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HIV/AIDS: DFID's New Strategy

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Oral and written evidence

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International Development Committee

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Witnesses

List of written evidence

Oral evidence

Taken before the International Development Committee

on Tuesday 28 October 2008

Members present:

Malcolm Bruce, in the Chair

John Battle
Hugh Bayley
Richard Burden
Mr Stephen Crabb
Daniel Kawczynski
Mr Marsha Singh
Sir Robert Smith

Witness: **Ms Lucy Chesire,** Kenyan HIV-TB Advocate, ACTION Project Kenya, gave evidence.

Q1 Chairman: Good morning, Lucy. Can you hear and see us?
Ms Chesire: Yes, I can hear you loud and clear. Can you hear me?

Q2 Chairman: Yes, we can hear you. That is fine. Thank you very much. First of all, can I say thank you very much for coming into the DFID office to talk to us. Some of us met you when you were in London in June and, obviously, we felt that you would be a very good person to share your experiences with us. I just wondered if you would perhaps start by saying, as somebody who has been living with HIV and TB, what are the biggest challenges that you face, and feel free to express what you think are the most important issues for you?
Ms Chesire: Okay. Thank you very much. It is excellent of you. First of all, the challenges and experiences of people living with HIV are very clear. Are you able to hear me?

Q3 Chairman: Yes, we can hear you now. There was a slight scramble, but carry on.
Ms Chesire: Okay; cool. What I wanted to say was that some of the challenges that people with HIV face in relation to TB/HIV, co-infection is the issue around the main diagnosis. The challenges are around diagnosis because, if I can give my own experience, what basically happened is that I was already living with HIV and I went for a chest x-ray but the truth was that none of them were actually showing that I had TB. So that is the biggest one. The kind of techniques that are being used should actually be updated. If you look at the chest x-ray, it has been used for over 100 years (inaudible), and that technically means that if you want to see a diagnosis for having HIV, for TB, it means, despite being in an area of (inaudible) it becomes very difficult for the patient to be able to survive.

Q4 Chairman: It is very difficult; I do not know whether we can get a better sound quality. While that is being done, can I say I certainly understood the main point you were making, which is that you believe that the diagnosis for TB is inadequate and outdated. I can perhaps ask you the question, if you can understand me, to follow that up: are you, therefore, saying that you would like to see priority given to improving the diagnosis and then also giving people with HIV routine screening with better techniques?
Ms Chesire: In relation to that, I think it is pretty clear what the demand for interaction activities is. When you look at the TB and HIV collaborative activities (inaudible) it states very clearly what programmes are supposed to do. Something that they need to do is establish mechanisms for co-infection, because here we have a reasonable ambition and, therefore, the programmes need to cognate together. The issue is around decreasing the burden of TB among people living with HIV/AIDS and, of course, decreasing the burden of HIV among TB patients. What basically programmes are supposed to do is be able to create each and every part. When you look at TB/HIV co-infection—

Q5 Chairman: Lucy, can I stop you?
Ms Chesire: Yes.

Q6 Chairman: The sound quality is variable and what they are suggesting is it might be better if we redial and see if we can establish a better connection. We are getting quite a lot of what you say, but it is very difficult to get a complete record. So if we can stop and see if we can re-establish the connection, I think it would be better for all of us.
Ms Chesire: That is fine.

Q7 Chairman: Hopefully we will see and hear you more clearly in a minute or two.
Ms Chesire: Okay.
Chairman: I am sorry about this, but I am assuming that people are all having difficulty with the sound.
The Committee paused whilst a new video link connection was established

Q8 Chairman: Hello, can you hear us?
Ms Chesire: Yes, we can.

Q9 Chairman: Okay. I think that is better. We will certainly try. I am sorry about that. Technology is great when it works but it is a problem when it does not. You were saying to us that you find the

techniques for diagnosing TB are primitive. Perhaps you would just say it again. Are you really saying more should be invested in improving the techniques for diagnosing and are there particular problems with people who are HIV positive? Do they require dedicated diagnosis?

Ms Chesire: I do not think they necessarily require dedicated diagnosis. The issue is that the diagnoses that are currently available are not all sufficient to be able to detect micro-bacterial problems with HIV, and what that basically means is that it calls for more research into TB/HIV co-infection with regard to diagnostic provision and co-ordinating bodies. Now, on reflection (inaudible) whereby it takes over six hours to be able to get a conclusive test. Of course, the challenge here is that the current diagnosis is not able to pick up the micro-bacteria and that is why we have to look at the global TB side. They are trying to see what can be done in relation to advancing the diagnostics for TB/HIV so that every person who has HIV is screened for TB, but, equally, antiretroviral therapy is continuing. When you look at the three basic donors for HIV, which is PEPFAR,[1] Global Fund and the World Bank, none of them are actually charting how many people living with HIV are being screened, and to me that is a crisis, because we cannot have over seven or eight hundred thousand people who are already infected and only less than 2% of them are being screened, and that shows that even the global donors are not really able to adopt and address co-infection as being a problem.

Q10 John Battle: I wonder if I could ask whether the problem in detection of TB is an issue of screening personnel staff and clinics, or is it a scientific problem that once a person has HIV scientifically the bacterial infections make it more difficult for even the best doctors to detect TB? What is the basic issue here? Is it scientific detection or is it lack of staff, medical personnel actually physically screening people?

Ms Chesire: The problem is actually both. It is both scientific and also it is medical. Why I say it is both scientific and medical is because all the TB/HIV programmes that are currently implementing the co-infection activity, only less than 1% of persons living with HIV around the world are actually being screened for TB, which to me is a disaster. We cannot afford to delay diagnostics. Programmes are not even doing the actual screening and at the same time, not even for the very few that are doing it, like in Kenya, Malawi and Rwanda, they are recording and reporting a problem, and that is why when you look at the countries' plans they do not even have a specific indicator for TB/HIV, which to me is a disaster.

Q11 John Battle: Could I follow that up? Are the health authorities screening for TB for people who are not yet diagnosed as HIV positive? In other words, is there a general anti TB campaign and screening running?

Ms Chesire: Absolutely. For those who are symptomatic, they are being screened, but the screening is not done for the generalised population. That is one thing we need to understand. What I am also trying to say is that when you look at the TB/HIV co-infection activities, when it comes to decreasing the volume of TB among people living with HIV, one requirement is each of us, for example, living with HIV should be screened for TB. Currently that is not happening. That is why I was trying to give examples of countries that are even implementing co-infection activities, we still see that it is just not happening.

Q12 Chairman: DFID are targeting a lot of their funding over the next few years to strengthening health services. Do you think this will help or do you think the HIV/TB at-risk patients will kind of get lost in the general service? In other words, do you think you need to continue to have a targeted service, and, if you have a targeted service, can you deliver it if you do not have an effective health service?

Ms Chesire: That is very interesting, because I always look at it as you have to do both—you cannot have one and not have the other—and so, at the end of the day, what we have seen in the past is that because of the burden of TB, HIV and malaria actually this whole area is a symptom of our current healthcare standards, and it shows everybody it means how do each work together so that at the end of the day even specific programmes are actually contributing to health system strengthening. If you look at the health system strategy, screening states that one of the clear components is the issue around the whole of the health strategy. How do we look at the six blocks in relation to that? You are talking about healthcare workers having adequate healthcare providers, healthcare financing, monitoring and evaluation in place—all these components are really significant, so we know that we cannot have one without the other because we have got to have both of them working in tandem so that at the end of the day the strengthening means that we have an efficient service so that at the end of the day somebody is able to actually get adequate services.

Q13 Sir Robert Smith: On that point, how do you think DFID should measure the effectiveness of its strategy? What sort of outcome should it be looking for to see if it has made a difference?

Ms Chesire: One of the things that DFID needs to do is that when you look at the current AIDS strategy there is not really much on what they are going to do specifically on TB/HIV, and that provides an opportunity, so it is important that it is clear-cut in terms of how much of DFID's money is actually going even to contribute to addressing the issue of the co-infection alongside the health system. Then, of course, the issue of monitoring, which is really critical. It is pretty clear that if DFID wanted to go that way, one of the indicators we will be looking at is how many persons are being screened for TB? How many TB/HIV co-infected patients are

[1] US President's Emergency Plan for AIDS Relief.

benefiting from prophylactics, which is Isoniazid preventive therapy, and then at the same time how many of these are being started on HIV antiretroviral therapy? So these are inherently difficult to look out for, and I think they are pretty well spelt out when you look at the TB/HIV co-infection activities but it is important that through the AIDS strategy, which is lacking currently, there is no allocation of funding that is going to address the co-infection, despite (inaudible), or people living with HIV around the world, and then, of course, the issue of monitoring and evaluating to see what progress is being made at the country level and within the country plan.

Q14 Chairman: Is the problem that not only are you not screening and diagnosing people who are vulnerable to TB and are HIV positive, but if you do not actually have the health infrastructure, you cannot treat it? It is almost worse to be told you have got TB but there is no valid treatment available. So is access to treatment at least as big or bigger a problem than diagnosis?
Ms Chesire: I think we have seen the issue of access to treatment being much more available to many people. It was a big challenge actually when starting antiretroviral therapy for many people, and today we have over 280,000 people who have been started on treatment. So we have come a long way in relation to that, but the thing is we have also got to be able to address the challenges that are coming up today, and that is why TB/HIV co-infection as a challenge has been very, very important in one area where we are having multi-drug resistant TB and also XDR,[2] and so, with resistance to most of the drugs, it becomes much more scary because it is becoming more expensive to be able to treat it. The cost is $5,000 to treat one person for multi-drug resistant TB over a period of two years, and this is something where we have drawn on the South African experience whereby the very first people who were diagnosed to have MDR-TB were actually people living with HIV, and so it means that we have got to look back and say what are the challenges and the plusses, think where (inaudible) has exposed the takeover healthcare and what can be done in order to be able to bring progress so that we are actually able to contribute to a period where we can offer our services, which will become an impediment if the challenges that are coming along are not being addressed as we go by.

Q15 Chairman: If I am right, the incidence of multi-drug resistant TB has got a lot to do with not having early diagnosis. So clearly for a developing country finding $5,000 for a patient is extremely challenging, but presumably you can find a smaller amount of money to actually catch them before they develop multi-drug resistant TB. Am I right in that judgment, and is that really one of the things you are focusing on?

[2] Extensive Drug Resistant TB.

Ms Chesire: You are pretty right in that, but I do not think your figure is right because when it comes to multi-drug resistant TB the issue of making the difference becomes also another greater challenge, because when you look at XDR and MDR, most countries do not even have the laboratory facility to be able to screen that, and that is why now the World Health Organisation has been trying to see if it can set up a laboratory within Africa, so that patients can get better services with the screening being done so that it does not become an impediment.

Q16 Chairman: I was going to ask you, because really this is an opportunity for you to provide from your experience your thoughts, as to how DFID could better deliver on HIV/TB; so do you have a specific point or points that you would like DFID to take on board if they are spending, as they are, or offering, substantial amounts of money that would meet your concerns and objectives? In other words, if you were writing DFID policy, what would your priority be?
Ms Chesire: I think my priority would be one of accommodation in terms of a financial commitment within the HIV strategy to be able to address the co-infection, and then, of course, secondly, the opportunity for DFID to be able to track the amount of money that it is spending on some of the diseases, which is currently not happening, and then, of course, most importantly, the issue of monitoring and evaluation.

Q17 Chairman: Do you have a view, then, about the Global Fund, because that clearly is designed to try and deliver that, but you feel that it is falling short?
Ms Chesire: The Global Fund has played its role, but it has also had its challenges along the way. I was going through some of the proposals from the first round of funding to the seventh round. It is pretty sad, in as much as it is either the fault of the countries. When they are putting in either HIV or TB proposals, they should be able to incorporate a TB/HIV indicator. Most countries actually do not do that. So we are seeing HIV proposals falling to the ground, particularly TB/HIV co-infection being addressed, and I think in the up and coming Global Fund meeting, which is taking place on the seventh and the eighth, part of the recommendation is to make sure that when they have a net core of proposals which are coming up, one of the requirements would be that all countries when submitting HIV proposals should specifically have a dedicated allocation for TB/HIV and also specify the type of activities that should be undertaken to be able to address that.

Q18 Chairman: Thank you very much. I am sorry we had a problem with the line and the sound. It was actually much better the second time. We are very grateful to you. I think it would have been nice for you to be here, because I think you are a very good witness, and the technology has slightly got in the way of us. Nevertheless, I think we have had a useful exchange and you have had an opportunity, I think, to give us some food for thought. I sincerely hope

our report will reflect some of the things you have said. DFID, of course, are listening, both given that you are in the DFID offices in Kenya they are listening, but here as well. Can I thank you very much indeed for coming in and can I wish you very well with your campaign and your own personal health too.

Ms Chesire: Okay. Thank you.

Witnesses: **Dr Kent Buse,** Health Policy Analyst and **Mr Alvaro Bermejo,** Executive Director of the International HIV/AIDS Alliance, gave evidence.

Q19 Chairman: We can resume on our second set of witnesses. Just to comment on the last session, I think Lucy Chesire is a real campaigner. Those of us who have met her in person know what kind of personality she has got and I do not think the technology completely communicated that, although I do think she said some very important and useful points. I wonder, first of all, if I could ask you both to introduce yourselves for the record and, obviously, for the benefit of the whole committee?

Dr Buse: Certainly. My name is Kent Buse, I am a political economist, I taught at Yale for a number of years and taught at the London School of Hygiene and Tropical Medicine. I have worked for a number of UN organisations. For the past three years I have been with the Overseas Development Institute here in London and I am about to join UNAIDS next week. I have done a fair amount of work on global health initiatives, but my real interest is in the politics of decision-making in the health sector.

Mr Bermejo: My name is Alvaro Bermejo; I am the Executive Director of the International HIV/AIDS Alliance UK charity, working on supporting community responses, the responses of people like Lucy in developing countries.

Q20 Chairman: Thank you for that. I think the point that emerged from that exchange is obviously how best to deliver funds in ways that actually really meet the needs. Clearly what is happening at the moment does not do it. The debate really is about the role of direct vertical funding targeted at specific diseases as opposed to horizontal funding building up the capacity of the health service. In one sense it is obvious that you need both, but the question is the priority. DFID appears to be focusing more on the horizontal, although they also contribute to the Global Fund. Do you have a view, both of you, on whether they have got that balance right in terms of what they are doing or how they should balance those two approaches?

Dr Buse: First of all, I think that a lot of people in the last year have started to object to those terms—the horizontal, vertical and diagonal—but just to be clear, there are clear differences in terms of vertical being tightly earmarked and horizontal being unearmarked. Unearmarked being towards a budget support sort of approach or systems approaches and looking at what is broken in the system. I just want to define the terms so we are all talking about the same thing. Diagonal has something to do with trying to achieve those disease-specific outcomes with the vertical funding but also to be achieving other kinds of health systems outcomes, whether it is more health workers or whether it is a laboratory strengthening, or whatever. I think DFID is trying to address or redress a past imbalance in its support. Chairman, you talked about a balance, but actually it is not, it is £6 billion into health system strengthening versus £1 billion towards the Global Fund, and I think that that is, in part, trying to rectify some of the problems that were inherent in the tight earmarking of funds. I suppose my position is coming through that I would see it to be a very reasonable decision to have taken for a number of reasons, and I would be happy to expand on those unless we want to come back to that question but I wanted to provide some general food for thought.

Mr Bermejo: I would like to add a couple of things. One is whether that is the right question. I would agree that the answer we need to do both is true, but the first big issue, I think, is to understand (and there are lots of studies that have shown that) that the efficiency of health systems increases proportionately to amount per capita investment until you reach $40–60 per person per year. We are not here having a discussion on what is the best investment in countries that have $9–14 per year per capita. That is not the right question. The question is how do we take it to a level where these systems can be effective? Because if not, you can talk more about the macro numbers, but from the communities where the HIV/AIDS Alliance comes from, I remember in Mozambique hearing from a community activist like Lucy who was HIV positive and had a TB infection—who said, with the current investment we have, why do we not stop the discussion and just invest it in cemeteries, because we are spending much more time discussing what to do with $14 per person per day, and money and resources and studies and meetings, than we are seeing how we take that amount further up? How can you really create an efficient health system? It does require more money. So I think that is one element that we need to remember. While I would agree that we need both—and that certainly has been the experience in different countries who need different balances to achieve the best health outcomes—it is a useful discussion, but we need to remember, within $14 a day it does not matter too much what approach you take, it just is not enough to reach the Millennium Development Goals and the objectives that we have set ourselves.

Q21 Mr Crabb: Given that there is research that suggests that certain vulnerable groups, for example, sex workers, are much less likely to access government provided treatment and services, what does that say about the system strengthening

approach, the horizontal approach, and what should DFID be doing to make sure that its horizontal funding still reaches these marginalised vulnerable groups?

Mr Bermejo: That is a very good question and one that the Alliance, because of its tradition of working with marginalised groups, lives on a day-to-day basis. Clearly the importance of these marginalised groups and the recognition of the role that they have in both preventing the epidemic and in providing solutions to the epidemic, our knowledge of how that works has grown and the epidemiology shows that epidemics that we thought were generalised epidemics are actually much more concentrated on these groups than we thought in the past. So there is no doubt, I think, in anybody's mind today that if you want to control the HIV AIDS epidemics, you have to reach out to these groups and involve them in the solution. As you say, health systems: first, most of the work with these groups, the prevention work in particular, is not a health system's work, it happens outside of the health system, the prevention work, to a great extent. In terms of treatment and access, clearly people living with HIV, whoever they are, know the importance of health systems—they need the health system to get medication on a day-to-day basis, so they do care about health systems—but, as you have said, there are barriers to access for these groups: whether they are transgender people, sex workers, MSM[3] drug users, there are very important barriers to access. So a general budget support system that just injects money into the public health system—because let us remember when we are talking about budget support as a mechanism for strengthening health systems, we are really talking about the public, government run health systems which are in most African countries and many other countries are a minority service provider—most of the care is anyway provided by faith-based private sector and other community organisations. So unless we can reach those, and particularly those that are closer to the organisations and the groups of people we are talking about, we will make some difference but not all the difference we need to make to guarantee that they have proper access to prevention, diagnostics, and treatment and care.

Q22 Mr Crabb: Sorry to be stuck with the horizontal and vertical jargon again, but what do you think are the ways in which vertical funds can strengthen or undermine health system strengthening, the health system approach?

Mr Bermejo: We have seen examples of both, and I am sure you will want to come in. In terms of how they can strengthen it, we have seen strengthening through, first, reducing the burden that HIV patients put on the health system itself. We remember those days where 60% of the beds in any southern African hospital was occupied by people living with HIV—so there is that burden. There is the improvement of health systems by the fact that health workers get access to treatment. Let us remember that the health workers crisis is one that is both produced by people, by health workers leaving the health sector, but also by health workers dying, particularly from HIV and TB. It also has been shown to strengthen health systems in terms of improving the procurement and supply management chain. When that has been well done it has brought men and other groups to healthcare that hardly ever visited the health clinics in these places; it has brought young people into health clinics. There are lots of examples where it has been done well, and many health systems were built years ago around SRH intervention (sexual and reproductive health services), so there is a tradition of building heath systems based on disease specific interventions. We have also seen, I think, examples, many of them I am sure you are aware of, where vertical interventions have weakened health systems by paying more through donor support, drawing resources from the primary healthcare and from the clinics and hospitals away from the public health system into donor-funded programmes. We have seen parallel systems for procurement and supply management and diagnostics being set up. So I think vertical intervention has the potential of doing both, and it is about how we do it in an iterative manner that is well focused, monitored and evaluated properly to see that health system strengthening becomes an outcome of those interventions and, equally, how we do health systems which should not be strengthening in a way that is not a goal in itself but that really delivers health outcomes. In many of the countries we are talking about HIV, TB and malaria are the main killers, and we need to remember that.

Dr Buse: I would say that that there is emerging evidence on positive and negative externalities, if you want to use that language, and that there is a process going on that is led by WHO[4] right now, that is trying to collect and analyse that evidence systematically, WHO it is part of a large network working on this and I am not sure if DFID is part of that process, but the aim is to develop guidance for next summer so as to ensure that all opportunities to identify and address not only the negative impacts, the unintended negative impacts from the past but also to identify where positive synergies can be grasped so if funding is put through a vertical system then automatically some non disease-specific health systems outcomes will be generated. Labs will be strengthened and shared, for example, between AIDS programmes and non-HIV programmes, that x-ray machines will be shared, that the staff will be shared. But I think one of the dangers is that the vertifical financing mechanisms create certain kinds of incentives as well that are not necessarily at the service delivery level but are more at the stewardship and governance level of the health sector. So if you have quite well funded programmes, there can often be an incentive for that programme manager to report back to their funders—be it the Global Fund, be it the World Bank, be it PEPFAR, be it DFID, if DFID were going down that route—as opposed to programme managers reporting up the chain of

[3] Men who have sex with men.

[4] World Health Organisation.

command within the health system to their parliament, for example. So DFID has, over the past 15 years, supported sector-wide approaches for more rational allocation of funds across the sector based on the burden of disease and the cost-effectiveness of various interventions, and one of the things that the financing of vertical programmes seems to have often done is remove the incentive for those programme managers to participate in wider sector dialogue and, therefore, to share and to look for where those positive synergies can be obtained. But to answer your question, there is a process going on, a lot of the large agencies are a part of it, and then it becomes more a political question how does DFID as a donor, with its billion dollars that it has given to the Global Fund, demand that the Global Fund take a more systems and holistic approach to its investments. I just want to come back to the question raised by my fellow witness. I would agree that we should be asking for $60 or $80 per capita for health, but the reality is right now we have $15, so it behoves us to use $15 or $20 in the most judicious way possible. I think there are a lot of cost-effective interventions addressing a number of health problems that are not HIV that deliver more health outcomes for every pound spent. There is a methodology and, again, a global process that has taken place, and it is on-going, it is called CHOICE at WHO, which looks at how much health is delivered per unit of spend, and a number of the HIV spends are not terribly cost-effective. In other words, it is not that those HIV/AIDS programmes are not having a profound effect, they are having an effect on a lot of people's lives, but more effect in terms of health impact could be had from spending the same amount of money. There are obviously really good reasons for spending on HIV/AIDS, and there is a huge amount of momentum now behind efforts to get money onto the table for HIV/AIDS. So I see this as quite an historic opportunity to use the AIDS funding and to use the profile that AIDS has garnered to reorient health systems so that they take advantage of those positive synergies and they reorient from simply delivering maternal and child health services in many low-income countries, to dealing with chronic and non-communicable diseases, as well HIV/AIDS is going to increasingly become a chronic condition and chronic problem, so that this opportunity is used not to say that "AIDS has been over funded" but that we need more funding for HIV/AIDS but it should be used in such a way as to strengthen health systems, I think that there are a number of global health initiatives that have revolutionised the AIDS business, the Global Fund being one of them, UNITAID, GAVI,[5] and so on. They have a lot of strengths to bring to the table, but their remit should be focused on making sure that they use vertical financing mechanisms to achieve these positive synergies and positive externalities from the AIDS funding.

Q23 Richard Burden: Thank you. You have given some very helpful comments about how we can achieve greater synergies and strengthen health systems from the position of vertical funding. Could I perhaps ask you to look at it the other way round though? DFID is putting £6 billion worth of its money into strengthening health systems. As well as seeing how vertical funding can be used to strengthen health systems, do you think enough emphasis is put by DFID on working out the impact of the funding it puts behind strengthening health systems on making tangible contributions to combating HIV/AIDS?

Dr Buse: I would say that there certainly is a lot less evidence. I have not done a study on this, and there is not a lot of money around to do studies on it, but I think it will be difficult, to answer your question, because we do not really know what is happening at country level because the emphasis over the past number of years has not really been on health system strengthening and this is a relatively new commitment that DFID has made in terms of the £6 billion. I notice in their strategy that they talk about one health system strengthening outcome measure that I could see by looking at it briefly, and it was 2.3 health workers per thousand population. I do not know if we want to go down having a conversation in terms of how you would measure health systems strengthening progress and what sort of indicators should we be looking to have.

Q24 Richard Burden: That is what I was getting at in a way. Would you think that that 2.3 health professionals per thousand people living with HIV/AIDS would be a meaningful indicator, or is it barking up the wrong tree?

Dr Buse: I think that the AIDS world has brought us very good outcome indicators in relation to universal access to prevention and care. The problem with a global target like 2.3 is that it ignores a lot of national specificity and differences and that one can have 2.3 health workers in one geographical area and not in another. That kind of global target is actually quite difficult to work with. I think a much better approach is to take a country-specific approach and look at what is broken in their national system and to identify which parts of the heath system require strengthening, and that might be around subcontracting NGOs to provide services to hard-to-reach populations. It might be around health workers, it might be around surveillance, it might be around procurement or the kind of diagnostics that you were asking Lucy about. But the point is to see it from a country perspective what needs fixing and developing a plan; that way you get the variety of stakeholders involved in owning whatever kinds of outcomes or targets you are trying to achieve. Coming back to why I think universal access is a reasonable ambition, or one possible approach, is that it is very equity oriented; that one

[5] UNITAID is an international drug purchase facility for HIV/AIDS, TB and malaria administered by WHO, The GAVI Alliance (GAVI) (formerly The Global Alliance for Vaccines and Immunization) is an alliance between different stakeholders, in both the private and public sectors, committed to the mission of saving children's lives and protecting people's health through the worldwide expansion of childhood vaccination programs.

can go through the healthcare system and say what sort of services do we think on the basis of economics or other preferences in terms of what everyone should have access to. Should everyone have access to essential drugs within two and a half kilometres? Should everyone have access to a package of health services? Does the surveillance system work? Is there a fair financing system? I know those are very challenging things to try to define and measure, but I think it is more useful than saying in five years are there 2.3 healthcare workers in Nigeria per thousand people.

Mr Bermejo: Can I add also to your question? I think there is an issue about the hard evidence, even in countries like the UK. To think that Kenya is going to be able to collect data as to how many sex workers, MSM or drug users are accessing the health services—it is not going to happen. If you can get age and gender disaggregation, you are pretty lucky; you are certainly not going to get that other type of information, so we will probably not have that hard data for a long time. But I can tell you of a study that has just been done trying to look at the HIV epidemic amongst transgender population, and this is the sub-group that has the highest HIV prevalence in the world. In many cases, like Mumbai, Latin America, 40% of these groups are living with HIV. 40% is a very high rate, hardly found in any other community. There has been a study to see access to healthcare services by the transgender population. It is appallingly low, because, firstly, if they are hospitalised they feel uncomfortable being sent to the male ward, which is where they are sent because their names have not changed. They are still registered as a man, so they are sent to the men's ward, where they are difficult to hide. They do not look like most of the other men that are in that ward and they do not relate to them; they see themselves as women. Most of them, a great majority of them, die without accessing treatment or even having a diagnosis. No amount of health system strengthening, of horizontal funding to a SWAp[6] is going to change that, and if we believe, as the Alliance does, and I think most people do, 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, then it is clear, I think, that if our focus is on containing the HIV epidemic in addition to health system strengthening that we need to do we also need targeted interventions that will reach these groups. I think there is no denying of that. I think DFID recognises that in its strategy, I do not think it is clear in the way it funds, and I think there is an issue here of: if you recognise it in a strategy do you have specific targets as to how much money you are actually going to target to these groups and what are the funding mechanisms you are going to use? That is the question, I think.

[6] Sector wide approach.

Q25 Sir Robert Smith: Is there anything we can look at just to assess whether DFID's strategy, predominantly health system strengthening, provides better value for money than going down a vertical route? Is there any way we can assess?
Mr Bermejo: Better value for money in terms of containing HIV?

Q26 Sir Robert Smith: Yes.
Mr Bermejo: That is the question. Will it contain HIV better than any other strategy? Not will it improve health better than any other strategy? It depends what the question is, and it is hard, I think, to respond because I think we would support 80 or 85% of what DFID is doing on the ground. I think the HIV strategy still is not specific enough to see what the outcomes that are expected to be achieved from DFID's investment is, so it is very hard to measure the outcome. The strategy does not say it, at least not in those clear terms, but if we are saying those £6 billion are going to be for health system strengthening through budget support and sector-wide support, if that is what we are saying, then I would say that is not the best investment to contain HIV, and I think most people would agree with that. You need a combination of health system strengthening and vertical interventions that reach marginalised groups. DFID would say we are doing that too, but that is not clear from the strategy and what the balance of those two things is not reflected in the strategy.
Dr Buse: I would have to agree that different approaches are needed in different contexts. I suppose I would like to know what any specific epidemic looks like. If we consider what is really going on in diverse epidemics, particularly with some of the fast emerging epidemics in places like Pakistan, amongst highly stigmatised groups, I think we need to put this in the context that there are six or seven thousand new infections every day. That is what we should have our eye on: how to prevent the future burden of this disease and think about sustainability. We should be thinking about prevention and what do we know works in prevention. I think I would agree that there are certain things that strengthening the health system probably cannot achieve in terms of dealing with the human rights abuses that lead to the new HIV infections in the populations that my fellow witness were just mentioning. Having said that, I do see within the DFID strategy quite a bit of emphasis placed on prevention amongst marginalised groups. But that is not talking about value for money necessarily. It is difficult to answer that question. To deal with HIV from a human rights perspective, let us say, and to talk about the way transgender persons or men who have sex with men are treated in society is a question that, if one were going to study, would take time-series analysis or data over quite a long period to see the human right intervention to be implemented and to have an effect on HIV transmission. So I do not think you are ever going to get a very neat comparison there in terms of value for money analysis, but I would say, from my perspective, that certainly prevention needs to be a

very large part of the picture. In addition to which is dealing with a number of the social and structural determinants which drive why people are vulnerable to HIV, and part of that then becomes DFID finding ways of supporting groups in countries who wish to deal with the political realities, dealing with small politics, if you will, of addressing the human rights of transgenders for example or men who sell sex. I agree that budget support probably is not the way that that is going to happen, to understand the political and social obstacle to support human rights, or social determinants interventions because there has to be very creative support to groups that are trying to change the policy environment within which people live and the legal framework and for example the way that police forces treat people once they arrest them, and so on and so forth. So I would defy an economist to give you a very simple answer to whether or not a human rights intervention delivered by NGOs is a cost effective way to avert a death or not. It is quite a difficult question to answer.

Q27 John Battle: In a sense I am pressing for an overview and a very generalist question: because the debate on HIV/AIDS seems to me to have changed over time. The Zambia example was highlighted for many years as a successful example of an African country that tackled it, but then—the problems with TB that we are now discussing—for 10 years we discussed access to antiretrovirals, for example, as treatment, and now that debate has slipped into the background. If you could just outline for me, and I like, I think, to have the kind of theoretics (and I do not use that term pejoratively) of the analysis, but in terms of the context, where do you see the epidemic rising? Which are the key marginal groups that we should be addressing? Which are the key places that we should be focusing on? I am not sure that I have got that clear in my mind. I have got this structure: is it clinics and holistic healthcare, is it prevention or is it treatment, but where are the real pressure points in the world? In the past we said: "Go to Zambia, see how they have done it and use that as the template." Now we know that there are problems with that template. Then we went to an antiretrovirals campaign. Is it second generation or third generation? Where are we now?

Mr Bermejo: It is a very difficult question, where are we now. I think one of the things we have realised, and I know I am just paraphrasing Peter Peart on this, the only thing we know is that there is not a magic bullet, so every time somebody says, "If we just did this we would contain the epidemic", before they even tell you what this is, you know that is wrong. We know we need a combined effort. I think what we have come to realise is that the prevention benefits that we thought would come out of scaling up treatment—there was all this talk about the synergy between the two and how, if we only managed to get all these people on treatment, prevention would take care of itself—that has also proven to, unfortunately, not be true. As you were saying Kent, in DFID's strategy and in PEPFAR too there is a great opportunity, while maintaining the scale-up of treatment, to focus and refocus on prevention. I think that is one place where we know we are. In terms of prevention though the situation is we know pretty well what can be done and what works to reduce the epidemic amongst key populations is focused prevention. There are a lot of studies and lots of countries such as India, Cambodia, Thailand and Brazil which can show we know what works there; it is political will that is needed in those places and sufficient investment. We need to understand that prevention, just as treatment, is a lifelong thing. It is not something you do once and then you say, "We already did prevention in this country." You need dosage, you need lifelong the same, and multiple drugs and multiple prevention interventions; we know that. I think the good thing is that for concentrated epidemics we know that a focus on prevention will close the tap and at the same time we have got an obligation to keep people alive. In the generalised epidemics I would say that what to do is much more complex and I would not claim to know. I wish I did! I think we need to continue focusing on treatment. When you have one-third of your adult population infected, to decide that you are not going to provide treatment is a pretty difficult decision, whether or not it is the most cost-effective intervention, but at the same time we need to realise that that is unsustainable and we need to reduce the incidence. We are beginning to see, even at country level and particularly at city level, a reduction in new infections in generalised epidemics. I think it is still unclear as to what is the most cost-effective combination of interventions in those countries. I really think more research is needed in that area and that is something that we need to be investing in. We need to be investing, which I think is your issue about Zambia, in not just HIV itself but HIV-related health issues, and certainly TB and sexual and reproductive health are important considerations. When we know 30% of women in many of these southern African countries are HIV infected it is clear that 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. I think it is a difficult answer but that is more or less where we are. I do not know, Kent, if you want to add anything.

Dr Buse: The only thing I would add is one of the positive things I have seen in the last few years is not only a mantra around "know your epidemic and respond accordingly" but increasingly a number of the organisations that were, unfortunately, funding AIDS programmes that were not based on much science are being pushed into a direction of being slightly more reasonable in terms of where they are putting their funding. So know your epidemic but I would also say know your politics, know what prevents you from being able to spend the money on the things that the evidence suggests you should be spending it on. That has not been happening enough and there need to be more brave voices who say, "Why are we spending our money on this? We could be spending our money in a more cost-effective way". One of the big things is going to be looking in

a very realistic way at what are we going to do about sustainability, how are we going to generate these resources, what sort of new resource-generation mechanisms will we need to keep people on antiretrovirals, and how are we going to make them affordable, and what sort of new deals can we come up with, with PhRMA[7] for example?

Q28 Daniel Kawczynski: Do you agree that a more diagonal or integrated approach to funding for HIV/AIDS is likely to be more effective than horizontal or vertical approaches? If you could make your answer as jargon-free as possible I would be grateful.
Mr Bermejo: I certainly will not use the "diagonal" word because I hate it, because I think it is very ill-defined. With a more integrated approach, yes, I think it is certainly integrated in the sense that when we are programming HIV vertical funds, in terms of raising funds, in terms of mobilising public opinion and political capital we need to see specific interventions. You do not get the UK public and your constituents enthused about health system strengthening and you will not; you get them enthused about making a difference on HIV, TB, malaria, and sexual and reproductive health, so I still think from that perspective of mobilising public opinion and funds we need disease-specific mobilisation, vertical if you want in that sense. In terms of how we use those resources best you do need a combination and that is a combination that does not just say we have these vertical programmes running on one side and then health systems in parallel track; that is not integration, that is a balance of two investments but it does not integrate. I think there is a lot that we can do to ensure that those two tracks integrate more together, which I think is your question, and certainly the growing attention and political oversight now on looking at whether that integration is truly happening. That means, as we have seen in many countries still, for example if you go to Ukraine, where we have one of our largest problems, the HIV and the TB people in the Ministry of Health continue not to talk to each other and continue to have resources spent in parallel. I have to say that one of the benefits of the Global Fund's intervention (they are funding HIV but they are as yet to fund TB because of the approach that they are following) has been at least to get that dialogue started and get civil society involved in health services that were extremely vertical and had no civil society and community participation, so you can see the effect of vertical interventions making that more horizontal. Does that make it more effective? There is no doubt in our mind that it does. It is equally important that health systems strengthening has specific health outcomes in mind and that we do not fall into this thing of we are strengthening health systems so our only targets are going to be number of health workers per population, number of beds, number of nurses, or the speed with which a pill gets to a clinic out in the field. 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. Yes, I believe that there is value in integration if we do it well and carefully.

Q29 Daniel Kawczynski: In terms of DFID, if you could clarify a little bit what do you see the main challenges that DFID faces in pursuing this integration?
Mr Bermejo: There is the fact that their strategy is not specific enough. It is not clear as to what resources are going to go where and what health outcomes and specifically what HIV outcomes are to be expected, so it makes monitoring very, very difficult. There is also the challenge that at country levels the developing countries where sector-wide or budget support has been provided they do not have the monitoring and evaluation plans and systems to be able to track whether their resources are being effectively utilised. So I think there are several challenges along the chain for DFID which are not easy to resolve. You have already highlighted some of them in your report of last year when you were calling for a stronger outcome target for DFID. I have to say I think this current strategy instead of taking it a step in the direction this Committee had highlighted, in that sense it has taken it a step further backwards. Your complaint was that it only had a spending target for HIV and it did not have other outcome targets. This one does not even have a spending target for HIV, so in terms of the strategy there is still more specificity needed and more ability to measure. Those things are getting in the way not just of DFID being able to contribute to implementation but all of us being able to truly monitor progress.

Q30 Chairman: As a final point we might look at civil society because that arises somewhat out of that. DFID says it wants to engage civil society but then says it is putting most of its money into building health services, so what is the balance?
Mr Bermejo: This is one area where we have a lot of discussions with DFID. I always say that we agree with DFID 80% and there is 20% we do not agree, and this is amongst the 20% we do not agree. 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 think it is a strategy that is driven by some constraints that they have like the reduction in personnel overseas in DFID offices which make mechanisms like multilaterals or SWApS more attractive because they have lower transactional costs in terms of the human resources required for DFID, but that should not be what is driving the strategy. We know and DFID knows, that if we are going to reach these hard-to-reach populations, and particularly if we are going to reach them in their bedroom or where they inject drugs, which is where HIV transmission occurs, then we need civil society, and I mean the local 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. I always say—and you

[7] Pharmaceutical Research and Manufacturers of America.

will know better than I do—that I have yet to meet an MP who got elected because of the great job they did with sex workers in their constituency and because of how close and supportive they were to drug users. You do not get elected on that basis. I have always said we will move the Alliance to the first constituency that proves that to me! That has yet to happen. If you acknowledge that and that is the case, then you need to have an AIDS system that acknowledges that and that acknowledges that it is very difficult for government services to reach these populations which are critical. We need civil society both in terms of service delivery as well as holding their own governments to account for the resources that come into the government and for the outcomes of those programmes.

Chairman: Can I go to Marsha Singh because I pre-empted his question.

Q31 Mr Singh: Just to follow up on that point, DFID's strategy gives a general commitment to increasing participation with civil society but only gives a couple of examples of doing so. Is that a sign of mistrust of civil society or is it a sign of no experience of engaging with civil society? Secondly, coming to the point of sustainability, is working through civil society sustainable rather than working through a public health system, which whether it is good or bad should be there for a long, long time whereas civil society might not be there for a long time? Finally, you have talked about the accountability of government which I think most certainly does play and should play a role, but what about the accountability of civil society for the resources that it might wish to put into them to deliver services, how are they accountable?

Mr Bermejo: There were several questions there. Firstly, it is certainly not the case that DFID does not have experience in working with civil society. DFID has been over the years one of the donor agencies that has worked more and better through civil society in the world, I would say, and has been a leading example of that. Clearly I would say that every one of the civil servants working in DFID that we have encountered has had a lot of willingness and openness to working with civil society. Is it an issue around at a particular point in time in the AIDS strategy a lack of political will? I think there was an element of that and we need to remember that this current strategy comes in the middle of changing ministers, changing governments, and the strategy gets caught in the middle of that, gets delayed, there is then talk that there is not going to be a strategy. Civil society's participation in designing that strategy, which had been from the beginning very intense, suddenly disappears. We hear that there is not going to be a strategy and then a strategy does in the end emerge. Part of the lack of civil society participation at some part of that process had an impact. I also think, as I said, that part of the lower willingness to work with civil society is really driven by the fact that there are fewer staff available from DFID so it is clear that engaging with civil society, whether it is here in the UK or in India or in South Africa, is resource intensive. You need people to do this and when you are being cut back in terms of the people that are available, you tend to cut those things that are more resource intensive, and I think civil society engagement is suffering from that. I think that is probably more the explanation as to why it is happening and it certainly is not good news for HIV, that is for sure. In terms of the accountability issue, I think there is a very interesting discussion now which I was hearing quite recently where suddenly the Global Fund is being characterised as an undemocratic, non-accountable mechanism of funding and IMF and the World Bank and others are suddenly portrayed as the most democratic funding mechanisms, which was a shock for me to hear. I know where it came from. It came from the fact that because of the vertical nature of the Global Fund in many countries it does not come into the national budget and it does not have parliamentary oversight. I think that certainly is unacceptable. I really think that that does not need to happen just because it is disease-specific. We should still have a policy dialogue that brings in those accounts and whether they go to civil society or to anybody they should be integrated in the national budget and under parliamentary oversight, and that would be a way of holding the NGOs to account, too. I realise that the issue of NGO accountability that you are raising is a real issue. I think civil society has taken some steps towards self-regulating codes of conduct and other things but I think that is still not enough and we need to do more; I agree.

Q32 Mr Singh: And sustainability?

Mr Bermejo: The sustainability issue is one where I have shifted my own thinking. I would have agreed with you because I used to think that civil society was less sustainable than the public health system. My time in the Alliance has shown me that that is not true in a way. If I give you the example of Ukraine, where we are implementing a multi-million dollar, nationwide programme, that was first implemented by the government but then because of corruption taken away from the government and given to an NGO to implement. During that time—and that was 2004—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. I think we are making assumptions partly around sustainability. Of course the sustainability of funding requires a commitment from the Government to include it in the budget, that I would agree, but it is not more sustainable because it is run through a government delivery system than because it is run through a civil society delivery system, provided the Government has it in the budget and it remains the overall steward. The implementation mechanism that it chooses does not necessarily impact the sustainability is what I have seen from that experience.

Mr Singh: I tend to agree with you because in May I went to Bangladesh to see their programme against TB which a weak government could not sustain and yet civil society is sustaining that programme.

Q33 John Battle: I think it is in a sense a response to the comment you made about politics and whether people could campaign on the basis of tackling HIV and drugs. I would encourage you and say that I do believe it is possible for politicians to change the perception. I represent a constituency which has a huge prison, and we tackle drugs and it is one of the most popular campaigns because everybody could be affected by people taking heroin and cocaine, so I just want to say it can be turned round which brings me to the political question that I would put to Dr Buse. In countries where there is political resistance to taking HIV/AIDS seriously, we have a bigger problem there, I am thinking of the issues around South Africa and maybe the issues I am very conscious of at the moment in some of the Caribbean countries. How do we tackle those and does DFID put them on the agenda or is that for us as politicians to do? Who addresses the really deep political resistance to tackling this challenge?
Dr Buse: I would like to see all this start with evidence in terms of what are the drivers of the epidemic and what do we think the solutions are. That is very country-specific and it depends on which bit of the epidemic we are discussing. In every country you will find constituencies, maybe not geographically as you were just discussing, but various groups that would like to see the problem addressed in one way or another. Often you will find allies inside and outside of government. I think that around the top five interventions, let us say, in any one country in terms of those interventions that are going to make the biggest amount of difference, that an organisation like DFID could usefully support groups—advocacy coalitions if you want to call them that—to undertake analysis on a long-term basis that did try to understand which groups are opposed to this and why, and seeing if it is an issue simply of framing the palatability of it, as you were suggesting, or taking care of a local problem. I do see a useful role for an external agency like DFID to provide money, and we are talking small amounts of money, although of course there is a human resource issue in terms of a lot of country offices are not necessarily set up for doing that, and that would help groups to understand the politics and to come up with strategies and tactics for dealing with them, because at the end of the day we can make commitments to getting 2.3 health workers or whatever, but I think we have an obligation to help countries also to meet the Millennium Development Goals or the targets around HIV/AIDS. If they are blocked because certain interest groups find it difficult to deal with the fact that certain men have sex with men, for example, DFID should use its creative powers to change the way that that political problem is perceived, and I think it is very context-specific challenge. You cannot sit here in London and suggest how that might work in Dhaka.

Q34 Chairman: I think we saw a good example of that when we were in Hanoi where DFID had worked with civil society both with intravenous drug users and the sex trade and actually persuaded the Government of Vietnam to go somewhere it did not think it wanted to go when it saw how it could be done.
Mr Bermejo: You were mentioning South Africa and one thing is clear—that the treatment action campaign in South Africa has been a big influence on a reluctant government who have installed prevention of mother-to-child transmission programmes and treatment programmes, and that has really been the most effective way of making sure that the new health minister and the new Government takes a different view on HIV. In the Caribbean where civil society is much weaker I think we have seen that we really need to find additional ways to try and change a very homophobic culture and government where it is more challenging.

Q35 Daniel Kawczynski: I just want to very briefly ask Mr Bermejo to go back to what he said before about politicians. I did not fully understand what you said. You said you had never come across a politician who has campaigned on—
Mr Bermejo: Not who has campaigned, who got elected on the basis of having worked closely with sex workers and drug users to minimise the health risks that they are exposed to. If you are the first one let me know! Honestly I am saying it because it is not a popular thing, it is something we know we need to do. Many of the politicians' and governments' values are there but we need to acknowledge that it is a difficult issue usually to work with and most people say "yes but not in my backyard" or "not in my neighbourhood" or whatever, so harm reduction programmes, programmes that tend to empower sex workers or drug users to take care of their own health and minimise the risks that they are putting are usually not particularly popular and their access to services is usually limited I think the best public health approach and human rights approach is to, in a way, acknowledge that these are difficult to reach for government service delivery and to find alternative mechanisms to reach them. That is where I was going.

Q36 Daniel Kawczynski: You seem to be giving me the impression that you feel that therefore politicians are not interested in helping these—
Mr Bermejo: That is not what I am saying. What I am saying is that in trying to think of which ways to help them you need to acknowledge that it is not a popular subject and find alternative ways of reaching those populations. I think many politicians in this country and Spain, where I come from, and in many other countries have established very strong harm reduction programmes in prisons, which you were talking about, and of course that requires politicians to support it, to establish it, to care about it and to make it happen. It still is not a popular intervention. I spend a lot of time in my country explaining to people why it makes sense to give needles in prisons. Most people, most of my

colleagues, friends that I went to university with, still think it is not a good idea, and you are faced with that challenge. I am not saying people do not care. I am just saying we need to acknowledge that and find ways of reaching them that are specifically designed for that and that a mainstream approach will probably not take us there. That is what I mean.

Q37 Chairman: Part of our role as a Committee is to be prepared to say these things so we will look forward to your amendments, Daniel!

Dr Buse: Obviously we do not need to lecture you on what political interests politicians and political leaders fact but there have been a number of leaders in southern Africa who faced political incentives to act on HIV/AIDS when they came into power. For example Museveni, with no tourist industry at stake and therefore nothing really to lose by coming to the international community and saying, "We have got a serious problem, can you help us solve it?" In other cases the political incentives have not necessarily been just around stigmatised groups but also some leaders have openly said, "Our workforce is small and specialised", or, "Our workforce is of a certain nature and we do not need to deal with this problem, it does not matter", so political incentives obviously do speak to whether or not leaders at all levels take action on HIV/AIDS.

Daniel Kawczynski: I think what you are proposing is a very progressive agenda and I think it will take politicians a certain amount of courage to do what you are doing. I very much hope that future generations of politicians will be more courageous in this regard.

Chairman: Thank you very much. We have probably overrun on that but I think it has been an extremely useful exchange. However, I want to be fair to our last group of witnesses to ensure they have an opportunity too, so thank you very much to both of you.

Witnesses: **Ms Fionnuala Murphy,** Campaigns and Policy Officer, ActionAid; **Dr Stuart Kean,** Chair of the Working Group on Children Affected by AIDS, and **Ms Carol Bradford,** Chair of the UK Network for Sexual and Reproductive Health Rights, UK Consortium on AIDS, gave evidence.

Q38 Chairman: Thank you very much for coming in and for being so patient. Obviously this last session is particularly important looking at the impact of HIV and AIDS on women and children. Before we start perhaps you could introduce yourselves and who you represent.

Ms Murphy: Good morning everyone. My name is Fionnuala Murphy and I have been working for five years as a campaigner and advocate on HIV and AIDS issues. Most recently I work in ActionAid where I have been running a campaign called Invisible Woman where the objective is to get DFID to put women's rights at the heart of their work on HIV and AIDS.

Ms Bradford: I am Carol Bradford, and I am representing the Indicators Working Group of the UK Consortium on HIV/AIDS. We have been working with DFID to monitor and evaluate the strategy.

Dr Kean: Good morning. I am Stuart Kean and I am Senior HIV and AIDS Policy Adviser with World Vision but I also co-chair the Children and AIDS Working Group of the UK AIDS Consortium.

Q39 Chairman: Even in the introduction you have slightly anticipated the first question which is: to what extent do you think that DFID's approach does actually pay sufficient attention to the impact of their strategy on the needs of women and children in terms of HIV/AIDS? You will be aware that last year we did a report on maternal health which raised the AIDS dimension so as a Committee we have covered it but we are anxious to hear from your point of view whether DFID is doing enough and what more it could do.

Ms Murphy: If you look at achieving universal access there are a lot of really important first steps in the strategy in terms of tackling the ways in which women and girls are affected by HIV and AIDS. ActionAid was really pleased to see a number of commitments in there and I have just made a list here. For example, there is a pledge to continue UK leadership on comprehensive HIV prevention that is evidence-based especially for vulnerable groups; a commitment to train DFID staff on women's rights; pledges to take action to stop violence against women and girls; a recognition of the importance of integrating HIV with sexual and reproductive health services which reflect the reality of women's lives; promises to include a gender analysis in HIV prevention strategies; moves to increase access to contraception and female-controlled HIV prevention such as female condoms and microbicides, and to work with other countries to increase access to those commodities; greater attention to the burden of care on women and a pledge of £200 million to be spent over the next eight years on social protection for carers; and broader pledges to address structural inequalities that keep women poor and that put women at risk of HIV infection. I am sure Carol will have a lot more to say about this. I think those are really important first steps but for us the real challenge is about how these pledges are going to be implemented because they are very top-line promises but 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 got there and that we have delivered real benefits for women and girls.

Ms Bradford: I am going to just speak very briefly. I am here more to talk about the monitoring and evaluation aspects, but I also represent the International Partnership for Microbicides which is a product in development that will help women

prevent HIV. DFID as part of its monitoring has agreed to up its research spend on both microbicides and vaccines, so these will both be very beneficial to women. Obviously it is prevention work in the future.

Q40 Chairman: And in relation to children?
Mr Kean: 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. For example, on the prevention of mother-to-child transmission goal, which is one of the very specific goals, to support the international target, we need to ask what is DFID going to contribute and what is going to be the system for trying to track that across even the PSA[8] countries. 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. Picking up on some of the discussion we have already heard this morning, one of my concerns is about how we get the policy dialogue because particularly in relation to direct budget support if you are working, say, in Zambia and you are putting money in through the budget, things will happen if those issues for example around children are in the national AIDS strategies which are then funded by the budget, but it does mean that you have got to have staff in the Lusaka office engaging on policy discussions, to ensure that those policy issues or those priorities that we are concerned about on mothers and children are actually included in national documents. I think there is a whole set of processes that requires targets and with the direct budget support being the main instrument for delivery, I do have concerns.
Chairman: I think we have made the point on a number of occasions that budget support is not necessarily a low staffing option.

Q41 Mr Singh: There are many, many shocking statistics in this field of HIV and AIDS but I think the most shocking one is the fact that 60% of all adults suffering from HIV and AIDS are women and 75% of young people suffering from HIV and AIDS are women. Given that context—and you did say earlier that women's rights should be at the centre of DFID policy and then you reeled off a list of commitments—do you think that those commitments (and I know you had reservations about how to implement them) represent DFID putting women's rights at the centre of their policy?
Ms Murphy: As I said, a lot of this is about implementation and I believe that if DFID implements all the pledges that they have made, in addition to doing some extra work around treatment accessibility for women and involvement of women, DFID could make really meaningful progress for women and girls. As far as ActionAid is concerned, in our written submissions we have listed specifics that we feel DFID should be doing that could really take this work forward but in terms of key things that we think need to happen in order to ensure the kind of progress we want, we have narrowed it down to four top things. The first of these is that DFID needs to create budget lines that allocate money for the intersection of women's rights and HIV and AIDS, including a specific budget line on the intersection of violence against women and HIV. At the moment we have been told that £6 billion has been allocated for health. We have no idea how much of that will go to support women. We have no idea how much money will come from other budgets such as education, because a big part of the issue of women's low status is the fact that more than 10 million more young girls than young boys still are not in education and three-quarters of the world's illiterate people are women, and that has an impact on how women later become vulnerable to HIV infection, so will money come out of education and how much money will go to these things, we do not know. That is one point. The second point is that we feel DFID need to be stepping up to the mark and showing more international leadership on issues around the feminisation of HIV and AIDS. They have made a number of pledges around championing evidence-based prevention, scaling up access to family planning, taking action on violence against women, but what we would really like to see is a long-term global advocacy plan that identifies key moments and key opportunities to influence these issues, and pinpoints the institutions where DFID will be pushing these issues and sets out strategic activities that DFID will undertake on them. Some of the outputs that we see coming from this are DFID visibly challenging female-unfriendly prevention strategies, increased momentum around access to sexual and reproductive health care, increased investment in microbicides and post-exposure prophylaxis, DFID really championing the fight against violence against women in international fora, and also DFID working with other donors and developing country governments to improve the economic status of women. The third thing that we think is really important is the training of staff because in ActionAid we have made women's rights our cross-organisational priority and we have recognised that if we really want to do that in our international work and in our community level work and everywhere in between then the first thing we do need to do is train our staff. I do not think that it is that different in DFID. I think they need to set aside money and time for a comprehensive programme, training their staff to understand and act on the linkages between women's rights and HIV. Finally, we would really like to see DFID commit to a concerted action plan on violence against women itself because we think this is an area where there is a really urgent need for action. If you look at countries like South Africa, a young girl at birth in South Africa has a higher chance of being raped than of learning to read and

[8] Public Service Agreement.

write and that is a really shocking statistic. I have come back from Nigeria recently where I have met young women who are forced into marriage at the age of 12 before many of them even know what sex is, and you can imagine what happens to them when they are taken home by their older husbands. There really is a need for concerted action on physical and sexual violence, which is a daily reality for many women around the world. Again some of the things we would like to see from DFID are funding streams for this, international leadership, pushing to get indicators on violence against women in fora like the Global Fund, IHP+,[9] the Education Fast Track Initiative and also making sure that there are indicators of violence against women and girls in national AIDS and health and education plans as well. Of course we feel that there is a strong role for DFID to work with the FCO in terms of spearheading political and legislative reform ensuring that perpetrators of violence can be prosecuted and women have access to justice and that things like marital rape and sexual abuse in schools are prevented through law and through prosecution. We feel that if DFID would take action in these four key areas then we could see a real change.

Chairman: That is a very long list and DFID will very often say they are not the governments of these countries.

Q42 Mr Singh: I was just coming to that point, Chairman, in terms of action on the ground, in terms of violence against women because it is obviously an issue of culture, law and order and enforcement, so what could DFID practically do in an in-country situation to prevent that violence, short of saying to these governments to whom we give money, "This is what we expect you to conform to in terms of international law in terms of women's rights, and if you do not conform to those practices then we will not be giving you money in terms of aid"? Is that the approach that you would like to see?

Ms Murphy: I think that would probably be going a bit too far for us from the point of view of country ownership, but what I will say is that this is not an idea that we have plucked out of our values in the UK and are trying to transport over to other countries; ActionAid is part of an international campaign called Women Won't Wait which is made up of women's movements in about 40 countries who are working against violence against women and HIV, so there are voices for change in these countries. Obviously part of it is about the fact that these voices are not being factored into civil society consultations and international AIDS plans and that even where these voices are heard, there is not always the political leadership to make sure that the demands of women who face violence trickle down into the health system and the education system and through the programmes of multilateral institutions, so it is partly about making sure that those voices really come through. I would just add that you pointed to international agreements. This is nothing that most governments have not signed up to in the numerous human rights accords and women's rights accords that have been signed over my lifetime and well before. We have to bear in mind that this is not something that we are importing; this is something that has been agreed to.

Q43 Mr Singh: But if we can suspend aid because of corruption in elections, why can we not suspend aid if they do not respect women's rights?

Ms Murphy: I think it is partly about making sure that aid is spent in a way that does respect women's rights instead of saying let us stop the aid and see what happens because women, who are most often dependent on the meagre state support that there is, would be the first to suffer from that. One of the things that we have looked at a lot is, how could DFID money be used to train health workers to understand the issues that women face, to recognise the signs and symptoms of violence and to understand what support and care and referrals they can offer to women to enable women to get out of a dangerous situation or to enable women to deal with violence in their lives. The same can be said of money that we give to education. How can we ensure that part of that money is spent on creating safe schools for girls, and making sure that girls have safe toilet facilities and making sure that their schools are near to girls so they are not at risk of violence on their way home and making sure there are systems within schools that enable girls that are the victims of sexual assault in schools to hold the perpetrators of those assaults to account. I think there is a lot that could be done to create positive change through aid rather than necessarily saying we should stop aid if we think that it is not respecting women's rights.

Q44 Mr Singh: Is there any point at all in engaging men in programmes that change their behaviour in terms of women's rights? Is there any mileage in that at all?

Ms Murphy: Absolutely and that is certainly mentioned in DFID's strategy both in terms of tackling violence against women and also in terms of challenging broader gender stereotypes and gender norms which are harmful and helping young men to resist peer pressure to be unfaithful to their girlfriends or to be violent towards women. Whilst women's rights are about women, gender is about everyone. We all have a gender and that is not necessarily set as one thing throughout our lifetime. I think there is a really important role to be played in educating young men, and supporting young men to consider their behaviour and to be brave enough to stand out from the crowd and say, "I do not think it is a brave man who beats up his girlfriend. I think it is a brave man who respects his girlfriend and is willing to think of her as an equal," so I think that is really important.

Chairman: I can testify to the fact that Marsha Singh took President Karzai head on on this particular issue when we met with him.

[9] International Health Partnerhip Plus.

Q45 Mr Kawczynski: Very briefly, Ms Murphy, following on from what Mr Singh was saying to you. You mentioned that you were working with 40 women's organisations around the world, I presume from 40 different countries?
Ms Murphy: It was women's organisations in 40 countries so a lot of them are national coalitions made up of smaller organisations, like the Stop AIDS Campaign.

Q46 Mr Kawczynski: Obviously you are collating information from them. Do you make a quarterly or yearly assessment of the progress that is being made in those 40 countries with regards to rights for women and do you publish that in any way?
Ms Murphy: Personally we do not. It is not being run by ActionAid UK because ActionAid UK is not our head office as such. Women Won't Wait is a global coalition which ActionAid helped to get off the ground but we are not the secretariat. We do regularly gather evidence and success stories and we have a woman coming over from Sierra Leone around World AIDS Day, who has headed up a national coalition which has managed to bring in two laws, one on domestic violence and one on marital rape, so criminalising both of those things and creating accountability mechanisms. Similarly in Ethiopia, a coalition there has been campaigning against a practice where a young girl will be abducted and then the abduction will be the precursor to marriage as such so the family will either barter to have the child returned or they will agree that the child will marry into the family. The coalition there has been very effective in getting that issue on to the Government's agenda and is hopefully moving towards legislative reform. I can certainly dig out some other success stories and send them to you if that would be useful.

Q47 Mr Kawczynski: It would be very useful because I think sometimes we tend to focus on being critical of these countries and beating them up. It would be very helpful to have some positive information that you can give us on specific legislative changes that Sierra Leone or Ethiopia have made following on from the campaigns that have been run. I would very much appreciate that information.
Ms Murphy: Absolutely and also, as I said, this lady is coming over from Sierra Leone for World AIDS Day, and will be speaking at an event we are hosting on the evening of World AIDS Day. We are hoping that Ivan Lewis will come along so it would be great if anybody on the panel is interested in that would come and join us as well.

Q48 Chairman: I was going to address the issue of children and mother-to-child transmission because clearly children in this context have done nothing, they are absolutely innocent victims. The DFID strategy is to reduce that transmission and to increase to 80% the number of women who receive antiretroviral treatment, yet when you look at the causes of transmission, that does not on the face of it appear to be a comprehensive approach. Is that adequate as a target?
Dr Kean: About 90% of children who acquire infection are infected vertically as a result of transmission through the mother. If it was an HIV-positive mother in the UK she would have full services including antiretroviral treatment and her chances of passing on the virus would be 1 to 2%, but in many developing countries it would be about 35 or 36%. By having access to comprehensive prevention of mother-to-child transmission services you can significantly reduce the number of HIV positive children. I think that improving the services is critical and having that as a top line action that DFID is going to support is great. The question, as I said before, is what will that mean they will be doing to contribute to that?

Q49 Chairman: That is my point, they are saying let us give mothers antiretroviral drugs and that has kind of dealt with it, but that does not seem to be the answer. Are you saying that DFID needs to take a rather broader approach?
Dr Kean: I think what they need to do is be able to strengthen support. When I was visiting Zambia two or three months ago I met the director responsible for prevention of mother-to-child transmission treatment and he said that the support that donors provide in a sense as external voices (but providing support on a number of things that I was raising that I would also like to bring to your attention) but certainly generally prevention of mother-to-child transmission treatment is critical because it does mean that more resources will be allocated particularly because they are coming through direct budget support. "Just having greater scrutiny" was how it was described to me by the director, having a score card that has prevention of mother-to-child transmission treatment (PMTCT) and a number of other child-related issues I think is critical. On the question of what will DFID be doing, I think they need to be identifying the best practices that have been working in a number of countries where now those coverage rates are up to 60 or 70%. They need to be able to document those, understand what has happened in successful countries and be able to try and ensure that those are passed to colleagues working in other DFID countries. If I could just mention one of the other issues in our submission which is around cotrimoxazole, which is a very cheap antibiotic that has been widely known about. In 2004 DFID funded with the HRSC research which identified that it could reduce infant mortality by 43%. If children were able to get this then the potential deaths from opportunistic infections such as pneumonia could be significantly lowered. The latest UNAIDS figures the access to cotrimoxazole, show only 4% and even in Zambia it is 16% coverage, and that is in a country where DFID has done this research and found that this drug has these amazing results. We are talking about one or two pence a day.

Q50 Chairman: It is not an expensive drug.
Dr Kean: It is just an antibiotic and yet it can have a very significant impact. I think it highlights the more general issue of how when a piece of research has been done how do you make sure that that moves on

into development and how do you scale up a piece of best practice. Something that has had a major success, funded by the UK Government, actually needs to be celebrated but then needs to be taken up further. This was the kind of issue that again the director of PMTCT in Zambia was saying we need to be doing much more on that. Certainly from civil society's point of view that is what we are trying to get but it needs to be policy.

Q51 Chairman: You would like DFID to be more specific on that?
Dr Kean: Very much so. That particular research finding was alluded to in the previous strategy when it had just been undertaken. It is again alluded to in the latest strategy but there is nothing being said about how that is going to be scaled up. I am aware that UNICEF is conducting some analysis at the moment to try and identify what the best practice is but I am really hoping that DFID will learn from that and be able to encourage it. The question is how through this strategy, can we ensure that steps are taken to get targets around such good practice.

Q52 Chairman: We will have an opportunity to question the Minister later this week so we might take that up.
Dr Kean: That would be a very helpful one.

Q53 John Battle: Can I sharpen the focus on children with HIV. Children make up 6% of the infected population and 14% die so their death rate is higher. I just wanted to ask about DFID's strategy because they focus on social protection if not social transfers—handing money over basically to traditional families and hoping that cash transfer helps. Do you think it does and do you think other services are needed instead to supplement that approach?
Mr Kean: There are two issues I would want to raise about that. One in a sense is the whole issue of paediatric treatment and what is needed to be done to try and scale that up because clearly at the moment barely 10% of the children are getting access to antiretroviral therapy. Clearly with two million children who are HIV positive you need to be doing something, so the question then is why is not that more prominent within the strategy, so from that point of view I really share your concern. There is a range of things that need to be done to do that. In terms of social protection it is not going to answer that issue. I think the social protection issue is there because increasingly in relation to the care and protection of orphans and vulnerable children, which was very much the focus of the child work in the Taking Action strategy, there was an assumption that resources would go to communities and that community-based organisations would provide the services needed. I still think that is very important. In the intervening time the role of cash transfers as part of social protection has clearly been an area that DFID together with ILO[10] has taken a lead role on. It is clear that cash transfers in a number of countries are showing promise, as a means of providing care and protection for many vulnerable children and clearly not just children affected by AIDS, and that can only be a good thing, but I think our concern certainly as the Children and AIDS Working Group is that it has got to be broader than just cash. The ministries that are responsible for providing social welfare, providing child protection, providing legal protection and providing birth registration, are the "Cinderella" ministries, the ones that do not have the resources, so you can put resources into the community but if in turn there are no child protection services, indeed if there is not the investment in education and health as well, then the services are not there to be bought into.

Q54 John Battle: I would have thought particularly in post-conflict countries that the number of children that are abandoned, orphaned or indeed are street children in cities would not be reached by social transfer and protection at all. Is that a group we should be concerned about?
Dr Kean: Absolutely, it is indeed, and there are various groups of children who are outside of the family context and cash transfers are not going to easily reach them and alternative methods have to be found. We have heard there are no such things as magic bullets, but I think whilst it is important to pursue the social protection work that is going on and the pilots and the long-term studies that are going on, we must not throw out the baby with the bath water and the various community-based organisations and faith-based organisations that are protecting and providing services to street children, to disabled children, to communities looking after orphans, you need to have those structures in place to be able to provide them with care and protection. That is not going to come from $10 delivered on a monthly basis.

Q55 Sir Robert Smith: You touched in quite a lot of the evidence on the emphasis in the DFID strategy which is firmly on health system strengthening, but how can funding allocated in this way be effectively monitored and evaluated? When it is reviewed in three years' time what do you think should be the key elements we are looking at to evaluate if it has been a success?
Ms Bradford: That is one tough question because, as has already been mentioned, the AIDS strategy has no budget for specifics. Let me step back just one second and explain a little bit about the process we just had with DFID. It was fairly ground-breaking in that civil society was invited by DFID to come in, and a small group of us went in and worked with them on their Monitoring and Evaluation Framework for their AIDS strategy. The process went very well. It began a bit stiffly, a bit formal, but it became very collaborative, and I would say that there was give and take on both sides. But, it did bring up many limitations to properly measuring, and many of them have already been brought up at the hearing already, and showed that without spending targets or budgets it is very difficult to track. The health systems measures and indicators

[10] International Labour Organisation.

are not very good and they need further developing as the evidence base is not really there nor the indicators with which to measure it. Also we ran into many problems with the harmonisation agenda, which is meant to make things simpler in measuring work across donors, and it does make things simpler at the country level to have a similar monitoring and evaluation framework, so the whole harmonisation agenda is basically positive but it does have a catch, in attribution: what has DFID done and what have other donors done is very difficult. Indeed the deal with harmonisation is not to get too much into attribution. We were trying to work with DFID to say how can you look at what your programmes have done. We were working under Chatham House Rules, so I am not able to give too many details, but we were able to work out some qualitative reporting that will be monitored. There will be a baseline, a mid-term and final evaluation that will begin to look at some of the things that DFID has actually done.

Q56 Sir Robert Smith: I understand they will be publishing the strategy for monitoring in November. Do you think in a way that is coming up with a strategy before you have worked out how to monitor it? Would it have made more sense to integrate the developments so that the monitoring and the strategy came together?

Ms Bradford: Let me just say that we are making real progress. Remember the last strategy did not have a framework at all and it was worked on towards the end, so this is definite improvement. An additional thing to say, and again this has been touched on here already, a problem we found was staffing limitations within DFID made it continually difficult to collect as much data. If you are already overworked, additional reporting requirements are always complicated. That is not meant to be a criticism, it is just the current set-up.

Q57 Chairman: Do the others have a comment on what they think should be in it?

Ms Murphy: I think I have already said quite enough in terms of the specifics of what we would like to see there.

Ms Bradford: May I make a comment quickly on gender just so you feel better. We had a gender expert in our group and DFID is very open to working on gender. I agree with Fionnuala that training within DFID might help more DFID people understand gender. It is a very complicated issue and it has got to be done more than gender champions. Some groups within DFID understand the concept very well, so training may help, but there is good give and take with bringing in gender aspects to the Monitoring and Evaluation Framework.

Dr Kean: We have as the Working Group submitted the indicators that we suggested that DFID should include in its M&E framework and in a sense I think it is trying to put the onus on a DFID field office to be able to say what they have contributed in a number of key areas. I have mention cotrimoxazole, paediatric treatment, prevention of mother-to-child transmission and indeed what they are doing for children outside of care, like street children and disabled children. It comes back to the first point I was making about the lack of targets. The best we are going to get is people saying what activities have you undertaken to be able to contribute towards this international goal. I will not read all the specifics but they are in the evidence that we have submitted.

Q58 Chairman: Thank you for that. Obviously across the whole piece monitoring what works and how effective it is is difficult but absolutely essential, partly to demonstrate that money is being spent in a way that delivers positive results and to keep on board the taxpayers who are funding it. It is difficult but it is obviously necessary and at the same time as the aid budget and the development budget raises (and one hopes in the circumstances that may still be possible) then to carry the public with you it is more important than ever that you show that the money is being spent effectively, so I think it is very helpful to have those kinds of suggestions.

Dr Kean: The other element to allude to is the point about trying to identify what are the best practices, what are the achievements, so it is not just a matter of being able to report back to the taxpayer but because there is good practice, if you are working in Malawi or Botswana next to Zambia, and Zambia has just found this fantastic research result, then surely it makes good sense to share that, so documenting good findings and good practice, asking what works and hearing the success stories. It is important that this monitoring framework does pick up this much more qualitative approach so that we can get that and share information as much within DFID as well as being able to publicise to the taxpayer that there has been some real success achieved.

Chairman: Thank you all very much. I think it has been a very helpful exchange. Obviously it is going to help us to question the Minister and also to formulate our report, so thank you for coming in and sharing those thoughts with us.

Thursday 30 October 2008

Members present:

Malcolm Bruce, in the Chair

John Battle
John Bercow
Richard Burden
Mr Stephen Crabb
Sir Robert Smith

Witnesses: **Mr Ivan Lewis MP,** Parliamentary Under-Secretary of State, **Mr Malcolm McNeil,** Team Leader, AIDS and Reproductive Health Team, and **Mr Alastair Robb,** Senior Health Adviser, DFID Uganda, Department for International Development, gave evidence.

Q59 Chairman: Good morning, Minister. It is nice to see you in front of us for the first time and I hope you do not find it too unpleasant an experience, but welcome. Could you perhaps introduce your team for the record.
Mr Robb: My name is Alastair Robb. I am DFID's Senior Health Adviser, working in Uganda.
Mr McNeil: I am Malcolm McNeil. I am the Team Leader for AIDS and reproductive health in the Policy and Research Division.

Q60 Chairman: Thank you very much. I think you will probably appreciate that the Committee has undertaken to look at the progress on meeting the HIV/AIDS targets on an annual basis and we have looked at different aspects of it each time, and this is part of our process. I perhaps also need to say that we are on a tight timescale because we want to publish our report in time for World AIDS Day, which actually is on the first day of the Committee's visit to China, which is a bit tricky, but we thought it important to coincide that. Obviously, we appreciate that DFID has a very substantial commitment to meeting the HIV/AIDS targets, but clearly there is some discussion as to how that can be achieved and what is the most effective way. Perhaps we could start with the funding. The Department is putting £1 billion into what would be called "vertical funding" to the Global Fund, but £6 billion into broadening funding for health services. I think the first question to ask is: can you put this in context? Is this new money or is this simply a reclassification of the money that is committed that the Department is, if you like, relating to its AIDS strategy?
Mr Lewis: First of all, can I welcome the opportunity to appear before the Select Committee for the first time. It is not entirely a voluntary arrangement, but I really do look forward to having a positive and constructive relationship with the Committee, and I am obviously very pleased to have a brief which, I think, is so central to the values of my Party and my Government, but I think the values of many Members of Parliament in terms of what matters in terms of our capacity to make a difference and, therefore, I am very much looking forward to developing my knowledge of the brief as well as obviously assuming responsibility for Africa, health and education across the developing world and also improving governance. Directly in response to the question, as far as I know, it is new money and, as the Committee is aware, we had a very generous Comprehensive Spending Review settlement which demonstrated both the Government's and particularly the Prime Minister's commitment to aid and development. The way we have chosen to direct the resources is very deliberate. We would argue that, in the early stages of the strategy in terms of tackling HIV and AIDS, the 2004 Strategy, if you like, we demonstrated very clearly world leadership and, as a result of our world leadership, we triggered a whole range of activity and investment from other donors and from multinational institutions which, frankly, would never have happened without that leadership. We believe stage two though is to continue providing that leadership and that leadership has to be about adding value and making the most difference, and we believe that making the most difference is actually now, in terms of the UK's distinct contribution, about investing and making the case both internationally and in every country of building universal healthcare systems. If you look at the inter-relationship between HIV/AIDS and other diseases, if you look at the interaction between HIV/AIDS and other social factors in those countries, the case for long-term sustainability, making a difference and tackling this dreadful disease, the case for ensuring there are universal healthcare systems in all of these countries has been the only way credibly on a long-term basis that we are going to achieve our goals in this area. We think that case is made and we believe that, for the UK to sustain its international leadership role, at this time the most appropriate way to do that is to focus on building healthcare systems, not simply focusing the resources on the whole, although we are putting some money into the international Fund, as you know, not simply focusing those resources on to one disease or on to one group of people.

Q61 Chairman: We understand that point and it has certainly been expressed to us both at country level and by the Department before. The evidence we had on Tuesday, for example, was slightly saying, however, that the funding in so many developing countries is so small that it is almost impossible to deliver adequate healthcare of any kind and that, if you happen to be an HIV/AIDS sufferer or, taking one witness we had via videolink, Lucy Chesire, who is a TB-affected HIV/AIDS sufferer, her concern would be that in that generalised funding, these people could get lost and they would not get the benefit of targeting. Indeed, I think one comment

said that what you're proposing is generalised insufficiency as compared with the benefit of targeting, at least ensuring that some sectors get the resources they need. So how can you ensure that, by doing what you are doing, you do not lose sight of addressing the people with HIV/AIDS and other related diseases specifically, that it just does not get spread too thinly?

Mr Lewis: Obviously in our country offices it is made very, very clear to them, in terms of the money that we are investing both in healthcare and HIV/AIDS, that it needs to be done in an integrated way with other donors and with NGOs, where appropriate. It is true that there will always have to be a judgment about where the UK's resources will add the most value and make the most difference, and that is the judgment we have now made, having, we believe, triggered an unprecedented level of investment and activity in this area and a different level really of commitment from donors, if you look at the US programme, for example. If you look at the progress that has been made in recent years, but, despite that progress, the overwhelming nature of the challenge, as you, Chairman, have just pointed out, if we are serious about long-term sustainable change in terms of tackling disease and preventing disease, because that should be our ultimate aim, it has to be about building those universal healthcare systems in those countries. If we can provide a leadership in that area, which over time leads the rest of the world to recognise that it has to come to the table in terms of supporting the building of healthcare systems, not just targeting money at one disease or one group of people, then that will be the best service that we can do for the developing world. Now, that is the judgment we made. It is not a judgment everybody agrees with. I have to say, from my knowledge, and I am new to the Department, as you know, initially it was highly controversial, there were a lot of concerns about the direction we were taking, but by the time we made the announcement, having consulted very extensively, 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.

Q62 Chairman: If we can set aside the vested interest, clearly there are some groups that benefit from vertical funding who are worried that they will lose out from horizontal funding, and we just have to make a value judgment as to how legitimate their complaints are, but I think there is a genuine concern which says that, if you are just creating a good health service, but inadequately resourced, is there not a danger that some of the programmes, which are currently delivering, stop delivering?

Mr Lewis: Well, we have weighed that risk up. We believe that we have made the right decision. It is true, Chairman, by the way, that, if you look at, for example, in the developing world some of the achievements around education, there is beginning to be a debate, is there not, about yes, we have increased massively the number of children in school, but the debate is moving on to quality, what kind of access and what kind of quality education are those children and young people receiving. I suspect that inevitably we are going to go through that cycle of debate in terms of healthcare, but should we be seeking, as a major part, frankly, of strengthening civic society in any nation with any chance of being successful long-term, should we be seeking to build, as an integral part of that state-building process, universal healthcare systems? It is absolutely essential, not just to the social wellbeing of such countries, but also the economic success of those countries, so we are saying that, if we do not do this at this time, nobody else will do it. As a consequence of that, the time-lag in terms of developing universal healthcare, we are talking decades ahead, so we believe, in terms of the UK, that this is the right thing to do and we believe that this will be a catalyst for a step-change in the way that the international community sees its obligations in terms of healthcare.

Q63 Chairman: I have just one final question before I bring in Richard Burden, and it is one that you will be familiar with, indeed the Secretary of State was challenged with it on Tuesday. When we had the new Permanent Secretary in front of us in July, we had a discussion about staffing constraints and pressures within the Department and her reply to us was, I think, honest because she knows the parameters, she knows that the Secretary of State accepts the constraints and I guess, therefore, that you, Minister, will be obliged to do so as well, but she said, "We are coping, but we are struggling". The Committee certainly is increasingly concerned that DFID has very ambitious commitments both to deliver and monitor what it is doing, and that is important from the taxpayer's point of view, that we know that what you are spending is actually producing results, but how are you going to ensure, with the staffing constraints that you have, that you can do that?

Mr Lewis: We have to work smarter. I have been in DFID three weeks and, I tell you what, I am very, very taken with the sense of mission amongst the staff of this government department, both in London and in Scotland. I went to East Kilbride this week, I have had videolinks with some of the people working internationally and I met all of the governance advisers who go there for an annual retreat within the last couple of weeks, and I have rarely come across a group of people so motivated and so passionate about what they do.

Q64 Chairman: I think the Committee will have no difficulty agreeing with that, but they are under pressure.

Mr Lewis: I understand and I will come on to the point that you make. I think we all recognise that there is a clamour from the public, quite rightly, and from politicians of all parties to shrink the level of resource that the State spends on bureaucracy and to get as much resource as possible to the front line. I think 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, so I think the challenge for us is going to be to recognise the realities, as you have said, of a shrinking centre and to consider carefully, as a consequence of that, our relationship with the country offices and also of course our relationship with NGOs as well and to make sure that our interventions are as smart as they possibly can be. Yes, it is a time of change, we are having to adjust to the realities of perhaps, in reality, less people at the centre, but I think that focuses the minds of the people who work within the organisation, and it will certainly focus some of my attention, as a Minister, and in the end this is one area of public policy where we need to get money to the front line. I think it goes beyond the relationship between the centre and the country offices, it is also about those real projects out there in the developing world and making sure that our money is really achieving change and making a difference, so it is difficult, it does require a very different view, for example, of human resources, and it is not just about numbers, but it is about the skills mix amongst DFID's staff, and there is a whole debate going on at the moment about how we create the right kind of workforce that cannot just, in a sense, deal with the challenges of the past, but how we implement this new opportunity where we have got record levels of resources. It is a much bigger priority for the Government than it has ever been in the history of any UK Government, so how do we adjust to those new challenges and deliver on the expectations that people, quite rightly, have without diluting the brand and the reputation that DFID has both in this country and around the world, but I do not think it does organisations any harm actually to say that the reality is that you are going to have to be much smarter in the way you do business and the way you operate and that you need a real focus on the front line.

Q65 Chairman: I would just add that an awful lot of people who deal with DFID, surprisingly enough, comment on how under-resourced they think they are. That is not usually the complaint you get about government departments.
Mr Lewis: That is true. That says it all really.

Q66 Richard Burden: Welcome. If we just return to the issue of, these horrible terms, horizontal funding, vertical funding and so on, the clear evidence we have had so far is actually across the piece, that you need both, that there is a role for vertical funding, disease-specific funding and so on, and clearly you have made a very powerful case for the importance of building up universal healthcare systems in the developing world. You have used the term on various occasions that this can be Britain's contribution to add value to what is going on, so my first question really is: how far is DFID's emphasis on horizontal funding for building up healthcare systems and so on driven by the fact that other donors, perhaps most notably PEPFAR[1] from the US, focus on disease-specific funding? How much is that a fact?
Mr Lewis: I think it is very significant because that, in a sense, again three weeks in, in my view, is the big question I keep asking myself: how do we add the most value, how do we make the most difference, how do I indeed, as a Minister in this area in terms of the use of my time and the decisions I will have to make, make the most difference? I thought social care was a big enough challenge in this country, but Africa is on a different scale, but I think the serious point is that it is not just the debate about whether we target money on particular diseases or particular groups of people, it spreads the debate about budget support more generally in terms of whether you support where a state has achieved certain benchmarks, whether you support civic society and the government in that state to actually build its own capacity, its own infrastructure or whether you continue to target resources on specific projects. Those judgments, if you look at DFID's role, have been made on an ongoing basis, so I think in this area you are absolutely right to ask if we have looked at the contributions that others are making, yes, and if we have looked at the difference that we have been able to make, if you like, since the 2004 Strategy, and we have now produced 2008, so, in a sense, it was right to review progress, it was right to review lessons learned, and we believe that all the evidence from those lessons led us to make the decision that we made.

Q67 Richard Burden: Given that, it is important that, somebody is providing substantial vertical funding to, in a sense, create the space for you to be able to concentrate Britain's resources on more horizontal funding with PEPFAR being very important to that with $90 million, is it, over the last five years going into that, but PEPFAR itself is fairly selective as a vertical fund. First of all, apart from Vietnam, it is almost entirely concentrated on Africa and Vietnam is the only Asian country that gets PEPFAR funding, and obviously there are limitations on what PEPFAR will fund anyway, most notably, I guess, the restrictions, the limitations, they place on condom provision and promotion. I suppose my question is that, if part of what we are doing is adding value and relying on the fact that vertical funds are happening, if there are big gaps in those vertical funds either geographically, large chunks of Asia, or in terms of what they can fund, for instance, condom provision, how far do we factor that in, as DFID?
Mr Lewis: Well, first of all, I think it is important to recognise that we accept that there is a gap. UNAIDS estimates a resource gap of £8 billion, so we acknowledge that that gap does exist. Of course, we want the international community to step up to the plate and in this area the United States, I think, has a positive record and, when we are talking about legacies of any particular President or another, this may be one of the few, dare I say, but this is quite an

[1] US President's Emergency Plan for AIDS Relief.

impressive level of investment. However, we know that other donors, and I am not going to get into a name-and-shame situation, but we want to—

Q68 John Bercow: Go on!
Mr Lewis:—but we want to see others do more. In other words, we are not in denial about the point you make, Richard, there is a gap and, despite the expansiveness of the US programme, that in itself is not enough either, but we still have made the judgment that at this stage our most effective contribution can be in the way I have described it. Of course, we are also giving, which should not be forgotten, £1 billion to the international Fund which is being targeted vertically specifically on HIV/AIDS, but this is a judgment call.

Q69 Richard Burden: I accept that.
Mr Lewis: I suppose the other point I ought to make is that we should remember that there is quite a lot of devolution in terms of country programmes, so there is still the opportunity, when country programmes are making decisions, for them to look, country by country, at where targeted investment in particular projects and in particular ways could make a difference.

Q70 Richard Burden: I understand that and, who knows, it may be that some of the limitations which have been placed on PEPFAR so far may change—
Mr Lewis: May be removed, yes.

Q71 Richard Burden:—after the events of next week, and we wait to see on that. I suppose what I am getting at really is that, given the fact that there are those judgments to be made and given the fact that different donors will make different judgments on that, how do we try to ensure that the judgments that we make are properly integrated with the judgments that others make? I suppose that is what I was getting at when I was saying that there is a very good reason for targeting universal healthcare systems and I accept other people are doing vertical funding, but, if there are big gaps in those vertical funds, how do we ensure that the jigsaw fits together?
Mr Lewis: I think in two ways. One is obviously through international institutions and through international agreements. The Prime Minister personally has been heavily involved in providing leadership around the world to say that this is not just about saying that we need to make a whole set of headline commitments, but actually how we are going to make sure there is delivery and how we are going to constantly hold other donors to account, and, frankly, they are not, some of them, honouring their commitments, so international institutions and continually applying the pressure, and there was a conference not that long ago, was there not, where that was one of the objectives. The other, increasingly through our country offices, is looking at the interconnectivity between DFID, other donors on the ground and indeed NGOs operating in those countries to make sure that we are getting best value for the resources. Now, obviously what you want, frankly, where you are talking about the donation states, you want signals being sent from their governments that they want a joined-up approach in terms of tackling HIV/AIDS, health, education, poverty reduction and social protection. Ideally, we will get to a situation where the same messages are being sent through donor organisations about the importance of joining up. We know that, for many developing countries at the moment, one of the nightmares they face is managing all these donors, whether it be, as I say, NGOs or whether it be nation states or whether it be multinational organisations, and we know that, for them, this is one of the major problems. If you like, as a new Minister, what would be one of the things that I would hope to achieve in some of the countries where we are very active and very involved is to try and persuade other partners to come together, not just at a very high level when the prime ministers and the ministers of finance meet around tables, but actually on the ground to come together and look in a more holistic way at how we can make the most difference. Obviously, one of those debates is about budget support, it is about building civic society, it is about social protection, it is about how much of our focus is to help nation states stimulate their economic growth and not just providing kind of social support, so I would say that a big part of the next stage in DFID's leadership role, and I do not think we should be timid about using the term 'leadership role', is to seek, wherever possible, a joined-up approach. Now, we need to recognise that we do not always share the same objectives, we do not always have the same values driving our respective contributions and there is sometimes *realpolitik* at play which gets in the way of joining up those responses, so the Foreign Office responsibilities are almost more than the DFID responsibilities, but we certainly think that we should be increasingly, country by country, seeking a maximum joined-up approach.

Q72 Sir Robert Smith: Some of the evidence we have had, which was generally welcoming the Strategy, was concerned about the outcomes and how you plan to monitor the impact of the Strategy. In three years' time, what key indicators will be used to assess whether it has had the impact that you hope for?
Mr Lewis: Perhaps I could take you through how we intend to do that; I think it is important. We intend to publish on World AIDS Day a monitoring and evaluation document which will define how the UK will monitor and track progress against the commitments made in the Strategy. This document, *Achieving Universal Access*, includes a commitment to commission an independent review of implementation after three years of the Strategy being in place, so that will take us to 2011. We have also committed to review our position on orphans and vulnerable children after every biennial Global Partners Forum on Children Affected by AIDS, and there is a cross-Whitehall working group on tackling AIDS which will monitor the implementation of actions across Whitehall, so we do have in place, I think, quite a significant approach to monitoring and evaluation.

Q73 Sir Robert Smith: But why did you decide to leave the development of the monitoring and evaluation until after the launch of the Strategy? It seems that the two should be going together and delivered together because obviously the Strategy could be better evaluated if it has been developed together with the evaluation.
Mr Lewis: Well, I am used to reading out this phrase in previous jobs, so I will do it here: "Ministers were in protracted negotiations with the Treasury regarding the resource allocation round, and it was not clear, therefore, whether it would be a three-year or a seven-year strategy", and that is the Department's position.

Q74 John Bercow: Did they duff you up?
Mr Lewis: Did they duff my predecessors up? I have no idea! No, I think we were very happy with being able to commit because I think that one of the other things we should have said is that we believe very strongly that part of our capacity to deliver in this area is some long-term certainty about the nature of our input and to have the capacity to have a seven-year strategy, which takes us to 2015 and the Millennium Development Goal period, that is really, really helpful, so the answer to your question is that it would have been much better to have published it at the same time, but you have heard the answer; it is the Treasury's fault!

Q75 Sir Robert Smith: Maybe you should be looking at a recommendation to the Treasury that, if they want an efficient use of resources, then they should allow the efficient development of strategies and monitoring together.
Mr Lewis: If you were ever in government, you would realise it is never quite as simple as that!

Q76 Sir Robert Smith: A lot of our witnesses are concerned that in the past we have been wanting a results-focused approach, and in the previous Strategy I think there were 126 targets and now there are hardly any targets. On World AIDS Day, will we be given a clear idea of targets that will be used to measure that Strategy? Is it going to be a target-orientated evaluation?
Mr Lewis: In terms of our objective, yes, it will be quite clear, not just about how we are going to monitor and evaluate, but equally what will be the best of progress and success. That is crucial and we have got to have those indicators, so it will be clear about how, at the end of that seven-year period, we will define this as being successful and having made a difference.

Q77 Mr Crabb: Just continuing on the theme of monitoring and evaluation, one of the issues that gets raised with us quite frequently is around the difficulties inherent in how you track and measure the outcomes from the contribution that we make to multilateral initiatives and multilateral agencies, so how do you propose assessing whether the £1 billion that we are giving to the Global Fund is an effective way of tackling HIV/AIDS?
Mr Lewis: Disentangling the value that we have added and the difference we have made is difficult, and I am not sure that it is ever going to be simple to do that, but, if you look at both the scale of the global challenge and, country by country, the challenges that those countries face and, in a sense, where you have clarity of what this country most wants to achieve or needs to achieve for itself over any given period of time, I think what we would say is that it will be clear as to how many of those outcomes and how many of those goals have been achieved, and it will be clear how significant the UK Government's contribution has been in those areas. Now, it is very difficult, so one area is the leadership we provided in terms of international institutions, and, without the leadership of this Government and this Prime Minister and, I have to say, parliamentarians on all sides because there has been a lot of consensus in this area, without that leadership, I do not believe the international community would be where it is on development. There is then the question of specific challenges, like access to universal primary education and HIV/AIDS and then there is state-building and the progress that individual nations make, and we are dealing in some countries, as you know, with trying to get to a situation of stability, some basic level of stable security to even begin to build the state. In other countries, we have been through that, and I did a debate yesterday on Sierra Leone and, although many of the indicators in Sierra Leone are still pretty dreadful, if you benchmark that against the state that Sierra Leone was in only a few years ago, actually that country is starting to do a lot better. Now, most people accept that, without the contribution we made to stabilising the security situation in that country, that would never have happened, so I have to be very honest with you, this is not easy, it is not like measuring other outcomes, but I think, as I say, in terms of international commitments, without Gleneagles and without the UK using its Presidency both of the EU and then the G8 and without the other leads we have taken globally, would we be in the position we are in in terms of the developing world? The answer is almost certainly that we would not. You would then have to look nation state by nation state and, in some countries, there is absolutely no doubt that DFID's contribution has made a significant difference. In others, we are a secondary part and our being there is very, very important, but are we making the most difference? No, but by our being there it is really important and our contribution is valued. I think that is trying to be as frank as I possibly can in response to the question.

Q78 Mr Crabb: Just to press you a bit further on the Global Fund, and forgive me if this is a bit unfair on you being three weeks into the job, but how satisfied are you with the accounting mechanisms of the Global Fund and how robust they are?
Mr Lewis: Well, I think we are always a country in this area that is arguing for greater transparency, greater accountability and a much closer synergy between money spent and outcomes achieved, so I

would argue that we still will continue to argue that that alignment needs to be better. We would not be contributing £1 billion to the Fund if we did not have some level of confidence that it was going to make a significant difference. Does it need to get better in terms of transparency, accountability and the relationship with achieving outcomes? Yes, definitely.

Q79 Mr Crabb: It was reported recently that the Global Fund is about to give, I think, £307 million to Zimbabwe. How concerned are you that the money will not reach those for whom it is intended?
Mr Lewis: Well, I think that is a bigger-picture discussion. Three weeks in, I am not sure I should start getting into FCO business, but I will try and give you a sensible answer. We all know the situation in Zimbabwe is fraught and we are all extremely concerned about the political and humanitarian situation in Zimbabwe. We all also believe that Mugabe should be made to honour the political commitments that were made to Mbeki and, if there is going to be some sense of shared way forward for Zimbabwe, however much we believe that the MDC probably won that election, we believe that the prerequisite to significant additional support to Zimbabwe has to be Mugabe honouring the commitments that he has made to Mbeki, the basic standards of conduct that we expect in any state that we are willing to support, and we have not reached that state yet. We all know that those negotiations have not progressed well so far and we remain hopeful that the negotiations will progress in the right direction, but I think we have to be very careful not to say anything which is, frankly, going to undermine what is a highly delicate political and humanitarian situation in Zimbabwe. As to the things that we say in London, we should be very, very careful, but of course part of achieving some level of political stability and obligations being honoured will then enable the international community to get resources where they most need to go in terms of humanitarian support.

Q80 Mr Crabb: I appreciate your answer, and it was less of a big-picture question and really a question about how well the Department assesses and manages the risks that are attached to the funding that you are providing.
Mr Lewis: That is slightly different. Yes, obviously the reason it is a good example is because we are working in countries and, when I met the governance advisers, we are working in countries often which are described as 'fragile states' where the security situation can be problematic, in some states where there are no seriously strong civic institutions, where there is no transparency and accountability and in some states where there are known high levels of corruption. In all of those states, our country offices do their best to make the right judgments and to ensure that our taxpayers' money is being spent in the way that we want it, and expect it, to be spent. I believe that in most cases they get those judgments right. Do I believe that we can somehow pretend to the taxpayer or to the public that we are working in some countries in ideal circumstances? Of course we are not. That is why you then get into another debate about devolution. We do have quite a high level of devolution in terms of DFID to those country offices because, in the end, in each country you are dealing with very, very different sets of circumstances, but I think you can always highlight the negative in this area, you can always point to concerns, you can always say, "Did all of the money get to the place it needed to get to?" I believe the vast proportion of resources does lead to significant improvement in the countries that DFID operates in.

Q81 Chairman: There is quite an important point here though given that quite a lot of DFID's money is going through multinational agencies or international agencies, like the Global Fund or the World Bank or what-have-you. I think, to back up what Mr Crabb is saying, that there is a concern and this report about Zimbabwe in the *Telegraph* is slightly concerning. Now, you, DFID, may not be able to be entirely accountable for a substantial amount of taxpayers' money going through international agencies or, in other words, your country programme does not monitor the Global Fund's spending in Zimbabwe.
Mr Lewis: Okay, when you pool resources, you do relinquish some extent of the total control, but, as a partner in those international institutions, again in terms of leadership, the UK has a very clear record in demanding maximum accountability and maximum transparency, and we will continue to do that. It is back almost to the discussion that you, Chairman, raised about the level of staffing and resources within DFID and I talked about my concern that our focus should be on getting money to the front line, that should be what it is all about. We all know in some of these international institutions and organisations that one of the concerns is how much of the money gets tied up in the bureaucracy and how much of it actually gets to the front line, and we will continue to use all of our influence and all of our power to make sure that the maximum amount gets to the front line. That is what the UK has done on every occasion in terms of discussions within those international institutions.
Mr Robb: I would just give an example of Uganda which was a country where there was a misuse of Global Fund resources and we were in country both to highlight that issue, but also to think about how remedial action could be taken in the future to move the Global Fund from its project support to incorporating it as one of the finances that go to the budget that can be monitored using the financial management system within Uganda, which is what we use for our budget support, which is a more efficient way of tracking the resources and the way that they are allocated, and to move the Global Fund to joint attribution for results. Where we see the Global Fund as a very useful instrument is that it highlights results-based financing and that is something that others are now moving towards in Uganda, so Uganda has actually brought the Global Fund much more into the fold rather than allowing

it to run parallel so that we have a better collective scrutiny over the way that the Global Fund resources are used.

Q82 Mr Crabb: Minister, perhaps I could just ask about the target in the Strategy to increase the staff:patient ratio to 2.3 health professionals per 1,000 people. Several previous witnesses that we have heard have criticised this target and they have said that it is too broad for it to be really meaningful and it is not country-specific. How would you respond to that criticism?

Mr Lewis: Well, I think again it is a judgment. It was based on the best available evidence and, if you look at the baseline situation in individual countries, but across the developing world, we believe, therefore, that that target is the most appropriate in terms of driving the system in the way that we want to drive it, but there will always be differences of opinion about specific proxies, but this session opened with concern about the scale of the challenge in terms of achieving universal healthcare across the developing world and, frankly, if we achieved the target that you have just said some people deride, that would be a massive advance and step forward. I think it is very hard to find a proxy. Let us give a domestic example. There are many, many people who have been critical of the 18-week target in the Health Service, many people for all sorts of reasons. At the end of this year, for most treatments, people will wait a maximum of 18, an average of maybe nine or ten or 11 weeks from going to see the GP to hitting the operating theatre. At the end of the day, in terms of 1948 to now, that is a revolutionary change in terms of the quality of healthcare in the United Kingdom, but it has taken 60 years for us to get there, so sometimes you need to set very clear targets to achieve radical change.

Q83 John Battle: On the point of clear targets, I wonder if I could look particularly at the issue of HIV/AIDS and women because 60% of adults with HIV/AIDS are women, three-quarters of young people who are HIV-positive are women, HIV-positive women are four times more likely to die in pregnancy and childbirth and there are two million HIV-positive women who become pregnant every year, so I think there is no doubt that the focus should be on women. However, when we look at the Strategy, there is an acknowledgement of the fact that women are disproportionately affected, but I do not see any detailed indicators on targets or any real meat of how that challenge is going to be addressed. How can the Strategy become more focused on the needs of women, in particular?

Mr Lewis: I will try and respond directly, John, to the question. First of all, you are right, we do accept that women and children are disproportionately affected. The Strategy stresses the need for the international community to work with governments and civic society to ensure that the needs and rights of women are fully integrated into the AIDS response. We recognise that social protection, including cash transfers, is an effective response and, for example, we have committed £200 million to social protection programmes as an effective way to reach both orphans and vulnerable children and their families. We also recognise the need to increase access to paediatric anti-retrovirals and other treatments, committing £90 million to UNITAID in 2008 to 2011. I think the other point I would make is that, in terms of individual countries in terms of HIV/AIDS programmes, we are saying in those countries that there needs to be a focus both on women and children, and that, both in terms of our spend, but also in terms of the messages we are sending out in terms of those individual countries, there is a clear recognition that right at the heart of those strategies has to be a specific focus on women and children because, if that does not happen, we are not going to put that right.

Q84 John Battle: Let me just put it as a reservation, if you like. If we were talking about obviously people like sex workers, street children, children who are orphaned who have HIV, the social transfers will not reach them, so I would just put a caveat there where the social transfers are directed at family units because, if you have kids wandering around the streets, it is not going to affect them, so I just want to put that as a caveat into the response that you gave me because I think we have got to take seriously where the action is, and I am not quite convinced that a kind of blanket social protection approach will reach everybody. It will not reach the parts we need to get to, and that is what I am saying, I am not against that strategy. If I could just say, we did a report and it ties in with maternal health and it is worth recalling that MDG5, is it, on maternal health, it is the furthest one behind and, in terms of gender, we have an appalling international record, not just on HIV/AIDS. We have made some effort, and I have to say here that the Prime Minister and indeed his wife have tried to raise this issue courageously internationally, and we did a report on maternal health on this Committee and we drew attention to some of the DFID programmes in Nepal, in Bangladesh and South Africa that have been addressing the gender issues. One of them that came across quite strongly in our last session was violence against women in this whole business, sadly, and I just wonder, it seemed to me that those strategies in Bangladesh, Nepal and South Africa, as attempts to reduce violence against pregnant women and women at risk of HIV, were good. Can it be replicated elsewhere or can the Department give us more examples of how that approach can be actually spread out across the world in a stronger way?

Mr Lewis: I think one of the things that maybe I should have said is that, if you look at our new Strategy, one of its priorities for action is that gender analysis should be integrated in every national AIDS plan and that specific targets and indicators should be developed to measure the impact of AIDS programmes on women and girls, so that is actually quite important, that, in terms of a national attack on HIV/AIDS, we are saying that we will argue in each of these countries for them to be at the centre. In terms of the point you make about tackling some of the underlying issues, violence, you are absolutely right. One of the things I need to get my head round

is that, whilst DFID is very proud of its devolved approach country by country, I have a sneaking suspicion that there are certain things which are relevant in every country and maybe, if you have a completely devolved approach, you miss the point, for example, on an issue about how you tackle violence against women, which may be a problem in most of the countries we operate in, and, if programmes in particular countries are working through innovative approaches, then surely we should be spreading that practice to all of the countries where that is an issue that we are working in. That is probably one of the things that, as a new Minister, I am going to want to have a look at because, if that particular programme has made a real difference, then it seems to me that we should be mainstreaming that strategy, where we have the capacity to do that, in the countries that we are working in.

Q85 John Battle: If I were to give a mild criticism of DFID, and it is only a sense of direction that I would want to change or direct differently, that is that I think DFID is world-class in its approach and world-class in its reach and in tackling the challenges that we face, whether it is looking at governance or actually developing strategies, but I am just slightly worried that the strategies on paper are praised worldwide, but we have got to make sure that we keep in touch on the ground and check them against it. We have good staff in the field and it is our job to go to the field and, may I add, it is yours as well, but we need all the time to check it against experience in the field, and I think in this area, in particular, I am just slightly anxious that what looks a good strategy on paper might not actually reach and do the job where it is needed to. If it does, we really could be leading the world in how we approach this particularly difficult challenge.

Mr Lewis: Well, I can assure you, John, that my focus will be on delivery. I do not think there is a question about DFID's overall strategy, its reputation, its brand, its mission, its commitment. What, I believe, is crucially important is that all that matters is the interaction between our programmes, our resources and our workers on the ground and the poorest people in the world and, if their experience cumulatively of our efforts and international efforts is that they are not making the difference they should be making, that is where we need to focus our energies and our efforts. I think part of that, if you take on board the point I have made, is that, in countries where we have proven successful programmes that have really made a difference, we should be spreading that best practice across all of the countries that we work in, and the danger with maximum devolution is that you miss that.

John Battle: I will just flag up two very small points, if I could, just to finish the point, if you like. Spreading best practice, but also looking to deepen the Strategy all the time, I will give one practical example. In the written evidence is the importance to empower women to negotiate safer sex, and I would be interested to know what specific strategies might work out on the ground, so can we put a bit more thought into those strategies, I am saying through you to the Department? Secondly, in negotiations with the World Health Organisation and the UN Population Fund, could we think out a deeper strategy of how we actually get them and UNAIDS, to acknowledge the linkages between HIV and sexual reproductive health and the violence questions as well? Are they really taking them on board at depth because, otherwise, I think we have gone round this issue for 10 or 20 years actually? The first time round was being aware of the crisis, the second time round was that we sat in here and did reports on the need for anti-retrovirals and the Global Fund, but I am not convinced that those approaches have got the depth that DFID is getting strongly towards now and we still need to embed that strategy with detail of how we push the agenda forward.

Q86 Chairman: Just following that through, you mentioned a question I was going to raise anyway which is the specifics of children because we know, certainly in the past, that children are more vulnerable to dying if they have AIDS and the treatment available until recently appears to have been not so adequate. I just wondered if you could give us a little bit more information on how you are going to target that, particularly their access to drugs and co-trimoxazole, a particular drug which appears to be effective, which UNITAID have said should be given to children who are at risk, yet they are not getting it, so how are you going to try and ensure that your funding achieves that objective?

Mr McNeil: Perhaps I could respond on the issue of co-trimoxazole. We feel that it is very effective in reducing co-infections in patients with HIV infection, and it is a very cheap drug. For some reason, there appears to be a view that DFID is not actively promoting this approach, and I would like to assure you that that is not the case. DFID is actively promoting the use of the drug, but the ultimate decision on whether a drug is adopted or not lies with the national authorities, so we have been pressing the individual governments to make sure that co-trimoxazole is on the essential drugs list and that the staff are effectively trained. The side-effects are relatively few and rare, but, when they come, they are quite serious, so staff do need to be effectively trained to use this.

Q87 Chairman: That of course makes the fundamental point about having a stronger health service to do that. Is that part of the problem, that there are not enough people?

Mr McNeil: Yes, and WHO have come out with particular guidelines that patients who are on co-trimoxazole should be given information about the potential side-effects, so there is an issue on staff training, but we believe that it is a very effective drug and should be actively promoted.

Q88 Chairman: The £90 million that you are targeting to UNITAID, is that a major part of it or what else is that designed to achieve?

Mr McNeil: Certainly the funding for UNITAID, UNITAID, as you know, is an attempt to make essential drugs and supplies more widely available across the board, so the UK has supported UNITAID with £20 million when it was launched and were given a 20-year commitment, so we see UNITAID as being a key step forward. It has been slightly slow in starting and getting off the ground, but we feel that it has huge potential. The key thing is for all the different donor agencies to work effectively together to make sure that drugs and supplies are made available.

Q89 Sir Robert Smith: I see it is funded mainly by a tax on airline tickets. Does that mean that, as obviously the global economy changes and air travel is likely to be badly hit, its future plans will be affected by its funding stream?
Mr McNeil: I have not had up-to-date information on that. In most of the countries, it is on the basis of the tax on tickets for air travel, but I think in the UK, if I remember rightly, the decision was that the money would be separately allocated. My understanding, and I am no expert on this, is that we will certainly see a downturn in air travel, but then it is likely to pick up again, so the long-term scenario is probably not so serious, but, if you would like, I could check with the staff who are involved in this and get back to you.
Mr Lewis: I think it is too early to say, is the honest answer.

Q90 Chairman: I think British Airways had a reception last night and they were quite clear.
Mr Lewis: Yes, but what I am saying is that I think we sit here in a situation where we have almost a unique economic challenge that the world faces, and much of our agenda is going to be affected by that. One of the things that we are doing at the moment is analysing, if you project economic change now and over the next period, what effect that is going to have on the developing world and what effect it is going to have on donors and their engagement with the developing world. Of course, we would argue very passionately that this economic situation has demonstrated more than any other the interdependency of our world and now is not the time to retreat from commitments to the developing world, but now is the time to step up to the mark and redouble our efforts. Whether everybody will share that view in the world remains to be seen, but that will be what we will be arguing very strongly and very assertively.

Q91 Chairman: I think I can predict that the Committee will give you strong support in that. The other thing is that you have got a commitment to do social protection programmes in eight African countries. Can you tell us which countries those are and, picking up the point that John Battle has already made, how can you ensure that they also reach the ones that fall outside the logical net or how can you be sure that the children will get a direct benefit from them?

Mr Lewis: I have not got that list of the countries to hand. We can get that for you, Chairman. How do we ensure? At the end of the day, there are a number of different ways that we are, country by country, intervening, so there is budget support, there is support for specific programmes, there is the building of civic society and there is the governance work that we are doing, so the key is, in a sense, not just in the work that we are doing in each country how we make sure that the hardest-to-reach groups are not losing out, but we also have to look in each country at the contribution of other donors and other organisations. Again, this is the whole point about joining up. By joining up, by being clear about the contribution of the different organisations and different donors, it gives you a much better chance of making sure that particular vulnerable groups do not actually fall through the net. Certainly within our country programmes, there is a very strong commitment to vulnerable children, to women, to a sort of focus of our interventions where we need to focus those efforts.

Q92 Chairman: But you are not at the moment able to give us the list of countries. Are you able to say what were the prime criteria? In other words, is it the incidence of HIV/AIDS or was it to do with the quality of their ability to deliver social programmes or what were the factors which determined which countries were selected?
Mr Lewis: It is back to the discussion we had earlier in the session about how we add the most value and how we make the most difference. If in a given country us investing in social protection in our judgement is the most powerful way we can make a difference in terms of the other contributions that are being made and the progress that has been made in that country over a period of time, those are the criteria that we apply.

Q93 Chairman: I think it is quite important to know which are the eight countries. "We do not know which the countries are and we do not what the criteria are" is not entirely satisfactory, so I do not know whether you are able to clarify that, Mr McNeil.
Mr McNeil: I have not been directly involved in this work but I know that the list of eight countries is in the process of being finalised now and there are specific criteria that are being used. This is particularly for programmes where we have highly endemic countries, so that is a key factor.

Q94 Chairman: Given that we have a very tight timescale, if you are able to give us a quick indication of where you are at on that in the next day or so it would be helpful because otherwise I think this is going to be a gap in our report and in the evidence. Another point is about the money that goes to assisting orphans and vulnerable children, which was £150 million that has been allocated in the past. How are you ensuring that you can track that effectively? It is obviously highly desirable that you are trying to reach those people. While you are thinking about that, this is an anecdote, but when we

were in Malawi visiting an orphanage three years ago we asked the staff of the orphanage about the incidence of HIV/AIDS deaths or illnesses for the children and their answer was, "We do not have that here", and then when we said, "Do you not have any child deaths?", they said, "They die of coughing". It was quite clear therefore that there was no screening; there was a denial, and I just wondered if you had ways of ensuring that the money gets through and has real results.

Mr Lewis: I can give some examples. We have a situation where a specific action plan for those children has been developed and now involves 30 countries and we think that is a major step forward. There are 30 countries which have a national approach specifically focused on the needs of orphans and vulnerable children. We believe that the social protection programmes have been shown to be highly effective in reaching those vulnerable children. If I give you some examples, in South Africa cash grants have resulted in increased height for age in children under three years, indicating that the impact of AIDS can be mitigated through these approaches. In Zambia cash transfers to households have helped reduce overall school truancy by 16%. Obviously, again, we believe that education is important because it does reduce the risk of HIV infection. In southern Africa we are providing a loan of £40 million to scale up national plans of action in seven countries in this area. In Kenya, Ghana and Zambia we are supporting innovative cash transfer programmes which are benefiting the most vulnerable, including children affected by AIDS. I think there is quite a step-change. Part of it is not just what are our programmes directly doing. Part of it is in each of these countries are they having specific approaches to orphans or vulnerable children. It seems to me that those statistics demonstrate a real recognition in an increasing number of countries that this is very important.

Q95 Chairman: That is a more general suggestion though because each year you produce an annual report, and we also report on your report, and I think if you incorporated that kind of information in the annual report it might be helpful.

Mr Lewis: Yes.

Chairman: I think that is what people like to see—what works. When there is a practical outcome it is always helpful to your cause as well as to the wider public.

Q96 John Battle: If I can just emphasise a point, I think I have spent probably far too long crossing the phrase "hard to reach" out of every Government document that ever crosses my desk because I do not believe people are too hard to reach. I think we have to make the effort to get there and give it serious attention, and I am encouraged by what I have heard this morning and the work the department is doing. Could you give me a bit more encouragement on that gap in the service that I detect for really marginalised groups like drug users and sex workers? Is there anything in the strategy that will give me some encouragement that we can really move into those neighbourhoods and those groups?

Mr Lewis: What I would say to you is that the way we should judge the effectiveness of our strategy is the difference we make with the most vulnerable groups and that runs all the way through the new strategy that we have produced, but, as you said to me, quite rightly, the proof of the pudding, to use a good northern expression, is in the eating. It will be about delivery in the streets, in the neighbourhoods, and the leverage that we are able to deploy to make sure that happens. One of the things you said was that you do not believe that anybody is impossible to reach. I agree with you, but you also would agree with me that you have to be innovative and imaginative and you have to think outside the box. When people talk about hard-to-reach groups in this country it is often because we try the same old solutions and interventions that have failed over the years and we do not take a step back and think about how you get to those people. They are influenced by different peer groups, by different networks, by different interventions. We have to do the same in the developing world, and that was why, when you talked about best practice, I think where we have had major success with particularly vulnerable groups in some countries we should be looking at what worked there and how we had that success and then making sure that happens elsewhere. What I would agree with on what you have said so far is that that is very much at the heart of our strategy, but is it at the heart of our delivery in each of the countries? That is my job to consider in the period ahead.

Q97 John Battle: I am not criticising. I am just not so convinced that it is at the heart of the strategy. By that I mean I do not want any gaps in the strategy so that staff can say, "I do not need to be sent out there. I have got enough on". That is what I am saying. I am wanting you to continue to encourage the staff—and DFID staff are among the most policy imaginative in the world at tackling challenges. We need them back here to work on some of the challenges, is my view. In that context, if they can just be encouraged to make sure we flag up those two groups I would be a bit more encouraged, but it may need to be written into the strategy as well as being understood as the interpretation of it.

Mr Lewis: As far as I know, and I have not read it, to be honest, cover to cover, it is quite significantly mentioned, but I agree with you: that is not the point. It is then how that is transferred into delivery. One of the things I have to reflect on in the country plans that we are now being asked to agree is how adequately do they reflect the need to respond to the needs of those groups. That is all I can say at this stage, but I think you are absolutely right to raise it as a concern. It is a concern.

Q98 Chairman: It will not be timely for this report but, for example, when the Committee was in Vietnam we were shown examples of work with sex workers and intravenous drug users which DFID successfully piloted. It would be interesting to know

what the follow-through from that was and to have other examples. It will not be in time for our report but I think it is useful information.
Mr Lewis: That is why I raised this question before of the virtues of maximum devolution, but also the dangers of not identifying and disseminating what works and then making sure that you provide that information in every country and you start implementing the strategies that work. That is a concern that I have at an early stage.

Q99 John Bercow: I apologise to the Minister for my extremely intermittent attendance. The fact that he is the witness and that I have been in and out are not in any way causally related. Just on this point, it occurs to me that in a document fairly recently published by DFID about development policy, which admittedly does not narrow the field very greatly, there was a reference to an Indian organisation, the Indian Association of Positive People Living with HIV/AIDS, or something like that, and I have the very distinct impression that DFID had devoted quite a significant resource to that, specifically looking at vulnerable groups, for example, intravenous drug users, women, men who have sex with men, and, if memory serves me right, Chairman, prisoners. It seems to me that one should extrapolate from that and I have a feeling, and I feel I ought to forewarn the Minister of this, that some written questions will be winging their way to his officials on these matters pretty shortly in my name because the question is: do you think the resource is being well spent, what are the results and can we expect that those results will be replicated elsewhere, simply because you are saying, "This programme has worked. Let us do something similar in other parts of the world"?
Mr Lewis: I look forward to receiving those questions.

Q100 Chairman: The issue here is that, of course, your strategy is to strengthen health services and at the moment we are discussing target groups. How do these two things interact?
Mr Lewis: It is a bit like in this country, that central to strengthening the NHS is tackling health inequality. If you do not tackle health inequality, frankly, long-term you are not creating—

Q101 Chairman: I am not disputing the objective. I am just talking in practical terms. How will you ensure that this continues to happen within the context of targeting strengthening the health services?
Mr Lewis: I would say again, Chairman, that the strategy makes it very clear that in creating universal healthcare systems there still needs to be a recognition of the targeting of particular groups who are most vulnerable and any creation of a universal healthcare system has to recognise and acknowledge that. The issue is how you make that real in terms of delivery and implementation.

Q102 Chairman: Can we assume that it will be part of the discussions country by country to try and incorporate the strategy?
Mr Lewis: Absolutely.

Q103 Mr Crabb: On Tuesday we heard evidence about the specific issue of the interaction between HIV and TB. Do you see generalised increased funding for healthcare systems as the main way that DFID plans to tackle the interaction between HIV and TB?
Mr Lewis: In short, yes. In a sense we would argue that the interaction makes the strongest case for the importance of going towards the creation of universal healthcare systems, so yes, we do believe that in a sense that strengthens our argument, very much so.

Q104 Mr Crabb: You do not see the need for any additional actions to try to build effective strategies to prevent deaths from TB amongst people who are infected with HIV, for example, improving diagnostics?
Mr Lewis: Sure, but I would say that improving diagnostics is right at the heart of creating improved universal health systems.

Q105 Chairman: We had evidence on Tuesday by video link from Lucy Chesire. It was a slightly difficult link; it was a fairly short session as well. She was very critical of the diagnostic status with chest X-rays 100 years out of date and yet it was all treatable, it was all doable; it just was not being done.
Mr Lewis: I think that reinforces the importance of seeking improved healthcare systems rather than simply targeting money condition by condition. Diagnostics is right at the heart of creating any healthcare system which is going to be effective. I just think it strengthens the importance of that.

Q106 Chairman: Just as a comment, I think the concern that we have had from a number of our witnesses, and it is not a fundamental criticism of DFID strategy at all, is not, as you are saying, Minister, that you wish to achieve all these things. It is how you can ensure these interactions will happen. I think what we are getting from you, which is fair enough three weeks into the job, is your commitment that that should be the outcome, but it is not entirely clear how you can ensure that is the outcome.
Mr Lewis: How you can ensure it is the outcome is that first of all in a sense we have had a two-stage approach. We had the 2004-2008 strategy which we believe demonstrated success, achieved the objectives that we set for ourselves but also triggered a lot more investment and activity from the international community. We now have the 2008 strategy going forward which is about building in each country healthcare systems rather than tackling this disease by disease. In a sense I do not think I can give you the solution today. What I can tell you is that our objective is as outlined in the strategy but I am very conscious that what will matter is delivery

on the ground. I think a lot of the comments from members of the Committee today have been about delivery and implementation. 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.

Q107 John Battle: Just to help clarify that, there is not a linear strategy just as there is not a magic bullet answer to this problem and we are all learning as we work through it. If I may just give two examples, I mentioned anti-retrovirals, stage one and stage two. We were not focused on that too well. Zambia was held up as the great example of success but it failed to take into account TB and we are now picking up the pieces of that. It is just whether the strategy is subtle enough, responsive enough. I think it is that which we are looking at rather than it simply being a clear roadmap through. It is the positioning along the way. It is a bit of a journey in the dark, actually, but we need to take others with us.
Mr Lewis: I take that.

Q108 Mr Crabb: This is a comment rather than a question. We heard evidence on Tuesday about the enormous rates of recurring infection. In sub-Saharan Africa people are living both with TB and HIV, and I think it is fair to say that DFID has picked up the importance of the relationship between HIV and TB, at least on the face of the document that we have been discussing. The Malaria Consortium has also given us evidence claiming that the relationship between HIV and malaria is not being picked up to anything like the same extent as the relationship between HIV and TB, and I am not sure whether you are going to have the information at your fingertips to respond to that criticism.
Mr Lewis: I will certainly go away and look at it. I think it is something we need to go and look at and respond to the Committee on.

Q109 Sir Robert Smith: What the strategy sets out, again which is welcomed, is a general commitment to increase its engagement with civil society. However, the strategy only provides two concrete examples of such engagement—partnerships to work with injecting drug users and on social protection issues. The International HIV/AIDS Alliance has expressed concern that DFID's focus on health sector support risks undermining the capacity of civil society to engage with and contribute to the response to the epidemic. Most of your funding is actually going through in-country health sectors rather than engaging directly with civil society. How can you reassure civil society organisations that they will be fully involved in implementing this new strategy?
Mr Lewis: I can give you a cast-iron assurance that they will be full partners. If you want me to give examples of our engagement with civil society in numerous countries I can do that but we will here probably for the rest of the day. I have got examples of Uganda, Tanzania, Ghana, Angola, Swaziland, Lesotho, Zambia. I could go on. There are loads of examples of where our ability to achieve objectives in this area are about engaging with civil society in many countries.

Q110 Sir Robert Smith: But if the bulk of the funding is going through the in-country health system how do you ensure that they have systems in place to engage with civil society?
Mr Lewis: I would argue that first of all that is not the sum total of our investment. We are also investing in building civil society in many of these countries, so at the same time as investing in, if you like, state-ist healthcare systems, we are also investing in civil society. This comes back to another debate I think we need to have about public service development in these countries. We are only getting to the stage where we recognise in this country that part of reforming public services is about active and involved citizens, and it seems to me as we are building health and education systems in these countries part of what we need to be doing is not just looking at the structures and the systems but we also need to be looking at the investment in civil society. Let me give an example about quality. We are going to be increasingly concerned not about development of new services and improved services but there is a real quality issue as we are increasing volume. One of the ways you tackle that is to have a strong civil society asking difficult questions about quality. The point has been made about innovation and getting to (I will not use the term hard-to-reach groups) some of the more vulnerable groups. Sometimes civil society is in a better place to get to those vulnerable groups than any state-ist-type institution. It is not an either/or. We are continuing to invest quite heavily in our relationships with civil society in each of these countries.

Q111 Sir Robert Smith: So there will be direct funding to civil society groups to advocate for people living with HIV and AIDS?
Mr Lewis: Yes, where that is appropriate in some countries that will be our aim.

Q112 Chairman: I wonder if people are getting confused between budget support and building up general healthcare. There is an assumption that if that is what you are doing it is mostly going through budget support. I think the answer we are getting from you is that country by country it will not all go through budget support because you will need to support these other groups. If that is what you are saying I think that probably helps reassure people. They will obviously want to see how it turns out in practice but—
Mr Lewis: It is also about the value that civil society can add in terms of our healthcare objectives. In some countries that will be massive. In others it may not be very well developed. Some of those judgments have to be made country by country where NGOs can make a tremendous difference and can demonstrate that we have to have a positive funding relationship with them. It is about effective

partnerships and collaboration but there are numerous examples where that is happening country-to-country and just because the strategy talks about building up universal healthcare systems, which is clearly the direction of travel now, that does not mean that where civil society has not got a significant contribution to make we will not be working closely with it.

Q113 John Battle: Can I ask about the question of middle-income countries as well because we have talked primarily about Africa and south east Asia? Some of the facts and evidence seem to suggest—and the department will probably be able to tell me better—that there is an emerging crisis of HIV/AIDS in the West Indian countries. Could we pay attention to them? Are they on the radar at all? Do we include them under middle-income and will they be included in the strategy?
Mr Lewis: If you look at the use of resources we are saying that 90% of our bilateral funds we are going to spend in low income countries. In terms of middle-income countries, our contribution is about working with the FCO, largely bilateral and multilateral partners, civil society and private sector organisations. There is specific reference in the strategy in terms of the FCO's role with regard to middle-income countries. Clearly, we recognise that we have responsibilities in this area. I do not think we apologise for spending the vast bulk of our resources in low income countries but the question is what role we play other than resource allocation.

Q114 John Battle: I understand the shift in the resources to Africa in the Strategy. What I am simply asking, perhaps international bodies as well, is if it needs to be flagged up could it be flagged up, because some of the information I am receiving, and I am just asking for it to be checked out really, is that there is an emerging real difficulty in some Caribbean countries. If that is the case then it would be a bit negligent not to include it in an overall strategy, and whether the WHO picks it up, UNAIDS picks it up or we pick it up, somebody has to, and I am simply putting in a plea could it be included and could the department look at it?
Mr Lewis: Yes, certainly.

Q115 Chairman: We have had discussions several times in the past about the 90/10 split in relatin to middle-income countries. I do not want to go into that but in that specific context, if you are going to achieve some of the MDGs, and the shortfall is significant in middle-income countries, then DFID's ability to deliver those MDGs—and this one particularly—might be compromised by that split. The question therefore is how the relationship with the Foreign Office is going to help achieve that? Particularly one is thinking of Caribbean and Latin American countries where effectively DFID's presence is minimal, and therefore it might be quite crucial to our contribution in achieving the MDGs.
Mr McNeil: May I respond to that? In my previous job I was the senior health adviser for Latin America and the Caribbean. A key thing in these middle-income countries is that the countries themselves have resources, so what they need is technical support to try and get the resources being allocated for the—

Q116 Chairman: I think Mr Battle is saying political will.
Mr McNeil: Indeed, and that is a key part of it. In the Caribbean in particular a key issue on HIV and AIDS has been the pervasive stigma and discrimination—

Q117 John Battle: Absolutely.
Mr McNeil:— and DFID has supported region-wide work and is now opening a new unit.

Q118 John Battle: And we have delivered work in South Africa on this agenda.
Mr McNeil: Indeed. The point I would like to make is that the key thing is that these countries often have resources but they may lack technical direction or the political will, and I think that is an area where the FCO can be helpful. Although DFID's programmes are small we do not need a lot of money to provide technical support to these countries and, of course, the Global Fund is under their regulations. They can still provide substantial resources for middle-income countries.

Q119 Chairman: In a practical sense does that mean you have to have some kind of training or engagement with Foreign Office officials?
Mr McNeil: Indeed, we have very regular discussions with FCO colleagues, both at headquarters level but much more so out in the regions, very regular contact. Many DFID officers are co-located with the FCO and so they have day-to-day contact.

Q120 John Battle: But we do not have many middle-income countries.
Mr McNeil: Not many, no, that is true.
Chairman: Thank you very much. Can I repeat specifically the point about the AIDS African countries and the social protection criteria? If you could provide us with a quick note this week it would be helpful to our report but also to reflection on you.[2] I think that is a bit of a *lacuna* for us but otherwise thank you very much for coming in. It has been very worthwhile. The Committee is obviously very pleased that the Government has these very big ambitions and commitments but I hope that the interaction between us and yourselves is constructive and trying to focus on how we get the delivery we all want. I trust our report will make some useful additional comments. Thanks very much.

[2] Ev 44

Written evidence

Memorandum submitted by the Department for International Development

Executive Summary

1. DFID welcomes the IDC's annual review of Government progress in tackling HIV and AIDS and particularly appreciates this year's focus on the newly published UK Strategy, "*Achieving Universal Access–the UK's strategy for halting and reversing the spread of HIV in the developing world*". Although less than three months have passed since the launch of the updated UK AIDS strategy on 2 June 2008, the inquiry provides an opportunity to reflect on the statements and commitments made within the strategy and to further consider action towards its implementation.

2. In 2004, the UK Government launched "*Taking Action, the UK strategy for tackling HIV and AIDS in developing countries*". This set out our commitment to lead the global response to AIDS through promoting the needs and rights of those most affected by the epidemic, increasing funding, strengthening political leadership, and supporting international and national responses. This year's updated UK AIDS strategy follows a detailed independent evaluation of *Taking Action* and wide consultation. It builds on the successes and original thrust of *Taking Action* to focus on addressing the latest challenges if Universal Access (UA) is to be achieved. The updated Strategy makes comprehensive prevention a priority recognising that it is only through effective prevention can we hope to minimise the impact of the disease decades from now.

3. The UK AIDS Strategy was launched in conjunction with an evidence paper entitled "*Achieving Universal Access—evidence for action*". This document summarises recent evidence and key issues underlying the policy decisions and commitments made in the updated strategy. The evidence paper is based on a robust summary of latest global evidence and on the findings of a series of experts' papers commissioned by DFID as part of the Strategy development process. The evidence paper is formatted in such a way as to link with the chapters of the Strategy document for ease of reference and to demonstrate the evidence base for each of the themes, actions and commitments in the Strategy. Given the short timeframe since its publication and launch, the evidence paper is likely to be an important resource for the IDC for this inquiry. In our responses in this memorandum, we anticipate that the committee has had the opportunity to read both the evidence paper and the updated strategy.

4. The UK AIDS Strategy sets out the Government's commitment to achieving the goal of Universal Access (UA) to comprehensive HIV prevention programmes, treatment, and care and Millennium Development Goal (MDG) 6. It also sets out the commitments required to accelerate progress towards building a long-term, sustainable response.

5. The focus of this IDC inquiry, on the disproportionate impact of AIDS on women and children and the interaction of AIDS with other diseases, is welcome. The evidence we provide in this memorandum demonstrates that the updated strategy places the needs and rights of vulnerable groups including women, orphans and other vulnerable children (OVC) at its heart and makes clear that underlying drivers of the epidemic, including gender inequality, need to be addressed. It emphasises that universal access to comprehensive HIV prevention programmes, treatment, care and support must meet the needs of all—including women, children and vulnerable groups. It outlines action the UK will take to support effective service delivery, supporting an integrated approach to AIDS, Tuberculosis (TB) and malaria and to sexual and reproductive health and rights (SRHR), including maternal, newborn and child health services (MNCH).

6. In addition, the evidence we provide in this memorandum emphasises the significant role civil society in the UK and overseas has played in developing the updated strategy and provides information on the valuable role of civil society in implementing the strategy and in monitoring progress.

7. Last year, as a global leader in the fight against AIDS, the UK announced funding of up to £1 billion for the Global Fund for AIDS, TB and Malaria up to 2015. Now, the UK has made another bold and ambitious step by announcing in the updated strategy, an additional long-term commitment to spend £6 billion to strengthen health systems and services up to 2015. This is based upon the fact that a stronger health system is critical to tackling AIDS. The IDC's decision to probe the rationale for this decision is welcome. The health spending target is however only one of our commitments. Throughout the strategy we highlight the multi-sectoral nature of the disease and the strategy includes a commitment to spend £200 million over three years on social protection programmes, to reach families, and orphans and other vulnerable children most affected by the epidemic. It also stresses the importance of partnerships, co-ordinated action and country led approaches. It commits us to supporting UNAIDS to lead and coordinate the global response to AIDS and to advocate for the needs of marginalised and vulnerable groups.

8. Finally, we welcome the IDC's interest in monitoring systems to ensure funding reaches the local level and in measuring the impact of funding for health service strengthening. These are complex issues and we share the IDC's interest in monitoring and evaluation and in ensuring that new and existing resources have the greatest impact. We provide evidence of our desire to focus on results and outcomes and we outline our

progress with the monitoring and evaluation framework that is due to be finalised in the autumn. We also highlight the independent review we will commission to examine the implementation of the strategy in three years time.

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
AMREF	African Medical and Research Foundation
ARVs	Anti-retroviral Treatment
CARHAP	Central Asia HIV and AIDS Programme
CEO	Chief Executive Officer
CSCF	Civil Society Challenge Fund
CSO	Civil Society Organisations
DAC	Development Assistance Committee
DFID	Department for International Development
DPFs	Divisional Performance Frameworks
DSO	Department's Strategic Objectives
DRC	Democratic Republic of Congo
GAMET	Global AIDS Monitoring and Evaluation Team
GFATM	Global Fund for AIDS, TB, Malaria
GPRHCS	Global Programme to Enhance Reproductive Health Commodity Security
GTF	Governance and Transparency Fund
HIV	Human Immunodeficiency Virus
HNPSP	Health, Nutrition and Population Sector Programme
IDC	International Development Committee
IDU	Injecting Drug User
IHP	International Health Partnership
IMCI	Integrated Management of Childhood Illnesses
IMCA	Integrated Management of Adult Illnesses
IPPF	International Planned Parenthood Federation
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
MoE	Ministry of Education
MNCH	Maternal, Newborn and Child Health
MSM	Men who have Sex with Men
NASA	National AIDS Spending Assessment
NGOs	Non-Governmental Organisations
OECD	Organisation for Economic Cooperation and Development
OVC	Orphans and Vulnerable Children
PEPFAR	US President's Emergency Program for AIDS
PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
PPA	Programme Partnership Agreements
PSA	Public Service Agreement
RAP	Results Action Plan
RFE	Rapid Funding Envelope
SRHR	Sexual Reproductive Health and Rights
STI's	Sexually Transmitted Infections (STIs)
TACAIDS	Tanzania Commission for AIDS
TB	Tuberculosis
UA	Universal Access
UN	United Nations
UNAIDS	Joint United Nation Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
UNITAID	An international drug purchase facility
UPHCP	Urban Primary Health Care Programme
WHO	World Health Organisation
ZAC	Zanzibar AIDS Commission

DFID response to the call for evidence for the IDC Inquiry: HIV and AIDS: UK's Updated Strategy—"Achieving Universal Access—the UK's Strategy for halting and reversing the spread of HIV in the developing world"

THE STATE OF THE EPIDEMIC SINCE 2004

1. Significant progress has been made in tackling the AIDS epidemic since *Taking Action* was published in 2004. The percentage of the world's adult population living with HIV has levelled off. Twenty times more people have access to life-saving treatment and the price of first line AIDS drugs has fallen considerably.

2. Despite the progress, the human cost of the epidemic remains immense. There are still more than 33 million people living with HIV. Every day, over 6,800 people become infected with HIV and over 5,700 people die from AIDS. In other words, somebody dies every 15 seconds. At the end of 2007, 3 million people were on antiretroviral therapy in low & middle income countries, up 42% on the previous year. However, this is still only 30% of the global need. In 2007, for every two people who received antiretroviral treatment another five were newly infected with HIV. This highlights the urgent need to increase efforts on HIV prevention.

3. Currently 2 million children under the age of 15 are estimated to be living with HIV and around 15 million children have been orphaned and many more made vulnerable by the epidemic. As a result of the AIDS epidemic, children and youth are experiencing stigma and discrimination, deepening poverty and have less access to education and parental support. The burden of care often falls on the poorest households and communities. Despite increasing donor resources for orphans and vulnerable children (OVC), currently only 10–25% of affected households in high HIV burden countries receive external support for the care of OVC.

4. Access to AIDS services remains unacceptably low—for example, most prevention strategies are available to fewer than one in five people who could benefit from them. In some high prevalence countries, AIDS is reversing decades of progress towards better health, education and wealth.

5. "*Achieving Universal Access– the UK's strategy for halting and reversing the spread of HIV in the developing world*", the updated UK strategy (hereafter referred to as "the Strategy") was launched on 2 June 2008. The Strategy highlights the importance of increasing effort on comprehensive HIV prevention. It sets out the UK's commitment to intensify prevention efforts that have proven to be effective, such as prevention of mother-to-child transmission, family planning and harm reduction. It also highlights the need to maintain momentum on treatment and increase coverage of care and support. It focuses on three main areas: responding to the needs and focussing on the rights of those most affected by AIDS; supporting more effective and integrated service delivery; making the money work harder through effective partnerships.

6. The Strategy made a bold and ambitious step by announcing a long term commitment of £6 billion to strengthen health systems and services up to 2015. It recognises that action is also needed outside the health sector and emphasises the importance of a multi-sectoral response that includes action in education, social protection and justice. The UK has already committed significant resources to education and is now committing to spend £200 million on social protection programmes over three years. Evidence[1] shows that social protection programmes, including predictable cash transfers are an effective way to meet the needs and rights of families and OVC.

7. DFID welcomes this IDC inquiry. Although less than three months have passed since the publication and launch of the UK AIDS Strategy, the inquiry provides an opportunity to reflect on the statements and commitments made and to think about implementation as we move forward. The UK AIDS strategy was launched in conjunction with an evidence paper, "Achieving Universal Access—evidence for action" which provides a summary of the latest evidence that support the themes, actions and commitments in the Strategy. The evidence presented in this memorandum assumes that the IDC has had the opportunity to read both the evidence paper and the updated strategy.

8. Below is our response to the nine issues posed by the IDC.

Issue 1. *The extent to which DFID's strategy will be effective in tackling the disproportionate impact of HIV/AIDS on women and children*

9. The Strategy continues our attention on the disproportionate impact on women and children developed in *Taking Action*. It recognises that they are among those most likely to be living with HIV; least able to deal with the impacts of the epidemic; and are most likely to be failed by existing policies, programmes, support and services.

10. The Strategy emphasises that gender inequalities mean that women and girls' cannot always decide if, when, how and with whom they have sex. It also acknowledges that gender violence can significantly increase women and girls risk of acquiring HIV infection. It emphasises the need to address gender inequality as one of the key drivers of HIV infection. This is an essential component of a comprehensive HIV prevention strategy. By empowering women to negotiate safer sex, we can prevent them from acquiring the virus.

[1] Including from the plenary presentations by Dr Linda Richter at the August 2008 International Conference in Mexico.

11. The Strategy stresses the need for the international community to work with governments and civil society to ensure that the needs and rights of women, young people, children and vulnerable groups are fully integrated into the AIDS response. It also stresses the need for responses in the health sector and beyond (especially education, social protection, justice and livelihood sectors) in order to ensure universal access.

12. AIDS places a huge burden on children affected by the disease, especially in sub-Saharan Africa. Social protection, including cash transfers along with broader family support and child protection initiatives, has been widely endorsed by experts, including the Joint Learning Initiative on Children and HIV/AIDS and the Inter-Agency Task Team for Children and AIDS as an important mechanism for improving the welfare of children, including OVC and their families. UNICEF estimates 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.[2] At the Children and HIV/AIDS: *Action Now, Action How* Symposium in early August 2008, in Mexico considerable attention was given to the importance of social protection and cash transfers. News of DFID's £200 million commitment to social protection was very well received by government and non-governmental representatives. The approach of programmes which focus only on individual orphans and AIDS affected children as opposed to vulnerable children more generally was strongly criticised during the XVII International AIDS Conference in Mexico City in August 2008. There is a clear shift in targeting towards an "AIDS conscious but not AIDS-exclusive" approach to reaching OVC consistent with the approach taken in the Strategy.

13. Some examples of how the Strategy will effectively respond to the needs of women and children include:

- Over the next three years, increasing UK spending to over £200 million to expand social protection programmes, including cash transfers which will directly benefit children made vulnerable by AIDS and their families. DFID will work with governments and civil society in eight African countries to develop social protection policies and programmes that will provide effective and predictable support for the most vulnerable households, including those with children affected by AIDS. The evidence to support social protection as an effective approach will be reviewed every two years following the Global Partners Forum for Children Affected by AIDS.
- The updated strategy recognises the importance of a multi-sectoral response to mitigate the impact of the epidemic on vulnerable groups including vulnerable children. As part of this support Ministries of social welfare will be assisted to ensure that appropriate and well-targeted social assistance programmes (such as old-age pensions and child support grants) are in place. The strategy recognises that cash transfers are only one part of a comprehensive system of care and support for vulnerable children and their families. OVC, including those living on the streets, also need to receive broader social support services, accessible and affordable healthcare and education, psychosocial support and livelihoods support. This support will be provided both through government and NGO channels.
- We are also committed to ensuring greater access to paediatric treatment. The UK has committed £90 million to UNITAID, from 2008–11, which will help increase access to paediatric treatment.
- Ensuring that gender analysis is integrated within national AIDS plans, and that targets and indicators are developed to measure the impact of AIDS programmes on women and girls.
- Taking action on neglected and sensitive issues, including sex workers and adolescents' Sexual and Reproductive Health and Rights.
- Supporting countries to develop and implement evidence-informed and gender sensitive prevention strategies that: promote and protect human rights; are relevant to the local epidemic context; and promote comprehensive approaches to HIV prevention based on the realities of people's lives.
- Working with others to intensify international efforts to halve unmet demand for family planning (including male and female condoms) by 2010, to achieve Universal Access to family planning by 2015. This includes the UK's new £100 million commitment to UNFPA for their Global Programme to enhance Reproductive Health Commodity Security.
- Working with others to intensify international efforts to increase to 80% by 2010 the percentage of HIV-positive pregnant women who receive anti-retroviral treatments (ARVs) to reduce the risk of mother to child transmission, both in low income and high prevalence countries.
- Supporting UNAIDS to lead and advocate for action on women, girls and vulnerable groups at the global and country level. This includes the setting of gender guidelines to help countries assess and mitigate against the impact of AIDS on women, girls and sexual minorities.

14. The focus on gender in the AIDS strategy complements DFID's 'Gender Equality Action plan' that was published in 2007. This aims to promote gender equality and to empower women by promoting a range of interventions to achieve better outcomes for women and girls across DFID programmes.

[2] Report on the global epidemic. UNAIDS 2008.

15. DFID is now developing a comprehensive monitoring and evaluation framework to ensure that progress towards the UK's priorities for action, including those focussing on women and children, are regularly assessed and that lessons and successes are identified and disseminated. This framework is covered in more detail in the response to Issue 8 in this memorandum.

EXAMPLES OF THE UK'S SUPPORT TO WOMEN AND CHILDREN INCLUDE:

16. In **Kenya**, within the new £40 million HIV and AIDS programme, funding will be channelled to Civil Society Organisations (CSOs) implementing HIV and AIDS programmes for women and young people. DFID recently approved a new programme to scale up cash transfers to 30,000 households. DFID Kenya has also funded research on the reproductive health and HIV prevention needs of older OVC (10–17 years) and has funded a home base care project in Nyanza, western Kenya, serving 240,000 OVC.

17. In **Zimbabwe**, DFID has provided £25 million support to a Maternal and Newborn health programme, through UNICEF, UNFPA and a range of other partners. This will support access to family planning services, provide emergency obstetric care, and protect the lives of mothers and newborns, especially those affected by HIV and AIDS. A further £23 million programme (administered by UNICEF) aims to reach 400,000 children and provides greater access to basic social services and helps protect them from all forms of abuse.

Issue 2. *(a) How HIV/AIDS interacts with other diseases, especially TB and malaria, and (b) how effectively this interaction is dealt with by donors and funds*

18. The updated AIDS strategy emphasises the important links between AIDS and other diseases, including tuberculosis (TB), malaria, and with Sexual and Reproductive Health and Rights (SRHR). It recognises the physiological interactions between AIDS and other diseases. For example, someone living with HIV is at greater risk of having TB. The Strategy highlights the need for HIV and TB care to be better integrated to improve the diagnosis of TB in HIV patients and vice versa. The Strategy recognises the need to strengthen health systems to provide services for individuals that address all health issues at the same time.

(a) The interaction of HIV and AIDS with other diseases

19. TB is the most common infection among people with HIV. In sub-Saharan Africa, for example, up to 80% of TB patients are co-infected with HIV. In the same region, HIV is the most important factor behind the dramatic increase in TB in the last 10 years. Worldwide, about 13% of AIDS deaths each year result from co-infection with TB. TB is also the most common cause of death in people already receiving antiretroviral therapy. TB is harder to diagnose in people living with HIV. Somebody co-infected with HIV and TB is far more likely to become sick with TB than someone with TB alone. So, the two diseases must be considered together.

20. There has been major progress in the implementation of interventions to deal with TB/HIV co-infection, but progress has not been sufficient to reach agreed targets. Less than 15% of TB patients are tested for HIV in Africa, despite very high rates of co-infection. Intensified efforts to identify TB in people with HIV are also needed. In 2008, only 42% of countries with generalised HIV epidemics reported that they routinely screened for TB in people with HIV. In the 63 countries that account for 97% of estimated TB cases in people living with HIV, approximately one-third of countries have still to establish national plans that integrate HIV and TB activities.

21. The UK government is committed to tackling HIV and TB co-infection and to increasing investment in research to promote the development of better tools for prevention, diagnosis and treatment of TB. For example, DFID's research Strategy for 2008–13 outlines how DFID will double its investment in research including health, to £220 million a year by 2010. In terms of health, the research strategy includes a focus on developing drugs for HIV and AIDS, TB, malaria and other diseases that affect poor people, as well as vaccines for HIV. DFID also provides support for research and development efforts around new TB drugs and diagnostics, including through the World Health Organization and the Global Alliance for TB Drug Development. DFID has been a significant investor in Product Development Partnerships (PDPs) which have been shown to be effective in developing new drugs and technologies for many neglected diseases. DFID plans to increase and diversify funding to PDPs which will include paying more attention to TB and health technologies such as diagnostics.

22. Linkages between HIV, maternal and child health services are also lacking. HIV increases the risk of maternal death (with subsequent serious impact on the child and wider family) by increasing the risk and impact of malaria and TB during pregnancy. WHO recommends that maternal and child health services should provide a platform for scaling up prevention of mother to child transmission responses.

23. The UK has provided global leadership on SRHR. The updated Strategy rightly emphasises the important links between AIDS and SRHR. Almost 90% of HIV infections are sexually transmitted or through mother to child transmission. Expanding access to SRHR, including improved access to family planning, treatment of sexually transmitted infections (STIs), and increased condom use is an integral component of HIV prevention.

(b) How effectively is the interaction being dealt with by donors and funds?

24. The interaction between AIDS and TB, malaria and other diseases is dealt with by donors and funds in different ways, with greater or lesser degrees of effectiveness. The UK government believes that the interaction is most effectively tackled by taking an approach that focuses on strengthening health systems and services overall, with the aim of supporting an integrated approach to health service delivery. An alternative way of funding AIDS is to take a more "vertical", disease-specific approach such as the US PEPFAR programme (the US President's Emergency Program for AIDS Relief).

25. Whilst recognising that a vertical approach can have certain benefits (eg ensuring that interventions prioritise AIDS, which is particularly useful in hyper-endemic situations), the UK's position is that interaction between AIDS and other diseases is most effectively dealt with through investments that support the development of well functioning, comprehensive, sustainable and robust health systems and services. And, to ensure efficacy, it is essential that whatever the chosen mechanism for support that donors do not create additional burdens or transaction costs for countries but that they honour donor commitments to the Paris Declaration principles of country ownership; harmonisation; alignment; managing for results; and mutual accountability.

26. One of the ways in which the UK is dealing with the interaction between AIDS and other diseases is by making a long term commitment of £6 billion to strengthen health systems and services up to 2015. This echoes the recommendations of a report published in June 2008 by WHO, UNAIDS and UNICEF, "Toward Universal Access; scaling up priority HIV/AIDS interventions in the health sector", in which they highlighted the need for a focus on health systems strengthening. The UK's health systems commitment will cover health systems, communicable diseases, maternal and child health, and sexual and reproductive health. Stronger health systems mean we can scale-up preventative measures, eg Prevention of Mother to Child Transmission (PMTCT), provide anti-retrovirals (ARVs), integrate sexual and reproductive health and rights (SRHR) with AIDS and effectively tackle other related illnesses, such as malaria and TB. 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.

27. In addition to the £6 billion commitment for health systems, the UK will provide the Global Fund for AIDS, TB and Malaria (GFATM) with up to £1 billion to support its global response. The GFATM is in a prime position to promote the linkages and interaction between AIDS, TB and malaria. The UK also remains committed to implementing the International Health Partnership (IHP), which it founded in 2007 to support developing country governments to improve the general health of their people, without focusing on any one type of illness. Our comprehensive approach to tackling AIDS and other diseases is also reflected in our support of UNITAID (the international drugs purchasing facility). UNITAID aims to bring down the price of drugs and diagnostics and to increase their availability. The UK has made a 20 year commitment to UNITAID which could see us providing as much as £760 million up to 2027.

28. Financial support to strengthening health systems is not the only way in which the UK is recognising the interaction between AIDS and other diseases. We are also supporting the technical work of UN agencies, such as the WHO, which has developed operational guidelines on Integrated Management of Childhood/Adolescent and Adult Illnesses. These tools support decentralisation of AIDS related services to district hospitals, health centres and community level and their integration with other health interventions such as TB, substance use, pregnancy and child health.

EXAMPLES OF HOW THE UK AND OTHER DONORS WILL ADDRESS THE INTERACTION BETWEEN AIDS AND OTHER DISEASES:

29. The **International Health Partnership** (IHP) was launched by the UK in September 2007 to deliver, among other things, stronger and lasting health systems to deliver better care for the poor. It is about working together to support developing country governments, based on the central role of health systems in National Strategies and the coordination of funding around these strategies. The IHP is now led by the World Health Organisation (WHO) and World Bank, supported by the other key international health agencies (UNICEF, UNFPA, UNAIDS, GFATM, GAVI and Gates Foundation). Ethiopia signed its IHP country compact on 26 August 2008. In this compact, the Government of Ethiopia has clearly set out how it wants all development partners—bilateral donors as well as health agencies—to support its national health plan.

30. DFID will harness the interaction between AIDS and other diseases by **supporting research** to develop drugs, microbicides and vaccines for HIV and AIDS, TB, malaria and other diseases that most affect poor people. These plans are outlined in DFID's Research Strategy for 2008–13, which includes the commitment to double investment in research, including health, to £220 million a year by 2010. Research funding also provides opportunities for operational research, so that researchers and policy makers can investigate how known interventions can be scaled up in countries, as well as research into the social and economic contexts of HIV and AIDS in the general population and some vulnerable groups.

31. In **Southern Africa**, DFID is finalising the design of a new Regional Health and AIDS programme, providing £55 million over five years, to address both AIDS and broader health issues, to support countries scale up their responses to AIDS, TB and malaria in women, children and other vulnerable groups.

Issue 3. *How will the new AIDS Strategy be incorporated into DFID's Country Programmes?*

32. The Strategy recognises that while AIDS presents a global challenge, epidemics within and across countries and regions can and do have different characteristics. Delivery of DFID's HIV and AIDS strategic priorities, in line with the AIDS Strategy, is carried forward through decentralised bilateral country programmes and also through some regional programmes, particularly in hyper-endemic areas, or in areas where neighbouring counties face similar challenges. 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.

33. In all settings, DFID works in close partnership with governments, civil society, the private sector and other bilateral funding agencies. DFID also works with multilateral institutions, including the World Bank, United Nations agencies and the European Commission. The UK delivers funding through a range of aid instruments including general budget support (often known as poverty reduction budget support), sector budget support (eg health or education), along with support to multilateral and civil society actors. Decisions on which aid instruments should be used are taken by DFID offices at a country level, depending on what is most appropriate for the situation in that country.

34. In some settings, the priority is to strengthen weak capacity in government or other country partners, while supporting direct service delivery via the UN or civil society (eg Nigeria, DRC, Zimbabwe, Burma). In other settings, DFID tends to focus on technical support and implementation of country-led HIV and AIDS strategies, working with governments, civil society and international donors and agencies (eg in Ghana, Ethiopia, Uganda, Zambia, Mozambique, India, Nepal, Pakistan, Bangladesh,Vietnam, China, Cambodia. In hyper-endemic middle income countries, such as Botswana, the approach is to provide technical support to unblock political and technical barriers to scale up and promote learning between countries. These programmes will cover a range of prevention, treatment, care and support interventions, working with UN, state and non state actors and vulnerable groups.

35. DFID is in the process of developing a framework for monitoring and evaluating (M&E) the updated AIDS Strategy. This framework, along with a baseline from which to measure progress, will be finalised in November 2008. More information on the M&E framework is set out in the response to Issue 5 in this memorandum.

Examples of DFID Country Programmes Reflecting Commitments made in the Updated AIDS Strategy:

36. **In Africa:**

— **Lesotho:** DFID has supported the establishment of the National AIDS Council (NAC), including the transparent recruitment of its CEO; establishment of its legislative framework; and the establishment of the national People Living with HIV (PLWH) network.

— **Rwanda:** DFID support to the HIV and AIDS unit in the Ministry of Education helped achieve the removal of primary school fees, support the piloting of alternative education options and research on barriers to access and special provision for Orphans and Vulnerable children (OVC).

— **Zimbabwe, Lesotho, Namibia, Botswana, South Africa, Swaziland and Angola:** DFID is working closely with UNICEF to take forward commitments on OVC including identifying appropriate forms of social protection and child support services, working with Ministries of social welfare to strengthen their capacity, and providing funding through civil society organisations to strengthen community based initiatives.

37. **In South Asia:**

— **Pakistan:** DFID has supported the generation of evidence on HIV and AIDS and has supported the National AIDS Control Programme to develop a new HIV and AIDS Control Strategy. DFID plans to continue with poverty reduction sub-sector budget support, technical assistance and encouraging stronger political commitments on the "*Three Ones*". DFID is working with the World Bank to rapidly scale up service delivery packages for vulnerable populations and will continue funding to increase the use of barrier contraceptives and efforts to deal with TB and HIV co-infection and treatment for sexually transmitted infections.

— **Bangladesh:** There has been a strong focus on targeted approaches to prevent HIV and AIDS amongst sex workers and Injecting Drug Users (IDUs). Key issues in the new AIDS strategy, including addressing stigma, increasing attention to the prevention of HIV infection in women and children, and better collaboration between development partners, will be addressed through DFID's support for a major urban health programme (the Urban Primary Health Care Programme II, (UPHCP-II) as well as DFID's overarching health sector support programme (the Health, Nutrition and Population Sector Programme (HNPSP). In the UPHCP-II, health workers and clinic managers are being given training on the technical issues around HIV and AIDS, as well as how to reduce the stigma associated with HIV infection. The UK is working through the

HNPSP, which includes agencies such as UNAIDS, to better address the needs of women and children in HIV prevention through strong collaborative efforts with government and other donor partners.

38. **In the Caribbean:**

— DFID is working through the regional Pan Caribbean Partnership on HIV/AIDS (PANCAP) to ensure that National AIDS Programmes, civil society and the private sector develop and implement high quality national progammes to tackle stigma and discrimination which is a major driver of the epidemic in the region.

Issue 4: *How will civil society be involved in implementing the new strategy?*

39. The updated Strategy covers a seven year timeframe and we are therefore at an early stage in terms of implementation. Since the public consultation closed and the strategy was launched, officials have met with civil society representatives on a number of occasions. One of the aims of these meetings has been to discuss working together to implement the Strategy.

40. Civil society was actively engaged in the consultation for the development of the strategy. A 12-week public consultation was held between May and August 2007, coordinated by the UK Consortium on AIDS and International Development. Strong efforts were made to ensure that southern voices were heard in the consultation, and to ensure that people living with HIV were centrally involved. Considerable effort was made to take into account the views and opinions expressed during the consultation process.

41. The Strategy acknowledges the vital role civil society organisations play in tackling AIDS and how they complement the work of governments and the private sector. It emphasises the importance of effective partnerships between governments, bilateral and multilateral agencies, civil society and the private sector in the AIDS response. It highlights the need to ensure resources are channelled to where they are most needed—including to communities and community based organisations.

42. The Strategy also acknowledges the significant role the private sector plays through funding and research and by influencing government. It highlights the importance of workplace policies and programmes and the role that the private sector, and trade unions have in this regard.

43. GFATM has been a key driver of the growth in funding for AIDS since 2003. It now provides over one-fifth of all international resources for AIDS. GFATM is widely acknowledged for its strong engagement with civil society. Civil society and NGOs represent an important part of the GFATM partnership. They participate in the strategic planning process through their involvement in the Partnership Forum and in specific countries through their involvement with Country Coordinating Mechanisms. Civil Society Organisations, from both developed and developing countries are represented on the Board and its committees. Provisional results from the submission of proposals to the Fund under Round 8 suggest that some 40% of the disease specific proposals have opted to nominate at least one Principal Recipient to receive and manage the GFATM funds from the Government sector and one from a non government sector, to follow the GFATM recommendation on so-called Dual Track Financing. In October 2007, DFID committed to provide GFATM with up to £1 billion over seven years.

44. DFID manages various funding mechanisms specifically for civil society organisations (CSO). These include the Civil Society Challenge Fund (CSCF), the Governance and Transparency Fund (GTF) and the Programme Partnership Agreements (PPAs). We have 26 PPAs with key UK and International civil society organisations. These Agreements provide untied strategic support based on mutually agreed objectives. DFID is committed to provide a total of £367 million over the next three years in support of these PPAs—eleven of which have strategic objectives specifically focussing on addressing HIV and AIDS. A number of civil society organisations (eg International HIV and AIDS Alliance, and International Planned Parenthood Federation) are partners in research programme consortia, funded through DFID's Central Research Department.

45. Decisions are taken at the country level as to the most appropriate range of aids instruments for a given context. There are many examples of DFID funding to civil society, including both national and international organisations, in different countries. In addition in some contexts DFID provides funding to a pooled funding arrangement for support to civil society organisations for example in Mozambique and in Tanzania.

46. We are working with UN agencies such as UNAIDS and UNICEF and directly with NGOs to find more effective ways to get resources down to communities. For example DFID is developing, with UNICEF, innovative mechanisms at country level to channel resources to community based organisations in Zimbabwe and Namibia. In Zimbabwe alone this is reaching over 130 community based organisations and to date has reached over 180,000 children. In Mozambique, DFID funds a UNAIDS social mobilisation officer to enhance civil society's participation in the national AIDS response.

47. At the biannual Global Partners Forum for Children Affected by AIDS in October 2008 development partners, including DFID, will be reviewing global progress on OVC commitments including mechanisms for getting resources down to community based initiatives. A working session will focus on learning the lessons from existing best practices including some DFID-funded programmes such as the Zimbabwe Programme of Support (see above in issue 3).

Examples of UK Support to Civil Society in Implementing the Updated Strategy:

— **Uganda:** DFID is funding civil society and the UN to increase public involvement in policy dialogue and to build local capacity to review and develop policy.

— **Tanzania:** DFID supported the establishment of a pooled fund arrangement with the Ministry of Finance and the Tanzania Commission for AIDS (TACAIDS). The Rapid Funding Envelope for HIV/AIDS (RFE) was established in 2002 as an innovative partnership between TACAIDS, the Zanzibar AIDS Commission (ZAC), bilateral donors, and one private foundation. The RFE's purpose is to enable civil society institutions in Tanzania to participate fully in the national multi-sectoral response to the AIDS epidemic. DFID sits on the RFE steering committee.

Issue 5: *What is the likely effectiveness of monitoring systems in ensuring that funding announced in the Strategy reaches local level?*

48. Monitoring and Evaluating (M&E) activities, both at national and sub-national levels, are a central part of DFID's management and business systems. This involves keeping track of inputs, processes, outcomes and impacts of DFID-funded bilateral and multilateral programmes. It is also about influencing other donors and partners, to address gaps in performance and to ensure transparency and accountability.

49. DFID is currently in the early stages of reviewing budget tracking processes as well as the impact of community level AIDS responses. This is in line with priorities identified in the Strategy. Discussions are underway with the Global AIDS Monitoring and Evaluation Team (GAMET) housed by the World Bank, to lead on this work. The proposed review will assess the impact of community interventions in 10 African countries. The aim of the work is to track the flow of funds from national to community level. It will answer questions such as "how much funding has actually reached the community? What are the obstacles hindering the flow of funds?" In so doing, it will contribute to the overall objective outlined in the updated Strategy of making the money work harder through an effective and coordinated response.

50. Improved data on the volume and sector destination of sub-national aid flows is also expected to arise out of the International Aid Transparency Initiative (IATI), which was launched by the Secretary of State, Douglas Alexander at the High Level Forum on Aid Effectiveness in Accra in September 2008. The IATI is a proposal for an international initiative to deliver a step shift in global public availability and access to information on aid flows, to promote increased accountability and effectiveness of aid. The IATI seeks to secure international agreement to a set of common information standards applicable to all aid flows.

51. In addition to general systems of M&E and work on budget tracking processes, a framework for M&E Achieving Universal Access is currently being developed. This reflects the fact that the updated Strategy focuses on outcomes and results. We aim to finalise the M&E framework and to develop a baseline from which to measure progress by November 2008. Both documents will be published and will be available on the DFID website once approved by Ministers.

52. The framework is being developed in consultation with regional divisions and country offices within DFID and other relevant government departments, including the Foreign and Commonwealth Office, Department of Health and the Home Office. DFID is also consulting with key funding agencies and with civil society organisations through the UK Consortium on AIDS and International Development. The framework will include a methodology to measure progress towards achieving the long term commitment of £6 billion to strengthen health systems and services up to 2015.

53. The effectiveness with which funds for HIV and AIDS are achieving the desired outcomes will be assessed when we undertake an independent review of the implementation of the Strategy in three years time. We have also committed to review the UK's approach to addressing the needs and rights of OVC, including the evidence base and effectiveness of our approach to social protection every two years following the Global Partners forum on Children Affected by HIV and AIDS, the next meeting of which will be held in October 2008. Plans are already underway to review the impact of social protection. We will use the findings of this review along with the outcomes of the biennial Global Partners Forum, to ensure that we continue to support the most effective ways of meeting the needs and rights of OVC.

54. In monitoring our strategy, together with the Cross-Whitehall Working Group on AIDS, we seek to attribute the UK's inputs through processes to outcomes and impacts in countries and globally. The ultimate goal of the strategy is to achieve the internationally agreed goal of Universal Access to comprehensive HIV prevention, treatment, care and support by 2010 and the Millennium Development Goal 6 target of halting and reversing the spread of HIV by 2015. Indicators will be selected according to agreed Paris Declaration principles which aim to harmonise monitoring activities between donors and minimise the burden on country systems.

55. In Achieving Universal Access, the UK commits to support progress towards a number of specific targets in five key priority areas. These targets are based on a mix of carefully chosen input, process, output and impact indicators. The indicators cover the breadth of our work in HIV and AIDS. However, they do not represent the sum of our work. We will also track progress through a mix of existing and harmonised data collection processes.

56. One such harmonised data collection process is the routine collection and monitoring of UNGASS indicators. This is a set of internationally agreed indicators and targets, which is collected by UNAIDS and partner countries. In addition, we will monitor AIDS related indicators and targets already embedded in DFID business systems as set out in the Divisional Performance Frameworks (DPFs) and annually collected overviews of the AIDS response from DFID country, regional, policy and multilateral representatives.

Examples of UK Support for Efforts to Ensure Funding reaches Local Levels include:

57. DFID supports efforts to track how AIDS funding is used and to ensure that resources reach community level. For example in **Mozambique**, DFID has supported a National AIDS Spending Assessment (NASA), which aims to monitor funding for specific HIV services and interventions, at national and local levels.

58. Monitoring trends in numbers of beneficiaries and the quantity and quality of services is also important to demonstrate that money is getting to where it is most needed. For example in **Vietnam**, the epidemic is still concentrated among vulnerable groups, including injecting drug users (IDUs) and sex workers. DFID was the first donor to fund HIV prevention and harm reduction in Vietnam. Starting in 2003, DFID provided £17.5 million to Vietnam's first HIV prevention project, focused on condom and needle and syringe distribution for IDUs. DFID's pioneering work in piloting new approaches to harm reduction helped lay the ground for high level policy change. In July 2007, the Government of Vietnam passed a ground-breaking law on HIV Prevention and Control, providing a legal framework of needle and syringe exchange programmes, drug substitution therapy and tackling stigma and discrimination. DFID is also planning a follow up programme to finance the scale up of harm reduction. This will join up with the World Bank programme to promote a large-scale and coherent approach to HIV prevention.

59. It is important to ensure that government works effectively with local NGOs so that funding reaches the people who need it most. In **Kenya**, DFID will provide support for strengthened integration and coordination between civil society and government for implementation through capacity building, grant-making, networking, documentation of lessons learned, and active collaboration, through support to AMREF (African Medical and Research Foundation, a regional NGO with headquarters in Nairobi).

Issue 6: *What is the impact of vertical funds on broader health system strengthening?*

60. Vertical funds can both strengthen and undermine broader health systems. Critics of vertical financing highlight that these programmes operate outside of national budget processes, largely by-pass government structures, often recruit staff from the public sector and can weaken national systems.

61. However, in certain contexts, vertical funding has been successful. When designed and implemented with sensitivity to their impact on the wider health system, they can have a positive impact. In hyper-endemic countries, the burden of the disease is so great that existing health systems may not have coped without a substantial boost from vertical funds. In addition, vertical funding for AIDS can have a multi-sectoral impact, which boosts other sectors such as education and health, by providing teachers or health care workers with anti-retroviral treatment. In some contexts, in the absence of vertical funds, supporters feel that governments would have made very little progress towards achieving universal access; for example, where political leadership and accountability are weak and commitment to AIDS is lacking.

62. In **Haiti**, a Global Fund supported AIDS and TB scale-up led over the course of a year to a range of improvements in primary health outcomes. Expanding capacity for PMTCT enhanced the quality of prenatal care and all women's health services, leading, for example, to a fourfold increase in prenatal care visits. The comprehensive AIDS care that was introduced improved staff morale and increased the flow of essential medicines and vaccines, with a readily measured impact on a number of primary health care goals including vaccination and family planning.

63. In **Ethiopia**, the Global Fund has become the major donor in training and allocating 30,000 community health workers. These have the potential to significantly strengthen the health sector for maternal health and immunisation as well as for AIDS, TB and malaria.

Issue 7: *What is the comparative effectiveness in tackling HIV/AIDS of vertical funds and funding allocated to broader health system strengthening?*

64. The previous question has looked at situations in which vertical funds can positively and negatively impact on health system strengthening. We respond to this question by outlining why the *either* vertical *or* horizontal debate is one we have considered but need to move beyond. Both approaches are needed. What is important, as the Strategy stresses, is to ensure effective coordination, honour donor commitments to the Paris Declaration Principles, and maximise positive impact.

65. Since *Taking Action*, there has been a significant increase in vertical funding, particularly by the USA. To compliment this increase in funding, the UK's new Strategy has made a series of commitments which includes a long term commitment of £6 billion for strengthening health systems and services up to 2015. This is in recognition that major, sustained efforts to strengthen health systems are critical to achieving Universal Access.

66. Making UK money work harder through an effective and coordinated response is a key aspect of the new AIDS Strategy and in order to achieve the best possible use of our funds, we have considered the comparative effectiveness of vertical versus horizontal approaches. We conclude that our aim should be to ensure that disease-specific (vertical) and health systems (horizontal) approaches are mutually reinforcing and contribute to achieving all of the health related MDGs. Increased funding for AIDS should help to build stronger health systems and investments in systems should support a sustainable AIDS response. Vertical funds have certainly been effective in bringing AIDS treatment to a great many people. But vertical funds are not enough. For a country to respond effectively to AIDS, it needs a properly functioning health system—including the health workforce needed to make it function.

67. We are aware of the argument that earmarking funds for AIDS can be distorting, unsustainable and can overload fragile health systems. In addition, where AIDS funding is "off-budget", governments can find it difficult to coordinate and fulfil the expectations of donors. This is because vertical funds can go through different budgeting and planning cycles, and can require extensive and burdensome reporting requirements and donor missions.

68. For the UK, the exact mix of aid instruments should depend on a country's state of development and capacity to absorb development funding. This requires an understanding of the epidemic and the required technical inputs but also the ability and capacity of any particular country to implement programmes. For example, a country with a well-established poverty reduction budgetary support programme would require a different approach to a country which was coming out of a period of unrest where institutional capacity was weak or non-existent. The UK government aims to tailor the choice of aid instruments to the country in question. We remain convinced that such funding allocations for health and the identification of priorities are best undertaken at the country level, in discussion with the country itself and with other donors.

69. Rather than comparing the effectiveness of vertical versus horizontal financing, the discussion should be more about ensuring that money is spent most efficiently and effectively, to achieve the best results. The updated Strategy provides details on how the UK will go about achieving value for money.

Example of UK Health System Strengthening Support

70. In four countries where the IHP overlaps with the US PEPFAR (**Ethiopia, Kenya, Mozambique and Zambia**), DFID is working with PEPFAR to support government health workforce plans, demonstrating that it is possible to bring together complementary financing streams for horizontal systems support and vertical disease programmes such as HIV & AIDS to support country health workforce priorities. By training sufficient health workers, including community health workers, and assuring an enabling environment for their effective retention in developing countries, we are helping to build reliable and sustainable health systems. In this regard, we encourage WHO to develop a voluntary code of practice regarding ethical recruitment of health workers.

Issue 8: *What are DFID's mechanisms for measuring the impact of its funding for health service strengthening?*

71. The UK government will track performance against the delivery of DFID's 2006 White Paper commitments, which includes strengthening health systems. We routinely monitor progress towards our Public Service Agreement (PSA) on International Poverty Reduction and DFID's own Department Strategic Objectives (DSOs). Impacts of our funding are reported twice yearly in our Annual Report and Autumn Performance Report.

72. In addition, DFID's Results Action Plan (RAP) published in 2007 sets out to establish DFID as a model of good practice on results and to drive reform across the international system to realise "a world in which evidence is used effectively to improve development and poverty outcomes". This will require better quality statistics and information, a stronger commitment to evidence-based policy making and robust systems for monitoring and evaluation. It also requires strengthening the demand for evidence of results by improving the systems which hold governments and donors to account. The Plan is in three parts with 10

priority actions aiming to embed results in DFID culture and systems, encourage partner countries to monitor and account for their poverty reducing policies and programmes and establish an international system with a clear focus on the impact of its policies and interventions of the poor.

73. A common monitoring and evaluation (M&E) framework was developed for the International Health Partnership (IHP) in February 2008 following technical and country consultations. This will now be taken forward on a country by country basis, linked to discussions on validation and completion of country compacts. The M&E framework for the IHP ensures that each of the specific health goals prioritised within the IHP (eg MDGs 4, 5 and 6) are included in a way which prioritised the health systems components that would directly contribute to the achievement of those goals, whilst ensuring that overall health systems in IHP countries are not distorted.

74. Finally, the monitoring and evaluation framework currently under development for the updated AIDS Strategy will seek to address the question of impact of the UK funding on health system strengthening. (See Issue 5 above).

Issue 9: *Does the AIDS Strategy address issues raised in the IDC's previous reports—Marginalised Groups; and Maternal Health?*

75. This question is answered in two parts, the first will look at the issues raised in the IDC report from 2006 on marginalised groups, and the second will comment on the issues raised in the IDC's maternal health inquiry from 2007, the report of which was published on 2nd May 2008—just before the publication and launch of the AIDS Strategy.

1. Marginalised Groups:

76. Much has happened since 2004 when DFID launched "*Taking Action*". The UK has spent some £1.5 billion on AIDS programmes. We have also taken action to promote the needs and rights of women, young people, children and vulnerable groups. Our updated strategy places people at the heart of the response and shows how we will continue to promote the needs and rights of women, young people and children, and vulnerable groups, and how we will support countries in providing stronger health, education and other basic services. It also includes commitments on prevention, the "sustainability of treatment", social protection for those made vulnerable by the disease, including orphans and other vulnerable children, and stronger health systems.

77. A whole chapter of the updated strategy is devoted to responding to the needs and protecting the rights of those most affected and draws upon the recommendations made in the previous IDC report on marginalised groups. It is accepted that greater efforts are needed to reach those most affected by the epidemic, including PLWH, women, young people, children and vulnerable groups such as men who have sex with men (MSM), injecting drug users (IDU's), sex workers and prisoners. AIDS responses must tackle the underlying drivers of the epidemic, and again these vary and so it is vital to use local knowledge of the epidemic and knowledge of the drivers related to gender inequality, harmful sexual norms, stigma and discrimination and economic need. As set out above, the strategy has a strong focus on the needs and rights of OVC, and informed by the strong evidence-base on social protection, will expand this as a key strand of our strategy. The Strategy sets out how we will support this.

78. Stigma and discrimination remain major barriers to achieving Universal Access and require urgent attention. National responses must also enable those most affected to participate in the design, implementation, monitoring and evaluation of services.

79. Four priorities for action have been identified in the updated strategy:

- Supporting the empowerment of People Living With HIV (PLWH) and vulnerable groups to act on their own behalf and in their own interest, and participate in all aspects of the AIDS response.
- Ensuring that gender analysis is integrated within national AIDS plans, and that targets and indicators are developed to measure the impact of AIDS programmes on women and girls.
- Promoting and taking action on neglected and sensitive issues—including adolescents sexual and reproductive health and rights (SRHR); the needs and rights of Men who have Sex with Men (MSM), and harm reduction.
- Working with our partners to ensure increased action against HIV stigma and discrimination.

Examples of DFID's Work with Vulnerable Populations includes:

80. DFID's support in Central Asia centres on the main drivers of the epidemic there. Central Asian countries straddle a major heroin trafficking route. The availability of cheap drugs, repressive laws targeting drug users, and limited availability of HIV prevention services, have all contributed to growing HIV prevalence. In addition, vulnerable populations such as injecting drug users (IDUs), sex workers and ex-prisoners, who already experience stigma and social exclusion in their communities, find this made worse by HIV-related stigma and discrimination, making them difficult to reach with services. In this context

DFID funds a £5.4 million Regional Central Asia HIV and AIDS Programme (CARHAP) in Kyrgyzstan, Tajikistan and Uzbekistan. This focuses on supporting and building the capacity of civil society organisations to scale-up harm reduction services, including condom distribution, needle and syringe exchange, raising awareness and reducing stigma and discrimination. DFID also provides a £1 million contribution to the World Bank's $25 million Regional Central Asia AIDS control project in Tajikistan, Kyrgyzstan, Uzbekistan and Kazakhstan. This programme, hosted by the Eurasian Economic Community, supports improving legislation and the quality of data collection and monitoring.

81. In Zimbabwe, DFID has been working with Population Services International to promote the use of the female condom. This initiative has been particularly welcomed by sex workers whose clients are often reluctant to use condoms, despite the high risks. Through an innovative programme of interpersonal communication and condom distribution, including through sex worker networks and hair salons, annual sales of female condoms have risen from 1.36 million in 2006 to around 2.8 million in 2008.

2. Maternal Health:

82. The importance of ensuring women and girls access to education featured strongly in the IDC Maternal Health Inquiry. Girls who are not in school have their right to education undermined and are at an increased risk of early marriage, domestic violence, HIV and AIDS. The AIDS Strategy places at its heart the needs and rights of women and girls. This includes: promoting the needs and rights of women through the integration of sexual and reproductive health and rights and HIV; challenging gender based violence; research into female controlled prevention techniques such as microbicides; supporting girl's education; and reducing the burden of care on women and children through social protection.

83. The updated strategy recognises that addressing gender inequality and ensuring women's rights are essential if we are to achieve Universal Access to comprehensive HIV prevention, treatment, care and support. DFID supports comprehensive programmes for women that address not only their access to sexual and reproductive health and rights but also access to education, employment and social protection.

84. DFID shares the concern about women's vulnerability to HIV and AIDS and the feminisation of the epidemic, particularly in sub-Saharan Africa. Women and men face different risks and barriers in relation to the AIDS epidemic and in accessing services. Gender inequalities mean that women and girls cannot always decide if, when, how and with whom they have sex, or when to access basic services. Violence against women and girls significantly increases their risk of HIV infection. Women and girls report increased violence for refusing sex, requesting condom use, accessing HIV counselling and testing, and for testing HIV-positive. Women and girls also bear the greatest burden of care, including caring for orphans and those that are sick.

85. DFID's overall commitment to gender equality is set out in the 2006 White Paper and the 2007 Gender Equity Action Plan. We will identify gender related targets in our corporate business plan and programmes, which will be monitored and evaluated at country level. Internationally, we are engaging with the OECD Development Assistance Committee (DAC) on how to improve the quality of gender statistics and we will work to ensure that national AIDS plans integrate gender analysis and development indicators to measure the impact of the response to women and girls.

86. In line with the IDC recommendation, DFID is updating its maternal health strategy. This will be consistent with the AIDS strategy and will also reflect the issues raised by the IDC on maternal health.

Examples of DFID's Maternal Health Related Work includes:

87. In **Nigeria**, DFID has invested £52.8 million promoting sexual and reproductive health for HIV and AIDS reduction and behaviour change to improve sexual and reproductive health among poor and vulnerable groups, including women. We are also supporting the Federal Government and UNICEF to accelerate girls' education (£26 million) and improve their quality of life. The £12.5 million Universal Basic Education Project also builds on this and has a specific HIV focused component for the educationally disadvantaged (including girls).

Conclusion

88. The updated AIDS Strategy, as in *Taking Action*, places people at the heart of the UK Government's response. If we are to achieve Universal Access and to halt and reverse the spread of AIDS, the evidence demonstrates we require a long-term approach, working in partnership with others.

89. The Strategy demonstrates the UK's determination to remain at the forefront of global efforts to achieve Universal Access. The UK, has made a bold and ambitious step by making long-term commitments of £6 billion to strengthen health systems and services up to 2015, and to spend up to £1 billion supporting the GFATM by 2015.

90. The Strategy recognises that stronger health systems and services are critical to tackling AIDS, but also highlights the multi-sectoral nature of the disease. The Strategy includes a commitment to spend £200 million over three years on social protection programmes, an approach widely endorsed by OVC experts.

91. The updated AIDS Strategy focuses on outcomes and results. Strong monitoring systems will be required to ensure funding reaches the local level and in measuring the impact of funding for health service strengthening, also in ensuring that new and existing resources have the greatest impact.

92. We welcome the IDC interest in these issues and look forward to working with the committee during the seven years of strategy implementation.

Background Documents

Achieving Universal Access—the UK's strategy for halting and reversing the spread of HIV in the developing world, DFID, 2 June 2008
http://www.dfid.gov.uk/pubs/files/achieving-universal-access.pdf

Achieving Universal Access—Evidence for Action

http://www.dfid.gov.uk/pubs/files/achieving-universal-access-evidence.pdf

Carr, Dara and Laura Nyblade, *Taking Action Against HIV Stigma and Discrimination: Guidance Document and Supporting Resources,* DFID, November 2007
http://www.aidsportal.org/repos/stigma%20guidance%20doc.pdf

Supplementary memorandum submitted by the Department for International Development

FOLLOW-UP TO ORAL EVIDENCE SESSION ON 30 OCTOBER

I welcomed the opportunity of giving evidence on HIV and AIDS this morning to the International Development Committee. One line of questioning we agreed to follow up with you very quickly was around our support for orphans and vulnerable children (OVC), in particular through social protection programmes.

In the recent UK AIDS strategy a commitment was made to spend over £200 million to support social protection programmes over the next three years. In doing so, we said we would work with governments and civil society in eight African countries to develop social protection policies and programmes. These policies and programmes will provide effective and predictable support for the most vulnerable households, including those with children affected by AIDS. During the course of the implementation of the 7 year UK AIDS strategy, countries where DFID is supporting these social protection programmes may change—mainly due to the fact that project cycles tend to have three to five year timeframes. However at anyone time DFID will be supporting social protection programmes in at least eight countries. The main criteria to determine which countries will receive this support include; demand from the countries themselves; a niche for DFID to provide this support; high HIV prevalence and high OVC burden.

Currently the UK's social protection response to OVC includes bilateral support in countries such as Ethiopia, Kenya, Ghana, Malawi, Mozambique, Rwanda, Tanzania, Uganda, Zambia, and Zimbabwe. It also includes multilateral support for example through UNICEF for social protection programmes in South Africa, Swaziland, Angola, Botswana and Namibia.

As we roll out social protection support we will continue to monitor closely the impact social protection has on OVC and their families. We are working with UNICEF and Save the Children UK to develop a multi-country and multi-year study to assess how cash transfers impact on different indicators of child vulnerability (eg nutrition, education attendance). In addition we have committed to review the evidence that social protection is an effective means to support OVC following each Global Partners Forum that occurs every two years.

The updated AIDS strategy "Achieving Universal Access" has a strong focus on the needs of orphans and other vulnerable children (OVC). The strategy recognises that social protection, including but not limited to cash transfers, are an effective response to the needs of OVC, but must be part of a comprehensive system of care and support. This includes affordable health care and education, psychosocial and broad livelihoods support. As part of our response we have committed £200 million for social protection programmes as an effective way to reach OVC and their families.

The evidence for social protection, including cash transfers to strengthen families affected by HIV and AIDS, is both robust and compelling. A recent (2007) review of 300 documents by the International Food Policy Research Institute, (http://www.ifpri.org/renewal/pdf/JLlCACashTransfers.pdf) shows how social protection can be used to protect children and families affected by HIV/AIDS. Specifically, it highlights how cash transfers can help secure basic subsistence, reduce poverty and protect children's access to education, health and good nutrition. These conclusions are drawn from studies of several well-established transfer programmes in South Africa, newer pilot programmes in southern and eastern-Africa and studies of conditional cash transfers in Latin America and Asia.

Other research has shown that in high HIV prevalence countries such as in eastern and southern Africa, where up to one in five adults are living with HIV, most children are directly or indirectly affected by AIDS. In these situations it makes more sense to programme more broadly for all vulnerable children not just those

affected by AIDS. Pilot cash transfer schemes from Zambia and Malawi which use AIDS-sensitive but not AIDS-exclusive criteria of poverty (high dependency ratios, and/or limited labour capacity) to identify eligible households, have demonstrated that approximately 70% of households reached with such social assistance were households directly affected by HIV and AIDS, including OVC.

This approach has been strongly endorsed at the recent International AIDS conference in Mexico and at the recent Global Partners Forum on Children Affected by AIDS held in Dublin.

I hope this is useful and is in time to help you with your report writing.

30 October 2008

Memorandum submitted by ActionAid

About ActionAid

Founded as a British charity in 1972 with a mission to eradicate global poverty, ActionAid has been working on HIV and AIDS since 1987. Since the launch of our strategy "Rights to End Poverty" in 2005, Women's Rights has been our overarching priority both in our programme and advocacy work.

ActionAid primarily supports poor and excluded people living with HIV and AIDS and has been giving practical support to people living with HIV in 23 countries, including, Malawi, Kenya, Zimbabwe, India, Bangladesh, Nepal, Cambodia and Guatemala. In addition, we designed Stepping Stones, a training programme now used by 2,000 organisations in 100 countries worldwide that helps people learn more about sexual health, discuss their own behaviour and explore how to change risky practices.

In 1972, ActionAid had 88 supporters. Three decades later we have expanded to more than 300,000 supporters in Europe and have offices in more than 40 countries. In 2003 we became ActionAid International and moved our global headquarters from the UK to South Africa. For more information about ActionAid's work on HIV and AIDS please contact Fionnuala Murphy on 02075 617656/ fionnuala.murphy@actionaid.org.

ActionAid welcomes the opportunity to input into the IDC's enquiry on how DFID are tackling HIV and AIDS in the developing world. We have chosen to focus on the question on women's rights in line with our areas of expertise.

Background on Women's Rights and HIV and AIDS

Today more than 60% of all adults living with HIV in Sub Saharan Africa are women and the numbers are rising. Among young positive people, three quarters are female.

These statistics are inextricably linked to the widespread and systematic denial of women's rights. In many societies, women and girls are routinely denied their basic rights to things like education, healthcare and a living wage. Many women are economically dependent on men and have no say over who they marry or have sex with, these decisions being made for them by the men in their families. High levels of gender based violence limit women's capacity to challenge rights violations.

All these factors make women vulnerable to HIV infection. And once infected, low income and poor access to healthcare mean many women don't get the care, treatment and support they need.

Women's Rights in DFID's HIV and AIDS Strategy

On World AIDS Day 2007, ActionAid and VSO launched "Walking the talk: putting women's rights at the heart of the HIV and AIDS response". This report analysed the barriers faced by women in relation to HIV prevention, treatment, care and support, and suggested areas for action. Off the back of this research ActionAid launched Invisible Women, a campaign with the aim of persuading DFID to put women's rights at the heart of its new HIV and AIDS strategy.

ActionAid was broadly pleased with DFID's new HIV and AIDS strategy Achieving Universal Access which included a number of important first steps to meeting the needs of women affected by HIV and AIDS. We were particularly pleased that it included pledges to:

- Continue UK leadership in championing evidence-based HIV prevention and the rights of vulnerable groups, including women and young girls.
- Train DFID staff on women's rights and HIV and AIDS.
- Take action to stop violence against women.
- Integrate HIV, SRH and other health services and ensure these services respond to the reality of women's lives.
- Include a gender analysis in HIV prevention strategies.

— Increase access to contraception and female controlled HIV prevention, including female condoms and microbicides.

— Improve the situation of women carrying the burden of care associated with HIV and AIDS, including spending £200 million in eight African countries over the next three years on social protection for carers.

— Address structural inequalities and women' economic disempowerment.

Moving forward, we particularly look forward to seeing what action DFID will take to tackle violence against women and girls, and to see a stronger commitment within DFID to strengthening primary health care systems which meet all of women's health needs.

However for Action Aid, implementation is the real challenge. In order to bring real benefits for women, we believe that DFID must build on the top line pledges included in their strategy. This submission will set out the steps which we believe are necessary in order to effect meaningful change in the area of women's rights and HIV and AIDS.

An Implementation Plan

Immediately after DFID's strategy was launched on 2 June, ActionAid and a number of other NGOs began campaigning for a plan of action to implement the pledges contained in the strategy. Many of our supporters—who took part in the Invisible Women campaign—have contacted the Parliamentary under Secretary for International Development Gillian Merron to call for this plan.

We are aware that a team within DFID is now working on a plan of action, to be completed by 31 October. A small number of civil society experts have been involved, but are subject to Chatham House rules. ActionAid is eager to ensure that this plan is as ambitious as possible. At the very least, it should commit DFID to action in the following four areas:

1. Creating budget lines for work on the intersection of women's rights and HIV and AIDS.
2. International leadership to tackle the feminisation of HIV and AIDS.
3. Training of all DFID staff to understand and act on the intersection of women's rights and HIV and AIDS.
4. Taking action to stop violence against women and girls.

1. *Creating budget lines for work on the intersection of women's rights and HIV and AIDS*

The DFID strategy pledges £6 billionn for health up to 2010. However it does not set out how much of this money will be allocated to improving the position of women, nor whether additional money is available from other budget lines such as education or gender and equity. As a starting point, DFID need to establish how much money will be allocated to women's rights and HIV, and should clarify which budgets this money will come from.

In terms of how funding for women's rights is allocated, ActionAid would particularly like to see:

— Sufficient long-term predictable funding pledged for strengthening of health systems, in particular to ensure female-friendly health systems that integrate HIV, sexual and reproductive health and gender based violence services at primary care level.

— Creation of budget lines for work on the intersection of HIV and AIDS and violence against women and girls.

DFID should also agree to disaggregate their spending data by gender, and should commit time and money to strengthening their own and their partners' capacity to do this. Funds should also be allocated to improving Monitoring and Evaluation systems so that funding can be tracked and its impact on women and girls assessed.

2. *International leadership to tackle the feminisation of HIV and AIDS*

Alongside increasing UK spending to tackle the feminisation of HIV and AIDS, there is much DFID can do to encourage other countries to take up the issue of women's rights and HIV and AIDS.

In the new HIV and AIDS strategy, DFID makes a number of pledges to take action at international level including:

— Continue UK leadership in championing evidence-based HIV prevention and the rights of vulnerable groups, including women and young girls.

— Work with donors, developing country governments and multilateral bodies to scale up access to family planning and SRHR services and to increase availability of female condoms.

— Work with other countries towards universal access to post exposure prophylaxis and emergency contraception by 2010.

— Take action to stop violence against women.

These pledges are all important steps forward, but now require further development. In particular "leadership" is difficult to measure. DFID should develop a long term global advocacy plan on women's rights and HIV, which will set out how they will implement this pledge. This plan should commit DFID to strategic activities at international level on the following issues; ending prevention strategies which ignore the needs and rights of women (eg abstinence-only programmes, criminalisation of HIV transmission and exposure laws, persecution of sex workers etc), improving access to contraception, female controlled HIV prevention and PEP, tackling violence against women and girls and ensuring women's economic empowerment. Key outputs from this global advocacy should include:

— DFID to continue visibly challenging female-unfriendly prevention strategies at international level, leading to decline of these strategies in practice.

— Increased global momentum towards the target of universal access to sexual and reproductive healthcare by 2015, and increased availability of female condoms and contraceptives.

— Significant investment in, and progress on, microbicide development.

— Significant increase in funding for and availability of PEP and emergency contraception.

— DFID championing the fight to stop violence against women and girls and HIV in regional and international forums working on HIV, education and health. This should lead to the inclusion of a stronger women's rights component in these forums.

— DFID working with donors, institutions and developing country governments to improve the economic status of women.

3. *Training of all relevant DFID staff to understand and act on the intersection of women's rights and HIV and AIDS*

The Gender Equality Action Plan commits DFID to training and incentivising staff to increase their knowledge of and commitment to gender equality. Given the rate at which women are becoming infected with HIV, and the disproportionate impact which the AIDS pandemic is having on them, training on the specific interactions between gender inequality and HIV and AIDS is particularly important and urgent. The DFID action plan must:

— Commit to and allocate funding for a programme of staff training on the intersections between women's rights, gender based and HIV and AIDS.

— Set a timetable for development of programmatic guidelines on women's rights, violence against women and girls and HIV.

— Agree to include an indicator on gender and VAWG in DFID's performance and incentive structure.

4. *Take action to stop violence against women and girls*

The DFID HIV strategy recognises that widespread violence against women and girls substantially increases their risk of HIV infection and can stop them from accessing HIV counselling, testing and other services. In ActionAid's programmatic experience, we have learned that the links between HIV and violence are multi faceted:

— Violence against women and girls in the home prevents women from making their own choices to protect themselves from HIV. Women in Nigeria tell us that domestic violence, or the threat of it, deters them from refusing to have sex or resisting an arranged marriage.

— Violence decreases women's chances of getting HIV treatment. In Zambia, women say that they are afraid to discuss AIDS with their husbands, even when they suspect the men are the source of their own infection. Many attend clinics and take HIV medicines in secret.

— Sexual violence in schools is common in some countries, and many girls contract HIV as a result. In South Africa, a country with the highest number of people living with HIV in the world, a girl has a higher chance of being raped than of getting a decent education.

— During war and conflict situations women's bodies often become a battleground. During the 1994 genocide, Rwandan women and girls were subjected to sexual violence on a massive and systematic scale. An estimated two thirds of women who were raped contracted HIV.

As set out above, as a first step DFID should ensure that significant funding is available from their budget to address the intersection between violence against women and HIV. They can do this by creating budget lines for work on violence against women and girls and HIV.

Leadership at international level on VAWG is crucially important. DFID should work to ensure inclusion of a stronger women's rights component in all regional and international forums working on HIV, health and education (eg GFATM, IHP+ and EFA Fast Track Initiative). DFID should also push for national education sector plans to explicitly address violence against girls in schools and for national AIDS plans and health strategies to include a gender analysis.

Working with the FCO, there is also much that DFID can do to combat violence (including violence against girls in schools) and increase women's access to justice. Working together, DFID and the FCO can help to promote political and legislative reform in-country and can support legal action against perpetrators of violence (particularly violence in schools) to ensure an end to impunity. In committing to this, DFID should aim to increase prosecutions for VAWG in at least 10 countries.

ActionAid believes that unless DFID takes action in these four key areas the new strategy is unlikely to deliver significant benefits for women.

Furthermore, practical action will be required on the specifics of the pledges included in the strategy (listed above). Below we have proposed a series of indicators in relation to these pledges, and on two additional areas; women's access and adherence to HIV treatment and increased involvement of women living with HIV and AIDS in policy making.

Integrate HIV, SRH and Other Health Services and Ensure these Services Respond to the Reality of Women's Lives

- Funding allocated to training health workers on women and girls' rights, gender based violence and how to meet the needs of women and girls living with or affected by HIV and violence as a routine part of HIV related care.
- An increased number of health workers trained accordingly.
- DFID recognises role of strengthened primary health care in rolling out HIV, sexual and reproductive health care and gender based violence services which are accessible to women.
- Funding allocated to expand and support services for survivors of gender based violence and rape which integrate SRHR, gender-based violence and HIV and AIDS.
- An increase in these services at primary care level.
- An increased number of women receiving accurate information and appropriate care, including ART, PMTCT and treatment of opportunistic infections, including at primary care level.
- Agreement to work with other countries towards UA to PEP and emergency contraception by 2010, leading to an increased percentage of emergency care facilities offering emergency contraception and PEP.

Include a Gender Analysis in HIV Prevention Strategies

- Allocation of funding for HIV awareness campaigns and prevention programmes which challenge gender norms in 10 countries.
- Development of long term global advocacy strategy on female-unfriendly HIV prevention.
- DFID visibly challenging female unfriendly prevention strategies at international level and decline of these strategies in practice.
- Increased DFID investment in promoting gender parity in schools.

Increase Access to Contraception and Female Controlled HIV Prevention, including Female Condoms and Microbicides

- Development of long term global advocacy strategy on access to family planning and female controlled HIV prevention.
- DFID begins working with donors, developing country governments and multilateral bodies to scale up access to family planning and SRHR services and increase availability of female condoms.
- Increased global momentum towards meeting the target of universal access to sexual and reproductive healthcare by 2015.
- Increased availability of female condoms and family planning.
- Significant investment in, and progress on, microbicide development.

Improve the Situation of Women Carrying the Care Burden of HIV and AIDS

- DFID commit to question country plans and programmes which rely exclusively or largely on unpaid labour for the provision of care, the majority of which is provided by women and girls.
- A timetable is set for the disbursement of and accounting for the £200m already pledged for social protection.
- Following this, increased funding allocated to programmes which cater to broader needs of women and girl carers including livelihoods training.
- DFID commit to invest in building the capacity of grassroots women's organisations to develop income generation and educational opportunities for home based carers.

Address Structural Inequalities and Women' Economic Disempowerment

- DFID allocates funding to increase social protection and improve the economic position of women, particularly women living with HIV.
- DFID agrees to work with Foreign and Commonwealth Office towards in-country political and legislative reform intended to promote gender equality and women's rights, including land and property rights, leading to an increase in the number of women owning and claiming their rights to own land and property.
- DFID allocates increased funding for education of girls and adult women, leading to training and educational opportunities.
- DFID pledges to work with donors, institutions and developing country governments to address the economic factors which undermine women's ability to avoid HIV infection and to cope with the impacts of HIV and AIDS and develops a global advocacy strategy accordingly.

Treatment Accessibility and Adherence for Women

While the DFID strategy did not refer to the need for a gender sensitive approach to HIV treatment, ActionAid believes that this is an area in need of attention. Our report "Walking the talk: putting women at the heart of the HIV and AIDS response" highlighted that while a slight bias in favour of women exists in relation to treatment access, a number of gender related obstacles impede women's adherence treatment and hence reduce their survival chances. These barriers include lack of money for travel and treatment related costs, dependence on male partners for money, inability to take time off work to travel to health facilities, distance to facilities, lack of confidentiality in health care settings, and many others. There is a need for research to promote better understanding of these barriers. We therefore recommend that:

- DFID promises to work with its partners to improve gender disaggregated data collection on HIV treatment access and adherence as well as understanding of this data.
- On the basis of this data, DFID pledges to address the barriers faced by women and girls in accessing and adhering to HIV treatment.
- DFID agrees to fund treatment literacy and out of pocket social protection programmes for women, leading to increased number of women accessing and adhering to ART.
- Recognising that cost is a barrier for women, DFID commits to championing the removal of user fees for services associated with HIV.
- Recognising that distance to health care facilities is a barrier for women, DFID increase funding for provision of HIV treatment at PHC level, and for mobile drug distribution and treatment points.

Increased Involvement of Women Living with HIV and AIDS in Policy Making

While the DFID strategy references the need to consult people living with HIV when making decisions and setting policies which affect them, it does not specifically tackle the need to consult women and girls. ActionAid believes positive efforts are needed to ensure the voices of women and girls affected by HIV and AIDS are heard. We therefore recommend that DFID:

- Commit to consult women living with HIV and AIDS on their own country plans and programmes.
- Pledge to question any civil society consultation where women have been excluded, particularly in-country consultations.
- Commit and allocate funding to support women's organisations and enable them to develop skills around management, leadership, community mobilisation, advocacy and self empowerment.

Memorandum submitted by the All Party Parliamentary Group on AIDS

Introduction

The All Party Parliamentary Group on AIDS uses its connections with those involved in evaluating, delivering or designing HIV-related development programmes to seek out views on current policy. The observations in this document do not represent the views of every individual member of the Group but do reflect the key questions being asked and views being raised. This short submission also suggests some specific questions the Committee might ask during as it takes its evidence.

1. *The comparative effectiveness in tackling HIV/AIDS through vertical funding and funding allocated to broader health systems strengthening*

Bearing in mind the considerable challenges ahead, and that the global AIDS epidemic is still far from under control, there is a need for Governments in the developed and developing world continue to focus on HIV. The challenge is to maintain this focus whilst delivering on the broader health goals, such as providing more doctors and nurses and health infrastructure. These broader goals are necessary for any kind of a long-term response to HIV. HIV will not disappear if and when the Millennium Development Goals are reached, and so the right human and capital infrastructure to sustain service provision is vital.

However, in generalised epidemics, HIV grows exponentially and to prevent the epidemic spiralling further out of control a near-term HIV specific response is also crucial. Views within the group differ as to the proper balance of vertical and horizontal funding but there is agreement that the key questions are:

— What will a health systems approach mean for tackling HIV in the short and medium term?

— Are there specific indicators and mid-term goals that can be developed to help maintain focus on HIV whilst taking a broader approach?

2. *The impact of vertical funds on broader health systems strengthening and Interaction with HIV and other diseases*

Vertical funding systems are not inherently incompatible with broader health system strengthening, but there are definite pitfalls that need to be avoided such as the "poaching" of medical staff to deal just with HIV. In many cases the influx of HIV funding has led to better services more broadly, such as better and increased access to pre-natal and ante-natal care, an important need identified in the Select Committee's enquiry into maternal health. Family Health International has some excellent data on this from Rwanda for example http://www.fhi.org/en/AboutFHI/Media/Releases/res_RwandaStudyHIVFundingHlthSvcs.htm

Some negative impacts of vertical funding are associated with illogical boundaries between for example sexual health services and HIV which should, by their nature be linked. A no-condom promotion approach for example is a serious brake on HIV prevention. The other side of the coin is that increasing access to condoms has much wider health benefits than just the reduction of HIV, and this is recognised in the strategy. The Group welcomes the closer links proposed in the strategy between HIV and sexual health.

The Group also welcomes an approach where HIV is linked with the diseases that are closely associated with it—such as TB and Malaria. A more-linked up approach will deliver wider benefits and funding should be sufficiently flexible to recognise this.

The drive that HIV related goals can give can help deliver on many health fronts. Again, this view reflects calls for a balance between vertical and horizontal funding systems but with HIV at the centre of a linked up approach.

3. *Protecting vulnerable groups and the impact of HIV/AIDS on women and children*

Looking at the provision for children in particular, this strategy has no specific funding for orphans and vulnerable children unlike the last strategy, which set aside £150 million for OVCs. Instead there is funding put aside for social protection programmes. It will be important to measure the effectiveness of this approach and the APPG encourages the Committee to ask:

— What short and long term indicators/systems will be in place to measure the impact of social protection on orphans and vulnerable children?

More broadly, the new strategy has a welcome emphasis on protecting the most vulnerable groups—not just women and children, but also MSM (men who have sex with men), sex workers and injecting drug users. DFID also has an impressive record on these issues and of lobbying other countries to take a similar approach. However, the NGO sector in the UK has raised worries with the APPG that where funding is delivered direct to developing country governments, through budget or sector support grants, the recipients may not take such an enlightened approach. It is generally accepted that too much conditionality on overseas aid is counter-productive. The Committee could therefore usefully ask:

— What safe-guards are there, that when using budget and sector support funding mechanisms the rights and particular needs of vulnerable groups such as women and MSM will be respected?

"Protecting and upholding the rights of vulnerable groups" also features heavily in the strategy (p59) as one of the tasks of the Foreign Office, and the strategy promises joint working between the two Departments on this and other HIV matters. A full enquiry into the strategy should therefore include evidence from the FCO.

According to a recent Parliamentary Question, the cross-Whitehall Coherence Group on Tackling HIV and AIDS in the developing world has met just three times since 2005. The Group would welcome more detail from the Foreign Office about the nature of its joint working with DFID, plans for the cross-Whitehall group, and information on whether there is any specific training for FCO staff on HIV and whether there is any dedicated funding for FCO commitments in the strategy.

4. *The likely effectiveness of monitoring systems in ensuring that funding announced in the strategy reaches local level and how civil society will be involved in implementing the new strategy*

This is a particular concern and the Group would like to raise further related questions including:

- Does an approach that channels the majority of funds either through budget/sector support or through multi-lateral organisations such as the EC and the World Bank make it more or less likely that funding reaches local level?
- What AIDS and development specialism do the decision makers in the multi-lateral organisations have to help inform their spending decisions?
- What special infra-structure is DFID putting in place to develop monitoring systems that are able to track funding through such broad funding channels?
- How confident is DFID about the accountability of these funding channels back to DFID and by extension to taxpayers.

The Group recognises that DFID cannot and should not micro-manage its funding, especially if principles of local-ownership are to be upheld, but that this should not undermine accountability and transparency. It also accepts that tracing each pound through pooled funding will be very difficult and that new types of monitoring may be needed.

Where money flows through large governmental organisations the involvement of local civil society in monitoring is all the more important. Civil society has the independence and local knowledge to deliver long-term monitoring in ways in which a foreign donor such as DFID could never hope to do. Supporting civil society as part of the monitoring system and ensuring that it is genuinely involved should therefore be a key feature of the implementation of the new strategy.

5. *DFID's mechanisms for measuring the impact of its funding for health systems strengthening*

As discussed above, monitoring funding that goes through pooled channels is difficult and the same applies for measuring impact. This is why it is important that DFID sets out at an early stage what it expects to achieve with the funding, and the Group welcomes the work currently being done by DFID in collaboration with NGOs to develop indicators. Key to the development of indicators must be the following questions:

- If you seek to strengthen health systems—how is a strong health system defined?
- How much can we expect to deliver as country and how much do we rely on other donor countries?

The APPG is concerned that DFID should not be able to blame any and every failure on the other partners in pooled funding but equally it recognises that there will be times when other partners are to blame. Combining shared responsibility with a Government's individual accountability requirements to its own people and to recipients of funding, is a potential problem when using multi-lateral organisations. It makes early identification of difficulties and good communication links between multi-laterals and Governments all the more important. There is therefore an important further question:

- How good is the communication and accountability between the UK Government/DIFD and the multilateral organisations that spend its money?

Despite these questions, the Group also recognises there are important benefits to the Department's multi-lateral approach in terms of coordination and avoiding duplication of work and limiting reporting requirements for recipient countries.

Memorandum submitted by Business Action for Africa

SUMMARY

1. DFID's new strategy acknowledges that business has a role to play in helping achieve universal access, but gives no indication of how the private sector's contribution could be leveraged. There is also no provision for encouraging and facilitating more employers, especially small and medium-sized enterprises, to take action on HIV and AIDS at the workplace, which represents a significant missed opportunity.

2. The new strategy recognises the importance of strong and effective partnerships in tackling the HIV/AIDS crisis in developing countries. However, the strategy fails to make any provision for active pursuit of partnerships and strategic collaboration with the private sector. This omission is in stark contrast with DFID's stated policy objective of working more closely with the private sector in scaling up efforts to reach the Millennium Development Goals.

3. Many members of the Business Action for Africa network have extensive experience of dealing with HIV and AIDS in the workplace and the community, in sub-Saharan Africa in particular but also in other regions where infection rates are on the increase. These companies are eager to work with governments and donors to ensure that all resources are optimised in responding to the pandemic.

4. Business Action for Africa urges DFID to develop practical policy measures designed to better harness the strengths of the private sector and to encourage more public-private partnerships. Specific recommendations on how to achieve these objectives are set out at the end of this document.

A Brief Introduction to Business Action for Africa

5. Business Action for Africa is an international business network focused on utilising the core strengths of the private sector to support Africa's development. The network was created during the consultation phase of the Commission for Africa in 2005, and today has close to 200 members, including companies, business organisations, multilateral and bilateral donors, government departments, NGOs and academics. 80% of members are from the business sector, ranging from small businesses to large multinational corporations and from national chambers of commerce to international business organisations. Members have extensive knowledge of and a deep commitment to Africa.

6. Business Action for Africa works towards three objectives: to positively influence policies needed for growth and poverty reduction; to promote a more balanced view of Africa; and to develop and showcase good business practice. These objectives are pursued with action in a number of areas:

- collective advocacy, by mobilising a business voice for policies to end poverty;
- collective action, through catalysing business-led partnerships across Africa; and
- sharing good practice, by harnessing latest thinking and showcasing best practice.

7. Secretary of State Douglas Alexander remarked in March 2008 that "*Business Action for Africa . . . demonstrates the knowledge and the commitment that many businesses—from large multinational corporations to small businesses—have to the continent of Africa . . . And I pay tribute to its work—an example of exactly the kind of effort we will need to see more of from across the private sector, governments, civil society and faith groups if we are to meet the Millennium Development Goals by 2015".*[3]

8. The network's strategic direction and range of activities are determined by an Oversight Group, which consists of 10 multinational companies and four non-company members. Oversight Group members also sponsor the network's modest costs (membership is free for all other members). DFID has been a member of the Oversight Group since the inception of the network.

More information is available at www.businessactionforafrica.org.

Recognising the Role of the Private Sector

9. Selected members of Business Action for Africa have been engaging for some time with the UK government on the role of business in fighting HIV and AIDS. They contend that the private sector has accumulated a range of skills, resources and experience in various methods of intervention. There is a growing understanding of which policies are the most effective in reducing infection rates and ensuring access to treatment for all those who need it. Given the severe public resource constraints faced by the most heavily affected countries, it is crucial that ways be found of leveraging the private sector's strengths. These arguments were captured in a submission to DFID during the consultation phase on *Updating Taking Action*[4] *in August 2007.*

10. Business Action for Africa therefore welcomes the new strategy's acknowledgement that the private sector has an important role to play in helping achieve universal access.[5] Whilst the reference to the role of the private sector in the strategy document is cursory, it is underpinned by a longer description in the Evidence paper of the many ways in which the private sector is contributing to tackling the impacts of HIV and AIDS.[6] However, this section comes across as a list of "some good things the private sector is doing" without placing enough emphasis on the importance of finding ways to optimise this contribution. There is an urgent need to help ensure that more employers become effectively engaged in fighting HIV and AIDS in the workplace and beyond.

11. In September 2007, Business Action for Africa invited three MPs to South Africa to learn more about what companies are doing to help address the effects of HIV and AIDS. The MPs reported that they found a clear and unique role for the private sector due to its responsibility for the occupational health programmes for employees, its capacity in health systems and the social investment which it undertakes in the community.[7] The businesses showcased—in particular, SABMiller and Anglo-American—are having a

[3] "*Growth at the heart of development*"—Speech by Douglas Alexander, Secretary of State for International Development, on Monday 31 March 2008, at the Institute of Directors, London, available online at http://www.dfid.gov.uk/news/files/Speeches/alexander-growth-fulltext.asp

[4] Business Action for Africa (2007)a. Submission for DFID consultation on "Updating Taking Action—the UK's strategy for tackling AIDS in the developing world", available online at http://www.businessactionforafrica.org/documents/BAAHIVAIDSSubmissiontoDFID.pdf. A copy of the submission is attached for reference.

[5] DFID (2008)a. *Achieving Universal Access—the UK's strategy for halting and reversing the spread of HIV in the developing world*, Executive Summary p4, and Chapter 4 p55.

[6] DFID (2008)b. *Achieving Universal Access—evidence for action*, p86.

[7] Business Action for Africa (2007)b. *Business and HIV/AIDS: What have we learnt? Report on fact-finding trip to South Africa, September 2007*, available online at http://www.businessactionforafrica.org/documents/BAABusinessandHIVAIDS.pdf. A copy of the report is attached for reference.

strong positive impact through comprehensive prevention, treatment and care programmes that reach beyond their workplaces into the broader community. In addition, many pharmaceutical and medical research companies such as Merck, who also participated in the Business Action for Africa project, are playing a vital role through conducting leading-edge research and developing new medicines and vaccines; accelerating access to medicines, for example through their pricing policies; and engaging in public-private partnerships to help ensure sustainable improvements in healthcare delivery for people living with HIV and AIDS.

12. However, it became clear during the visit that these large companies are not representative or typical. Many others lack the resources, know-how or conviction to implement effective programmes. The MPs made a strong argument that good practice needs to be extended to more employers, in particular the small and medium-sized enterprises (SMEs) who employ such a large proportion of the workforce in a typical developing country. They pointed out that dynamic and pro-active business associations have a key role to play in facilitating the sharing and wider implementation of good practice through strategic partnerships.

13. In their report, the MPs therefore recommend that the government should encourage more companies in high-prevalence countries to adopt HIV/AIDS policies based on a human rights framework and to implement robust workplace intervention programmes. The report also recommends funding and supporting pro-active business associations that provide a platform for sharing good practice and initiate partnerships with key stakeholders. Business Action for Africa fully supports these recommendations.

Partnership

14. On partnership, there is recognition in DFID's new strategy that achieving universal access requires "deep, broad partnerships between national governments, international partners and civil society . . . as well as the private sector".[8] Business Action for Africa strongly endorses this approach. In many of the African countries most seriously affected by AIDS, government resources are insufficient to meet the enormous demands of dealing with the epidemic. If DFID is to realise its goal of achieving universal access, it will be crucial to ensure that it works efficiently with all its potential partners—and this includes the private sector.

15. However, in the experience of our members, partnership is often talked about but not usually pursued as actively as it could be. This was confirmed during the Business Action for Africa visit to South Africa in 2007. MPs reported a strong sense of a "missed opportunity" regarding partnership, with less evidence than had been expected of productive cooperation between the public and private sectors in fighting AIDS.

16. Disappointingly, DFID's new strategy makes no provision for active pursuit of partnerships and strategic collaboration with the private sector. This omission is in stark contrast with government's stated policy objective of working more closely with the private sector in scaling up efforts to reach the Millennium Development Goals. It is also out of step with the pro-active approaches of other donor organisations such as PEPFAR and GTZ who have committed vast resources to identifying and facilitating public-private partnerships. According to USAID:

> "There are certain activities whose successful implementation is central to the success of enterprises. They include marketing, recruiting, training, logistics, manufacturing, and policy and advocacy. Because these are core competencies in business, many companies have personnel who excel in these areas. With the right guidance and assistance, companies can apply their in-house expertise to enhancing the HIV/AIDS response—and they often do so in innovative ways. USAID partners with many companies on a broad range of initiatives".[9]

17. Many members of the Business Action for Africa network have been addressing the impacts of HIV and AIDS on their workforce for over a decade, in sub-Saharan Africa in particular but also in other regions where infection rates are now on the increase. They have invested substantial resources of time, money and expertise to finding ways to minimise the impact of AIDS on their workforce. They have a long planning horizon and a finite number of people that they are responsible for, and they are in a position to collect longer-term health data on their workforce. As a result, they can pioneer new strategies and test new techniques, and observe their results, with much greater speed and ease than government. They are keen for government to recognise this strategic advantage and to explore ways in which it could be optimised for the benefit of the rest of the population through innovative partnerships.

18. Businesses report that they still perceive a limited view in many quarters of the potential contribution that business could make to government's efforts. Companies expressed a strong desire to work more closely with government as a true strategic and delivery partner.

19. Business Action for Africa urges DFID to actively pursue closer cooperation with business in formulating and delivering policies for addressing HIV and AIDS in developing countries. DFID should look beyond traditional perceptions of business as providers of money for programmes and build relationships based on strategic partnership. Business could be called upon for strategic input into policy design, drawing on their experience from developing and implementing workplace programmes; find ways to leverage their health infrastructure; and utilise their management skills to help deliver services.

[8] DFID (2008)a. Ibid.

[9] For more information on PEPFAR's approach to public-private partnerships, see the brief at http://www.usaid.gov/our_work/global_health/aids/Partnerships/partnerships_brief.html

20. Part of the problem, as perceived by our members, is a lack of understanding on the part of DFID of precisely what the private sector could contribute to its own programmes, while businesses for their part do not always know how to access the right officials within DFID with ideas for partnering opportunities. It is vital that a conversation be started to address these obstacles to productive collaboration.

21. As a first step in addressing these issues, Business Action for Africa has offered to DFID to arrange a workshop with a number of HIV/AIDS practitioners selected from among our members, to create a platform for exchanging ideas and exploring opportunities.

22. In addition to collaborating with Business Action for Africa, DFID could also convene business leaders along with other organisations such as the Global Business Coalition on AIDS, tuberculosis and malaria (GBC) and the World Economic Forum's Global Health Initiative (GHI) with the goal of providing clear entry points for partnership within the DFID initiatives to maximize impact and effectiveness.

Recommendations

Business Action for Africa recommends that DFID:

23. Encourage more employers in developing countries to implement workplace programmes; and facilitate the implementation of such programmes for small and medium-sized enterprises (SMEs) or employers with limited resources, through direct support as well as support for proactive and well-run business associations.

24. Advocate internationally for the effective harnessing of private sector resources in the global fight against AIDS.

25. Urgently arrange a meeting with private sector representatives to discuss practical ways in which more strategic partnerships with the private sector can be promoted in the design and implementation of programmes covering prevention, access to treatment and care, provision and distribution of drugs and action to tackle stigma and discrimination.

26. Develop specific guidelines for DFID and for businesses on how partnerships could be pursued, at the departmental as well as country level.

Business Action for Africa
www.businessactionforafrica.org

1 October 2008

Memorandum submitted by Lucy Chesire, ACTION Project-Kenya

Introduction

This submission will attempt to address issues around TB/HIV co-infection, the strategies currently in place and the concerns around DFID's AIDS Strategy.

TB/HIV—Background Information

TB remains a major public health problem, although Africa is worst hit by both epidemics of TB and HIV. The deadly synergy between TB and HIV continues to cause havoc around the world. The World Health Organization realized this and declared TB a global emergency in 1993. Global targets and indicators have been developed within the framework of the Millennium Development goals, as well as by the Stop TB Partnership and the WHO World Health Assembly. The impacts are to halt and reverse TB incidence by 2015 and to halve prevalence and death rates by 2015 compared with the baseline of 1990.

The Stop TB Strategy spells out what countries need to do in addressing TB. This includes:

1. Pursuing high quality DOTS expansion and enhancement.
2. Addressing TB/HIV, MDR-TB and other challenges.
3. Contributing to Health System Strengthening.
4. Engaging all care providers.
5. Engaging people with TB and communities.
6. Enabling and promoting Research.

The Challenge

Recognising that we can't fight AIDS unless we do much more to fight TB, which has been rated as the leading cause of death among people living with HIV/AIDS. TB is a disease linked with poverty and thus the need to ensure that HIV in the contextual field means also being able to incorporate TB/HIV strategies into the country plans so that they have a coordinated response.

Scale of the Challenge remains Huge

- 1,500 die every day from TB in Africa, this amounts to 2.3 million TB deaths yearly around the world. Among the 9.2 million new TB cases in 2006, WHO estimates that around 709,000 were HIV positive. This estimate is based on the global estimates of HIV prevalence among the general population (all ages) published by the Joint United Nations Programme on HIV/AIDS(UNAIDS) and WHO in December 2007, as well as data on the relative risk of developing TB in HIV positive and HIV negative people.
- The African region accounts for 85% of the HIV positives cases in 2006. Countries like South Africa, has 0.7 of the world's population but accounts for 28% of the global number of HIV positive TB Cases and 33% of the HIV cases in the African Region. Kenya like South Africa has seen an increase in the number of MDR-TB infections over the years. The sad part is that we do not know the scale of Extensive Drug Resistant TB, as Kenya does not have the capacity to be able to detect this. African countries are seeing an increase with the emerging challenge of MDR-TB, which has resulted from non-adherence to DOTS treatment, poor treatment management and due to under investment in TB control efforts. The worse of it is, is that it is more expensive to treat MDR-TB as it takes two years treatment at a cost of 20,000 USD per patient. Countries need to implement the Stop TB Strategy, which outlines measures to be able to deal with all TB challenges. DFID has the potential to ensure support for such cost effective interventions.

Components of the Stop TB Strategy

The Stop TB Strategy was launched by the World Health Organization in 2006. It set out the interventions that need to be implemented to achieve the Millennium Development Goals and World Health Assembly targets.

The second component dwells on TB/HIV, MDR-TB and other challenges.

The goal of the TB/HIV collaborative activities is to be able to reduce the burden of TB and HIV in dually affected populations. Three objectives are well spelt out to include:

- Establish Mechanisms for collaboration between TB and HIV programmes.
- Decrease the burden of TB among people living with HIV.
- Decrease the burden of HIV among TB Patients.

Establishing Mechanisms for Collaboration

These include:

- TB/HIV coordinating bodies.
- HIV surveillance among TB patients.
- TB/HIV planning.
- TB/HIV monitoring and evaluation.

Decrease the Burden of TB among People living with HIV

The elements are commonly referred to as the 3 Is.

- Pursuing Intensified TB case finding among people living with HIV.
- Proving Isoniazid preventive therapy to PLWHA to reduce the burden of TB.
- TB infection control in care and congregate settings.

Decreasing the Burden of HIV among TB Patients

- HIV testing and counselling.
- HIV preventive methods.
- Cotrimoxazole preventive therapy.
- HIV/AIDS care and support.

— Antiretroviral therapy to TB patients.

Implementing TB/HIV activities is a sure way of ensuring that people living with HIV, stop dying from TB in an era where anti-retroviral therapy is becoming readily available to those who need it.

International Response

During the AIDS Conference 2008 held in Mexico, it was revealed that a mere 1% of people living with HIV around the world are being screened for TB. This is contrary to WHO targets that emphasize the need for all PLWHA to be screened for TB frequently and if found to be smear positive to be initiated on ART. The report further noted that of the more than one in every four PLWHA had TB.

HIV country programmes have not only been slow in responding to the dual epidemic, but donors have also turned a deaf ear to the synergy between the two diseases. The majority of HIV positives being initiated on ART are people living with HIV, classified by WHO as Category 3 and require ART. We are also further aware of the complexities around starting ART with TB treatment due to the interactions among Rifampicin and Nevirapine. This notwithstanding, there are regimens that can be used to address this. Internationally PEPFAR and the Global Fund to fight AIDS are the two leading donors in responding to the epidemic, but they have fallen short of screening all people living with HIV for TB, and even monitoring them on a frequent basis.

Countries are two years from the global targets set in order to be able to achieve universal access to HIV treatment care and prevention. At the progress being made, many countries will not be able to achieve this, as the upsurge of TB continues to undermine the progress made in the fight against HIV and AIDS. Civil society is thus calling for more action to address the dual epidemic in order to avert the unnecessy deaths caused by TB, an old disease that is curable, treatable and preventable. The emergence of multi-drug resistant TB among people living with HIV and AIDS in South Africa should be used as an opportunity to address the twin diseases.

DFID HIV/AIDS Strategy

DFID's AIDS strategy is more focused on strengthening health systems, which for many years have been down-graded due to donor conditionalities like the IMF policies on health, which were a necessary evil. Sadly with the launch of the New DFID strategy of 2008, HIV/AIDS has taken a back bench position, and this approach will have repercussions in the fight against HIV and TB in the coming years, considering that these are programmes that have yielded specific results. And saved many lives over the years. In 2007 DFID spent about 500 million pounds on Health, of which 130 millions pounds went into HIV/AIDS, however come 2008, the Health strategy does not have specific indicators and outcomes for Health Systems Strengthening and this becomes a major challenge in holding DFID to account on what it is planning on HSS.

The Stop TB strategy realizes health systems strengthening as one of its major elements and thus the need for countries to be able to operationalize and implement how through TB programmes they will be able to contribute to health systems strengthening. Recognizing the role that vertical and horizontal programmes play, it is thus very important that DFID ensures that Health system strengthening efforts do not in any way undermine the gains made in addressing both TB and HIV over the years.

Recommendations to DFID

1. There is a need for DFID to understand the number of lives saved through support to Vertical and Horizontal programmes and this becomes an opportunity, to recognize the role such programes play in the context of Health System strengthening.
2. Implementation of TB/HIV collaborative efforts is a sure way of addressing the emerging challenge of co-infection around the world. Efforts towards this should be highly supported by the donor community and DFID has an opportunity to provide leadership in this alongside PEPFARS initiatives.
3. DFID needs to evaluate its priorities on funding in order to be able to line up and complement Country Action Plans and emerging global challenges like Multi-drug resistant TB and XDR-TB.
4. DFID may highly consider other funding opportunities besides current support given to the Global Fund to fight AIDS, TB and Malaria.
5. 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 and E.
6. 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.

7. Lastly, coordination among country donor partners remains a major challenge in many countries. What role can DFID play in its Health strategy in fostering this, so that countries can move forward and work beyond ensuring health for all globally?

Memorandum submitted by the Consortium for Street Children

Introduction

1.1 The Consortium for Street Children (CSC) is the only worldwide network that works collectively to promote the rights and well-being of street children on a global scale. With the collective voice of over 55 organisations working internationally, CSC aims to end the discrimination and abuse that prevents street children from exercising the rights granted to them under the Convention on the Rights of the Child. CSC aims to make positive systematic and sustainable changes to the lives of street children across the world. Our main areas of focus are HIV/AIDS, Violence, Child Labour. Action oriented and committed to tackling the root causes behind the growing phenomenon of street children, CSC coordinates and supports its members to make a difference in these focus areas through its integrated programmes: Advocacy, Organisation Development, and Action Research.

1.2 CSC published *State of the World's Street Children: Violence* report last year, and is currently planning to research and publish *State of the World's Street Children: HIV/AIDS* report.

1.3 CSC's submission to the International Development Committee's enquiry focuses on the impact DfID's strategy will have on the most vulnerable children living and working on the streets, and supplements the UK Consortium on AIDS and International Development's submission, of which CSC is a member of their Children Affected By AIDS (CABA) working group.

Street Children

2.1 The term "street children" is hotly debated. Some say it is negative—that it labels and stigmatises children. Others say it gives them an identity and a sense of belonging. It can include a very wide range of children who are homeless; work on the streets but sleep at home; either do or do not have family contact; work in open-air markets; live on the streets with their families; live in day or night shelters; spend a lot of time in institutions (eg prison). The term "street children" is used because it is short and widely understood. However, we must acknowledge the problems and wherever possible we should ask the children what they think themselves. In reality, street children defy such convenient generalisations because each child is unique.

2.2 HIV/AIDS are creating many more street children, many of them left orphaned by the epidemic. An NGO in Cambodia has seen a 45% increase in the numbers of children arriving at their centre who stated HIV/AIDS as the reason for them being on the street. Once on the street the children are then themselves extremely vulnerable to HIV/AIDS.

2.3 Street children live transitory lifestyles, unsupervised by adults, and have little, if any, access to health, education or social services. As a result of their neglect, they are exposed to a great variety of diseases and abuses, including sexual abuse, prostitution and intravenous drug use, and are more likely to be sexually active at a younger age. Street children are unlikely to use testing, counselling or treatment services, as access often depends on consent from a parent or guardian, and a stable, supportive home life. Prevention services are often focused on adults and children living in relatively stable families. Other barriers to accessing health services include not having correct documentation, the experience of stigma and discrimination, lack of education, and the design of programmes. For example the Star of St. Petersburg, an NGO working with street children in Russia, reported that of 1,210 street children tested for HIV at their clinic in 2004–05 67.12% tested positive. All had sought help from Government run health clinics—all had been turned away due to lack of documentation and stigma. In 2005 Child Welfare Scheme, an NGO working in Nepal, carried out a survey of the knowledge, attitudes, practices and beliefs of HIV/AIDS among street-based children of Kathmandu and Pokhara. The survey concluded that the majority of these children had only very limited access to sexual and reproductive health education because of their unique circumstances.

2.4 Due to the complex and varied circumstances of children living and working on the street, it is very difficult to estimate the number of street children that exist worldwide. In 1989, UNICEF estimated that 100 million children were growing up on urban streets around the world, and in its 2005 report it stated that the figure runs into tens of millions across the world, but recognised the difficulty in quantifying the precise number. It further noted that it thought it likely that the number of street children was increasing. Despite the difficulties of estimating a precise figure, it is an undeniable fact that street children are particularly vulnerable group with complex characteristics and specific needs.

2.5 It is often assumed that street children's unique and complex needs will be met through programmes designed for "Orphans and Vulnerable Children" (OVC) and "Children Affected By AIDS" (CABA). Several of our members working in the field directly with street children affected by HIV/AIDS report this not to be the case. These terms very often mask the fact that children living or working on the street seem

catered for, when in fact they are chronically neglected. Care for OVC often evolves from home-based care programmes which by their very nature are poorly suited to reach children living and working on the streets. CSC is therefore challenging the notion that street children's needs are met by programmes designed for OVC and CABA. Street children require tailored programmes designed to meet their specific needs and unique characteristics.

CSC Recommendations

3.1 One of the priorities in DfID's new HIV/AIDS strategy is to spend £200 million to support social protection programmes over the next three years in eight African countries. The programmes are said to provide effective and predictable support for the most vulnerable households, including those with children affected by AIDS. CSC believes it is vital that a broad understanding of social protection is adopted and enforced, one which focuses not only on social transfers (cash, food etc) to vulnerable households, but also on a range of support services and policies that focus on family support, child protection, access to affordable health care and education—only then will the most overlooked and vulnerable children benefit. DfID's strategy does refer to this in passing, but it is CSC's conviction that a broad notion of social protection should play a fundamental part in the implementation of the strategy.

3.2 CSC therefore recommends that as part of its Monitoring and Evaluation DfID adopt the following indicators:

3.3 DfID Field Offices report annually on activities related to street children in particular, thereby avoiding the problem of the assumption that street children benefit from OVC and CABA programmes. However, it is crucial that in order for DfID's Field Offices to carry out this activity, DfID employees must be properly trained in street children and HIV/AIDS issues.

3.4 DfID undertake an evaluation of their eight country social protection programme in two to three years, which includes a thorough analysis of the impact of social protection programmes on vulnerable children, including street children.

3.5 In order to ensure that street children benefit from HIV/AIDS prevention and education services it is crucial that programmes are specifically designed to reach those children and young people out of school. CSC therefore recommends that DfID adopt an indicator which measures the number of national governments that have put in place national HIV prevention programmes for out of school youth in most or all districts in need.

3.6 Due to the problems of measuring the number of street children affected by HIV/AIDS, CSC recommends that DfID contracts a baseline study in five countries looking at what services and resources are already available to street children and identify key gaps and maps the prevalence of HIV among street children. CSC is ideally placed to carry out such a study.

3.7 It is CSC's conviction that, because of the issues mentioned above with regards to street children and HIV/AIDS, DfID must provide long-term funding and support to organisations working specifically to deliver HIV/AIDS prevention, health and education services to street children.

October 2008

Memorandum submitted by Interact Worldwide

1. *Interact Worldwide welcomes the opportunity to feed into the enquiry.*

We are a UK based NGO working in sexual and reproductive health and rights, HIV and AIDS with implementing partners in Ethiopia, India, Malawi, Nicaragua, Tanzania, Uganda, Pakistan. Our partners are engaged in efforts to scale up comprehensive and integrated response to sexual and reproductive health, including maternal health, and HIV services in low-level, concentrated and generalised AIDS epidemics.

2. *Interact Worldwide has concentrated its efforts in answering three questions set by the IDC on:*

- How HIV/AIDS interacts with other diseases, especially tuberculosis and malaria and how effectively this interaction is dealt with by donors and funds.
- The comparative effectiveness in tackling HIV/AIDS of vertical funds and funding allocated to broader health system strengthening.
- DFID's mechanisms for measuring the impact of its funding for health service strengthening.

RECOMMENDATIONS

— DFID should continue their leadership in the area of strengthening linkages between sexual and reproductive health and HIV and AIDS as one of its key comparative advantages.

— The UK should use its leadership on the UNITAID Board and the Reproductive Health Supply Coalition to promote availability of the female condom.

— The UK Government should ensure the full remit of PMTCT is considered in the commitment to expand access within the new AIDS Strategy, including those linkages to sexual and reproductive health and maternal responses.

3. *How HIV/AIDS interacts with other diseases, especially tuberculosis and malaria and how effectively this interaction is dealt with by donors and funds*

3.1 In order to respond to the question how HIV/AIDS interacts with other diseases, and how effectively this interaction is dealt with by donors and funds we must broaden the set of cohorts to include sexual and reproductive health and rights (SRHR). Causes of poor SRHR 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.

3.2 One of Interact Worldwide's three strategic aims is to promote responses, both within our global policy and advocacy work as well as in our international programs, to SRHR and HIV and AIDS that are integrated and linked so as to better meet the needs of poor, vulnerable and marginalised people. We endeavoured through our organizational submission to the DFID Consultation on Updating Taking Action the UK Strategy for Tackling AIDS in the Developing World (Annex 1) and interventions in two joint submissions through the UK Consortium on AIDS and International Development and the UK Sexual and Reproductive Health and Rights to assert the importance of DFID maintaining its strong commitment to strengthening linkages between sexual and reproductive health and HIV and AIDS. We recommended that **DFID continue leadership on this area as one of its key comparative advantages and to work with partners to promote a broader SHR-HIV integration agenda**.

3.3 The revised strategy[10] states as a Priority for Action: Supporting the integration of HIV and AIDS with TB, malaria and SRHR including maternal, newborn and child health services. The inclusion in the strategy of the commitment to "work with others to intensify international efforts to halve unmet demand for family planning (including male and female condoms) by 2010 to achieve Universal Access to family planning by 2015" is welcome as condoms are the only contraceptive method which provides dual protection against unintended pregnancy and STIs, including HIV.

3.4 **UK efforts to leverage greater availability of the female condom within DFID's leadership on the UNITAID Board and the Reproductive Health Supply Coalition to make a market impact would be strategic**. Currently the need for the female condom far outweighs supply given the average price of female condoms is currently up to 33 times more expensive than male condoms. As such not only is this commodity not prioritised on country procurement lists but it is also largely overlooked by other bilateral donors and UN technical agencies. Compliance with this commitment should be measured by significant UK donations in settings where there has been an uptake of female condoms in response to demand, and further promoting their use by assuring sustainability.

3.5 The commitment in the Strategy to: "work with others to intensify international efforts to increase to 80% by 2010 the percentage of HIV infected pregnant women who receive ARV treatments to reduce the risk of mother to child transmission, both in low income and high prevalence countries" seems not to consider the full scope of interactions between HIV and SRH and Maternal Health. According to the WHO comprehensive PMTCT also includes: delivery and post-partum care; HIV treatment for women, infants and their families as appropriate; SRH services, including family planning; and dual protection advice for women and their partners. Thus, **it is unclear if the strategy's commitment to promote PMTCT has considered fully this interaction and spectrum of services**.

3.6 In terms of how effectively interaction between HIV and SRH is dealt with by other donors, given that Interact Worldwide has been a leader in pursuing high level international advocacy on SRH-HIV integration especially towards the Global Fund to Fight AIDS, TB and Malaria for over two years, we have assessed that DFID should prioritise performance on this in their institutional strategies with UNAIDS, UNFPA and WHO which are all currently under renegotiation. These technical partners are committed to:[11]

— Advocate and support SRH and HIV linkages at the policy, systems and service levels since they are demonstrated to improve outcomes.

[10] Achieving Universal Access—The UK's strategy for halting and reversing the spread of HIV in the developing world. HM Government June 2008.

[11] Sexual & Reproductive Health and HIV Linkages: Evidence Review and Recommendations. WHO, UNFPA, IPPF, UNAIDS, UCSF (forthcoming).

— Develop, adopt, modify and strengthen relevant policies, HIV and SRH strategic plans and co-ordination mechanisms to foster effective linkages.

— Create a supportive policy environment to ensure the implementation of a collective human rights and gender-sensitive approach to SRH and HIV linkages.

— Advocate for additional funding of rigorous research to address important outcomes, such as health cost and stigma of integrated services as well as novel approaches to integration.

— Act on commitment made through regular assessments of national responses to SRH and HIV linkages.

4. *The comparative effectiveness in tackling HIV/AIDS of vertical funds and funding allocated to broader health system strengthening*

4.1 **The response to HIV and AIDS currently requires both horizontal and vertical approaches**. Responding to the substantial medical impact of HIV and AIDS, including expanding access to ART and ensuring adequate linkages to sexual and reproductive health services, has seen limited improvements in health system. It is now widely acknowledged that expanded support for health systems strengthening is essential to furthering the response to HIV and AIDS. Especially where services should be integrated into broader responses to SRH and other diseases broader health system strengthening is central to ensuring the ability of the health sector to achieve this. In this light, **the UK must maintain its commitment to the Global Fund until the impact of investment in health system strengthening pays off**.

4.2 To date vertical medical interventions have resulted in HIV services that are superior to general health services. This disparity must be addressed. However, we cannot allow for the standard of performance of these vertical interventions to be reduced to the level of basic health services. All services must be uplifted to the level of effective HIV interventions which have for example managed procurement and distribution of ART. This will only be achieved through broader health systems strengthening.

4.3 However, while horizontal responses are central to furthering the response there remains a place for vertical responses. HIV and AIDS is a societal emergency, as recognised by the International Red Cross, as such it has both drivers and impacts that are multi-sectoral. **Any response therefore must be multi-sectoral, as such a response that only focuses on health systems strengthening will not respond to the whole dynamic of HIV and AIDS**. In addition, civil society organisations are central to the provision of services in many hard to reach areas and with hard to reach and vulnerable groups of people. Without them high risk groups are often omitted from the response as they are unable to access to regular health services.

4.4While 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.

5. *DFID's mechanisms for measuring the impact of its funding for health service strengthening (HSS)*

Recommendations:

— DFID must ensure that the allocations of funding to health systems strengthening which allow for the response to HIV, SRH, maternal health is transparent and accountable.

— More resources are required for the UK to meet its fair share of ODA dedicated to ensure that the health MDG's are achieved.

5.1 The commitment in the Strategy for fighting AIDS in the developing world "Achieving Universal Access" to spend £6 billion on health systems and services up to 2015 will allow for DFID to meet a commitment to integration of HIV and AIDS services with SRHR including maternal, newborn and child health services. This will be a major step toward having a major impact on the overall strengthening of heath services worldwide, as it is understood that the provision of sufficient and adequate maternal, newborn and child health services reflects the health of the overall health system, as these services link from primary through to referral level services.

5.2 The main concern around how DFID will measure the impact of its funding for HSS is that the allocation of this funding has not been well articulated. Much of it may already be committed to multilateral financing processes, such as IDA replenishment. Parliamentary Under Secretary of State Gillian Merron stated at a public consultation on the strategy on 21 June that DFID will "fund what works". The development of indicators for monitoring and evaluation of the Strategy are currently being 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**.

5.3 As commitments are implied across HSS to impact specific cohorts of HIV it is important to consider the resources required to adequately fund these service areas. For example: best available estimates indicate that US$ 29.8 billion will be needed by 2010 rising to US$ 35.8 billion by 2015 globally to achieve universal

access to reproductive health services and the SRH related aspects of HIV prevention. Based on the UK's share of global income this equates to a UK fair share of £898.4 million in the budgeting period 2008–09 to2010–11 and £1,027.5 million between 2011–12 to 2013–14.[12]

5.4 Whether or not the spilt of the overall HSS commitment is fairly balanced it is unlikely that £6 billion will be adequate to achieve the goal of reaching 0.1% of ODA dedicated to health which the Commission on Macroeconomics and Health recommended was required to meet the health MDGs. **More resources are thus required for the UK to meet its fair share of health spending and to ensure that the health MDG's are achieved**.

Annex 1

SUBMISSION TO DFID CONSULTATION ON UPDATING TAKING ACTION THE UK STRATEGY FOR TACKLING AIDS IN THE DEVELOPING WORLD

August 2007

Interact Worldwide is a UK based NGO working in sexual and reproductive health and rights, HIV and AIDS with implementing partners in Ethiopia, India, Malawi, Nicaragua, Tanzania, Uganda, Pakistan. Our partners are engaged in efforts to scale up comprehensive and integrated response to sexual and reproductive health, including maternal health, and HIV services in low-level, concentrated and generalised AIDS epidemics.

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Interact Worldwide Partners providing content to the Submission:

Mekdim and the Ethiopian Muslim Relief and Development Association, Ethiopia; Lepra Society and collaborating partners including Aruna, Kalinga Network of Positive People, and Udyama, India; Uganda Protestant Medical Bureau, Uganda

Interact Worldwide county technical advisors in Ethiopia and India engaged in facilitation this consultation process.

1. *What is the UK's comparative advantage in changing the course of the AIDS epidemics?*

What is UK's comparative advantage in relation to the other big donors in AIDS

The UK's commitment to poverty reduction and improving global health demonstrated by its intention to scale up development financing and recommit itself, and other major donors, to achieving the health Millennium Development Goals provides comparative advantage amongst major donors in efforts to tackle AIDS in the developing world. The UK Government has provided significant leadership[13] to highlight the need for scaling up basic HIV services and intends to continue to support[14] developing countries to achieve Universal Access to comprehensive HIV services by 2010.

At national level DFID has demonstrated comparative advantage technically in health systems strengthening and sexual and reproductive health as well as a long standing commitment health sector financing.

As the second largest bilateral donor on HIV and AIDS the UK has demonstrated comparative advantage in pursuing evidence based approaches to dealing with the underlying issues of the spread of HIV infection, with particular attention to respect of human rights and acknowledgement of harmful gender norms. This places them in contrast to the current US administration which sponsors the largest bilateral programme to combat AIDS but imposes policy conditionality on developing countries which are based on religious fundamentalism and are neither culturally relevant, scientifically sound or in respect of rights to sexual and reproductive choice.

The UK has demonstrated leadership in Europe and has ensured that European development Ministers committed to supporting comprehensive evidence-based approach to HIV prevention.[15] The UK is well placed to ensure that EU member states set the bar high for provide their fair share to fully finance the resources required to provide comprehensive services for HIV and AIDS in the developing world. It is crucial for the UK to ensure that European Commission funding to combat HIV and AIDS, especially to

[12] Countdown 2015 Europe (2008) Strategic Options to Ensure Greater European Investment in Reproductive Health Supplies, 2nd Edition.
[13] Labour Party Election Manifesto 2005, G8 2005 Gleneagles Communique, World Summit Outcome 2005.
[14] Gleneagles Implementation Plan for cross Whitehall action, White Paper on International Development DFID 2006, Working Together for Better Health DFID 2007.
[15] 2005 European Union Statement on HIV Prevention.

meet their share of funding for the Global Fund to Fight AIDS, TB and Malaria, are additional as there are concerns that funds committed for sexual and reproductive health and other development priorities have been appropriated for HIV and AIDS resource needs.

In the Indian context DFID's comparative advantage has been the predominant role in funding the HIV and AIDS programme, of states including Orissa, West Bengal, Gujarat, Kerala and Andhra Pradesh. These states have taken advantage of the technical support unit established by DFID (RCSHA) and have had an advantage as the Programme Support Units were established within the state. DFID is compared favourably to other donors who have not supported performance in states individually but have focused on supporting the Central Indian Government.

Partners in Ethiopia remark that the UK has also been working on addressing the root causes of the epidemic, including poverty, lack of access to education, weak health systems, gender inequity, and violence. They find this holistic is the best way to secure concrete results for people living with HIV and AIDS and at risk of HIV infection over time.

From a Ugandan perspective it is clear that partners appreciate the leadership the UK has taken to influence decisions in the EU and the UN regarding programming and resource mobilization. They hope that the UK will continue to play a role at the international level on pursuing more harmonised approaches by donors on funding policies and priorities.

How can the UK work most effectively to ensure the involvement of major Foundations (eg the Bill and Melinda Gates Foundation, the Clinton Foundation HIV/AIDS initiative)?

The foundations involved in global health and HIV and AIDS are important allies for the UK government, especially US based foundations which are not beholden to US administration policy conditionality. There is however growing concern that the work of Foundations can exacerbate problems of health system coordination at national level. When foundations donate through financing mechanisms, eg the Global Fund to Fight AIDS, TB and Malaria, then they are more beholden to agreed governance processes. These donors should be encouraged to increase efforts at national harmonisation of funding by providing resources directly through fund health SWAps and providing support to national AIDS councils to implement national AIDS plans.

Our partners in India note that the Foundations have been choosing partners to support based on their own benchmarks and feel there is greater need for Foundations to involve major donors to avoid replication but also to develop a strong consortium based approach in States where there civil society organizations require greater capacity. For example, money has been given to Catholic Relief Services in Orissa for Orphans and vulnerable children infected and affected by AIDS by the Clinton Foundation, however CRS does not have many civil society partners, only diocese partners. Here it would have been more effective if there was some mechanism amongst the donor agencies and the Foundations to understand where resources should be put, who are the best stakeholders who should facilitate spending.

How can the UK best influence the global and country progress to integrate sexual and reproductive health and rights (SRHR) within the AIDS response?

DFID's strong commitment to strengthening linkages for sexual and reproductive health and HIV and AIDS (SRH/HIV) integration is regarded as one of its key comparative advantages. Interact Worldwide appreciated that there was a consistent and wide ranging focus on reflecting on opportunities for UK leadership on SRH/HIV integration in the Consultation document. It would be highly useful if as part of the process of updating the AIDS strategy, DFID re-developed its SRHR position paper to reflect their Health Resource Center technical guidance and reflect on opportunities and constraints faced in operationalising this approach.

DFID should continue to work with partners to promote a broader integration agenda. Countries need to want and to be in a position to implement integrated services such as; antenatal care that includes HIV testing, antiretroviral treatment for women and for PMTCT; delivery practices that take HIV into account; support for choice in infant feeding including ART to make breastfeeding safe; appropriate SRH services for HIV positive women.

Southern practitioners are clear that their clients want single points of access for a range of services wherever possible.[16] There is also a gap around integrated strategic health communications in relation to sexuality, sexual behaviour and sexual health. Additionally, integrated services for adolescents and older children must begin with comprehensive sexuality education in schools and be grounded in referral systems which allow them access to appropriate services.

[16] A discussion on http://www.aidsportal.org/Messages.aspx?ID=45 focused on "how the UK can best influence global and country progress to integrate sexual and reproductive health and rights with in the AIDS response".

Our partners in India note that SRH integration only appears in policy documents but is not operationalised at grassroots. They call on the UK to facilitate in developing and building the capacity of national policy makers in order to integrate SRH within the AIDS response and ensure it is implemented. Ugandan partners call for DFID support for integrated youth friendly SRH services is both clinical and community based health services.

DFID has been very supportive of initiatives to enhance support integrated SRH/HIV services in proposals funded by the Global Fund. These efforts may ultimately make an important contribution to address structural and policy barriers to enhancing integrated programmes. DFID should continue and expand its support through its role on the Board of the Global Fund. Within and in addition to its current efforts to define the Fund's role in strengthening health systems, the Board should be explicit in its support for integration by approving guidelines that include SRH/HIV integration and outline the funding opportunities for SRH/HIV integration and for reproductive health supplies. The UK delegation to the Board will be key in working with the Fund to create a more enabling environment to demonstrate greater commitment to gender and enhancing service access by women and girls.

DFID should incentivise the enabling environment for broader integration agenda by urging expansion of integrated programming by the World Bank. The Bank states in its Health Nutrition and Population Strategy that it aims to, "strengthen its capacity to support country efforts to improve health systems integration and reduce fragmentation . . . ultimately, the choice of a path to transition toward health system integration is the country's decision".[17] The World Bank does not specifically address the role it might play in ensuring SRH/HIV service integration in country programmes.

The national development policy frameworks the World Bank requires countries to develop inadequately address SRH/HIV integration. Poverty reduction strategies rarely provide analysis of links between poverty, development, population, HIV and AIDS, or address linkages between SRH and HIV in the health section. DFID should therefore advocate with Governments for the mainstreaming of SRH and HIV into Poverty Reduction Strategy Papers and advocate for the World Bank to invest in research that demonstrates the benefits, including cost, of integrated approaches to SRH and HIV.

DFID also has an important role to play in closely monitoring the role of the World Bank in pursuing macro-system integration in a way that does not disable effective approaches to provision of SRH and HIV services. Additionally given the UK's own policy to end the support of user fees they must do more to work with Multilateral and national partners to combat the promotion of user fees/private sector provision of health services. DFID must work to confront issues of exclusion based on vulnerability and gender that underpin the poor health of poor people.

2. *How can the UK best support the scale up to universal access to comprehensive HIV prevention programmes, treatment, care and support by 2010?*

The UK Government was instrumental in gaining global commitment to Universal Access. Determined and continuing leadership from the UK is required to deliver on it, working with their partners in national government, other donors and the international community. DFID's focus on strengthening health systems is vital to achieve Universal Access to HIV and AIDS prevention, treatment, care and support by 2010.

Partners in Ethiopia and Uganda note that the amount of monetary support from the UK to different development partners in Africa is encouraging. But as the problems are deep rooted inside the community, the need for scaling up financing is acute and the UK ought to have a policy of guide lines of increasing monetary support as epidemics spread.

They call on DFID for greater support to:

- Allow developing countries access to affordable HIV and AIDS medicines.
- Provide support to countries to implement an appropriate regulatory framework for the promotion of access to medicines.
- Fund clinical management, antiretroviral therapy (ART) follow up and nutritional support for those who are enrolled on ART.
- Enlisting greater political support in PSA countries by ensuring national plans for the response to HIV and AIDS are comprehensive and fully financed.
- Ensuring that implementing bodies (including civil society organisations) reduce fragmentation and duplication of efforts.
- Encourage adequate and sustainable mechanisms for SWAps.
- Recognition of and involvement of civil society and non-governmental services providers.

Our partners in India argue that providing services through the health system is important but due to stigma and discrimination and lack of quality services client's access to services are limited. For instance, in Orissa state there is one ART centre catering to thirty districts which even in a low prevalence setting is

[17] World Bank (2007). *Healthy Development. The World Bank Strategy for Health, Nutrition and Population Results*, Washington DC, World Bank, p 50.

inadequate for existing clients from remote villages who can not avail services without transportation and mobility facilities. As the epidemic in Orissa is growing, mainly due to migration for livelihood opportunities, partners recommend that DFID integrate programme funding to ensure that livelihood programmes address HIV and AIDS issues including stigma and discrimination.

3. *How can the UK work within the international system to improve the overall response to AIDS?*

What role on AIDS, including integration of sexual and reproductive health and rights (SRHR), should the UK seek for the Global Fund, World Bank, UN, EC and Foundations working on AIDS in different epidemics and fragile states?

DFID should continue its support for SRH/HIV integration efforts within the Global Fund. This approach has the potential to make a very meaningful contribution to addressing structural and policy barriers to enhancing integrated programmes. **Countries have identified the need for increased funding for integration through the Fund and he Global Fund indicated that SRH integration would be supported if the impact on HIV can be clearly demonstrated**. As such SRH commodities could be funded and proposals that include planned and costed technical support and capacity building could be considered. Furthermore, if CCMs do not have the capacity to undertake integration, they can request funds through their proposals to the Global Fund to strengthen their capacity in this regard.[18] DFID as a participant of the Advocacy Summit[19] was very supportive of this initiative.

It is important to highlight that countries have identified the need for increased funding for SRH/HIV integration through the Global Fund. At the country level, DFID can play a stimulating demand for SRH/HIV integration among stakeholders of the country coordinated proposals. By building the capacity of civil society to engage with Global Fund processes at the national level, DFID can support CCMs in becoming fully representational of stakeholders at the national level, including SRH organisations, which can allow for greater expertise on integration and potential allow for more effective referral mechanisms within Global Fund funded programmes.

The "One UN" framework which is being piloted in selected countries provides an opportunity for increased engagement of DFID in processes that support SRH/HIV integration at national level. "One UN" aims to achieve faster and more effective development operations by UN technical agencies and accelerate progress toward the Millennium Development Goals (MDGs) by establishing a consolidated UN presence with one programme and one budgetary framework. SRH and HIV and AIDS, included under MDG5 and MDG6 respectively, should be key components of a coordinated approach that strengthens possibilities for future integration as part of a broader development framework. Other efforts to increase harmonisation of the AIDS response such as the (expanded) joint UN country teams on AIDS, also provide an important opportunity for the integration of SRH and HIV and AIDS within the broader framework of ensuring improved and more coherent programmes.

5. *How can the UK support stronger and more effective engagement by civil society, particularly networks of People Living with HIV and AIDS, and vulnerable groups (women, adolescents, males who have sex with males, sex workers, injecting drug users, and prisoners) in the global response to AIDS?*

DFID could do more to support networks of people living with HIV and AIDS and should increase funding to these groups through the Civil Society Challenge Fund and the new Governance and Transparency Fund as well as other means, although these are difficult to access. DFID needs to exploit its comparative advantage in harmonised and aligned health financing to more effectively co-opt non state actors into national health plans and HIV responses. Examples where DFID has already begun this include the PMO initiative in support of NACO in India and the HAPAC initiative in Kenya. These approaches need to be significantly scaled up.

The funding currently provided directly to southern based networks is currently fairly modest and it is important to recognise the role that these networks can play in terms of advocating for their rights, reducing stigma and discrimination and providing care and support services. DFID needs to use their influence to encourage government to invest in creating greater competency among non state actors in budget monitoring and overall accountability for delivery against HIV and health targets.

The effectiveness of networks of people living with HIV and AIDS in advocating at the national level is limited by lack of capacity including funding for core costs. Partners in Uganda and Ethiopia concur that broad based civil society capacity building must be undertaken to support network organizations to develop, contribute and implement effective AIDS policies and programmes.

[18] Interact Worldwide, Global AIDS Alliance, Population Action International, the International HIV/AIDS Alliance, IPPF, and Advocates for Youth (2007). *Guidelines for Integrating Sexual and Reproductive Health into the HIV/AIDS Component of Country Coordinated Proposals to be submitted to the Global Fund to Fight AIDS, TB and Malaria Round 7 and Beyond.*

[19] Interact Worldwide co-coordinated Advocacy Summit on Global Round 7:Integrating Sexual and Reproductive Health within the HIV and malaria components of country coordinated proposals, Geneva, Switzerland.

In efforts to support vulnerable groups, partners in Africa recommended a greater focus on overall social and economic vulnerability with efforts to identify alternative income generating activities for the vulnerable segments of the community and programmed for the empowerment of youth with skills, information, knowledge, exposure and opportunities to lead and to be heard within responses to improve SRH and combat HIV and AIDS.

Our partners in India find that more must be done to ensure that government at Central, State and local level need to have of people living with HIV and AIDS part of decision-making processes in AIDS strategies. They call for DFID, and other donors, to conduct and audit to determine how many Government Departments have a written HIV and AIDS policy and assess how many people living with HIV and AIDS have been hired by Government to render services.

In sub-Saharan Africa, the recognition of Faith Based Organisations as a critical player in clinical and community based health service delivery (up to 60% in some countries) will continue to be critical. Partnerships between Governments and this sector or between DFID and this sector if HIV and AIDS is to be seriously combated in these countries. This sector has comparative strengths such as credibility with communities, authority to speak and inform communities about prevention strategies and have the strength of being viewed as having compassion for clients.

6. *What should the UK do to ensure the needs of children affected by AIDS are met?*

Our partners in India find that much more must be done by civil society organizations to fill the gap left by the state. They note that there is a lack of professionals in Orissa trained to provide services to Children Affected by AIDS. They note that government is the biggest stumbling block to provide SRHR and AIDS education and that DFID should ensure that government not "play politics" with SRHR and AIDS education but provide civil society with resources to ensure success of SRHR and AIDS education.

Ethiopia and Uganda call for DFID to oversee significant progress to:

- Increase funding and support for treatment and research into paediatric HIV and support PMTCT scale up.
- Address low uptake of ANC services and address social barriers including stigma, discrimination and gender based violence to PMTCT.
- Support legislation for the protection of the rights of orphans, widows and other caretakers such as grand parents.
- Delivering and encourage and supporting community based organisations and faith based organisations to deliver sustained care and support activities including home based care, food and nutrition, medical access and psychological support.
- Support/assist organizations and the government working on children living with HIV/AIDS develop.
- Support countries to develop and implement national plans of action for the care and protection of children affected.

7. *How can the UK best contribute to addressing AIDS related stigma and discrimination?*

Within a health systems strengthening approach the provision of integrated services, whether situating HIV services within SRH services or situating both within basic health services, can combat the stigma associated with access to stand alone HIV services. Such integration efforts must maintain best practice in HIV components. It is also important to ensure that discrimination is not tolerated among health workers. Additionally gender-sensitive training of health workers should be prioritized for those conducting SRH or HIV and AIDS services.

Our partners in India were not clear that DFID has already made combating AIDS related stigma and discrimination a priority. In Orissa they have the impression is that DFID support to date has been towards strengthening of service delivery and Targeted Intervention Programme. Stigma and discrimination cases in Orissa are rampant and have been also reported. In this low prevalence setting HIV positive people have been ostracized and in some cases murdered. State government has often termed the cause of abuse as a problem over property dispute. Our partners are dismayed that even women's commission and human rights organisations have not condemned these cases.

They recommended that DFID support civil society organizations to be able to track cases of HIV stigma based murders and build up consortium to pressurize government to protect the rights of the poor. They call for more money should be directed through NGOs, and PLHA organizations to conduct programmes against stigma and discrimination as the government is not sufficiently sensitised.

Our partners in Ethiopia argued that greater capacity for basic services for can also combat stigma. They recommended that people living with HIV and AIDS have sufficient training and emotional support to live positively and openly among the community. This in turn can help on increased uptake of testing if there is more support for countries to open voluntary counselling and testing centre which are youth friendly.

They also call for DFID to support trainings like "community conversations" and other efforts at social mobilization to raise awareness of the rights of people living with HIV and AIDS.

DFID must support civil society organisations that are lobbying for legislative reform. National legislation that criminalizes behaviours such as sex between males, injection drug use and sex work, is the ultimate barrier to these groups accessing prevention services and can also dramatically impact work that civil society organisations (CSOs) endeavour to undertake in support of vulnerable groups. DFID should both fund and advocate for CSOs working to create an enabling environment for reducing stigma and discrimination. In Uganda, our partner recommended DFID support the implementation of national policy and legislation to protect the rights of workers living with HIV.

8. *What approaches should the UK promote for HIV prevention? Including the social factors that drive the epidemic, particularly amongst women and girls*

DFID has and should continue to provide a counter-balance to limited interpretations of prevention programming. The UK government should do the following to ensure a comprehensive, evidence-based approach to HIV prevention:

- Fund governments, multilateral institutions and programmes that demonstrate a comprehensive, gender-sensitive and evidence-based approach to HIV prevention.
- Prioritise funding for HIV prevention programmes that target vulnerable groups which may not receive funding due to other donor's restrictions.
- Fund health system strengthening to ensure that quality, comprehensive HIV prevention services and commodities are widely available within integrated HIV and AIDS and SRH services.
- Support capacity building of civil society to address rights violations in-country that have an impact on evidence based prevention methods eg legislation which criminalises homosexuality; legislation which bans the sale or promotion of condoms to minors, legislation that criminalises injection drug use and makes needle exchanges or harm reduction programmes illegal.
- Support comprehensive sexual and reproductive health education and programmes that foster the development of communication skills for young women and girls and channel resources accordingly. This must go beyond comprehensive, evidence-based information about HIV and AIDS to include sexuality education which introduced skills around negotiation and equality within sexual relationships, insisting the right to consent and the illegality of physical and sexual violence and coercion.[20]
- Partners in Ethiopia and Uganda call for enhancing the involvement of girls and women in community based development initiatives, including income generation schemes, as part of overall empowerment efforts.

Data from family planning programmes have shown increasing number of prevention options increases the number of people who choose to use at least one of those options. People deserve more choices in HIV prevention. The UK has demonstrated global leadership in supporting the research and development of new prevention technologies in order to expand the range of HIV prevention options.

As part of its long-term investment in HIV prevention strategies, the UK needs to continue supporting research and development until safe, effective and affordable microbicides and vaccines are found. As these technologies are still in development a focus on the immediate commodities gaps to address prevention needs are crucial. DFID must continue to be a major funder of condoms and fight increasing mythology about the inefficacy of condoms which have been exacerbated by policy conditionality of other major bilateral donors.

9. *How can the UK support efforts to ensure that the response to AIDS strengthens national health services and the delivery of basic services?*

Well functioning public health systems are essential to achieve and sustain the health MDG's as well as universal access to HIV and AIDS prevention, treatment, care and support by 2010. Health systems in developing countries have been severely under funded for decades and clearly need significant re-investment over the long term. Programmes providing HIV and AIDS services have potential to exert a positive impact on wider health systems strengthening. Thus health system impacts should form part of appraisal of HIV and AIDS interventions.

Opportunities in regard to this include the following:

- PMTCT(+) as an opportunity for improving access and quality of expanded maternal and child health services.
- Access to ART, which requires greater investment in strengthening drug procurement, supply and management systems.

[20] International Women's Health Coalition, 2006, "Realizing the Reproductive Health Rights and Needs of People Living with HIV & AIDS". A panel at the XVI International AIDS Conference, Toronto, Canada, 2006.

— Integrating SRH and HIV services to increase access, especially for women and adolescents.

DFID should lead on delivering funding support for 10 year national health plans in PSA countries and should increase bilateral budget support to the health sector, particularly through SWAps, in order to resource health systems strengthening. Partners in Ethiopia echoed a call for supporting longer-term financing commitments for national health plans through different aid instruments.

Inadequate numbers of health workers are a major constraint to the rapid scaling up of the health system required to effectively meet the challenge of HIV and AIDS. The critical shortage of health workers in regions of the world worst affected by HIV and AIDS has undermined possibilities of scaling-up to ensure comprehensive HIV and AIDS services and has placed additional burdens on already undersized and overburdened workforces providing all health services.

DFID should facilitate the immediate and longer-term financing of human resources as a health systems investment and ensure that low public expenditure is not the primary constraint to workforce expansion. They should work with developing country governments and civil society organizations to address the fundamental reasons for health worker migration and as a partner in Ethiopia pointed out support capacity building of health workers. DFID should invest in short term plans for increased salaries and improved working conditions for health workers, building upon the support it has provided in Malawi.

As the second largest investor in the World Bank, the UK should work to ensure that programmes funded by the Bank going forward overcome concerns with regard its record in health, commitment to sexual and reproductive health, support of fiscal conservatism and the promotion of user fees/private sector provision of health services. DFID should also use its leverage on the World Bank board to encourage greater monitoring of World Bank programming and ensure their self appointed role in leading on health systems strengthening efforts is well harmonised with other financing instruments for global health.

How should the UK take action—at national and international level—to ensure AIDS and SRHR services are integrated into the delivery of basic services?

DFID has provided leadership on a growing evidence base which emphasises integration of SRH as being critical to the effectiveness of responses to HIV and AIDS, and the success of HIV and AIDS programmes. They have recognised that it can be confusing, costly and time consuming for people to visit different facilities for HIV, STI and other SRH information and care.

DFID's Health Strategy argues that global health initiatives should also support strengthening of health systems that deliver health services more broadly and cites SRH and HIV and AIDS services as key. DFID could take action to strengthen the evidence base and use its influence to ensure adequate proportional investment in HIV and broader SRH services within the overall essential service mix. It is hoped that integrated delivery of a comprehensive package of care can reduce the costs of both accessing and providing services; improve client knowledge, confidence and satisfaction; and ensure better service quality.

There have been significant barriers to applying this principle within national-level SRH and HIV programmes no less within the current state of health systems providing basic health services. They remain independently designed, administered, funded, and supported by different technical agencies, and are often managed through decentralised integrated administrative systems at the regional provincial and/or district levels. Several departments or administrative entities need to be involved in planning and organising integrated services, and collaboration between these different actors is often inadequate.

DFID is a key supporter of the Partnership for Maternal Newborn and Child Health which is promoting a "continuum of care" model. This approach would require increased funding for care for mothers and children from pregnancy to delivery, the immediate postnatal period, and childhood, recognising that safe childbirth is critical to the health of both the woman and the newborn child.

DFID staff implementing its Health Strategy, Maternal Health Strategy, Sexual and Reproductive Health and Rights position paper along side the AIDS strategy must continue to advocate with Ministries of Health and other relevant Ministries for the coordinated and harmonised management of SRH and HIV programmes and look for opportunities wherein these can be provided within a strengthened health system.

DFID's support to health sector-wide processes represents a major opportunity for developing comprehensive health sector responses to SRH and HIV in order to fulfil the commitment to universal access to comprehensive AIDS services by 2010 and universal access to reproductive health by 2015. Sector strategies provide opportunities for stronger strategic and operational integration between various Ministry of Health programmes and coordinated efforts to strengthen policies, human resources, procurement, infrastructure and services.

At the international level, United Nations technical agencies can promote and advocate for integrated programming and services. The proposed "One UN" framework could provide an opportunity for increased engagement of DFID in processes that support integration at national level. UN technical agencies should ensure faster and more effective development operations and accelerate progress by establishing a consolidated UN presence, which will have one programme and one budgetary framework.

While the UK pursues these efforts at UN reform, the UNAIDS Secretariat can ensure that information on SRH integration is provided to UNAIDS Country Coordinators (UCC) and on to the United Nations Theme Group. Additionally DFID should continue to support efforts for better service integration being lead by UNFPA to influence progress to integrate SRHR within the AIDS response by supporting ongoing efforts to improve effectiveness and coherence of programmes and policies. Where these agencies do not take up the approach, DFID should continue to work to get this information out to other partners in-country.

DFID should urge for the potential expansion of this approach by the World Bank which states in its Health Nutrition and Population Strategy that it aims to, "strengthen its capacity to support country efforts to improve health systems integration and reduce fragmentation…ultimately, the choice of a path to transition toward health system integration is the country's decision". The Bank does not specifically address the role it might play in incentivising SRH-HIV service integration.

The national development policy frameworks the Bank requires countries to develop inadequately address SRH-HIV integration. Poverty reduction strategies rarely provide analysis of links between poverty, development, population dynamics, HIV/AIDS, or address linkages between SRH and HIV in the health section. DFID should advocate with Governments for the mainstreaming of these issues into Poverty Reduction Strategy Papers.

One of our partners in Uganda added that programs should have health system strengthening and integration component with community based models that have been proven successful in order to qualify for funding. DFID should support operational research to determine models and best practices for integration and address the lack of integration of HIV and SRHR (but mainly HIV), which has aggravated existing human resource deficits. They added that currently there is too much parallelism, whereas HIV services should be routine and integrated into existing health services.

It has been noted by African partners that enhanced management and leadership capacity in the health sector is the catalyst required to help these countries achieve the MDGs and national HIV and AIDS targets. The emphasis so far has been on in-service technical and clinical training and development of what one partner called "more and more guidelines". Focusing on improving the governance of both state and civil society institutions must be addressed to ensure the response to the AIDS pandemic and general health systems management is enhanced.

Memorandum submitted by the International HIV/AIDS Alliance

1. Executive Summary

1. The International HIV/AIDS Alliance (the Alliance) has been working alongside ODA and then DFID since it was established in 1993. From its inception, the Alliance has worked to ensure that the experiences and expertise of our partner organisations and their communities are heard by policy makers. The Alliance supports a wide range of HIV and AIDS work in more than 40 counties globally and our work covers all contexts of the epidemic as classified by UNAIDS.

We will focus on five areas in this written submission:

- The involvement of civil society in implementing the strategy;
- Financing "Achieving Universal Access";
- The extent to which DFID's Strategy will be effective in tackling the disproportionate impact of HIV/AIDS on women and children;
- To what extent does the new AIDS strategy address the issues raised in the Committees previous reports on Marginalised Groups?
- Monitoring systems and measuring impact.

2. We welcome this new strategy and the emphasis it places on achieving universal access and view this IDC Hearing as an important moment to review the strategy and give us confidence that HMG will play a significant role in removing barriers to universal access and supporting other governments, multi-laterals and civil society to do the same.

3. In the current political environment, where AIDS is perceived to be over-funded and there is an impetus to increase AIDS funding through budget support mechanisms, this is an important moment to challenge some of these assumptions and take stock of any evidence there is to ensure that the UK governments strategy is based on sound evidence and listening to the voices of those most affected.

4. The strategy misses an important opportunity to clarify how DFID will ensure the full participation of civil society in global response. To close the gap between commitments and reality, DFID must support national governments to develop processes that allow for meaningful engagement with civil society. These include developing processes and frameworks with civil society for how national governments and civil society can form effective partnerships.

5. There is a lack of robust information about the effectiveness of budget support for funding civil society responses, As such there is an inherent tension in the strategy between the frequently stated recognition of the importance of civil society and the choice to prioritise a funding mechanism which, without significant and rarely achieved reform to planning and funding process, is likely to reduce civil society's ability to participate.

6. We warmly welcome the role of the FCO to work with national governments to advocate for the human rights of marginalised groups. We see the recent policy advice on LGBT populations as evidence of progress, but would like clarity of the current structure and resources in FCO to deliver on this important role. In 2006 the Committee raised a concern that the FCO does not have a specific desk or unit to deal with HIV/AIDS issues.

2. Recommendations for and Challenges in the New Strategy

The involvement of civil society in implementing the strategy

DFID must support national governments to develop processes that allow for meaningful engagement with civil society. This includes facilitating and financing the development of processes and frameworks, so that more robust partnerships are developed and supported across health systems and the HIV/AIDS response.

Financing "Achieving Universal Access"

Given there is little evidence about the impact of budget support on HIV/AIDS programmes, it is imperative that this information is developed. This is a role that DFID should take on if it wants to be confident that the work it is committed to in the strategy is funded and for furthering our global knowledge about how best to fund HIV/AIDS programming.

We welcome DFID's ongoing support for the work of the Global Fund, who in our experience is critical for ensuring the participation and funding of civil society at all levels of the AIDS response, and ask the UK government to commit to a minimum three year pledge of £703 million for the three year period.

The impact of vertical funds on broader health system strengthening

There are numerous examples within the Alliance network of the HIV and AIDS response contributing substantially to building strong health systems, especially where civil society has been involved. Therefore we recommend that DFID continues to allocate significant resources to HIV/AIDS programmes as part of its health system strengthening strategy.

The emphasis in the strategy on health system strengthening is therefore a concern in that there is no financial target for spending on HIV/AIDS, so we will not know how much of UK government funds will be spent on HIV/AIDS programmes.

The extent to which DFID's Strategy will be effective in tackling the disproportionate impact of HIV/AIDS on women and children

Addressing issues of women's income, or of domestic violence and women's autonomy in sexual decision making, requires the broadest approach to sexual and reproductive health. As such, the same concerns we hold in relation to key populations within concentrated epidemics apply to the impacts of the proposed DfID approach on women and children in generalised epidemics. Within concentrated epidemics, the violence directed towards sex workers, the increased vulnerability of female injecting drug users and female partners of male injecting drug users are all examples of challenges which general budget support is highly unlikely to have any impact on.

To what extent does the new AIDS strategy address the issues raised in the Committees previous reports on Marginalised Groups?

The strategy doesn't include recent evidence on the significance of working with MSM populations and so doesn't give enough attention to the specific needs of this population.

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. We ask the UK government to reconsider its position in relation to MICs.

We believe there should be a wider application of the principle of the involvement of marginalised groups at all levels of HIV/AIDS policy and programming work and that DFID should reflect this value through ensuring this happens in its own processes; and advocate for participation and more transparent processes across other parts of Whitehall.

Monitoring systems and measuring impact

What is DIFD doing to guarantee that the funding given to national governments will be used according to the priorities set out in Achieving Universal Access? This includes what statistics, data and monitoring information will they be assessing before committing to budget support?

The financial target for strengthening health systems and services does not indicate how much will be spent on HIV/AIDS programmes and so it will be difficult to hold DIFD to account for HMG's contribution towards financing the global AIDS response.

The Alliance questions whether civil society is involved in the National AIDS Spending Assessment (NASA) process and the degree to which this methodology is able to measure the impact of funds at the local level. It is possible that this is just monitoring spend against the national plan. It is also important to know the number of countries supported to use this methodology.

3. The International HIV/AIDS Alliance

The International HIV/AIDS Alliance (the Alliance) is a global partnership of national based NGOs working to prevent HIV infection, improve access to HIV treatment, care and support, expand communities' ability to influence the policy environment, and lessen the impact of HIV and AIDS worldwide, particularly among the most vulnerable and marginalised. Established in December 1993, the Alliance supports communities in developing countries to play a full and effective role in the global response to AIDS. Over the last 14 years, the Alliance has worked in more than 40 countries to provide grants, technical and organisational support to an array of community-level partners to scale up HIV/AIDS prevention, care, support, treatment and advocacy programming. The Alliance also works closely with national governments and multilateral partners to support the implementation of national HIV programmes towards the achievement of universal access targets.

The Alliance has shown global leadership and developed extensive technical expertise in key areas of HIV/AIDS programming, including: community mobilization for ART; prevention with most-at-risk populations; PMTCT, counselling and testing, care and support for orphans and vulnerable children and working with networks of people living with HIV.

DFID has funded the Alliance through a Programme Partnership Agreement (PPA) since 2004. This relationship with DFID enables us to engage with DFID over key policy issues. In 2006–07, the Alliance received support from the Challenge Fund to implement an HIV/Sexual and reproductive Health (SRH) project in India. The Alliance is currently implementing a £2 million HIV/AIFDS programme in the Caribbean with DFID support.

The Alliance currently has an annual operating budget over US$65 million, with a high annual growth rate. In 2007, the Alliance provided grants totalling more than $14 million to over 754 local NGOs and CBOs—the average grant size was $19,000.

4. The Role of Civil Society in the AIDS Response

How civil society will be involved in implementing the new Strategy

Most often, it is the people affected by HIV/AIDS that best appreciate the causes and consequences of the epidemic and the need for change. Yet this perspective is poorly represented in most health programmes, national policies and global strategies. The Alliance's programming experience consistently illustrates that involving key populations in programme design and delivery builds the skills and social capital necessary to reduce HIV transmission, and to care for and support people living with HIV.

Further, these populations are among the best monitors and advocates for a more equitable and therefore effective response. Without organisations with the capacity to engage with and monitor the implementation of commitments made by governments, the goodwill, skills and capacity of the most affected communities are often underutilised and overlooked, with consequent impacts on the HIV epidemic. Low levels of civil society participation in planning, coordinating and monitoring local, national and international responses will mean policies and programmes are less likely to be responsive, targeted and rapidly scaled up. Further, the involvement of beneficiaries in ODA projects and programs has been shown to have a significant impact on aid effectiveness and impact, reducing the likelihood of project failure and increasing the chances of success. As such, participation is essential to extracting the most value from ODA.[21] We warmly welcome DFID's lead on supporting the participation of civil society in the Country Compacts of the IHP+[22] and hope that what is learned from this work will be used more widely to ensure meaningful Civil society involvement in the delivery of this strategy.

[21] *Assessing Aid: What Works, What Doesn't and Why* World Bank report 1998 Ch 4 accessed at http://www.worldbank.org/aid/pdfs/ch4.pdf

[22] DFID has been a very strong supporter of civil society engagement in the International Health Partnership and Related Initiatives (IHP+), working with civil society at a global level to ensure their meaningful engagement in the Scaling up Reference Group and, more recently, exploring how civil society engagement with the development of country compacts can be supported and financed.

In "Achieving Universal Access", the role of civil society is recognised as critical to realising many of the aims within the strategy, including the provision of services, planning and budgeting and advocacy to ensure that national governments deliver on their obligations. However there are still tremendous gaps between the commitments made to ensure civil society engagement and the reality on the ground. "Achieving Universal Access" commits the government to forming partnerships with civil society to work with IDUs and on social protection issues, but beyond this the strategy does not clarify what DFID will do to improve support to civil society organisations. And thus enable them to participate in the development, monitoring and evaluation of national AIDS strategies and plans.

Unfortunately, the text of "Achieving Universal Access" distinguishes the work of civil society organisations (CSOs) in health care from the work of the government led health system. It is our belief that it is unhelpful to separate these roles as this may lead to funding being spent in ways which undermine an effective continuum of care and fail to reflect the reality of how health care is delivered. In many of the countries most heavily affected by HIV, community care and support systems are a critical—often the only—form of care available to mitigate the impact of HIV on people's lives, particularly in rural areas where the poorest and most marginalised may reside. Further, the engagement of communities and community systems with "formal" or secondary/tertiary health sector services will in itself enhance continuity of care as well as build civil society participation in health system development and strengthening

Civil society's contribution to health systems have been extensively documented and includes:

- enhancing government accountability and transparency;
- influencing social policy through social mobilization and promoting participatory development;
- raising, advancing and claiming rights, including the right to health;
- advocating for equitable and pro-poor health policies;
- acting as intermediaries between communities and government;
- providing public goods and services not met by the State or the private sector with a comparative advantage in dealing with particular social issues, situations, geographical areas and vulnerable groups.[23]

What do we think DFID should do?

Rarely do national governments and civil society form productive partnerships without clear incentives for the government and without support to civil society organisations to build the knowledge and skills necessary for meaningful participation in political processes. Therefore DFID should play a central role in supporting and encouraging national fora which enable civil society to take part in policy and planning decisions.

While HM government would agree with the above conclusions, it is not clear what role DFID will play in ensuring that the political space is created for this to happen. In this respect the strategy misses an important opportunity to clarify how DFID will ensure the full participation of civil society in global response. To close the gap between commitments and reality, DFID must support national governments to develop processes that allow for meaningful engagement with civil society.

Our experience working with the Global Fund has shown that putting in place processes and frameworks which require government and civil society to work together is an important prerequisite for enabling this to happen. The Global Fund's Dual Track Financing requires the national Country Coordinating Mechanism (CCM) to select two Principal Recipients, one of which should be a non-governmental organisation. This gives both government and civil society the framework and the incentives needed to work together. DFID should facilitate, lead and finance the development of such frameworks, so that these partnerships are supported across health systems and the HIV/AIDS response.

We welcome DFID's ongoing support for the work of the Global Fund, which in our experience is critical for ensuring the participation and funding of civil society at all levels of the AIDS response, However, we note recent reports that a number of donors, in the current global economic context, may be reviewing their commitment to the Global Fund, as well as to ODA more generally, and urge the UK government to sustain its support for a demonstrated, effective institution which has been shown to be unusually effective in generating country-led, participatory, yet accountable mechanisms for funding health system and HIV responses. An appropriate level of support from the UK government would be to commit to a minimum replenishment pledge of £703 million for a three year period.

It remains a concern to the Alliance that an emphasis on "mainstreaming" HIV services, without the meaningful participation of those whose services will be mainstreamed, may lead to a further reduction in access to services of the most marginalised populations affected by HIV/AIDS. In particular, members of the most marginalised and vulnerable communities, especially those marginalised through behaviours which are subject to legal reprisal or social exclusion, have limited trust in government and even some NGO providers to meet their needs. This will be discussed in a later section of this paper.

[23] Action for global Health, Supplementary Notes on the IHP+ Civil Society Engagement Concept Paper, 1st April 2008.

5. Financing "Achieving Universal Access"

The comparative effectiveness in tackling HIV/AIDS by vertical funds and funding allocated to broader health system strengthening

"Achieving Universal Access" acknowledges that health system strengthening and AIDS specific programmes can be "mutually reinforcing" and there are many examples where a strengthened health system has supported health care for positive people and where HIV/AIDS responses have led to a more effective health system. The Alliance welcomes more financing for health system strengthening and recognises that as well as benefiting many health care programmes for people with HIV and AIDS, this will also bring long-terms benefits to the health of the nation. However we have a number of concerns about how the comparative advantage of funding health systems and HIV/AID specific projects is represented in the strategy.

The strategy represents a shift in DFID thinking about how to fund the AIDS response and this has led to a much greater emphasis on funding health systems as a way of funding AIDS programmes.

In recent years DFID has increasingly been channelling more aid through budget support rather than through project aid. The amount of ODA channelled through budget support is likely to substantially increase in the coming years, in accordance with the Paris Declaration on Aid Effectiveness and the recently adopted "Accra Agenda for Action", in which donors aim to: channel 50% or more of government-to-government assistance through country fiduciary systems, including by increasing the percentage of assistance provided through programme based approaches. The European Commission aims to spend more than 30 percent of the €23 billion in its European Development Fund for 2008–13 through general budget support.[24] DFID's use of budget support has increased from £268 million to £461 million over the past five years. It now represents nearly 20% of DFID's bilateral expenditure and is likely to increase.

There are a number of assumptions made about budget support, namely that it results in:

- improved coordination and harmonization among donors and alignment with partner country systems (including budget systems) and policies;
- lower transaction costs;
- higher allocative efficiency of public expenditures;
- greater predictability of funding;
- increased effectiveness of the state and public administration as budget support is aligned with and uses government allocation and financial management systems;
- improved domestic accountability and ownership through increased focus on the government's own accountability channels; and
- increased access to health care and education (as it provide more funds to finance recurrent costs, such as health workers and teachers salaries).

However, not all preconceptions about budget support are positive:

- It can be more vulnerable to corruption than other forms of aid, and sometimes it is crudely characterized as "money for governments to do what they like with."
- It can only be as good as the strategy it finances (budget support is used to support national poverty reduction strategies), and so it reflects the strengths and weaknesses of those strategies.
- It is not free from harmful economic policy conditions (one of the entry conditions for both general and sector budget support is that countries must aim for macroeconomic stability, which is usually translated into having an IMF programme in place).
- It has predominantly increased recipient government accountability to donors rather than to their own citizens (the dialogue is mainly between the recipient country's Ministry of Finance and the donor, with often no involvement of civil society and national parliaments and a weak negotiation position of line ministries, such as the MoH).
- The lack of monitoring processes to track how budget support is used prevents a comprehensive understanding of the implications of this funding approach. This needs to be addressed if resources for AIDS are increasingly channelled through this mechanism.
- Budget support is given to governments with little requirements for reporting on performance management and the impact of the resources. This requirement has proved an important component in other funding mechanisms to guarantee funds achieve required outcomes.
- Populations which experience the highest prevalence of HIV in almost all settings are often those marginalised or excluded from wider political and social participation. As such, general health service development may continue to fail to meet their needs. The experience of Alliance partners

[24] Stop AIDS Alliance, Aid Effectiveness, the Division of Labour and Health as a Tracer Sector: Recommendations for the Alliance and Stop AIDS Now!, 2008. The Stop AIDS Alliance is a joint partnership between the International HIV/AIDS Alliance and Stop AIDS Now!

is that, even where good HIV services are available, their accessibility to members of key populations is often compromised or restricted by issues of stigma, discrimination or inappropriate service design and delivery.

The benefits and challenges relating to budget support as a funding mechanism for aid have been analysed by various stakeholders, including DFID.[25] While these findings relate to the use of budget support for aid generally, analysis and evidence on its effectiveness to support the AIDS response is limited. The assumptions above need to be monitored and a stronger body of evidence gathered before we can be confident that budget support is an effective way of funding the response to the AIDS epidemic. This is a role that DFID should take on if it wants to be confident that the work it is committed to in the strategy is funded and for furthering our global knowledge about how best to funds HIV/AIDS programming.

Certainly there are reasonable concerns, which DFID shares[26] about whether funding to government treasuries reaches the local level, including community based organisations. These concerns are exacerbated in the case of marginalised groups who are stigmatised, and in many instances discriminated against in national laws which criminalise their behaviours.

It is notable that the UN Secretary General's Report to the 2008 UN High Level Meeting on AIDS observed that civil society groups have access to adequate financial support in only 19% of countries. Given that HIV funding is one of the few sources of reliable funding for civil society in health in many contexts, this is an alarmingly low figure.

UNAIDS stated in the 2006 Report of the Global AIDS epidemic that "while funding for HIV programmes has increased in recent years, many countries fail to direct financial resources towards activities that address the HIV prevention needs of the populations at highest risk."[27] As such there is an inherent tension in the strategy between the frequently stated recognition of the importance of civil society and the choice to prioritise a funding mechanism which, without significant and rarely achieved reform to planning and funding process, is likely to reduce civil society's ability to participate.

The impact of vertical funds on broader health system strengthening

There are numerous examples within the Alliance network of the HIV and AIDS response contributing substantially to building strong health systems, especially where civil society has been involved. The examples cover a wide range of countries and types of programmes, from work to access ART in the Ukraine and Zambia, the Uganda Network Support Agents and a number of smaller programmes in West Africa where small community-based of civil society lead interventions have resulted in the scaling up of services to a national level and broadening out of service provision to more than HIV and AIDS services.

The contribution of AIDS programmes to health system strengthening is also seen at the system level and examples of this include:

— effective PMTCT interventions, as a way of rescuing child health services;

— effective ART programmes, which will reduce the number of hospital admissions and reduce the impact of HIV on health workforce availability; and

— both the above will have a positive effect on staff morale within the health care system.

However, on the whole, the health system/HIV response model is not a helpful dichotomy as many countries have unacceptably low levels of funding for AIDS work and health systems,—as such, both need significantly higher levels of funding to achieve universal access targets. Further, in the most highly impacted countries where HIV accounts for a significant proportion of morbidity and premature mortality, the distinction between strengthening HIV responses and strengthening health systems is specious.

The emphasis in the strategy on health system strengthening is therefore a concern in that there is no financial target for spending on HIV/AIDS, so we will not know how much of UK government funds will be spent on HIV/AIDS programmes. This lack of clarity could have dire consequences in terms of guaranteeing funds for AIDS programmes, particularly those focused on prevention and impact mitigation and other areas of work which fall outside of the health system. It will also be difficult for the work of the IDC, in terms of scrutinising the degree to which DIFD is meeting its commitments in the strategy.

One possible approach to ensure that both the health system and AIDS programmes gain from the strategy would be to concentrate health system work on certain components of the health system essential in the critical pathways to tackling the AIDS crisis such as:

— supply chain for medicines;

[25] National Audit Office (2008). Department for International Development. Providing budget support to developing countries. Report by the Comptroller and auditor General. HC 6 Session 2007–08. 8 February 2008; ECDPM and Action Aid. Whither EC Aid? WECA Briefing Note: Budget support; OECD DAC (2006). Evaluation of General Budget Support. A Joint Evaluation of General Budget Support 1994–2004.

[26] DFID recognises that one of the weaknesses with budget support for health is that as donors move towards this mode of aid financing there is a need for a strong civil society voice in order to ensure that money is being allocated by the government according to priority needs. A key challenge, however, is that budget support does not include clear provisions for financing civil society, thereby making it difficult to build the capacity of civil society organisations to conduct advocacy work and support service delivery.

[27] UNAIDS (2006) Report on the Global AIDS epidemic.

— the training and retention of health workers;
— strengthening laboratory services; and
— strengthening the role of communities as key actors in health systems.

The Global Fund to fight AIDS, TB and Malaria is a vertical funding mechanism committed to funding health systems. Early on it was recognised by the Fund that as well as improving health care for people affected by the three diseases, "the Fund may have system-wide effects due to the sheer magnitude of the resources it is distributing (particularly in low income countries) and its emphasis on efficient and rapid disbursement. These effects could be on equity, efficiency, access, quality, and sustainability of health systems, which in turn influence the utilization and coverage of non-focal services, and, ultimately, the burden of diseases from sources other than the focal diseases."[28] An evaluation framework was developed to monitor the impact of the Funds work on strengthening health systems.

A good example of this is the grant to Rwanda which runs from 2005–09, which has specific HSS objectives and which was found in a mid term evaluation to have exceeded many of its targets (2004).[29]

In addition to ensuring that health systems are strengthened through work that focuses on the three diseases, the Global Fund now directly funds health system strengthening work. This includes having established a health systems strengthening window that aims to explicitly support the strengthening of health systems necessary to deliver results in relation to the three diseases as well as more recent efforts to develop "National Strategy Applications" that aim to allow the Global Fund to provide funding to national governments in direct support of national AIDS and national health plans.

6. The Extent to which DFID's Strategy will be Effective in Tackling the Disproportionate Impact of HIV/AIDS on Women and Children

We are delighted, in the context of the current focus on developing effective guidance on gender and on incorporating gender into sensitive assessments and policies into national AIDS responses, which the IDC is seeking to assess the impact of the new DfID strategy on ensuring equitable outcomes for women and children.

It may appear that a health systems approach would stand a good chance of addressing the enhanced vulnerability of women and children to HIV in generalised epidemic settings. However, as the DfID strategy notes, many of the issues which need to be addressed to ensure effective HIV prevention lie outside the remit of health services. For example, while coverage of services for the prevention of transmission from mother to child (PMTCT) has increased substantially over recent years, the fact that a low cost, efficacious service still only reaches 34% of those women who may benefit from it speaks to the challenges of health system capacity, integration of HIV and SRH services, and addressing the stigma still attached to HIV in even hyper-endemic settings.

The structural issues—political, social, religious and economic aspects—which make women more vulnerable to HIV infection in the first place; and less likely to be able to afford or access care once infected, are unlikely to be resolved by health systems acting alone, if at all. These issues need to be addressed at the social, cultural and political levels at which they are manifested, and require effective social mobilisation, the empowerment and participation of women and the engagement of advocates for orphans and vulnerable children—all actors historically marginalised or overlooked within mainstream health and political settings. Addressing issues of women's income, or of domestic violence and women's autonomy in sexual decision making, requires the broadest approach to sexual and reproductive health. As such, the same concerns we hold in relation to key populations within concentrated epidemics apply to the impacts of the proposed DfID approach on women and children in generalised epidemics. Within concentrated epidemics, the violence directed towards sex workers, the increased vulnerability of female injecting drug users and female partners of male injecting drug users are all examples of challenges which general budget support is highly unlikely to have any impact on.

7. To what Extent does the new AIDS Strategy Address the Issues Raised in the Committees Previous Reports on Marginalised Groups?

Since the IDC Hearing on marginalised groups in 2006, there has been a lack of progress made globally in providing the services needed by marginalised groups.

In the 2008 UN Secretary General's Report on progress made in implementing the Declaration of Commitment 2001, notes that:

— globally, most IDU and MSM lack meaningful access to HIV prevention services; sex workers are somewhat more likely to receive HIV prevention services, although access is sharply limited in many countries;

[28] http://www.theglobalfund.org/en/links_resources/library/evaluation_framework/1/
[29] http://www.theglobalfund.org/programs/grantdetails.aspx?CountryId=RWN&compid=711&grantid=247&lang=en

— while 74% of countries have policies in place to ensure equal access to HIV-related services for vulnerable groups, 57% of these have laws or policies that impede access to HIV services;

— in many countries, low levels of infection in the general adult population mask higher infection levels among populations most at risk, including sex workers, IDU and MSM; in countries with low levels of infection, populations most at risk are experiencing an exceptionally heavy burden of disease;

— although nearly all countries have national strategic frameworks addressing populations most at risk, fewer than half have implemented HIV prevention services focused on IDU, MSM or sex workers in all or most districts in need.

A presentation on MSM at the 2008 High Level Meeting on HIV/AIDS showed that of those country reports analysed, fewer than 25% included any indicators on MSM coverage or prevalence, and fewer than 10% reported on all agreed indictors for this population. In Africa, 3/35 reports analysed had no indicators at all for MSM (Asia 5/22; LA 5/21). Nonetheless, where HIV prevalence surveys are conducted, it is invariably found to be significantly higher among MSM than among the general population, including in generalised epidemics.

Recent data from the World Bank's Global AIDS Program gives new insights into the degree to which the global epidemic is far more concentrated than originally thought. However, this evidence also 'shows we are systematically under-investing in MSM programmes . . . and that "Coverage of MSM programs are lower than for sex workers or IDU"—and these are no better than 25% for sex workers, and around 10% for IDU.

Achieving Universal Access recognises that there are many barriers faced by marginalised groups which prevent them from accessing services, and that much more action is needed if this is to be redressed. The strategy says that "the UK will play its part" to support this work, and the evidence from our work with DFID is that the UK government has played a leadership role in advocating for removing the barriers which prevent marginalised groups from accessing effective interventions.

In particular, The FCO's policy position on Lesbian, Gay, Bi-sexual and Transgender populations is an example of the contribution the UK can make to advancing the human rights of the LGBT community and the Alliance warmly welcomes this progress and its implications for the human rights of stigmatised and marginalised populations. We also welcome the commitment to "Intensify efforts to increase the coverage of HIV and AIDS services for Injecting Drug Users (IDUs) in countries where they are most affected. Work in partnership with governments, multilateral agencies, civil society and through nine bilateral programmes, to improve the international environment on harm reduction."[30]

However, aside from the commitment to IDU, the strategy gives inadequate attention to the challenges of meeting the needs of key populations, including sex workers and MSM. This is a concern in the context of Ian Pearson's observation that "The UK has raised cases of discrimination on grounds of sexual orientation bilaterally or in partnership with the EU with third countries. However, I do not wish to under-play the difficulty that we sometimes have in raising such cases with certain states. In these instances, keeping a line of communication about human rights issues open, and stressing their universality, is a primary concern."[31]

Given the intensified focus on health systems support, the FCO has been given a pivotal role in working to protect the human rights of marginalised groups and to address the structural aspects of HIV vulnerability. However, the transparency and accountability of Whitehall to the international civil society HIV movement—or to in-country civil society players—is limited. It is understood that a cross-Whitehall group has been established to guide and co-ordinate this work—however this group has no civil society participation and information on its deliberations is hard to find. In its previous report, the IDC recommended that the FCO establish a dedicated HIV/AIDS desk—yet it remains unclear if this has been done or how such a position would relate to the DfID HIV/AIDS programme and to in-country HIV mechanisms such as Global Fund CCMs. The alliance is concerned that there are inadequate resources and structures in place at the FCO to take on this role, and that no clear systems have been set up to enhance policy coherence and information sharing across Whitehall.

Another concerning development in "Achieving Universal Access" is that DFID is "withdrawing" much of its resources from Middle Income Countries. These countries have concentrated epidemics and include the fastest growing epidemics 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. There is enormous value to the work of DfID in these settings, both in terms of creating enabling environments and in supporting the work of networks of marginalised groups key to local epidemic dynamics. We would argue that this is one of the areas where DFID has added value and its investment in these countries would be cost effective.

In point 22, of the IDC HIV/AIDS: Marginalise groups report, the IDC recommends that key populations are involved in all key areas of the programmes which DFID funds. We believe there should be a wider application of this principle and that DFID should reflect this value through ensuring the involvement of marginalised groups and civil society CS in its own processes; and insists on participation and more transparent processes across other parts of Whitehall.

[30] P 29.
[31] Ian Pearson MP, FCO Minister for Trade Unions and Human Rights, TUC, LGBT Conference 2006.

8. Monitoring Systems and Measuring Impact

DFID's mechanisms for measuring the impact of its funding for health service strengthening

Achieving Universal Access marks a change in how DFID will finance its work on HIV/AIDS. DFID has chosen to predominantly allocate resources to government departments in support of national plans, in alignment with the Paris Declaration on Aid Effectiveness. This approach has inherent challenges including transparency, accountability, fungibility and ensuring adequate beneficiary involvement and participation.

In choosing to disburse money through financing national government spending on health "DFID will be relying heavily on national monitoring and evaluation systems to find out whether outcome level indicators are being achieved. Increased commitment to budget support should be accompanied by work to strengthen national planning and monitoring systems. It is well established that the financial risk for budget support is higher than many other funding approaches. What is DIFD doing to guarantee that the funding given to national governments will be used according to the priorities set our in Achieving Universal Access? This includes what statistics, data and monitoring information will they be assessing before committing to budget support."

In the IDC report on HIV/AIDS: Marginalised groups and emerging epidemics, the Committee raised the concern that DFID's position on supporting nation plans and so national monitoring processes should not prevent DFID from committing to "transparent benchmarks" for its own contribution. In particular the IDC noted that they do "not accept that DFID support for national HIV/AIDS plans and transparent benchmarks for DFID's contribution to the achievement of international 'outcome targets' are mutually exclusive".[32] We share this view and in fact it's now greater as DFID has moved even further away from national AIDS plans to national health plans, while continuing to make the case that contribution to international outcomes is unrealistic to measure.

We are also concerned about the status of the indicators that national governments have committed to for marginalised populations. In the original Universal Access plans which were developed at the national level, very few countries committed to comprehensive targets with marginalised groups. Our sense is that there is little commitment to working with these groups . . . Need to make a much bigger difference . . . not enough to leave it to national governments.

Other marginalised populations are also a 'Priority for Action', however there is an unclear distinction running through the strategy between areas of work which are priorities for action and areas which come under the heading, "The UK will". From the way these issues are presented it appears that work with marginalised groups is a priority but other than IDUs does not have very clear actions for the UK government attached to them?

The strategy contains two new financial targets. The financial target for strengthening health systems and services does not indicate how much will be spent on HIV/AIDS programmes and so it will be difficult to hold DIFD to account for HMG's contribution towards financing the global AIDS response.

DFID has recently run a consultative process to develop indicators to measure the outcome level of the strategy. This inclusive approach to setting an M&E plan is welcomed by the Alliance who took part in the civil society working group. This process was challenging as the commitments in the strategy are sometimes vague and the distinction between priority areas for action and the heading entitled 'the UK will' is not clear. From this work we have some observations to make about how effective the monitoring systems are for measuring the impact of the strategy.

— The likely effectiveness of monitoring systems in ensuring that funding announced in the strategy reaches local level.

The strategy says that the National AIDS Spending Assessment (NASA) tool is the chosen method to track whether funds reach local levels. Leaving aside for the moment the question of whether these are an effective way to track the flow of funds to the community level, a prior concern must be that the systematic exclusion—or lack of involvement -of those most affected in processes of planning and allocation means that funds may be under— or miss-allocated from the beginning. Given the data reported earlier in this report, tracking spending in the absence of strengthening civil society participation in planning is only likely to give us a more accurate of the extent of systemic failure to meet priority needs. Further, the Alliance questions the degree to which this methodology is really able to measure the impact of funds at the local level.

— The likelihood of being able to develop agreed, robust indicators to demonstrate that commitments have been implemented.

The current UK strategy identifies priority areas and a limited number of priority actions, not always aligned in ways that make sense to the casual reader. However, the specific commitments made tend to be vague and non-specific, and our experience in trying to frame indicators against these is that very few are able to be reduced to an easily measurable output or indicator of success. As such, there needs to be a reliance on country level indicators in relation to HIV specific impacts eg incidence and prevalence rates; coverage

[32] House of Commons, International Development Committee, HIV/ADIS: Marginalised groups and emerging epidemic. Second Report of Session 2006–07. Vol 1.

of treatment services, evidence of increasing equity in health service provision; and for a clear framework which links the UK's contributions to governments and multilaterals and its policy initiatives, to HIV/AIDS outcomes.

Memorandum submitted by the Malaria Consortium

1. Malaria Consortium is an international charity dedicated to improving the delivery of prevention and treatment to combat malaria and other communicable disease in Africa and Asia. We work with communities, health systems, government and non-government agencies, academic institutions and local and international organisations to ensure good evidence supports delivery of effective services. More than 90% of our human and technical resources are based in Africa and Asia supporting Ministries of Health and partners in over twenty countries through our offices in Uganda, Mozambique, Sudan, Southern Sudan, Zambia, Nigeria, Ethiopia, Thailand and the UK.

2. Malaria Consortium welcomes the opportunity to submit evidence to the International Development Select Committee's inquiry on the Department for International Development's (DFID) new AIDS strategy. Together with our partners in the South and in Europe we have been investigating the interactions between HIV/AIDS and malaria for some time and are pleased that one of the things this inquiry is addressing is how HIV/AIDS interacts with other diseases such as malaria.

3. In order to reduce the detrimental consequences of dual infection with HIV and malaria, prevention and treatment of the two diseases must mutually reinforce each other. There is immense potential for synergies in particular at this time of growing political and financial commitment to reduce the burden of HIV/AIDS, malaria and tuberculosis.

4. Although we are pleased that DFID has made supporting the integration of HIV and AIDS with malaria a priority for action, we have the following concerns:

(a) The relationship between HIV and malaria was not alluded to. The human cost of the epidemic of AIDS will continue to be underestimated until the link with malaria is more thoroughly acknowledged. Studies in recent years have highlighted the interaction between malaria and HIV infection and revealed HIV is playing a role in boosting adult malaria-infection rates.

(b) HIV/AIDS and malaria are also linked by geography, extreme poverty and limited access to resources such as clinical care and treatment. DFID need to acknowledge this more. People living with HIV/AIDS who become infected with malaria are more likely to develop severe manifestations of malaria such as anaemia and cerebral malaria and are less responsive to malaria treatment and at a higher risk of death from the disease. However it has to be noted that this is only true for immuno-compromised AIDS patients (CD4 count 200) and not for persons in the latent HIV infection stage. The lowered immune response also contributes to a reduced effectiveness of malaria treatment because this is usually a result of both the medicine's effect and the immune system's contribution. So in AIDS patients malaria parasite strains with slightly reduced susceptibility will lead to treatment failure when they would still be cleared in immuno-competent persons. There is strong evidence for these relationships and they can be assumed "proven".

(c) Specifically on page 34 there is mention of the fact that HIV increases the risk of maternal death, for example by exacerbating malaria and tuberculosis (TB) during pregnancy. However DFID does not go on to explain how prevention and treatment of all three diseases could be addressed through the platform of maternal health services (especially antenatal clinic services). It only talks about how the opportunity of integration of AIDS services could be beneficial. Given there is increasing evidence of a direct link between malaria and HIV with one disease making the other worse and more difficult to treat, we feel DFID needs to expand on this point. Pregnant HIV-positive women with placental malaria infection are more likely to experience anaemia, adverse birth outcomes such as pre-term birth and intrauterine growth retardation, and deliver a low-birth-weight baby. Maternal Newborn and Child Health (MNCH) services should include both prevention of mother-to-child transmission (PMTCT) and malaria components as they are important entry points for women into health services.

(d) On page 12, DFID say it is important to improve rates of TB diagnosis among People Living with HIV/AIDS (PLWHA) and to improve HIV diagnosis among people with TB. Again malaria and HIV are neglected in terms of the possibilities of joint diagnostic tools.

(e) On page 35, there is a mention of "stronger links must also be forged between TB, malaria and HIV services". The paragraph goes on to discuss TB but fails to mention malaria again. We urge DFID to clarify and elaborate how they intent to forge strong links between malaria and HIV as no where else in this document is this mentioned.

5. Recommendations

We would suggest that several activities to better integrate HIV and malaria could be undertaken but hasten to add DFID makes no mention of them in this strategy:

(a) As stated already in the text malaria has to be seen as one of the more common opportunistic infections among AIDS patients in sub-Saharan Africa and malaria treatment and prevention has to be part of any care package. The fact that malaria control is moving to universal coverage helps as once 70-80% of the population are protected from malaria, PLWHA will be included (knowingly or unknowingly).

(b) All AIDS patients with a CD4 count 200 should receive weekly cotrimoxazole prophylaxis (cotrim is an antimalaria and antibiotic shown to reduce a range of opportunistic infections) as part of their treatment package.

(c) Protocols for preventive malaria treatment in pregnancy (IPT) need to be adjusted to accommodate the fact that women with HIV will need at least three doses of antimalarials to have the same effect as in un-infected women. But also that HIV + women on cotrimoxazole should not receive IPT in addition.

(d) Voluntary Counselling and Testing (VCT) should be offered to any adult patient with repeated febrile illnesses (that is true for malaria but should cover all other febrile illnesses also and as such is not a very specific integration but just good practice of VCT).

6. We would like to see what Monitoring and Evaluation framework DFID will put in place to measure the strong links they are hoping to forge, in particular what indicators they propose to monitor progress in terms of integrating malaria and HIV services better.

7. We would like to see DFID make a firm quantifiable commitment in terms of this integration and what they wish to achieve rather than what seems to be at the moment a broad aspiration lacking any concrete plans on how to achieve it.

Submitted Autumn 2008

Memorandum submitted by Médecins sans Frontières

A. Evidence on Questions 6, 7, 8

6. *The impact of vertical funds on broader health system strengthening*

7. *The comparative effectiveness in tackling HIV/AIDS of vertical funds and funding allocated to broader health system strengthening*

8. *DFID's mechanisms for measuring the impact of its funding for health service strengthening*

In the current situation of providing AIDS treatment and care, many countries, particularly those with high HIV prevalence, face the double challenge of expanding the provision of treatment to more people who need it while continuing to provide quality treatment for those already on treatment. These objectives give rise to different challenges. Continued treatment will focus on quality of care as well as patient empowerment and treatment literacy. Furthermore, much of the follow-up can and should be organised outside health services. For the expansion of treatment, on the other hand, speed of enrolment and access to services providing AIDS treatment are key. Health system strengthening therefore needs to focus on ensuring access to care and the inclusion capacity of health services which initiate AIDS treatment. The role of health services, and strengthened health systems, gains in importance for those patients facing complications, side effects or in need of new treatment regimens. Below we will elaborate on some of the more important aspects.

1. *Increased health care utilisation is key for the expansion of AIDS care*

In countries where expansion and scale-up is the key challenge, health systems strengthening should focus on measures that allow increased utilisation of health services, building additional capacity in terms of the offer of services and overcoming access barriers. In MSF's experience three areas are particularly important:

1. essential services should be provided **free of charge** to patients (all service-related costs, not just medicines);
2. the supply of **drugs and medical supplies** needs to be sufficient and reliable; and
3. the number, quality and productivity of **health workers** needs to be increased.

We would therefore recommend that health systems strengthening (HSS) focus on funding and supporting measures at health service level, with a rapid and direct effect on health service provision and access improvement. The risk of the current HSS approach by WHO and other international agencies is that efforts are spread broadly across the entire health system. Moreover, the focus on long-term strengthening

will not bring about the rapid change required for improved offer of and access to health services. We know from experience that general systems measures take a long time to bring about improvements at the patient interface. We therefore propose that increased utilisation of health care and health services be the required key component and recognised as the central indicator of success.

This could also include specific measures for clinical health workers and support staff at clinic level (eg improved remuneration—basic salary levels remain insufficient—non-monetary retention incentives and recruitment of additional health workers). These measures could be targeted at priority rural or other underserved areas.

Additional funding for health systems strengthening should carry the condition that the system becomes available and accessible to patients and addresses their needs. Too many countries still fail to link health systems to concrete output in terms of improved access for patients and utilisation of care. We suggest that DFID not only provide the means to strengthen services but actually require improved access; not only increased funding and subsidies, but actually more patients to benefit from these subsidies.

A case in point is financial accessibility—in too many countries international subsidies for ART, malaria treatment or other medical supplies fail to translate into reduced costs for patients. So for example essential drugs already paid for by international aid need to be paid for again by the patient, while despite the provision of incentives to health staff patients are still required to pay for consultations. The entry point to the general health system therefore remains very limited for vulnerable groups, including impoverished AIDS patients. Without these specific service and utilisation-focused requirements, we fear that an overall improvement in health systems performance will not lead to a more effective response to patients' health needs.

We propose that DFID therefore introduce some conditionality to the funds provided (eg not only support the principle of free care but also introduce conditions of essential care free of charge for patients), channel a significant portion of funds to the health structure/clinic level and use indicators at this level to measure progress.

Furthermore, given the lead role that DFID has played on the removal of user fees, it is surprising that there is no clear statement about the importance of removing financial barriers to health care access for HIV/AIDS patients. The strategy document mentions "universal access" 127 times, but user fees and financial barriers only twice, including the non-committal statement "Address barriers that prevent people from accessing health services such as financial barriers, eg user-fees and cost of transport for people to reach clinics" (p36). Based on the existing evidence and DFID's commitment to helping government partners implement free access to basic health services, we would have liked DFID's position to be much more clearly represented in "Achieving Universal Access". In the light of the current policy revision of financial contributions of patients by donors such as the EU and member states such as Denmark (see recent statement on abolition of user fees for children and women) as well as international agencies such as UNICEF, DFID could play a much more proactive role in these processes.

In conclusion, therefore, HSS and AIDS care can and should be mutually reinforcing (sometimes referred to as "diagonalisation"). Even with a focus on HSS it is possible to create a "win-win situation" so that efforts on HIV/AIDS treatment and care are not put on hold while the general health system catches up. We suggest that DFID focus on specific elements of health systems that allow an effective platform for service delivery to be created at periphery level, in such a way that effective HIV/AIDS care is not compromised. As outlined above, the priority areas for support should be the abolition of user fees, recruitment of additional clinical staff and reliable drug supply. These priorities should of course be reflected in specific budgetary allocations.

2. *Quality health systems for patients with specific needs*

While standard ART treatment has permitted rapid roll-out, people with specific needs remain underserved. This group includes children, patients with HIV-TB co-infection and patients in need of alternative first-line or even second-line treatment.

As time passes the subgroup of patients suffering side effects, complications and treatment failure will grow larger. Health systems strengthening measures need to build capacity to respond to these needs.

Cost of ARV and OI drugs, laboratory tests and other medical supplies

It would be a mistake to assume that the price of AIDS drugs on the international market will continue to fall. This may be true of the standard first-line regimen but not of other necessary regimens. Price-reducing competition from generic manufacturers has diminished dramatically over the last five years. The statement in the DFID strategy on foreseen price drops through further standardisation (thereby enabling treatment to be provided to more people) therefore appears overly optimistic. More robust first line regimens, specific OI drugs and second-line ART are available on the international market only at prohibitive prices. Specific action will be needed to

fundamentally change this situation (please refer to MSF's publication "Untangling the Web" for more details, available on request). As a result, increased financial resources will probably be required to ensure supply.

Paediatric treatment and PMTCT

The drugs and protocols currently available are poorly adapted to clinic level. This is an important obstacle to the expansion of treatment to children and mothers.

MSF's experience with children on ART has shown that good outcomes, even with nurse-based care, depend on specific investment in diagnostics, child-adapted treatments and specific child-oriented counselling and social support. Nutrition supplements are also an important factor of success for children.

B. Evidence on Questions 3, 4, 5

3. *How the new AIDS Strategy will be incorporated into DFID's Country Programmes*

4. *How civil society will be involved in implementing the new Strategy*

5. *Likely effectiveness of monitoring systems in ensuring that funding announced in the Strategy reaches local level*

We have a particular concern with the universal application of country plans and approaches. The specific characteristics of so-called "fragile states" are particularly problematic in this respect. Although there is considerable variation in the definition of the term "fragile states", there is a tendency for donors to invest a country's leadership and government with unrealistic expectations very early on in the transition towards "less fragility". DRC, Burundi, Cote d'Ivoire, Sierra Leone and Chad are particularly relevant examples of this. Even where states are recognised as barely representative of their populations, donors and multilateral agencies still tend to engage primarily with their governments, use standard coordination mechanisms and, frequently, funding channels.

So called "country plans" are a particular concern:

- The reality is that the quality and inclusiveness of the process of building a country plan, with the participation of all stakeholders, remains very variable. Many authorities see government as synonymous with "country"; as a result, civil society and non-state providers like religious health networks and PLWHA are excluded or only nominally consulted. The experience from the Global Fund's Country Coordinating Mechanisms (CCM) shows that even civil society representation can be manipulated, pressured or made devoid of real significance.
- Even in International Health Partnership (IHP) countries, there is a risk that dialogue is effectively intergovernmental (between host country government and donors) rather than a truly interactive and inclusive process involving all stakeholders. The fact that the common IHP planning & priority setting process is located at country level renders it vulnerable to local pressures and power relations.
- Country plans often exclude vulnerable groups. This is partly due to the generalised, one-size-fits-all approach, which frequently neglects specific needs and gaps in care delivery. It is also due to stigmatisation and the prejudices of some planners. Examples include proposals for interventions benefiting men who have sex with men (MSM), commercial sex workers (CSW) and intravenous drug users (IDU), which have been rejected in certain African countries, including by the CCM.
- Even with full participation and inclusion, the quality of the country plan can be questionable. Consensus generally does not lead to innovation and the reality is that, in fragile states in particular, a rigid country plan can smother or even reverse progress obtained in ensuring access to AIDS treatment.
- Plans are not (yet) reality. Sometimes the process of turning a plan into implementation can be very lengthy. Populations, however, still need to be served, services delivered and needs covered. A particular risk lies in the misconception that progress in HIV/AIDS care should "wait" or adapt in order to fit with plans. Equity arguments are often used to justify this. If realism dictates that plans be implemented gradually, this should not jeopardize progress on AIDS treatment expansion. There are several pertinent examples here. Effective malaria treatment, for instance, is an essential component of care for HIV infected patients, particularly mothers and children. Many countries have foreseen gradual implementation of the new artemisinin combination therapy (ACT) at primary health care; however, this should not be a reason for denying HIV/AIDS patients correct malaria diagnosis and treatment. Similarly, governments requiring more time to implement generalised free care and therefore using a step-by-step approach (eg initially exempting only children) should not maintain user fees for adult AIDS patients, for whom free care has proved to be a significant benefit in terms of uptake of ART, adherence and survival.

— A specific, related concern is the emphasis on using planned improvements in primary health care as a platform for HIV/AIDS treatment delivery and the consequent emphasis on the integration of HIV/AIDS with other services: "AIDS services need to be integrated with Tuberculosis (TB), malaria, Sexual and Reproductive Health and Rights (SRHR), including Maternal, Newborn and Child Health (MNCH) services" (p30). In principle this is a sensible way forward, but the current reality is that in many contexts PHC services 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. 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.

The issue of funding reaching the population and the periphery is crucial. 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 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. While "Achieving Universal Access" does refer to the possibility of ". . . providing flexible resources… through international NGOs" (p6), there is far more emphasis on non-state support being provided through multilateral agencies (eg p6, p42, p51), particularly in "fragile states" and always within the "country plan" logic ("Funding multilaterals in a way that contributes to coherent implementation of national plans at country level, promotes institutional effectiveness and delivers results", p56). MSF would like DFID to clarify to what extent it is prepared to fund NGOs in contexts where budget and sector support, or in contexts like DRC, multilateral support, is likely to be relatively ineffective.

Two final points on sustainability and budgetary allocations:

The strategy uses the term "sustainability" on a number of occasions. While the distinction between economic/fiscal, political and technical sustainability is useful, DFID's view of fiscal sustainability seems somewhat unclear, despite the backdrop of an HIV/AIDS epidemic which will require predictable long-term external financial support. There appears to be some incoherence in this respect:

— "The cost of ARV therapy is likely to be unaffordable both for individuals and the state, and that those countries have to rely on donor funding for larger and larger outlays. This degree of dependence may not be sustainable in the long term". (p13)

— "Our long-term view is being extended to an integrated package of health and AIDS commitments. We are committing to spend £6 billion on health systems and services over seven years to 2015". (p46)

Moreover, given that seven years will be a very short time in the fight against HIV/AIDS, it would be good to see clearer recognition that DFID's commitment to HIV/AIDS in low income countries really is long-term.

Finally, while we recognise that a strategy paper will focus on broad strategic lines rather than detailed, costed activities, it would be very useful to have clarification on the relative prioritisation of the different areas of focus identified in "Achieving Universal Access". £6 billion is a substantial financial commitment—disaggregated data on the different budget lines would be a telling indication of the financial rather than rhetorical priorities within DFID's overall HIV/AIDS response.

Memorandum submitted by the National Aids Trust

Executive Summary of Recommendations

NAT (National AIDS Trust) welcomes the opportunity to provide evidence to the International Development Committee on the Department for International Development's (DFID) new global HIV strategy *Achieving Universal Access*. NAT congratulates DFID on this new strategy and particularly welcomes its unprecedented commitment to spend £6 billion between 2008 and 2015 to support health systems, including HIV activities, in developing countries. In summary:

1. NAT is concerned about how the significant amount of DFID funding to be funnelled through international agencies like the World Bank will be monitored. Reassurance from DFID that these funding flows will be transparent would be welcomed. NAT recommends that DFID include in its monitoring and evaluation framework indicators around tracking and regularly reporting on the support it provides through international agencies including the World Bank.
2. NAT recommends Government funding should support social and behavioural research around HIV vaccines and microbicides. This will ensure that these prevention products, when developed, will be acceptable to and used by those who need them most.

3. NAT believes that it is increasingly and urgently important that the UK Government has a consistent and "joined-up" approach to the HIV pandemic. The FCO, Home Office, Department of Health and other Government departments must ensure their policy positions, particularly around human rights, support DFID to take forward the commitments in the strategy. International standards on HIV and AIDS and human rights should be used as a basis to support and guide this work.

4. For example NAT recommends that DFID and the FCO proactively engage with UNAIDS, other international agencies and their in-country representatives to influence Governments to not enact legislation which stigmatises people living with HIV.

5. NAT recommends that the cross-departmental Whitehall committee on HIV should:

   — hold meetings on a regular basis;

   — include departments with relevant domestic responsibilities; and

   — look at both national and international responses.

   For example domestic policy in the Home Office and Department of Health on HIV and migrant populations has to be integrated according to principles of human rights and public health with our international efforts. As such, NAT also recommends that HIV treatment be provided to all in the UK free of charge irrespective of residency status.

1. NAT (National AIDS Trust) is the UK's leading charity dedicated to transforming society's response to HIV. We provide fresh thinking, expert advice and practical resources. We campaign for change.

2. NAT welcomes the opportunity to provide input into the International Development Committee's inquiry on the Department for International Development's (DFID) new global HIV strategy *Achieving Universal Access.* This inquiry provides an important opportunity to increase effectiveness of the UK Government's HIV programmes and policies for the benefit of both the UK and developing world.

3. NAT commends DFID for its longstanding commitment to tackling HIV and AIDS in the developing world. The UK has shown great leadership on HIV and in championing the rights of women, young people and other vulnerable groups. The Government has also taken a central role in the international community, particularly the Group of Eight (G8) and United Nations, to help secure international commitments for achieving universal access to comprehensive prevention programmes, treatment, care and support. Under the new strategy, DFID will continue to be a strong leader and support further resources for tackling HIV.

4. NAT welcomes DFID's unprecedented commitment to spend £6 billion between 2008 and 2015 to support health systems, including HIV activities, in developing countries. About half of this support will reach countries through international agencies like the World Bank.

RECOMMENDATION

5. **NAT is concerned about how the significant amount of DFID funding to be funnelled through international agencies like the World Bank will be monitored. Reassurance from DFID that these funding flows will be transparent would be welcomed. NAT recommends that DFID include in its monitoring and evaluation framework indicators around tracking and regularly reporting on the support it provides through international agencies including the World Bank.**

6. NAT particularly welcomes the commitment by DFID to increase by 50% funding available for the research and development (R&D) of HIV vaccines and microbicides. Vaccines and microbicides form an important part of a combination approach to HIV prevention. Just as no single drug or medical approach is effective in treating a person living with HIV, a combination approach and an enabling environment are needed to help people prevent HIV transmission. Strategies must offer people, including those living with HIV, real choices which meet their different and changing needs and that address the contexts in which decisions are made.

7. Investment in R&D for new prevention tools such as HIV vaccines and microbicides today will pay significant future dividends. In the best case, widespread availability of new prevention methods will dramatically increase the impact of HIV prevention efforts and open the possibility of bringing the HIV and AIDS pandemic to an end. Policy and advocacy relating to the support and development of NPTs forms an important element of the work plan of NAT.

8. However, there is a clear need for social research into NPTs to complement scientific R&D and to ensure the products will be acceptable to and used by those who need them most. Social research will enable an effective assessment of likely uptake and of the fit with existing prevention technologies such as condoms.

RECOMMENDATION

9. **NAT recommends Government funding should support social and behavioural research around HIV vaccines and microbicides. This will ensure that these prevention products, when developed, will be acceptable to and used by those who need them most.**

10. *Achieving Universal Access* is a Government-wide strategy, which includes actions for not only DFID but for other Government departments. With globalisation, public health issues in both domestic and international agendas are inextricably linked and NAT believes there is a vital need for clear and explicit coordination between Government departments as well as domestic and international strategies.

11. In particular, the new strategy states that the Foreign and Commonwealth Office (FCO), Department of Health and Home Office will work with DFID to ensure broad and effective UK support to international and national HIV responses.

12. For example the FCO is responsible for working with DFID to ensure broad and effective UK support to international and national HIV responses that promote and protect human rights. The FCO is primarily responsible for this in all middle-income countries. These countries include those in central and eastern Europe where concentrated HIV epidemics are growing among injecting drug users and other vulnerable communities, as well as some sub-Saharan African countries with generalised epidemics such as South Africa.

RECOMMENDATION

13. **NAT believes that it is increasingly and urgently important that the UK Government has a consistent and "joined-up" approach to responding to the HIV pandemic. The FCO, Home Office, Department of Health and other Government departments must ensure their policy positions, particularly around human rights, support DFID to take forward the commitments in the strategy. International standards on HIV and AIDS and human rights should be used as a basis to support and guide this work.**[33]

14. Particularly worrying is a trend in some highly-affected countries to pass legislation which claims to act to end discrimination against people living with HIV, but which in fact stigmatises them. For example recent legislation in some countries has required people with HIV to disclose their status in a wide range of contexts or has placed inappropriate limitations on their sex lives. Mozambique is the latest in a line of countries that have enacted, or may well enact this "model" HIV legislation.[34]

RECOMMENDATION

15. **NAT recommends that DFID and the FCO proactively engage with UNAIDS, other international agencies and their in-country representatives to influence Governments to not enact legislation which stigmatises people living with HIV.**

16. In addition, whilst the Government's G8 commitments are to be commended, antiretroviral (ARV) access policy in England does not appear to be based on public health considerations or to be consistent with G8 commitments. Nowhere is this more clear than immigration policy. For example undocumented migrants who are then diagnosed with HIV are denied access to free HIV treatment. NAT believes that migrants to the UK, who are often traumatised, extremely vulnerable and destitute, should whilst resident in the UK have their human rights protected and upheld. If ARV provision is to be truly universal by 2010, what will DFID have to say when anyone can access ARVs in Lusaka but people are effectively being denied them in Lewisham?

17. The UK Government should implement domestically the same policies on access to HIV treatment that it wants high-prevalence developing countries to adopt. To restrict access to treatment in high-prevalence developing countries only to those with the right papers would fatally undermine the global response to the pandemic. This is a particularly blatant example of inconsistent Government policy, which both the House of Commons Health Committee and Parliament's Joint Committee on Human Rights have recommended should be changed to provide free HIV treatment in the UK to all who need it.[35, 36]

[33] OHCHR and UNAIDS (2006) *International Guidelines on HIV/AIDS and Human Rights*, www.ohchr.org/Documents/Publications/HIVAIDSGuidelinesen.pdf.

[34] For further information about these "model" laws see the Canadian HIV Legal Network at www.aidslaw.ca and the discussions on this issue held at the 2008 International AIDS Conference at www.aids2008.org/Pag/PSession.aspx?s = 554.

[35] House of Commons Health Committee (2005) *New Developments in Sexual Health and HIV/AIDS Policy*, www.publications.parliament.uk/pa/cm200405/cmselect/cmhealth/252/252.pdf.

[36] Joint House Committee on Human Rights (2007) *The Treatment of Asylum Seekers*, www.publications.parliament.uk/pa/jt200607/jtselect/jtrights/81/81i.pdf.

18. It is particularly important that migrants with no further right to remain in the UK should be maintained appropriately, consistently and without interruption on antiretroviral therapy so they can benefit from whatever first-line therapy is available in the country to which they are deported or removed.

RECOMMENDATIONS

19. **NAT recommends that the cross-departmental Whitehall committee on HIV should:**

- **hold meetings on a regular basis;**
- **include departments with relevant domestic responsibilities; and**
- **look at both national and international responses.**

For example domestic policy in the Home Office and Department of Health on HIV and migrant populations has to be integrated according to principles of human rights and public health with our international efforts. As such, NAT also recommends that HIV treatment be provided to all in the UK free of charge irrespective of residency status.

NAT

October 2008

Memorandum submitted by Results UK

Introduction

This submission will primarily address the question of how HIV/AIDS interacts with other diseases, especially tuberculosis (TB), and how effectively this interaction is dealt with by donors and funds. This will be followed by some concerns about DFID's New HIV/AIDS strategy in relation to monitoring and evaluation and measuring impact.

TB and HIV: Background Information

Despite being preventable and treatable, TB remains the most common life-threatening opportunistic infection and a leading cause of death among people living with HIV/AIDS (PLWHA).[1] In Africa, which has the highest rates of both diseases, TB is the leading killer of PLWHA.[2] Autopsy studies have produced results ranging from 14% to 54% of people with HIV infection co-infected with undiagnosed TB.[3] Without proper treatment, approximately 90% of PLWHA die within months of developing TB.[4] Drug-resistant TB strains pose a particular threat to those with HIV, with mortality rates from extensively drug-resistant TB (XDR-TB) exceeding 95% in Africa.[5]

For more than two decades the international community has known that TB and HIV/AIDS are intimately linked, particularly in sub-Saharan Africa where HIV/AIDS has caused TB incidence to triple since 1990.[6] In 2002, officials from the World Health Organisation (WHO)'s Stop TB Department clarified the need for TB testing for PLWHA, stating ". . . those found to be both HIV-positive and with active TB need referral for TB treatment; those without active TB should be offered TB preventive treatment with isoniazid".[7] In 2004, WHO and UNAIDS unveiled plans to expand collaboration between national TB and HIV/AIDS programmes, promising that "TB case finding will be intensified in high HIV prevalence settings by introducing screening and testing for TB into HIV/AIDS service delivery points".[8]

International Response

According to the most recent data available, a mere 1% of PLWHA are reported to have been screened for TB. Of those who were screened for TB, more than 1 in 4 had TB.[9]

Country-level HIV/AIDS programmes are not the only actors failing to address TB/HIV. The leading sources of international HIV/AIDS funding; PEPFAR, the Global Fund to Fight AIDS, TB and Malaria and the World Bank Multi-country AIDS Program do not routinely monitor how many PLWHA are being screened for TB in HIV/AIDS programmes that they support, although PEPFAR does urge funding recipients to screen PLWHA for TB. As of August 2008, none of the three biggest donors were reporting the proportion of PLWHA being screened for TB within their programmes.

Progress towards Universal Access to HIV/AIDS treatment will not be made as long as people living with HIV are dying of TB. The global community's collective failure to address TB/HIV co-infection has led to unnecessary disease and death and has allowed TB to undermine the global response to HIV/AIDS, including the reductions in morbidity and mortality achieved through scaling-up of antiretroviral therapy. Civil society groups, including those from affected communities, are therefore calling for universal access to high-quality TB-HIV care by 2015, including diagnosis, treatment, preventive therapy, and infection

control. Achieving universal access to existing TB-HIV interventions by 2015 is both necessary and achievable. Accomplishing this goal would reduce TB deaths in PLWHA by 80-90% with an investment of US$19 billion, according to WHO calculations.[10]

Response to HIV/AIDS Strategy

DFID's 2008 HIV/AIDS strategy has a welcome focus on prioritising achieving Universal Access to comprehensive HIV prevention programmes, treatment, care and support. The revised strategy also recognises the value of an effective, integrated and co-ordinated response to HIV, prioritising HIV prevention as well as responding to the needs and protecting the rights of those most affected. RESULTS UK agrees that the UK is well placed to deliver the strategy within a wider development context, to promote political leadership and aid effectiveness in line with previous commitments.

RESULTS UK believes, that despite high-minded aspirations, the strategy suffers from a number of significant problems. These problems revolve around a central concern that there is an unclearness and disjuncture between the means and the ends of the strategy. More specifically RESULTS UK is concerned about:

1. **The lack of a more substantial emphasis on the global TB/HIV co-epidemic, including the absence of specific policy recommendations or investment targets.**
2. **The method of aid delivery.**
3. **The lack of an effective monitoring framework to assess the progress of the strategy.**

1. The lack of a more substantial emphasis on the global TB/HIV co-epidemic

1.0 In November 2007, RESULTS UK produced a report *An Inadequate Response: More than two decades of complacency in addressing the TB/HIV co-epidemic* in which in which it recommended that DFID should "Address TB and TB/HIV in the updated AIDS strategy", and set out specific recommendations for actions that should be included.[11] The acknowledgement of the need to address TB/HIV—absent from the UK Government's previous AIDS Strategy "*Taking Action*"—was therefore welcome and reinforces the UK Government's commitment to addressing the co-epidemic.

1.1 Specifically, the new strategy states that "It is important to improve rates of TB diagnosis among PLWH—and to improve HIV diagnosis among people living with TB—in places where both diseases are endemic" (page 21). The strategy also recognises that "TB and HIV are fuelling each other, and the need for integration is made more urgent by the steep rise in drug resistant TB infections" (page 35).

1.2 Despite acknowledging the need to tackle TB/HIV and the threat posed by drug-resistant forms of TB, the strategy fails to state what measures DFID will take to address TB/HIV or drug-resistant TB. DFID outlines its commitment to support "closer integration of AIDS, TB, malaria and SRHR, including maternal and child health services" but provides no further clarification on how it will fulfil this commitment and how it will measure success (page 4).

1.3 The strategy notes on page 8 that "We have seen encouraging progress in the implementation of integrated HIV and tuberculosis (TB) interventions in Africa". It is important that this progress not be overstated. There has been some progress in screening TB patients for HIV but still less that 15% of TB patients are currently being tested for HIV.[12] Furthermore, as noted above less than 1% of PLWHA are currently being screened for TB.

1.4 TB control is a necessary component in the fight against HIV and AIDS and essential to the achievement of Universal Access. There is a growing amount of evidence which attests to the value of integrating efforts to confront TB and HIV. In the Evidence for Action accompanying the AIDS strategy DFID highlights WHO's recommendation of "isoniazid preventive therapy to reduce the risk of TB in people with HIV" but recognises that this will require "much greater integration of HIV and TB care if it is to be successful" (page 36). Studies in South Africa have shown that integrated TB and HIV treatment can enable up to 150,000 co-infected people to start antiretroviral therapy earlier and therefore prevent around 10,000 deaths per year.[13]

1.5 The strategy commits to increase funding for research into an AIDS vaccine and microbicides. It does not make any similar commitment to increase funding for new tools for TB which will be crucial to reducing morbidity and mortality among PLWHA. A new regimen of drugs is required that can combat TB in a shorter time period and that are compatible with ART. New diagnostics that can detect all forms of TB in PLHA and that can be used in low resource settings are urgently needed to detect TB earlier. Ultimately, to eliminate TB as a public health problem and threat to PLWHA a new TB vaccine is needed.

1.6 The success of the new AIDS strategy will depend on how recommendations are implemented at country-level. The House of Lords Select Committee on Intergovernmental Organisations recently released its report, *Diseases Know No Frontiers* in which it recommends that before committing funds DFID "should satisfy itself . . . that there is adequate local recognition of the problem of TB/HIV co-infection and that there are sound programmes in place to address it".[14] *An Inadequate Response* also recommends that in order for DFID to improve their response to TB/HIV, central policy should be more closely reflected at country

level. A survey of DFID country offices in high TB burden countries last year found that only two out of eighteen were providing direct support for TB/HIV collaborative activities suggesting that many DFID country offices are not giving sufficient priority to TB or TB/HIV.

2. The method of aid delivery

2.0 Unlike *Taking Action,* the new AIDS strategy is not accompanied by a specific financial commitment for HIV and AIDS. The strategy does outline welcome financial commitments; £6 billion for strengthening heath systems and services up to 2015 and £200 million for social protection programmes over the next three years, as well as noting the £1 billion pledged in 2007 to the Global Fund to Fight AIDS, Tuberculosis and Malaria up to 2015. The new strategy does not detail how exactly this new funding will reach those most affected by HIV or, for example, how it would be used to strengthen the integration of TB and HIV services.

2.1 The House of Lords Select Committee on Intergovernmental Organisations recently 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".[15]

2.2 The new AIDS strategy has been developed at a time when DFID is reducing the quantity of disease-specific programmes that it supports, instead favouring sector-wide budget support to country governments.[16] The House of Commons Public Accounts Committee have recently raised concerns over DFID's preference for budget support, their recent audit concluding "DFID has not established the effectiveness of budget support relative to other types of aid, or been able to conclude whether, as currently implemented, it represents value for money".[17]

2.3 The House of Commons International Development Select Committee 2007 report on DFID have also suggested that DFID place too much emphasis on inputs and not enough on outcomes in the delivery of its aid.[18]

2.4 At present, DFID does not track spending on specific diseases through general budget support or health sector support. It is therefore difficult to evaluate how much DFID is actually spending on TB, malaria and other diseases and what impact DFID's aid is having in reducing their burden. As DFID's support for HIV and AIDS moves in a similar direction it will become equally challenging to monitor what impact DFID's support is having and whether it is reaching the intended recipients.

2.5 Targeted investments are important for addressing priority diseases as part of a broader approach to improve health systems. An effective balance is needed between "vertical" and "horizontal" health interventions and balance will be different in different contexts. Without "vertical" interventions, progress would not have been made to date in the fight against AIDS, TB and malaria. The AIDS strategy promotes "stronger, more effective systems", but notes that "evidence gaps" persist concerning how "disease-specific funding…contributes to the wider health system". DFID's move away from funding programmes that focus on a specific disease should not be based on a lack of evidence.

2.6 The strategy does not address the question of how strengthening health systems might undo progress in tackling the spread of priority diseases. The recent report *Healthy Aid* by Action for Global Health cited with evidence the case of Zambia, in which the introduction of general budget support and a sector-wide approach (SWAps) to health led to "the collapse of the Zambian TB programme". The report concluded that general budget support "only helps the Government deal with regular health problems and not extraordinary problems such as HIV, AIDS and TB".[19]

3. The lack of an effective monitoring framework to assess the progress of the strategy

3.0 In *An Inadequate Response*, RESULTS UK recommended that DFID's new AIDS strategy should include specific targets to address TB/HIV co-infection with clear steps outlining how they will be achieved. This recommendation was not taken on board and, in fact, the new AIDS strategy contains very few specific, quantifiable and time bound targets against which it can be held to account. Without clear targets the strategy will be both difficult to implement and monitor. DFID's overall Public Service Agreement (PSA) targets (as detailed in the 2008 DFID Annual Report), include no TB/HIV indicators and no TB indicators for Africa where the burden of TB is greatest. It is therefore crucial that TB/HIV targets are included in the new strategy's monitoring and evaluation framework in order to have some way of assessing the outcomes of DFID's efforts in this area. Suggestions for targets that could be used to monitor the progress of a DFID supported country in achieving TB/HIV collaboration are included in Appendix A.

3.1 The strategy states that an independent review will be commissioned in three years time, and the Government will also work through the cross-Whitehall working group on tackling AIDS to monitor implementation. Without more detailed spending targets and a monitoring and evaluation framework which outlines how DFID will measure impact and outcomes it is not clear how useful any such review will be.

Conclusion

In the foreword to the strategy Douglas Alexander states "This strategy places people at the heart of the response". RESULTS UK strongly endorses this approach and agrees that civil society and those most affected by HIV/AIDS should be involved at all levels of a multi-sectoral approach to achieving Universal Access. To effectively implement the new AIDS strategy the UK will need to address the specific challenges presented by the co-epidemic of TB/HIV and demonstrate a much stronger emphasis on outcomes; connecting the means of the strategy with the ends. Without this, the strategy may fail to benefit those people whom it intends to reach.

APPENDIX A

SUGGESTED TB/HIV INDICATORS TO MONITOR THE PROGRESS OF DFID SUPPORTED COUNTRIES IN ACHIEVING TB/HIV COLLABORATION

1. TB treatment for PLWHA in care.
   - Number of adults and children enrolled in HIV care who have started TB treatment.
2. HIV testing of TB Patients.
   - Proportion of all registered TB patients with documented HIV status recorded on the TB register.
3. ART in TB Patients with HIV.
   - Proportion of HIV-positive registered TB patients given ART during TB treatment.
4. TB status assessment in PLWHA in care: Intensified TB case-finding among People living with HIV.
   - Number of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit.
5. Proportion of HIV-positive TB patients who receive co-trimoxazole preventive therapy (CPT).
   - Number of HIV-positive TB patients who receive (at least one dose of) CPT during their TB treatment.
6. Proportion of adults and children newly enrolled in HIV care given treatment for latent TB infection.
   - Number of adults and children newly-enrolled in HIV care who are started on isoniazid preventive therapy (IPT) for latent TB infection.
7. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV.
   - Number of adults with advanced HIV infection who are currently receiving ART in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) and who were started on TB treatment (in accordance with national TB programme guidelines).

References

[1] World Health Organization. 2008. The Three I's: Intensified Case Finding (ICF), Isoniazid Preventive Therapy (IPT) and TB Infection Control (IC) for people living with HIV. Report of a WHO Joint HIV and TB Department Meeting. Geneva, Switzerland, April 2–4, 2008. Online. http://www.who.int/hiv/pub/meetingreports/WHO_3Is_meeting_report.pdf. Accessed 3 August, 2008.

[2] WHO. 2008. The Three I's.

[3] World Health Organization. TB/HIV: General Context and Implementation Issues. Presentation delivered to the 2008 Lambeth Conference July 28, 2008, Kent, UK.

[4] WHO. Frequently asked questions about TB and HIV. Online. http://www.who.int/tb/hiv/faq/en/. Accessed 3 August, 2008.

[5] Gandhi N, et al. 2006. Extensively drug-resistant tuberculosis as a cause of death in patients co-infected with tuberculosis and HIV in a rural area of South Africa. *The Lancet*. 368:1575–1580.

[6] World Bank. 2008. *The World Bank's Commitment to HIV/AIDS in Africa: Our Agenda for Action, 2007–2011*. Washington, DC.

[7] Godfrey-Faussett et al. 2002. How human immunodeficiency virus voluntary testing can contribute to tuberculosis control. Bulletin of the World Health Organization vol 80 no 12.

[8] World Health Organization. 2004. Interim Policy on Collaborative TB/HIV Activities. World Health Organization, Geneva. Ref. in http://www.who.int/mediacentre/news/releases/2004/pr5/en/

[9] World Health Organization. 2008. Global tuberculosis control: surveillance, planning, financing : WHO report 2008. (Data from 2006) WHO/HTM/TB/2008.393. Nigeria data from Nigeria Country TB-HIV report, 2008. (Data from 2007).

[10] K. Floyd, WHO, June 2008. unpublished calculations based on the *Global Plan to Stop TB*, 2006–2015.

[11] RESULTS UK, November 2007. An Inadequate Response: More than two decades of complacency in addressing the TB/HIV co-epidemic. Online http://www.results-uk.org/userfiles/inadequateresponse.pdf

[12] World Health Organisation. Global Tuberculosis Control—surveillance, planning, financing. WHO, March 2008. Online: http://www.who.int/tb/publications/global_report/en/

[13] Centre for the AIDS Programme of Research in South Africa (CAPRISA) study findings released 17

September 2008. Cited online at Aidsmap: *HIV treatment at same time as TB treatment halves death rate in South African study*: http://www.aidsmap.com/en/news/81BF3B62-9197-42D6-9DB3-44A784E2F0B1.asp

[14] House of Lords Select Committee on Intergovernmental Organisations. July 2008. Diseases Know No Frontiers: How effective are Intergovernmental Organisations in controlling their spread? London. The Stationery Office. Page 48.

[15] House of Lords Select Committee on Intergovernmental Organisations. July 2008. Diseases Know No Frontiers. London. The Stationery Office. Page 48.

[16] National Audit Office, February 2008. Department for International Development: Providing Budget Support to developing countries. London. The Stationery Office. Page 6.

[17] House of Commons Committee of Public Accounts, May 2008. Department for International Development: Providing budget support for developing countries. London. The Stationery Office. Page 5.
Online: http://www.publications.parliament.uk/pa/cm200708/cmselect/cmpubacc/395/395.pdf

[18] House of Commons International Development Select Committee. Department for International Development Annual Report 2007. London. The Stationery Office. Page 3.

[19] Action for Global Health, June 2008. Healthy Aid. Why Europe must deliver more aid, better spent to save the health Millennium Development Goals. Page 19.
Online: http://www.actionforglobalhealth.eu/publications/healthyaid/healthy_aid_english_version

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Memorandum submitted by STOP THE TRAFFIK

1. STOP THE TRAFFIK welcomes the Inquiry of the International Development Committee (IDC) into DFID's New Strategy on HIV/AIDS. However, we are disappointed that the IDC's Second Report of Session 2006–07 "HIV/AIDS: Marginalised Groups and Emerging Epidemics" made no mention of victims of human trafficking.[37] In particular, whilst the report identified sex workers as one of four key populations at risk, it did not identify trafficking victims as such.

2. DFID references to human trafficking victims in the context of HIV/AIDS have been present but sporadic. In the IDC's Fourth Report on Session 2006–07 "HIV/AIDS: Marginalised Groups and Emerging Epidemics: Government Response", DFID refers to its support of a programme in China and Nepal tackling the trafficking of children and women into prostitution.[38] DFID's New Strategy on HIV/AIDS, "Achieving Universal Access", recognises that "Female migrants and women and children caught up in conflict face increased risk of abuse, violence and trafficking and are at higher risk of HIV infection".[39] Yet they neglect to specifically address the spread of HIV/AIDS through human trafficking.

3. The centrality of human trafficking to the spread of HIV/AIDS is unavoidable and self-evident. STOP THE TRAFFIK urges the IDC and DFID to address the points raised in the evidence below.

4. The Southern African Network against Trafficking and Abuse of Children (SANTAC), a Southern African Development Community (SADC)-derived NGO, identifies HIV/AIDS as both a cause and a consequence of child trafficking.[40] As a causal factor of child trafficking, HIV/AIDS increases the number of orphans who are vulnerable to child trafficking, through lack of a secure environment and increased numbers of exploitable street children. It also increases the demand for sex with younger girls, who are perceived to be free from STDs. Furthermore, HIV transmission rates increase as a consequence of child trafficking, as child trafficking victims have little control over the conditions in which they are forced to have sex. UNICEF concurs, stating that children forced into the sex trade are the most vulnerable to contracting and spreading HIV/AIDS.[41]

5. In August 2007 the Journal of the American Medical Association (JAMA) published the results of a review into the prevalence of HIV/AIDS in Nepalese victims of sex trafficking.[42] Of 287 sex trafficking victims identified by a major Nepalese NGO, 38% tested positive for HIV. Girls trafficked prior to the age of 15 were at increased risk, with 60% of this age group infected, and were also at increased risk of longer duration in forced prostitution in multiple brothels. The review recommended increasing intervention in and reduction of sex trafficking to reduce the spread of HIV/AIDS.

6. Advocates for Human Rights, a US-based NGO, states that the rise of trafficking in women and girls for prostitution has led both to the emergence of new and the re-emergence of old STDs.[43] This has contributed to the increase of HIV transmission rates in women by two to ten times. Eastern European countries that have the highest numbers of trafficked women and girls also have the quickest spread of HIV/

[37] http://www.publications.parliament.uk/pa/cm200607/cmselect/cmintdev/46/46i.pdf
[38] http://www.publications.parliament.uk/pa/cm200607/cmselect/cmintdev/329/329.pdf
[39] http://www.dfid.gov.uk/pubs/files/achieving-universal-access.pdf
[40] http://www.againstchildabuse.org/en/human_trafficking/relationship_between_trafficking_and_hiv_aids
[41] http://www.unicef.org/newsline/01pr93printer.htm
[42] http://jama.ama-assn.org/cgi/content/abstract/298/5/536?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=trafficking&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT
[43] http://www.stopvaw.org/Trafficking_and_HIV_AIDS.html

AIDS. Human trafficking victims are particularly vulnerable to HIV/AIDS as they are forced to have sex against their will with multiple partners and no protection, and with no subsequent access to medical care. Human trafficking is also aiding the global dispersion of HIV subtypes, which are more resistant to treatment. Physicians recommend that anti-trafficking laws be enforced in order to stop the spread of HIV/AIDS.

7. The Global Fund To Fight AIDS, TB, and Malaria reports on the emergence of sex trafficking as an HIV/AIDS risk factor.[44] One study estimates that 25% of trafficked women in Mumbai, India, are HIV positive. Another found that over 60% of 218 trafficked Nepalese sex workers in Mumbai were HIV positive. The Fund notes the recommendation of the 8th International Congress on AIDS in Asia and the Pacific (ICAAP) that governments must work to merge their anti-trafficking and HIV prevention efforts.

8. STOP THE TRAFFIK particularly endorses this recommendation. The IDC should examine the feasibility of and recommend to DFID that the UK government integrate anti-trafficking work into all its poverty-reduction strategies. The sixth Millennium Development Goal (MDG) to halt and begin to reverse the spread of HIV/AIDS will only be achieved if human trafficking is tackled as both a cause and a consequence of the geographical and quantitative increase of HIV/AIDS and the vulnerability associated with it. This can be implemented by including criteria for anti-trafficking initiatives, such as preventative education, victim protection, and perpetrator prosecution, within both the multilateral Poverty Reduction Strategy Papers (PRSPs) of international financial institutions, and DFID's bilateral Country Assistance Plans (CAPs).

9. Such moves would fall under the long-term, preventative, and integrated human rights approach that DFID aspires to in its new strategy "Achieving Universal Access". It is only when DFID and the UK government take such steps that the spread of HIV/AIDS and human trafficking can be effectively tackled.

10. STOP THE TRAFFIK is a global movement of local communities campaigning against human trafficking. For more information, please contact 020 7921 4251, info@stopthetraffik.org, or visit www.stopthetraffik.org.

Memorandum submitted by Tearfund

Executive Summary

1. The Committee is aware that the new Strategy "*Achieving Universal Access—the UK's strategy for halting and reversing the spread of HIV in the developing world*" was published on 2 June 2008. Tearfund welcomes the new Strategy and recognises that it incorporates many of the concerns raised by civil society organisations during the consultation period in 2007.

2. Tearfund believes that 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. To this end, DFID and the FCO should strengthen national monitoring and evaluation systems to enable them to collect sufficient data for comprehensive reporting.

Introduction

3. Tearfund is a Christian relief and development agency working with partners to bring help and hope to communities in over 62 countries around the world. Tearfund currently supports over 190 faith based organisations and church groups to respond to HIV epidemics in Africa (generalised epidemic), Asia (concentrated epidemic), Latin America (concentrated epidemic), Russia (concentrated epidemic) and the Central Asian States (concentrated epidemic). We welcome the opportunity to input our views to the International Development Select Committee inquiry into HIV/AIDS: DFID's new Strategy.

4. Tearfund will address the following issues set out by the Committee:

- the extent to which DFID's Strategy will be effective in tackling the disproportionate impact of HIV/AIDS on women and children;
- how the new AIDS Strategy will be incorporated into DFID's Country Programmes;
- how civil society will be involved in implementing the new Strategy; and
- the likely effectiveness of monitoring systems in ensuring that funding announced in the Strategy reaches local level.

We have focused on those areas of the inquiry where we feel our experience of working with and on behalf of poor communities around the world enables us to make a valuable contribution to the work of the IDC.

[44] http://www.theglobalfund.org/programs/news_summary.aspx?newsid=2&countryid=SRL&lang=en

FACTUAL INFORMATION

The extent to which DFID's Strategy will be effective in tackling the disproportionate impact of HIV/AIDS on women and children

5. Tearfund will specifically address the Prevention of Mother to Child Transmission (PMTCT) and social protection in relation to the disproportionate impact of HIV on women and children.

6. Mother-to-child transmission (MTCT) of HIV, which can occur during pregnancy, delivery or breastfeeding, is responsible for over 90% of paediatric infections. Sub-Saharan Africa, where women represent 61% of adults living with HIV, accounted for 90% of the 420,000 children newly infected with HIV in 2007.[45] Without any interventions, one in three children of women living with HIV will be infected with HIV. With interventions, the rate of transmission of HIV from mother to child can be dramatically reduced. While many developing countries have made significant progress, there is an urgent need to scale up access to services to achieve global targets for PMTCT.

7. The risk of MTCT can be reduced by taking a comprehensive approach to PMTCT, including the engagement of male partners. A comprehensive approach includes preventing HIV infection in women, unintended pregnancy in women living with HIV and providing follow-up treatment, care and support for women who are positive, their children and families, in addition to interventions to prevent transmission during pregnancy, delivery and breast feeding. Antiretroviral treatment (ART) for pregnant women living with advanced HIV can also reduce the risk of MTCT, as well as improve the health of these women and, hence, of their children.

8. The new Strategy highlights that HIV disproportionately affects women and children and has an increased focus on prevention. Tearfund welcomes DFID's statement that prevention mechanisms must be based on the realities of people's lives. DFID should support the development and implementation of strategies which have increased involvement of male partners and communities as this supports the scale-up of PMTCT.[46]

9. DFID has identified PMTCT as an effective way to reduce the impact of HIV on women and children. Priority 1 includes a commitment to work with others to increase to 80% by 2010 the percentage of HIV-infected pregnant women who receive ARVs. Tearfund welcomes this reaffirmation of the commitment to universal access[47] to PMTCT and calls on the UK government to harness political leadership at international and national levels to strengthen government and donor accountability for existing commitments.

10. Tearfund welcomes the commitment to spend £6 billion on health systems and services up to 2015, and the Strategy's emphasis on the integration of PMTCT services into broader Maternal, Newborn and Child health services. Higher coverage of PMTCT has been achieved by countries that have taken steps to strengthen health systems and maternal, neonatal and child health services, and to integrate PMTCT interventions into existing services. Full integration of PMTCT into services and high coverage with antenatal care and delivery supervised by a skilled attendant are essential for successful scale-up of PMTCT.[48] DFID should ensure that:

- initiatives to strengthen health systems are used as an opportunity to address requirements for scale-up of PMTCT and paediatric care;
- maternal and child health services have the capacity to provide HIV counselling and testing, assess CD4 count or HIV clinical stage and offer ART or referral to nearby facilities providing ART; and
- human resource planning is strengthened and innovative solutions to shortages of human resources for health are developed and implemented.

11. DFID's new Strategy contains strong rhetoric on the rights and needs of women, but this needs to be reflected in the monitoring and evaluation (M&E) framework. DFID should build the capacity of national M&E systems to capture comprehensive data on PMTCT coverage, including data on:

- women accessing PMTCT services through the private sector and vertical programmes;
- how many pregnant women are assessed for ART eligibility;
- the proportion of people receiving ART who are pregnant women; and
- infant feeding and on the quality of follow-up treatment, care and support for women and infants.

12. Tearfund welcomes the announcement of £200 million for social protection which will help ensure that more orphans and vulnerable children have access to better nutrition, health and education. This demonstrates that children are a continuing priority for the UK Government. Social protection is an important mechanism to secure predictable support and welfare to vulnerable children and their carers.

[45] UNICEF (2007) Global campaign on children and AIDS: Unite for Children, Unite against AIDS. Stocktaking report.
[46] Tearfund (2008) Scaling up prevention of Mother-to-child transmission of HIV http://tilz.tearfund.org/webdocs/tilz/HIV/C8786_web.pdf
[47] UN (2006) Resolution adopted by the general assembly 60/262. Political Declaration on HIV/AIDS.
[48] Tearfund (2008) Scaling up prevention of Mother-to-child transmission of HIV http://tilz.tearfund.org/webdocs/tilz/HIV/C8786_web.pdf

13. However, social protection is only part of a comprehensive response to children affected by HIV. Children living with HIV remain at a higher risk of mortality than adults. A report by the World Health Organisation states that HIV has been the leading cause of death in children under 5 in six countries in Southern Africa. Children make up 6% of all HIV infections but 14% of overall deaths from HIV. It is not clear from the strategy how DFID will support the development and delivery of medicines and diagnostics for children living with or exposed to HIV in poor communities.

14. The Strategy includes information from DFID-funded research from 2004 showing a 43% reduction in mortality when children exposed to HIV are given cotrimoxazole, an affordable and simple antibiotic. Information from the World Health Organisation shows that four years on only 4% of children born to women living with HIV received this. Over 90% of children born to pregnant women in 2007 were not tested for HIV within the first two months of their lives. As part of DFID's new Southern African regional programme on Access to Medicines announced in the Strategy, concrete action must be taken to ensure the rapid development of improved infant diagnostics, increased availability of cotrimoxazole for children and paediatric antiretroviral treatment. DFID Southern Africa should produce an annual report on the regional Access to Medicines programme and include progress on support for paediatric diagnostics and paediatric treatment.

Incorporating the new AIDS Strategy into DFID's country programmes

15. The direction and commitment in the new Strategy is underpinned by the UK's comparative advantage in responding to HIV epidemics and where DFID can offer leadership. These include supporting country-led responses, building sustainable national systems and providing flexible resources directly to countries.

16. DFID field offices are highly decentralised, which has many advantages including a considerable degree of flexibility in responding to HIV. The UK's previous strategy on HIV "*Taking Action*" provided a broad framework that could be used as a guide to decision making in the national context rather than a set of prescribed aims and objectives. Under this arrangement there are fewer requirements to satisfy a centrally generated policy, but nevertheless make it more difficult to appraise the extent to which commitments are being adopted and to measure their impact effectively. Responding to HIV epidemics must be included in DFID Country Assistance Plans and in Director Delivery Plans.

17. The indicators in the monitoring and evaluation framework currently being devised are those which are already internationally agreed and are largely being reported on via the UNGASS Declaration of Commitment or as part of national monitoring systems. The indicators included in the final framework need to measure the impact of specific actions DFID is taking to contribute towards the achievement of international targets. Related to this, DFID field offices need to report annually on activities they have supported against each indicator.

18. Like its predecessor "*Taking Action*" the new Strategy is a UK government strategy, not a DFID strategy. Where the FCO has a presence in middle income countries, it too must be held accountable to the monitoring and evaluation framework and report against agreed indicators on an annual basis. This means that responding to HIV must be included in FCO country plans. Concentrated HIV epidemics in middle income countries primarily affect vulnerable groups, such as IDUs, sex workers, MSM and prisoners. These groups are less able to access services due to discrimination, criminalisation and exclusion. The FCO in middle income countries has a role to ensure that the rights of vulnerable and marginalised groups are protected and that their needs are met.

Civil society involvement in implementing the new AIDS Strategy

19. The Strategy acknowledges the vital role that civil society organisations play in responding to HIV epidemics; noting their role in service provision, awareness-raising activities and in advocacy, particularly with, and on behalf of, those most affected by HIV. It also highlights the role and work of faith-based organisations as a distinctive part of civil society. Studies indicate that half of all education and health care provision in sub-Saharan Africa are provided by faith groups.[49] In Lesotho 40% of HIV care and treatment services are being provided by Christian hospitals and health centres, and faith-based organisations run almost a third of HIV treatment facilities in Zambia.[50]

20. The funding commitment of £200 million to support social protection programmes announced in the new Strategy indicates that DFID will work with both government and civil society organisations. It is not yet clear how DFID intends to utilise and support the extensive experience of civil society stakeholders in responding to the rights and needs of vulnerable children in the planning and implementation of social protection programmes in the eight African countries identified in the Strategy.

[49] African Religious Health Assets Programme, 2006. *Appreciating Assets: The contribution of Religion to Universal Access in Africa*. Report for WHO, Cape Town: ARHAP, October 2006.
[50] ibid.

21. HIV epidemics demand more than a medical response. For example, the spread of HIV is exacerbated by ongoing gender equity, lack of education and employment opportunities. HIV effects the young and economically active. In hyper-epidemic countries HIV threatens to reverse hard won development gains and could adversely impact the achievement of the other MDGs. The Strategy acknowledges that an effective response includes harnessing expertise from other sectors including education, justice and social welfare. Aside from the £6 billion for strengthening health systems, and the £200 million for social protection programmes, the Strategy does not articulate how DFID intends to fund a comprehensive multi-sectoral response. Civil society organisations provide a range of responses outside of health care provision and are further marginalised because of the lack of clarity on how responses to HIV outside of health will be supported by the UK government.

22. Supporting the empowerment of people living with HIV and vulnerable groups is the only explicit reference to a civil society grouping under priorities for action (Priority 2: Respond to the needs and protect the rights of those most affected). 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 (vulnerable groups, women and children) are supported by a vast array of civil society programming in many low and middle income countries.

23. DFID field offices have a role to play in improving co-ordination, collaboration and partnership between civil society organisations, government departments and other donors. Country-owned plans must not become a euphemism for government-owned plans. The "Three Ones" principles provides a framework for engagement between government, donor and civil society stakeholders, but does not in and of itself promote better collaboration. The "Three Ones" principles can only be effective if there is a recognised and effective representation of all stakeholders on the co-ordinating structures through which government operates, and a common commitment to monitoring and evaluation.[51]

24. The interim evaluation[52] of 'Taking Action' acknowledges that HIV will require financial support through other aid instruments alongside Poverty Reduction Budget Support. It also highlights the need for DFID to identify and support effective mechanisms of direct funding to civil society; especially where civil society are providing services (including advocacy) that may be difficult for governments to deliver effectively. There is no clear indication in the new Strategy how DFID have incorporated these recommendations from the interim evaluation of "*Taking Action*". We would therefore recommend that DFID needs a clear strategy for engaging with civil society, including faith-based organisations, both here in the UK and at country level. DFID needs to support staff to become more literate about faith in their context to be effective in their roles.

25. A National Audit Office review in 2006[53] indicated that DFID needs to be better at assessing within country the roles and capacity of civil society organisations to contribute to poverty reduction. It is critical that DFID develops indicators in its monitoring and evaluation framework that measures the type, amount and impact of its support to civil society groups, including faith-based organisations. Civil society is not a homogenous group. Data must be disaggregated to reflect the diverse range of civil society actors involved in the response to HIV and to monitor effectively DFID's engagement across different civil society groupings. DFID needs to provide long overdue leadership on this issue, as there appears to be no internationally agreed indicators on government and donor engagement with civil society organisations.

Tracking funds to community level

26. Community-based organisations have a significant role to play in ensuring that hard-to-reach communities and vulnerable groups have access to health and education services, home-based care and livelihood initiatives. Local churches are responding to HIV. In Zimbabwe, for example, more than 20,000 local churches are running HIV programmes.[54] They are often the focal point in communities and, importantly, trusted by community members. Church-based programmes are mobilising thousands of volunteers to deliver community-based services and support with quality and compassion, motivated by their religious conviction. In some cases, these initiatives receive external support—but most start as a local response to need and exist on contributions from within the community. This raises concerns about the long-term sustainability of community-based initiatives in the face of chronic need.[55] Like other CBOs, local churches are struggling to meet the needs of community members affected by HIV. They are often underfunded and under capacity. Such groups are seldom seen or championed by policy-makers.

[51] Haddad, B, Olivier J, De Gruchy, S. 2008. *The potential and perils of partnership: Christian religious entities and collaborative stakeholders responding to HIV and AIDS in Kenya, Malawi and the DRC*. Study commissioned by Tearfund and UNAIDS. Interim report. ARHAP.

[52] Social & Scientific Systems, Inc. (2007) Interim Evaluation of "*Taking Action: The UK Government's Strategy for Tackling HIV and AIDS in the Developing World*": Final Report. DFID, Glasgow, Evaluation Report 676, xxxiii + 282pp.

[53] National Audit Office, 2006. *DFID: working with Non-Governmental Organisations and other Civil Society Organisations to promote development*. 6 July 2006.

[54] African Religious Health Assets Programme, 2006. *Appreciating Assets: The contribution of Religion to Universal Access in Africa*. Report for WHO, Cape Town: ARHAP, October 2006.

[55] Taylor, N. 2007. *DFID, faith and AIDS: A review for the update of "Taking Action"*. UK Consortium on AIDS and International Development—Faith Working Group, July 2007.

27. Tearfund welcomes the commitment in the new Strategy to track the flow of funds from national to community level and alleviate bottlenecks under priority 4. As DFID seeks to reduce its transaction costs by disbursing large amounts of funding via PRBS and through multi-laterals initiatives it is critical that funds can be effectively tracked to beneficiary level.

28. There are clear benefits to direct budget support including the strengthening of government capacity, increasing harmonisation between donors and expanding service delivery. It is designed to improve aid effectiveness by reinforcing developing country policies and systems and to reduce transaction costs. However, a recent report by the Committee of Public Accounts[56] indicates that the benefits of budget support have not been quantified and DFID has yet to establish the effectiveness of budget support relative to other types of aid or whether it represents value for money. DFID should support research on resource tracking and activities to alleviate bottlenecks and this should be reported on annually by DFID field offices. Research should focus on funds distributed by budget support and via multilateral initiatives, and support efforts to establish the effectiveness of budget support in comparison to other types of aid mechanisms.

Recommendations for Action

DFID should:

1. Support the development and implementation of strategies which have increased involvement of male partners and communities as this supports the scale-up of PMTCT.
2. Harness political leadership to strengthen government and donor accountability for existing commitments on PMTCT.
3. Ensure that initiatives to strengthen health systems are used as an opportunity to address requirements for scale-up of PMTCT and paediatric care.
4. Ensure that maternal and child health services have the capacity to provide HIV counselling and testing, assess CD4 count or HIV clinical stage and offer ART or referral to nearby facilities providing ART.
5. Ensure that human resource planning is strengthened and innovative solutions to shortages of human resources for health are developed and implemented.
6. Build the capacity of national M&E systems to capture comprehensive data on PMTCT coverage, including data on:
   - women accessing PMTCT services through the private sector and vertical programmes;
   - how many pregnant women are assessed for ART eligibility;
   - the proportion of people receiving ART who are pregnant women; and
   - infant feeding and on the quality of follow-up treatment, care and support for women and infants.
7. Take concrete action to ensure the rapid development of improved infant diagnostics, increased availability of cotrimoxazole for children and paediatric antiretroviral treatment and produce an annual report on the regional Access to Medicines programme which includes progress on support for paediatric diagnostics and paediatric treatment.
8. Develop a robust monitoring and evaluation framework which sets out clear targets and indicators to be reported on annually by DFID and FCO field offices; ensuring that data from these indicators is made publically available and clearly articulates the UK's contribution towards the achievement of international targets.
9. Ensure that responses to HIV epidemics are included in DFID Country Assistance Plans and in Director Delivery Plans.
10. Develop indicators in its monitoring and evaluation framework that measures the type, amount and impact of its support to civil society groups, including faith-based organisations. Civil society is not a homogenous group. Data must be disaggregated to reflect the diverse range of civil society actors involved in the response to HIV and to monitor effectively DFID's engagement across different civil society groupings.
11. Develop a clear strategy for engaging with civil society, including faith-based organisations, both here in the UK and at country level.
12. Identify and support effective mechanisms of direct funding to civil society organisations.
13. Set out clear plans for the involvement of civil society stakeholders in the development and implementation of social protection programmes in eight African countries over the next three years.
14. Support research on resource tracking and activities to alleviate bottlenecks. This should be reported on annually by DFID field offices.

[56] House of Commons. Committee of Public Accounts. June 2008. Department for International Development: Providing budget support for developing countries. Twenty-seventh Report of Session 2007–08.

The FCO should:

15. Report annually against agreed indicators in the monitoring and evaluation framework and incorporate relevant aspects of the new Strategy into country plans.

Memorandum submitted by UK Consortium on Aids and International Development

The UK Consortium on AIDS and International Development welcomes the opportunity to write a submission to the International Development Committee Inquiry on "Achieving Universal Access—the UK's strategy for halting and reversing the spread of HIV in the developing world".

The UK Consortium on AIDS and International Development is a group of more than 80 UK based organisations working together to understand and develop effective approaches to problems created by the HIV epidemic in developing countries. It enables each agency to bring its own expertise and experience to be shared and used to help all members improve their responses to the epidemic, through information exchange, networking, advocacy and campaigning. The Consortium has a number of working groups made up of member agencies and others who meet to strengthen their capacities through sharing good practice, exchanging information and developing collective policy position and advocacy initiatives. The Stop AIDS Campaign is the campaigning arm of the Consortium.

The UK Consortium's submission involves contributions from the Children affected by AIDS Working Group, the Gender Working Group and the Stop AIDS Campaign. The Executive Summary explains that the two Working Groups have written submissions to IDC Question 1 on the impact on women and children and the Stop AIDS Campaign has answered IDC Questions 6 and 7 on vertical funding and health systems strengthening.

Sally Joss
Coordinator

26 September 2008

Executive Summary

The UK Consortium on AIDS and International Development has answered four questions to the International Development Committee Inquiry on "Achieving Universal Access—the UK's strategy for halting and reversing the spread of HIV in the developing world". Both the Children Affected by AIDS Working Group and the Gender Working Group have answered IDC Question 1 on the impact on women and children. The Stop AIDS Campaign has combined IDC Questions 6 and 7 on vertical funding and health system strengthening. In this Executive Summary, the main recommendations for each IDC Question have been listed.

IDC Question 1. *The extent to which DFID's strategy will be effective in tackling the disproportionate impact of HIV and AIDS on women and children*

Annex 1—Children affect by AIDS (CABA) Working Group main recommendation is that DFID agree to take the following steps:

1. Indicate what specific actions DFID will be taking to contribute towards the accomplishment of the international targets listed in the M&E Framework.
2. Require DFID Field Offices in each PSA country to report annually on what activities they have supported against each agreed indicator.
3. Strengthen the national M&E systems in PSA countries to enable them collect the data required for comprehensive reporting.

Annex 2—Gender Working Group main recommendations are:

1. There is a need for greater detail and concrete commitments on key issues.
2. Addressing gender inequality and the impact of HIV, AIDS on women and children, requires supporting programmes with men.
3. DFID's leadership in integrating HIV, AIDS, sexual and reproductive health agendas and services, is essential in ensuring that women and girls have access to comprehensive services.

IDC Questions 6 and 7. *The impact of vertical funds on broader health system strengthening and comparative effectiveness in tackling HIV and AIDS of vertical funds and funding allocated to broader health system strengthening*

Annex 3—Stop AIDS Campaign recommendations are:

1. Include key AIDS specific targets and indicators in all funding.

2. The AIDS response is multisectoral and cannot be adequately responded to through the health sector alone.
3. Establish mechanisms to ensure the ongoing participation and involvement of civil society in the development, implementation and monitoring of funding allocations.
4. Investigate the possibility of using IHP+ as a model for how to effectively align, harmonise and coordinate the various funding mechanisms—both vertical and horizontal—for AIDS and health systems strengthening.
5. Ensure that the integration of vertical initiatives and broader health systems strengthening is done incrementally and methodically so that quality and results are protected.

Annex 1

CHILDREN AFFECTED BY HIV AND AIDS WORKING GROUP[57]

IDC Question 1—*The extent to which DFID's strategy will be effective in tackling the disproportionate impact of HIV and AIDS on women and children*

Indicators for Monitoring Issues related to Children Affected by HIV & AIDS in DFID's AIDS Strategy

The Children Affected by HIV & AIDS Working Group has been advocating for targets and indicators related to children affected by HIV & AIDS to be included in DFID's AIDS Strategy and M&E Framework.

The indicators below relate to issues outlined in the Strategy as priority actions and other issues that are mentioned as requiring attention.

The indicators are those which are internationally recognised and most are being collected by governments either for reporting progress on the UNGASS Declaration of Commitment or as part of national monitoring systems.

The main recommendation of the CABA Working Group is that DFID agree to take the following steps:

1. Indicate what specific actions DFID will be taking to contribute towards the accomplishment of the international targets listed in the M&E Framework.
2. Require DFID Field Offices in each PSA country to report annually on what activities they have supported against each agreed indicator.
3. Strengthen the national M&E systems in PSA countries to enable them collect the data required for comprehensive reporting.

DFID Priority 1: Increase Effort on HIV Prevention; Sustain Momentum for Treatment; Increase Effort on Care and Support

Top line UK priorities

— Work with others to intensify international efforts to increase to 80% by 2010 the percentage of HIV-positive pregnant women who receive anti-retroviral treatments (ARVs) to reduce the risk of mother to child transmission, both in low income and high prevalence countries. (P62)

Indicator

— Number and percentage of HIV-infected pregnant women who received antiretroviral to reduce the risk of mother-to-child-transmission. (UNGASS, 2008)

Other issues related to children highlighted by DFID

— Provide support to ensure that cotrimoxazole is better utilised as a paediatric prophylaxis. (P20)

[57] Members of The Working Group on Orphans and Vulnerable Children: AVERT, British Red Cross, Cafod, Care International, ChildHope, Christian Aid, Consortium for Street Children, Egmont Trust, Healthlink Worldwide, HelpAge International, Hope HIV, International HIV/AIDS Alliance, Learning for Life, Mildmay International, Partnership for Child Development, Plan UK, Religions for Peace UK, Samaritan's Purse International Relief, SOS Children's Villages, Street Child Africa, Tearfund, Uganda AIDS Action Fund, UNICEF UK, VSO and World Vision UK.

Indicator

— Number of infants born to women living with HIV receiving cotrimoxazole within two months of birth. (WHO & UNICEF for IATT, Report Card on PMTCT, 2008)

DFID Priority 2: Respond to the Needs and Protect the Rights of Those Most Affected

Other issues related to children highlighted by DFID

— National plans of action for OVC should be supported in a long-term, predictable manner. (P27)

Indicator

— Increasing score from 59% (2007 baseline) of the OVC Policy & Planning Effort Index in sub-Saharan Africa. (UNICEF, 2008)

DFID Priority 3: Support more Effective and Integrated Service Delivery

Top line UK priorities

— Spend over £200 million to support social protection programmes over the next three years. Work with governments and civil society in eight African countries to develop social protection policies and programmes that will provide effective and predictable support for the most vulnerable households, including those with children affected by AIDS. (P64)

Indicators

— Percentage of orphaned and vulnerable children aged 0–17 whose households received free basic external support in caring for the child. (UNGASS, 2008)

— Current school attendance among orphans and among non-orphans aged 10–14. (UNGASS, 2008)

— PROPOSED—DFID Field Offices in the eight countries provide annual progress reports on social protection programme.

— PROPOSED—DFID undertake evaluation of eight-country social protection programme in two to three years, which will include analysis of impact of cash transfers and appropriate social protection policies and services on children.

— PROPOSED—DFID Field Offices report annually on activities related to especially vulnerable children eg street children and disabled children.

Other issues related to children highlighted by DFID

1. We also need to ensure that . . . provide better diagnostics of children infected with HIV and greater access to paediatric treatment. (P39)
2. Regularly review our approach (on vulnerable children), including publishing a report following the biennial Global partners Forum on Children Affected by HIV & AIDS to ensure that the approach outlined here supports the most effective ways of meeting the needs and rights of OVCs. (P40)
3. Supporting the development, implementation and review of credible, ccomprehensive and costed national AIDS plans, which are linked to national health and other sector delivery plans. (P64)
4. Cash transfers must be part of a comprehensive system of care and support that includes family support services, accessible and affordable healthcare and education, psychosocial support, and broad livelihood support. (P39)
5. A new DFID Southern African regional programme on Access to Medicines will start in 2008. This will spend over £10 million (in the first three year phase) to improve availability and affordability of quality essential medicines and diagnostics in Southern Africa Development Community (SADC) Member States. (P45)
6. Promoting the implementation of education programmes that help young people, both those in and out of school, to have safe and healthy sexual relationships, free from stereotyping, violence and exploitation.

Indicators (numbers relate to issues above)

1a. Total number of HIV-infected children (<15 years of age) receiving ART.

1b. PROPOSED—Provide progress report on DFID support for UNITAID including activities on paediatric diagnostics and paediatric treatment.

2. PROPOSED—Produce report analysing DFID approach for effectively supporting OVCs, following Global Partners Forum.

3. Increasing score from 59% (2007 baseline) of the OVC Policy & Planning Effort Index in sub-Saharan Africa. (UNICEF, 2007)

4. PROPOSED—DFID undertake evaluation of 8-country social protection programme in two to three years, which will include analysis of impact of cash transfers and appropriate social protection policies and services on children.

5. PROPOSED—DFID Southern Africa to produce annual report on progress of Southern African regional programme on Access to Medicines and include analysis of support for paediatric diagnostics and paediatric treatment.

6a. Percentage of schools that provided life skills-based HIV education in the last academic year. (UNGASS, 2008)

6b. Number of national governments that have put in place national HIV prevention programmes for out of school youth in most or all districts in need. (UNGASS, 2008)

DFID Priority 4: Making Money Work Harder through an Effective and Co-ordinated Response

Other issues related to children highlighted by DFID

— Promoting efforts to track the flow of funds from national to community level and alleviate bottlenecks. (P65)

Indicators

— Total number of HIV-infected children (<15 years of age) receiving ART.

— Proposed—DFID supporting research on resource tracking and activities to alleviate bottlenecks (DFID Field Office Annual HIV & AIDS Activity reports.

Annex 2

GENDER WORKING GROUP[58]

IDC Question 1—*The extent to which DFID's strategy will be effective in tackling the disproportionate impact of HIV and AIDS on women and children*

1.0 Introduction

The HIV and AIDS epidemic is both fuelled by and exacerbates gender inequality. Traditional gender systems often put men and women at a disadvantage in the face of HIV and AIDS by restraining their ability to both stem the epidemic, and respond to its consequences effectively. In many countries, women are disproportionately infected and affected by HIV and AIDS. In sub-Saharan Africa, 59% of adults living with HIV are women and young women make up 75% of HIV positive 15–25 year olds in the region, with the majority of new infections occurring within heterosexual sexual relations.[59] This is due to a complex interaction of factors including the dependency of women and girls on men as a result of social, economic, legal and political factors, and their survival strategies in conditions of poverty, such as intergenerational sex, early marriage, and sex work.[60] Webs of historic and cultural gender traditions and contemporary attitudes shape the sexual behaviours of men and women and have a crucial impact on the spread of HIV. Gender norms of masculinity and discriminatory attitudes around sex between men can also distance and inhibit men and boys from taking responsibility for their own and others' safety and health.[61]

In order for DFID's strategy to be effective in addressing the impact of HIV and AIDS on women and children and responding to gender-related issues more broadly, the GWG suggests the following:

[58] The Gender Working Group consists of Action Aid, African HIV Policy Network, AMREF, CAFOD, Interact Worldwide, International Community of Women Living with HIV/AIDS, Naz Foundation International, One World Action, Progressio, Tearfund, VSO, Womankind, and a few consultants with expertise in gender and HIV.

[59] Karen Leiter, Senior Research Associate, Physicians for Human Rights, from Epidemic of Inequality: Women's Rights and HIV/AIDS in Botswana & Swaziland: An Evidence-based Report on Gender Inequity, Stigma and Discrimination http://physiciansforhumanrights.org/library/news-2007-05-25.html?print=t

[60] UNAIDS "Women and Girls" http://www.unaids.org/en/PolicyAndPractice/KeyPopulations/WomenGirls/default.asp—Accessed 19 September 2008

[61] UNAIDS Inter-Agency Task Team on Gender and HIV/AIDS "HIV/AIDS, Gender and Male Participation" http://www.genderandaids.org/downloads/events/Fact%20Sheets.pdf—Accessed 19 September 2008

2.1 *There is need for greater detail and concrete commitments on key issues*

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 to ensure this is achieved. In many cases, it also does not specify the support or resources that will be allocated to addressing the different gender drivers of HIV. Below are some key examples of issues that require further detail and solid commitment:

2.1.1 The strategy recommends that gender analysis is integrated into national AIDS strategies and plans and stresses the importance of tracking targets and indicators to measure outcomes for men, women and sexual minorities (pages 25 and 63). What are these targets and indicators? How will DFID ensure civil society engagement at country level? How will they ensure that gender analysis is integrated into country plans and how will this be measured in the implementation of the strategy?

2.1.2 We welcome the UK strategy commitment to fund social protection programmes to reduce the vulnerability of children and their carers through cash transfers, pensions and child support (page 39). The strategy commits to spend over £200 million to expand its social protection programmes in at least eight African countries (page 40). However, it is unclear how the eight countries will be selected, how these funds will be allocated, which social protection mechanisms will be supported and how the most vulnerable households will be identified. While the strategy recognises that the greatest burden of HIV care falls on women and girls, it makes no specific commitments regarding the vulnerabilities of primary or secondary carers for adults living with HIV.

2.1.3 The strategy recognises that violence against women and girls significantly increases their risk of HIV infection (page 24). What kind of support has been allocated to this intersection? How will DFID promote this intersection (violence and risk of contracting HIV) or underscore the need for other agencies to recognise it?

2.1.4 There is a welcomed emphasis in the strategy on the need to upscale and strengthen HIV prevention. The participation of people living with HIV in prevention is stressed, often to increase others' awareness or to reduce transmission between "couples". While the importance of wider strategies of HIV prevention for positive people is mentioned, the strategy needs to be clear about HIV prevention within the context of both discordant and concordant couples. Additionally, sexual and reproductive rights and well-being of people living with HIV needs to be stressed.

2.1.5 The strategy describes DFID's support of global and national networks of PLWH and affected communities (page 29) but does not detail how they support the networks and whether the support will be intensified as networks enhance their leadership in the HIV and AIDS response.

2.1.6 How will DFID support national governance structures such as National AIDS Councils and Country Coordinating Mechanisms of the Global Fund?

2.1.7 The strategy addresses stigma and discrimination throughout the document and suggests ways to address some stigma and discrimination issues (usually by suggesting that groups that experience stigma and discrimination are or can be empowered to advocate for issues that affect them). What specific interventions will DFID be supporting to address stigma and discrimination within the context of gender?

2.1.8 The strategy builds a strong case for new HIV prevention technologies, such as vaccines and microbicides (page 19). They are mentioned as a key priority, alongside the scale-up of existing technologies. The GWG welcomes the funding commitment to this issue. However, there is no discussion about how to engage stakeholder support for new technologies. Will DFID support advocacy and social research to explore and promote the potential use and uptake of new prevention technologies?

2.1.9 DFID has committed to spending up to £1 billion on development research over the next five years. One of their aims is to fill the gaps in our knowledge about gender and inequality in relation to HIV and AIDS (page 58). There is also reference to the need for more research to explore the structural drivers of the epidemic (page 15). What measures does DFID plan to take to support social research to gather more evidence about the impact of gender inequalities on HIV and AIDS responses?

The GWG recommends that DFID works with civil society organisations to establish clear and transparent mechanisms to track how much HIV and AIDS spending in DFID programmes reaches women and girls. We also recommend a dissagregation of data in budget lines and programmes so that the impact on gender equality can be measured.

2.2 *Addressing gender inequality and the impact of HIV and AIDS on women and children requires supporting programmes with men*

2.2.1 The involvement of men in discussion and reassessments of gender norms is crucial to the building of transformative HIV and AIDS awareness and programming.[62] However, there are few references to working with men outside Men who have Sex with Men (MSM). Men appear in the report in order to highlight how many women are infected, to highlight women's susceptibility (never their own) as deceivers

[62] World Health Organisation (2003). Review paper, "Integrating Gender into AIDS Programmes" http://www.genderandaids.org/downloads/events/Integrating%20Gender.pdf

or transmitters (page 15); as bracketed additions (for example, the section on family planning on page 17); in relation to circumcision; as having different risks from women (but only women's vulnerabilities are listed pages 24 and 25); or as having problem attitudes or behaviours (page 25).

2.2.2 Although the strategy states that "ultimately success relies on enabling people to change their behaviour" (page 4), it neglects addressing how men might do this. Condoms are mentioned in terms of increasing supply (pages 5 and 62). Even though the strategy states that on average, men in Africa use only three condoms a year, condom awareness and confidence-building or safer sex education for boys and men and the gender issues around this are never mentioned. The strategy speaks of it being an "urgent priority to improve strategies controlled by women", but says nothing of urgency of educating and enabling more men and boys to be more effective in strategies they can control.

2.2.3 The section on the sexual and reproductive health needs of men and MSM (page 26) fails to mention the ways social conditions disempower many men, how traditional gender formations of masculinity often inhibit change in boys and men, and reproduce the behaviours that put themselves as well as others at risk or in neglect. Additionally, while the strategy recognises that men are also at risk of sexual abuse during armed conflict and in prisons (page 28), the strategy recommends support systems for women, young people, children and vulnerable groups, without mentioning men (page 28). A gender analysis of national plans is promoted to measure the impact on women and girls—not boys and men too (29, 63). Men and women are listed as having the right to a satisfying sex life and reproductive choices (page 35) but the strategy does not address the complex power dynamics in how gender systems position men and women in relation to these. The recognition of the burden of care on women makes no mention of the need to challenge gender norms and stereotypes that discourage men from caring roles. The call for stronger political leadership makes no mention of ways male political leaders can play a crucial role in influencing masculinity norms and inspiring (or even requiring) men and boys to think differently about gender and act differently.

2.3 *DFID's leadership in integrating HIV and AIDS and sexual and reproductive health agendas and services is essential in ensuring that women and girls have access to comprehensive services*

The GWG welcomes the strong support for more effective and integrated service delivery. The strategy provides clear arguments for linking AIDS and other health services, integrating sexual and reproductive health rights with HIV and AIDS, and strengthening the wider health system (pages 34 and 35)—all of which will contribute to ensuring that individuals have a single point of access for key services. The GWG recommends that DFID uses its leadership position to advocate for more attention to this issue globally and uses its influence to actively support more effective and integrated service delivery, for example within the UN system, the World Bank and the Global Fund to fight AIDS, Tuberculosis and Malaria.

2.4 *In-country political initiatives to change legal frameworks and structural gender inequalities should be supported by DFID and the FCO*

The strategy raises several human rights issues in relation to HIV and AIDS. For example, it refers to the need for safe spaces for adolescent girls to meet and opportunities for them to learn life skills (page 27); the need to create social, legal and political environments to allow key populations to receive the support and services they need (page 28); and the fact that legal systems can be critical for tackling gender inequality, as well as stigma and discrimination (page 38). The strategy also states the FCO and DFID will work together to ensure broad and effective UK support to international and national AIDS responses that promote and protect human rights (page 58) and that the FCO will, through representation in multilateral institutions, provide and advocate for leadership on HIV programmes incorporating sexual and reproductive health and rights (page 59). These commitments are welcomed. However, in order to realise them, it is important that DFID promotes leadership on specific issues that influence women's rights, including the right to land and property, the right to sexual and reproductive health rights and services, and laws on inheritance and against gender-based violence. It is also important that cross-Whitehall meetings regularly take place in order to discuss and take forward these cross-cutting issues.

2.5 *In order to effectively implement, monitor and evaluate the strategy's effectiveness in addressing gender-related issues, DFID needs to clarify its commitment to gender equality in relation to the strategy and ensure that its staff are trained on gender equality analysis in the implementation of the strategy*

2.5.1 DFID states it is committed to gender equality (page 25) and refers to its Gender and Equality Action Plan (2007). However, it does not detail how the action plan relates to the implementation of the strategy.

2.5.2 DFID commits to strengthening the skills and competences of its staff to address gender inequality and promote women's rights in the context of AIDS, in line with the Gender Equality Action Plan (page 60). It is important that both the HIV and AIDS and Reproductive Health teams receive proper training on how to monitor and evaluate partnerships and funding to deliver on commitments for women and girls.

Annex 3

STOP AIDS CAMPAIGN

IDC Questions 6 and 7—*The impact of vertical funds on broader health system strengthening and the comparative effectiveness in tackling HIV/AIDS of vertical funds and funding allocated to broader health system strengthening*

1. Recommendations for Questions Six and Seven on Funding

1. Include key AIDS specific targets and indicators in all funding; including budget support and Health SWAp design, implementation and monitoring processes. Implementing systems such as National Health Accounts and/or National AIDS accounts, which allow for monitoring and tracking of funds, will be crucial as DFID move towards delivering aid through these broader health systems strengthening mechanisms.
2. The AIDS response is multisectoral and cannot be adequately responded to through the health sector alone. In light of this, the government must ensure that in addition to broader health systems strengthening, the specific resources required to deliver an effective response to the epidemic are made available and accessible to other sectors particularly the education and social sectors.
3. Establish mechanisms to ensure the ongoing participation and involvement of civil society in the development, implementation and monitoring of funding allocations. This will help ensure general budget support is more accountable to the communities it is meant to serve.
4. Investigate the possibility of using IHP+ as a model for how to effectively align, harmonise and coordinate the various funding mechanisms- both vertical and horizontal- for AIDS and health systems strengthening.
5. Ensure that the integration of vertical initiatives and broader health systems strengthening is done incrementally and methodically so that quality and results are protected. An approach that was not gradual seriously risks reversing gains in HIV prevention, treatment, care and support, which in turn would create additional burdens on health systems.

The Impact of Vertical Funds on Broader Health System Strengthening

2.1 There are many examples of how HIV programmes have strengthened health systems. A six country (Argentina, Brazil, the Dominican Republic, Uganda, Zambia, and Zimbabwe) study describes the following positive effects of HIV service scale up:

1. promoting integration of HIV, TB, and other health services;
2. relieving demand for hospital beds, emergency room services, and antibiotics that the AIDS crisis had created;
3. motivating and expanding the capacity of health care workers;
4. increasing access to health services for marginalised groups and the poor;
5. raising community awareness about health, sexuality, and human rights issues;
6. making AIDS-financed clinics, laboratories, and equipment available for other health services; and
7. improving commodity procurement and negotiation skills with suppliers.[63]

2.2 In Ghana, AIDS programme contributes to increasing health worker salaries across the health system. In Cambodia, the AIDS programme has contributed to strengthening integrated laboratory services and the supply management chain. In Argentina, HIV services have improved health care access for marginalised populations—sex workers, men who have sex with men, transgender and migrant populations.[64] Experience from Cambodia shows that the national continuum of care programme for People Living with HIV has generated a range of system wide benefits such as: improved staff motivation, increased utilisation of health facilities, improved infrastructure, health worker training, and a reinvigoration of paediatric care.[65] Evidence from Ethiopia, shows that the Global Fund to fight AIDS TB and Malaria (GFATM) programme has had positive impacts on human resource management, institutional development, commodity supply, and private/NGO sector involvement.[66] Evidence from rural Haiti shows

[63] International Treatment Preparedness Coalition, (July 2008), "Missing the Target 6: The HIV/AIDS response and Health Systems: Building on Success to Achieve Health Care for All.".
[64] Ibid.
[65] Dhaliwal M et al, (October 2007), "Cambodia's Continuum of Care for People Living with HIV Programme: Assessment of Quality and Cost Effectiveness", DFID Health Resource Centre.
[66] Banteyerga H, Kidanu A, Stillman K, (August 2006), "The system wide effects of the Global Fund in Ethiopia: final study report".

that an integrated HIV-TB programme resulted in improvements in the utilisation of primary health care services and health outcomes.[67] All these experiences offer key opportunities to build on and leverage for improving health care.

2.3 However, there is also a body of evidence on how HIV programmes have weakened health systems. A report on AIDS and health systems looked at the interactions between AIDS and health systems in Mozambique, Uganda and Zambia. It highlighted how certain AIDS programmes have adversely affected health systems in terms of the health information management processes and systems, supply management and human resources.[68] One of the most common criticisms levelled at AIDS programmes is that they weaken health systems by drawing away precious human resources from the public sector. In the context of a global deficit of 4.25 million health workers, this is particularly critical.[69]

2.4 Experience from Malawi shows that when political commitment from donors, government and civil society and robust national AIDS and health planning are present, both universal access and health systems strengthening goals can be advanced.[70] Malawi's Emergency Human Resource Plan, a six-year programme, funded by the Government of Malawi, GFATM and DFID, expands training capacity by 50%, addresses re-allocation of human resources, and increases the salaries of several cadres of health care workers. This is an example of how vertical and funding for health systems strengthening can be used together to achieve positive outcomes for both HIV and AIDS and the health MDGs. A further example of the positive synergies between disease specific funding and health systems strengthening is provided by examining Malawi's ART programme, the scale up of which has kept HIV-positive health workers healthy and reduced the burden on health facilities.[71]

The Comparative Effectiveness in Tackling HIV/AIDS of Vertical Funds and Funding Allocated to Broader Health System Strengthening

3.1 The most important issue to highlight in responding to this question is the fact that tackling HIV and AIDS requires a multisectoral response and cannot be tackled through a medical response alone. To draw on two important examples; the empowerment of women and the provision of HIV prevention education are key to tackling the epidemic. The funding of health systems alone would leave these sectors under funded and reverse the important gains made in working towards universal access to prevention, treatment, care and support.

3.2 This submission provides evidence on two types of broader health systems funding used by DFID; general budget support and Health Sector Wide Approach (Health SWAp). It argues that a mixture of both funding for health systems strengthening and vertical programmes is required and that coordination, harmonisation and alignment of these initiatives is crucial for tackling HIV and AIDS and meeting the health MDGs.

Broader Health Systems Strengthening

4.1 The National Audit Office (NAO) report on the Department for International Development's provision of budget support to developing countries, published in February 2008 highlights the following challenges associated with the provision of general budget support:

1. service expansion has often been at the expense of quality;
2. progress in strengthening financial management systems has been slower than expected;
3. budget support is expected to reduce the transaction costs of administering aid but it is difficult to quantify this; and
4. difficulties in monitoring utilisation of funds and therefore in monitoring impact.[72]

4.2 A case study examining the use of general budget support in Zambia[73] highlighted that it only helped the government deal with regular health problems and not the extraordinary problems such as AIDS, TB and malaria. It is vital that in working with governments to support the development of national health plans, DFID ensure that the HIV response is adequately mainstreamed. In Mozambique it was noted that

[67] Walton D A, Farmer P E et al, (2004), "Integrated HIV prevention and care strengthens primary health care: lessons from rural Haiti". J Public Health Policy 25(2):137–58.
[68] Oomman N, Bernstein M, Rosenzwig, (2008), "Seizing the opportunity of AIDS and health systems", The Centre for Global Development.
[69] WHO, (2006), "Working Together for Health, The World Health Report", http://www.who.int/whr/2006/en/
[70] Compernolle P, (2007), "Impact of increased aid flows for HIV/AIDS in developing countries: working towards a sustainable response", Royal Institute of Tropical Medicine, HEARD.
[71] McCoy D, McPake B, Mwapasa V, (2008), "The double burden of human resource and HIV crises: a case study of Malawi", Human Resources for Health 6:16.
[72] National Audit Office, (February 2008), "Department for International Development: Providing budget support to developing countries".
[73] Action for Global Health, (June, 2008), "Why Europe must deliver more aid, better spent to save the health Millennium Development Goals".

even though aid delivered through budget support has increased resources for health and underpinned a significant improvement in service delivery and outcomes, these only benefit selected population groups and resources for health are still insufficient.

4.3 More significant risks identified by the NAO report include:

1. funds being misapplied for political reasons or because of corruption; and
2. monitoring human rights dimensions.[74]

4.4 In the context of HIV AND AIDS which is highly stigmatised, these risks may translate into a lack of adequate investment in appropriately targeted HIV prevention, treatment, care and support services. The most at risk populations such as sex workers, men who have sex with men, people who use drugs and transgender populations typically do not access health services in the public sector. Therefore the use of budget support and SWAps alone are unlikely to improve their access to services. Civil society often plays an important role in the delivery of HIV services and the UK government must ensure that in addition to direct budget support funding is made available to civil society implementers.

4.5 By contrast, a recent report by the WHO[75] states that vertical programmes if a rapid response to a disease is needed; to gain economies of scale; to address the needs of target groups that are difficult to reach and to deliver certain very complex services when a highly skilled workforce is needed.

4.6 Without clear outcome indicators in place to monitor the achievement of important benchmarks such as the universal access targets, it cannot be assumed that budget support effectively contributes to poverty reduction and the achievement of the MDGs.

The Need for an Integrated Approach

5.1 Despite the risks and challenges associated with funding for broader health systems strengthening 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. In countries which have demonstrated significant progress in achieving universal access targets (eg: Cambodia, Kenya), investments in health systems strengthening—investments in laboratory and supply chain strengthening, expansion of health work force, training for health workforce, task shifting, involvement of civil society, including PLHIV—were key enabling factors.

5.2 The Global Polio Eradication Initiative (GPEI) and the African Programme for Onchocerciasus Control (APOC) provide examples of where the activities of vertical programmes have been integrated into the broader health systems. More than 40% of staff time funded through GPEI is devoted to provision of health services and the APOC community treatment networks are now being used by national health systems to deliver a range of health services.[76] In the context of achieving universal access, many are now suggesting that an integrated or "diagonal" approach offers an important solution for achieving universal access goals and expanding primary health care for all.[77, 78]

5.3 This submission recommends that vertical and health systems strengthening initiatives are integrated so that efforts are coordinated and harmonised, and the positive synergies between vertical initiatives and systems strengthening maximised. However, experience from the integration of TB programmes shows that rapid integration led to a decline in quality and results. For example, in Zambia the integration of the vertical TB programme into the mainstream health system led to the collapse of the TB programme.[79] The TB experience highlights that integration of vertical programmes into broader health systems and services requires political commitment and careful planning and management.[80]

Memorandum submitted by World Vision

Introduction

1. World Vision is a Christian relief, development and advocacy organisation, dedicated to working with children, families and communities to overcome poverty and injustice. Motivated by our Christian faith, World Vision is dedicated to working with the world's most vulnerable people. World Vision serves all people, regardless of religion, race, ethnicity or gender.

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[74] Ibid.
[75] Atun R A, Bennett S, and Duran A, (2008), "When do vertical (stand-alone) programmes have a place in health systems?", World Health Organisation.
[76] WHO, (2008), "Maximising Positive Synergies between health systems and Global Health Initiatives".
[77] Accessed at www.aids2008.org
[78] Ooms et al, (25 March 2008) "The 'diagonal' approach to Global Fund financing: a cure for the borader malaise of health systems".
[79] Action for Global Health, (June 2008), "Healthy Aid. Why Europe must deliver more aid, better spent to save the health Millennium Development Goals".
[80] Uplekar M, Raviglione M, (2007), "The 'vertical–horizontal' debates: time for the pendulum to rest (in peace)?"

Specific Comments on the IDC Question 1: "The Extent to which DFID's Strategy will be Effective in Tackling the Disproportionate Impact of HIV and AIDS on Women and Children"

2. Considerable progress has been made in recent years towards achieving universal access to prevention, treatment care and support for adults and children living with and affected by HIV and AIDS.[81] With greater political and financial attention, advances have been made on providing antiretroviral therapy for adults and children, preventing mother-to-child transmission of HIV and reducing the rate of new infections in a number of countries.

3. However, children are not benefiting equally from all of the recent advances that have been made, especially in terms of access to treatment for HIV. A recent report from UNAIDS states that in sub-Saharan Africa, children living with HIV are only one third as likely as adults to receive antiretroviral therapy.[82]

4. Sub-Saharan Africa remains the region where AIDS continues to have the most impact on the health, education, protection and survival of millions of children. Approximately 1.8 million children are living with HIV in the region and about 12 million children under 18 have lost one or both parents to AIDS.[83] HIV has contributed to increased child mortality rates across the region and has been the leading cause of death among children younger than five years of age in six countries, all in East and Southern Africa.[84]

5. Urgent and sustained action is needed by governments and the international community[85] to protect the rights and needs of all children living with and affected by HIV and AIDS to reach the goal of universal access. This must include enabling children to participate themselves according to their evolving capacities in all policies and programmes concerning them.

Care and Support for Orphans and Vulnerable Children

6. Taking Action, the UK Government's previous strategy to tackle HIV and AIDS, demonstrated the UK Government's commitment to children by including an earmark of 10% of all HIV and AIDS spending for orphans and vulnerable children (OVC). The earmark was an important statement of the UK's global leadership role and through this DFID encouraged other donors to follow their example and make children affected by AIDS a clear priority. As other donors, primarily PEPFAR, have pledged increases in funding for OVC, DFID's response in their new AIDS strategy is to move away from earmarked funding and take a multi-sectoral approach, with the aim of integrating National Plans of Action for OVC into national health, education and social protection plans.

7. The assumption that there will now be sufficient funding from other donors to provide essential care and support for OVC is not supported by recent information released by the UN. A report from the Secretary General on the UN High Level Meeting on AIDS in June this year highlighted a concern that many of the policies to address the needs of children orphaned or made vulnerable by HIV in high prevalence countries were not being implemented. Information from 11 high prevalence countries showed that only 15% of orphans were living in households receiving some form of assistance, representing only a modest increase from the 10% reported in 2005.[86]

8. DFID have restated their commitment to meet the needs of OVC within the new AIDS Strategy and announced the allocation of £200 million to develop social protection policies and programmes in at least eight African countries. This is welcomed by World Vision, especially as it is intended to ensure that orphans and vulnerable children should have access to education, health care and nutrition.

9. However there are two main concerns regarding this commitment:

- That there will be many competing demands for this money. Vulnerable households with children will be just one group, though money given to grandparents (as a pension) has been found to be an effective means of benefiting vulnerable children.
- There is a danger that funding for social protection will be regarded as limited to providing cash transfers, which whilst important, are only one part of the required package of policies and services needed to care and protect vulnerable children affected by HIV & AIDS (others include: child and legal protection services, psycho-social support, and strengthened community support). There is also evidence that social transfers do not necessarily benefit vulnerable children living outside family settings and in households where there is poor intra-household distribution.

[81] UNAIDS, August 2008 *Report on the Global AIDS Epidemic 2008.*
[82] ibid.
[83] ibid.
[84] WHO, UNAIDS and UNICEF, 2008, *Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector.*
[85] The international community includes: international non-governmental organisations, civil society organisations, UN agencies and international donors.
[86] UN General Assembly, Report of the Secretary General, April 2008, *Declaration of Commitment on HIV/AIDS and Political Declaration on HIV/AIDS: midway to the Millennium Development Goals.*

Recommendations:

10. It is essential that DFID supports holistic social protection which is well integrated and multi-sectoral, focusing on (i) social transfers (eg social transfers eg cash, vouchers and in-kind); (ii) support services (eg family support services, psycho-social support, child protection services, legal assistance) and (iii) social policies (eg legislation, policies and regulations).

11. It will be crucial for DFID to monitor the targets and indicators for the £200 million commitment to social protection, especially regarding the 8 African countries, to ensure that they support this comprehensive package. (See Annex 1 for more details on monitoring DFID's new AIDS Strategy).

12. DFID should support further efforts to disaggregate all data collected in relation to HIV and AIDS by age, to ensure that a clear picture of the status of children is available and is subsequently used to inform a more effective response.

Provide Paediatric Treatment

13. There are 2 million children under the age of 15 living with HIV world-wide, nearly nine out of 10 of them in sub-Saharan Africa. While rapid developments have been made over the last two years in the number of adults accessing anti-retroviral therapy, treatment for children has not kept pace. This was highlighted recently by the UN Secretary General who said that "Children living with HIV are significantly less likely to receive anti-retrovirals than HIV positive adults in sub-Saharan Africa".[87]

14. There are now a number of fixed-dose combinations for children, and the price of these first-line drugs has reduced dramatically, with the aid of negotiating power from the Clinton Foundation and UNITAID. But many ARVs simply do not exist in the easier to administer, child-adapted tablet formulation, and children continue to endure sub-standard treatment. Second-line regimens for children are expensive and complex, and more research and development is urgently needed in this area.

15. Early treatment within the first few months of life can dramatically improve the survival rates of children with HIV. A recent study in South Africa found that mortality was reduced by 75% in HIV-infected infants who were treated before they reached 12 weeks of age.[88] Diagnosis by clinical symptoms or by CD4 testing is not reliable and obviously delays the delivery of paediatric treatment, contributing to the low survival rates of HIV-infected infants. Most infants with HIV die under the age of two years and about one third will not live to see their first birthday.

16. The new DFID AIDS Strategy recognises the situation, stating that "Access to treatment for children remains inadequate. This is due in part to poor capacity to diagnose HIV infection in infants and the difficulty in tailoring dosage and formulations to meet their specific needs". (Page 19) Current diagnostics capable of detecting the HIV virus in infants are very costly and not quick, leading to difficulties in diagnosis and an increased risk of losing children to follow-up where services are available.

17. There have been some promising developments in diagnostics but they urgently need to be made affordable, adaptable and appropriate for resource-poor settings for infants below 18 months old, in whom antibody testing is unreliable. A recent report stated that only 8% of infants born to HIV positive pregnant women in 2007 were tested for HIV within two months of birth, further highlighting the need for urgent action.[89] It is also necessary to recognise the specific treatment needs of adolescents.

18. But despite reference to, and recognition of, the need to provide better diagnostics for children infected with HIV and greater access to paediatric treatment within the new AIDS Strategy, these crucial areas are not reflected in DFID's priority actions. Instead there seems to be an assumption that providing funding to UNITAID alone will ensure greater access to paediatric treatment. But DFID need to do much more to ensure that children living with HIV benefit from equal access as adults to HIV treatment, unlike the current situation in so many countries.

19. There is an announcement in the new AIDS Strategy of a new DFID Southern African regional programme on Access to Medicines in 2008 with £10 million to be spent in the first three year phase on quality essential medicines and diagnostics. (Page 45) Given that 90% of all children living with HIV are in sub-Saharan Africa, DFID should ensure that infant diagnostics and paediatric HIV treatment feature prominently in this programme and that real progress is made within the region in children's access to these life-saving services.

[87] United Nations General Assembly, April 2008, *Declaration of Commitment on HIV/AIDS and Political Declaration on HIV/AIDS: midway to the Millennium Development Goals—Report of the Secretary General.*
[88] UNAIDS, UNICEF and WHO, 2008, *Children and AIDS: Second stocktaking report: Actions and Progress.*
[89] WHO, UNAIDS and UNICEF, 2008, *Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector.*

Recommendation:

20. DFID must do more to scale up research and development, as well as access to infant diagnostics and paediatric antiretroviral therapy, through exisiting and new initiatives.

Scale Up Access to Cotrimoxazole

21. The new DFID AIDS strategy repeats findings highlighted in the previous AIDS strategy, from DFID funded research in Zambia in 2004 on cotrimoxazole, a cheap antibiotic, which when given to children exposed to HIV, gives a 43% reduction in mortality from opportunistic infections such as pnuemonia. (Page 20) However, a recent World Health Organisation report released this year, shows that four years on, globally only 4% of children born to women living with HIV received the drug.[90] A plan is urgently required to translate these DFID research findings into action so that the deaths of thousands of children can be prevented.

Recommendation:

22. DFID should commission research to identify key barriers at country level that prevent children accessing cotrimoxazole and subsequently provide support to countries to implement the recommendations of this research. The urgent scale up of cotrimoxazole should be a priority action for DFID.

Prevent Mother to Child Transmission of HIV (PMTCT)

23. One of DFID's priorities for action in the new AIDS strategy is the urgent improvement of services to prevent mother to child transmission of HIV. This is a key area for reducing new infections in children as the transmission of HIV from mother to child during pregnancy, childbirth and breast-feeding accounts for 90% of all HIV-positive children. 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.[91] Yet providing a mother with a full range of PMTCT services, including anti-retrovirals (ARVs), can reduce the risk of transmission to less than 2%.

24. In sub-Saharan Africa, young women between the ages of 15–24 are three to four times more likely than young men to contract HIV, and consequently their yet-to-be born babies are also at significant risk of being born with HIV.[92] There is an urgent need to scale up PMTCT services and pioneer comprehensive and accessible family-centred and child-friendly approaches in countries with generalised epidemics.

25. It is critical that the effectiveness of PMTCT services are measured to ensure that evidence-informed and well-targeted scale-up can take place. The potential of PMTCT programmes for targeting vulnerable mothers and children for additional assistance, including food, social protection and welfare is vastly under exploited. Family-centred approaches urgently need to be strengthened to provide comprehensive and integrated packages of treatment, care and support.

26. Substantial progress has been made over the past few years towards preventing mother-to-child transmission. In sub-Saharan Africa, the proportion of HIV-positive pregnant women receiving antiretroviral prophylaxis to reduce the risk of transmission in 2007 was 34%.[93] But despite recent scale up of PMTCT services, Africa, and the world, remain far short of the target of 80% coverage by 2010.

27. DFID's commitment on PMTCT in the new AIDS Strategy is directly linked to this international target, seen in the pledge that the UK will "Work with others to intensify international efforts to increase to 80% by 2010 the percentage of HIV-infected pregnant women who receive anti-retroviral treatments to reduce the risk of mother to child transmission". (Page 62)

Recommendation:

28. DFID should outline what the specific contribution they will make to meeting the international target of 80% coverage for PMTCT will be, and how it will be measured.

Specific Comments on the IDC Question 3: "How the New AIDS Strategy will be Incorporated into DFID's Country Programmes"

29. It is critical for the successful implementation of DFID's AIDS Strategy that it is incorporated and implemented within DFID's Country Programmes. Specific indicators related to the new AIDS Strategy must feature in Country Assistance Plans as they are updated, and in the Director's Delivery Plans or other strategic documents, to ensure that DFID's response to HIV and AIDS can be monitored.

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[90] ibid.
[91] UNAIDS, 2005, *AIDS epidemic update: December 2005.*
[92] UNICEF, PMTCT Report Card 2005, Monitoring Progress on the Implementation of Programs to Prevent Mother to Child Transmission of HIV.
[93] UNAIDS, UNICEF and WHO, 2008, *Children and AIDS: Second stocktaking report: Actions and Progress.*

Recommendation:

30. DFID should include indicators related to country level implementation within the Monitoring and Evaluation Framework currently in development. (See Annex 1 for more details on monitoring DFID's new AIDS Strategy).

Specific Comments on the IDC Question 5: "The Likely Effectiveness of Monitoring Systems in Ensuring that the Funding Announced in the Strategy Reaches Local Level"

31. One of the "Key Messages" of DFID's new AIDS Strategy is that resources need to be channelled to where they are most needed—including to communities and community-based organisations. In the response to HIV and AIDS it is essential that the value of providing funding to civil society and community-based organisations be recognised. The AIDS Strategy goes on to say "Money and opportunities must be made available to community-based organisations and networks of those most affected by AIDS to maximise their contribution" which should include: "delivering services and creating demand, challenging inequality, advocacy and strengthening accountability". (Page 47) It is essential that community structures are strengthened in order to play a vital role in providing the care and child protection services, which must be provided alongside cash transfers. However, the strategy does not say what DFID will do to support this.

Recommendation:

32. DFID should outline how they will support community-based organisations to ensure that they have the capacity to strengthen community structures.

Monitoring and Evaluation

33. The effectiveness of monitoring the commitments made by DFID in the new AIDS Strategy relies mainly on the Monitoring and Evaluation Framework, which is currently being developed. Detailed recommendations of specific indicators to monitor issues related to children affected by AIDS in the Strategy are included in Annex 1 of this submission. These indicators represent the work of the Children Affected by AIDS Working Group of the UK Consortium on AIDS and International Development, of which World Vision is an active member.

Annex 1

CHILDREN AFFECTED BY HIV AND AIDS (CABA) WORKING GROUP[94]

IDC Question 1—*The extent to which DFID's strategy will be effective in tackling the disproportionate impact of HIV and AIDS on women and children*

Indicators for Monitoring issues related to Children Affected by HIV and AIDS in DFID's AIDS Strategy

The Children Affected by HIV and AIDS Working Group has been advocating for targets and indicators related to children affected by HIV and AIDS to be included in DFID's AIDS Strategy and Monitoring & Evaluation Framework.

The indicators below relate to issues outlined in the Strategy as priority actions and other issues that are mentioned as requiring attention.

The indicators are those which are internationally recognised and most are being collected by governments either for reporting progress on the UNGASS Declaration of Commitment or as part of national monitoring systems.

The main recommendation of the CABA Working Group is that DFID agree to take the following steps:

1. Indicate what specific actions DFID will be taking to contribute towards the accomplishment of the international targets listed in the M&E Framework.
2. Require DFID Field Offices in each PSA country to report annually on what activities they have supported against each agreed indicator.
3. Strengthen the national M&E systems in PSA countries to enable them collect the data required for comprehensive reporting.

[94] Members of The Working Group on Children Affected by HIV and AIDS: AVERT, British Red Cross, Cafod, Care International, ChildHope, Christian Aid, Consortium for Street Children, Egmont Trust, Healthlink Worldwide, HelpAge International, Hope HIV, International HIV/AIDS Alliance, Learning for Life, Mildmay International, Partnership for Child Development, Plan UK, Religions for Peace UK, Samaritan's Purse International Relief, SOS Children's Villages, Street Child Africa, Tearfund, Uganda AIDS Action Fund, UNICEF UK, VSO and World Vision UK.

DFID Priority 1: Increase Effort on HIV Prevention; Sustain Momentum for Treatment; Increase Effort on Care and Support

Top line UK priorities

— Work with others to intensify international efforts to increase to 80% by 2010 the percentage of HIV-positive pregnant women who receive anti-retroviral treatments (ARVs) to reduce the risk of mother to child transmission, both in low income and high prevalence countries. (P62)

Indicator:

— Number and percentage of HIV-infected pregnant women who received antiretrovirals to reduce the risk of mother-to-child-transmission. (UNGASS, 2008)

Other issues related to children highlighted by DFID

— Provide support to ensure that cotrimoxazole is better utilised as a paediatric prophylaxis. (P20)

Indicator:

— Number of infants born to women living with HIV receiving cotrimoxazole within two months of birth. (WHO & UNICEF for IATT, Report Card on PMTCT, 2008)

DFID Priority 2: Respond to the Needs and Protect the Rights of those Most Affected

Other issues related to children highlighted by DFID

— National plans of action for OVC should be supported in a long-term, predictable manner. (P27)

Indicator:

— Increasing score from 59% (2007 baseline) of the OVC Policy & Planning Effort Index in sub-Saharan Africa. (UNICEF, 2008)

DFID Priority 3: Support more Effective and Integrated Service Delivery

Top line UK priorities

— Spend over £200 million to support social protection programmes over the next three years. Work with governments and civil society in eight African countries to develop social protection policies and programmes that will provide effective and predictable support for the most vulnerable households, including those with children affected by AIDS. (P64)

Indicators:

— Percentage of orphaned and vulnerable children aged 0–17 whose households received free basic external support in caring for the child. (UNGASS, 2008)
— Current school attendance among orphans and among non-orphans aged 10–14. (UNGASS, 2008)
— Proposed—DFID Field Offices in the eight countries provide annual progress reports on social protection programme.
— Proposed—DFID undertake evaluation of eight-country social protection programme in two to three years, which will include analysis of impact of cash transfers and appropriate social protection policies and services on children.
— Proposed—DFID Field Offices report annually on activities related to especially vulnerable children eg street children and disabled children.

Other issues related to children highlighted by DFID

1. We also need to ensure that… provide better diagnostics of children infected with HIV and greater access to paediatric treatment. (P39)
2. Regularly review our approach (on vulnerable children), including publishing a report following the biennial Global partners Forum on Children Affected by HIV & AIDS to ensure that the approach outlined here supports the most effective ways of meeting the needs and rights of OVCs. (P40)

3. Supporting the development, implementation and review of credible, comprehensive and costed national AIDS plans, which are linked to national health and other sector delivery plans. (P64)
4. Cash transfers must be part of a comprehensive system of care and support that includes family support services, accessible and affordable healthcare and education, psychosocial support, and broad livelihood support. (P39)
5. A new DFID Southern African regional programme on Access to Medicines will start in 2008. This will spend over £10 million (in the first three year phase) to improve availability and affordability of quality essential medicines and diagnostics in Southern Africa Development Community (SADC) Member States. (P45)
6. Promoting the implementation of education programmes that help young people, both those in and out of school, to have safe and healthy sexual relationships, free from stereotyping, violence and exploitation.

Indicators (numbers relate to issues above):

1a. Total number of HIV-infected children (< 15 years of age) receiving ART.
1b. Proposed—Provide progress report on DFID support for UNITAID including activities on paediatric diagnostics and paediatric treatment.
2. Proposed—Produce report analysing DFID approach for effectively supporting OVCs, following Global Partners Forum.
3. Increasing score from 59% (2007 baseline) of the OVC Policy & Planning Effort Index in sub-Saharan Africa (UNICEF, 2007).
4. Proposed—DFID undertake evaluation of eight-country social protection programme in two to three years, which will include analysis of impact of cash transfers and appropriate social protection policies and services on children.
5. Proposed—DFID Southern Africa to produce annual report on progress of Southern African regional programme on Access to Medicines and include analysis of support for paediatric diagnostics and paediatric treatment.
6a. Percentage of schools that provided life skills-based HIV education in the last academic year. (UNGASS, 2008)
6b. Number of national governments that have put in place national HIV prevention programmes for out of school youth in most or all districts in need. (UNGASS, 2008)

DFID Priority 4: Making Money Work Harder through an Effective and Co-ordinated Response

Other issues related to children highlighted by DFID

— Promoting efforts to track the flow of funds from national to community level and alleviate bottlenecks.(P65)

Indicators:

— Total number of HIV-infected children (< 15 years of age) receiving ART.
— Proposed—DFID supporting research on resource tracking and activities to alleviate bottlenecks (DFID Field Office Annual HIV & AIDS Activity reports.

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