TOWARDS A DFID STRATEGY ON GLOBAL HEALTH

How the UK can maximise the effectiveness of its investments in global health and enhance its leadership in efforts to end the HIV and TB epidemics
'AS THE WORLD AGREES NEW, LAUDABLE HEALTH GOALS, NOW IS THE TIME FOR THE UK TO TURN UNPRECEDENTED RESPONSES TO THESE EPIDEMICS INTO AN EVEN MORE UNPRECEDENTED DRIVE TO END AIDS AS A PUBLIC HEALTH THREAT, AND SECURE EQUIVALENT TRANSFORMATIONS ACROSS GLOBAL HEALTH.'
My career has been defined by two of the most devastating diseases humanity has faced: HIV and Ebola. Although distinct, there are many unhappy similarities between the two. Both primarily affect poor countries with weak health systems. Both are characterised by high mortality rates, and stigmatised, unforgiving death.

But one happy parallel is the centrality of the British government and the British people to overcoming them: unprecedented devastation met with unprecedented action.

Through substantial investment in resources and the heroism of many the UK has helped to bring some normality back to Ebola-affected West Africa. DFID’s leadership as one of the world’s largest donors to the global AIDS response has transformed what once seemed like an unstoppable pandemic and cut deaths by a third in just eight years.

But the fight is far from over. The latest UNAIDS analysis, included in these pages, shows that significant hurdles still exist. To capitalise on an increasingly robust body of evidence showing that early HIV treatment both prevents new infections and leads to better individual outcomes, efforts will need to be redoubled. There is an urgent need to reinvigorate HIV prevention efforts, particularly among those at highest risk.

This STOPAIDS paper argues that a global health strategy incorporating and informed by the HIV response will deliver stronger health systems and improve all health outcomes. For example, we know that community-led HIV programs have been essential to reaching more people, more efficiently and effectively, especially in under-resourced areas. This decentralised approach should inform other programmes, from the further use of community healthcare workers, to the scale-up of community cancer screening.

The paper also shows that putting people at the centre of the AIDS response has been essential – and putting key populations and patients at the centre of the next global health push is imperative.

We can learn from what isn’t working, too. Second- and third-line ARVs remain expensive and out of reach all over the world. And for the most part, we’re still lacking paediatric formulations. These access problems are replicated across health, and must be addressed to ensure the availability of effective and affordable tuberculosis, cancer and diabetes treatment. The chronic neglect of HIV prevention, especially amongst key populations groups must be reversed. And the world must stand guard against success breeding complacency.

When I look back on my career, I see millions of lives lost, and millions more saved. The hard but significant lessons we’ve learned together over these decades must now be put into action. Scaling up and integrating programmes will take significant financial and human resources, and significant political and technical leadership. But that investment is the only way to make the response sustainable – and the only way to reduce long-term costs.

As the world agrees new, laudable health goals, now is the time for the UK to turn unprecedented responses to these epidemics into an even more unprecedented drive to end AIDS as a public health threat, and secure equivalent transformations across global health.

Professor Peter Piot  
Director, London School of Hygiene & Tropical Medicine
NOW IS THE RIGHT TIME FOR AN UMBRELLA DFID GLOBAL HEALTH STRATEGY THAT RESPONDS DIRECTLY TO THE UK’S ROLE IN DELIVERING THE HEALTH-RELATED ASPECTS OF THE SUSTAINABLE DEVELOPMENT GOALS, INCLUDING ELEVATED UK AMBITIONS FOR ITS ROLE IN THE RESPONSE TO THESE MAJOR KILLER DISEASES.
The start of the new UK government’s five year term coincides with the agreement of a new set of sustainable development goals that will shape the development trajectory until 2030. These milestones present a significant opportunity for us to reflect on and reframe the UK government’s approach to global health. ‘Towards a DFID Strategy on Global Health’ sets out STOPAIDS’ recommendations for how the UK can maximise the effectiveness of its investments in global health and enhance its leadership in efforts to end the HIV and tuberculosis (TB) epidemics.

The next five years are also a critical and short-lived window when global action can contain and reverse the trajectories of HIV and TB. Taken together, TB and HIV claim the lives of 2.6 million people each year, a burden that continues to undermine not only health systems but also economic growth and sustainable development more broadly. They also have continued relevance for the UK, where TB and HIV persist in our capital and other major cities.

The goal and targets of MDG 6 have not been met. But the global effort exerted over the past 15 years has brought us to a tipping point. The next five years have been described as a fragile window within which we can finally see long-awaited results bear fruit.

UNAIDS asserts that the ‘end of AIDS’ can be achieved through pursuing the ‘90-90-90’ goals. However these goals will only be achieved if increased funding and effective interventions are ‘fast-tracked’ over the next five years and if prevention and the needs of key affected populations are addressed.

WHO has likewise set out an ambitious plan to end the global TB epidemic, with targets to reduce TB deaths by 95% and cut new cases by 90% between 2015 and 2035. Achieving this strategy will require the launch of new tools by 2025, necessitating significant increase of investments in research and development now.

This is therefore a crucial moment for DFID to identify the political leadership, technical capacity and volume of financing it will dedicate over the next five years to contribute to these ambitions. We can complete the work on HIV and TB and apply the lessons learned to accelerate improvements in the health of women and girls, men and boys. Now is the right time for an umbrella DFID global health strategy that responds directly to the UK’s role in delivering the health-related aspects of the sustainable development goals, including elevated UK ambitions for its role in the response to these major killer diseases.
THIS PAPER OFFERS A VISION OF A NEW DFID GLOBAL HEALTH STRATEGY THAT WOULD REALISE CONSERVATIVE MANIFESTO PLEDGES ON GLOBAL HEALTH AND WOMEN AND GIRLS TO LEVERAGE RESULTS FOR HIV AND TB.
This paper makes the case for a DFID strategy on global health and explores how, within this strategy, the UK can articulate a continued leading role for itself in the global responses to the global HIV and TB epidemics.

As a network of 80 UK agencies working since 1986 to secure an effective global response to HIV and AIDS and long-standing partner to DFID, STOPAIDS draws on its members’ extensive experience to suggest a revised approach to HIV and TB within a global health strategy. The development of this paper has been timed to coincide with the formation of the new government following the 2015 general election and the agreement of new global sustainable development goals.

DFID continues to spend the majority of its aid on health. The UK’s record on supporting countries to achieve the health MDGs has been substantial – the 2013 pledge of £1bn to the Global Fund a shining example – and has continued to grow in alignment with the Government’s commitment to dedicating 0.7% of GDP toward official development assistance (ODA), a provision which was enshrined in law on 26th March 2015. Securing maximum return on investment and value for money for this investment rests upon having a strategic approach which harnesses synergies and increases efficiency to deliver greater impact across all of DFID’s health programming.

‘Towards a DFID Strategy on Global Health’ offers a vision of a new DFID global health strategy that would realise Conservative Manifesto pledges on global health and women and girls to leverage results for HIV and TB. The paper outlines clearly the time-bound opportunity and commitment needed in order to achieve the goals of ending the AIDS and TB epidemics by 2030 and is intended to serve as a resource that DFID can draw upon in deciding how to identify and structure its priorities around HIV, TB and broader health.

In this paper, evidence is provided to show:

- how goals on HIV and TB could be achieved
- how HIV and TB could be integrated into DFID’s broader health, development and human rights priorities
- how lessons learned from the AIDS response can bring greater efficiency and effectiveness to other health and development interventions; and
- where agendas pursued by other departments of Government might be rationalised to support DFID-led action on HIV and TB.

The development of this paper was funded by the CAF Advocacy for Development Fund. A qualitative health policy research methodology was taken through data collection, including two half-day workshops attended by participants across the STOPAIDS network in March and April 2015, and semi structured interviews with key informants, including from within DFID; and data analysis through document review of DFID policy documents, UN publications, peer reviewed literature and reports produced by members of STOPAIDS. A Steering Group was appointed to guide and review the work as documented in the Appendix along with a list of key informants.
This is a crucial year for international development as the world is set to agree new global poverty targets, including a standalone goal on women and girls that will guide action for years to come. I will ensure the UK remains at the forefront of this work to create a better world for us all.
From many standpoints – nationally, internationally, strategically and scientifically – an over-arching strategy on global health from now until 2020 makes good sense. In September 2015, a new set of global Sustainable Development Goals will be agreed that will include a strong outcome-focused health goal and health-related targets in other goals. This new framework will structure the worldwide approach to international development for the next 15 years.

For the new UK Government, the central importance of tackling global health and infectious diseases is clearly acknowledged in the Conservative Manifesto as part of a renewed commitment to international development. Ebola is mentioned as an example of how emerging infectious disease can present a ‘serious threat’ to Britain, a major emergency for a developing country and put the stability of countries at risk. The goal of eliminating the world’s deadliest diseases – which clearly includes TB and HIV – is set and with it the commitment to accelerate the development of the tools needed to achieve it.

**Why a framework for results on global health?**

Only a strategy with the same status as a Framework for Results will be sufficient as DFID enters into a critical five year period in the field of global health.

**A Framework for Results on Health will:**

- Deliver synergies that will increase the impact of DFID’s work across global health, improving outcomes and securing better value for money for UK investment targeting women and girls and other priority areas
- Reflect and articulate the priority that DFID places on global health in terms of both ODA and policy leadership
- Set out the UK response to and role in delivering the health SDG within the new post 2015 agenda
- Prepare the way for high level meetings and replenishment conferences on HIV and TB in 2016
- Deliver the Conservative Manifesto pledges on global health and gather together its stated priorities under one umbrella
- Carry forward lessons learned from the UK investment in HIV and TB over several decades into new areas of health concern
- Enable a cross-Whitehall approach to deliver better value for money and greater consistency
Coalition government positions and frameworks on global health

During the course of the previous Coalition Government, DFID developed Frameworks for Results on Malaria and on Reproductive, Maternal and Newborn Health (RMNH), Position Papers on HIV, Hunger and Nutrition, and Water and Sanitation, and a Health Position Paper summarising many of these policy aims. The timelines for these frameworks and papers are now expiring.

The Framework for Results (FfR) on Malaria and Framework for Results (FfR) on RMNH detailed DFID commitments to accelerate progress on certain health concerns and demonstrated an enhanced focus on achieving results by supporting health interventions that have strong evidence of effectiveness, including cost effectiveness, and that demonstrate value for money. The FfR on Malaria specifically was the result of the commitment to address Malaria within the Conservative Party 2010 Manifesto and is the first comprehensive UK policy statement on addressing malaria as a health and development challenge. A Mid Term Review (MTR) of both FfRs undertaken in 2013 showed significant investment in line with these commitments. However, the FfR on RMNH did not allow for sufficient synergies with efforts to address the impact of HIV on women and girls.

DFID’s Health Position Paper was published in 2013. As the paper itself makes clear, this was not a full strategy.
DFID’s current *HIV Position Paper* which was published in advance of the 2011 UN High Level Meeting on HIV also concludes this year. The paper prioritised interventions that built upon DFID’s previous record in the response to HIV: to significantly reduce new HIV infections; to scale up access to HIV diagnosis, treatment, care and support; and to significantly reduce HIV related stigma and discrimination. Performance on these stated goals was presented in a 2013 review *Towards Zero Infections – Two Years On: A Review of the UK’s Position Paper on HIV in the developing world*. STOPAIDS worked closely with DFID on the review of the *HIV Position Paper* and welcomed an update of its priorities, which placed a new focus on supporting key affected populations, tackling HIV among women and girls and integrating the HIV-response within sexual and reproductive health and rights (SRH), TB and wider health system strengthening, as well as with other development priorities. STOPAIDS argued however that the lack of a baseline or a theory of change made achievements against these priorities difficult to establish.

DFID’s Health Position Paper was published in 2013. As the paper itself makes clear, this was not a full strategy and not a reflection of the whole of the UK Government’s health interventions in developing countries.

DFID’s *Health Position Paper* also stated the intention to focus on overcoming multiple health systems challenges in low income countries such as: lack of medicines and health supplies; inequitable distribution of health infrastructure, services and trained health workers; low incentives and accountability mechanisms to deliver quality health services to the poorest and most marginalised; and insufficient investment in the social, economic and environmental determinants of health.

While it referenced the importance of HIV and TB service integration and access to medicines, it did not include HIV or TB within the seven health outcome targets that UK aid was being used to achieve between 2010 and 2015. This was despite the underscoring of DFID’s approach to “targeted implementation of cost-effective interventions”, citing the Disease Control Priorities Project that lists addressing HIV in the top 10 “best buys for global health”.

**Policy opportunities in 2015 and beyond**

A new DFID global heath strategy would articulate UK global health priorities for key global policy processes and for the term of the current government 2015 to 2020. A new strategy would be perfectly timed to respond directly to the Sustainable Development Goals (SDGs) that will be finalised and agreed in September 2015 by UN member states. These global goals will guide the work of development partners towards ensuring healthy lives and promoting wellbeing for all at all ages.

The Conservative Manifesto stated the intention for this Government to push for the global goals to eradicate extreme poverty by 2030 and promote
human development, gender equality and good governance. While health is not a stated priority for the UK’s work to influence the final set of SDGs, it is hoped that the health goal will be a priority in the UK government’s implementation thereof.

The SDGs include an outcome-focused health goal (Goal 3) that aspires to “ensure healthy lives and promote well-being for all at all ages.” Goal 3 has nine targets including: achieving Universal Health Coverage, ending the AIDS and TB epidemics by 2030 and securing universal access to sexual and reproductive health care services by 2030. There are also a range of important synergies with other goals that can support interventions on HIV, TB and broader health and create new opportunities for development partners to join up investment. Relevant goals include:

- **Goal 1**: End poverty in all its forms everywhere
- **Goal 2**: End hunger, achieve food security and improved nutrition and promote sustainable agriculture
- **Goal 4**: Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all
- **Goal 5**: Achieve gender equality and empower all women and girls
- **Goal 6**: Ensure availability and sustainable management of water and sanitation for all
- **Goal 10**: Reduce inequality within and among countries
- **Goal 17**: Strengthen the means of implementation and revitalize the global partnership for sustainable development

Universal Health Coverage (UHC) is a bold new target aiming to ensure equitable coverage of health care for all, including financial risk protection and universal access to quality services and safe, effective and affordable essential medicines and vaccines. The International HIV/AIDS Alliance is calling for action to ensure that the UHC targets and indicators address the needs of key populations most at risk of HIV, including positive language on eliminating punitive and discriminatory laws, policies and practices, and to make sure that marginalised groups are included in the accompanying monitoring and accountability mechanisms.

A DFID global health strategy would articulate the UK government contribution to achieving all health related goals and targets. Specifically in relation to HIV, a strategy would also identify how the UK government would contribute to the broader set of priorities identified in key multilateral strategies that are being completed in 2015. These include the new UNAIDS strategy 2016–2021 (to be finalised in October), the revised strategy of the Global Fund to Fight AIDS, TB and Malaria 2016–2021 (to be finalised in November) and the WHO HIV strategy 2016–2021 (to be finalised in May 2016). All of these multilateral strategies emphasise that front-loading investment is necessary to support countries to aspire toward bold ambitions to end the HIV and TB epidemics.
Most compelling is the alignment of the five year term of this government and the window UNAIDS has set out in its Fast Track strategy up to 2020 when we can build on investments to date and utilise the newest tools and most efficient programmatic design to secure a truly sustainable response to the AIDS epidemic – one that will result in dramatic declines in infections, deaths and required external investment over the subsequent decades. The next five years will determine whether we do or don’t end AIDS and TB.

A DFID global health strategy that has a focus on HIV and TB would make clear the UK contribution toward the ambition of these internationally agreed strategies. It would also support UK engagement in upcoming global health policy processes and opportunities, such as the 2016 UN High Level Meeting on HIV and the next replenishment of the Global Fund, at which the UK could demonstrate its commitment and leadership with an increased financial contribution.

The call for DFID to publish a new global health strategy in 2015 is supported by a broad base of health and human rights advocates. Action for Global Health, a coalition of over 30 health and development organisations, has urged DFID to “show the priority it attaches to health by developing a strategy for global health that builds on its existing health policy paper and places DFID’s proposed health systems strengthening framework at its centre…clearly demonstrate how it will deliver towards the health related sustainable development goals.”

STOPAIDS supports these recommendations and asserts that the development of a revised strategy can serve as an opportunity for the UK to renew and elevate DFID’s response to HIV and TB, and deliver better value for money and greater impact with its commitments to other global health challenges and towards the pursuit of strengthening health systems.
WE WILL LEAD A MAJOR NEW GLOBAL PROGRAMME TO ACCELERATE THE DEVELOPMENT OF VACCINES AND DRUGS TO ELIMINATE THE WORLD’S DEADLIEST INFECTIOUS DISEASES, WHILE INVESTING TO SAVE LIVES FROM MALARIA AND WORKING TO END PREVENTABLE CHILD AND MATERNAL DEATHS.
We have a historic opportunity to end AIDS, TB and malaria as public health threats by 2030.

STOPAIDS calls for concrete UK Government commitment to approach HIV and TB both as significant unmet health challenges and as barriers to broader development. In terms of targeting efforts to need, DFID calculated in 2013 that HIV accounts for 77% of the global DALYS in their 28 focus countries.\(^6\) The burden of these two epidemics on low and middle income countries continues to be substantial and both are leading killers of women of reproductive age. DFID’s continued robust multilateral aid to HIV and TB accompanied by bilateral programmes where the burden of disease is high, will ensure that the epidemics do not remain entrenched in these settings.

Targeting HIV and TB also makes sound economic sense in an era of financial constraint. As acknowledged by DFID in its *Health Position Paper*, the prevention and treatment of HIV and TB are also among the top ten most cost-effective ways to improve global health as a whole.\(^7\)

**HIV**

Despite recent rhetoric about the end of AIDS, HIV remains a global public health threat and a health emergency for young women in low and middle income countries, especially sub-Saharan Africa.

Globally, deaths related to AIDS are the sixth leading cause of death,\(^8\) the leading cause of death of women age 15–49,\(^9\) and the second largest cause of death of adolescents.\(^10\) 35 million people are now living with HIV\(^11\) worldwide, a record high. This is both a marker of failure and achievement: the number of AIDS related deaths has reduced substantially as a record number of people have been accessing antiretroviral therapy (ART) but high numbers are also continuing to be infected.\(^12\) Children are roughly only half as likely as adults to obtain antiretroviral therapy when needed. Even as AIDS-related deaths decline overall, HIV-related mortality among adolescents has increased by 50% since 2005.\(^13\)
UNAIDS has also highlighted the burden of HIV faced by key populations most affected by the disease, men who have sex with men, people who inject drugs, sex workers and transgender people, which is compounded by punitive legal environments and human rights abuses that impede their access to HIV prevention and treatment services.

The burden of HIV on women and girls

Every hour, 50 young women are newly infected with HIV.

AIDS is the leading cause of death globally among women of reproductive age and of adolescent girls in Africa, despite the availability of treatment. In low- and middle-income countries, young women account for 24% of all new HIV infections among adults, 50% more than young men of the same age group. Young women aged 15–24 continue to be the hardest hit by new HIV acquisition in all regions of the world, including where overall prevalence is decreasing. In 2013, 64% of new adolescent infections globally were among young women, and throughout the world, HIV prevalence is substantially higher among women in key populations, compared with the general population.

A combination of biological and socio-economic factors combine to place the highest burden on young women and girls. Gender inequality, gender based violence and denial of their social, political, economic and reproductive rights all place them at higher risk, while current methods of HIV prevention – such as the male condom – are of little use.
The need for continued commitment to HIV and TB

The HIV ‘tipping point’

The UK has played a leading role in the concerted efforts on the indicators of MDG 6 to combat HIV, TB, Malaria and other diseases by countries and their development partners. As a result, the number of people who are newly infected with HIV is declining in most parts of the world. However UNAIDS has warned that if the world does not rapidly scale up in the next five years, the epidemic is likely to spring back with a higher rate of new HIV infections than today.

More recently, scientific breakthroughs have provided hope that a ‘tipping point’ in the HIV epidemic could be reached where the number of HIV positive people commencing ART can outpace new HIV infections. HIV incidence has been shown to decrease through Voluntary Medical Male Circumcision programming and several trials have now demonstrated the efficacy of daily oral PrEP. Several other ARV-based prevention options are in the pipeline and despite mixed results of vaginal microbicides trials to date there is expectation that more long-acting candidate products may demonstrate greater impact to be considered for programming at scale.

The START trial results have powerful implications for the design of the HIV response. It has now been clearly proven that early treatment initiation is beneficial for both treatment and prevention, and for personal and public health. Immediate treatment for all people living with HIV has the potential to drastically lower burdens on health systems and government budgets in the long term. The majority of the 1.7 million annual AIDS-related deaths are concentrated among people at their most productive working ages resulting in severe economic implications. Conversely, investments tackling HIV not only save lives and have a proven impact on household income, they also pay for themselves within a decade through increased economic productivity and averted future costs.

Research has shown for example that on average, HIV-positive patients stay in hospital four times longer than other patients. In Nigeria, private healthcare costs and income losses of people living with HIV in Nigeria equated to approximately 56% of annual income per capita. Four years after the initiation of antiretroviral therapy amongst South Africans living with HIV, employment among people living with HIV had recovered to about 90% of baseline rates observed in the same individuals three to five years before they started treatment. A similar study in India showed significant increases in employment and income following commencement of ART.

The combined potential of the breakthroughs in new HIV prevention technologies, the benefits of ‘Treatment as Prevention’ and combination prevention have all raised hope that HIV incidence could decrease significantly to a point where it is no longer an epidemic. In the meantime however, there remains a high burden of disease and complex structural drivers of vulnerability that will continue to require the scale up of existing targeted interventions if we are to achieve the health equity
The need for continued commitment to HIV and TB being envisioned within the SDGs. Indeed, the focus on the non-biomedical interventions critical to an effective response – and within which the UK has been a leading voice for action – has been reduced as DFID’s visibility in HIV policy discussions has reduced. Part of ending the epidemic, and a rationale for a health strategy, must be active implementation of the improved understanding gained from research such as STRIVE, which *inter alia* unpacks the relationship between violence against women and HIV.16

The UNAIDS’ Gap Report poses the most sobering challenges:17

- Fifteen countries’ (nine of which are DFID focus countries) account for nearly 75% of all people living with HIV. Ensuring that people living with HIV in these countries have access to HIV treatment services is especially critical.
- A largely overlapping set of fifteen countries** (seven of which are DFID focus countries) accounted for more than 75% of the 2.1 million new HIV infections that occurred in 2013.
- Three out of every four children living with HIV are not receiving HIV treatment.
- In sub-Saharan Africa, only eight male condoms were available per year for each sexually active individual. Among young people, condom access was even less.

* Ethiopia, Kenya, Malawi, Mozambique, Nigeria, Tanzania, Uganda, Zambia, Zimbabwe, South Africa, India, China, Russia, Brazil, the United States. The first nine of these are currently DFID focus countries.

** Kenya, Mozambique, Nigeria, Tanzania, Uganda, Zambia, Zimbabwe, China, South Africa, India, the United States, Russia, Indonesia, Cameroon, Brazil. The first seven of these are DFID focus countries.
Despite recent progress, UNAIDS cautions that without scale-up of the response to HIV, the epidemic will continue to outpace us, increasing the long-term need for HIV treatment and thus increasing future costs. Projecting forward based on current funding, the future financial obligation for HIV has been estimated to exceed $250 billion in sub-Saharan Africa alone and will create a huge debt. Beyond the moral obligation, there is also a cold financial imperative to avert these future costs by acting now.

**Tuberculosis (TB)**

Recent increases in the number of TB cases found by new prevalence surveys indicate that TB mortality could be at least as big a killer as HIV. Over 95% of TB deaths occur in low- and middle-income countries, and it is among the top five causes of death for women of reproductive age. Most deaths from TB are completely preventable and as with HIV, progress is being made. It is estimated that 37 million lives were saved between 2000 and 2013 through effective treatment and diagnosis.

TB is a leading killer of people living with HIV, causing one quarter of all AIDS-related deaths. The WHO Global TB Report outlined the ongoing challenges in the prevention and treatment of tuberculosis and the dynamics of disease where there are twin epidemics of HIV and TB:

- An estimated 1.1 million (13%) of the 9 million people who developed TB in 2013 were HIV-positive.
- The African region accounts for about four out of every five HIV-positive TB cases and TB deaths among people who were HIV positive.
- In 2013, an estimated 510,000 women died as a result of TB, more than one third of whom were HIV-positive.
- In 2013, only about 64% of the estimated 9 million people who developed TB were diagnosed cases. Therefore about 3 million cases were either not diagnosed, or diagnosed but not reported to national TB programmes. Major efforts are needed to close this gap.

The emergence of multi-drug resistant TB is a major concern. There were 480,000 new cases of MDR TB in 2013 (WHO 2014).

- Globally, 3.5% of new and 20.5% of previously treated TB cases were estimated to have had MDR-TB in 2013.
- On average, an estimated 9% of patients with MDR-TB had extensively drug resistant TB (XDR-TB).
- If all notified TB patients had been tested for drug resistance in 2013, an estimated 300 000 cases of MDR-TB would have been detected.

Acting now could eliminate the disease within a generation. However, if we allow drug-resistance to take hold, TB could claim millions of lives a year deep into the next century. Experts have estimated that by 2050, an additional 2.59 million people will die every year from drug-resistant strains of TB at a cost of US$16.7 trillion to the world’s economy (equivalent to the GDP of the entire EU for the year 2013).
UK historical leadership on HIV and TB

The UK has been a global champion for global health and the fight against HIV, TB and malaria. A global health strategy would reflect the high priority that DFID places on global health, its technical expertise and the comparative advantage it holds in this area.

DFID has long been the second largest donor to the global HIV response among OECD DAC members. A significant part of UK ODA is delivered through the UK’s contribution to the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). In September 2013 the Secretary of State for International Development announced that the UK would contribute up to £1 billion (US$1.5 billion) to the Global Fund for 2014-2016, or £333 million per year, the second-largest pledge by any government to the Global Fund’s replenishment. DFID tied their pledge to 10% of the total amount raised through the replenishment process in order to encourage other donors to give more. This incentive to other donors is no longer relevant and we call on the government to release the full £1bn during this replenishment window. DFID’s bilateral spending on HIV in FY 2013/2014 was 0.9% (approximately £49 million) of £5,453 million spent across all other development sectors.

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being. We are therefore strongly committed to continuing our engagement in this field with a specific focus on strengthening health systems through bilateral programmes and multilateral structures.

G7 Summit Declaration, 2015
The Department for International Development (DFID) supports HIV prevention, treatment and care through a variety of bilateral channels including projects and programmes at the country level; strengthening health systems in our partner countries to deliver better HIV outcomes; civil society grants; and funding research. We also provide support through multilateral channels including: projects and programmes at the country level; strengthening health systems in our partner countries to deliver better HIV outcomes; civil society grants; and funding research. We also provide support through multilateral channels including: projects and programmes at the country level; strengthening health systems in our partner countries to deliver better HIV outcomes; civil society grants; and funding research.

The need for continued commitment to HIV and TB

The review of DFID’s HIV Position Paper noted that UK bilateral funding for HIV decreased by £75 million from 2009-2013 as the number of countries receiving ODA decreased. The decrease is related to the outcome of DFID’s 2011 bilateral aid review resulting in a decision to focus on fewer countries, particularly those with the lowest GDP. DFID also reported in the HIV Position Paper Review that spending on reproductive health and family planning, which has impacts on HIV outcomes, increased by about £70 million over 2009-2013.

Whilst DFID’s investment in multilaterals like the Global Fund and UNITAID is highly valued and respected, the decline in bilateral spending is a concern. Part of DFID’s historic leadership – leadership that has positively shaped the global response – has come from its pioneering bilateral programmatic work. The next 15 years needs the impact and the lessons learnt from high quality DFID HIV and TB programming.

DFID was an early and robust funder of new HIV prevention technologies including vaccines and microbicides. The graph below illustrates that funding trends for HIV prevention R&D have been on the downturn following earlier peak financing.
The need for continued commitment to HIV and TB

Trends in DFID HIV Prevention Research Funding 2006–2013

Spending on TB

DFID’s ODA for TB control is mainly multilateral and channelled primarily through the Global Fund and UNITAID. Bilateral ODA for TB control has not been reported in DFID’s Annual Report and Accounts for several years including 2012-2013, although DFID’s reply to a Parliamentary Question accounted for £12.7 million “direct bilateral spend” on TB in 2012-2013.\(^\text{10}\)

RESULTS UK’s tracking of DFID’s bilateral spend on TB shows that country level programmatic investments in TB amount to only an estimated £2.2 million for the last two financial years.\(^\text{11}\)

DFID Bilateral ODA to TB FY13/14 and FY14/15

<table>
<thead>
<tr>
<th>Recipient</th>
<th>FY 13/14</th>
<th>FY 14/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global TB Alliance</td>
<td>£6,000,000</td>
<td>£8,000,000</td>
</tr>
<tr>
<td>Aeras Global TB Vaccine Initiative</td>
<td>£3,300,000</td>
<td>£1,900,000</td>
</tr>
<tr>
<td>The Three Millennium Development Goal Fund for addressing essential maternal and child health needs of poor and vulnerable women, children and for people with HIV, Tuberculosis and Malaria in Burma</td>
<td>£1,205,400</td>
<td>£1,553,280</td>
</tr>
<tr>
<td>Reducing Tuberculosis and HIV in Mining Communities of Southern Africa</td>
<td>£1,000,000</td>
<td>–</td>
</tr>
<tr>
<td>Support for Conflict Affected People and Peacebuilding (Burma)</td>
<td>£507,204</td>
<td>£461,716</td>
</tr>
<tr>
<td>WHO Core Voluntary Contributions (TB) (2011–2015)</td>
<td>£450,000</td>
<td>£900,000</td>
</tr>
<tr>
<td>Harnessing Non-State Actors for Better Health for the Poor (HANSHEP)</td>
<td>£335,952</td>
<td>£251,268</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£12,798,556</strong></td>
<td><strong>£13,066,264</strong></td>
</tr>
</tbody>
</table>
DFID has been a major funder of TB R&D increasing funding from 2007 and reaching a peak in 2010 with a recovery of volume by 2013.\textsuperscript{32}

DFID has been urged to shift the balance of its research spending towards enhancing R&D capacity and capitalise on DFID’s record in supporting research, particularly into new tools which are least likely to be developed in the private sector, and return its spending on health R&D to the levels of FY 2012/2013, at 33\% of the total R&D budget.\textsuperscript{53}

The need for long term sustainable financing for HIV and TB

The decisions that are made in the next 6–12 months about the direction of global HIV-TB financing by global bilateral and multilateral donors will determine whether the opportunity of ending the HIV and TB epidemics by 2030 will be realised or not.

It is a crucial moment to identify what DFID’s technical capacity and political leadership will be over the next five years to contribute to these ambitions. The following chapters reflect on how DFID could reassert its commitment to end AIDS and TB through its health and development priorities as well as suggest where enhanced cross Whitehall policy coherence could support DFID actions.

Projections show that if the world accelerates the fight against HIV over the next 15 years, 21 million lives can be saved.\textsuperscript{54} However, UNAIDS has argued that these goals will only be achieved if the right funding and interventions are ‘Fast-Tracker’ over the next five years to 2020.\textsuperscript{55}

The post-2015 Global TB Strategy by WHO sets out an ambitious plan to end the global TB epidemic, setting targets to reduce TB deaths by 95\% and cut new cases by 90\% between 2015 and 2035.\textsuperscript{56} Achieving this strategy will require the launch of new tools in 2025 necessitating a significant increase of investments in R&D. The Treatment Action Group has found major shortfalls in funding TB research: of the US$9.8 billion in funding called for to support basic science, diagnostics, drugs, vaccines, and operational research between 2011 and 2015 only US$1.99 billion had been invested by the end of 2013.\textsuperscript{57}

Health economists assess that “the magnitude of the conflict between current commitment levels and long term fiscal liabilities (on HIV) is
There is a need for a reinvigorated response and sustainable, long term commitments to ending AIDS, including through ODA and multilaterals, innovative funding mechanisms and increasing synergies with health systems strengthening.

**ODA Allocations**

Following the global economic crisis in 2007–2008, some donors have cut allocations of official development assistance (ODA) to HIV and TB due to budgetary austerity. According to analysis undertaken for Countdown to 2015, donor funding from all OECD DAC donors to family planning, sexual health, and sexually transmitted infections including HIV, was USD 4.7 billion in 2011 (up from USD 3.8 billion in 2010, an increase of 22.8%), but decreased in 2012 to USD 4.5 billion (down by 3.7% relative to 2011). However, it must be recognised that implementation of austerity measures in a donor country did not always mean a reduction in ODA – the UK actually increased its total ODA spend in this period to meet the target of 0.7% of GNI by 2014.

While an increased overall donor ODA spend critical, it is actually becoming a smaller percentage of overall funding due to increasing domestic funding by low and middle income countries. Many countries have been moving from low income to middle income status and have therefore been in a position to fund more of their HIV responses. In 2013, global domestic HIV spending was higher than ODA funding for HIV for the first time and this trend is set to continue.

Health economists also suggest that the existing resources could go a lot further. An estimated 20%–40% of resources dedicated to health are wasted. Improvements in efficiency could be achieved through re-examination and justification of the costs of services to help decrease the drain on domestic budgets.

However, even with increasing domestic budgets and greater efficiencies, low income countries and most lower middle income countries with a high disease burden are just not in an economic position to increase domestic funding sufficiently to fund their own disease responses. Significant ODA funding for low and lower middle income countries is therefore critical, particularly for expensive items such as key commodities and health infrastructure.

Over the last five years DFID has used the above rationale to focus their bilateral aid on low income countries and pull out of middle income countries. It has reduced its number of bilateral HIV programmes significantly with only one remaining HIV programme in Asia. The UK and other key donors have also influenced the Global Fund Board to ensure that access to Global Fund resources would be aligned to countries’ economic status and that middle income countries at a certain GDP would lose their eligibility for Global Fund grants.

However, there have been concerns about the speed of the funding withdrawals and the sustainability of the national HIV and TB responses.
particularly in middle income and upper middle income countries with a high disease burden (such as South Africa, Nigeria and India) and those with a concentrated epidemic in specific marginalised key populations (such as Vietnam). While these countries can often afford to fund their HIV responses, many of them do not have the political will to prioritise sufficient domestic resources to health and/or to the groups most affected by HIV, particularly key populations. Therefore, the challenge for donor governments is to push these countries to take full responsibility for a comprehensive HIV response without abandoning the poorest and most marginalised to disease and death by pulling out funding too quickly.

There have been a few global initiatives that have sought to solve some of these challenges:

GAVI, The Global Fund, UNAIDS, UNICEF, UNDP, UNITAID, WHO and the World Bank are currently convening the Equitable Access Initiative to identify and agree possible additions or replacements for GDP in decision-making on development allocations. Their goal is to obtain a more accurate picture of health realities on the ground in order to help donors be more responsive to countries as they transition.

Last year the Global Fund convened the Development Continuum Working Group, drawing together key global stakeholders to ‘establish key facts about development in countries across the world and the changing development landscape’. It did so in order to ‘provide recommendations to the Global Fund Secretariat on how to improve the strategic impact and effectiveness of the Global Fund’s engagement with countries across the development continuum’ by addressing differentiation, transition of countries, sustainability and equity. The final report of the group proposed that the Global Fund evolve its assessments about the funding and interventions. It suggested a broader set of criteria for decision making than just GDP and disease burden, including: disease burden; relevant policies; governance, leadership and management; financial resources; institutional capacity, national systems and human resources; and systems for accountability and managing risks.65 It also proposed an increased focus on sustainability planning in all Global Fund grants and a broader set of interventions that would ensure responsible transitions for countries that are ‘graduating’ from Global Fund support so that critical gains made on the three diseases are not lost. Key focus areas identified were on the critical role of and support for civil society and advocacy to hold governments to account for delivering a comprehensive HIV and TB response.
INTEGRATIVE PROCESSES ARE NECESSARY FOR DELIVERING AND ASSESSING VALUE IN GLOBAL HEALTH. 66
CHAPTER 3

OPPORTUNITIES TO ADDRESS HIV AND TB WITHIN GLOBAL HEALTH

There are valuable lessons to be learnt from the responses to HIV and TB which can inform future strategy on global health. This chapter sets out examples of how to integrate them into broader health, development and human rights priorities.

Much has been learned through the delivery of HIV and TB services that have implications for scaling up toward the provision of Universal Health Coverage. It is vital that these lessons are captured, both to benefit the HIV and TB response and to inform and strengthen our approach to global health more generally.

The HIV response, in recognising that properly functioning, robust national health systems are critical to its success, has impacted positively on both national and local level health systems and supported progress towards other health goals. It has also played a key role in helping to decrease stigma of marginalised populations.

STOPAIDS’ 2012 publication Positive Gains: Promoting Greater Impact on Health Through HIV and AIDS Programming presented evidence from implementing partners active in the network of the benefits of HIV programming on all the key building blocks of health systems, including: health service delivery in terms of access, particularly for marginalised communities; quality of care and infrastructure contributions; access to medicines; health workforce approaches including task shifting; health information systems and the crucial role of communities including the advocacy of people living with HIV, peer education and community systems. For many of these benefits to accrue for broader health systems, bi-directional integration of HIV initiatives with other health services should be pursued where feasible.
**Integrating HIV and TB in health services**

In response to increasing rates of TB-HIV co-infection and as more has been learned about the dual infection, the World Health Organisation (WHO) has developed a list of 12 policy recommendations, or collaborative activities, that seek to improve health services and health outcomes for people with and at risk of TB-HIV co-infection. These activities have been recognised as essential for improving diagnosis, treatment, and outcomes for people affected by both diseases.

This recognition has been affirmed in Khayelitsha, a township outside of Cape Town, South Africa, where Médecins Sans Frontières (MSF) has been working with the Department of Health to scale-up TB-HIV integration. As a result of these efforts, Khayelitsha has seen decreasing rates of both illness and death among people living with HIV. The capacity of health care professionals, particularly nurses, has also been improved with reports of enhanced skills in managing the two diseases. In Swaziland, where 74% of people living with HIV also have TB, there are similar success stories. In the Shiselweni Region of Swaziland, the decentralisation of integrated TB-HIV services has resulted in an increasing number of people on ART treatment as well as sharp reduction in TB cases each year.

DFID’s *Health Position Paper* cites the importance of integrating HIV and TB services through “investment in strengthening collaborative TB-HIV control programmes through multilateral support and a number of bilateral country programmes.” A good example of this integrated approach was DFID’s assistance to the Government of South Africa to provide TB-HIV control through their public health system. South Africa is struggling to cope with a dual HIV-TB epidemic although the country has been demonstrating leadership in addressing the issue and has integrated TB and HIV into a single National Strategic Plan that included all 12 TB-HIV collaborative activities. DFID has however now ceased technical assistance and allocation of ODA to South Africa.

Despite DFID’s health policies committing to achieving integrated TB and HIV services there is limited evidence that bilateral programmes are standardising the collaborative HIV-TB approaches recommended by WHO. RESULTS UK has urged DFID to “conduct a thorough review of health programmes in countries with high TB-HIV burdens, and ensure TB-HIV collaborative activities are being systematically financed, implemented and evaluated.”

**Integration of HIV and SRH services**

The integration of HIV and sexual and reproductive health (SRH) services has gained momentum for over a decade and DFID was actively involved in the Interagency Working Group on SRH and HIV Linkages. Integrated HIV and SRH services have been shown to be cost-efficient, cost-effective.
and have high levels of acceptability among female and male patients and health care providers. DFID asserts that its increased funding of sexual and reproductive health can achieve outcomes for HIV, particularly where integrated SRH and HIV services are pursued. DFID’s Framework for Results on RMNH aimed for bilateral programmes to increase “coverage and integration of health services that provide high impact, cost effective interventions for family planning, safe abortion, antenatal care, safe birth, emergency obstetric care, postnatal care, newborn care, with PMTCT, HIV prevention, nutrition, malaria, water, sanitation and hygiene.”

STOPAIDS welcomes the increase in spending on SRH but argue that DFID should not subsume HIV within SRH, a perception which was reinforced by the change of the name of DFID’s AIDS and Reproductive Health Team to the Sexual and Reproductive Health and Rights (SRHR) Team. Such a move potentially excludes HIV prevention-interventions, such as drug-related harm reduction, and HIV care and support interventions tailored to non-sexually active people, and/or who fall outside of the reproductive age bracket, including children and older people. An over integration of HIV into SRHR will obscure the need to focus upon prevention interventions for HIV that fall outside of SRHR as well as the structural and legal barriers to effective programming which key affected populations face.

The Integra Initiative, a five year research project conducted by the International Planned Parenthood Federation (IPPF) with the London School of Hygiene and Tropical Medicine and Population Council, found that integrating family planning into HIV care and treatment was associated with a higher proportion of women, including women living with HIV, using more effective contraception. The findings showed that people with greater exposure to integrated facilities had better rates of using HIV counselling and testing services whereas people with less exposure to integrated facilities had less consistent condom use. This implies that better integrated services do lead to a reduction in HIV-risk behaviour. Many people living with HIV preferred to receive family planning and other SRH services in an ‘HIV only’ environment showing the importance of bi-directional integration.

The Integra findings also showed integrated services have the capacity to reduce HIV related stigma if they can ensure client confidentiality, which is also a key concern for VSO who are working to ensuring young people’s access to SRH-HIV services. The International HIV/AIDS Alliance’s Link Up project is undergoing its mid-term review and is soon to publish evidence of insights gained on the barriers that young people (aged 10-24) most affected by HIV faced in accessing services and the need for peer-led youth-friendly services. Thus far the project claims to have strengthened service providers’ skills at community and clinic settings to provided tailored intervention packages and innovative service delivery approaches that address the needs of young people living with and most affected by HIV, including key affected populations.
An integrated approach to HIV and reproductive, maternal and newborn health is inherent in the prevention of vertical transmission of HIV (PVT or PMTCT). The four components recommended by WHO: primary prevention of HIV infection among women of childbearing age; preventing unintended pregnancies among women living with HIV; preventing transmission from a woman living with HIV to her infant; and providing appropriate treatment, care and support to mothers living with HIV and their children and families provide several entry points for integrated services. It is vital that all collaborating partners take this broader approach and do not only focus on the PVT component.

There are a range of gaps in integration of HIV and newborn health and provision of maternal health care through the duration of the post-partum period which can lead to health threats such as transmission through breast feeding. While access to HIV counselling and testing (HCT) of pregnant women is promoted in maternal health care there are disconnects around uptake of testing among male partners. Quality of HCT is problematic when pregnant women who receive a positive diagnosis are provided little ongoing counselling and support around facing intimate partner violence or stigma and discrimination, including within health services, wherein poor attitudes of midwives to HIV positive women as well as cases of forced sterilisation persist.

The introduction of Option B+, the provision of lifelong ART to all pregnant women living with HIV, has highlighted that providing treatment immediately upon diagnosis is not always delivered within a human rights framework and respectful of individual patient autonomy. Women living with HIV have urged that: treatment is initiated when individuals are ready and choose to start; women living with HIV should be always given accurate information about treatment options, side effects, drug resistance and co-infections; and all people living with HIV, especially women who start lifelong treatment during pregnancy, should have access to regular CD4 counts and periodic viral load tests. DFID’s prioritisation of the empowerment of women and girls and promotion of reproductive choice should extend to ensuring that treatment choices for pregnant women living with HIV are upheld. Moreover, these lessons need to be taken forward into the expansion of the anticipated WHO recommendations for lifelong treatment for all regardless of CD4 count.

Mainstreaming HIV services into primary and tertiary care can also bring benefits. Help Age International points out that SRH services are less sensitive to ageing people’s sexual health needs and integration with non-communicable disease management is more relevant to needs of older patients. Meanwhile, the integration of HIV within water and sanitation (WASH) is important for the control of diarrhoea and opportunistic infections. Access to sufficient amounts of clean water is essential for the use of formula for infants rather than breast feeding as well as for all people taking ART daily. Thus Water Aid and CAFOD urge that WASH integrates HIV in whole-community targeted projects at local authority level.
Addressing key populations through HIV and other services

In 2011, the framework for an investment approach adopted by UNAIDS\(^2\) stressed that reaching key populations should be a critical priority in HIV programmes. Key populations most affected by HIV – people who inject drugs, sex workers, men who have sex with men and transgender people – and other marginalised groups face particular challenges in accessing the public health system and have complex HIV and SRH needs which can make integrated services particularly more appealing and relevant to them. Baseline studies from the Link Up project highlight the potential for integrated SRH-HIV services to reach young men who have sex with men and young sex workers.\(^3\) The early evidence suggests that innovative approaches developed through the programme are increasing the reach of integrated services to these populations.\(^4\)

In contexts where key populations are criminalised, for example in Uganda where LGBT people have experienced increasing violence, stigma and discrimination as a result of proposed anti-homosexuality legislation, marginalised groups are unable to access non-discriminatory care within the health system. Men who have sex with men and transwomen have increasingly relied on Link Up’s partners serving the LGBT community in order to access HIV and SRH services.\(^5\)

For people who inject drugs, WHO identifies essential core harm reduction interventions including needle and syringe exchange and opioid substitution therapy alongside testing and treatment for HIV and STIs and condom distribution. A DFID and World Bank funded HIV programme in Vietnam which delivered both needle and syringe exchange and condom programming is estimated to have prevented over 30,000 new HIV infections over a nine year period.\(^6\) DFID’s investment helped to significantly increase the capacity of local NGOs to provide services to people who inject drugs, but an evaluation raised concerns that attitudes among government officials and law enforcers was not wholly supportive. Compulsory detoxification centres continued to operate in Vietnam alongside harm reduction interventions and people who use drugs continued to be criminalised.\(^7\) This became a key unresolved problem when DFID pulled its funding from this programme in 2013.

Human resources and community systems for health

Even thirty years into the HIV epidemic, significant challenges persist in the management of human resources for health among health workers engaged in the response. HIV has shed light on the discriminatory attitudes held by some health workers and the high level of stress affecting health workers which sometimes impacts negatively on service users. Task shifting is
3 • Opportunities to address HIV and TB within global health

Beyonce Karungi, from TRANSGENDER EQUALITY UGANDA in Parliament during the Student Stop AIDS Campaign speaker tour
critical for allowing for cost effective, quality care with greater access than a physician-centred model, it alleviate gaps in coverage in HIV treatment and care and addresses the pressures on health workers. There is great potential for better results for the same level of investment if lessons from the HIV response were to be applied across the broader health field and to address non-communicable diseases (NCDs).

Community members also have important roles in the delivery of community-level health systems as both volunteer and paid members of community-based organisations. Their work ranges across the whole continuum of care from prevention education, support to access testing, physical and psychological support through promoting ART adherence, and the management of DOTS programming or active case finding in the response to TB. According to a new report co-authored by Médecins sans Frontières (MSF), community-based ART delivery is efficient, effective and high quality. Despite forming the backbone of the community response to HIV, community-based approaches have still not received sufficient attention in human resources for health strategies. Strengthening and expanding community-based approaches to delivering HIV treatment is vital to the long-term success of the AIDS response.

The ‘know your epidemic’ principle has encouraged greater interface with affected communities. Monitoring ART adherence and measuring viral load is essential to realise benefits of treatment as prevention and an important form of disease surveillance. Weakness in surveillance systems have been highlighted in the Ebola outbreak in West Africa and this is an important area for reinvestment. Avert has emphasised the need for DFID to find innovative ways to continue funding smaller community based organisations that often play a far more successful and cost efficient role in supporting case identification, surveillance and monitoring at the primary care level.

At a global level, the Global Fund has led the way on community system strengthening (CSS) by building this approach into its new funding model, but it recognises that there are still significant barriers to its effective implementation in many national contexts. Health systems strengthening is not automatically being accompanied by CSS in many national programmes. This will be a particularly important aspect of the HIV response in middle income countries with concentrated epidemics which may become ineligible for major global health financing.

CSS strengthens the capacity of community based organisations to support the mobilisation of community involvement, community-based service delivery and accountability of services through monitoring and advocacy. CSS funding has been essential to increase access to funding for key populations to increase access to services and to protect and promote their rights. For example CSS funding has enabled Alliance Ukraine to reached nearly 200,000 people who inject drugs with needle and syringe programmes though the Community Action on Harm Reduction (CAHR)
programme, which aims to expand harm reduction services to their partners and children in China, India, Indonesia, Kenya and Malaysia. CSS can be understood as a major part of the work conducted by STOPAIDS members with a significant part of this funding and supported by DFID’s PPA funding. It is this funding that enables international NGOs to reach that bit further into marginalised communities than many donors are able to do.

**Decision making and governance in health**

DFID has been involved in many efforts to develop tools to help decision-makers improve their health system response. DFID’s engagement in the development of the SRH and HIV Linkages Compendium and its support to the WHO consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations is very helpful. Nevertheless there is a perception that guidance is not being picked up in programmes with difficulty in interpreting WHO guidelines on TB and paediatric HIV treatment. There is an enhanced role for DFID in ensuring not just that toolkits are funded but also in urging implementers to utilise guidance that has been developed within actual programmes.

DFID is also concerned with ensuring accountability in health care delivery, an area where STOPAIDS members have been very active: building collaborative relationships with stakeholders in countries; developing research and policy positions to inform evidence-based positions and providing technical and financial support for civil society to undertake health budget tracking to enhance accountability. Christian Aid’s work on HIV and governance benefited by engaging networks of people living with HIV and religious leaders living with HIV to bring the evidence base they had developed on health budget tracking to hold governments to account for their commitments and urge for expanded health and HIV service delivery.

Nothing is more effective in improving governance than ensuring strong accountability to citizens. The treatment literacy, patient empowerment and activism seen within HIV has been essential to secure improvements in services. But organisations that have led this work across the world are facing funding challenges. This work must continue to be supported, and similar investments should be made across health to improve patient literacy, advocacy and ultimately governance and service delivery.

**Structural drivers of vulnerability to HIV and TB**

It has been acknowledged by DFID that there has been insufficient collective investment in the social, economic and environmental determinants of health and there have been significant insights through efforts to address the structural drivers of vulnerability to HIV and TB including harmful cultural norms. DFID has brought attention to the fact that due to “stigma and discrimination and poorly functioning health systems, at least 16
35 million people in need of treatment are still not accessing services under new World Health Organization 2013 treatment guidelines.”

There is hope that the SDG focus on the promotion of equity may attract additional support for marginalised populations including key populations vulnerable to HIV. However, STOPAIDS members are concerned about the UK government’s stated preference that the SDGs should focus on ending extreme poverty and not inequality. They are also uneasy that behind the rhetoric of ‘no one left behind’, there has been no consensus throughout the SDG negotiations to specifically include text on marginalised groups to allow for LGBT people, sex workers and people who use drugs to access Universal Health Coverage. Thus attention to these and other marginalised people is likely to be left to the discretion of country level actors. Action to strengthen the inclusion of key populations in all national monitoring and accountability mechanisms therefore remains critical. It is vital that Universal Health Coverage is approached through a human rights perspective in order to eliminate stigma around poor health and barriers to access among the most marginalised.

DFID could significantly help fill gaps that may emerge when the SDGs are finalised by identifying who are the most marginalised by any health issue and how can they best support attention to their human right to health. The next section considers where DFID’s other development priorities could be better synergised with these health concerns, and highlights where other departments of Government could constructively contribute to the end of the AIDS and TB epidemics.
ENSURING THAT WOMEN AND GIRLS ARE EMPOWERED TO PROTECT THEMSELVES FROM HIV, TO MAKE DECISIONS ABOUT THEIR OWN HEALTH AND TO LIVE FREE OF VIOLENCE, INCLUDING VIOLENCE RELATED TO THEIR HIV STATUS, WILL BE CRUCIAL TO ENDING THE AIDS EPIDEMIC BY 2030.
The UK Health is Global Strategy (2011) set out commitments across Government departments and is internationally regarded as an example of good practice. This chapter highlights where agendas pursued by other departments of Government might be rationalised to enhance and support DFID-led action on HIV and TB.

**Strategic vision for girls and women**

The UK has a strong reputation for supporting the achievement of women’s empowerment and addressing gender inequality through its assistance. In 2011 DFID issued a Strategic Vision for Girls and Women outlining four areas where a focus on getting results for women and girls would be enhanced: delay first pregnancy and support safe childbirth, economic assets direct to girls and women, get girls through secondary school, prevent violence against girls and women.\(^\text{106}\)

Not co-incidentally, these are all areas that could combine to drive down HIV acquisition in young women and girls. There is therefore a two-way benefit to an approach that addresses the synergies between the goals of the Strategic Vision and those of UNAIDS. Specific actions however on HIV were not cited in the Strategic Vision, representing a missed opportunity. The STOPAIDS policy brief *Girls and Women: Mainstreaming HIV and AIDS into DFID’s Strategic Vision* pointed out how these four areas could be leveraged for specific interventions to address the gendered nature of the HIV epidemic.\(^\text{106}\) These include structural interventions such as conditional cash transfers, which have been shown to have positive impact on the uptake of HIV testing and reducing gender-based violence\(^\text{109}\), itself a risk factor for HIV infection.\(^\text{109}\) There is a need for DFID to do more to address the intersections between gender based violence and HIV, showing greater initiative to address the violence that women living with HIV experience “before, because of, and after HIV acquisition and diagnosis.”\(^\text{110}\)

Positively, DFID’s review of the HIV Position Paper confirmed that several HIV related activities had been pursued in line with the priorities of the Strategic Vision.\(^\text{111}\) Detailed reporting on these interventions could measure correlations between selected interventions and HIV outcomes for women and girls and determine which approaches are the most effective in the DFID portfolio.
Preventing sexual violence in conflict

The Foreign and Commonwealth Office leads the Coalition Government’s Preventing Sexual Violence in Conflict initiative. This initiative unfortunately does not allow for flexibility to focus on other settings where there are high rates of sexual violence – both a cause and consequence of HIV and poor sexual and reproductive health. For instance, South Africa has an estimated prevalence of non-partner sexual violence double the global rate, almost half of all women in South Africa have a forced sexual debut, and there are numerous cases of lesbian and bisexual women targeted for rape based on their sexuality. South African women aged 15–26 years who have experienced intimate partner violence (IPV) are 50% more likely to have acquired HIV than women who had not. Eligibility of countries where DFID can act precludes further attention to dual epidemics of HIV and gender-based violence entrenched in South Africa and the frame of the initiative on ending sexual violence will exclude other important sites for these interventions. There is however, scope for continued work through the Foreign and Commonwealth Office (FCO) in-country and through regional programmes and these opportunities should be fully realised.

Cross-Whitehall positions affecting key populations vulnerable to HIV

There are several examples of policy stances taken by other departments of Government which can actively undermine DFID’s approach to addressing the determinates of vulnerability to HIV and TB. A more enabling policy environment across departments would support the decriminalisation of drug use, same sex relationships and sex work.

The approach of the Department of Health and the Home Office to people who use drugs is increasingly focused on recovery within ongoing drug control efforts. This shift has resulted in reduction of funding to domestic harm reduction services, which have been long-proven as highly effective. This undermines the UK’s authority to promote harm reduction for HIV prevention abroad and may be related to the scale back of DFID’s funding to harm reduction programming. Harm reduction allows countries to move away from the human rights abuses associated with draconian responses to drug use such as: compulsory detox, corporal and capital punishment and imprisonment for possession. Several studies have demonstrated that harm reduction is also highly cost effective wherein for every $1 spent on harm reduction there are cost savings of $4-$12 within the response to crime and $12 within the response to health.

Harm Reduction International is calling on governments to redirect 10% of the $100 billion spent a year on the war on drugs to fill major gaps in harm reduction programming. UNAIDS estimates that US$ 2.3 billion is required in 2015 to fund HIV prevention among people who inject drugs but at last estimate only US$160 million had been invested by international donors.
approximately 7% of what is required. STOPAIDS’ recent stocktake of DFID’s work on key populations urged that the UK explicitly call for the decriminalisation of drug use at the 2016 UN General Assembly Special Session on Drugs. This stance should be grounded in DFID global health policy that reasserts the importance of harm reduction on the grounds of health and human rights and must be supported by both the Home Office and Foreign and Commonwealth Office (FCO).

The promotion of the human rights, including the right to health, of lesbian, gay, bisexual and transgender (LGBT) people in low and middle income countries requires the combined leadership of DFID and the FCO. STOPAIDS applauds DFID’s development of a Theory of Change for LGBT people and notes the importance of the UK negotiating with governments pursuing regressive laws punishing same sex sexuality. The Kaleidoscope Trust in particular is keen to see DFID own and embed the approach to LGBT rights by formalising and publicising the Theory of Change. More work is needed to support LGBT rights defenders in the countries where DFID works and opportunities should be expanded within DFID’s focus on women and girls and addressing harmful gender norms to consider women in all their diversity, particularly lesbian, bisexual and transwomen.

In its review of the HIV Position Paper, DFID stated it “has increasingly worked with the FCO to highlight and challenge punitive and discriminatory laws and other human rights abuses affecting key populations, particularly LGBT people.” While the FCO has increased its capacity to address these issues there are inconsistencies in their approach which weakens solidarity around countries where violations of LGBT people’s rights are intensifying. For example, STOPAIDS members were dismayed when the FCO invited the Ugandan Prime Minister to a business conference in London during the same time period where other donors to Uganda were withholding ODA to the country to express disapproval of the Prime Minister’s support of the Anti-Homosexuality Act.

Decriminalisation of sex work has gained increasing support as it is widely evidenced that criminalisation of sex work and other discriminatory laws and practices subject sex workers to repression, stigma, discrimination, and violence. Vulnerability driven by the criminalised nature of sex work results in sex workers bring approximately eight times more likely to be living with HIV than other adults globally. In low and middle income countries female sex workers are 14 times more likely to be living with HIV than other women of reproductive age. Prevalence and incidence among male and trans sex workers is thought to be even higher yet epidemiological
data is not widely available compounded by lack of awareness and understanding about these sex worker communities, and their needs in the context of HIV services. The Swedish model of ‘ending demand’ is extremely unhelpful. DFID and the Home Office could realise public health and other benefits from endorsing full decriminalisation.

Research and development

The Conservative Manifesto commitment to accelerate the development of vaccines and drugs to eliminate deadliest diseases is timely and welcome. Given the potential of the science, this would be the worst time to scale back on research.

The World Health Assembly Strategy for the elimination of TB in the next 20 years can only be achieved with the development of new TB drugs, diagnostics and vaccines by 2025. With a current TB R&D funding gap of roughly $2bn a year, it is hard to see how such products will reach patients on the timeline required by the End TB Strategy. Several major obstacles need to be overcome to ensure that patients have quick and accurate diagnosis, and short, safe and effective treatment:

• There is a lack of fundamental understanding of how the TB bacteria interact with the host. Similar problems hamper efforts to develop HIV vaccines and paediatric drugs, let alone develop an HIV cure. A sizeable injection of funds into basic research is needed to plug these knowledge gaps and unlock new avenues for drug, diagnostic and vaccine development. DFID already funds basic research through a special Concordat with the MRC, so a vehicle already exists for delivery enhanced funding.
• TB, much like paediatric HIV, does not represent an appropriately sized financial market to incentivise commercial sector development. The O’Neill Review of anti-microbial resistance (AMR) has proposed a ‘delinked’ model for antibiotic development and similar approaches must be developed by TB, HIV and other poverty related and neglected diseases (PRNDs). One potential model is MSF’s 3P Project. If sufficiently funded and proven to be successful, this approach could be expanded from its initial focus on TB drugs to support the development of other key global health products.
• Patients must access effective new products quickly, and at affordable prices. Access issues around anti-retrovirals are examined in the section below, but with the development of new TB drugs, access issues are also arising for TB patients. Few patients anywhere in the world have yet accessed Bedaquiline or Delamanid – the two new TB drugs. At the time of the 2015 General Election, in the UK no patients had been treated with either drug, despite approval being granted for both more than a year before. Any new DFID approach to address the poor pipeline for TB commodities needs to be complemented by a thorough review of DFID’s efforts to overcome access barriers.
Access to second and third-line anti-retrovirals is limited in low- and middle-income countries due to lack of financing, low availability of viral load testing and high drugs prices, with progressively higher drug prices for middle and upper middle income countries. Paediatric treatment also remains considerably behind adult treatment and access to first, second and third-line treatment is restricted in upper middle income countries, particularly for marginalised populations, due to a combination of inability to access generic medicines, legal barriers and the aforementioned ODA trends.

International trade and access to medicines policies are two of the starkest examples of poor policy coherence between departments of Government, undermining DFID’s strategic objectives. The Department for Business Innovation and Skills (BIS) leads UK engagement with the EU on trade agreements which include frameworks on trade and intellectual property law determining countries’ ability to produce generic medicines. Previously DFID led on these policy areas and showed strong support for the Trade-Related Aspects of Intellectual Property (TRIPS) flexibilities which can promote access to medicines in developing countries.

As the shift to BIS leadership has taken place, it has become less clear that the UK is pushing back on EC efforts to incorporate TRIPS-Plus terms in these agreements. These stricter requirements for intellectual property rights in bilateral trade agreements, including the EU-India and EU-Thailand agreements, will lead to higher medicine prices and lower levels of access. In effect, UK trade policy risks undermining TRIPS flexibilities and by extension UK investments in global health, despite while DFID’s continued stated support for TRIPS flexibilities.

This presents another paradox in the UK’s approach to global health: while there are increasing concerns about the long term financial burden of provision of ART and other essential medicines the frameworks for generic production and cheaper drugs are being weakened.

STOPAIDS urges DFID to take back the lead on trade policy related to access to medicines from BIS. The UK’s leadership was important in expanding access to generic medicines for HIV and if this could be reinstated it would help to secure affordable treatment for other emerging health issues, such as non-communicable diseases (NCDs).
CONCLUSION

The timing could not be more right for the development of a DFID strategy on global health that places a clear emphasis on HIV and TB. We cannot wait until 2020 to find out if we are still on track to defeat these major killers.

The connection between global health and broader sustainable development is complex and defies neat policy boxes. The moment is perfect for DFID to produce a global health strategy that is based on and responds to the new sustainable development goals, laying out the UK response to and role in delivering the health goal and the health related targets of other goals. A unifying global health strategy would facilitate delivery of the new Conservative Government’s manifesto pledges on infectious disease and women and girls, gathering together its stated priorities of childhood immunisation, new drug development, gender and health inequities and outbreak response under one umbrella. Strategically, the adoption of such a strategy this year will furnish DFID with a strong and perfectly timed articulation of its global health priorities in readiness for key global policy and financing opportunities such as the High Level Meeting on HIV and the replenishment of the Global Fund in 2016.

Internationally, the UK has long and distinguished track record in health expertise and in supporting countries to achieve the health related MDGs. A global strategy will reflect, reinforce and promote the UK’s leadership in meeting the UN target of 0.7% and do justice to the major investments that have been made to date.

Thanks to this long-standing investment in HIV and TB, we are at a tipping point. The five years of this Conservative Government parallel critical years for containing and reversing the trajectories of both these epidemics. Scientifically, there is a critical and ‘fragile five year window of opportunity’ that DFID is ideally placed to support, the outcome of which will be concrete results paying dividends in terms of reaching broader development goals. Left to their own devices, HIV and drug-resistant TB will continue to undermine every effort to make real progress in broader health, human rights and development and are likely to spring back with even greater devastating effect.

An overarching results-focused strategy will be essential to DFID maintaining its eminent role in global health and the response to HIV and TB specifically. We look forward to enhanced UK leadership on global health that clearly articulates the how the UK will play its part in ending the HIV and TB epidemics within the context of a new era in global sustainable development.
Recommendations

How the UK can maximise the effectiveness of its investments in global health and enhance its global leadership on HIV and TB.

**Adopt a synergistic approach**

- Develop a new DFID global health strategy in 2015 that is structured around how the UK will deliver its contribution to reaching the SDG health goal and all relevant health-related targets.
- Ensure this new DFID global health strategy maximises the return on UK investments across health to deliver better outcomes for women and girls, strengthen health systems, and realise our opportunity to eliminate the world’s deadliest infectious diseases. This should include an assertion of commitment to the goal of ending the HIV and TB epidemics by 2030 and a clear description the UK’s role in achieving that.
- Sustain and apply across health the lessons learned from the response to HIV and TB, including the prioritisation of communities in health advocacy, decision making and service delivery.
- Finance and standardise the collaborative HIV-TB integration approaches recommended by the WHO across all DFID bilateral health programmes.
- Enhance health outcomes through interventions that bi-directionally integrate with sexual and reproductive health interventions where appropriate but also maintain a focus on the non-SRH aspects of the HIV response.
- Acknowledge and reflect that there are many different HIV epidemics, and that some must be treated as exceptional and demanding of on-going, standalone interventions.
- Join up the approach and investment to empower women and girls and tackle harmful gender norms and gender-based violence – address the needs of women in all their diversity and leverage insights from interventions on the structural drivers of women and girls’ vulnerability to HIV.

**Support a sustainable response to the three diseases**

- The only sustainable response to an epidemic is one which is reducing its size, and therefore future costs. Finish the work – leverage the UK’s already significant investments and technical insight to end AIDS and TB by 2030.
- Raise the level of bilateral funding for TB control and treatment to meet demand – particularly for dual HIV-TB epidemics, and at least maintain bilateral HIV spend. DFID’s high quality bilateral programmatic work means the UK can retain the thought leadership required to shape global health.
- Support continued smart and targeted investment in middle income countries to avoid undermining historical investment with the ambition of securing sustainable transition to domestic resourcing. This is a role for DFID and the FCO, as well as multilaterals such as the Global Fund. Support an approach to funding decisions based on a more complex analysis of context than simply GNI per capita, including disease burden, levels of extreme poverty, levels of fragility, and the political and legal environment for key population groups.
• Maintain support for a Global Fund which has ending the epidemics as its core mandate, releasing all of the £1bn 2013 pledge, and at least maintain that contribution in the 2016 replenishment. Actively encourage donors to support the replenishment effort.

Prioritise those furthest behind
• Recognise that HIV is still an exceptional challenge in many contexts, and requires a distinct response to ensure health outcomes across the board are not undermined.
• Continue to support effective evidence-based approaches, championing DFID’s pioneering work in areas such as harm reduction.
• Support the decriminalisation of homosexuality, sex work and drug use to address the links between criminalisation, stigmatisation, repression and vulnerability to HIV; and increase financial and political support from across the UK government for harm reduction services and organisations focused on the rights of key population groups around the world – particularly those led by sex workers, drug users, transgender and gay people.
• Act upon the recommendations within STOPAIDS’ report ‘Increasing DFID’s Contribution to Addressing HIV among Key Populations’ including the creation and adoption of a ‘Theory of Change’ for all key population groups to complement the existing LGBT plan.

Overcome barriers to access to effective medicines
• Develop and deliver a global programme to overcome R&D failings and secure the medical and diagnostic tools required for effective responses to global health challenges. Work with UNITAID, the Medicines Patent Pool, civil society and the WHO CEWG process to achieve this.
• Maintain funding support to UNITAID to ensure innovative solutions to critical market failings for the three diseases are funded.
• Review DFID’s approach to access to medicines, and increase support for country governments and civil society to utilise TRIPS flexibilities to increase availability of generic medicines.

Ensure cross-Whitehall coordination
• Undertake an audit to assess how policy stances of other departments support or undermine DFID objectives – particularly in relation to key populations affected by HIV and access to affordable medicines.
• Work with the FCO to ensure a coordinated approach to promoting and protecting the rights of lesbian, gay, bisexual and transgender people, including the right to health.
• DFID global health policy should reassert the importance of harm reduction on the grounds of health and human rights and ensure support by both the home office and the FCO.
• Take back leadership from BIS on trade and intellectual property and fully support the use of TRIPS flexibilities in negotiation of bilateral trade agreements.
APPENDIX

Steering Group members

Georgia Burford / Harriet Jones – CAFOD
David Deakin – Tearfund
Dr Sarah Hand – AVERT
Jon Hopkins – International Planned Parenthood Federation
Anton Kerr / Mike Podmore – International HIV/AIDS Alliance
Aaron Oxley – RESULTS UK
Sophie Strachan – Positively UK
Professor Charlotte Watts – London School of Hygiene and Tropical Medicine
Rebekah Webb – AVAC

Key Informants

Kerstin Akerfeldt, MSF ● Rachel Albone, HelpAge International
Georgia Burford, CAFOD ● Daisy Byaruhanga, Innovative Vision Tottenham
Laura Boughey, RESULTS UK ● Sally Chakawhata, Programme Manager, DFID
Vivian Cox, MSF ● Rachel Crockett, TB Alliance ● David Deaken, Tearfund
Jane Edmondson, Head of Human Development, DFID
Louisa Gosling, WaterAid ● Ian Govinder, AIDS Orphan
Tabitha Ha, Restless Development ● Jon Hopkins, IPPF
Clive Ingleby, VSO ● Harriet Jones, CAFOD ● Stuart Kean, World Vision
Jay Levy, INPUD ● Diarmaid McDonald, STOPAIDS ● Fionnuala Murphy, HRI
Will Niblett, Head of Sexual and Reproductive Health Team, DFID
Matt Oliver, RESULTS UK ● Luisa Orza, Athena ● Aaron Oxley, RESULTS UK
Maria Phelan, HRI ● Mike Podmore, International HIV/AIDS Alliance
Alysa Remtulla, STOPAIDS ● Lorrain Robinson, ONE ● Ben Simms, STOPAIDS
Liam Sollis, Action for Global Health ● Sophie Strachan, Positively UK
Laura Taylor, Christian Aid ● Bruce Warwick, RESULTS UK
Rebekah Webb, AVAC ● Saoirse Fitzpatrick, STOPAIDS

Acknowledgements

This report was authored by Dr Felicity Daly and edited by Rebekah Webb as independent consultants. Written contributions were made by Diarmaid McDonald, Mike Podmore, Luisa Orza, Aaron Oxley, Bruce Warwick and Matt Oliver. STOPAIDS would like to thank all the members who contributed to the process of developing this report.
References

2 Ensuring that 90% of people living with HIV know their status, 90% of those individuals are on ART and 90% of those individuals are virologically suppressed by 2020.
4 UK Development Tracker, accessed at devtracker.dfid.gov.uk/.
5 International Development Act 2015, accessed at services.parliament.uk/bills/2014-15/internationaldevelopmentofficialdevelopmentassistance/target.html
6 E-Pact, Mid-Term Review of the UK Malaria and RMNH Frameworks for Results, 2013.
20 UNAIDS, All In! to #EndAdolescentAIDS, 2014.
25 UNAIDS Global Coalition on Women and AIDS, Advancing young women’s sexual and reproductive health and rights in the context of HIV, 2014.
27 UNAIDS Global Coalition on Women and AIDS, Advancing young women’s sexual and reproductive health and rights in the context of HIV, 2014.
28 UNAIDS Global Coalition on Women and AIDS, 2014 ibid.
34 In a study of a population cohort in South Africa, HIV patients on antiretrovirals had nearly full recovery of employment; Bor et al, Economic spillover effects of HIV treatment on rural South African households and communities, presentation at IAEN Pre-Conference, 20-21 July 20-21, 2012, Washington, D.C.
35 Thirumurthy et al, Two-year impacts on employment and income among adults receiving antiretroviral therapy in Tamil Nadu, India: a cohort study, 2011.
36 strive.lshtm.ac.uk
38 UNAIDS Fast Track 2014.
40 WHO, Factsheet on Tuberculosis, 2015.
Appendix

50 www.publications.parliament.uk/pa/ld201415/ldhansrd/text/141021w0001.htm#14102178000176
51 Data sources: www.publications.parliament.uk/pa/ld201415/ldhansrd/text/141021w0001.htm#14102178000176 and Development Tracker data at devtracker.dfid.gov.uk/.
52 Data sources: www.publications.parliament.uk/pa/ld201415/ldhansrd/text/141021w0001.htm#14102178000176 and Development Tracker data at devtracker.dfid.gov.uk/.
54 www.gatesnotes.com/Health/An-AIDS-Number-That’s-Almost-Too-Big-to-Believe?
59 Ibid
61 UNAIDS, Financing the Response to HIV in Low and Middle Income Countries, 2013.
63 Ibid
64 TB Europe Coalition, After Aid: What is next for Tuberculosis and HIV in Europe? 2015
66 www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)61047-8/abstract


71 www.msf.org/article/treating-hiv-and-tb-swaziland-%E2%80%9Cwe-didn%E2%80%99t-know-what-expect%E2%80%9D

72 ibid

73 ibid

74 Republic of South Africa. 2011. National Strategic Plan on HIV, STIs and TB.


77 integrationforimpact.org/wp-content/uploads/2012/05/Integrating-FP-into-HIV-services-PROGRAM-BRIEF.pdf

78 DFID, Choices for women: planned pregnancies, safe births and healthy newborns: The UK’s Framework for Results for improving reproductive, maternal and newborn health in the developing world, 2010.

79 STOPAIDS, Letter to Secretary of State for International Development, 4 March 2015.


81 www.integrainitiative.org/frequently-asked-questions/does-integration-lead-to-an-increase-in-hiv-testing-uptake/

82 VSO, Regional Health and AIDS Initiative for Southern Africa (RHAISA), Towards improving the health outcomes and realizing the rights of the disadvantaged, 2014.


84 ibid

85 WHO, PMTCT strategic vision 2010-2015: Preventing mother-to-child transmission of HIV to reach the UNGASS and Millennium Development Goals, 2010


88 International Community of Women Living with HIV, Global Network of People Living with HIV. Understanding the perspectives and/or experiences of women living with HIV regarding Option B+ in Uganda and Malawi: In Support of the Forthcoming WHO Consolidated ARV Guidelines. 2013.

89 HelpAge International, Strategic Plan 2009.

90 United States Agency for International Development. The Hygiene Improvement Project WASH HIV Integration Toolkit. 2010.

91 STOPAIDS, WASH and HIV Factsheet, 2013.


93 Population Council, Sexual Health and HIV Risk Behaviors of Men Who Have Sex With Men in Myanmar—Baseline Findings From Link Up and Sexual and Reproductive Health Among Young Female Sex Workers in Bangladesh Brothels—Baseline Findings From Link Up, 2015.

94 www.aidsalliance.org/resources/510-report-visions-voices-and-priorities-of-young-people

95 http://www.aidsalliance.org/resources/276-link-up-srhr-hiv-project-overview


100 CBOs can achieve a near 100% success rate in providing a HIV test to all pregnant women at least once in their pregnancy. See for example their work with the Umunthu Foundation at: www.avert.org/umunthu-foundation-malawi.htm.


106 DFID, Strategic Vision for Girls and Women: Stopping Poverty Before it Starts, 2011


116 Ibid


120 Harm Reduction International 10 by 20 Campaign, see www.ihra.net/10by20

121 International Harm Reduction Association, The funding crisis for harm reduction: Donor retreat, government neglect and the way forward, 2014.

122 STOPAIDS, Increasing DFID’s Contribution to Addressing HIV Among Key Populations: Review and Recommendations. 2014.

Appendix


125 STOPAIDS, Sex work, HIV and human rights, Factsheet, June 2015.


131 ibid
