



House of Commons
International Development
Committee

**Progress on the
Implementation of
DFID's HIV/AIDS
Strategy: Government
Response to the
Committee's First
Report of Session
2009-10**

**Third Special Report of Session
2009-10**

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International Development Committee

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Third Special Report

On 1 December 2009 the International Development Committee published its First Report of Session 2009-10, *Progress on the Implementation of DFID's HIV/AIDS Strategy*, HC 49-I. On 1 February 2010 we received the Government's Response to the Report. It is reproduced as an Appendix to this Special Report.

In the Government Response, the Committee's conclusions and recommendations are in bold text. The Government's response is in plain text.

Appendix: Government response

Monitoring and Evaluation

[Paragraph 14] We welcome the innovative approach which DFID used in drawing up the Monitoring and Evaluation Framework for its HIV/AIDS Strategy. We look forward to the publication of the first biennial report on World Aids Day 2010, and expect it to provide valuable information on progress made by DFID against its commitments in the Strategy. To further enhance transparency and accountability, we recommend that DFID publishes, in full, the completed biennial country overviews of progress against its priorities for action. This will assist all stakeholders, including ourselves, in assessing whether DFID is achieving its objectives for its HIV/AIDS activities.

[Paragraph 15] A challenge remains in disaggregating DFID's contribution from that of other partners in the global AIDS effort. This is necessary to demonstrate to UK taxpayers what the UK's substantial funding for HIV/AIDS is achieving. We recommend that, in response to this Report, DFID provides us with further information on its plans for measuring the specific contribution its funding is making to tackling HIV/AIDS.

We welcome the Committee's recognition that the Government has led the way with our approach to monitoring and evaluating the Strategy. The report cites witnesses from civil society who have welcomed our Baseline Report as a "massive move forward" and applauded DFID for "leading well at the international level in terms of global indicators."

The Government accepts the first recommendation of the Committee's report. We will publish the country returns that will inform the first biennial report on World AIDS Day 2010.

We also agree that it is challenging to disaggregate one country's contribution from global efforts. Despite these challenges, it is clear that UK taxpayers' investment is buying results for the developing world.

Where we fund directly, we have very strong evidence that our actions are achieving results. Provision of condoms is a clear example: for instance, 75% of the condoms in Nigeria between 2002 and 2008 were provided by DFID. That period also saw condom use at first sex rise from 64% to 75%.

This type of engagement is crucial if we are to reach the poorest and most marginalised—but it is not enough in itself. It is important to recognise that working with partners, in a way that is harmonised and aligned with country plans, as enshrined in the Paris principles, is the best way to tackle the epidemic.

In such, environments, where we are but one of many players, the Strategy's success must be measured in terms of national level progress against the epidemic. So for example, the 2009 DFID Annual Report reports on HIV prevalence in our 22 PSA countries. This shows progress in some countries (Uganda, Zambia, Zimbabwe, Malawi and Rwanda)—but still a long way to go.

Even in complex environments, where attribution is more challenging, we still have evidence that our work is leading to real gains. For example, in Pakistan, as a result of DFID support to the National AIDS Control Programme, injecting drug users are more likely to use clean needles and syringes: the percentage using new needles and syringes increased from 22% in 2005/06 to 48% in 2007/08. Other examples can be found in our AIDS baseline report, published in October 2009.

Attribution of result to our contribution to multilateral efforts is also complicated—but again we can demonstrate impact. For example, on the basis of our share of funding, we calculate UK support to the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) has saved over 300,000 lives since 2001.

The first opportunity to assess in detail the impact of the AIDS Strategy will come with our first report on its implementation, which is due in December 2010. We will take the points raised by the Committee into account as we prepare this report. At the same time our monitoring of the International Health Partnership, through the consortium "IHP+Results", will also measure DFID's progress against IHP+ commitments to make our health aid more effective.

Health system strengthening

[Paragraph 25] We strongly support the substantial funding which DFID is providing to strengthen health systems in developing countries and fully accept that capable and well resourced health services are an integral part of an effective HIV/AIDS strategy. We remain seriously concerned, however, that DFID has no mechanisms in place to track the impact which its £6 billion funding for health systems will have specifically on HIV/AIDS care, despite this being one of the key elements of its Strategy. We reject DFID's assertion that it is not "feasible, practical or desirable" to specify how its £6 billion in health systems funding will be allocated. We recommend that, in response to this Report, the Department provide us with a meaningful breakdown of its spending plans for this funding package, at least over the next two to three years, including an indication of how HIV/AIDS programmes are likely to benefit.

[Paragraph 26] The focus on health systems also ignores that fact that some of the essential components of universal access, particularly prevention and long-term care in the community, may not benefit from health systems funding. We recommend that, in response to this Report, DFID sets out how it will ensure that its HIV/AIDS Strategy promotes an holistic approach which includes prevention, treatment, care and support

for all people living with HIV/AIDS, including those vulnerable to discrimination and stigmatisation. This approach must also recognise that prevention and care services are frequently provided outside the public health sector, by family members and community groups, and that targeted prevention programmes aimed at marginalised groups are often one of the most effective HIV interventions.

We fully agree that strengthening health services (to provide the appropriate levels of treatment, care and support) is only one part of a broader and comprehensive HIV and AIDS response, as outlined in our Strategy.

We reject the assertion that we have no mechanism in place to track the impact of this spend on AIDS

DFID continues to improve the quality of all its monitoring systems. In addition to continuing to track spend specifically targeting HIV and AIDS initiatives, we now have improved systems for monitoring the impact of those interventions. In 2009 we introduced a new log frame format which is helping us improve the quality of project design, monitoring and measuring results. We have also introduced a set of standard indicators at output and outcome level to enable DFID to better aggregate the impact of its aid across countries. The first results of this work were reported in our 2009 Annual Report showing, for example, that in 2007/08 through our bilateral programme alone we provided anti-retroviral (ARV) drugs for nearly 100,000 people and distributed half a billion condoms.

It is true that there are challenges in attributing how far a country's progress against AIDS is attributable to any particular health system strengthening measure, such as investment in workforce. But the evidence shows that tackling these underlying issues are crucial to any sustainable response.

The success of health system strengthening as a tool to tackle AIDS will ultimately be judged by the progress benefiting countries make against the disease. This is a long term solution; we shall return to the impact of investment since 2008 in our 2010 report and in subsequent years.

We have not changed our view about specifying in advance how the £6 billion funding for health systems and services will be spent. Our spending plans over the 3 year period to 10/11 are set out in the Comprehensive Spending Review. We have also made some commitments beyond this within country programmes and at global level. The commitment to spend £6 billion over 7 years is one example. However, circumstances inevitably change at both country and global level; and so we cannot fully anticipate now how our money will be allocated and what results it will achieve. This becomes clear on a country by country basis, as plans are developed according to each country's planning cycle.

As the Committee is aware, DFID has a decentralised and country-led funding model, in order to meet the specific needs of different country contexts. Many of the decisions on how resources are allocated and spent are made at country level, taking into account the disease burden, the role of other donors and other factors. The Strategy sets out the overall strategic frameworks and commitments within which DFID country programmes will make specific programming choices according to the specific national and regional profiles of the epidemics they face. We will report on the progress of the programmes in our first

report. But it would be wrong for the detail of these programmes to be set in advance as part of a global strategy.

It is also important to stress (as the Government did in its response to the IDC's 2008 AIDS report) that our commitment to health systems is only one part of our approach. We completely agree with the Committee that action beyond health systems is crucial if we are to tackle the epidemic—amongst vulnerable and marginalised groups in particular. For example our support to bilateral and multilateral programmes in India, Pakistan and Nepal explicitly target marginalised groups such as injecting drugs users and sex workers, including working through the non-state sector. Our Strategy makes this clear and calls for an effective response and the need for all sectors including health, education, justice and social welfare to be involved. We will report on progress in next year's progress report.

Integration of HIV/AIDS with other disease programmes

[Paragraph 33] We were disappointed that no measures for monitoring the integration of HIV/AIDS, TB and malaria programmes were included in the Monitoring and Evaluation Framework. An integrated approach to tackling these diseases is a key element in an effective AIDS strategy, given that so many people with HIV die from TB and malaria and that people with TB and malaria are more vulnerable to HIV. More resources are needed to promote early detection of TB, including funding for new diagnostic tools, as well as support for research into new drug treatment regimes. Greater attention must also be given to interaction with other diseases, particularly hepatitis C. We recommend that, in response to this Report, DFID provides us with information on its plans for developing programmes and funding research into co-infections between HIV/AIDS and other diseases, beyond TB and malaria.

[Paragraph 36] We welcome DFID's acknowledgement of the close links between promoting sexual and reproductive health and tackling HIV/AIDS. We were, however, disappointed to learn that DFID had postponed indefinitely the publication of its Maternal Health and Sexual and Reproductive Health and Rights Strategy, initially planned for mid- 2009. We urge DFID to publish this important document as soon as possible and to ensure that it takes full account of the need for the integration of HIV/AIDS programmes with sexual, reproductive and maternal health services.

We agree TB/HIV co-infection is now a central and worrying feature of the epidemic. However, TB diagnosis is difficult in people living with HIV, and TB and HIV drug interactions make treatment very complex. Systems are working independently, with failure to link both testing and treatment services. New TB diagnostic tools are needed (particularly to pick up "latent" TB). There is also a growing problem of Multi and "Extreme" Drug Resistance (totally untreatable TB) partly due to ignoring co-infection. This is a rapidly growing problem: TB incidence rates have doubled or tripled in Sub-Saharan Africa in the last 15 years. 50% of TB deaths are in people living with HIV in Africa (7% in SE Asia). The TB Case fatality rate in HIV-positive individuals is over three times that for those uninfected.

The 2 diseases must be considered together, and treatment of TB in people living with HIV must be started without delay. The biggest challenge to integration in resource limited

settings is human resources; integrating diagnosis will also stress weak and under-resourced systems, by identifying new cases.

WHO guidelines for TB/HIV are under development and are expected to provide key recommendations on how to address the challenges posed by the overlapping epidemics.

DFID provides significant funding for communicable disease research. While it is correct that the bulk of this funding is for research into HIV, tuberculosis and malaria, there is also substantial funding for research into other diseases. The current major programmes include:

- Funding for the Global Alliance for Tuberculosis Drug Development, with a major focus on developing new drugs, which people co-infected with both HIV and TB may use effectively. (£18 million 2008–2013)
- The Special Programme for Research into Tropical Diseases (TDR) at WHO is also working on diagnostics for a range of diseases, including tuberculosis. (£12 million 2008–13)
- The Drugs for Neglected Diseases Initiative (DNDi) has been supported to develop new drugs for Sleeping Sickness, Chagas Diseases and Leishmaniasis. (£18 million 2008–13)

DFID is currently finalising a number of new research programmes which will further enhance our work on communicable diseases. These include:

- Currently calling for new bids for Research Programme Consortia (RPC) for the delivery of effective health services. Some of this work will focus on communicable diseases, particularly HIV, tuberculosis and malaria.
- Foundation for Innovative New Diagnostics (FIND) new Product Development Partnership (PDP) about to be funded for work on diagnostics, including for tuberculosis. (£5 million 2010–14)
- About to increase funding for Diarrhoeal Disease through funding for the Institute for One World Health (iOWH) and the PATH Diarrhoeal Diseases Vaccine Programme (each to receive £5 million 2010–14)
- PDP for research into TB Vaccine, AERAS, with significant focus on those who are co-infected with HIV. (£8 million 2010–14)

As advised to the Chair of the IDC, after careful consideration by DFID Ministers it was decided that the updated strategy on reproductive and maternal health would not be produced in 2009 as was originally planned, but in 2010. This has enabled DFID to take advantage of and influence the unprecedented international political interest in reproductive and maternal health in 2009. This resulted in the launch of the groundbreaking Consensus for Maternal, Newborn and Child Health in New York on 23 September. The outcomes of this event also included pledges for £3.2 billion for health systems to be used to improve health services across the developing world with the potential of saving millions of lives, especially those of women and children. The event also highlighted the importance of providing health services free at the point of delivery.

Leaders from Nepal, Malawi, Ghana, Liberia, Burundi and Sierra Leone all announced expanded access to free health care which will result in ten million more people gaining access to free care. The UK also pledged £100 million on health over the next three years in those countries which announced their free health care plans. We continue to play a leading role in driving the operationalisation of the Consensus.

The detailed process of analysing data and evidence for the production of an updated strategy is well underway for publication in late 2010.

Social protection programmes

[Paragraph 42] We remain concerned that many of the most vulnerable people affected by HIV/AIDS, particularly children, may be excluded from social protection programmes. Cash transfers, while very effective in some situations, are not a sufficient mechanism for reaching those most in need because marginalised people, particularly those engaged in activities deemed to be illegal, are often unwilling or unable to access services. We are not convinced that DFID has the necessary mechanisms in place to enable it to measure the impact which its funding for social protection is achieving and to assess whether it is reaching the priority groups affected by HIV/AIDS. We recommend that, in response to this Report, DFID provides us with detailed information on how it plans to track its social protection funding and sets out the mechanisms it will use to measure its impact.

Annually, DFID tracks overall spend against the baseline published in November 2009. The current estimate for DFID's 2008/09 spend on social protection programmes is £80.5 million, up from the baseline of £45.5 million in 2007/08. Of this total, £54.5 million was spent in Africa. This spending focuses on social assistance in particular and is part of wider support to scaling up social protection systems that reaches 50 million people, our White Paper commitment.

Through our country offices who implement the majority of the strategy, DFID tracks its support to social protection programmes through the national programmes' monitoring and evaluation systems that we work to improve. For more in-depth monitoring of outcomes, we will focus on particular countries delivering support to social protection. Currently, focus countries in relation to AIDS strategy commitments are: Kenya, Malawi, Mozambique, South Africa, Tanzania, Uganda, Zambia, Zimbabwe. Countries in which DFID supports social protection may change over the 3 year period in response to national priorities and reflecting other donor actions. At a global level we are currently updating our tracking systems to collate this information, which will be presented in our next annual report.

At a country level, it is important to recognise that programmes are designed by country offices, in response to country priorities and needs, in line with national plans, including National Plans of Action for Orphans and Vulnerable Children (OVCs) and will fund a range of interventions.

The issue of tracking who benefits from wider social protection programmes is an important one. Who benefits will depend on the goal and design of the national programme, which will be agreed through country-led processes in response to multi,

country-identified needs and rights. An understanding of who is vulnerable and how to reach them underpins the design of all social protection programmes and many explicitly aim to reach children and/or their carers in the context of AIDS.

Evidence does show that, rather than target relatively small numbers of marginalised children (that can risk increasing stigma and discrimination through specifically AIDS-targeted programmes), broader social protection programmes do mitigate the impact of AIDS on large numbers of poor and vulnerable children and their carers. The shift in approach to supporting wider social protection programmes was strongly endorsed at the last International AIDS conference in Mexico in 2008 and at the Global Partners Forum on Children Affected by AIDS held in Dublin in October 2008. DFID will continue to work with government and non-governmental partners to analyse who is being included and who is not, why and how to address this. Individual mechanisms should be as inclusive as possible and barriers to access should be removed.

DFID is in the process of planning its research funding to advance knowledge on social protection, which includes important work to assess and evaluate the impact of social protection. We continue to engage with UNICEF and Save the Children who we funded to design a multi-country study on the impact of social protection on vulnerable children. Understanding who benefits and who does not, why and what needs to be improved, including in the context of AIDS, is an important element of this work.

We also work with international partners, to whom DFID provides institutional core funding, including UNICEF and the World Bank, who share our concern to understand who is being reached by social protection programmes.

Marginalised and vulnerable groups

[Paragraph 51] Reaching the most marginalised people and those excluded from society with effective HIV/AIDS interventions can often best be achieved by small civil society organisations who understand the needs of specific groups of disadvantaged people. Engaging with such organisations requires adequate staff time and expertise. We remain concerned that DFID staff reductions mean that the Department is less well equipped to do this necessary work than previously.

[Paragraph 52] DFID has given us some impressive examples of how it is using Challenge Funds channelled through umbrella organisations to support community-based organisations. We are not, however, convinced that DFID yet has a comprehensive strategy for working through civil society and community groups to reach the people most in need of HIV/AIDS services. We recommend that DFID, in response to this Report, provide us with further information on how it will use its monitoring and evaluation mechanisms to measure the effectiveness of its funding for HIV/AIDS civil society groups.

[Paragraph 55] Gender-based violence is an abuse of women's human rights and is a significant contributory factor in the spread of HIV. In its new White Paper, DFID has given a commitment to support women and girls affected by violence and its HIV/AIDS Monitoring and Evaluation Framework includes a provision for gender analysis of AIDS programmes. Although welcome, neither of these measures directly

tackles the impact of gender-based violence on women and its links with HIV. DFID told us last year that it was reviewing its work on violence against women to assess where and how it could do more to tackle it. We recommend that it shares the results of that review with us, in response to this Report.

DFID recognises that civil society organisations are often well placed to reach excluded and marginalised populations. We have an extensive range of funding mechanisms to support civil society partners—including through international NGOs, multilaterals, country programmes and centrally funded projects. The recent White Paper has committed DFID to doubling our non-humanitarian central support to civil society to £300 million to 2013, to expand partnership agreements and offer new development innovation funding.

DFID's stakeholder survey shows that civil society stakeholders think that DFID is responsive to their needs but there is room for improvement. DFID places a high value on our relationships with civil society organisations and significant amounts of staff time is spent engaging with civil society partners.

We are also supporting an evaluation of the community response to the AIDS epidemic which is being led by the World Bank Global AIDS Monitoring and Evaluation Team. The primary objective of this evaluation is to help build a robust pool of evidence on the effects of specific HIV and AIDS activities and programmes implemented at the community level along the continuum of prevention, care, treatment, and support. The overarching hypothesis to be tested is how the community response adds value to national programmes.

Whilst overall DFID staff numbers have reduced to 2,400 in 2008-09 from 2,563 in 2007/08 (including staff appointed in country) we have managed these reductions in a way that protects front line services in priority countries. DFID has taken a rigorous approach to choosing the number of sectors, programmes and projects we support in each country, as well as the type of instruments used, ensuring that the overall portfolio can be effectively managed by our staff.

Moving forward, DFID will focus efficiency efforts on back office corporate service functions (Finance, HR, Office services etc) and on reducing management layers. This is intended to free up resources, for redeployment to front line programme delivery.

We have recently launched an updated strategic workforce planning process. Through this process we will continue to review the number of staff and skills needed in different parts of our business. This process informs our recruitment, redeployment and learning and development activities and helps us ensure we have the right people, with the right skills in the right place at the right time.

Gender based violence is certainly of concern beyond the context of conflict-affected states and the links between HIV and violence against women persist across the world. We will make DFID's review available to the Committee separately. This review was carried out with a view to increasing our work on the important issue of gender based violence, including in the context of HIV.

Access to treatment

[Paragraph 57] Although we welcome the increase in access to anti-retroviral treatment which has been achieved, it is a serious concern to us that the global commitment to provide universal access to treatment by 2010 will not be met. We urge DFID to expand its programmes to increase access to anti-retroviral treatment.

[Paragraph 63] We are seriously concerned that the number of women receiving prevention of mother-to-child transmission treatment (PMTCT) remains well below target levels. DFID and its donor partners should prioritise treatment to women and children and use the opportunities presented by antenatal care to promote the take-up of HIV/AIDS treatment by women. DFID should also ensure that the PMTCT services which it supports recognise the wider health needs and potential vulnerability of women living with HIV/AIDS.

[Paragraph 68] A growing number of people living with HIV and AIDS will require access to antiretroviral treatment (ART) if the target of universal access is to be reached. The number of people requiring ART is increasing because more people are being infected; the increased rate of testing is leading to more diagnoses; and people with HIV are now living longer due to successful treatment. We welcome DFID's cooperation with pharmaceutical companies to reduce the cost of first-line drugs for developing countries and to increase their accessibility. Wider availability of second line drugs is now needed. We recommend that DFID provide us with more details, in response to this Report, of its plans to increase availability and reduce the cost of vital HIV/AIDS treatments through its co-operation with UNITAID and use of patent pools.

The Government agrees that resources need to be made available so that more people can access the treatment they need in the most cost-effective way possible. Reliable access to high quality, affordable medicines is a necessary part of functioning health systems. That is why, since Gleneagles in 2005, the UK has led the push for universal access to HIV prevention, treatment, care and support—and why we have committed to spend £6 billion on health systems and services up to 2015. We are also committed to work with others to reduce drug prices and increase access to more affordable and sustainable treatment over the long term. This could yield cost efficiency savings of at least £50 million per annum, enough to fund medicines for an additional 1 million people every year

In 2007, the UK made an unprecedented long-term commitment of up to £1 billion to 2015 to the Global Fund to Fight AIDS TB and Malaria (GFATM)—one of the key providers of AIDS drugs. We also made a commitment of up to approximately £760 million over 20 years to UNITAID, the International Drug Purchase Facility. Both these commitments are subject to performance. UNITAID helps increase access to treatment by lowering the price of quality drugs and diagnostics, and by increasing the pace at which they are made available.

We share the Committee's concern about PMTCT services. *Achieving Universal Access*, makes it clear that the UK is already prioritising scaling up prevention of mother to child transmission services. In Mozambique, for example, DFID's support has contributed to an increase in the number of health units offering PMTCT services from 386 in 2007 to 744 in

2008. As a result, the number of HIV positive pregnant mothers receiving treatment to prevent HIV transmission to their babies increased from 24,320 in 2007 to 46,848 in 2008. The total number of patients receiving ARV has also increased dramatically, from zero in 2001 to 118,937 in 2008.

We made a specific commitment to work with others to intensify international efforts to increase to 80% by 2010 the percentage of HIV positive pregnant women who receive ARVs, to reduce the risk of mother to child transmission in low income and high prevalence countries. DFID's main approach to increase access to PMTCT is through investments in health systems' strengthening as unless women access a health service when pregnant, there will be no scope for further intervention.

Appropriate HIV services can then be offered in an integrated manner, with maternal and child health services. This is the best way to address the wider health needs and improve health outcomes, as highlighted by the Committee.

Although we recognise that more efforts are needed, the latest UNAIDS report on the epidemic shows that significant expansion of services for women and children has taken place. We will continue to work with others towards an accelerated expansion of these services.

The Government has consistently supported the efforts of UNITAID to investigate the feasibility of a patent pool as a means to provide better access to drugs for HIV/AIDS, and to facilitate the production of fixed dose combinations, including those suitable for children. We have also encouraged the pharmaceutical industry in the UK to engage with UNITAID in its work on the pool.

The UNITAID Board has now decided to approve the establishment of the patent pool as a separate entity, to fund its establishment and operation in 2010 and has also set benchmarks for performance in 2010. The patent pool could be a key means of addressing the treatment crisis and the UK government welcomes the decision as an important step forward in taking action now to save lives in the future. It is important that the benchmarks set for 2010 are attained in order to demonstrate the ability of the patent pool to deliver these health benefits.

Funding for HIV/AIDS programmes

[Paragraph 73] The Government has reiterated its commitment to meet the target of allocating 0.7% of Gross National Income to Official Development Assistance, despite the impact of the global economic downturn. However, other countries are renegeing on the pledges they have made. HIV/AIDS remains a serious development challenge and we are concerned about the impact that reduced development assistance funding will have on HIV/AIDS programmes. It is very disappointing that the 2010 target for universal access will be missed by a wide margin. This must not be compounded by failure to maintain the levels of support for HIV/AIDS programmes agreed by the international community.

[Paragraph 77] The US\$3 billion funding shortfall announced by the Global Fund to fight AIDS, TB and Malaria will affect its ability to deliver vital HIV/AIDS programmes. The UK's long-term funding commitment is commendable but, as a

leading contributor to the Fund, the UK also has a responsibility to press other countries properly to support the Fund. The UK should take every opportunity to convey to international partners the importance of substantial and predictable allocations to the Fund and the serious consequences, including deaths, which will result from countries renegeing on their funding pledges.

[Paragraph 82] We welcome the prospect of closer collaboration between the UK and the US on HIV/AIDS work which the relaxation of some of the restrictions on the operation of the President's Emergency Plan for AIDS Relief (PEPFAR) offers. The two countries are leading donors in this area and joint working, which includes developing country governments, is an effective approach to tackling HIV/AIDS which we recommend DFID pursues wherever possible.

We remain committed to the goal of universal access to comprehensive HIV prevention, treatment, care and support. Our long-term multilateral and bilateral financing commitments, laid out in the Strategy and reiterated in the White Paper, are proof of this commitment. We do have to acknowledge the competing priorities for health resources at country level, and the need for countries and development partners to collaborate in ensuring the best value for money and investment proportionate to burden of disease and threats to health and wellbeing.

The UK has consistently pressed donors to make long-term predictable finance available to support the long-term plans of our country partners. Although some recognise the value of this, the concept has not been broadly adopted.

Global Fund supported programmes have delivered some impressive results. And so they should. The Fund has committed over \$18.4 billion of donor funds in over 140 countries, although it has only disbursed roughly half of this amount—\$9.3 billion.

There is no doubting the current significance of the Global Fund, but there are clearly questions about its future sustainability. Looking to the future, the next replenishment will need to raise between \$7-8 billion simply to service the existing portfolio, and before any new programmes can be supported. The high numbers of people on ARV using Global Fund support presents a “treatment mortgage” which is a challenge not only for the Global Fund but for other international players too. We hope the Board will consider the ‘fundamentals’: how the Fund prioritises and allocates resources, who should be eligible, how work will be sustained, how the Fund secures maximum value for money from its spending and how the Fund can work effectively with others globally and in-country.

The economic situation makes it even more important that we all deliver on our pledges—for example by pushing for G8 accountability against commitments. In 2008, for the first time, the G8 published an interim accountability framework showing individual country progress against some key G8 commitments on food, water, health (including HIV) and education. A working group of experts has been tasked to undertake a full accountability process for 2010 which the Canadians, as next year's G8 President, have agreed to take forward. This will be a deeper, more comprehensive process to take stock of G8 development promises from past Summits.

We continue to work closely with the USA. We were extremely pleased to see the new five-year Strategy for phase two of PEPFAR that was published in December. This strategy, with its focus on health systems, country-led sustainable programmes and multilateralism, outlines how the US can bring its huge influence and resources in line with an approach that DFID has long advocated and which is articulated in our own AIDS strategy.

[Paragraph 74] We support the Government's intention to work with Canada, when it holds the G8 presidency in 2010, to press donor countries to specify and publicise their targets for HIV/AIDS funding. We recommend that the Government sets an example to its G8 partners by specifying, in response to this Report, what the UK's HIV/AIDS annual expenditure targets will be from 2010 and how this funding will be allocated.

[Paragraph 86] The focus in the DFID White Paper on fragile states provides an opportunity for the Department to strengthen its HIV/AIDS programmes in those countries and to work with others to ensure that effective prevention and treatment programmes are available to those affected by conflict, particularly women who are often the victims of sexual violence. It is vital, however, that this change of emphasis in DFID's priorities does not affect future funding for core HIV/AIDS activities in other developing countries. We recommend that DFID, in response to this Report, provide us with information on how HIV/AIDS funding will be broken down between fragile and conflict-affected states and other country programmes.

As explained earlier in this response, the UK does not have an HIV annual expenditure target. The essence of the country led approach is that investment and interventions are nuanced to the needs and opportunities of different countries. We will continue to have substantial programmes where appropriate—for example Zimbabwe, and Nigeria where we are initiating a £100 million programme to enhance the national response to AIDS, and have seconded staff into the World Bank.

We need stronger health systems to scale up the AIDS response and achieve universal access. This is why the Strategy pledged £6 billion on health systems and services to 2015. AIDS funding and funding for health systems are mutually reinforcing: increased funding for AIDS can help to build stronger health systems, and investments in health systems can support a sustainable AIDS response. The health target captures our spending on integrated health systems, communicable diseases, maternal and child health, and sexual and reproductive health. All of these are strongly linked to AIDS. The baseline report shows DFID spent £776 million on health systems and services in 2007/08.

The health spending target should not be seen as the sum of our work. The AIDS strategy emphasises the critical role of other sectors, such as education, in addressing social and economic factors that influence behaviour and limit people's ability to make healthy choices. AIDS responses are not only in the health sector and, at country-level: our AIDS portfolio will extend beyond support to health systems. Nevertheless we are convinced that this broader target is a better way to ensure integration within strengthened health systems than an AIDS target.

The same argument applies to fragile states. However, renewed commitment to existing pledges—including those on AIDS—are at the heart of the White Paper.

Our work in Burma offers one example of an effective AIDS programme in a fragile state. On 12 November, the Global Fund Board approved approximately US\$111 million for two years and up to US\$288 million over five years, to fight AIDS, TB and malaria in Burma. The Fund's decision to return to Burma is a coup, not only for the estimated 238,000 Burmese people living with HIV—one of the highest infection rates in Asia—but also for the DFID-FCO team who worked behind the scenes to help make this happen.

The Global Fund withdrew from Burma in 2005 citing concerns about government restrictions on its staff travel and procurement procedures. When the Burmese Minister of Health announced the decision to develop a new proposal in September 2008, the key question for some donors was whether these earlier concerns had been addressed.

We had the evidence to answer that question. After the Global Fund left, a \$100 million pooled funding mechanism, the Three Diseases Fund (3DF), was set up between the UK, Australia, the European Commission, the Netherlands, Norway and Sweden to maintain funding for AIDS, TB and malaria. The 3DF showed that programmes could be monitored properly in Burma, and safeguards put in place to ensure that aid reached those in greatest need. In its three years of operation, 3DF's HIV prevention programmes have reached over 600,000 people; 700,000 have been treated for malaria; and over 30,000 for TB.

The DFID-FCO Burma team worked with colleagues in Washington, Geneva and London, to provide factual briefing to influence key stages of the Global Fund process. As the elected donor representative on the Country Coordinating Mechanism, DFID coordinated donor inputs in country and through our network of posts we were able to achieve donor consensus in support of the proposal. Burma's final proposal to the Global Fund was a wider collaborative effort, involving the Health Ministry, the UN, donors, international NGOs, and a DFID supported network of local NGOs and people living with HIV. It was an important, and so far rare, example of all these actors working together in Burma.

To support continuing needs until the Global Fund aid comes on stream, we are increasing DFID's contribution to the 3DF by £10 million, bringing the total to £30.1 million (US \$48 million) over five years to 2011.

Cross-Whitehall working on HIV/AIDS

[Paragraph 90] The evidence we received from the Government has not persuaded us that the Foreign and Commonwealth Office has either the resources or the expertise to take lead responsibility for HIV/AIDS programmes in middle-income countries where DFID no longer has a presence. We remain concerned about the lack of clarity on how the FCO will perform this role. Yet it is in many middle-income countries that HIV infections are spreading most rapidly. We recommend that, in response to this Report, the Government provides us with specific examples of HIV/AIDS programmes which the FCO is pursuing in high-prevalence middle-income countries, including those aimed specifically at vulnerable and marginalised groups, together with the criteria which it has developed for selecting the countries where it will undertake this work.

[Paragraph 93] We have not been provided with enough evidence to convince us that the Cross-Whitehall Working Group has sufficient authority or capacity to act as the main mechanism for monitoring the implementation of the UK's HIV/AIDS Strategy.

Its terms of reference are vague; it involves officials rather than ministers; and its administrative support does not appear to be adequate. One small step which would improve its transparency and accountability would be to publish the Group's meeting papers. Putting this information in the public domain may also help to persuade stakeholders that the Group is taking its monitoring task seriously and that it is capable of making a meaningful contribution to the biennial reporting process for the AIDS Strategy.

The FCO is committed to meeting its commitments in the strategy. Since its launch, the FCO's network of overseas Posts is working on the AIDS strategy through the multilateral system (e.g. UNAIDS, WHO) as well as bilaterally through dialogue with host governments and others actors, such as NGOs, in country. The FCO funds work on HIV work in middle-income countries within existing resources and balanced with the Government's other foreign policy priorities, including its other international development objectives.

In meeting its commitments in the strategy, the FCO's role is primarily focussed on advocacy and lobbying to support the strategy's aims. Middle-income countries are more likely to have the resources available to fund their own HIV prevention programmes and healthcare. The UK Government's support, provided through DFID, is therefore focused on the low-income countries set out in PSA29. In middle-income countries, issues of gender inequality, stigma and discrimination are stopping people from taking up preventive services and testing, disclosing their status, and seeking treatment and care.

We do not believe there is an expertise gap in the FCO on HIV. The FCO's ability to deliver relies more on the traditional diplomatic skills of negotiating, lobbying and working through others, for example, through NGOs in country. The FCO works closely with DFID and can and does call on DFID to provide technical expertise, when this is necessary. Furthermore, in the Government's 2009 White Paper on international development, we committed to establish a network of development professionals working with UK Government teams on key G20 emerging economies.

Examples of the FCO's recent work on HIV include work by our Embassy in Kyiv, which is working closely with NGOs and host government alike to promote increased and more effective HIV prevention programmes. In Uganda, our combined High Commission/DFID team is working closely with local NGOs and development partners against the introduction of draft legislation seeking to further criminalise homosexuality, which has the potential to restrict HMG's work on HIV. Our High Commission in Singapore has brought over UK experts to explain why government should subsidise medicines for people living with HIV, and is giving public health NGOs a platform to raise the challenges with government decision-makers and civil society. In Namibia, our High Commission has provided political support for the Namibian government's Public Service Workspace Policy on AIDS and for the PEPFAR conference hosted by Namibia in June. Through our Mission to the UN in Geneva, the FCO works as part of a combined DFID-FCO team to represent the UK's interests on the governing body at UNAIDS.

Through its human rights work, the FCO continues to place issues of equality and non-discrimination at the heart of its dialogue in both bilateral and multilateral fora, including at the EU and the UN. The FCO adopted its programme of action on Lesbian, Gay

Bisexual and Transgender rights in 2007, and in 2008 launched an LGBT "toolkit" designed to help our overseas posts add value to equality and non-discrimination work. We remain committed to raising instances where persecution and discrimination have occurred because of sexual orientation or gender identity (e.g. the arrest of nine HIV prevention workers in Senegal, in January 2009), and lobby for changes in discriminatory practices and legislation (e.g. in Lithuania and Uganda). Such discrimination has a severely adverse impact on human rights, and acts as a barrier to work on the right to health, especially prevention of HIV. The FCO takes a leading role in the key international human rights fora, promoting a progressive and inclusive approach on LGBT rights and on sexual and reproductive health rights. For example, in September 2009, in the face of determined opposition, the UK delegation to the Human Rights Council played a leading role in securing a strong resolution on HIV. The outcome demonstrated the value of the strong working relationship between the FCO team in Geneva and the DFID team in London.

The Committee has rightly identified the high rate of infection of HIV in certain middle-income countries. To ensure that the FCO's work is targeted on those countries in which intervention could make the most difference, the FCO and DFID are in the process of identifying and agreeing a smaller group of countries in which to prioritise the FCO's work over the next eighteen months. We will be happy to share the list of priority countries with the Committee when it has been finalised, including details of the criteria used, which will include consideration of both the current level of HIV prevalence and the recent rate of growth in HIV infection. To facilitate the work of FCO Posts in these countries, DFID will provide bespoke materials to better support Posts' work on HIV. For the wider FCO network in other low- and middle-income countries, the FCO and DFID will provide supporting materials which will strengthen Posts' capacity to undertake work on HIV, where there is a need for a targeted intervention or activity which supports the strategy's objectives.

The Cross-Whitehall Group is a group of officials tasked with monitoring cross-Government elements of the implementation of the Strategy. It is only one part of our monitoring and evaluation arrangements; member Departments also report on progress through the process set out in our M&E framework.

In response to the Committee's recommendation, we will make the agenda and minutes of the Group's future meetings publicly available.