



House of Commons
International Development
Committee

HIV/AIDS: DFID's New Strategy

Twelfth Report of Session 2007–08

Volume I



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Strategy**

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Volume I

Report, together with formal minutes

*Ordered by The House of Commons
to be printed 25 November 2008*

International Development Committee

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Footnotes

In the footnotes for this Report, references to oral evidence are indicated by 'Q' followed by the question number. References to written evidence are indicated by the page number as in 'Ev 12'.

Contents

Report	<i>Page</i>
Summary	3
1 Introduction	5
The scale of the challenge	6
Structure of our Report	6
2 Funding	8
Funding for health system strengthening	8
Disease-specific funding	12
An integrated approach to funding	14
Tackling HIV/AIDS in middle-income countries	16
3 Interaction with other diseases	17
Tuberculosis	17
Malaria	18
4 Children	20
Social Protection Programmes	20
Paediatric care	22
5 Women	24
The 'feminisation' of HIV/AIDS	24
DFID's Strategy and women	25
Gender-based violence	26
Prevention of mother-to-child transmission of HIV/AIDS	27
Integration with sexual and reproductive health	29
6 Marginalised Groups	32
7 Engagement with Civil Society	34
8 Implementation, Monitoring and Evaluation	37
Implementing the Strategy	37
Monitoring and Evaluation	40
9 Conclusion	43
List of Conclusions and Recommendations	44
Formal Minutes	49
Witnesses	50
List of written evidence	50
List of Reports from the Committee during the current Parliament	51

Summary

The AIDS epidemic continues to have a devastating impact in the developing world. 33 million people currently live with AIDS; every day nearly 6,000 people die and nearly 7,000 become infected. 12 million children are estimated to have lost one or both parents to the disease in sub-Saharan Africa.

Against the background of an ongoing global search for solutions to this epidemic, the Department for International Development (DFID) launched its new HIV/AIDS Strategy *Achieving Universal Access: the UK's strategy for halting and reversing the spread of HIV in the developing world* in June 2008.

DFID is widely acknowledged as a global leader in tackling HIV/AIDS, particularly amongst vulnerable and marginalised groups, including women and children. Its Strategy provides an excellent analysis of the challenges faced in tackling HIV/AIDS effectively. It makes substantial financial commitments, most notably £6 billion over seven years to strengthen health systems in partner countries. We wholeheartedly support this level of funding for health systems: HIV/AIDS will never be halted without well-resourced and capable health services in developing countries.

DFID has also allocated £1 billion over the same period for the Global Fund to Fight AIDS, Tuberculosis and Malaria. We agree that direct and specific HIV/AIDS funding of this kind continues to be necessary to fill the gaps in prevention and treatment services in high-prevalence countries. However, it is crucial that DFID ensures that the two funding streams are fully integrated to avoid some of the negative impacts which have occurred in the past.

Despite these significant funding commitments, we find the Strategy to be strong on rhetoric but weak in communicating how DFID will implement it. There are few measurable targets or indicators of how the Strategy's effectiveness will be assessed. DFID fails to explain how the high-level funding commitments will be broken down by country or sector, making it difficult to understand how implementation will occur on the ground.

No monitoring and evaluation framework has yet been provided for the new Strategy although DFID is expected to publish this very shortly. It is essential that this sets out specific targets and corresponding indicators so that it is possible to identify whether the programmes which DFID supports are achieving their aims.

We have concerns that social protection programmes, which are now DFID's main instrument for assisting children orphaned and made vulnerable by HIV/AIDS, will not be specifically targeted at this vulnerable group and may not reach children who live outside traditional households.

Women are more likely than men to be affected by HIV/AIDS. Gender inequalities and lack of financial empowerment mean that they are more vulnerable to infection and have less capacity to access prevention and treatment services. Gender-based violence is a frequent contributory factor in transmission of HIV infection. DFID fully acknowledges

these problems but fails to set out in any detail how it plans to address them.

DFID has a strong record of assistance to people living with HIV who belong to so-called marginalised groups: intravenous drug users, sex workers, prisoners and men who have sex with men. However, the Strategy does not make clear what specific practical steps DFID will take to assist these vulnerable people in the future. The Strategy also fails to explain how DFID will engage with civil society to implement its pledges. Civil society organisations fulfil a crucial role in providing advocacy and services for people who suffer stigma and discrimination and are therefore much less likely than the general population to use state-provided health and social services.

The Strategy is best seen as laying the foundations for a new UK approach to tackling HIV/AIDS in developing countries. The challenge remains for DFID to build on this and to make clear to all stakeholders, and particularly partner countries, how these plans will be taken forward. This needs to be done soon. The overall aim of the Strategy is universal access to HIV prevention, treatment and care, but the target date for achieving this is only two years away in 2010.

1 Introduction

1. Millennium Development Goal 6 is to combat HIV/AIDS, malaria and other diseases by 2015. In 2005, under the UK presidency of the G8 and the European Union, the international community made a further commitment: to ensure universal access to comprehensive HIV prevention, treatment, care and support by 2010.¹

2. It has been our practice during this Parliament to conduct an annual inquiry to assess the extent to which the Department for International Development (DFID) is fulfilling its pledges on HIV/AIDS. In 2005, we looked at provision of anti-retroviral treatment; in 2006 we focussed on marginalised groups; and in 2007 we integrated our work on HIV/AIDS into our inquiry into Maternal Health.² DFID's role as a global leader on HIV/AIDS is widely recognised. The launch in June 2008 of the Department's updated HIV/AIDS Strategy, *Achieving Universal Access: the UK's strategy for halting and reversing the spread of HIV in the developing world*, therefore provided an obvious focus for our inquiry this year.

3. The main elements of DFID's 2008 strategy are:

- £6 billion over seven years targeted at health system strengthening;
- £1 billion for the Global Fund to Fight AIDS, Tuberculosis and Malaria to 2015;
- A pledge to work with others to increase to 80% the percentage of HIV-infected women who receive anti-retroviral treatment by 2010 to reduce the risk of mother to child transmission;
- An undertaking to work with international partners to provide at least 2.3 health professionals per 1,000 population;
- A commitment to work with others to halve the unmet demand for family planning by 2010 and to achieve universal access by 2015;
- £200 million to support social protection programmes over the next three years to assist children orphaned and made vulnerable by HIV/AIDS;
- A 50% increase in funding for research and development of AIDS vaccines and microbicides;
- £90 million channelled through UNITAID to increase access to paediatric care.³

¹ DFID, *Achieving Universal Access: the UK's strategy for halting and reversing the spread of HIV in the developing world*, June 2008, Foreword

² International Development Committee: First Report of Session 2005-06, *Delivering the Goods: HIV/AIDS and the provision of anti-retrovirals*, HC 708-I; Second Report of Session 2006-07, *HIV/AIDS: Marginalised groups and emerging epidemics*, HC 46-I; Fifth Report of Session 2007-08, *Maternal Health*, HC 66-I

³ *Achieving Universal Access*, pp 4-5; Ev 34

The scale of the challenge

4. Since DFID's 2004 Strategy *Taking Action*⁴ was launched, some progress has been made in tackling the HIV/AIDS epidemic. The percentage of the world's adult population living with HIV has levelled off although the absolute number is still rising; the number of people with access to anti-retroviral treatment reached three million in 2007, reducing the number of HIV related deaths; and the cost of front line drugs has dropped below \$100 per unit for the first time.⁵

5. However the AIDS epidemic continues to pose a huge challenge in the developing world. More than 33 million people are living with HIV and nearly 7,000 more become infected every day. Prevention services are still not reaching a large proportion of marginalised groups which include sex workers, intravenous drug users, men who have sex with men and prisoners.⁶ As well as the human costs of the AIDS epidemic, it poses a severe threat to economic development, security, and public services in many countries. Tackling the disease therefore remains central to effective development assistance.

Structure of our Report

6. DFID's new Strategy (and its accompanying evidence volume⁷) provides an excellent analysis of the challenges the world faces in tackling HIV/AIDS and offers significant high-level funding commitments to take forward DFID's work in this area, which have been welcomed by our witnesses and which we fully support. But as the Minister himself admitted in oral evidence:

Nobody has questioned DFID's mission or its strategy but there are some serious questions to be asked about delivery and also about our interaction with donors, with NGOs and with governments in terms of achieving what we say we want to achieve.⁸

We share the concern that many questions remain to be answered about delivery of the Strategy. Our Report therefore seeks to highlight the areas where we believe DFID needs to provide more detail and explanation than is given in the Strategy document. In particular we will examine:

- how the funding will be allocated and spent and the steps which will be taken to ensure that it specifically benefits people living with HIV and AIDS (Chapter 2);
- the action DFID will take to tackle the interaction between HIV/AIDS and other diseases, particularly tuberculosis (Chapter 3);
- how the disproportionate impact of HIV/AIDS on women, children and other vulnerable and marginalised groups can be mitigated (Chapters 4 to 6);

⁴ DFID, *Taking Action: Summary of the UK's strategy for tackling HIV and AIDS in the developing world*, 2004

⁵ *Achieving Universal Access*, pp 1 and 8

⁶ *Achieving Universal Access*, p 8

⁷ DFID, *Achieving Universal Access — Evidence for Action*

⁸ Q 106

- how DFID intends to involve civil society in delivering the Strategy (Chapter 7); and
- how DFID plans to monitor and evaluate the Strategy (Chapter 8).

We hope that some of these issues will be clarified when DFID publishes its Monitoring and Evaluation Framework for the Strategy, which was not available to us in preparing this Report but which the Minister told us would be available on World AIDS Day on 1 December 2008.⁹

7. In the course of this inquiry, we received written submission from 16 organisations and individuals. We held two oral evidence sessions: the first was with non-governmental organisations (NGOs), activists and academics, including by videolink with Lucy Chesire, an HIV/TB advocate based in Kenya. The second session was with Ivan Lewis MP, Parliamentary Under-Secretary of State for International Development and DFID officials. We would like to thank all those who contributed to our inquiry.

⁹ Q 72

2 Funding

8. As the International HIV/AIDS Alliance points out, DFID's new Strategy represents "a shift in DFID thinking about how to fund the AIDS response" which has resulted in a much greater emphasis on funding health systems rather than specific HIV/AIDS programmes.¹⁰ DFID plans to spend £6 billion in the period to 2015 to strengthen national health systems and services in developing countries (this is sometimes referred to as "horizontal" funding). DFID, in common with many other major donors, already allocates a significant proportion of its development assistance direct to national governments' budgets. This can be unallocated general budget support or more targeted support for particular sectors, such as health and education (also known as Sector-Wide Approaches (SWAps)).

Funding for health system strengthening

9. DFID states that "major, sustained efforts to strengthen health systems are critical to achieving universal access" to HIV/AIDS treatment.¹¹ It explains that: "We want to fund the health sector in its entirety rather than individual elements of it as this will deliver the sustainability needed in the longer term."¹² DFID's Strategy refers to the UNAIDS (the Joint UN Programme on HIV/AIDS) recommendation that 25% of the resources needed to achieve universal access should go to strengthening health systems.¹³

10. Witnesses agreed that there are advantages in directing funds towards health systems. Interact Worldwide's written evidence said "it is now widely acknowledged that expanded support for health systems strengthening is essential to the response" to HIV/AIDS. Interact believes that dedicated HIV/AIDS funding has resulted in HIV services which are superior to general health services; the latter now need to be brought up to the level of HIV services and this can only be achieved through broader health system strengthening.¹⁴ The UK Consortium on AIDS echoed this view: "it is undeniable that health systems funding and budget support is an essential aspect of the AIDS response and critical to delivering the health MDGs".¹⁵

11. Strengthening national health systems provides a sustainable long-term solution to HIV/AIDS as it builds countries' own capacity, enabling them to respond to the demands which HIV/AIDS makes on them. For example, it is estimated that Africa needs an additional 427,500 health workers to achieve universal access to HIV/AIDS treatment.¹⁶ Funds for national health systems will contribute to training more health professionals and paying them at a rate which may help to prevent them leaving their home countries to earn

¹⁰ Ev 72

¹¹ Ev 41

¹² Ev 36

¹³ *Achieving Universal Access*, p 35

¹⁴ Ev 60

¹⁵ Ev 102

¹⁶ UNAIDS, *Financial Resources Required to Achieve Universal Access to HIV Prevention, Treatment Care and Support*, September 2007

higher salaries abroad. Such funding will also contribute to the other necessary elements in building up a capable and sufficient health workforce including: the expansion of health education systems; in-service training; human resource management; and improvements in working conditions.¹⁷

12. When asked about the reasons for DFID's decision to concentrate on strengthening health systems the Minister said;

I think there was a broader consensus that actually, in terms of the UK's continued world leadership in this area, this was the right thing to do. Now, it is a judgment call and not everybody agrees with us, but we are absolutely convinced that this is the right thing.¹⁸

DFID's written evidence makes clear that the UK's decision to focus on horizontal funding was at least in part to complement the strong emphasis which other donors place on targeted (or "vertical") HIV/AIDS funding. The Minister reinforced in oral evidence that the need to balance vertical funding from other donors had been a significant factor in DFID's decision to give such weight to funding for health systems.¹⁹

13. One of the most notable sources of vertical funding for HIV/AIDS comes from the United States through the President's Emergency Plan for AIDS Relief (PEPFAR) which has provided \$19 billion to support national AIDS responses since 2004.²⁰ However, PEPFAR funding comes with certain conditions. For example, the initiative has a special emphasis on 15 countries—all of them in Africa except for Vietnam; and it advocates abstinence and being faithful—the so-called 'AB' strategies—with limits being placed on condom provision and promotion.²¹ Similar conditions also apply to US development funding more broadly. **Should the new US Administration decide to review its approach to development funding, including the US President's Emergency Plan for AIDS Relief (PEPFAR), we would urge the UK Government to take an early opportunity to discuss with them potential areas for co-operation.**

14. Strengthening health systems is an important component of HIV prevention. As the Strategy emphasises, nearly 7,000 people become newly infected each day; the disease is not curable; the cost of providing anti-retroviral drugs throughout an individual's life may therefore be considerable and, given the high prevalence in many countries, the burden of treating people with HIV/AIDS is likely to be unsustainable for those countries in the future.²² Prevention is therefore central to a cost-effective and sustainable approach to tackling HIV/AIDS. Prevention is multi-faceted. Messages about the steps which can be taken to prevent infection, such as condom use and avoiding high-risk behaviour, need to

¹⁷ UNAIDS, *Financial Resources Required to Achieve Universal Access to HIV Prevention, Treatment Care and Support*, September 2007

¹⁸ Q 61

¹⁹ Qq 66-71

²⁰ Ev 41; and *Achieving Universal Access*, p 49

²¹ The President's Emergency Plan for AIDS Relief online at www.usaid.gov/our_work/global_health/aids and "What is the President's Emergency Plan for AIDS Relief?", Avert website, www.avert.org/pepfar. It should be noted that in practice PEPFAR funding can go to any US-funded HIV/AIDS work worldwide. Condom provision and promotion is aimed at certain groups under PEPFAR, mainly high risk users, rather than general populations.

²² *Achieving Universal Access*, pp 8, 44 and 46

be conveyed at every opportunity when people access health services. National health systems in developing countries will have much greater capacity to take forward this cross-cutting approach to HIV prevention if they are well-resourced and staff are properly trained. DFID's funding can clearly make a significant contribution to building this capacity.

15. Concerns have, however, been raised as to whether horizontal funding actually improves health systems to a level where high quality treatment is being given. Some fear that funding for health sector strengthening might stretch resources too thinly, to the point where the actual improvements in the services that people receive are marginal. This has led some commentators to characterise horizontal funding as resulting in "generalised insufficiency".²³ Evidence from Médecins sans Frontières (MSF) also points out that "general systems measures take a long time to bring about improvements at the patient interface" and will not produce the rapid change required in access to HIV/AIDS services. MSF believes that the focus of DFID's health systems funding should therefore be on the abolition of user fees, recruitment of health professionals and ensuring that a reliable supply of drugs is available.²⁴

16. It is also much more difficult to pinpoint the effect that health systems funding has on tackling a particular disease than it is with dedicated, disease-specific funding. Witnesses believed that DFID must ensure that health system strengthening delivers results on the ground. Alvaro Bermejo, Executive Director of the International AIDS Alliance, told us:

It is [...] important that health systems strengthening has specific health outcomes in mind [...] We need to retain that focus on health outcomes and if it is not improving health outcomes then it is not good health system strengthening.²⁵

Dr Kent Buse, a health policy analyst, highlighted that, at the moment, there is little evidence about the tangible impact that money spent on health system strengthening has on combating HIV/AIDS.²⁶ The UK Consortium on AIDS drew attention to a case study in Zambia which found that support for the health sector budget helped the government deal with routine health problems but "not the extraordinary problems such as AIDS, TB and malaria". The Consortium also highlighted that in Mozambique it had been found that funding delivered through budget support increased resources for health services but that these only benefited certain groups.²⁷ Interact Worldwide was concerned that measuring the impact of DFID's health system funding would be difficult because:

[...] the allocation of this funding has not been well articulated. Much of it may already be committed to multilateral financing processes [...] The development of indicators for monitoring and evaluation of the Strategy are currently being

²³ "The 'diagonal' approach to Global Fund financing: a cure for the broader malaise of health systems?", Gorik Ooms et al, *Globalisation and Health*, Volume 4, 2008

²⁴ Ev 79

²⁵ Q 28

²⁶ Q 23

²⁷ Ev 101-102; see also Action for Global Health, *Healthy Aid: Why Europe must deliver more aid, better spent to help save the health MDGs*, 2008

negotiated. Without a transparent split of available of funds it will be impossible to trace the impact of this regardless of the indicators in place.²⁸

17. We were anxious to clarify how much of the £6 billion pledged for health services strengthening in the Strategy represented new money rather than funding that DFID had already committed or planned to spend through its country programmes or through multilateral programmes. The Minister told us “as far as I know, it is new money”.²⁹

18. Witnesses highlighted in oral evidence that, despite the substantial amounts of development assistance specifically allocated to the health sector in developing countries, a significant funding gap remains. They told us that around \$9–14 per capita per year is being spent on healthcare, against an estimated required spending level of somewhere between \$40 and \$80 to provide an adequate level of healthcare.³⁰ The Minister pointed to the UNAIDS estimate of an overall funding gap of £8 billion in the resources needed to tackle HIV/AIDS.³¹ Alvaro Bermejo of the International HIV/AIDS Alliance believed that increasing current overall per capita health expenditure, which is insufficient to meet the health Millennium Development Goals (MDGs), was more important than discussing how funds should be allocated.³²

19. Funding for health system strengthening is an essential part of development assistance and we welcome the substantial sums that DFID is allocating to it. Developing countries will never be capable of tackling HIV/AIDS effectively unless the overall capacity of their health systems is built up through adequate funding, including the capacity to pursue robust prevention strategies. Our concern, however, is that DFID has included this funding as part of its HIV/AIDS Strategy but the specific impact that it may have on HIV/AIDS will be difficult to measure. We recommend that, as part of its monitoring and evaluation of the Strategy, DFID put in place indicators to assess the impact that funding directed at health system strengthening is having on reducing the spread of HIV/AIDS and related diseases.

20. The Minister was only able to give us a partial reassurance that the £6 billion DFID has allocated for strengthening national health services is genuinely new money, which is additional to any previous funding announcements, rather than simply being a redirection of existing commitments. Further clarification is required. We therefore request a full breakdown of how this £6 billion total has been calculated in response to this Report. Moreover, DFID has not yet spelled out in clear terms how this substantial sum will be spent. Until the precise allocations, and their timescales, are known, it will be impossible to assess how much impact this apparently bold allocation of funding is likely to have or whether it will be adequate to meet the ambitious target of universal access by 2010. We therefore invite DFID to provide the necessary detail in response to this Report.

²⁸ Ev 60

²⁹ Q 60

³⁰ Q 20 [Mr Bermejo], Q 22 [Dr Buse]

³¹ Q 67; UNAIDS, *Financial Resources Required to Achieve Universal Access to HIV Prevention, Treatment Care and Support*, September 2007, p 4

³² Q 20

Disease-specific funding

21. The second significant block of funding within the Strategy is targeted specifically at addressing HIV/AIDS and associated diseases (often referred to as “vertical funding”). This funding, first announced in September 2007, will provide £1 billion to the Global Fund to Fight AIDS, Tuberculosis and Malaria (“the Global Fund”) over a seven-year period.³³ DFID’s view is that it is important to maintain its support for targeted funding of this kind as without it, it is unlikely that health systems in hyper-epidemic countries would have coped with the burden that HIV/AIDS has placed on them.³⁴ Its submission draws attention to the view held by supporters of vertical funding that, without such funding, “governments would have made very little progress towards achieving universal access” particularly “where political leadership and accountability are weak and commitment to AIDS is lacking.”³⁵ Interact Worldwide agrees that disease-specific funding continues to fulfil an important function:

While horizontal funding through health systems strengthening will be able to improve the medical response to the epidemic, vertical funds have a place in ensuring that this response is comprehensive in its impact.³⁶

22. Alvaro Bermejo, of the International HIV/AIDS Alliance, told us of several cases where vertical funding had contributed to the creation of a stronger health system. Such funding has reduced the burden that HIV patients put on the health system, provided treatment for health staff (who themselves are often living with HIV), improved procurement procedures and brought groups that do not normally attend clinics into the healthcare system.³⁷ In its written submission, DFID gives the example of Ethiopia where the Global Fund has become the major donor in training and allocating 30,000 community health workers.³⁸

23. However, disease-specific funding can also have a negative impact. DFID states that “vertical funds can both strengthen and undermine broader health systems” and that it is “aware of the argument that earmarking funds for AIDS can be distorting, unsustainable and can overload fragile health systems”.³⁹ Disease-specific programmes can draw staff away from working in the public health system by offering higher salaries. The UK Consortium on AIDS highlights a study in three African countries (Mozambique, Uganda and Zambia) which found that AIDS programmes had adversely affected health systems in terms of information management, supply and human resources.⁴⁰

24. Disease-specific AIDS-funding is also generally ‘off-budget’—it is not part of the national government’s expenditure, and it can therefore be difficult for partner countries to

³³ <http://www.dfid.gov.uk/news/files/pressreleases/global-fund.asp>

³⁴ Ev 40

³⁵ Ev 40

³⁶ Ev 60

³⁷ Q 22 [Mr Bermejo]

³⁸ Ev 40

³⁹ Ev 40-41

⁴⁰ Ev 101

track and monitor.⁴¹ As we pointed out in our recent Report on aid effectiveness, funding which is not part of national budgets can also place onerous reporting requirements on partner countries.⁴² DFID is keen to point out that “it is essential that whatever the chosen mechanism for support that donors do not create additional burdens or transaction costs for countries”.⁴³

25. Country health systems can also be by-passed by vertical funding because it does not come from national governments and therefore does not incentivise programme managers to co-ordinate their work or engage with government-run programmes. This risks undermining “country ownership”, a key principle of the Paris Declaration on Aid Effectiveness, which emphasises that developing countries themselves should exercise leadership over their development policies and strategies.⁴⁴ We have commented previously on the importance of this principle in improving aid effectiveness.⁴⁵

26. We welcome DFID’s substantial funding for the Global Fund to Fight AIDS, TB and Malaria. Disease-specific funding continues to provide vital resources to tackle the HIV/AIDS epidemic and the Global Fund’s work has been invaluable. However, it is important that vertical funding supports rather than conflicts with national government healthcare systems and that it adheres fully to the principles of the Paris Declaration on Aid Effectiveness, to which the Global Fund is a signatory. We recommend that DFID continues to use its position as a major donor to the Global Fund to ensure that its funding is fully accountable to national governments and civil society in the countries where the Fund operates.

Tracking the impact of disease-specific funding

27. We have commented previously on the challenges presented in tracking funding channelled through multilateral organisations.⁴⁶ It is very difficult to disaggregate the impact of DFID’s specific funding within the multilateral body’s overall expenditure. Channelling funding through a multilateral organisation also puts DFID at arm’s length from the delivery of the services it is funding.

28. In our evidence session with the Minister we questioned him about the Global Fund’s decision to grant \$500 million to Zimbabwe. Zimbabwean law requires foreign exchange to be deposited with the Reserve Bank, which the government controls. Concerns had been raised by opposition parties and NGOs in Zimbabwe that the money would be diverted by the government away from the intended beneficiaries—those living with HIV/AIDS and related diseases.⁴⁷ The Minister acknowledged that, when DFID contributes to multilateral organisations, it relinquishes some control over its resources. But he assured us that “the

⁴¹ Ev 41

⁴² International Development Committee, Ninth Report of Session 2006-2007, *Working together to make aid more effective*, HC 520-I

⁴³ Ev 36

⁴⁴ Q 22 [Dr Buse]; see also the Paris Declaration on Aid Effectiveness, reproduced in the Committee’s Ninth Report of Session 2007-08, *Working together to make aid more effective*, HC 520-I, Appendix

⁴⁵ Ninth Report of Session 2007-08, *Working together to make aid more effective*, HC 520-I, paras 18-20

⁴⁶ See for example First Report of Session 2007-08, *DFID Annual Report 2007*, HC 64-I, para 15

⁴⁷ “Corruption fears over Zimbabwe’s £300m aid”, *Daily Telegraph*, 23 October 2008

UK has a very clear record in demanding maximum accountability and maximum transparency, and we will continue to do that.”⁴⁸ Since the evidence session, the Global Fund has requested the return of \$7.3 million of the \$12.3 million it gave to Zimbabwe last year as it was discovered that these funds had not been used for their proper purpose. The Global Fund has temporarily frozen its funding for Zimbabwe.⁴⁹

29. We were concerned to learn that a substantial sum from the Global Fund has been misappropriated by the Zimbabwean government. Zimbabwe is arguably a unique case and it appears that the Global Fund has dealt appropriately with this example of misuse of its money. However, the case highlights the need for DFID to continue to press for the highest standards of accountability and transparency in the use of funds which it channels through multilateral organisations, particularly in countries with weak or undemocratic governments.

An integrated approach to funding

30. The different challenges presented in using health system strengthening (horizontal funding) and disease-specific (vertical) funding to tackle HIV/AIDS means that greater attention is turning to using an integrated (or ‘diagonal’) approach. This aims both to tackle HIV/AIDS and to support and drive growth in health systems and services by using “funding for AIDS treatment and prevention [...] [as] the driving wedge for urgently needed increases in the overall level of resources available for health.”⁵⁰

31. DFID acknowledges that an effective strategy requires both horizontal and vertical funding. However, as Alvaro Bermejo pointed out, if DFID is to pursue effective integrated funding, it is not sufficient merely to fund both health system strengthening and disease-specific programmes: “that is not integration, that is a balance of two investments”.⁵¹ To achieve effective integration, DFID needs to take steps to ensure that its funding for health system strengthening reinforces the positive benefits that disease-specific funding has for health systems.⁵² In terms of delivery of services, MSF cautioned that “the emphasis on integration needs to be handled with care”; the primary health care systems in many countries are:

[...] non-existent or of very poor quality. Much work needs to be done before HIV/AIDS care can be integrated without compromising on quality and access, and premature integration could cause a setback in AIDS care delivery.⁵³

The UK Consortium on AIDS points to an attempt in Zambia to integrate the vertical TB programme into the mainstream health system which led to the collapse of the TB

⁴⁸ Q 81

⁴⁹ “Zimbabwe ‘misused millions of dollars meant to fight Aids’”, *The Herald*, 4 November 2008 and “Mugabe bank accused of pilfering from aid agency”, *The Times*; 7 November 2008

⁵⁰ “The ‘diagonal’ approach to Global Fund financing: a cure for the broader malaise of health systems?”, Gorik Ooms et al, *Globalisation and Health*, Volume 4, 2008

⁵¹ Q 28

⁵² Q 28

⁵³ Ev 81

programme. It believes this highlights the need for political commitment and proper planning and management if integration is to be successful.⁵⁴

32. The International HIV/AIDS Alliance provided a positive example of the integrated approach. The Global Fund's grant to Rwanda for the period 2005–09 included specific health systems strengthening (HSS) objectives; a mid-term evaluation found that many of the targets had been exceeded. More broadly, the Global Fund has established an HSS funding window which aims to strengthen health systems to provide HIV/AIDS, TB and malaria services but also to directly fund partner governments in support of their national AIDS and health plans.⁵⁵ Another positive example of an integrated approach, and one that we highlighted in our Maternal Health Report earlier this year, is Malawi's Emergency Human Resource Plan, a six-year programme funded by the Government of Malawi, the Global Fund and DFID, which has expanded training capacity in the health service by 50%, increased the salaries of health workers and addressed the reallocation of health resources.⁵⁶

33. There is therefore a consensus that a more integrated approach to HIV/AIDS funding is required to ensure that disease-specific funding supports broader health systems and that the capacity of national health services is built up to enable them to provide essential care and treatment to people living with HIV and AIDS. The International Health Partnership (IHP) launched by the UK in September 2007 and now led by the World Health Organisation would seem the obvious mechanism for DFID to take forward an integrated approach, particularly as UNAIDS, the Global Fund and the UN Population Fund are members of the Partnership.

34. A new Taskforce on Innovative Financing of Health Systems has also been established under the chairmanship of the UK Prime Minister and the President of the World Bank, with the aim of mobilising funding for health systems. The Taskforce is intended to complement the IHP which has no funding capability but which focuses on co-ordination. The UK has pledged to spend almost £450 million over three years to support national health plans in eight IHP countries.⁵⁷ This funding is included in the £6 billion commitment which DFID has made to health systems strengthening as part of the AIDS strategy.⁵⁸

35. We believe that a more integrated approach to HIV/AIDS funding is required. The International Health Partnership and the Taskforce on Innovative Financing of Health Systems are UK initiatives which feed directly into a more integrated approach to HIV/AIDS funding. We would encourage DFID to use the full capacity of these initiatives to ensure that its funding streams for health systems strengthening and disease-specific programmes are mutually reinforcing and to press other donors to follow the UK lead towards such an integrated approach.

⁵⁴ Ev 102

⁵⁵ Ev 74

⁵⁶ Fifth Report of Session 2007-08, HC 66-I, paras 106-107; see also Ev 101

⁵⁷ The countries are: Ethiopia, Mozambique, Kenya, Zambia, Burundi, Nigeria, Cambodia and Nepal. See UN, *Committing to action: achieving the MDGs – Compilation of Partnership Events and Commitments*, 25 September 2008

⁵⁸ Written Evidence submitted by DFID in the Committee's inquiry into the DFID Annual Report 2008, relevant to the oral evidence session with the Secretary of State on the UN High Level Event on the MDGs, 30 October 2008, para 14

Tackling HIV/AIDS in middle-income countries

36. If Millennium Development Goal 6 is to be achieved by 2015, and universal access to treatment for HIV/AIDS by 2010, tackling HIV/AIDS in all high-prevalence countries needs to be given a higher priority. Several of these are middle-income countries (MICs), including in southern Africa, Latin America and the Caribbean. However some witnesses have raised concerns that DFID is no longer paying sufficient attention to the prevalence of HIV/AIDS in middle-income countries. The International HIV/AIDS Alliance said in its written evidence:

Middle Income Countries with concentrated epidemics have some of the highest incidence rates in the world. It does not make sense for one of the leading donor governments to withdraw its resources, including expertise, at such a critical time in the progress of the epidemic in these countries.⁵⁹

MICs will not benefit from the bulk of the funding that DFID has pledged in the Strategy because of the UK's longstanding commitment to spend 90% of its bilateral resources in lower income countries (LICs) and only 10% in middle-income countries.

37. DFID makes it clear in the Strategy that “we have limited capacity to support work in MICs”.⁶⁰ DFID officials told us that these countries have sufficient resources of their own to tackle HIV/AIDS and that therefore DFID's focus should be on providing technical support to enable them to use these resources effectively.⁶¹ In addition to relying on multilateral organisations to lead HIV/AIDS work in MICs, the Strategy envisages an enhanced role for the Foreign and Commonwealth Office (FCO) in supporting the UK's efforts on HIV/AIDS.⁶² When we asked what practical training and engagement DFID officials had undertaken with FCO officials we were told that there were regular discussions but were given no details of what further support DFID intends to provide to the FCO to ensure it is properly equipped to take on this enhanced HIV/AIDS role.⁶³

38. Targets for tackling HIV/AIDS will not be achieved without substantial progress in prevention and treatment in middle-income countries. The Strategy envisages that the Foreign and Commonwealth Office will take on an enhanced role in tackling HIV/AIDS, particularly in middle-income countries where DFID has a minimal presence. It is vital to ensure that FCO officials are properly equipped to carry out these duties. We invite DFID to share with us its detailed planning for cross-departmental working on HIV/AIDS, particularly in middle-income countries with high prevalence levels.

⁵⁹ Ev 69

⁶⁰ *Achieving Universal Access*, p 50

⁶¹ Qq 115-118

⁶² *Achieving Universal Access*, p 59

⁶³ Q 119

3 Interaction with other diseases

Tuberculosis

39. A recent report by the House of Lords Select Committee on Intergovernmental Organisations, *Diseases know no frontiers*, recommended that “UK funding to combat HIV/AIDS in developing countries should be conditional on the adoption of an integrated approach to fighting TB-HIV co-infection.”⁶⁴ Tuberculosis (TB) is the most common cause of death among people with HIV: about 13% of AIDS deaths each year are a result of co-infection with TB.⁶⁵ In sub-Saharan Africa up to 80% of TB patients are co-infected with HIV.⁶⁶ TB is much harder to diagnose in people living with HIV and someone who is co-infected with TB and HIV is much more likely to become sick with TB compared to someone suffering from TB alone. Currently less than 15% of TB patients in Africa are tested for HIV despite the high rate of co-infection.⁶⁷ The most recent data shows that only 1% of people living with HIV/AIDS are screened for TB; but of those who have been screened, more than 25% were found to have TB.⁶⁸ DFID's evidence indicates that only 42% of countries with generalised HIV epidemics screen for TB, and approximately one-third of affected countries does not have a national plan that integrates HIV and TB activities.⁶⁹

40. Witnesses drew attention to the increase in multi-drug resistant strains of TB (MDR-TB) which make it more difficult and costly to deal with the impact of TB.⁷⁰ MDR-TB can result when TB treatment is incomplete or in cases where an incorrect or incomplete combination of drugs is prescribed. Treatment of drug resistant forms of the disease takes longer, and requires a higher quantity of more expensive drugs. Besides the added time and expense required for treatment, fatality rates are high. If a person has drug resistant TB, anyone they pass it on to will also have the same resistance. TB Alert says that a standardized drug regimen (known as “directly observed treatment”) a good supply of high quality drugs, and isolation of infectious patients with drug resistant forms of the disease are some of the main ways to prevent the spread of MDR-TB.⁷¹

41. DFID argued in its written evidence that the best way to deal with the interaction between HIV/AIDS and other diseases is through an approach that focuses on strengthening health systems and services overall.⁷² The main element of DFID's work to tackle disease interaction is therefore the £6 billion funding for strengthening health

⁶⁴ House of Lords Select Committee on Intergovernmental Organisations, First Report of Session 2007-08, *Diseases know no frontiers: How effective are Intergovernmental Organisations in preventing their spread?*, HL Paper 143-I, p 48

⁶⁵ World Health Organisation, *The Three I's: Intensified Care Finding (ICF), Isoniazid Preventive Therapy (ITP) and TB Infection Control (IC) for people living with HIV*. Report of a WHO Joint HIV and TB Department Meeting, Geneva, Switzerland, April 2008

⁶⁶ Ev 35

⁶⁷ Ev 35

⁶⁸ Ev 84

⁶⁹ Ev 35

⁷⁰ Ev 55

⁷¹ TB Alert: see <http://www.tbalert.org>

⁷² Ev 36

services which we have discussed above. In addition, DFID has already made a commitment to increase research into tools for the prevention, diagnosis and treatment of TB in its Research Strategy 2008–2013.⁷³ The £1 billion pledged to the Global Fund to Fight AIDS, TB and Malaria will also address the interaction between HIV and TB.

42. In its written evidence, the non-governmental organisation Results UK raised concerns that the Strategy failed to set out what measures DFID will take to address the interaction between TB and HIV.⁷⁴ The NGO is concerned that the Strategy provides no clarification on how DFID will fulfil its commitment to support “closer integration of AIDS, TB, malaria and SRHR [sexual and reproductive health rights] including maternal and child health services”⁷⁵ and no indication is given of how DFID will measure its effectiveness in tackling the interaction. Results UK suggested that meaningful indicators could include the proportion of TB patients being tested for HIV; and the number of people in HIV care who had started TB treatment.⁷⁶

43. We also heard from Lucy Chesire, a Kenyan HIV-TB advocate, about the problems in the diagnosis of TB in people living with HIV. There is a reliance on outdated diagnostic techniques such as x-rays which are not sufficiently effective in identifying TB.⁷⁷ During our session with the Minister he stressed that “improving diagnostics is right at the heart of creating improved universal health systems.”⁷⁸ However, while the Strategy acknowledges the importance of improving diagnostics, only one concrete funding proposal is made to increase general access to diagnostics, and this is limited to southern Africa.⁷⁹

44. While the funding for health systems strengthening committed by DFID may well contribute to the treatment and diagnosis of patients with HIV and TB, we are not convinced that DFID is taking sufficient steps to ensure that the specific challenge of interaction between the two diseases is tackled. Nor has DFID set out how it will measure the effectiveness of its Strategy in addressing the interaction. We expect to see a clearer indication of how this work will be taken forward and measured in DFID's forthcoming Monitoring and Evaluation Framework.

Malaria

45. The interaction between HIV/AIDS and malaria also poses a serious challenge to public health in developing countries. People living with HIV/AIDS who become infected with malaria are more likely to develop severe manifestations of the disease such as anaemia and cerebral malaria. They are also less responsive to malaria treatment and have a higher mortality rate from the disease. Pregnant HIV-positive women with placental malaria

⁷³ DFID, *Research Strategy 2008-2013*, p 8

⁷⁴ Ev 85

⁷⁵ *Achieving Universal Access*, p 4

⁷⁶ Ev 87

⁷⁷ Qq 4-5 and 9-11

⁷⁸ Q 104

⁷⁹ *Achieving Universal Access*, p 45

infection are more likely to experience anaemia, adverse birth outcomes such as pre-term birth and intra-uterine growth retardation, and deliver a low-birthweight baby.⁸⁰

46. The Malaria Consortium argued in its written evidence that the Strategy does not address the interaction between HIV and malaria.⁸¹ DFID says that “stronger links must be forged between TB, malaria and HIV services”,⁸² but the Strategy does not elaborate on how such links could be forged. Nor does it explore the possibility of joint diagnosis for HIV and malaria.

47. At the UN High Level Event on the MDGs held on 25 September a Global Malaria Action Plan was announced. The Plan aims to achieve “near zero preventable deaths” by 2015, with the ultimate aim of eradicating the disease.⁸³ In support of the Plan, the UK has pledged:

- £40 million for the Affordable Medicines Facility for Malaria
- To increase funding for malaria vaccine research to up to £5 million per year by 2010; and
- To provide 20 million of the 125 million bed nets that are needed to close the global shortfall in bed nets by 2010.⁸⁴

48. The interaction between HIV/AIDS and malaria must be tackled as part of an effective AIDS Strategy. We welcome the commitments made by DFID in support of the Global Malaria Action Plan. It is not clear to us, however, how this important work on malaria will be integrated with the HIV/AIDS Strategy. We invite DFID to provide us with further information on this in its response to this Report.

⁸⁰ Ev 77

⁸¹ Ev 77

⁸² *Achieving Universal Access*, p 35

⁸³ “\$3bn ploughed into fight against malaria”, *The Guardian*, 26 September 2008

⁸⁴ “World leaders commit record billions to tackle malaria”, DFID Press Release, 25 September 2008

4 Children

49. HIV/AIDS is having a disproportionate impact on children. Around 12 million children in sub-Saharan Africa have lost one or both of their parents to HIV/AIDS.⁸⁵ Approximately 1.8 million children are living with HIV/AIDS in the region; and the World Health Organisation found that HIV was the leading cause of death of children under five in six southern African countries.⁸⁶ Children who live with HIV/AIDS are more likely to die as a result of infection than adults: children make up 6% of the infected population but account for 14% of deaths.⁸⁷ Moreover, children are only a third as likely as adults to get access to anti-retroviral medication.⁸⁸

Social Protection Programmes

50. Evidence from World Vision pointed out that DFID's previous AIDS Strategy *Taking Action* included £150 million in earmarked funding for children orphaned or made vulnerable by HIV/AIDS, which represented 10% of all the Department's AIDS expenditure during that period.⁸⁹ However, the new Strategy has moved away from this approach. Instead, DFID intends to spend £200 million over the next three years to expand social protection programmes (SPPs) in eight African countries, including the provision of cash transfers. DFID says that this funding "will provide effective and predictable support for the most vulnerable households, including those with children affected by AIDS."⁹⁰ The Strategy explains that the change of approach is intended to complement continued high levels of direct support for orphaned and vulnerable children (OVCs) from other donors, notably PEPFAR.⁹¹

51. We asked the Minister which eight countries DFID had selected to work with on SPPs for the first three-year period. We were told that this was still being finalised. Nor was the Minister able to tell us at that time what criteria would be used in selecting the countries.⁹² However, in subsequent written evidence DFID has clarified that the criteria it will use to determine to which countries it will provide this support are "demand from countries themselves; a niche for DFID to provide this support; high HIV prevalence and high OVC burden."⁹³ The countries chosen for SPP support may change during the Strategy's seven-year period, "mainly due to the fact that project cycles tend to have 3–5 year time frames."⁹⁴ DFID identified 10 countries where it is already providing bilateral support for social protection for children affected by AIDS and five others where it contributes to multilateral

⁸⁵ Ev 103

⁸⁶ Ev 103 and Ev 91

⁸⁷ Ev 91

⁸⁸ UNAIDS, *2008 Global Report*

⁸⁹ Ev 103

⁹⁰ *Achieving Universal Access*, pp 5, 41

⁹¹ *Achieving Universal Access*, p 39

⁹² Q 93

⁹³ Ev 44

⁹⁴ Ev 44

support.⁹⁵ In separate oral evidence, DFID's Director General Policy and Research told us that DFID was funding social transfers in 20 African countries.⁹⁶

52. DFID cited evidence from UNICEF that “well designed social cash transfer programmes could reach 80% of HIV affected households in need of assistance in low and middle income countries with high HIV prevalence”.⁹⁷ Such assistance can “help secure basic subsistence, reduce poverty and protect children’s access to education, health and good nutrition”.⁹⁸ Children whose families receive cash transfers are less likely to need to keep their children home from school to help support their family.⁹⁹ In Zambia cash transfers have reduced school truancy by 16%.¹⁰⁰ DFID argues that ensuring that children get access to education is not only an important end in itself but also plays a role in preventing children becoming infected with HIV as it provides essential knowledge about HIV and helps to challenge some of the underlying factors that fuel the spread of HIV including harmful social norms around gender, sexuality and stigma.¹⁰¹ Girls who complete secondary education are less likely to become infected with HIV while boys who complete their education are more likely to practise safer sex.¹⁰²

53. The evidence we received expressed two main concerns about DFID’s proposal to support social protection programmes. The first is that there is a need to ensure that social protection plans have a wider focus than just providing cash transfers. NGOs who work with orphans and vulnerable children highlighted the need for social protection programmes to include improvements in support services for vulnerable children—for example, family support services, psycho-social support, child protection services and legal assistance.¹⁰³ DFID’s written evidence states that its support for social protection would not be limited to cash transfers, but no detailed information was provided about the other kinds of support it intended to provide.¹⁰⁴

54. The second concern is that social protection programmes risk not reaching some of the most vulnerable children. Cash transfers will be targeted at households but many of the most vulnerable children, including orphaned children and street children, do not live in traditional households and therefore might not benefit from programmes targeted at households. Stuart Kean of the UK Consortium on AIDS told us: “There are various groups of children who are outside of the family context and cash transfers are not going to easily reach them.”¹⁰⁵ The Consortium for Street Children reinforced the point that “home-

⁹⁵ Ev 44

⁹⁶ Oral evidence taken on 30 October 2008 on the UN High Level Event on the MDGs, Q 140 [Mr Steer]

⁹⁷ Ev 34

⁹⁸ Ev 44

⁹⁹ Adato, M. and Bassett L. “What is the potential of cash transfers to strengthen families affected by HIV and AIDS? A review of the evidence on impacts and key policy debates”, Joint Learning Initiative on Children and AIDS, August 2008

¹⁰⁰ Q 94

¹⁰¹ *Achieving Universal Access*, p 38

¹⁰² *Achieving Universal Access*, p 38

¹⁰³ Ev 103

¹⁰⁴ Ev 34

¹⁰⁵ Q 54

based care programmes [...] are poorly suited to reach children living and working on the streets”.¹⁰⁶ World Vision stressed that vulnerable households with children would be only one of the groups which social protection programmes were trying to assist and that even where money reached such households, there was no guarantee that it would benefit children specifically, because of the risk of “poor intra-household distribution”.¹⁰⁷

55. DFID already funds social protection programmes in a number of countries. It is therefore unclear to us whether the pledge in the AIDS Strategy to spend £200 million on such programmes over a three-year period is a new commitment or a continuation of DFID's existing work in this area. We expect clarification on this. Nor is it clear to us how DFID will ensure that children affected by HIV/AIDS, specifically, are assisted through social protection programmes and cash transfers. Indicators to measure impact in this area are needed and we would expect these to be included in the Monitoring and Evaluation Framework which DFID is developing.

Paediatric care

56. The second substantial commitment that DFID has made towards dealing with the impact of HIV/AIDS on children is its plans to allocate £90 million over the next three years to improve paediatric treatment.¹⁰⁸ This funding will be channelled through UNITAID, which was established in 2006 as a joint initiative between the UK, France, Norway, Chile and Brazil to supply poor countries with lower cost life-saving medicines for AIDS, tuberculosis and malaria. It is administered by the World Health Organisation with a mission “to intervene in markets to lower the cost of drugs and speed up the rate at which they are made available”. The DFID Strategy reports that, to date, in partnership with other donors, UNITAID has achieved a 40% reduction in the cost of paediatric anti-retroviral treatments.¹⁰⁹ DFID officials told us that UNITAID “has been slightly slow in starting and getting off the ground, but we feel that it has huge potential.”¹¹⁰

57. In addition to improving the supply of anti-retroviral medication for children, witnesses drew to our attention the importance of treatment to prevent opportunistic infection in children with HIV. HIV weakens the ability of a child's immune system to fight off infection. Provision of the prophylaxis cotrimoxazole can reduce the number of deaths from infections such as pneumonia by 43%.¹¹¹ Stuart Kean told us that cotrimoxazole costs “one or two pence a day”.¹¹² Yet World Vision pointed to a recent WHO report which showed that only 4% of children born to women living with HIV had received the drug despite a WHO recommendation that all children exposed to HIV should receive it until they are shown to be uninfected.¹¹³ Malcolm McNeil, DFID's AIDS and Reproductive Health Team Leader, told us that DFID is actively promoting the use of

¹⁰⁶ Ev 57-58

¹⁰⁷ Ev 103

¹⁰⁸ Ev 34

¹⁰⁹ *Achieving Universal Access*, p 52; see also UNITAID website at www.unitaid.eu

¹¹⁰ Q 88

¹¹¹ Q 49

¹¹² Q 49

¹¹³ Ev 105; *Achieving Universal Access: evidence for action*, pp 31-32

this drug, but that the ultimate decision on whether to use it rests with national authorities.¹¹⁴

58. Children living with HIV should not be dying needlessly when a cheap and effective antibiotic is available to mitigate their vulnerability to opportunistic infections. We would encourage DFID to continue to press partner governments to ensure that cotrimoxazole is prescribed for children likely to be infected with HIV and to train their health staff to administer the drug safely.

¹¹⁴ Q 86

5 Women

The 'feminisation' of HIV/AIDS

59. A key characteristic of the HIV/AIDS epidemic in recent years has been the disproportionate impact on women—which DFID describes as the 'feminisation' of the disease.¹¹⁵ As ActionAid told us, 60% of all adults living with HIV/AIDS are women and three-quarters of young people who are HIV-positive are female.¹¹⁶ Whilst the proportion of women among people living with HIV globally has remained stable for several years, women's share of infections has increased in many regions.¹¹⁷

60. Multiple factors have driven this. Firstly, women can far more easily become infected through sex than men due to biological factors. Secondly, socio-economic factors put women and girls at higher risk of the infection. In many developing countries, pervasive gender inequalities disadvantage women and girls—especially those living in poverty—in multiple ways. For example, cultural norms and lack of economic empowerment mean that women often struggle to negotiate their rights to safe sex and some are led into sex work. Women also struggle to access adequate treatment once they are infected: written evidence from ActionAid cited lack of money for treatment and travel, dependence on male partners for money, inability to take time off work to access health treatments, distance to facilities and lack of confidentiality as the main barriers women face when trying to access HIV/AIDS treatment.¹¹⁸

61. The disproportionate impact of the epidemic on females also reflects the fact that the needs of women and girls are not being adequately addressed in national and international responses to HIV.¹¹⁹ For example, the 'ABC' (Abstinence, Be Faithful and Condomise) strategies promoted in many developing countries tend to focus on 'high risk' groups (for instance, sex workers and drug users). In some countries, this has helped popularise the mistaken assumption that marriage protects against HIV. In South Africa married women are identified as the group most at risk of HIV infection and more than four-fifths of new infections in women result from sex with their husbands or primary partners.¹²⁰

62. Addressing gender inequalities should be at the heart of effective prevention and treatment of HIV/AIDS. Specially tailored policies that focus on education and socio-economic empowerment of women and girls are needed to help reverse the current trend of high levels of infection amongst women. We believe that efforts should be made to target these strategies beyond traditional high risk groups such as sex workers to include young people and married couples.

¹¹⁵ *Achieving Universal Access*, see pp 2 and 9

¹¹⁶ Ev 45

¹¹⁷ UNAIDS, *2008 Global Report*, p 30

¹¹⁸ Ev 49

¹¹⁹ UNAIDS, Statement to the Fifty-first session of the Commission on the Status of Women 2007, online at <http://data.unaids.org/pub>

¹²⁰ HIV/AIDS and the Media Project, University of the Witwatersrand, online at <http://www.journals.org/gender.php>

DFID's Strategy and women

63. DFID's new Strategy highlights that medical approaches towards preventing and treating the virus will never be fully effective unless the social and behavioural actions that drive the epidemic are addressed.¹²¹ The Strategy underlines the close relationship between HIV and violence, and the link with harmful traditional practices such as child marriage and female genital mutilation.¹²² It supports a holistic approach to women and HIV that recognises the need for a broad-ranging approach encompassing working with men and boys, with the justice and education sectors, and through the provision of social protection measures (to support people, often women, who are caring for relatives suffering from AIDS).¹²³ **We support the holistic approach towards women and HIV that DFID advocates in its new Strategy. Addressing embedded gender inequalities will rely on wide-ranging strategies that bring together health, education, justice and social protection agendas.**

64. The new Strategy makes several commitments to address the impact of HIV on women, including:

- support for female-controlled HIV prevention—a pledge to increase by at least 50% DFID funding for research and development of AIDS vaccines and microbicides between 2008–2013;¹²⁴
- a recognition of the importance of integrating HIV with sexual and reproductive health services (see paragraphs 76–82);
- a pledge to train DFID staff on women's rights (in line with the Department's Gender Equality Action Plan); and
- attention to the burden of care on women with £200 million funding over the next three years for social protection programmes.¹²⁵

65. However, welcome as these commitments are, few have practical strategies attached to them and details as to how they will be implemented are lacking. The UK Consortium on AIDS Gender Working Group told us:

There are mentions of gender throughout the strategy and recognition of the need to address gender as a key driver of the pandemic. However it does not detail how this will be achieved or what might be done differently.¹²⁶

Fionnuala Murphy of ActionAid emphasised to us that the challenge regarding the Strategy's "important first steps" on gender lies in their implementation:

¹²¹ *Achieving Universal Access*, p 16

¹²² *Achieving Universal Access*, p 25

¹²³ *Achieving Universal Access*, p 25

¹²⁴ Microbicides are gels and creams which women can use to protect themselves from HIV, and offer a female-controlled route to protection (for example where a woman is unable to persuade her partner to wear a condom). DFID currently contributes over £9 million each year to research and development (*Achieving Universal Access*, p 19).

¹²⁵ Q 39 [Fionnuala Murphy]

¹²⁶ Ev 98

They are very top-line promises and they are actually talking about very complex cultural and structural issues, so the real challenge is what action does DFID propose to take and how will DFID measure success and make sure [...] that we have delivered real benefits for women and girls.¹²⁷

She highlighted four specific requirements that ActionAid believes DFID needs to fulfil to have a meaningful impact on HIV/AIDS amongst women and girls:

- a breakdown showing what proportion of DFID's £6 billion health systems funding will go towards addressing the impact of HIV/AIDS on women;
- a commitment to greater international leadership on the feminisation of HIV/AIDS, including the development of a "long-term global advocacy plan that identifies key moments and key opportunities to influence these issues" and highlights "strategic activities that DFID will undertake";
- a comprehensive training programme for DFID staff on the linkages between women's rights and HIV; and
- the development of an action plan on violence against women, with associated funding.

This could include using DFID funds to train health workers to recognise signs of violence and understand the particular support needed to address it.¹²⁸

66. We commend the emphasis in the new DFID Strategy on the disproportionate impact of HIV/AIDS on women and girls. However, we are concerned by the lack of concrete and country-specific policies within the document. The Strategy does more to describe the impact of HIV/AIDS on women and girls rather than to indicate how DFID will tackle it. Beyond an important but limited set of commitments on HIV prevention and social protection, gender-specific policies and funding pledges are lacking. We recommend the development of a global action plan, linked to the AIDS Strategy, which sets out the actions DFID will take to support women-specific approaches to the epidemic over a specified timescale.

Gender-based violence

67. Sexual and/or gender-based violence (GBV) is closely linked to the spread of HIV. Studies from southern Africa show up to threefold increases in HIV risk among women who have experienced violence compared to those who have not.¹²⁹ Violence-related factors that increase women's risk to HIV include:

¹²⁷ Q 39 [Fionnuala Murphy]

¹²⁸ Qq 41-43

¹²⁹ The Global Coalition on Women and AIDS and WHO, 'Violence Against Women and HIV/AIDS: Critical Intersections – Intimate Partner Violence and HIV/AIDS' (Information Bulletin Series, No.1), pp 1-3, online at <http://www.who.int/gender/violence/en/>

- exposure to blood and direct transmission through sexual violence;
- sexual abuse during childhood and forced sexual initiation during adolescence (including sex with higher risk/older men); and
- constraints on women's ability to negotiate condom use.¹³⁰

68. No concrete actions aimed at addressing gender-based violence are included in the Strategy commitments.¹³¹ In our Report on Maternal Health published earlier this year, we highlighted successful DFID-funded projects addressing gender-based violence (GBV) in Nepal, Bangladesh and South Africa and recommended that DFID seek to replicate these approaches elsewhere.¹³² However, no such strategies or approaches are included in DFID's new Strategy.

69. We are concerned about DFID's lack of dedicated strategies and funding to address gender-based violence (GBV), which is closely linked to the spread of HIV. We highlighted successful DFID-funded approaches to addressing GBV in Nepal, Bangladesh and South Africa in our Maternal Health Report earlier this year and were disappointed not to see information on scaling up or replicating these initiatives included in the new Strategy. We recommend that, in its Response, DFID provides us with a policy update which sets out details of the specific approaches it will take to address GBV, including the necessary funding commitments.

Prevention of mother-to-child transmission of HIV/AIDS

70. A further Strategy commitment in relation to women living with HIV is the pledge to "intensify international efforts to increase to 80% by 2010 the percentage of HIV-infected pregnant women who receive anti-retroviral treatments (ARVs) to reduce the risk of mother-to-child transmission" of the infection.¹³³

71. The prevention of mother-to-child transmission (PMTCT) is a central platform within international strategies to prevent the spread of HIV. 90% of paediatric HIV is due to mother-to-child transmission. Without access to services to prevent transmission, about 35% of infants born to HIV-positive mothers will acquire the virus during pregnancy, labour, delivery or breast-feeding.¹³⁴ As Stuart Kean of the UK Consortium on AIDS told us, developed countries such as the UK have virtually eliminated paediatric HIV cases through a package of care that includes the provision of ARVs.¹³⁵ Yet worldwide only 34% of women currently have access to PMTCT services.¹³⁶ Of the 21 countries on track to meet

¹³⁰ The Global Coalition on Women and AIDS and WHO, 'Violence Against Women and HIV/AIDS: Critical Intersections – Intimate Partner Violence and HIV/AIDS' (Information Bulletin Series, No.1), pp 1-3, online at <http://www.who.int/gender/violence/en>

¹³¹ *Achieving Universal Access*, pp 4-5

¹³² International Development Committee, Fifth Report of Session 2007-08, *Maternal Health*, HC 66-I, paras 26 and 29

¹³³ *Achieving Universal Access*, p 4

¹³⁴ Ev 105

¹³⁵ Q 48

¹³⁶ *Achieving Universal Access*, p 17

the 80% ARV provision target by 2010, only four are from the eight “hyper endemic” southern African countries listed in DFID’s Strategy.¹³⁷

72. Witnesses welcomed DFID’s pledge to help increase access to PMTCT.¹³⁸ However, Interact Worldwide was concerned that DFID’s commitment focused exclusively on ARV provision rather than a fuller strategy that included other aspects of the care package needed to protect against transmission. Interact stated:

According to the World Health Organisation, comprehensive PMTCT also includes: delivery and post-partum care; HIV treatment for women, infants and their families as appropriate; SRH [sexual and reproductive health] services, including family planning; and dual protection advice for women and their partners.¹³⁹

Alvaro Bermejo of the International HIV/AIDS Alliance emphasised the importance of making a full package of integrated services, including family planning, available. He stated that the “the most cost-effective way of preventing mother-to-child transmission is investing in preventing unwanted pregnancies and making sure that the general population has access to good sexual and reproductive health services.”¹⁴⁰

73. World Vision’s evidence highlighted the concern that DFID’s commitment to “work with others to intensify international efforts” on PMTCT is couched in terms of a contribution to global efforts. Disaggregating the Department’s specific contribution and setting out ways of measuring it are therefore of increased importance.¹⁴¹

74. We welcome DFID’s pledge to support an increase in the percentage of HIV-infected pregnant women who receive anti-retroviral treatments (ARVs) to 80% by 2010, and thereby reduce mother-to-child transmission of HIV. However, ARV provision is only one of a number of interventions to prevent transmission recommended by the World Health Organisation. We recommend that DFID works to ensure ARV provision forms one, critical, part of a care package for HIV positive mothers that also includes the full range of required interventions.

75. We note the ambitious level of percentage increase needed to meet DFID’s commitment to increasing ARV coverage for HIV-infected pregnant women: from the current rate of 34% to 80% in just two years’ time. We expect to see a clear commitment on how progress towards this ambitious and short-term target will be measured in DFID’s Monitoring and Evaluation Framework which is due to be published on 1 December 2008. We recommend that the Framework includes an indication of the level of DFID’s specific projected contribution to the international efforts to reach this target.

¹³⁷ The eight hyper-endemic countries are: Botswana, Lesotho, Namibia, Swaziland, South Africa, Mozambique, Zambia and Zimbabwe.

¹³⁸ Q 48

¹³⁹ Ev 59

¹⁴⁰ Q 27 [Alvaro Bermejo]. See the following sub-section for more discussion of integrating health services.

¹⁴¹ Ev 105

Integration with sexual and reproductive health

76. There are close intersections between sexual, reproductive and maternal health and HIV/AIDS. As Interact Worldwide stated:

Causes of poor sexual and reproductive health (SRH) and HIV and AIDS are intimately related and have common drivers: poverty, gender inequity, marginalisation and stigma, discrimination and denial. To separate the responses is therefore to divorce them from the reality in which sexual and reproductive behaviour takes place and is, in turn, contributing towards the lack of progress being made to address issues such as maternal mortality, unintended pregnancies and HIV and AIDS.¹⁴²

77. Yet in many national health systems, sexual and reproductive health (SRH) and HIV/AIDS treatment and care are administered and funded separately, with poor collaboration between the sectors.¹⁴³ Integrated responses help avoid the creation of parallel systems and bring policy and programming for HIV and SRH closer together. It can be confusing, expensive and time-consuming for people to visit different facilities for HIV, sexually transmitted infections and other SRH treatment and care. Integrated delivery can also reduce the costs for providers of services.¹⁴⁴ As DFID points out in its Strategy, women's first interaction with the health system is often their use of maternal health services, and thus integration of AIDS services offers an important opportunity to engage women in HIV prevention and care.¹⁴⁵ According to the World Health Organisation, integrated interventions that address HIV and SRH, along with maternal health, might include:

- counselling on reproductive choices including protecting against unwanted pregnancies;
- condom provision (male and female);
- screening and treatment programmes for sexually transmitted infections (STIs) including HIV;
- prevention of mother-to-child transmission of HIV;
- provision of anti-retroviral therapy and treatment for STIs; and
- programmes for adolescents and young people focusing on their particular SRH needs.¹⁴⁶

78. We explored the issue of integrating SRH with HIV and maternal health services in our Report on Maternal Health, published in February 2008. We drew attention to the importance of making screening and treatment for sexually transmitted infections

¹⁴² Ev 59

¹⁴³ Ev 66-67

¹⁴⁴ Ev 66-67

¹⁴⁵ *Achieving Universal Access*, p 34

¹⁴⁶ WHO HIV Technical Briefs, *Strengthening Linkages between Sexual and Reproductive Health and HIV*, April 2007

including HIV available at family planning clinics, because attendance at such clinics is often routine for women, thereby helping to remove the stigma attached to HIV testing.¹⁴⁷ We highlighted that witnesses to our inquiry believed that the Global Fund should do more to support integrated HIV, maternal, and sexual and reproductive health interventions, for instance through the training of skilled birth attendants.¹⁴⁸

79. DFID's Strategy includes closer integration of HIV/AIDS and SRH, as well as maternal and child health services, TB and malaria as a Priority for Action.¹⁴⁹ It highlights efforts it is making to improve integration, for example its provision of £52.8 million over seven years to promote SRH services for HIV prevention in Nigeria.¹⁵⁰

80. Witnesses were broadly impressed with the Strategy's emphasis on integration. Interact Worldwide considered DFID to have a comparative advantage amongst donors in strengthening the linkages between SRH and HIV/AIDS.¹⁵¹ The UK Consortium on AIDS and International Development agreed that DFID's leadership in integrating HIV/AIDS and SRH agendas and services is 'essential'.¹⁵² However, as we have noted, Médecins sans Frontières cautioned against trying to integrate services prematurely in contexts where primary health care is not yet operational or of sufficient quality. MSF stated:

Much work needs to be done before HIV/AIDS care can be integrated without compromising on quality and access, and premature integration could cause a setback in AIDS care delivery. The emphasis on integration therefore needs to be handled with care. 'Achieving Universal Access' refers to service delivery that is effective as well as integrated—in many cases these objectives will be at cross purposes and a trade-off will be required.¹⁵³

DFID's perspective was that governments and agencies working with health systems that were not set up to integrate services were "missing opportunities to deliver more effective services."¹⁵⁴ However, its Strategy does note that "integration needs to recognise the stage of the epidemic and the needs of specific groups."¹⁵⁵

81. A key route towards ensuring national health systems are ready and willing to better integrate responses will be advocacy work by donors such as DFID to promote a broader integration agenda. As Interact Worldwide stated, "Countries need to want and to be in a position to implement integrated services."¹⁵⁶ Interact suggested that DFID should target its advocacy not just at national governments but at the Global Fund, the World Bank, the World Health Organisation, the UN Population Fund (UNFPA) and UNAIDS who all

¹⁴⁷ Fifth Report of Session 2007-08, *Maternal Health*, HC 66-I, paras 81-82

¹⁴⁸ Fifth Report of Session 2007-08 (HC 66), *Maternal Health*, HC 66-I, paras 81-82

¹⁴⁹ *Achieving Universal Access*, p 4

¹⁵⁰ *Achieving Universal Access*, p 35. This support is offered between 2002 and 2009.

¹⁵¹ Ev 59

¹⁵² Ev 94

¹⁵³ Ev 81

¹⁵⁴ *Achieving Universal Access*, p 34

¹⁵⁵ *Achieving Universal Access*, p 35

¹⁵⁶ Ev 62

potentially play a key role in the integration of health services.¹⁵⁷ It also suggested that DFID's support for health sector-wide approaches (SWAps) offered an opportunity for different funding partners to support comprehensive health sector responses to SRH and HIV.¹⁵⁸

82. We welcome the focus in the Strategy on closer integration of HIV/AIDS and sexual and reproductive health services (SRH), together with maternal and child health, TB and malaria. SRH and HIV/AIDS cannot be separated as health issues and accordingly DFID is right to include better integrated responses as a priority action. We believe that integration will be more effective where it is prioritised by health systems that are ready and willing to implement it. Accordingly, we recommend that DFID presses both national governments and multilateral donors—particularly the Global Fund, the World Bank and the relevant UN agencies—to do more to support the integration of services.

¹⁵⁷ Ev 59 and Ev 68

¹⁵⁸ Ev 67

6 Marginalised Groups

83. Our 2006 Report on HIV/AIDS focused on emerging epidemics amongst what UNAIDS described as “marginalised groups”: sex workers, intravenous drug users, men who have sex with men, and prisoners. We pointed out that, in some countries, the existence of these groups is often denied or the illegal nature of their activities means that governments fail to address their needs.¹⁵⁹ We stressed then that marginalised groups are central to an effective HIV/AIDS response because they are frequently the ‘drivers’ of the epidemic: infection becomes endemic within these groups and then spreads out to the general population. We recommended that DFID ensure that all the national programmes it supported tackled stigma and discrimination and that social and legal barriers to prevention and treatment were addressed. We also recommended that DFID work with partner governments to ensure that HIV/AIDS programmes were properly focused on marginalised groups and that their rights and needs were not overlooked.¹⁶⁰

84. In its written evidence, DFID acknowledged that “stigma and discrimination remain major barriers to achieving Universal Access and require urgent attention.”¹⁶¹ The Strategy makes clear that DFID recognises that marginalised groups “are most likely to be failed by existing policies, programmes, support and services” and that “we will collectively fail to address the epidemic if we fail to reach these groups with appropriate services—which take into account the realities of their lives”.¹⁶² DFID accepts that it is often difficult to reach these groups with effective interventions and that some national authorities continue to deny the existence of some groups or classify their behaviour as illegal.¹⁶³ The International HIV/AIDS Alliance stressed that members of marginalised and vulnerable groups “have limited trust in government” to meet their needs and that they are often excluded from wider political and social participation so that “general health service development may continue to fail to meet their needs.”¹⁶⁴ MSF emphasised that “country plans often exclude vulnerable groups” partly due to the “generalised, one-size-fits-all approach which frequently neglects specific needs and gaps in care delivery” and partly due to “stigmatisation and the prejudice of planners”.¹⁶⁵

85. The Alliance acknowledged the leadership role DFID has played in advocating for barriers to be removed which prevent marginalised groups from accessing services and welcomed the actions the FCO has taken to promote the rights of marginalised groups through its policy position on lesbian, gay, bisexual and transgender populations. But the Alliance believed that the Strategy gave “inadequate attention to the challenges of meeting

¹⁵⁹ Second Report of Session 2006-07, *HIV/AIDS: Marginalised Groups and Emerging Epidemics*, HC 46-1, Summary

¹⁶⁰ Second Report of Session 2006-07, paragraph 5 and Summary

¹⁶¹ Ev 42

¹⁶² *Achieving Universal Access*, p 23

¹⁶³ *Achieving Universal Access*, p 23

¹⁶⁴ Ev 71

¹⁶⁵ Ev 80

the needs of key populations, including sex workers and MSM [men who have sex with men].”¹⁶⁶ Its Executive Director stressed in oral evidence that:

[...] containing the HIV epidemic requires stopping the fastest growing epidemics, many of which are outside sub-Saharan Africa, many of them are in middle income countries and many of them are fuelled by key populations, by marginalised groups.¹⁶⁷

86. We have set out earlier why we believe prevention is vital. Effective prevention strategies which reach the ‘drivers’ of the epidemic—marginalised groups—are clearly crucial if DFID is to achieve its aim of halting and reversing the spread of HIV. Alvaro Bermejo of the International HIV/AIDS Alliance emphasised the need for interventions targeted on the needs of marginalised groups. He gave the example of transgender individuals, in India and Latin America, amongst whom HIV prevalence is around 40%, the highest sub-group prevalence in the world. He stressed that no amount of funding channelled through health system support would reach groups such as transgender individuals because they are stigmatised and publicly-provided services cannot properly cater for them. He believed that DFID’s Strategy recognised this need but did not specify how the challenge would be addressed.¹⁶⁸

87. If the global effort on HIV/AIDS is to achieve the goal of halting and reversing the spread of the disease, it must be effective in reaching marginalised people, including sex workers, intravenous drug users, men who have sex with men and transgender individuals. If the epidemic is not tackled in these groups it will continue to spread to the general population and the number of people affected will continue to increase. DFID’s Strategy acknowledges this reality but does not adequately explain how DFID will ensure that these marginalised people are provided with the prevention, treatment and support services they require. We would welcome further information on DFID’s plans in this area in response to this Report.

88. Civil society is particularly important in reaching marginalised groups who are much less likely to use services provided by the state. It is not clear to us from the Strategy how DFID will support civil society organisations in this vital work. We will explore the role of civil society in the next chapter.

¹⁶⁶ Ev 75

¹⁶⁷ Q 24

¹⁶⁸ Q 24

7 Engagement with Civil Society

89. In the previous chapter, we explored the ways in which DFID's Strategy will address the particular challenge of tackling HIV/AIDS amongst marginalised and vulnerable groups. Civil society organisations are vital to this work because they can reach stigmatised groups and people who fear discrimination in ways which are unlikely to be possible for state-funded agencies, and they have proved that they can find innovative ways of providing them with prevention, treatment and support services.

90. DFID's Strategy states that "Civil society has a key role to play in advocating and providing services, in particular for vulnerable populations, in strengthening accountability, and in building social movements."¹⁶⁹ However, as Tearfund pointed out in its evidence:

[...] despite the positive rhetoric in the Strategy regarding the role of civil society, there is no clear indication of how DFID intends to harness and support the considerable contribution of civil society actors. This is particularly concerning as the population groups highlighted for particular attention in the Strategy [...] are supported by a vast array of civil society programmes.¹⁷⁰

91. While witnesses were generally complimentary about DFID's willingness to work with civil society, we also heard that DFID's engagement with civil society in the development of the Strategy had been variable.¹⁷¹ Nor does the Strategy clarify what DFID plans to do to improve support to civil society.¹⁷²

92. Civil society organisations can enhance government accountability and transparency, influence policy through social mobilization, act as intermediaries between communities and government, and provide goods and services which the private sector or the state does not.¹⁷³ This is particularly important for the delivery of health services as in many African countries governments are the minority supplier of health services with most care being supplied by faith and community-based organisations.¹⁷⁴ The International HIV/AIDS Alliance argues that low levels of civil society participation in planning, co-ordinating and monitoring programmes can result in projects that are less likely to be responsive to the situation on the ground, less well-targeted and which are not rapidly scaled up.¹⁷⁵

93. Alvaro Bermejo, Executive Director of the Alliance, told us that working with civil society groups sometimes offered a more stable and sustainable way of providing treatment as in some countries there was greater continuity in civil society provision of treatment

¹⁶⁹ *Achieving Universal Access*, p 4

¹⁷⁰ Ev 92

¹⁷¹ Q 31

¹⁷² Ev 71

¹⁷³ Ev 70-71

¹⁷⁴ Q 21

¹⁷⁵ Ev 70-71

than was found with government-supported healthcare. He cited an AIDS programme which the Alliance has been supporting in Ukraine since 2004. During that time:

[...] there have been four different governments and seven different health ministers in Ukraine. The national AIDS programme has changed leadership at least half a dozen times and has been for months without leadership. The civil society programme—and it is run by a national NGO—has continued operating regardless.¹⁷⁶

94. One particular concern expressed to us was that there is an inherent tension between DFID's intention to work more closely with civil society on the one hand and its focus on health services strengthening on the other.¹⁷⁷ If funding is being directed to government health systems then less support will be available to local civil society organisations (CSOs). National governments may not necessarily include CSOs in the planning and delivery of services. Alvaro Bermejo told us that:

We are seeing a greater emphasis on multilateral and bilateral government-to-government support and the proportion of DFID funds going to that increasing. We do not think that that is a good HIV strategy [...] we need civil society [...] to get involved in service delivery as well as having the capacity to monitor the difficult decisions that politicians and governments have to make.¹⁷⁸

95. Médecins Sans Frontières made similar points in its written evidence, and argued that there was a need for direct funding for civil society organisations to increase their capacity to deliver services and maintain their independence from national governments:

Many countries face disbursement problems and administrative delays through the usual government channels. Combined with weak accountability and health systems that are poorly accountable to their users, this can jeopardize results and benefits for the target population and end-users. It is therefore essential to preserve the possibility of working with non-state providers such as civil society, PLWHA [people living with HIV and AIDS] and NGOs. This should include direct funding, in order to promote capacity building and preserve the independence of civil society from government funds and influence.¹⁷⁹

96. The Minister said that he could give a “cast-iron assurance” that civil society would be full partners in the implementation of the Strategy. Where appropriate, there would be direct funding for civil society groups to advocate for people living with HIV and AIDS as part of the Strategy, and there was a “need to be looking at the investment in civil society.”¹⁸⁰ DFID emphasised that the Global Fund “is widely acknowledged for its strong

¹⁷⁶ Q 32

¹⁷⁷ Ev 69

¹⁷⁸ Q 30

¹⁷⁹ Ev 81

¹⁸⁰ Qq 109-111

engagement with civil society". CSOs participate in the strategic planning process and are represented on the Fund's board and on its committees.¹⁸¹

97. We welcome the Minister's assurance that civil society will be fully engaged in the implementation of the Strategy. However, further details are needed on how DFID will pursue this engagement, including how much funding will be allocated to support the work of civil society on the ground in countries with a high prevalence of HIV/AIDS and related diseases. We request that DFID provides this detailed information in its response to this Report.

¹⁸¹ Ev 38

8 Implementation, Monitoring and Evaluation

Implementing the Strategy

98. We very much welcome the substantial funding commitments which DFID has made, particularly the £6 billion allocation over seven years for health service strengthening. However, we agree with Interact Worldwide that the allocation of this funding is not well articulated in the Strategy and it is not yet clear how it will be broken down between different funding streams and different countries.¹⁸² As ActionAid commented, “implementation is the real challenge”.¹⁸³ Yet it is worth noting that the chapter in the Strategy on *How we will turn our strategy into action* is the shortest one in the document.¹⁸⁴ MSF accepted that £6 billion “is a substantial financial commitment” but added that “disaggregated data on the different budget lines would be a telling indication of the financial rather than the rhetorical priorities within DFID’s overall HIV/AIDS response.”¹⁸⁵

99. The Minister told us that the role of DFID’s country offices, and its dedicated country programmes, would be crucial in ensuring that the Strategy as a whole, and the sector support aspect in particular, was implemented effectively.¹⁸⁶ DFID described its approach to implementation in the following terms:

In countries with strong commitments to development, good governance and improving capability, we tend to focus on supporting the development and implementation of comprehensive country-led HIV and AIDS strategies, directly funding governments, as well as working with civil society and international donors and agencies. In more fragile states, where governments may be unable or unwilling to respond effectively, we tend to provide technical support to strengthen government capacity alongside direct support for service delivery via the UN or civil society.¹⁸⁷

100. Witnesses emphasised to us the value of taking a country-specific approach. Dr Buse told us that this was particularly important in relation to health system strengthening where DFID should aim to identify the weaknesses affecting the health service in a particular country and then to seek to address them specifically, rather than adopting a broad-brush approach which treated every country as if the problems were identical. He highlighted that global targets, such as the one DFID has set of ensuring that there are 2.3 health professionals per 1,000 population, ignores “national specificity and differences” and were difficult to work with.¹⁸⁸ It was important to assess “from a country perspective what

¹⁸² Ev 60

¹⁸³ Ev 46

¹⁸⁴ See *Achieving Universal Access*, Chapter 5

¹⁸⁵ Ev 81

¹⁸⁶ See for example Qq 61, 64, 80

¹⁸⁷ *Achieving Universal Access*, p 58

¹⁸⁸ Q 24

needs fixing”—whether that might be more health professionals, better diagnostics, or improved health surveillance—and then develop a plan to address that specific need: “that way you get the variety of stakeholders involved in owning whatever kinds of outcomes or targets you are trying to seek.”¹⁸⁹ Dr Buse also emphasised that the form the epidemic was taking, and the required response, were country-specific.¹⁹⁰

101. DFID makes clear in the Strategy that it understands how important it is to ‘know your epidemic’ because “when interventions are tailored to local circumstances, the money will have a greater impact.”¹⁹¹ Its written evidence explained that:

Working in line with the AIDS Strategy, country offices are responsible for the design and delivery of HIV and AIDS responses as agreed in negotiation with the host government and other key stakeholders, and taking into account the local context and the constraints of DFID's overall financial framework. [...] Decisions on which aid instruments should be used are taken by DFID offices at country level, depending on what is more appropriate for the situation in that country.¹⁹²

The Minister accepted that different countries faced very different circumstances but he believed that DFID was able to address this effectively because “one of the strengths that DFID has is its country offices and its country programmes where there is a very high level of devolution within this organisation compared to many other government bodies”.¹⁹³

102. The Strategy and DFID’s written evidence have provided us with some examples of how its country offices are responding to the different challenges faced in implementing its HIV/AIDS strategies in partner countries. In Bangladesh DFID is supporting a major urban health programme which will address stigma and increase the focus on prevention of HIV in women and children, in line with the country’s own AIDS strategy. In Lesotho, DFID’s work has focused on supporting the establishment of the National AIDS Council, legislative reform and support for the People Living with HIV network.¹⁹⁴ In 2007, we saw for ourselves the valuable and innovative work DFID was undertaking in partnership with the Government of Vietnam to tackle HIV/AIDS amongst sex workers and intravenous drug-users.¹⁹⁵

103. There are many excellent examples in the Strategy of HIV/AIDS work which DFID is undertaking with specific countries and specific groups. What is not clear to us, however, is the extent to which DFID intends to scale up or replicate these projects elsewhere.

104. The Strategy states that individual countries’ Poverty Reduction Strategy Plans, which determine how development assistance will be used, and other national development plans

¹⁸⁹ Q 24

¹⁹⁰ Q 33

¹⁹¹ *Achieving Universal Access*, p 44

¹⁹² Ev 37

¹⁹³ Q 64

¹⁹⁴ Ev 37-38

¹⁹⁵ *Eighth Report of Session 2006-07, DFID's Programme in Vietnam*, HC 732, paras 34-36

“should reflect AIDS plans”.¹⁹⁶ It also emphasises the importance of the International Health Partnership in this respect. As discussed earlier, this is a partnership of donors, developing countries and multilateral agencies launched in 2007 by the UK Prime Minister to reinvigorate progress towards the health Millennium Development Goals. One of the IHP’s two guiding principles is that “developing countries should prepare robust national health strategies that reflect national AIDS plans that highlight the need for stronger health systems”. The IHP is being piloted in eight countries.¹⁹⁷

105. We agree with our witnesses that the significant funding commitments which DFID has made in the Strategy are impressive and that its analysis of the current situation is excellent. However, the challenge remains for DFID to turn the rhetoric into practical implementation and to demonstrate much more clearly how it will achieve the targets it has set and the commitments it has made.

Impact of DFID staffing constraints

106. Witnesses expressed concern that implementation of the Strategy may be hindered by DFID having insufficient staff to take on the necessary tasks. Alvaro Bermejo believed that this was a factor in DFID reducing its direct engagement with civil society organisations working on HIV/AIDS.¹⁹⁸ Carol Bradford from the UK Consortium on AIDS pointed out that DFID staffing constraints also affected the ability to collect the data required for evaluations: “if you are already overworked, additional reporting requirements are always complicated”.¹⁹⁹

107. We have expressed concerns in the past that the headcount reductions which DFID is required to make to meet Government efficiency targets may be beginning to have an impact on its ability to deliver its objectives. In our Report on the DFID Annual Report 2007 we accepted that DFID could not be exempt from efficiency targets but highlighted our anxiety that this might affect the Department’s ability to work in the poorest countries, often fragile states, which most need assistance, but where activity is most labour-intensive.²⁰⁰ The significance of this issue for DFID was reinforced when we explored it in oral evidence with the Permanent Secretary as part of our work on this year’s DFID Annual Report. Her view was “Our staff are very pressed, they are working very, very hard. [...] we are coping but we are struggling”.²⁰¹

108. We welcome the Permanent Secretary’s frankness and appreciate that this is probably as far as a senior Government official can go in highlighting the difficulties that departmental staff reductions are creating. We raised these concerns, as they relate to implementation of the HIV/AIDS Strategy, with the Minister. He paid tribute to the “sense of mission” amongst DFID staff and said “I have rarely come across a group of people so

¹⁹⁶ *Achieving Universal Access*, p 32

¹⁹⁷ *Achieving Universal Access*, p 33. The eight pilot countries are: Burundi, Cambodia, Ethiopia, Kenya, Mali, Mozambique, Nepal and Zambia

¹⁹⁸ Q 31

¹⁹⁹ Q 56

²⁰⁰ First Report of Session 2007-08, *DFID Annual Report 2007*, HC 64-I, para 40

²⁰¹ Oral evidence taken on 15 July 2008, Qq 103-104

motivated and so passionate about what they do”—an assessment with which we would wholeheartedly agree. Nevertheless, he accepted that it was difficult, with fewer staff, to ensure that DFID was “achieving change and making a difference” and using effectively the “record levels of resources” it has been allocated. He believed the Department would have to “work smarter”, use its country offices properly and ensure that it had the right skills mix.²⁰²

109. We will return to this subject in our forthcoming Report on the DFID Annual Report 2008 but we are keen to reiterate our concerns, in the specific context of the new HIV/AIDS Strategy, that staff reductions at DFID may have reached the point where they risk adversely affecting the Department’s ability to deliver its objectives in vital fields such as health and social care.

Monitoring and Evaluation

110. A recurrent theme running through the evidence we have received is that DFID’s new Strategy lacks quantifiable and verifiable targets and that there are very few indicators against which its effectiveness in tackling HIV/AIDS can be measured. Lucy Chesire, a TB/HIV advocate working in Kenya, told us:

Monitoring and Evaluation are critical components of country programmes, yet it is still very unclear in the current health system strengthening strategy how DFID will carry out its M&E [...] DFID should come out very clearly and tell us what targets and indicators they are setting for health system strengthening and how different partners will be able to work collectively to achieve this.²⁰³

Tearfund echoed this view:

DFID needs to develop a robust monitoring and evaluation framework to accompany the new Strategy. It should set out clear targets and indicators to be reported on annually by DFID and FCO field offices. Data from these indicators must be made publicly available and clearly articulate the UK’s contribution towards the achievement of international targets.²⁰⁴

111. Alvaro Bermejo believed that the Strategy was not sufficiently specific to assess what outcomes are expected from DFID’s investment.²⁰⁵ Carol Bradford of the UK Consortium on AIDS, who has been working with DFID to develop indicators, accepted that there were currently “many limitations to proper measurement” and that the absence of spending targets or budgets made the funding commitments very difficult to track. She acknowledged that “the health systems measures and indicators are not very good and they need further developing”.²⁰⁶

²⁰² Qq 63-64

²⁰³ Ev 56

²⁰⁴ Ev 89

²⁰⁵ Q 26

²⁰⁶ Q 55

112. In our 2006 Report on HIV/AIDS, we expressed concern that DFID's indicators of success in its 2004 Strategy *Taking Action* were linked primarily to funding targets rather than to outcomes—a weakness in DFID's overall approach which we have highlighted in other previous reports. We recommended the development of outcome indicators which “should set out DFID's contribution to achieving the international targets on HIV/AIDS treatment and care”.²⁰⁷ Despite DFID's claim in its written evidence that the new Strategy “focuses on outcomes and results”,²⁰⁸ there remains an emphasis on the amount of money which will be spent rather than the impact which will be measured.

113. Alvaro Bermejo told us that he believed that DFID had taken a backwards step in the new Strategy in terms of the lack of targets and specificity, which would hamper its implementation and the ability to monitor progress.²⁰⁹ Stuart Kean of the UK Consortium on AIDS echoed this:

In relation to the indicators at this time, I think there really are questions to be asked about the targets and I think that, as with so much within the strategy, it is a matter of if you were sitting in Lusaka or in Nairobi what would you be doing and how would you interpret it. A high level of interpretation is going to be required. [...] I recall DFID saying that they had 126 targets in the previous strategy and there was a concern to move the other way. I believe they have probably gone too far the other way and now it is very difficult to see what are the specific targets that individual civil servants are going to be trying to implement.²¹⁰

114. We were struck by the contrast in the approach taken in the HIV/AIDS Strategy compared to the process which DFID told us it had undertaken in developing the Global Malaria Action Plan which was launched at the UN High Level Event on the Millennium Development Goals on 25 September. Andrew Steer, DFID's Director General Policy and Research, told us in our evidence session on the UN High Level Event:

I think the issue of money is what certainly gets the headlines but what we would rather do is start from the desired outcomes and increasingly focus on that. There was a very real effort here to ask the question “What is the problem and what are we trying to solve?” For example, there are 500 million people suffering acutely from malaria every year and one million deaths. What is reasonable to achieve? It is a halving of that number, and we can monitor those. [...] While the money is absolutely essential [...] it is the delivery on the ground that we need to monitor from now on as much as it is the money.

The Secretary of State emphasised that, in relation to the Malaria Action Plan, “the very specificity of the pledges” was one of the best guarantees that they would be delivered.²¹¹

²⁰⁷ Second Report of Session 2006-07, *HIV/AIDS: Marginalised Groups and Emerging Epidemics*, HC 46-I, para 4. See also First Report of Session 2007-08, *DFID Annual Report 2007*, HC 64-I, para 11.

²⁰⁸ Ev 39

²⁰⁹ Q 29

²¹⁰ Q 40

²¹¹ Oral evidence taken on 30 October 2008 on the DFID Annual Report 2008, Q 110

115. **There are obvious similarities in the global challenges of tackling HIV/AIDS and tackling malaria. We are impressed by the process which DFID followed in developing the Global Malaria Action Plan which focused on desired outcomes and used that information to determine decisions about inputs and mechanisms. However, it is not evident to us that DFID adopted a similarly rigorous procedure for developing its new AIDS Strategy. We believe this was a missed opportunity and we regard the lack of specific budget allocations, targets and outcome indicators as a significant deficiency in the new HIV/AIDS Strategy, which we hope will be addressed in the next stage of the process.**

116. DFID says that the Strategy will be independently reviewed in three years' time and that the social protection programmes will be reviewed after two years.²¹² In addition, a Monitoring and Evaluation Framework is being developed which DFID originally stated would be finalised "by November 2008"²¹³ but which the Minister subsequently told us would be published on World AIDS Day on 1 December.²¹⁴ We asked the Minister why the Monitoring Framework had not been developed in parallel with the Strategy and published at the same time, which would have given all stakeholders a better understanding of what DFID was trying to achieve. Mr Lewis agreed that it would have been better for the Framework to have been published at the same time but this had not been possible because DFID had been involved in "protracted negotiations" with the Treasury on whether it would be a "three-year or seven-year Strategy".²¹⁵ Carol Bradford reassured us that "real progress" was being made with developing the Framework. She pointed out that DFID's last HIV/AIDS Strategy did not have a monitoring and evaluation system in place at all—"so this is a definite improvement".²¹⁶

117. **We regret that DFID was not able to publish the Monitoring and Evaluation Framework at the same time as the Strategy was launched in June. All stakeholders, including ourselves, need to understand the specific outcomes that DFID is seeking to achieve through the funding commitments it has announced and how it intends to measure progress towards them. We hope that, when it is published, the Framework will provide the answers to the important questions about implementation and monitoring and evaluation which the Strategy itself has left open.**

²¹² Ev 39

²¹³ Ev 39

²¹⁴ Q 72

²¹⁵ Q 73

²¹⁶ Q 56

9 Conclusion

118. HIV/AIDS will continue to present a huge challenge, to both developing countries and donors, for many years to come. Indeed, the combination of 7,000 people being newly infected each day and drug regimes helping people with HIV to live longer means that the cost of providing HIV/AIDS services may well become unsustainable. As we have made clear, prevention is key, particularly for marginalised groups but also for general populations in high-prevalence countries.

119. DFID's approach of focusing its efforts on funding health services in developing countries is a logical response to the HIV/AIDS challenge. Capable and well-resourced health systems will be able to take forward effective prevention strategies as well as offering treatment and care. But this is a longer-term strategy. Dedicated funding to tackle HIV/AIDS will also continue to be needed to fill the wide gaps that exist in services in developing countries and which will remain in the short and medium-term. It is vital that these two mechanisms for funding HIV/AIDS services are complementary and well-integrated.

120. We look forward to the next stage of DFID's Strategy: its Monitoring and Evaluation Framework, which is expected to be published around the same time as this Report. We hope it will answer some of the many important questions that we have raised.

List of conclusions and recommendations

Funding

1. Should the new US Administration decide to review its approach to development funding, including the US President's Emergency Plan for AIDS Relief (PEPFAR), we would urge the UK Government to take an early opportunity to discuss with them potential areas for co-operation. (Paragraph 13)
2. Funding for health system strengthening is an essential part of development assistance and we welcome the substantial sums that DFID is allocating to it. Developing countries will never be capable of tackling HIV/AIDS effectively unless the overall capacity of their health systems is built up through adequate funding, including the capacity to pursue robust prevention strategies. Our concern, however, is that DFID has included this funding as part of its HIV/AIDS Strategy but the specific impact that it may have on HIV/AIDS will be difficult to measure. We recommend that, as part of its monitoring and evaluation of the Strategy, DFID put in place indicators to assess the impact that funding directed at health system strengthening is having on reducing the spread of HIV/AIDS and related diseases. (Paragraph 19)
3. The Minister was only able to give us a partial reassurance that the £6 billion DFID has allocated for strengthening national health services is genuinely new money, which is additional to any previous funding announcements, rather than simply being a redirection of existing commitments. Further clarification is required. We therefore request a full breakdown of how this £6 billion total has been calculated in response to this Report. Moreover, DFID has not yet spelled out in clear terms how this substantial sum will be spent. Until the precise allocations, and their timescales, are known, it will be impossible to assess how much impact this apparently bold allocation of funding is likely to have or whether it will be adequate to meet the ambitious target of universal access by 2010. We therefore invite DFID to provide the necessary detail in response to this Report. (Paragraph 20)
4. We welcome DFID's substantial funding for the Global Fund to Fight AIDS, TB and Malaria. Disease-specific funding continues to provide vital resources to tackle the HIV/AIDS epidemic and the Global Fund's work has been invaluable. However, it is important that vertical funding supports rather than conflicts with national government healthcare systems and that it adheres fully to the principles of the Paris Declaration on Aid Effectiveness, to which the Global Fund is a signatory. We recommend that DFID continues to use its position as a major donor to the Global Fund to ensure that its funding is fully accountable to national governments and civil society in the countries where the Fund operates. (Paragraph 26)
5. We were concerned to learn that a substantial sum from the Global Fund has been misappropriated by the Zimbabwean government. Zimbabwe is arguably a unique case and it appears that the Global Fund has dealt appropriately with this example of misuse of its money. However, the case highlights the need for DFID to continue to press for the highest standards of accountability and transparency in the use of funds

which it channels through multilateral organisations, particularly in countries with weak or undemocratic governments. (Paragraph 29)

6. We believe that a more integrated approach to HIV/AIDS funding is required. The International Health Partnership and the Taskforce on Innovative Financing of Health Systems are UK initiatives which feed directly into a more integrated approach to HIV/AIDS funding. We would encourage DFID to use the full capacity of these initiatives to ensure that its funding streams for health systems strengthening and disease-specific programmes are mutually reinforcing and to press other donors to follow the UK lead towards such an integrated approach. (Paragraph 35)
7. Targets for tackling HIV/AIDS will not be achieved without substantial progress in prevention and treatment in middle-income countries. The Strategy envisages that the Foreign and Commonwealth Office will take on an enhanced role in tackling HIV/AIDS, particularly in middle-income countries where DFID has a minimal presence. It is vital to ensure that FCO officials are properly equipped to carry out these duties. We invite DFID to share with us its detailed planning for cross-departmental working on HIV/AIDS, particularly in middle-income countries with high prevalence levels. (Paragraph 38)

Interaction with other diseases

8. While the funding for health systems strengthening committed by DFID may well contribute to the treatment and diagnosis of patients with HIV and TB, we are not convinced that DFID is taking sufficient steps to ensure that the specific challenge of interaction between the two diseases is tackled. Nor has DFID set out how it will measure the effectiveness of its Strategy in addressing the interaction. We expect to see a clearer indication of how this work will be taken forward and measured in DFID's forthcoming Monitoring and Evaluation Framework. (Paragraph 44)
9. The interaction between HIV/AIDS and malaria must be tackled as part of an effective AIDS Strategy. We welcome the commitments made by DFID in support of the Global Malaria Action Plan. It is not clear to us, however, how this important work on malaria will be integrated with the HIV/AIDS Strategy. We invite DFID to provide us with further information on this in its response to this Report. (Paragraph 48)

Children

10. DFID already funds social protection programmes in a number of countries. It is therefore unclear to us whether the pledge in the AIDS Strategy to spend £200 million on such programmes over a three-year period is a new commitment or a continuation of DFID's existing work in this area. We expect clarification on this. Nor is it clear to us how DFID will ensure that children affected by HIV/AIDS, specifically, are assisted through social protection programmes and cash transfers. Indicators to measure impact in this area are needed and we would expect these to be included in the Monitoring and Evaluation Framework which DFID is developing. (Paragraph 55)

11. Children living with HIV should not be dying needlessly when a cheap and effective antibiotic is available to mitigate their vulnerability to opportunistic infections. We would encourage DFID to continue to press partner governments to ensure that cotrimoxazole is prescribed for children likely to be infected with HIV and to train their health staff to administer the drug safely. (Paragraph 58)

Women

12. Addressing gender inequalities should be at the heart of effective prevention and treatment of HIV/AIDS. Specially tailored policies that focus on education and socio-economic empowerment of women and girls are needed to help reverse the current trend of high levels of infection amongst women. We believe that efforts should be made to target these strategies beyond traditional high risk groups such as sex workers to include young people and married couples. (Paragraph 62)
13. We support the holistic approach towards women and HIV that DFID advocates in its new Strategy. Addressing embedded gender inequalities will rely on wide-ranging strategies that bring together health, education, justice and social protection agendas. (Paragraph 63)
14. We commend the emphasis in the new DFID Strategy on the disproportionate impact of HIV/AIDS on women and girls. However, we are concerned by the lack of concrete and country-specific policies within the document. The Strategy does more to describe the impact of HIV/AIDS on women and girls rather than to indicate how DFID will tackle it. Beyond an important but limited set of commitments on HIV prevention and social protection, gender-specific policies and funding pledges are lacking. We recommend the development of a global action plan, linked to the AIDS Strategy, which sets out the actions DFID will take to support women-specific approaches to the epidemic over a specified timescale. (Paragraph 66)
15. We are concerned about DFID's lack of dedicated strategies and funding to address gender-based violence (GBV), which is closely linked to the spread of HIV. We highlighted successful DFID-funded approaches to addressing GBV in Nepal, Bangladesh and South Africa in our Maternal Health Report earlier this year and were disappointed not to see information on scaling up or replicating these initiatives included in the new Strategy. We recommend that, in its Response, DFID provides us with a policy update which sets out details of the specific approaches it will take to address GBV, including the necessary funding commitments. (Paragraph 69)
16. We welcome DFID's pledge to support an increase in the percentage of HIV-infected pregnant women who receive anti-retroviral treatments (ARVs) to 80% by 2010, and thereby reduce mother-to-child transmission of HIV. However, ARV provision is only one of a number of interventions to prevent transmission recommended by the World Health Organisation. We recommend that DFID works to ensure ARV provision forms one, critical, part of a care package for HIV positive mothers that also includes the full range of required interventions. (Paragraph 74)

17. We note the ambitious level of percentage increase needed to meet DFID's commitment to increasing ARV coverage for HIV-infected pregnant women: from the current rate of 34% to 80% in just two years' time. We expect to see a clear commitment on how progress towards this ambitious and short-term target will be measured in DFID's Monitoring and Evaluation Framework which is due to be published on 1 December 2008. We recommend that the Framework includes an indication of the level of DFID's specific projected contribution to the international efforts to reach this target. (Paragraph 75)
18. We welcome the focus in the Strategy on closer integration of HIV/AIDS and sexual and reproductive health services (SRH), together with maternal and child health, TB and malaria. SRH and HIV/AIDS cannot be separated as health issues and accordingly DFID is right to include better integrated responses as a priority action. We believe that integration will be more effective where it is prioritised by health systems that are ready and willing to implement it. Accordingly, we recommend that DFID presses both national governments and multilateral donors—particularly the Global Fund, the World Bank and the relevant UN agencies—to do more to support the integration of services. (Paragraph 82)

Marginalised groups

19. If the global effort on HIV/AIDS is to achieve the goal of halting and reversing the spread of the disease, it must be effective in reaching marginalised people, including sex workers, intravenous drug users, men who have sex with men and transgender individuals. If the epidemic is not tackled in these groups it will continue to spread to the general population and the number of people affected will continue to increase. DFID's Strategy acknowledges this reality but does not adequately explain how DFID will ensure that these marginalised people are provided with the prevention, treatment and support services they require. We would welcome further information on DFID's plans in this area in response to this Report. (Paragraph 87)

Engagement with civil society

20. We welcome the Minister's assurance that civil society will be fully engaged in the implementation of the Strategy. However, further details are needed on how DFID will pursue this engagement, including how much funding will be allocated to support the work of civil society on the ground in countries with a high prevalence of HIV/AIDS and related diseases. We request that DFID provides this detailed information in its response to this Report. (Paragraph 97)

Implementation

21. There are many excellent examples in the Strategy of HIV/AIDS work which DFID is undertaking with specific countries and specific groups. What is not clear to us, however, is the extent to which DFID intends to scale up or replicate these projects elsewhere. (Paragraph 103)
22. We agree with our witnesses that the significant funding commitments which DFID has made in the Strategy are impressive and that its analysis of the current situation

is excellent. However, the challenge remains for DFID to turn the rhetoric into practical implementation and to demonstrate much more clearly how it will achieve the targets it has set and the commitments it has made. (Paragraph 105)

23. We will return to this subject in our forthcoming Report on the DFID Annual Report 2008 but we are keen to reiterate our concerns, in the specific context of the new HIV/AIDS Strategy, that staff reductions at DFID may have reached the point where they risk adversely affecting the Department's ability to deliver its objectives in vital fields such as health and social care. (Paragraph 109)

Monitoring and Evaluation

24. There are obvious similarities in the global challenges of tackling HIV/AIDS and tackling malaria. We are impressed by the process which DFID followed in developing the Global Malaria Action Plan which focused on desired outcomes and used that information to determine decisions about inputs and mechanisms. However, it is not evident to us that DFID adopted a similarly rigorous procedure for developing its new AIDS Strategy. We believe this was a missed opportunity and we regard the lack of specific budget allocations, targets and outcome indicators as a significant deficiency in the new HIV/AIDS Strategy, which we hope will be addressed in the next stage of the process. (Paragraph 115)
25. We regret that DFID was not able to publish the Monitoring and Evaluation Framework at the same time as the Strategy was launched in June. All stakeholders, including ourselves, need to understand the specific outcomes that DFID is seeking to achieve through the funding commitments it has announced and how it intends to measure progress towards them. We hope that, when it is published, the Framework will provide the answers to the important questions about implementation and monitoring and evaluation which the Strategy itself has left open. (Paragraph 117)

Formal Minutes

Tuesday 25 November 2008

Members present:

Malcolm Bruce, in the Chair

John Battle
Hugh Bayley
John Bercow

Richard Burden
Mr Marsha Singh

Draft Report (*HIV/AIDS: DFID's New Strategy*), 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 120 read and agreed to.

Summary agreed to.

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

Ordered, That the Chairman make the Report to the House.

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

Written evidence was ordered to be reported to the House for printing with the Report, together with written evidence reported and ordered to be published on 7 October and 28 October 2008.

[Adjourned till Tuesday 13 January 2009 at 10.00 am

Witnesses

Tuesday 28 October 2008

	<i>Page</i>
Lucy Chesire , HIV-TB Advocate, ACTION Project Kenya	Ev 1
Dr Kent Buse , Health Policy Analyst, and Alvaro Bermejo , Executive Director of the International HIV/AIDS Alliance,	Ev 4
Ms Fionnuala Murphy , Campaigns and Policy Officer, ActionAid; Stuart Kean , Chair of the Working Group on Children Affected by AIDS, and Carol Bradford , Chair of the UK Network for Sexual and Reproductive Health Rights, UK Consortium on AIDS and International Development	Ev 12

Thursday 30 October 2008

Ivan Lewis MP , Parliamentary Under-Secretary of State, Malcolm McNeil , Team Leader, AIDS and Reproductive Health Team, and Alastair Robb , Senior Health Adviser, DFID Uganda, Department for International Development,	Ev 18
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List of written evidence

1	Department for International Development	Ev 31; Ev 44
2	ActionAid	Ev 45
3	All-Party Parliamentary Group on AIDS	Ev 49
4	Business Action for Africa	Ev 51
5	Lucy Chesire, ACTION Project-Kenya	Ev 54
6	Consortium for Street Children	Ev 57
7	Interact Worldwide	Ev 58
8	International HIV/AIDS Alliance	Ev 68
9	Malaria Consortium	Ev 77
10	Médecins sans Frontières	Ev 78
11	National AIDS Trust	Ev 81
12	Results UK	Ev 84
13	STOP THE TRAFFIK	Ev 88
14	Tearfund	Ev 89
15	UK Consortium on AIDS and International Development	Ev 94
16	World Vision	Ev 102

List of Reports from the Committee during the current Parliament

The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2007-08

First Report	DFID Departmental Report 2007	HC 64-I&II (HC 329)
Second Report	Development and Trade: Cross-departmental Working	HC 68 (HC 330)
Third Report	Work of the Committee 2007	HC 255
Fourth Report	Reconstructing Afghanistan	HC 65-I&II (HC 509)
Fifth Report	Maternal Health	HC 66-I&II (HC 592)
Sixth Report	DFID and the World Bank	HC 67-I&II (HC 548)
Seventh Report	DFID and the African Development Bank	HC 441-I&II (HC 988)
Eighth Report	Scrutiny of Arms Export Controls (2008): UK Strategic Export Controls Annual Report 2006, Quarterly Reports for 2007, licensing policy and review of export control legislation	HC 254 (Cm 7485)
Ninth Report	Working Together to Make Aid More Effective	HC 520-I&II (HC 1065)
Tenth Report	The World Food Programme and Global Food Security	HC 493-I&II (HC 1066)
Eleventh Report	The Humanitarian and Development Situation in the Occupied Palestinian Territories	HC 522-I&II (HC 1067)

Session 2006-07

First Report	DFID Departmental Report 2006	HC 71 (HC 328)
Second Report	HIV/AIDS: Marginalised groups and emerging epidemics	HC 46-I&II (HC 329)
Third Report	Work of the Committee in 2005-06	HC 228
Fourth Report	Development Assistance and the Occupied Palestinian Territories	HC 114-I&II (HC 430)
Fifth Report	EU Development and Trade Policies: An update	HC 271 (HC 622)
Sixth Report	Sanitation and Water	HC 126-I&II (HC 854)
Seventh report	Fair Trade and Development	HC 356-I&II (HC 1047)
Eighth report	DFID's Programme in Vietnam	HC 732 (HC 1062)

Ninth report	Prospects for sustainable peace in Uganda	HC 853 (HC 1063)
Tenth report	DFID Assistance to Burmese Internally Displaced People and Refugees on the Thai-Burma Border	HC 645-I&II (HC 1070)
Session 2005–06		
First Report	Delivering the Goods: HIV/AIDS and the Provision of Anti-Retrovirals	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	HC 730–I&II (HC 1425)
Fourth Report	Private Sector Development	HC 921–I&II (HC 1629)
Fifth Report	Strategic Export Controls: Annual Report for 2004, Quarterly Reports for 2005, Licensing Policy and Parliamentary Scrutiny	HC 873 (Cm 6954)
Sixth Report	Conflict and Development: Peacebuilding and post-conflict reconstruction	HC 923 (HC 172)
Seventh Report	Humanitarian response to natural disasters	HC 1188 (HC 229)