



# UK's Call for Action on **HIV/AIDS**



Front Cover Photo: A grandmother in Zambia with the nine orphaned grandchildren who are in her care.

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# Foreword by the Prime Minister, The Rt Hon Tony Blair MP

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The scale and devastation of the HIV/AIDS epidemic is almost impossible to over-emphasise. Sixty million people have been infected worldwide. Twenty million have already died. It is a human tragedy on a massive scale. Many of the countries worst affected are already the poorest on our planet.

Two in three people with HIV/AIDS live in sub-Saharan Africa. It's already the biggest killer across the whole of the continent. It is predicted to halve life expectancy in Botswana in just two decades. HIV/AIDS is not just the biggest problem these countries face, it is the biggest barrier to tackling poverty. New challenges are also emerging. In some parts of Asia, numbers infected are rising rapidly. The fastest increases of all are found in the countries of the former Soviet Union.

Health care systems, already weak and badly under-resourced, face incredible pressures. As I saw for myself in Mozambique, nurses and other trained staff are being lost faster than they can be trained. The sickness, loss of life and caring demands on family and friends are destroying the chances of prosperity and economic growth.

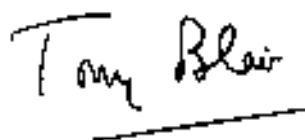
It would be difficult for any country alone to deal with such a terrible tragedy. It is simply impossible for countries already gripped by poverty. It must therefore be the duty of the entire world community to act. For unless we act now and decisively, the deepening poverty and instability arising from this appalling epidemic will reach far beyond the parts of the world worst affected. It is important to recognise, too, that decisive and co-ordinated action by governments, the international community, business and civil society delivers results. Uganda,

Senegal, Thailand and Brazil have all cut rates of infection dramatically.

I am proud that this Government and this country have taken a leading role over the last few years both in pushing HIV/AIDS up the world agenda and in giving financial and practical help. We are the world's second biggest bilateral donor on HIV/AIDS. Our funding has increased seven-fold in the last six years. We were instrumental in setting up the Global Fund to Fight AIDS, TB and Malaria and in providing funding to help ensure its long-term future.

But we can't rest on these achievements. There is too much ground to make up, too much to do. What's important about this 'Call for Action' is not the impact of HIV/AIDS it identifies or the steps Britain has already taken to tackle these problems. It is the scale of the challenge ahead.

I am personally determined that this country will not just step up its efforts bilaterally and internationally to tackle HIV/AIDS, but that we will also continue to offer the leadership needed to get the world to focus on what we must do together. I can promise that HIV/AIDS will be at the top of our international agenda as we work towards our Presidencies of the G8 and the European Union in 2005. This issue will remain a high priority for me and I have asked the Secretary of State for International Development, Hilary Benn, to take forward this vital work over the coming months.



**TONY BLAIR**

December 2003

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# Summary

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**1.** HIV/AIDS is a major threat to development. It has infected 60 million people worldwide. Twenty million have already died, and another three million will die this year. Fourteen million children have lost a parent to AIDS. Unless urgent action is taken, the epidemic will turn the clock back decades in the fight against poverty. The challenge is especially acute in Africa where AIDS is the biggest killer; in the hardest hit countries, 1 in 4 people are infected. The failure to mount an effective response in some parts of Asia and Eastern Europe is leading to rapid increases in HIV infection. And other parts of the world could face as great a challenge, unless we act now.

**2.** Arresting the epidemic is an achievable goal. We know what needs to be done. The road map was laid out in the UNGASS Declaration of Commitment on HIV/AIDS, which all UN members signed up to in 2001, and some countries have shown that it can be done. In Uganda, Senegal, Thailand and Brazil decisive action has cut prevalence rates dramatically. The basic ingredients of success were the same: political leadership, reducing stigma, targeted programmes for groups at risk, and coordinated efforts by government, the international community and civil society.

**3.** We can do more for people with AIDS. Drug prices are falling. International and political interest and commitment is growing and new money has been committed.

**4.** But challenges remain. Political direction could be stronger. The surge in international interest has led to a proliferation of activity and greater funding. But the money and energy are not being used as well as they could be. Already hard-pressed governments in developing

countries are spending more time dealing with donors, which can mean less time tackling the epidemic. And there is still a significant funding gap.

**5.** Important gaps in our knowledge and experience remain: how do we apply the successful lessons of prevention in other countries? When will a vaccine be available? What is the potential of microbicides to protect women from the virus without harming their fertility? How do we ensure that vital drugs benefit poor people? How can we help orphans avoid falling into chronic poverty? How can we prevent HIV/AIDS increasing the food security crisis?

**6.** No matter how much money, interest and commitment we provide, if key elements of a coherent government response are not in place all these cannot be put to good use. These elements are the same everywhere – although each country will need to adapt them to their needs: one HIV/AIDS strategy, one HIV/AIDS Commission, one way of measuring and reporting progress (the ‘Three ones’ commitment). We also need to underpin these with fully staffed and effective government services.

**7.** This Call for Action is the first step in an intensification of effort by the UK government to tackle the epidemic. We will provide high-level political leadership, push for more resources to be made available and work together more effectively with other donors. We will make HIV/AIDS – with Africa – a centrepiece for our Presidencies of the G8 in 2005 and of the EU in the second half of 2005. In the run up to our Presidencies we will work with the international community to:

- make a reality of the UN's "Three ones" commitment in every developing country afflicted by HIV/AIDS;
- seek to meet the UN target to cut HIV infections among young people by one quarter;
- seek to meet the WHO's targets to get 3 million people worldwide on treatment by 2005, and ensure that women and poor people are reached.

This will require a greater effort over the next year.

**8.** Across the UK government we will work with countries to develop a response to HIV/AIDS which involves all sectors of government and society. This response must tackle the vicious cycle of HIV/AIDS and poverty. It will bring together efforts to prevent HIV with social and medical care for people affected by HIV/AIDS and action to mitigate the impact of the epidemic on societies.

**9.** We will increase the UK's own political commitment. The Prime Minister will raise the issue with other leaders at the Commonwealth Heads of Government Meeting (CHOGM) and other international meetings. We will support calls for a debate on HIV/AIDS in the UN Security Council and provide high-level UK participation in this. We will also continue to support efforts in Africa through the New Partnership for Africa's Development (NEPAD), Southern African Development Community (SADC) and the Africa Partners' Forum.

**10.** To promote a more effective donor effort we call on UNAIDS – to which we will double UK core funding – to strengthen their work in countries, and to back this up by convening an annual meeting of the main agencies active in HIV/AIDS. This annual meeting should agree practical steps, including the "Three ones", to improve coordination and deliver stronger country responses. We will also take steps to improve our own coordination in country with other donors working on HIV/AIDS.

**11.** The solution to this crisis demands a response from all sections of the community. It is a challenge we must all rise to. This Call for Action is a first step by the UK Government. Government, NGOs, people living with HIV/AIDS and the private sector must all play their part. We welcome views on all these issues, and will be involving all sections of the development community and our partners in the coming months.

**12.** We will draw on these views to formulate a new Government HIV/AIDS strategy in 2004. This will set out the UK's planned response to tackle HIV/AIDS internationally and the resources that will be made available for this.



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In South Africa, a baby whose mother is HIV-positive is given an anti-retroviral drug to prevent HIV.

## Call for Action

The UK Government calls on the international community to intensify its efforts to tackle HIV/AIDS and to achieve real progress towards the key international targets in the UNGASS Declaration of Commitment on HIV/AIDS, and in particular:

- 25% fewer young people infected with HIV/AIDS by 2005.
- Three million people – two million in Africa – receiving treatment by the end of 2005.
- One national strategy, one national AIDS commission and one way to monitor and report progress in every country affected by HIV (the ‘Three ones’).
- On track to slow the progress of HIV/AIDS by 2015.

### What we will do: Stronger political direction

- The UK Government will make HIV/AIDS – and Africa – a centrepiece of our Presidencies in 2005 of both the G8 and EU.
- The UK will work with the New Partnership for Africa’s Development (NEPAD) and the Africa Partners’ Forum to focus on HIV/AIDS.
- We will push for a special session on HIV/AIDS at the United Nations Security Council in early 2004.

### What we will do: Better funding

- We will make HIV/AIDS a priority for the extra £320 million the UK will be devoting to Africa by 2006.
- We will press for support for the International Financing Facility to meet the funding gap for HIV/AIDS and other Millennium Development Goals.
- We will work with the Global Fund for AIDS, TB and Malaria to enable it to disburse funds quickly and effectively.

### What we will do: Better donor coordination

- We will step up our coordination with the US and other donors starting in Ethiopia, Kenya, Nigeria, Uganda and Zambia.
- We will double our core funding of UNAIDS.
- We will work with UNAIDS to strengthen their coordination role in countries and to establish an annual forum on donor coordination. We will work with the EU and UN to support their role in improving donor coordination.

### What we will do: Better HIV/AIDS programmes

- We will work with developing countries and other partners to strengthen health systems.
- We will produce a new UK government strategy on AIDS next year. This will define how the whole government will work with countries to establish a stronger response.
- We will issue new policy guidance on the role of HIV treatment and care.

# The epidemic and its impact

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## Introduction

**13.** HIV/AIDS is the greatest threat to development in the world today. 60 million people have been infected since the late 1970s. 20 million have died, and 40 million are living with the virus. In 2003 alone, HIV/AIDS will kill 3 million people. All told, HIV/AIDS has touched the lives of more than 160 million people worldwide, including 14 million children who have been orphaned. Every country is affected but developing countries have been hardest hit. Two in three infected people live in Sub Saharan Africa, where HIV/AIDS is the leading cause of death (it is the fourth biggest killer globally). More than half of new infections are among young people (aged 15–24). Prevalence is highest among women and girls. People with the disease are often stigmatised and discriminated against.

## Which parts of the world are hardest hit?

**14.** Sub-Saharan Africa is by far the hardest hit region. But the epidemic is gaining ground in other regions.

**Africa:** Close to 28 million people are infected – in the worst affected countries 1 in 4 of the population are infected. 13 million people have died, and the rate of infection is still rising. By 2025 100 million people are expected to have died of HIV/AIDS. 3.2 million will be infected in 2003 alone; 2.3 million will die. The impact has been particularly devastating in some parts of the continent. In sixteen countries (including Botswana, South Africa and Zimbabwe) the infection rate among 16–25 year olds is more than 10%. In Swaziland and Botswana one in four have HIV. 80% of deaths among young adults are HIV-related. Women and girls have a far higher rate of infection – 3 times higher among teenage girls compared with boys.

**Asia and the Pacific:** While overall prevalence is low (less than 1%), some countries contain serious localised epidemics. In the region as a whole, almost 7.4 million people are infected, 4.5 million of whom live in India (second only to South Africa in number of infections), and 850,000 in China. In a few countries incidence is declining (Cambodia, Thailand), but Asia's large population means that by 2010 more people will be infected there than in Africa. And with current rates of spread, by 2020 Asia will be the major centre of the epidemic if decisive action is not taken.

**Eastern Europe and Central Asia:** This part of the world has the fastest growing rate of infection in the world. 1.5 million are infected and the numbers are expected to grow substantially. What began as a concentrated epidemic is now spreading. Several regional factors are fuelling the spread of the virus, notably the post-Soviet collapse of the health and social security systems, the increase in injecting drug use, unemployment and economic turmoil.

**Latin America and the Caribbean:** HIV/AIDS has long taken hold, and now more than 2 million people are infected. Many countries (including the Bahamas, Guyana and Haiti) have a prevalence rate above 1% (an indication of generalised spread). The Caribbean is worst affected and several islands face bigger epidemics than anywhere outside sub-Saharan Africa.

## Why are developing countries so badly affected?

**15.** HIV/AIDS has spread rapidly in the developing world for a complex set of reasons, which vary between countries and regions. Most cases are through sexual transmission.

Others involve mother-child transmission, unsafe injecting and blood transfusions. While risky sexual behaviour may be the direct cause, underlying factors drive risk, such as poverty, vulnerability and cultural norms.

**16.** Women are particularly vulnerable. They are biologically more susceptible to infection than men and less able to exercise control over their sexual lives. Violence against women contributes further to their vulnerability.



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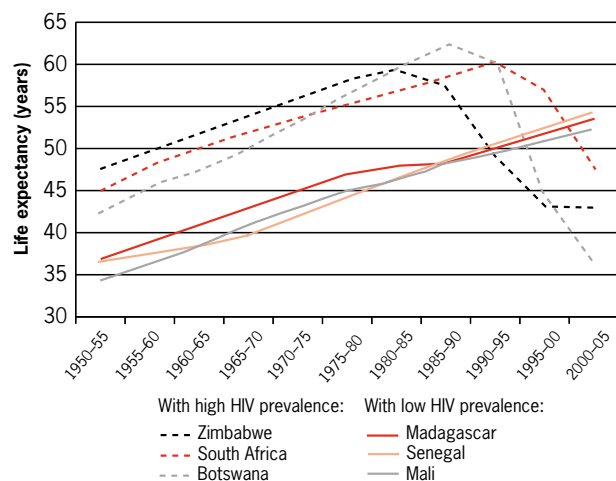
A Thai mother with AIDS holds her child.

**17.** People living in poverty are also vulnerable. Those marginalized by society – including men who have sex with men, sex workers, injecting drug users and migrants – have been at most risk. They have less access to information, supplies such as condoms, reproductive health services and good quality public services.

**18.** Conflict is a particular aggravating factor. People living in conflict are at greater risk of sexual violence – from others in their communities and from the military. Women may be coerced into sex, or exchange sex for money, goods or food. Demobilising forces pose a particular risk. Military forces tend to have higher infection rates than civilians.

# What is the impact of HIV/AIDS?

## Declining life expectancy: Changes in life expectancy in selected African countries with high and low HIV prevalence: 1950-2005



**19.** HIV/AIDS is having a devastating impact. In the worst affected countries, it has wiped out 50 years of development gains.

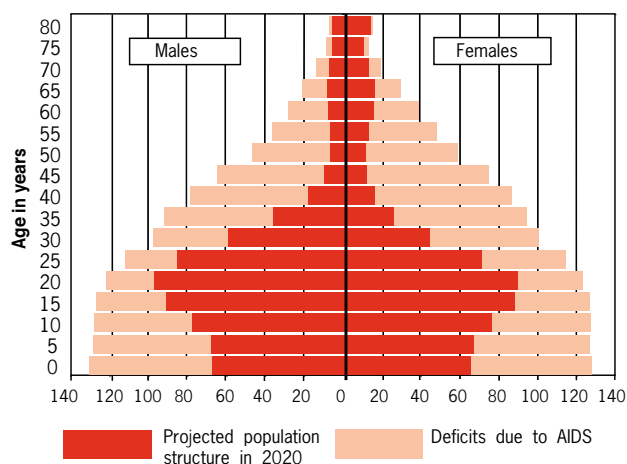
**20.** The epidemic is having a serious negative effect on:

- population and health.
- the social fabric.
- public services.
- household and national income.

## Population and health

**21.** The epidemic is dramatically reducing life expectancy in the worst affected countries. By 2010 life expectancy in many African countries will fall to around 30 years of age, levels not seen since the end of the 19th century. Botswana – the worst affected – faces a decline in life expectancy from 65 years in 1990–95, to 40 years today and a predicted 27 years by 2010.

## Projected population structure with and without the AIDS epidemic, Botswana, 2020



**22.** Deaths among young people are hollowing out the population structure, increasing the proportion of old people and young orphans. This is decimating the workforce and potential carers. Many countries will see their populations decline overall. Infant mortality is also being pushed higher, reversing the gains since 1980. HIV is also generating a TB epidemic which is increasing the pressure on already over-stretched health services.

## Social fabric

**23.** HIV/AIDS is breaking societies apart, particularly in Africa. 14 million children have lost at least one parent to the virus, and the numbers are set to rise to 25 million by 2010. In the worst affected communities, families of children often have elderly grandparents as their only form of support. Children who have lost a parent – especially a mother – are often sent away to live with distant relatives. Many of these foster parents themselves have HIV/AIDS, or are living in poverty, and are ill-equipped to provide adequate care.

**24.** Orphans are much more vulnerable than other children. They are less likely to attend school, more likely to suffer poor health, and are vulnerable to physical and sexual abuse. Consequently, they are at greater risk of HIV infection. When a parent falls ill with the virus, children may take responsibility for providing care, as well as generating an income for the family. Apart from the direct impact of orphanhood – psychological distress, limited education and acute poverty – destitute children may also be drawn into conflict as child soldiers or join criminal gangs.

**25.** Women – mostly elderly widows – shoulder most of the burden of caring. In Zimbabwe, over 70% of carers are women over 70. Women, in turn, are less likely to be cared for or to have access to services. They also suffer greater discrimination. Women with HIV – or whose husbands died as a result of HIV infection – may lose inheritance and land rights.



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A cemetery in a region in Zambia where more than 20% of the adult population has HIV or AIDS.

## Public services

**26.** Across the public sector, deaths from AIDS – and absences from work to care for sick relatives or attend funerals – have significantly depleted human resource capacity. In Malawi death rates among public sector employees increased 10-fold between 1990 and 2000, primarily because of HIV/AIDS.

**27.** Education and health services have been hardest hit. In Zambia, teacher absenteeism because of HIV infection is expected to cut the number of teaching hours by 20 million between 1999 and 2010. In Botswana, estimates suggest that up to one third of health workers may have been infected in 1999 and up to 40 per cent could be infected by 2005.

**28.** At the same time as HIV/AIDS is weakening the capacity of public services, it is also placing new demands on them, for instance for better education about HIV and better health services. The depletion of public services may, in the worst affected countries, undermine public confidence in the ability of government to provide for its citizens. Discrimination and stigmatization of people living with HIV/AIDS could serve to add to this decline in confidence.

**29.** On the other hand, the epidemic could serve as a catalyst for stronger community organisation, and where there is an effective response, increase public confidence in, and legitimacy of, government.

## Household and national income

**30.** Households struck by HIV/AIDS are much less able to sustain themselves. To cope with the crisis, households may stop producing high value crops (like coffee), which require a lot of work, and start producing low value root crops (like cassava), which are easier to grow, but of poor nutritional value. Moreover, parents are not able to transfer skills to their children before they die. Households may also be forced to sell off assets and to send their children out to work.

**31.** At a national level, HIV/AIDS will significantly slow down economic growth, because of the depletion of the workforce and the related decline in the provision of public services and productivity of the private sector. It has been estimated that in Sub-Saharan Africa as a whole, growth rates could be cut by between

0.3 and 1.5 percentage points per year between now and 2015.

**32.** The private sector is also affected by HIV/AIDS morbidity, mortality and related absenteeism. Absenteeism and the disruption caused can lead to lower productivity, higher costs and reduced reliability. In India, absenteeism in some industries is expected to double in the next two years because of HIV/AIDS and other sexually transmitted infections. A transport company in Zimbabwe estimated its costs due to HIV/AIDS at 20 per cent of its profits.



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A young vendor near an AIDS poster in Vietnam.

# Combating HIV/AIDS – What works?

**33.** Faced with these challenges, some countries are succeeding in combating the epidemic. Most notable are Brazil, Senegal, Thailand, and Uganda:

- Brazil has controlled its infection rate to a little over 0.5% – half that projected.
- Uganda cut prevalence from a peak of 15% in 1991 to 5% in 2001.
- Early action in Senegal has kept infections at 2%.
- Thailand brought down infections amongst commercial sex workers from 15.2% in 1991 to 10.5% (rural areas) and 6.7% (cities) in 2000.

**34.** Central to this success has been the right overall policy response and programme design.



A condom demonstration among women waiting for a rural health clinic in South Africa.

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## Box 1: How to Succeed – Lessons from Uganda and Senegal

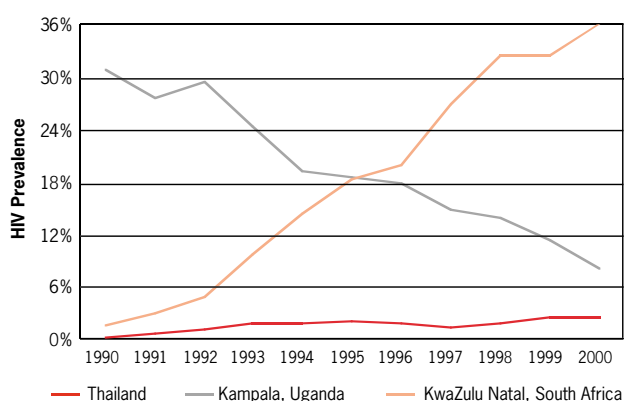
The experience of Senegal and Uganda demonstrates that decisive action can prevent a crisis from developing, and that where prevalence rates are already high, they can be reduced. Senegal and Uganda between them teach us the importance of:

- Strong political direction
- Involvement of faith groups, NGOs and the private sector
- Early response
- Free press willing to publish candid articles
- Good data to track the epidemic
- Targeting of sex workers
- Voluntary counselling and testing centres, backed up by support (but not treatment)
- Blood screening
- Condom distribution
- Company policies to offer AIDS treatment
- Outreach to young people
- Awareness raising amongst the military
- Programmes for orphans

**35.** The main components of an effective policy response are:

- Strong political commitment and leadership. President Museveni's role in leading the Ugandan effort was key. In Thailand the sanctioning of public support among groups who are otherwise legally marginal (drug users, men who have sex with men, sex workers) was central to success.
- Early and decisive action—in Senegal this prevented further spread. Countries that were in similar situations in 1990 such as Thailand and South Africa are in very different circumstances now. This demonstrates that early decisive action can make the difference. China and other countries in Asia (and elsewhere) are now at the stage that these two countries faced in 1990.

#### HIV Prevalence Thailand, Uganda, South Africa, 1990-2000



- A comprehensive approach, which addresses all the dimensions of HIV/AIDS, from health and labour market impacts to issues of stigma and discrimination, and effective Government structures. These structures need to support the line ministries in tackling these problems, rather than marginalise them. Mozambique's National Strategic Plan (2000–2002) and Malawi's cross-government National Aids Commission are good examples of these.

- Engaging a broad range of stakeholders in mounting a response – civil society, local leaders, religious groups, people living with HIV/AIDS, the private and public sectors. Involving people affected by HIV/AIDS in the design of programmes is key to these being sustained. The private sector can play an important role by educating their workforce and providing free treatment, as well as giving financial support for combating AIDS.
- Support from international donors, in backing up national efforts.

**36.** While there is still much to learn about the most effective responses to combat HIV/AIDS, some general lessons are clear:

- Programmes should include prevention, care and treatment. Equally importantly, they must include measures to reduce the impact of the epidemic on vulnerable people and communities, for example programmes to support orphans, and counselling and advice for people living with AIDS. People will feel more comfortable about coming forward for counselling or an HIV test if there is a prospect of receiving care and treatment if they are found to have HIV. Treating pregnant women with antiretrovirals (ARVs) can be an effective way of preventing the virus from being transmitted to their newborn children, and ultimately reducing orphaning. Keeping a focus on prevention in countries where prevalence is low is essential to keep infection rates down. And we must maintain prevention programmes even where prevalence is high.
- The precise mix and balance of responses needs to vary according to local social and institutional conditions and the stage of the epidemic. In Brazil, there has been a heavy reliance on ARVs. This was made possible by significant price discounting on locally manufactured generic drugs and the fact that there is a reasonably robust health system.

In Uganda – and other low-income countries – where these circumstances do not prevail, strategies have focused on prevention. Even where ARV treatment is available some people will not be able to maintain or access treatment and palliative care is needed to improve the quality of life for those who are ill or dying.

- Prevention programmes should enable people to make safe and healthy choices. They need to encompass raising awareness of HIV/AIDS, support for behavioural change and improved access to reproductive health information and services. Simple messages about abstaining from sex do not work. Prevention approaches need to focus on the needs of specific groups. In the right circumstances, support to children (particularly girls) to delay the onset of sexual activity and resist coercion can help reduce infection rates. These messages must be put in a broader context.
- Targeted programmes work well where HIV incidence is concentrated within certain parts of the population. They are most effective when coupled with efforts to reduce stigma. Harm reduction programmes, including needle exchange programmes, across Russia have successfully reduced risk behaviour among drug users. The involvement of the security forces in these efforts was key. Thailand's successful approach was based on national prevention programmes focused on sex workers and their clients across the country.

**37.** Up to now, treatment has not featured heavily in low-income countries. In Africa only 1% of people with HIV in need of treatment are receiving ARVs, and they are predominantly the better off. However, recent dramatic reductions in price mean that treatment is becoming more affordable. The price of ARVs is falling, in some cases by up to 95% over the last three years. This has been helped by various initiatives including UN and drug industry efforts and the availability of generic drugs, the G8 plan of 2003 to extend access to essential medicines in developing countries and work by the Clinton Foundation (see box 2 below).

**38.** However, costs (\$140 for a year's supply) remain high compared with current health expenditure in Africa (an average of \$20 per person). Treatment needs to be given for life, so it is a long-term financial commitment. Weak – and deteriorating – health systems pose a major challenge to ensuring that the drugs get to those who need them. However, there is evidence from small-scale pilots that treatment can be administered effectively in poorer countries – if integrated in a strong programme incorporating prevention, counselling, training and community mobilisation.

# How is the International Community – including the UK – responding to the epidemic?

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**39.** In recent years, the international community has significantly stepped up its efforts to combat HIV/AIDS, through international advocacy, new financing, lower drug prices and research. The main elements of the UK's contribution are summarized in box 3.

## Advocacy

**40.** Governments around the world have strengthened their commitment to fighting HIV/AIDS. At the Millennium Summit (2000), world leaders agreed to 'halt and begin to reverse the spread of HIV/AIDS' by 2015, setting this as one of the Millennium Development Goals, an ambitious set of targets to reduce global poverty.

**41.** In 2001 member states agreed a new framework for combating HIV/AIDS at a special session of the UN General Assembly. The UNGASS Declaration of Commitment on HIV/AIDS provides a clear road map with targets for action, including the goal to cut infections amongst young people by one quarter. The World Health Organisation has subsequently set targets to get 3 million people on treatment by 2005 (the 3x5 initiative).

**42.** Other political groupings are also exerting a stronger leadership role.

- The G8 at its 2003 summit in Evian reiterated its commitment to the international health agenda, including the new Global Fund for AIDS, TB and Malaria.
- The New Partnership for Africa's Development (NEPAD), an Africa-led initiative to revive the continent's fortunes, has HIV/AIDS as a top priority.

- Members of the African Union in the Abuja Declaration on HIV/AIDS, tuberculosis and other infectious diseases (2001) committed themselves to take personal responsibility and provide leadership in national AIDS commissions.
- The Southern African Development Community (SADC) adopted a joint HIV/AIDS 'strategic framework' in July 2003.
- The Secretary General of the UN has established a Commission on HIV/AIDS and Governance in Africa, and this has begun work.
- The Asia Pacific Leadership Forum is mobilising stronger political commitment.
- The Africa Partners Forum has recently agreed that HIV/AIDS will be one of its four priorities for future work.

**43.** In addition to the critical role of current political leaders, civil society organisations and international figures – such as former Presidents Clinton and Mandela, and Bill Gates – can also do a lot to raise the profile of HIV/AIDS.

**44.** At the heart of any response is the need to strengthen health systems. Where HIV/AIDS has hit hardest, trained staff are in short supply, stocks of basic drugs fall far short of need, and information systems to track progress are weak. Providing treatment and care on the scale needed will require an overhaul of years of neglect. DFID has invested £1.5 billion in health systems strengthening since 1997. We are working with partners to build sound systems as the cornerstone of efforts to accelerate progress to

achieve the MDGs, to improve maternal and child health and reduce the impact of HIV and other major communicable diseases.

## Financing

**45.** International funding for HIV/AIDS has risen substantially in the last five years. Support – from official development assistance and private foundations – is now \$4.7 billion a year, compared with around \$400 million a year in 1998. Several new sources of money have come onto the scene:

- The Global Fund to fight AIDS, TB and Malaria (GFATM) was set up in 2001 as a public-private partnership, to provide significant new long-term financing.
- The Bill and Melinda Gates Foundation – founded in 2000 – has allocated \$640 million to AIDS, largely to support research and innovative country programmes.
- In 2003 the main funders of efforts to tackle the epidemic were the US (\$576 million), the UK (\$452 million), GFATM (\$4.5 billion in pledges, of which \$142 million has been disbursed) and the World Bank (\$1.5 billion). The US has pledged a total of \$15 billion over 5 years to HIV/AIDS programmes in 12 African and 2 Caribbean countries in President Bush's new 'Emergency Plan for AIDS Relief'.



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A volunteer in Zambia teaches a class of 87 pupils – 47 are AIDS orphans.

## Drug prices

**46.** There is significant international interest in lowering drug prices. Research and development based pharmaceutical companies have done much to reduce prices, through differential pricing and donation initiatives. This year's WTO agreement giving countries without their own manufacturing capacity better access to cheaper drugs is a major step forward. This should help cut the price in poor countries of patented medicines that come onto the market after 2005. The Clinton Foundation has also achieved major recent success in securing substantial reductions in the price of generic anti-retrovirals (see box 2). Other companies with operations in developing countries (e.g. Heineken and Diaego) provide workplace education programmes and are offering their workers – and in some cases families and communities – free treatment for life.

### Box 2: The Clinton Foundation and ARV Pricing

The William J. Clinton Foundation has negotiated a deal to provide greater access to anti-retroviral drugs. The foundation has brokered an agreement with three Indian generics companies – Cipla, Ranbaxy and Matrix – and a South African one, Aspen, to offer two key ARV cocktails for as little as 38 cents per person a day. This is less than half the price of the cheapest drugs previously available in these countries. The Foundation's success is based on sound business analysis, which has identified ways to reduce production costs. The Foundation means to do the same for costly HIV diagnostics.

## Research

47. Significant research efforts are focused on the search for effective vaccines and microbicides. Most experts believe that a microbicide to prevent HIV infection is seven to ten years away. There is also a significant effort in HIV treatment and basic research, although there are limited vehicles for international coordination of this effort. Continued study on epidemiological trends, emerging risk groups and changing behaviour patterns is essential. Research on the non-health aspects of HIV/AIDS (such as political responses to the epidemic and its economic impacts) has lagged behind the bio-medical efforts.



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Sex workers in Zimbabwe perform an educational drama to educate other sex workers and their clients about HIV and AIDS.

### Box 3: The UK's Contribution

- The UK has sharply increased the priority we give to tackling HIV/AIDS in the developing world in response to the growing epidemic. We have successfully worked to push the crisis up the agenda of all international bodies including the UN, the G8 and the EU. And the UK has significantly increased its own funding to developing countries. We are working with non-governmental, private and multilateral partners to improve prevention, treatment and care programmes.
- We are now the world's second biggest bilateral donor on HIV/AIDS. UNAIDS says our bilateral funding has increased over the last six years from £38 million in 1997/8 to more than £270 million in 2002/03. The UK contribution accounts for 28% of all projected bilateral spending this year on HIV/AIDS, behind only the 35% contribution of the United States.
- The UK government has a progressive workplace policy, particularly for staff working overseas. This covers HIV awareness, education and treatment for workers and their families.
- The UK is working on HIV/AIDS in 40 countries. Our bilateral funding largely supports the national HIV/AIDS strategies of our developing country partners. This makes it easier for countries to address HIV/AIDS in a comprehensive way, involving all relevant parts of government.
- The UK has, for example, committed £123 million to India's National AIDS Control programme and is supporting hundreds of Government-led programmes which are having a major impact in halting the rise in infection. Among them is a popular TV series, developed with the BBC World Service Trust, to take the message of HIV awareness to a 150 million audience.
- We are helping provide male and female condoms for vulnerable groups in South-East Asia and elsewhere.

- We support wide-ranging HIV/AIDS work in Malawi, South Africa and Zambia. We are major donors to the Ugandan government's Poverty Eradication Action Plan, which drives its response to HIV/AIDS.
- The UK's early efforts were concentrated primarily on prevention. But in the last two years increased focus has been given to treatment, care and impact mitigation – supporting those programmes already operating and helping set up new programmes in other developing countries.
- The UK also works extensively through multilateral organisations including UNAIDS, WHO and the World Bank. We also support worldwide research initiatives on vaccines and microbicides.
- We were a prime mover in setting up the Global Fund to fight AIDS, TB and Malaria (GFATM) and have committed \$280 million over 7 years to contribute to long-term stability of funding. We also contribute to GFATM through the EC. Together with EU Member States the EC has provided over 50% of the funding of the Global Fund. This is in line with the call from the Prime Minister and President Chirac for Europe to play its part.
- Countering the devastating impact of HIV/AIDS on developing countries also requires improved access to affordable medicines and good health care services. This has been a priority for the UK.
- We have provided substantial support – £1.5 billion since 1997 – to strengthen the health systems of developing countries.
- By working with our colleagues at the World Trade Organisation, the UK helped secure an agreement to enable those countries without pharmaceutical manufacturing capacity of their own to access cheaper medicines produced elsewhere.
- New tax incentives for research into HIV/AIDS vaccines were one of the results of the Prime Minister's working group on 'Access to Essential Medicines', which recommended an international commitment to differential pricing and increased research and development into diseases affecting poor people.

## What challenges remain?

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48. Despite the efforts of the international community, many challenges remain:

- Many countries are still not taking the epidemic sufficiently seriously. The challenge remains of getting effective high-level political commitment to tackle the epidemic.
- There is a global resource gap. UNAIDS estimate that developing countries will need \$10.5 billion in 2005 and \$15 billion by 2007, compared with current support of \$4.7 billion.
- Donor funding remains unpredictable and funds are not always disbursed as quickly as they need to be.
- The entry of so many new donors has created serious coordination difficulties for developing countries. At its worst, donors are refusing to coalesce around national plans and are demanding that countries prepare separate strategies. In some countries e.g. Mozambique, officials are spending up to a year in form filling, often to the detriment of other work. Not only is this unnecessarily bureaucratic, it is also leading to distorted priorities. In some countries it is fuelling government infighting. Worse still, some countries are still waiting for promised new funding to arrive.
- The poorest countries are not able to take advantage of the lower treatment prices because they do not have good enough health systems to administer the drugs. Where the drugs are available, there is not enough attention to ways to ensure they reach poor people and women.
- Much is still unknown about what interventions will have the greatest impact. Uncertainties include: how do we ensure equal access to services in the poorest countries and where there is little social protection for poor people? How can countries absorb substantial new flows of funds for HIV/AIDS and maintain other key services?
- People living with HIV/AIDS continue to suffer stigma and discrimination and few countries have begun to address the long-term impact on society that will threaten development efforts for decades to come.

# Call for action

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**49.** We believe that these many challenges can be met, but only with concerted action. This will need to involve the whole community – people living with HIV/AIDS, the private sector, academia, developing country governments, civil society organisations, and donor agencies.

**50.** The UK Government will continue to play a leading role, both bilaterally and internationally. We are increasing further our already large funding and we will work with developing countries to make sure our support has the greatest impact in the fight against HIV/AIDS.

**51.** We will make HIV/AIDS – and Africa – a centrepiece of our Presidencies in 2005 of both the G8 and EU. We will press the world community – through extra funding and increased focus – to achieve real progress towards the key international targets for HIV/AIDS, in particular:

- 25% fewer young people infected with HIV/AIDS by 2005.
- Three million people – two million in Africa – receiving treatment by the end of 2005.
- One national strategy, one national AIDS commission and one way to monitor and report progress in every country affected by HIV (the ‘Three ones’).
- On track to slow the progress of HIV/AIDS by 2015.

**52.** We remain committed to the UNGASS Declaration of Commitment on HIV/AIDS and we will set out specific objectives in the first part of 2004 for our G8 and EU Presidencies, around which we can galvanise support.

**53.** If we are to succeed in our ambitions, we need to step up our efforts immediately. During 2004 we will focus on the four challenges that we see as key to unlocking faster progress:

- Stronger political direction.
- Better funding.
- Better donor coordination.
- Better HIV/AIDS programmes.

## Stronger political direction

**54.** We will use the personal commitment of the Prime Minister, the UK’s position in international meetings and the influence of international experts to raise significantly the political profile of HIV/AIDS:

- The UK will work with the New Partnership for Africa’s Development (NEPAD) and the Africa Partners’ Forum to focus on HIV/AIDS.
- We will push for a special session on HIV/AIDS at the United Nations Security Council in early 2004.



In South Africa, a HIV-positive volunteer on antiretroviral therapy tells others about the virus.

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- We will engage directly with leaders, for example at the Commonwealth Heads of Government Meeting (CHOGM).

### Better funding

**55.** We will push harder for higher global spending and raise our own commitments:

- We will press for support for the International Financing Facility to meet the funding gap for HIV/AIDS and other Millennium Development Goals.
- We will continue to lead by example on our own funding for HIV/AIDS. It will be a priority for the extra £320 million being devoted to Africa by 2006.
- We will continue to work with the Global Fund for AIDS, TB and Malaria to enable it to disburse funds quickly and effectively.

### Better donor coordination

**56.** We will work with the rest of the international community – including other major funders – to make sure that countries receive seamless support:

- We will step up our coordination with the US and other donors starting in Ethiopia, Kenya, Nigeria, Uganda and Zambia.
- We will work with UNAIDS to strengthen co-ordination at country level and to establish an annual forum on donor coordination; the first meeting is planned in early 2004. We will be doubling the core funding of UNAIDS so that they are better able to play their convening role.
- We will work with the EU and UN to support their role in improving donor coordination.

### Better HIV/AIDS programmes

**57.** We will work with developing countries and other partners to determine what more can be done to strengthen health systems and AIDS programmes.

- We will produce a new UK Government strategy on AIDS next year. This will define how the whole Government will work with countries and the international system to establish a stronger response.
- The UK will produce a new policy document early in 2004 giving details of the increased emphasis we are giving to HIV treatment and care for poor people.

**58.** We would welcome views on all these issues – from developing countries, NGOs, the private sector, faith-based groups, and international agencies.

**59.** These will feed into the new UK strategy for HIV/AIDS in 2004, which will in turn help shape our plans for the UK G8 and EU Presidencies.

**60.** We are planning a series of consultation meetings over the coming months. We would also welcome direct feedback, which can be sent to **[AIDS@dfid.gov.uk](mailto:AIDS@dfid.gov.uk)**

The Department for International Development (DFID) is the UK Government department responsible for promoting sustainable development and reducing poverty. The central focus of the Government's policy, based on the 1997 and 2000 White Papers on International Development, is a commitment to the internationally agreed Millennium Development Goals, to be achieved by 2015. These seek to:

- Eradicate extreme poverty and hunger
- Achieve universal primary education
- Promote gender equality and empower women
- Reduce child mortality
- Improve maternal health
- Combat HIV/AIDS, malaria and other diseases
- Ensure environmental sustainability
- Develop a global partnership for development

DFID's assistance is concentrated in the poorest countries of sub-Saharan Africa and Asia, but also contributes to poverty reduction and sustainable development in middle-income countries, including those in Latin America and Eastern Europe.

DFID works in partnership with governments committed to the Millennium Development Goals, with civil society, the private sector and the research community. It also works with multilateral institutions, including the World Bank, United Nations agencies, and the European Commission.

DFID has headquarters in London and East Kilbride, offices in many developing countries, and staff based in British embassies and high commissions around the world.

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We would also welcome direct feedback,  
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12/03 6K Produced for DFID by Stairway Communications

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ISBN 1 86192 589 1