House of Commons

International Development Committee

HIV/AIDS: Marginalised groups and emerging epidemics

Second Report of Session 2006–07

Volume I

Report, together with formal minutes

Ordered by The House of Commons
to be printed 28 November 2006

HC 46-I
Published on 1 December 2006
by authority of the House of Commons
London: The Stationery Office Limited
£0.00

International Development Committee

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Footnotes

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Report

Summary

The UN Report on HIV/AIDS in 2006 shows that Africa remains the region hardest-hit by the HIV/AIDS pandemic. It also highlighted emerging epidemics in Eastern Europe and Asia. These new epidemics are often being 'driven' by groups that are marginalised in these societies, including commercial sex workers, intravenous drug users, men who have sex with men, and prisoners. The existence of these groups is often denied or the illegal nature of their activity means that governments fail to take action appropriate to their needs.

Questions of morality are not the issue: what is important is finding the most effective way to halt the spread of HIV/AIDS. Emerging epidemics generally start with concentrated epidemics among marginalised groups and can then spread to the wider population. Countries may then face a hyper-epidemic where HIV can spread exponentially — as can be seen in many southern African countries. To combat epidemics effectively, the rights and needs of those most at risk must be as central to strategies as are treatment and prevention.

It is right that DFID and the international community are channelling money to countries' national AIDS programmes. DFID must work with governments to ensure that these programmes are properly focused and that the rights and needs of marginalised groups are not overlooked. Marginalised groups are in fact key to an effective response to the epidemic. Therefore, AIDS prevention programmes which target the general population should not be getting the lion's share of the resources made available by the international community.

There is no one-size-fits-all response to HIV/AIDS epidemics. National programmes should be based on careful assessments of local need. Africa has carried the heaviest regional HIV/AIDS burden for decades and has seen a wide range of responses employed. As a key development partner in Africa, DFID has a valuable perspective on these responses and on best practice that most national governments facing new epidemics will not have. DFID must ensure best practice in Africa is shared with governments elsewhere, especially in Asia and Eastern Europe.

Background

The UNAIDS[1] 2006 *Report on the global AIDS epidemic*[2] offers a sobering assessment of national — and international — level responses to the AIDS pandemic. Africa remains the global epicentre of the pandemic. But the report reveals worrying new trends in Eastern Europe and Central Asia, which together have the fastest growing rate of HIV in the world. It also notes significant new epidemics in Asia, whose high populations mean even low rates of HIV infection translate to large numbers of infected people. The UNAIDS Report highlights the links between these emerging epidemics and 'marginalised' groups, which it terms the "four key populations": sex workers, men who have sex with men, injecting drug users and prisoners, groups which it is argued are 'driving' many general epidemics.[3]

For the purposes of this Report, these four 'marginalised' groups are treated as distinct from 'vulnerable' groups such as women, children, young and older people. Although some of the evidence we received identified these latter groups as marginalised, they are not perceived to be 'driving' epidemics but rather are groups on which the pandemic has a significant impact.

1 Joint United Nations Programme on HIV/AIDS

2 May 2006

3 'Driving' refers to the idea that people who engage in high risk behaviours are more likely to contract the virus if they come into contact with it, and if they have it are more likely to pass it on into low risk groups such as spouses and children as well as within the high risk groups.

1 International targets on HIV and AIDS

1. Since our last Report on HIV and AIDS in 2005 the pandemic has continued to have a dramatic impact across the developing world.[4] Of the estimated 39.5 million people living with HIV/AIDS globally in 2006, 24.7 million were in sub-Saharan Africa and 7.8 million in south and south-east Asia. Over 95% of the 4.1 million new infections in 2005 were in low- and middle-income countries.[5] In responding to the HIV/AIDS pandemic, the international community has set a series of targets on prevention and treatment, including the HIV/AIDS target within the Millennium Development Goals (MDGs) and the World Health Organisation (WHO) '3 by 5' target.[6] The Gleneagles G8 commitment to "as close as possible to universal access to [HIV/AIDS] treatment for all those who need it by 2010" builds on these targets.[7] Our previous Report underlined the importance of these commitments, noting that lack of progress on this single issue had the potential to undermine many of the MDGs, and therefore global efforts towards poverty reduction more broadly.[8]

DFID's role in achieving the international targets on HIV/AIDS

2. The international community has found significant financial resources to begin to meet the commitments it has made on HIV and AIDS. The US$8.3 billion dedicated to responding to the pandemic in low- and middle-income countries in 2005 is within the target range of US$7-10 billion set out at the UN Special Session in 2001.[9] While we welcome this funding commitment and the consequent scaling up of programmes, we are concerned that evidence from UNAIDS suggested that a funding gap remains.[10] More worrying still is the fact that, despite progress towards global funding targets, universal access to anti-retroviral therapy (ARVs) and the prospect of halting and reversing the spread of HIV, what might be called 'outcome targets' rather than 'funding targets', appear some way off. [11] Adequate funding is a means not an end. Outcomes such as fewer infections and more people on appropriate treatment are the underlying aims of action on HIV/AIDS. If these programmes are not delivering the necessary outcomes fundamental questions arise about the focus of the programmes into which international funding is being channelled. The UNAIDS 2006 Report found that:

4 International Development Committee, First Report, Session 2005-06, *Delivering the goods: HIV/AIDS and the provision of anti-retrovirals*, HC 708

5 UNAIDS, *Report on the global AIDS epidemic*, May 2006, and UNAIDS/WHO, *AIDS Epidemic Update*, December 2006

6 Target 7 in Millennium Development Goal 6; the WHO '3 by 5' initiative aimed to have 3m people in low- and middle-income countries on anti-retroviral therapy by the end of 2005 (50% coverage).

7 http://www.fco.gov.uk/Files/kfile/PostG8_Gleneagles_Communique,0.pdf

8 International Development Committee, *Delivering the goods: HIV/AIDS and the provision of anti-retrovirals*, HC 708, para 1

9 UN, *Declaration of Commitment on HIV/AIDS*, June 2001 [A/Res/S-26/2]

10 Qq 3 and 4 [Dr Anindya Chatterjee]

11 http://www.fco.gov.uk/Files/kfile/PostG8_Gleneagles_Communique,0.pdf; and Target 7 in Millennium Development Goal 6

> "While funding for HIV programmes has increased in recent years, many countries fail to direct financial resources towards activities that address the prevention needs of the populations at highest risk, opting instead to prioritise more general prevention efforts that are less cost-effective and less likely to have an impact on the epidemic."[12]

3. 2007 will be the mid-point between the Millennium Summit and the 2015 deadlines for many of the MDGs, and there remain just three years before other deadlines fall, such as the Gleneagles G8 commitment on universal access to ARVs.[13] As the time for setting targets recedes and deadlines for achieving those targets draw nearer, a key period of delivery is approaching for donors and the developing world alike. Leadership by respected development agencies such as DFID will be critical. In our 2005 Report, we commended DFID for the "important role which it played in securing the G8 commitment to universal anti-retroviral treatment provision by 2010".[14] In evidence to the Committee, Plan UK argues that DFID should continue "to provide political leadership to ensure that the world comes as close as possible to the goal of universal access".[15] DFID believes that it is doing just that:

> "The UK is the second largest bilateral donor to AIDS, committing £1.5 billion to AIDS work over the period 2005–2008… [and] The UK has helped influence international discussion on the importance of comprehensive prevention strategies"[16]

4. DFID's Parliamentary Under-Secretary of State, Mr Gareth Thomas, explained how DFID's strategy relies heavily on effective national HIV/AIDS plans:

> "I think the targets for the response to AIDS must be country-owned and they must be put in place by the country. Ideally they should be targets which the whole of the donor community in a particular country endorse … I think we can show how our programmes have made a difference … but our approach is not to have separate targets ourselves but to come in behind the targets that countries themselves set."[17]

We understand that DFID is in the process of making an interim evaluation of *Taking Action*, the UK strategy on HIV/AIDS in the developing world.[18] We fully support efforts to measure progress in the implementation of such strategies and look forward to the results of the evaluation. We accept that DFID's strategy of support for effective national HIV/AIDS plans is vital if developing countries are going to meet the targets they set themselves. We do not, however, accept that DFID support for national HIV/AIDS plans and transparent benchmarks for DFID's contribution to the achievement of international

12 UNAIDS, 2006 Report, pp 14-15

13 Another goal linked to 2010 is to have 80% of pregnant HIV-infected women on ARVs which is in the 2001 UN Declaration on HIV/AIDS.

14 International Development Committee, *Delivering the goods: HIV/AIDS and the provision of anti-retrovirals*, HC 708, para 2

15 Memorandum submitted by Plan UK, para 34

16 Memorandum submitted by DFID, para 3

17 Q18

18 DFID, *Taking Action: The UK's strategy for tackling HIV and AIDS in the developing world*, July 2004

'outcome targets' are mutually exclusive. **We are concerned that DFID's indicators of success are linked primarily to funding targets rather than to outcomes. We recommend that in the interim and final evaluations of *Taking Action*, success is measured against transparent 'outcome indicators' as well as 'funding indicators'. Outcome indicators should set out DFID's contribution to achieving the international targets on HIV/AIDS treatment, prevention and care.**

Whitehall policy coherence on HIV/AIDS in the developing world

5. In our 2005 Report, we looked principally at DFID, the lead Government Department on HIV/AIDS in the developing world. We also looked at other Departments which have responsibilities in this area and at the relationship between Departments.[19] In *Taking Action*, DFID undertook to "Improve coherence across UK policy-making on AIDS by establishing an informal cross-Whitehall working group on AIDS".[20]

6. Despite efforts at improved Whitehall coherence, evidence from the International HIV/AIDS Alliance (IHAA) noted the need for closer cooperation on the Government's international action on HIV/AIDS and in particular between DFID and the Foreign and Commonwealth Office (FCO):

> "Significant gains in HIV prevention and impact mitigation could be made through UK efforts outside the remit of the Department for International Development. The Foreign Office's efforts aimed at promoting good governance, respect for human rights, democratic principles and sound management of natural resources… do not currently adequately consider opportunities to advance the UK's commitment to universal access to HIV treatment, prevention and care."[21]

At present, the FCO does not have a specific desk or unit to deal solely with HIV/AIDS issues.

7. In our 2005 inquiry, we were informed about a lack of coordination and consultation between the Home Office, FCO and DFID concerning access to ARV treatment for people living with HIV who have failed in their application for asylum and deportation of some people living with HIV.[22] Evidence received from African HIV Policy Network and Naz Project London suggests that the situation remains substantially the same in 2006: people living with HIV in the UK without documentation who have been refused asylum or leave to remain must routinely pay for HIV/AIDS treatment while in the UK and may be returned to countries where ARVs are "not practically available".[23] The Parliamentary Under-Secretary of State said that payment was an issue if asylum seekers wanted to start a course of treatment after their application had been rejected.[24] He viewed these issues as a

19 International Development Committee, *Delivering the goods: HIV/AIDS and the provision of anti-retrovirals*, HC 708, paras 9 and 10

20 DFID, *Taking Action*, p 3

21 Memorandum submitted by the International HIV/AIDS Alliance, para 11

22 International Development Committee, *Delivering the goods: HIV/AIDS and the provision of anti-retrovirals*, HC 708, para 10

23 Memorandum submitted by Naz Project London, para 6

24 Q 42

question of balance "between the needs of an individual who is HIV positive and the overall need to ensure that we have a strong immigration system".[25] **We see a clear contradiction between a policy of routinely charging those failed asylum seekers who want to start a course of treatment after their application has been rejected and Government advocacy of the universal access goal. We believe that undermining the needs of minority groups in this way is a denial of their human rights and weakens DFID's international leadership on this issue. We believe that DFID should play a role in ensuring that asylum seekers living with HIV are not returned to countries where access to ARVs is not practical. We regret that more progress has not been made on these matters since our last report.**

8. **We are concerned that *Taking Action*, although billed as the UK strategy on HIV/AIDS in the developing world, is in reality only the strategy of DFID. We recommend that DFID work closely with other Departments, particularly the FCO and the Home Office, to develop a truly integrated strategy for the UK's action on HIV/AIDS internationally. This should draw the FCO fully into the governance and human rights aspects of HIV/AIDS and the Home Office into broader UK advocacy of the international goals on HIV/AIDS, such as universal access to treatment.**

25 Q 43

2 Emerging epidemics

Emerging epidemics in Asia and Eastern Europe

9. Sub-Saharan Africa remains the region hit hardest by the HIV pandemic. Across the region, HIV prevalence has stabilised at a high 6% (compared with a global prevalence of 1%).[26] The situation in many individual states is dire. Adult HIV prevalence in Swaziland, for example, is estimated at around 33% and some epidemics, including the one in South Africa, show no signs of decline. There are also disturbing signs that other regions could be on the verge of serious epidemics. The number of people living with HIV/AIDS in Eastern Europe and Central Asia has increased almost twenty-fold in less than a decade.[27] In Asia, though prevalence is low, large populations mean that there are significant numbers of people living with HIV/AIDS, including in India which has the largest single such population in the world. The Parliamentary Under-Secretary of State told us "on current trends the numbers of people as opposed to the prevalence rates in Asia will be higher than for Africa by 2010 if things do not change."[28]

Lessons learned from Africa

10. Some African countries have put in place innovative approaches to HIV/AIDS. We were interested to hear whether these approaches might offer lessons for countries facing new epidemics. For example, the rate of AIDS testing in Botswana has quadrupled as a result of a policy move to 'opt-out testing'.[29] In 2004, 10% of Botswanan people living with HIV had access to ARVs. Today, a third of Botswanans know their HIV status and 85% of those who need treatment get it.[30] Nevertheless when we visited Botswana earlier this year we were told that the sex trade and homosexuality were illegal and that there were no AIDS programmes for these groups. Evidence from UNAIDS acknowledged the benefits of 'opt-out testing' in generalised epidemics but warned that "we have to be very careful in terms of advocating that approach for every country because situations vary enormously and stigma and discrimination are rife. In many settings there is no confidentiality in the healthcare sector… [but] the Botswana approach holds promise in many high prevalence settings".[31] We also heard about the Ugandan experience, where a relatively successful ABC approach ('Abstinence, Be faithful and use Condoms') has been followed by a less successful abstinence-focused programme.[32] UNAIDS and WHO have noted that "current findings do hint at the possible erosion of gains Uganda made against AIDS in the 1990s".[33]

26 UNAIDS, 2006 Report

27 Memorandum submitted by DFID, para 13

28 Q 23

29 Unless they object, all patients entering a clinic or hospital are routinely given an AIDS test. Figures from the Global Policy Forum, www.globalpolicy.org

30 Figures from the Global Policy Forum

31 Q 10 [Dr Anindya Chatterjee]

32 Qq 14, 15 and 37 [Mr Joseph O'Reilly and Mr Gareth Thomas]

33 UNAIDS/WHO, *AIDS Epidemic Update*, December 2006, p 18

11. We accept that there is no one-size-fits-all response to HIV/AIDS epidemics. National programmes should be based on careful assessments of local need. Africa has carried the heaviest regional HIV/AIDS burden for decades and has seen a wide range of responses employed. As a key development partner in Africa, DFID has a valuable perspective on these responses and on best practice that most national governments facing new epidemics will not have. **As emerging epidemics become more generalised, we recommend that DFID ensure that its experience of best practice in Africa is put at the disposal of governments elsewhere, including in Asia and Eastern Europe.**

3 Marginalised groups

"Four key populations"

12. According to much of the evidence we received, four groups, which UNAIDS terms the "four key populations" — sex workers, men who have sex with men, injecting drug users and prisoners — are 'driving' epidemics. The DFID submission notes:

> "Responding to the needs of marginalised groups is not only important in itself, it is often key to halting emerging epidemics, which usually start with concentrations of HIV prevalence in certain groups. These concentrated epidemics … can then spread beyond these contained groups to the wider population. Once HIV moves beyond marginalised groups, countries may face a mixed-, generalised- and ultimately hyper-epidemic where HIV can spread exponentially as can be seen in many southern African countries."[34]

13. While such evidence underlines the importance of reaching these groups, we are concerned that, as UNAIDS told us, national and multilateral programmes often do not succeed in doing so.[35] In oral evidence, UNAIDS gave the example of countries in western Africa where 95% of people are infected through paid sex although only 5% of the national AIDS budget targets sex workers.[36] This view was supported by evidence from the International Planned Parenthood Federation (IPPF):

> "In many settings HIV is concentrated within specific populations … and is not generalised across the population. Despite this, resources to combat the HIV epidemic are frequently used in programmes aimed at the general population."[37]

Human rights of marginalised groups

14. There is significant social stigma attached to HIV/AIDS and this often overlaps with stigma towards, and at times official denial of, marginalised groups. IHAA told us that "marginalisation, discrimination, stigma and invisibility fuel HIV infections for these groups which makes them much more vulnerable … [and unable] to access services".[38] In effect, marginalised groups are therefore doubly vulnerable to the impact of HIV/AIDS. The UNAIDS 2006 Report says:

34 Memorandum submitted by DFID, para 15

35 UNAIDS, 2006 Report, pp 14-15

36 Q 8 [Dr Anindya Chatterjee]

37 Memorandum submitted by International Planned Parenthood Federation, para 4.2

38 Q 5 [Mr Joseph O'Reilly]

> "Ending the AIDS pandemic will depend largely on changing the social norms, attitudes and behaviours that contribute to its expansion. Action against AIDS-related stigma and discrimination must be supported by top leadership and at every level of society, and must address women's empowerment, homophobia, attitudes towards sex workers and injecting drug users."[39]

15. Of the 126 countries who contributed national reports to UNAIDS in 2006, over half acknowledged the existence of policies that interfere with the accessibility and effectiveness of HIV prevention and care measures, such as laws criminalising consensual sex between men or which drive the sex industry underground, and policies limiting or prohibiting condom and needle access in prisons. According to a FCO-funded study conducted by Naz Foundation International (NFI) on policies in South Asia:

> "Prevalent social attitudes and beliefs often inform governmental policies for combating HIV/AIDS. Therefore, while the health ministries of South Asian countries advocate work with MSM [men who have sex with men] to reduce the spread of HIV, the home ministries often persist with promoting laws that criminalise homosexual behaviour." [40]

16. Against this background, tackling HIV effectively emerges not simply as a question of prevention and treatment but also of human rights. As the Secretary of State for International Development said at the UN in June, "We need to recognise that tackling AIDS is not only about money. It's also about culture and social attitudes."[41] The DFID submission expands on this point:

> "There are… both human rights and public health rationales for countries facing emerging epidemics to take immediate action to reduce vulnerability to HIV in marginalised groups... Reaching these groups is vital to halting emerging epidemics; it is also their human right to receive the AIDS services they need."[42]

17. The evidence from IPPF, NFI and IHAA emphasises the importance of developing HIV prevention and care strategies "within a human rights framework".[43] This is often termed a 'rights-based approach' or an approach which emphasises non-discrimination and attention to vulnerability and empowerment. Evidence from IHAA referred to the case of Cambodia, where community-based advocacy groups took a rights-based approach to persuade the Government that not only did marginalised groups exist but that they were key to an effective national response to the epidemic.[44]

18. **We believe that programmes which address the drivers of epidemics, rather than generalised programmes, will be most successful in combating the spread of HIV/AIDS. Social and legal barriers to effective prevention and treatment programmes for key groups need to be addressed in some countries to ensure successful**

39 UNAIDS, 2006 Report

40 NFI, *From the Front Line*, www.nfi.net

41 Memorandum submitted by DFID, para 28

42 Memorandum submitted by DFID, para 16

43 Memorandum submitted by International Planned Parenthood Federation, para 2

44 Q 11 [Mr Joseph O'Reilly]

implementation of national HIV/AIDS strategies. We support such a rights-based approach and recommend that DFID ensure that all national programmes it supports address stigma and discrimination to prevent further marginalisation of those at highest risk of infection. We recommend that, as well as continuing to make these points bilaterally and internationally, DFID make specific efforts to encourage the repeal of restrictive policies, at both domestic and international level, that impede effective services.

Advocacy in international forums

19. The UN high-level meeting in New York this year was an opportunity to put the rights and needs of marginalised groups at the heart of the international community's response to HIV/AIDS.[45] In the event, negotiations did not deliver such a message and the declaration emerging from the meeting remains largely silent on this point. In that context, the evidence from IHAA highlighted an opportunity for the UK:

> "The international community at the UN is not at a point of agreement around an international declaration, for instance, or a new convention on the rights of sexual minorities, but what I think the good offices of the British Government could do is work with countries on a bilateral basis to generate greater community interest and political will aimed at securing greater recognition of the special needs of sexual minorities in the international community and the UN in particular."[46]

In specific terms, IHAA made the case for a UK Special Representative to look at these issues, modelled on the UK Special Representative for Climate Change, and for a UN Special Rapporteur on HIV/AIDS and Human Rights.[47] The international community will need to keep under review the scope for, and value in, more bilateral and multilateral institutions to deal with HIV/AIDS advocacy.

20. **A series of initiatives will be necessary to maintain momentum towards achieving the challenging targets for tackling HIV/AIDS. DFID should remain open-minded about this and should keep under review the case for further bilateral and multilateral representatives to push for progress in neglected areas of HIV/AIDS advocacy.**

Better policy-making through engagement with marginalised groups

21. Some of the evidence we received points to pitfalls in designing and implementing targeted programmes. World Vision's evidence notes that "In most cases, the risks faced by marginalized groups are compounded by virtue of the fact that they belong to more than one 'risk group'".[48] According to IPPF, this overlapping "has implications for how services and information are designed, in that they need to reflect this complexity.

45 UN General Assembly Special Session on HIV/AIDS, June 2006, http://www.un.org/ga/aidsmeeting2006

46 Q 6 [Mr Joseph O'Reilly]

47 Memorandum submitted by International HIV/AIDS Alliance, para 11

48 Memorandum submitted by World Vision, para 3b

Categorising of individuals… [can lead to] stigma and discrimination — where 'groups' become identified as 'vectors for transmission' rather than as individuals".[49]

22. DFID and NGOs provided examples of how support for involvement of marginalised groups in policy formulation could produce policies that better reflect the complexity of the groups, and the overlaps between the groups, being targeted.[50] This is an encouraging start. **We recommend that DFID ensure that key populations are involved in policy formulation consistently across the range of programmes that DFID designs, implements and funds. We also recommend that DFID ensure that its partners, whether NGOs or national governments, support the involvement of people living with HIV and AIDS and marginalised groups in guiding governments and NGOs in their policy-making and in providing the right services.**

49 Memorandum submitted by International Planned Parenthood Federation, para 3.2

50 Memoranda submitted by DFID, paras 46 and 47, and by Naz Foundation International, para 3.2.2.1

4 Conclusion

23. Action to deal specifically with marginalised groups and emerging epidemics is crucial to halting the increase in numbers of people living with HIV/AIDS worldwide. We intend to continue to monitor annually DFID's contribution to this vitally important work, as well as progress more generally towards the Millennium Development Goal and other international targets on HIV/AIDS.

5 List of recommendations

1. We are concerned that DFID's indicators of success are linked primarily to funding targets rather than to outcomes. We recommend that in the interim and final evaluations of *Taking Action*, success is measured against transparent 'outcome indicators' as well as 'funding indicators'. Outcome indicators should set out DFID's contribution to achieving the international targets on HIV/AIDS treatment, prevention and care. (Paragraph 4)

2. We see a clear contradiction between a policy of routinely charging those failed asylum seekers who want to start a course of treatment after their application has been rejected and Government advocacy of the universal access goal. We believe that undermining the needs of minority groups in this way is a denial of their human rights and weakens DFID's international leadership on this issue. We believe that DFID should play a role in ensuring that asylum seekers living with HIV are not returned to countries where access to ARVs is not practical. We regret that more progress has not been made on these matters since our last report. (Paragraph 7)

3. We are concerned that *Taking Action*, although billed as the UK strategy on HIV/AIDS in the developing world, is in reality only the strategy of DFID. We recommend that DFID work closely with other Departments, particularly the FCO and the Home Office, to develop a truly integrated strategy for the UK's action on HIV/AIDS internationally. This should draw the FCO fully into the governance and human rights aspects of HIV/AIDS and the Home Office into broader UK advocacy of the international goals on HIV/AIDS, such as universal access to treatment. (Paragraph 8)

4. As emerging epidemics become more generalised, we recommend that DFID ensure that its experience of best practice in Africa is put at the disposal of governments elsewhere, including in Asia and Eastern Europe. (Paragraph 11)

5. We believe that programmes which address the drivers of epidemics, rather than generalised programmes, will be most successful in combating the spread of HIV/AIDS. Social and legal barriers to effective prevention and treatment programmes for key groups need to be addressed in some countries to ensure successful implementation of national HIV/AIDS strategies. We support such a rights-based approach and recommend that DFID ensure that all national programmes it supports address stigma and discrimination to prevent further marginalisation of those at highest risk of infection. We recommend that, as well as continuing to make these points bilaterally and internationally, DFID make specific efforts to encourage the repeal of restrictive policies, at both domestic and international level, that impede effective services. (Paragraph 18)

6. A series of initiatives will be necessary to maintain momentum towards achieving the challenging targets for tackling HIV/AIDS. DFID should remain open-minded about this and should keep under review the case for further bilateral and multilateral representatives to push for progress in neglected areas of HIV/AIDS advocacy. (Paragraph 20)

7. We recommend that DFID ensure that key populations are involved in policy formulation consistently across the range of programmes that DFID designs, implements and funds. We also recommend that DFID ensure that its partners, whether NGOs or national governments, support the involvement of people living with HIV and AIDS and marginalised groups in guiding governments and NGOs in their policy-making and in providing the right services. (Paragraph 22)

List of witnesses (oral evidence to be published in Volume II of this Report)

Thursday 16 November 2006

Dr Anindya Chatterjee, Senior Adviser, Prevention and Public Policy, UNAIDS, **Kim Mulji,** Executive Director for External Affairs, Naz Foundation International and **Joseph O'Reilly,** Senior Policy Adviser on Prevention, International HIV/AIDS Alliance,

Gareth Thomas MP, Parliamentary Under-Secretary of State, **Robin Gorna,** Senior AIDS Adviser and Team Leader, Global AIDS Policy, Policy and Research Division and **Andrew Rogerson,** Head of Human Development Group, Policy and Research Division, Department for International Development

List of written evidence (to be published in Volume II of this Report)

Written evidence submitted by witnesses who also gave oral evidence

1 Department for International Development
2 International HIV/AIDS Alliance
3 Naz Foundation International

Other written evidence

4 African HIV Policy Network
5 HelpAge International
6 International Planned Parenthood Federation
7 Naz Project London
8 Plan UK
9 Results UK
10 SABMiller
11 World Vision

Formal minutes

Tuesday 28 November 2006

Members present:

Malcolm Bruce, in the Chair

John Battle	James Duddridge
Richard Burden	Ann McKechin
Mr Quentin Davies	Joan Ruddock

Draft Report (HIV/AIDS: Marginalised groups and emerging epidemics), proposed by the Chairman, brought up and read.

Ordered, That the Chairman's draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 23 read and agreed to.

Summary agreed to.

Resolved, That the Report be the Second Report of the Committee to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Ordered, That the Appendices to the Minutes of Evidence taken before the Committee be reported to the House.

[Adjourned till Thursday 30 November at 2.15pm

Reports from the International Development Committee

The Government Responses to International Development Committee reports are listed here in brackets by the HC (or Cm) No. after the report they relate to.

Session 2006–07

First Report	Department for International Development Departmental Report 2006	HC 71

Session 2005–06

First Report	Delivering the Goods: HIV/AIDS and the Provision of Anti-Retrovirals — Volumes I and II	HC 708–I&II (HC 922)
Second Report	Darfur: The killing continues	HC 657 (HC 1017)
Third Report	The WTO Hong Kong Ministerial and the Doha Development Agenda — Volumes I and II	HC 730–I&II (HC 1425)
Fourth Report	Private Sector Development — Volumes I and II	HC 921–I&II (HC 1629)
Fifth Report (First Joint Report)	Strategic Export Controls: Annual Report for 2004, Quarterly Reports for 2005, Licensing Policy and Prior Parliamentary Scrutiny	HC 873 (CM 6954)
Sixth Report	Conflict and Development: Peacebuilding and Post-conflict Reconstruction — Volumes I and II	HC 923–I&II
Seventh Report	Humanitarian Response to Natural Disasters — Volumes I and II	HC 1188-I&II