9	2007	28	<1	550
Rwanda	37.9	2005	17	60	48,569
Sierra Leone	n/a	n/a	4	21	2649
South Africa	15.0	1998	60	57	428,951
Sudan	5.7	2006	7	<1	1,198
Swaziland	24	2007	48	67	24,535
Tajikistan	n/a	n/a	34	6.5	86
Tanzania	21.8	2005	26	32	135,696
Uganda	40.6	2006	20	34	111,232
Uzbekistan	7.8	2006	68	39.5	n/a
Vietnam	4.8	2002	77	21.5	14,969
Yemen	23.6	2006	23	n/a	107
Zambia	27.4	2002	34	47	151,199
Zimbabwe	12.8	2005	54	29	97,692

Source (unless otherwise stated): United Nations Population Division, 2009

Annex 3

Data on Health Workers countries covered by Achieving Universal Access

WHO recommends that countries require at least 2.3 health workers per 1000 population to achieve 80% coverage for skilled birth attendance and measles vaccination by 2015 (World Health Report 2006). This figure includes doctors, nurses and midwives only and is therefore a minimum.

	2000–2007		
	Physicians per 1000	Nursing and midwifery personnel per 1000	TOTAL per 1000
Afghanistan	0.22	0.55	0.77
Angola	0.07	1.09	1.15
Bangladesh	0.27	0.25	0.52
Botswana	0.38	2.53	2.91
Burma	0.36	1.01	1.38
Cambodia	0.14	0.77	0.91
China	1.39	0.94	2.34
Democratic Republic of Congo	0.09	0.46	0.55
Ethiopia	0.02	0.19	0.21
Ghana	0.14	0.84	0.98
India	0.55	1.17	1.73
Kazakhstan	3.73	7.33	11.06
Kenya	0.12	0.99	1.11
Kyrgyz Republic	2.39	5.80	8.19
Lesotho	0.04	0.56	0.60
Malawi	0.02	0.52	0.54
Mozambique	0.02	0.29	0.31
Namibia	0.29	2.96	3.25
Nepal	0.19	0.42	0.61
Nigeria	0.24	1.42	1.66
Pakistan	0.77	0.29	1.06
Rwanda	0.04	0.38	0.42
Sierra Leone	0.03	0.43	0.46
South Africa	0.72	3.80	4.51
Sudan	0.29	0.86	1.15
Swaziland	0.15	5.98	6.13

	2000–2007		
	Physicians per 1000	Nursing and midwifery personnel per 1000	TOTAL per 1000
Tajikistan	1.97	4.92	6.89
Tanzania	0.02	0.33	0.35
Uganda	0.07	0.61	0.69
Uzbekistan	2.58	10.60	13.18
Vietnam	0.51	0.71	1.22
Yemen	0.30	0.61	0.91
Zambia	0.11	1.85	1.95
Zimbabwe	0.16	0.70	0.86

Source: World Health Organisation: World Health Statistics 2009

Annex 4

Drug Prices

2006 WHO guidelines recommend the following tenofovir (TDF)–based regimens:

1. EFV600 + 3TC150 + TDF 300 = 2008 global median price = $360/person/year
2. EFV600 + FTC200 + TDF 300 = 2008 global median price = $465/person/year
3. FTC200 + NVP 200 + TDF 300 = 2008 global median price = $360/person/year
4. 3TC150 + NVP 200 + TDF 300 = 2008 global median price = $255/person/year

Table 1. 2008 Brand and Generic ARV Regimen Prices, by World Bank Income

					World Bank Income Stage					
ARV REGIMENS	FDC/I/H N/A*	Global			Low		Lower–Middle		Upper–Middle	
Expected to be most commonly used 1st line regimens 2008–onward		**All**	**Brand**	**Generic**	**Brand**	**Generic**	**Brand**	**Generic**	**Brand**	**Generic**
Lamivudine 150mg + Tenofovir 300mg + Efavirenz 600mg	I	400	536	357	533	349	834	383	525	466
Emtricitabine 200mg/Tenofovir 300mg/ Efavirenz 600mg	FDC	612	612	–	612	–	–	–	–	–
Emtricitabine 200mg/Tenofovir 300mg + Efavirenz 600mg	H	475	607	470	571	465	738	400	689	644

Table 1. 2008 Brand and Generic ARV Regimen Prices, by World Bank Income *(Continued)*

					World Bank Income Stage					
ARV REGIMENS	**FDC/I/H N/A***	**Global**			**Low**		**Lower–Middle**		**Upper–Middle**	
Lamivudine 150mg + Tenofovir 300mg + Nevirapine 200mg	I	286	567	247	525	244	–	259	583	360
Emtricitabine 200mg/Tenofovir 300mg + Nevirapine 200mg	H	361	638	361	563	360	–	276	747	538
Abacavir 300mg + Efavirenz 600mg + Lamivudine 150mg	I	528	735	517	763	512	869	544	728	537
SECOND–LINE ARV REGIMENS										
Expected to be most commonly 2nf–line used regimens 2008–onward		**All**	**Brand**	**Generic**	**Brand**	**Generic**	**Brand**	**Generic**	**Brand**	**Generic**
Atazanavir 300mg + Ritonavir 100mg + Lamivudine 150mg/Zidovudine 300mg	H									
Atazanavir 300mg + Ritonavir 100mg + Lamivudine 150mg + Zidovudine 300mg	I	3129	3225	–	–	–	–	–	5517	–
Lopinavir/Ritonavir 200mg/50mg + Lamivudine 150mg/Zidovudine 300mg	H	632	752	689	752	688	1214	698	1473	837
Lopinavir/Ritonavir 200mg/50mg + Lamivudine 150mg + Zidovudine 300mg	I	658	747	715	–	710	–	727	747	830
Atazanavir 300mg + Ritonavir 100mg + Lamivudine 150mg + Tenofovir 300mg	I	3232	3279	–	–	–	1703	–	5571	–
Lopinavir/Ritonavir 200mg/50mg + Lamivudine 150mg + Tenofovir 300mg	I	761	801	780	781	777	1468	786	801	960

**FDC = fixed dose combination*

H = hybrid regimen (comination of FDC+individual drug)

I = all individual drugs

N/A = not available

Annex 5

Monitoring the Global Fund's implementation of Paris

2008 baseline results of the Paris monitoring process

Note: Information in the table below covers data reported in 47 countries out of 55 and reflects 66% of country programmed aid in 2006.

Indicators		2007		Illustrative 2010 Targets
		33 countries	All countries	
3	Aid flows are aligned on national priorities	44%	33%	85%
5a	Use of country public financial management systems	42%	38%	59%
5b	Use of country procurement systems	42%	42%	56%
6	Avoid parallel implementation structures	2	5	1
7	Aid is more predictable	41%	43%	67%
8	Aid is untied	100%	100%	100%
9	Use of common arrangements or procedures	76%	66%	Target of 66% achieved
10a	Joint missions	18%	20%	40%
10b	Joint country analytic work	23%	23%	66%

Annex 6

Part Two: Our Bilateral Response : Regional Specific M&E Indicators

1. Africa

Progress on MDG 6 (Africa)

MDG Target	PSA Indicator	2011 Success Criteria	Baseline Position (2007)	Current Position (2008)
MDG 6: HIV prevalence among 15–49 year old people11 *By 2015 to have halted and begun to reverse the spread of HIV*	HIV prevalence rate (%), 15–49 year olds.	At least 14 of 22 countries report reducing HIV prevalence rates among 15–49 year olds.	At baseline 4 countries reported reducing HIV prevalence. In 15 countries, the trend is broadly flat. There is insufficient data to monitor trends in 3 PSA countries.	• Several countries report success in reducing HIV prevalence rates in adults. • Based on recent trends, an improvement was seen in Uganda, Zambia, Zimbabwe, Malawi and Rwanda. However, the prevalence rate remained high in most of these countries. • Progress in reducing prevalence rates has reversed recently in Kenya and Mozambique. • There has been little improvement in this indicator, and much remains to be done if the target is to be met.

2. South Asia

India

Outcome	Indicator	Target	Baseline	Baseline source and date
Halt the spread of HIV/AIDS	HIV prevalence rate (%) among 15–49 years old by sex	< 0.5 in years to 2015	0.36	National AIDS Control Organisation GoI (2006)
	HIV prevalence rate (%) among female sex workers (FSW)	< 10 in years to 2015	10.3	National AIDS Control Organization, GoI 2007
	Condom use (%) by high risk groups with most recent client : i) FSW; ii) MSW	i) 90 ii) 75 by 2015	i) 50 ii) 20	National AIDS Control Organisation of (2006)
	Number of people with advanced HIV infection receiving ARVs	340,000 (2011/12)	42000	National AIDS Control Organisation of (2006)

Nepal

Outcome	Indicator	Target	Baseline	Baseline source and date
Reduction in HIV prevalence	HIV prevalence declines in some high risk behaviour groups by Mid 2012	HIV prevalence amongst injecting drug users (IDU) is 20% by mid 2012	HIV prevalence in IDUs = 34.7% (2007)	IBS (FHI/MOHP 2006 – 2008)
		HIV prevalence amongst migrants is 1% by mid 2012	HIV prevalence amongst migrants = 3.3% (2008)	
	No of IDUs and migrants completed HIV counselling and testing process	10,000 (50%) of IDUs and 569,760 (40%) of migrants and families completed HIV counselling and testing process	2,332 IDUs and 44,319 migrants and families	2008 UNDP Annual Report

Pakistan

Outcome	Indicator	Target	Baseline	Baseline source and date
Halting spread of HIV.	No. of individuals from High Risk Groups with access to HIV services.	205,800 individuals from HRGs (injecting drug users, male sex workers, Hijras, female sex workers, truckers and jail inmates) have access to HIV services by 2013.	39,500 individuals from HRGs.	2007/08, HIV Surveillance Project (HASP Round II, 2007).
	(a) % of injecting drug users (IDUs) using new syringe (almost all IDUs are men); (b) % of female sex workers using a condom; (c) no. of targets for delivery of Treatment & Care to AIDS patients met successfully.	(a) More than 60%; (b) More than 60%; (c) All target met – by 2013.	(a) 41%; (b) 45%; (c) no targets met yet (targets to be agreed in WB Programme Appraisal document by mid 2009) but 600 cases have been enrolled for treatment and care.	(a) and (b) = HIV Surveillance Project 2006/07. (c) Agreement with National Aids Control Programme by end 2009.

The epidemic and our response elsewhere in the world

Indicator	Target	2008 Baseline
MDGs		
HIV prevalence rate among 15-49 year people.	HIV prevalence rate among 15-49 year olds maintained below 1% in Cambodia and Vietnam.	1% in Cambodia and Vietnam.
Cambodia		
	By December 2009, the % of high risk men in Phnom Penh who use condoms consistently with their "sweethearts" increases to 54%.	52%.
Vietnam		
	Condoms distributed through non traditional outlets, which target the high risk groups, increases to 24 million in 2010.	16.8 million in 2008.
Burma		
	Total condoms distributed (including those sold) increases to 34,000,000 by end 2011: of which at least 2,600,000 to commercial sex workers and 500,000 to men who have sex with men.	23,700,000 condoms distributed (or sold) in 2008 of which at least 1,975,000 to commercial sex workers and 416,000 to men who have sex with men.
	Total condoms distributed (including those sold) increases to 13,600,000 by end 2011: of which at least 1,000,000 to commercial sex workers and 200,000 to men who have sex with men.	7,600,000 condoms distributed (or sold) in 2008 of which at least 630,000 to commercial sex workers and 130,000 to men who have sex with men.
Country and Regional Objectives		
Central Asia		
	Regionally 20,000 male and female intravenous drug users are reached by harm reduction services by 2011 through DFID supported programmes.	14,891 in 2008.
Caribbean		
	Reduction in HIV aids stigma and discrimination in region. Caribbean Stigma and Discrimination Unit fully functioning.	No stigma unit existing in the region.

Indicator	Target	2008 Baseline
North and East Asia		
	Vietnam: 24 million needles and syringes distributed to IDUs in 2010.	15 million in 2008.
	China: Increased coverage of HIV prevention activities among high-risk groups in 7 high-prevalence provinces according to targets jointly agreed with GoC and Global Fund. (By Jan 2009: 34,800 IDUs on MMT; 442,500 hi-risk pop received VCT; 24,000 patients on ARVs; 46,000 PLWHAs received care; 271,800 hi-risk pop received BCC; 2,800,000 youth received BCC.).	25,000 IDUs on MMT, 386,000 people received VCT, 18,000 on ARVs, 32,000 PLWHAs received care, 212,000 high risk population received BCC, 2.2m youth received BCC.

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 6 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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