



House of Commons
International Development
Committee

Progress on the Implementation of DFID's HIV/AIDS Strategy

First Report of Session 2009–10

Volume I

Report, together with formal minutes

*Ordered by the House of Commons
to be printed 24 November 2009*

HC 49-I
[Incorporating HC 1053-i, Session 2008-09]
Published on 1 December 2009
by authority of the House of Commons
London: The Stationery Office Limited
£0.00

International Development Committee

The International Development Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department for International Development and its associated public bodies.

Current membership

Malcolm Bruce MP (*Liberal Democrat, Gordon*) (Chairman)
John Battle MP (*Labour, Leeds West*)
Hugh Bayley MP (*Labour, City of York*)
Richard Burden MP (*Labour, Birmingham Northfield*)
Mr Nigel Evans MP (*Conservative, Ribble Valley*)
Mr Mark Hendrick MP (*Labour Co-op, Preston*)
Daniel Kawczynski MP (*Conservative, Shrewsbury and Atcham*)
Mr Mark Lancaster MP (*Conservative, Milton Keynes North East*)
Mr Virendra Sharma (*Labour, Ealing Southall*)
Mr Marsha Singh MP (*Labour, Bradford West*)
Andrew Stunell (*Liberal Democrat, Hazel Grove*)

Powers

The Committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the Internet via www.parliament.uk.

Publications

The Reports and evidence of the Committee are published by The Stationery Office by Order of the House. All publications of the Committee (including press notices) are on the Internet at www.parliament.uk/indcom

Committee staff

The staff of the Committee are Carol Oxborough (Clerk), Keith Neary (Second Clerk), Anna Dickson (Committee Specialist), Ian Hook (Senior Committee Assistant), Vanessa Hallinan (Committee Assistant), and Alex Paterson (Media Officer).

Contacts

All correspondence should be addressed to the Clerk of the International Development Committee, House of Commons, 7 Millbank, London SW1P 3JA. The telephone number for general enquiries is 020 7219 1223; the Committee's email address is indcom@parliament.uk

Contents

Report	<i>Page</i>
Summary	3
1 Introduction	5
The inquiry	5
Structure of our Report	6
2 Monitoring and evaluation	7
3 Health system strengthening	11
4 Integration of HIV/AIDS with other disease programmes	15
Integration with sexual and reproductive health	17
5 Social protection programmes	19
6 Marginalised and vulnerable groups	22
Role of civil society in providing HIV/AIDS services	23
Gender-based violence	25
7 Access to treatment	27
Anti-retroviral treatment	27
Provision of treatment for women and children	27
First- and second-line drugs	29
UNITAID and patent pools	30
8 Funding for HIV/AIDS programmes	32
The impact of the global economic downturn	32
The Global Fund to fight AIDS, TB and Malaria	33
Working with other donors	34
The implications for HIV/AIDS programmes of DFID's White Paper	35
9 Cross-Whitehall working on HIV/AIDS	37
Cross-Whitehall Working Group	38
10 Conclusion	40
List of recommendations	41
Formal Minutes	46
Witnesses	47
List of written evidence	47
List of Reports from the Committee during the current Parliament	48

Summary

Progress has been made on providing HIV/AIDS treatment in developing countries but the 2010 target of universal access to treatment will not be met. The disease remains a significant development and public health challenge in many developing countries.

The absence of a monitoring and evaluation framework for DFID's new HIV/AIDS Strategy when it was published in June 2008 meant that there were few measurable targets or indicators of how its effectiveness would be assessed. The subsequent publication of the Framework and the accompanying Baseline document are positive developments. The next step will be the publication of the first biennial progress report in December 2010.

Capable and well-resourced health services are an integral part of an effective HIV/AIDS strategy and DFID's substantial funding for health system strengthening is welcome. However, DFID still 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.

Some of the essential components of universal access, particularly prevention and long-term care in the community, may not benefit from health systems funding. DFID needs to set 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. It must recognise that prevention and care services are often 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.

Social protection is another key element in DFID's AIDS Strategy. However, only £80 million of the £200 million pledged to social protection programmes is new money, additional to existing commitments. This funding is part of DFID's broader support for vulnerable households rather than being specifically aimed at those affected by HIV/AIDS.

Moreover, cash transfers, while very effective in some situations, are not a sufficient mechanism for reaching those most in need and many of the most vulnerable people affected by HIV/AIDS, particularly children, may be excluded from social protection programmes. Marginalised people, particularly those engaged in activities deemed to be illegal, such as sex workers and drug users, are often unwilling or unable to access services and their children may therefore fail to be reached by generalised provision of this kind. DFID needs to have mechanisms in place to track its funding for social protection to ensure that it is reaching children and other vulnerable people affected by HIV/AIDS.

The global economic downturn has contributed to the failure of many donors to honour pledges made on HIV/AIDS funding. The UK's adherence to its commitments is welcome but it must do more to put pressure on donor partners to meet their pledges, including to the Global Fund to fight AIDS, TB and malaria, which has suffered a US\$3 billion deficit in funding this year. 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.

Treatment for women and children, and particularly prevention of mother to child transmission services, must be prioritised. DFID should continue to work to develop mechanisms which help to increase availability and lower the cost of anti-retroviral treatment in developing countries, including patent pools.

DFID's focus is now shifting to fragile states. Lead responsibility for HIV/AIDS programmes in middle-income countries, where DFID no longer has a presence, but where prevalence rates are often high, will be taken by the Foreign and Commonwealth Office. It is not clear that the FCO has the necessary resources or expertise to undertake this task, particularly in relation to marginalised and vulnerable people, or that mechanisms are in place for DFID to provide the necessary advice and assistance.

1 Introduction

1. HIV/AIDS remains a significant global health challenge. While the percentage of adults living with HIV worldwide has been stable since 2000, there were an estimated 2.7 million new infections in 2007. The annual number of new infections remains high and continues to outpace the annual increase in the number of people receiving treatment.¹ The total number of people living with HIV (PLWH) is now 33 million. In its latest report on the global AIDS epidemic, UNAIDS (the Joint UN Programme on HIV/AIDS) estimated that 2 million people died due to AIDS in 2007. This was an increase on the 2001 estimate of 1.7 million.² Moreover, the number of deaths is increasing in parts of Africa, particularly eastern and southern Africa.³

2. Some progress in providing treatment is being made and the use of anti-retroviral (ARV) therapy has increased: of the estimated 9.5 million people in need of treatment in 2008 in developing countries, 42% had access, up from 33% in 2007. The greatest increase in access has been in sub-Saharan Africa, where two-thirds of HIV infections occur.⁴

The inquiry

3. At the beginning of this Parliament, we made a commitment to undertake an annual inquiry into HIV/AIDS. In 2005 we examined the provision of anti-retroviral treatment; in 2006 we looked at marginalised groups; in 2007 we combined our work on HIV/AIDS with our inquiry into Maternal Health; and last year we assessed the Department for International Development's (DFID) recently published HIV/AIDS Strategy.⁵

4. Our 2008 Report welcomed many of the initiatives and commitments announced in DFID's new HIV/AIDS Strategy.⁶ However, we expressed concern about a number of issues. In particular, we had been unable to examine the process which DFID planned to use to monitor and evaluate the Strategy's implementation because its Monitoring and Evaluation Framework was not published until after our inquiry had been completed. Our Report also identified significant deficiencies in detail in the Strategy which the Government Response did not adequately address, despite a number of requests for specific information.⁷ In this year's inquiry, we therefore decided to follow up some of the

-
- 1 World Health Organisation, *Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector*, Progress Report 2009, September 2009, p 4
 - 2 UNAIDS, *2008 Report on the global AIDS epidemic*, July 2008, p 32. The estimate range was 1.8-2.3 million in 2007 and 1.5-2.3 million in 2001
 - 3 World Health Organisation, *Progress on health-related Millennium Development Goals*, May 2009
 - 4 World Health Organisation, *Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector*, Progress Report 2009, September 2009, p 5
 - 5 International Development Committee, First Report of Session 2005-06, *Delivering the goods: HIV/AIDS and the provision of anti-retrovirals*, HC 708-I; Second Report of Session 2006-07, *HIV/AIDS: Marginalised groups and emerging epidemics*, HC 46-I; Fifth Report of Session 2007-08, *Maternal Health*, HC 66-I; Twelfth Report of Session 2007-08, *HIV/AIDS: DFID's New Strategy*, HC 1068-I
 - 6 DFID, *Achieving Universal Access: the UK's strategy for halting and reversing the spread of HIV in the developing world*, June 2008
 - 7 International Development Committee, First Special Report of Session 2008-09, *HIV/AIDS: DFID's New Strategy: Government Response to the Committee's Twelfth Report of Session 2007-08*, HC 235

issues which we felt had not been resolved in the Government's Response, as well as examining recent developments in the implementation of the Strategy.

5. In the course of this inquiry we received written submissions from 19 organisations. We held one oral evidence session in two parts: the first with non-governmental organisations and the second with Mr Michael Foster MP, Parliamentary Under-Secretary of State for International Development and DFID officials. We would like to thank all those who contributed to our inquiry.

Structure of our Report

6. In Chapter 2 we examine how DFID's Strategy will be monitored and evaluated. In Chapter 3 we look at DFID's funding for strengthening health systems and its likely impact on HIV/AIDS programmes. Chapter 4 analyses how effectively HIV/AIDS programmes are integrated with strategies for tackling other related diseases. The extent to which social protection programmes will help those made vulnerable by HIV/AIDS, particularly children, is discussed in Chapter 5. Chapter 6 examines the Strategy's approach to marginalised groups. Chapter 7 looks at access to anti-retroviral treatment. We then examine overall funding for HIV/AIDS programmes and DFID's co-operation with other multilateral and bilateral donors (Chapter 8). The final chapter looks at the effectiveness of cross-Whitehall working and, in particular, the role of the Foreign and Commonwealth Office in taking forward HIV/AIDS work in middle-income countries.

2 Monitoring and evaluation

7. In last year's Report we expressed our regret that DFID had not made available its Monitoring and Evaluation (M&E) Framework at the same time as its new Strategy was published, in June 2008.⁸ We found the Strategy to be “strong on rhetoric but weak on communicating how DFID will implement it.” We noted that there were “few measurable targets or indicators of how the Strategy's effectiveness will be assessed” and stressed the need for the M&E Framework to set out specific targets and indicators, to enable an assessment to be made of whether DFID's HIV/AIDS programmes were achieving their aims.⁹ We highlighted that, in its 2004 Strategy, DFID's indicators of success had been linked primarily to funding targets rather than to outcomes. We observed that, in the new Strategy, DFID was still concentrating on funding levels rather than measuring effectiveness: “there remains an emphasis on the amount of money which will be spent rather than the impact which will be measured”.¹⁰

8. DFID eventually published the M&E Framework, *Achieving Universal Access: Monitoring performance and evaluating impact*, in December 2008.¹¹ The document states that the Department sees monitoring of the performance and evaluating the impact of its HIV/AIDS activities as a “central part of DFID's corporate performance systems”. It emphasises that:

Keeping track of the inputs, processes, outputs, outcomes and impacts of DFID funded bilateral and multilateral programmes, and UK activities to influence others, is key to ensuring that the UK responds quickly to fill gaps in performance as well as ensuring transparency and accountability.¹²

A further document, *Achieving Universal Access—a 2008 baseline*, was published in October 2009.¹³ This provides a snapshot of the global AIDS epidemic in mid-2008, when the new Strategy was launched, and sets a baseline against which the impact of DFID's HIV/AIDS commitments will be measured. DFID says that “It is against these commitments that we will be held to account in future biennial reporting.”¹⁴

9. Several witnesses praised DFID for publishing the Baseline to complement the M&E Framework. Sally Joss of the UK Consortium on AIDS and International Development said that it was “a massive move forward from the previous AIDS strategy where there was no baseline and not really a monitoring and evaluation framework to even start to measure what is happening”. Mike Podmore of VSO applauded DFID for linking its Strategy to

8 Twelfth Report of Session 2007-08, *HIV/AIDS: DFID's New Strategy*, HC 1068-I, para 117

9 *ibid*, Summary

10 *ibid*, para 112

11 DFID, *Achieving Universal Access—Monitoring performance and evaluating impact*, December 2008

12 *Achieving Universal Access—Monitoring performance and evaluating impact*, p 4

13 DFID, *Achieving Universal Access—a 2008 Baseline*, October 2009

14 *ibid*, p iv

global targets and indicators and said that DFID was “leading well at the international level in terms of global indicators”.¹⁵

10. DFID has committed to reporting on performance of its HIV/AIDS Strategy every two years, with the first progress report to be published on World AIDS Day (1 December) 2010.¹⁶ The information for the biennial reports will be compiled from:

- biennially collated overviews of the AIDS response from DFID country, regional, policy and multilateral representatives; and
- information embedded in DFID corporate performance systems.

This information will then be set in the context of internationally agreed targets and indicators administered and collated routinely by UNAIDS and partner countries.¹⁷ The overviews will be collated systematically every two years and will describe the situation in-country, including the epidemic status, the aid environment and the key actors. They will provide details of how DFID is performing against each of the five priorities set out in *Achieving Universal Access*:

- **Priority 1:** Increase effort on HIV prevention; sustain momentum for treatment; increase effort on care and support
- **Priority 2:** Respond to the needs and protect the rights of those most affected
- **Priority 3:** Support more effective and integrated service delivery
- **Priority 4:** Making money work harder through an effective and co-ordinated response
- **Priority 5:** How we will turn our strategy into action.¹⁸

A template showing the information that will be collected from DFID country offices has been included as an annex to the M&E Framework.¹⁹

11. Witnesses commended DFID for the process it had followed in the development of the M&E Framework, commenting that it had used a “groundbreaking approach in engaging civil society in the monitoring process [...] and in making the framework more relevant for those involved in the implementation of the Strategy”.²⁰ At DFID’s request, the UK Consortium on AIDS and International Development (“the UK Consortium”) set up an Indicators Working Group (IWG). The International HIV/AIDS Alliance (“the Alliance”) said that:

Whilst the IWG was asked to focus [on] the development of indicators, it was able to provide support and expertise to inform other parts of the framework. DFID’s

15 Q 3 [Mike Podmore]

16 *Achieving Universal Access—Monitoring performance and evaluating impact*, p 5

17 *ibid*, p 6

18 DFID, *Achieving Universal Access*, June 2008, pp 62-66

19 *Achieving Universal Access—Monitoring performance and evaluating impact*, pp 16-20

20 Ev 51

commitment to the process and the IWG was clearly shown through the continued engagement of staff and the openness and honesty with which meetings were conducted [...] the discussion between the IWG and DFID led to a more balanced approach to monitoring and evaluation of the Strategy. It allowed DFID's efforts to be informed by recognized good practice and the direct experiences of monitoring HIV responses. The discussion and joint inputs have resulted in more requests for qualitative information within the data collection tools, which will facilitate documentation of good practice for knowledge sharing and learning.²¹

However, there was some criticism of the process. The Alliance pointed out that:

The short timeframes for review of draft documents and provision of feedback, and the application of Chatham House rules to the IWG proceedings, limited the ability of the IWG to consult and engage the stakeholders it was representing. From the outset there appeared to be lack of clarity of the purpose of the group, with no efforts to agree on Terms of Reference for the IWG or to clarify its role in the final decisions related to the selection of indicators. IWG members were not assured endorsement of the final product.²²

Alvaro Bermejo, Executive Director of the Alliance, told us that he “welcomed the initiative at the beginning in the sense it was very innovative, it was one of the first times that DFID was really involving civil society in setting up indicators they were going to use”.²³ But he regretted that “both from civil society and from the DFID side I think we were unable to see that translated into the final product and many things slipped in that path. The one thing we did not really achieve was to get a clear definition of what success would look like.”²⁴

12. Witnesses remained concerned about the likely effectiveness of the monitoring and evaluation process. World Vision said that, before the publication of the M&E Framework, there had been “high expectations” that answers to important questions about how the Strategy would be monitored would be provided. However, in their view, the question of what the UK Government's contribution would be towards achieving the Strategy's goals had yet to be answered:

While the Framework outlines how the collective progress by the international community will be monitored, it does not attempt to systematically measure the contribution made by the UK Government. This impedes monitoring of the Government's performance and evaluation of the impact of the Strategy on UK Government policy.²⁵

Sally Joss of the UK Consortium had similar reservations:

21 Ev 51

22 Ev 51

23 Q 2

24 Q 2

25 Ev 84

One of the difficulties with a lot of the present AIDS strategy is that it is going to be very difficult to attribute what DFID has done in the harmonised international efforts to tackle HIV and AIDS and I think it will be very difficult to work out exactly what DFID has contributed to the general battle against AIDS.²⁶

13. The Minister told us that he appreciated that monitoring and evaluation was “not an easy task” and that “complexity does provide us with a test”. The AIDS Strategy and the Baseline assessment were geared at the “strategic end rather more than at a [...] more operational level”. He stressed that DFID was keen to listen to the views of others, but it did not want to “spend valuable resource measuring for no benefit”. It was necessary to balance “the need for detailed measurement against using numbers and data that are already available”.²⁷ Many witnesses believed that publication of the completed biennial country overviews would make a significant contribution to increasing transparency and accountability and would assist those outside DFID to assess the impact of its HIV/AIDS programmes. When we pressed DFID officials on their plans for making this information public, Jerry Ash, Team Leader for AIDS and Reproductive Health, said that DFID would “seriously consider publishing the country returns in full”.²⁸

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.

15. A challenge remains, however, 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.

26 Q 3 [Sally Joss]

27 Q 23

28 Q 25 [Jerry Ash]

3 Health system strengthening

16. One of the central pillars of DFID's HIV/AIDS Strategy is the commitment to spend £6 billion in the period to 2015 on health system strengthening. This includes: increasing the number of health staff in developing countries; funding for more and better hospitals and clinics, improving the supply of drugs and equipment; increasing access to services; and improving the management and co-ordination of health services.²⁹

17. In our Report last year, we welcomed this substantial funding and emphasised that “developing countries will never be capable of tackling HIV/AIDS effectively unless the overall capacity of their health systems is built up through adequate funding.” We expressed concern, however, “that DFID has included this funding as part of its HIV/AIDS Strategy but the specific impact that it may have on HIV/AIDS will be difficult to measure”. We recommended that the monitoring and evaluation framework included mechanisms to track the impact of funding for health systems strengthening specifically on HIV/AIDS treatment and care. We also asked for much greater detail on how this sum would be spent, including precise allocations and timescales.³⁰

18. In its response to our Report, DFID failed to provide the information that we had requested. It said that “specific decisions about spending and allocations to programmes, including on AIDS, are taken at country level. These programming choices are made according to specific national and regional profiles.” It was emphatic in telling us that “it is not feasible, practical or desirable to set out detailed multi-country plans in a 7-year Strategy.”³¹ Despite our recommendation on the need for indicators to track the impact specifically on HIV/AIDS of health systems funding, the only provision in the M&E framework in relation to health systems funding is that:

DFID corporate performance systems will be used to report on progress against the strategy's £6 billion health systems and services commitment. This will be derived from bilateral expenditure identified as targeting the health sector as well as an imputed share of core contributions to multilateral organisations, civil society organisations and DFID's provision of debt relief.³²

19. The UK Consortium told us that there is consensus among health and HIV professionals globally that “health system strengthening is critically under-funded in most developing countries and that health and HIV funding and programming needs to be more closely integrated”.³³ However, witnesses shared our concern that, a year on, it remains unclear how the £6 billion would contribute to supporting the achievement of universal access to HIV/AIDS care.³⁴ Whilst welcoming DFID's substantial funding, VSO said that

29 See DFID, *Achieving Universal Access—the UK's Strategy for halting and reversing the spread of HIV in the developing world*, June 2008, pp 35-36 and *Achieving Universal Access—Monitoring performance and evaluating impact*, p 13

30 Twelfth Report of Session 2007-08, *HIV/AIDS: DFID's New Strategy*, HC 1068-I, paras 19-20

31 First Special Report of Session 2008-09, *HIV/AIDS: DFID's New Strategy: Government Response to the Committee's Twelfth Report of Session 2007-08*, HC235, pp 2-3

32 *Achieving Universal Access—Monitoring performance and evaluating impact*, p 9

33 Ev 73

34 Ev 52

“it remains controversial that there was no commitment to what percentage of that will be spent on HIV and that there were very few HIV-specific funding targets.” It considered that this sent a “worrying message” that broader health system strengthening would be promoted at the expense of funding for HIV programmes.³⁵

20. Witnesses emphasised that an effective response to HIV requires activities beyond public health systems. In particular, some commentators were concerned that, while strengthening health systems was necessary to improve HIV/AIDS *treatment*, there was a risk that it would not contribute effectively to HIV *prevention*. The Alliance told us that:

DFID's focus on health systems strengthening potentially undermines DFID's own commitment to HIV prevention, as there is a limit to how much of a role health services can play in HIV prevention. [...] Given the urgent need to increase investment in HIV prevention if the spread of the virus is to be halted and reversed by 2015, it is essential that DFID supports more immediate investments to maintain progress and inject support into urgent preventative measures that may need to be addressed outside the formal health system.³⁶

In our 2006 Report on marginalised groups affected by HIV/AIDS, we said:

[...] programmes which address the drivers of epidemics, rather than generalised programmes, will be most successful in combating the spread of HIV/AIDS. Social and legal barriers to effective prevention and treatment programmes for key groups need to be addressed in some countries to ensure successful implementation of national HIV/AIDS strategies.³⁷

Targeted prevention programmes aimed at high-risk marginalised groups have the potential to be a much more effective intervention than generalised treatment programmes offered by public health services. Where such prevention programmes are successful in reaching the marginalised groups which are the “drivers” of epidemics, this may reduce the rate at which the disease spreads into the general population. Fewer resources would then need to be devoted to treating large numbers of infected people in public hospitals and clinics.

21. Alvaro Bermejo stressed that there is a “need to work beyond the health system to really prevent new sexually transmitted infections and new infections transmitted through the sharing of injecting equipment”. He added:

The money is going very much to health systems and I think you can see other efforts outside of health systems strengthening suffering from that focus, and it will be important to remind DFID, I think, that there is much more to a strategy that can curb the epidemic than just health systems.³⁸

35 Ev 82

36 Ev 52

37 Second Report of Session 2006-07, *HIV/AIDS: Marginalised Groups and Emerging Epidemics*, HC 46-I, para 18

38 Q 4

He raised the issue of stigma and discrimination in the healthcare system and workforce which may prevent people in high-prevalence groups seeking or gaining access to treatment and care. He called for DFID, and other donors, to ensure that indicators are put in place to enable the tracking of the impact of health system strengthening initiatives on vulnerable groups.³⁹ (We will examine the issue of marginalised groups in more detail in Chapter 6.)

22. Mr Bermejo was also concerned that prevention programmes might suffer as a result of the global economic downturn reducing the funding available for HIV/AIDS work. He believed that as “money gets tighter” the political response would be to concentrate on people who are currently receiving treatment at the expense of prevention programmes:

I think we are going to see in the next two or three years the tendency started two years ago of a more reductionist approach in which the HIV/AIDS response is seen just in terms of healthcare systems and it will not be enough, it will not curb the epidemic.⁴⁰

23. Evidence from UNICEF highlighted that it remains unclear how HIV/AIDS prevention programmes would be funded, particularly programmes to improve life skills education for young people and “initiatives to address the underlying drivers of HIV infection, such as gender norms, multiple concurrent partnerships and age disparate relationships, which increase young people’s vulnerability to HIV infection.”⁴¹

24. In addition to the risk of HIV prevention receiving insufficient funding and attention, Mike Podmore of VSO pointed out that care and support was the “often-forgotten pillar of universal access”. Health system strengthening focused on hospitals and clinics and ignored the important aspects of care and support provided in the community. As people with HIV and AIDS live longer, due to the increased provision of anti-retroviral treatment, there was a growing need for more long-term care and support services. He stressed that it was most often poor women and children in communities who were providing the necessary support. Their contribution was largely unrecognised, nor were they being provided with the resources they needed. He believed that DFID should ensure that health system strengthening encompassed “hospitals all the way to the home” and recognised that it “is not just about channelling money through governments because it is the community-based responses that are really delivering care and support on the ground and a lot of prevention interventions.”⁴²

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

39 Q 4

40 Q 5

41 Ev 80

42 Q 6 [Mike Podmore]

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.

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.

4 Integration of HIV/AIDS with other disease programmes

27. We highlighted the importance of an integrated approach to tackling HIV, tuberculosis (TB) and malaria in our Report last year.⁴³ In its Strategy, DFID recognised the link between AIDS and other diseases and the need for more integrated care. It says that “in hyper-endemic countries, 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”.⁴⁴ DFID pointed out that around one-third of AIDS deaths worldwide are due to TB, and that TB is the most common cause of death in people receiving anti-retroviral therapy.⁴⁵

28. In our 2008 Report we said that we were not convinced that DFID was taking sufficient steps to ensure that the specific challenge of interaction between HIV and TB was tackled, nor had it set out how it would measure the effectiveness of its Strategy in addressing the interaction. We requested a clearer indication of how this work would be taken forward and measured in DFID's Monitoring and Evaluation Framework.⁴⁶ In its response, DFID pointed out that the data which it now plans to collect from its country offices on a biennial basis will include specific questions on how DFID is supporting the integration of HIV and AIDS with TB, malaria and sexual and reproductive health and rights (SRHR). It could not, however, provide details on specific programme plans that we had asked for: DFID said that detailed information on implementation was documented in country and regional assistance plans.⁴⁷

29. Witnesses told us that a lack of clarity remained about how DFID would support integration. Sally Joss said that:

Unfortunately, the M&E framework which has been set up for the new AIDS strategy does not require DFID offices to measure progress on TB and HIV integrated programmes and there is no indication of how much of the £6 billion that is to be spent on health systems will actually go to those programmes [...] there needs to be something added into the monitoring and evaluation framework which does track the integration of programmes of co-infections and other diseases like TB and malaria.⁴⁸

In its written evidence, the non-governmental organisation Results UK said that “the integration of HIV-TB services appears to have been unevenly prioritised in DFID's work in the last twelve months”. Despite the progress that has been made by DFID, there was still a lack of integration in a number of high-burden countries. It urged DFID to “re-emphasise the need for tailored integrated service delivery and that a framework for such

43 Twelfth Report of Session 2007-08, *HIV/AIDS: DFID's New Strategy*, HC 1068-I, paras 39-48

44 *Achieving Universal Access*, p 35

45 *Achieving Universal Access—evidence for action*, p 36

46 Twelfth Report of Session 2007-08, *HIV/AIDS: DFID's New Strategy*, HC 1068-I, para 44

47 First Special Report of Session 2008-09, *HIV/AIDS: DFID's New Strategy: Government Response to the Committee's Twelfth Report of Session 2007-08*, HC235, p 6

48 Qq 7-8

be incorporated into all Country Assistance plans".⁴⁹ Similarly, Kanco appealed to DFID to integrate specific TB and TB-HIV related interventions in the health programmes it supports.⁵⁰

30. Another of the issues we raised last year was that of diagnostic tools for TB. We highlighted the reliance on outdated diagnostic techniques, such as x-rays, which were not sufficiently effective in identifying the disease. The Minister stressed then that "improving diagnostics is right at the heart of creating improved universal health systems".⁵¹ Results UK, in its written evidence to us this year, pointed out that, while DFID's Strategy committed it to increase funding for research into an AIDS vaccine and microbicides, it had not made a similar commitment to increase funding for new diagnostic tools for TB.⁵² These tools would be crucial to reducing morbidity and mortality among PLWH. Sally Joss of the UK Consortium told us:

DFID's future support for HIV in research and development should be looking at faster and more effective diagnostic tools for detecting TB because often current tests miss TB in people living with HIV, which means that there is a very high death rate.⁵³

31. World Vision highlighted that children, particularly those aged under five, are extremely vulnerable to contracting TB from infected adults in their households. It noted that the diagnosis of TB in HIV-infected children is "notoriously challenging" and that this difficulty could result in the under-reporting of the level of co-infection in children. The lack of paediatric drug formulations for TB made treatment of these children difficult.⁵⁴

32. Much of the focus is on co-infection with TB and malaria, but effort is also required to integrate HIV prevention with other disease programmes. Sally Joss stressed that "there are also co-infections like hepatitis that need to have an integrated programme of HIV services."⁵⁵ The Alliance noted the "urgent need for greater integration between hepatitis C and HIV responses among people who use drugs". Large numbers of injecting drug users have HIV and hepatitis C virus (HCV) co-infection. The interaction of the two diseases produces more rapid disease progression and higher rates of mortality and morbidity. Diagnostic and treatment outcomes for both diseases could be significantly enhanced with greater integration. The Alliance stated:

Rates of HCV testing are low, and despite being increasingly successful, access to treatment for HCV is very poor due to the high cost of patented drugs and the lacking capacity in health systems and community organisations to manage HCV treatment.⁵⁶

49 Ev 67

50 Ev 56

51 Twelfth Report of Session 2007-08, *HIV/AIDS: DFID's New Strategy*, HC 1068-I, para 43

52 Ev 67

53 Q 7

54 Ev 85

55 Q 7

56 Ev 53

The World Health Organisation (WHO) in its recent report on HIV/AIDS, *Towards Universal Access*, highlighted that: “Underlying viral hepatitis is becoming a major cause of death among people with HIV and hepatitis.”⁵⁷

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.

Integration with sexual and reproductive health

34. In our Report last year, we stressed that “there are close intersections between sexual, reproductive and maternal health and HIV/AIDS.”⁵⁸ We welcomed DFID’s acknowledgement in the Strategy of the need to integrate sexual and reproductive health and rights services (SRHR) with HIV/AIDS programmes. The Strategy pointed out that nine out of ten people with HIV were infected through sex or mother to child transmission. It emphasised that “sexual and reproductive ill health and HIV are influenced by the same underlying factors and can usually be tackled through the same channels”.⁵⁹

35. Interact Worldwide agreed that the causes of poor SRHR and HIV/AIDS are closely related and highlighted that they have common drivers: poverty, gender inequality, marginalisation, stigma, discrimination and denial.⁶⁰ The Alliance noted that DFID’s Maternal Health and SRHR Strategy, initially planned for publication in mid-2009, had been postponed indefinitely and that DFID had lost the opportunity to “concretise” its position:

Beyond the promise to intensify efforts to halve unmet need for family planning by 2010, neither the Strategy nor the M&E framework include a target related to universal access to comprehensive reproductive health, as articulated in the MDG target 5b, or to sexual health, and the realisation of sexual and reproductive rights as a critical component of HIV responses.⁶¹

It believed that:

57 World Health Organisation, *Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector*, Progress Report 2009, September 2009, p 54

58 Twelfth Report of Session 2007-08, *HIV/AIDS: DFID's New Strategy*, HC 1068-I, para 76

59 *Achieving Universal Access*, p 35

60 Ev 47

61 Ev 53

Upgrading the 2004 SRHR Position Paper to the level of a strategy to guide the UK's support for maternal health and SRHR, with its accompanying targets and M&E framework, will reinforce and support the operationalisation of the emphasis on linkages with HIV outlined in the Strategy.⁶²

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.

5 Social protection programmes

37. In its new HIV/AIDS Strategy, DFID moved from providing earmarked funding for children orphaned or made vulnerable by HIV/AIDS (OVCs) to a new approach of spending £200 million over three years on social protection programmes, including cash transfers. DFID said that this funding would provide “effective and predictable support for the most vulnerable households, including those with children affected by AIDS.” The programmes were intended to operate in eight African countries.⁶³ DFID told us that “robust evidence” had shown that social protection can strengthen families affected by HIV and AIDS:

[...] cash transfers can help secure basic subsistence, reduce poverty and protect children's access to education, health and good nutrition. Cash transfers should be seen as part of broader social protection measures that include family support services to protect children from abuse, accessible and affordable health care and education, psychosocial support and broad livelihoods support.⁶⁴

38. In our Report last year, we asked DFID to clarify how much of the £200 million was new money, given that it already had social protection programmes in place in a number of countries. We also stated that we expected to see indicators included in the Monitoring and Evaluation Framework which would measure the extent to which social protection funding was specifically benefiting children affected by HIV/AIDS.⁶⁵ In its Response, DFID informed us that £120 million had already been committed for social protection programmes in the period 2008-2011 and therefore £80 million could be considered as “new money for new programmes”. Under the M&E Framework, DFID country offices would report on the impact of this expenditure on OVCs as part of its biennial reporting.⁶⁶

39. Witnesses in this year's inquiry continued to express concern that social protection programmes may not benefit children affected by HIV/AIDS. World Vision told us:

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 for and protect vulnerable children affected by HIV and AIDS (others include: child and legal protection services, psycho-social support, and strengthened community support.) Social transfers do not necessarily benefit vulnerable children living outside family settings and in households where there is poor intra-household distribution.⁶⁷

The International HIV/AIDS Alliance pointed out that “children who are the most vulnerable to HIV infection and also to the impact of HIV on their lives are most likely not to benefit from development interventions”. This includes children with disabilities, street

63 *Achieving Universal Access*, pp 5, 41

64 Ev 37

65 Twelfth Report of Session 2007-09, *HIV/AIDS: DFID's New Strategy*, HC 1068-I, para 55

66 First Special Report of Session 2008-09, *HIV/AIDS: DFID's New Strategy: Government Response to the Committee's Twelfth Report of Session 2007-08*, HC 235, pp 8-9

67 Ev 86-87

and working children, and children of people who use drugs and of sex workers. It highlighted that “social protection programmes in general, and in particular programmes that promote community targeting of vulnerable families, are in danger of excluding families due to stigma and discrimination by community members and institutions”. People affected by HIV/AIDS are often engaged in activities which are categorised as illegal in the countries where they live, for example sex work and drug use. This contributes to the difficulties in identifying children and families in need of assistance because people often do not come forward due to “fear of police harassment, legal action and separation of children from their families” and are therefore often excluded from services.⁶⁸

40. Sally Joss told us that “one of the biggest issues around all of the social protection is that cash transfers are not enough and that there need to be on the ground welfare support services that are supporting vulnerable households, vulnerable groups”.⁶⁹ DFID witnesses confirmed that “a lot of the work we are doing at the moment is looking at cash transfers”.⁷⁰ When we asked about people who were excluded from social protection schemes, Alastair Robb, Senior MDG Results Adviser, said that, although there were a huge number of very poor people who would benefit from cash transfers, “those people that are really out of reach of the whole system are not going to be the ones who will benefit from this”. He told us that “over time” DFID would produce an analysis to assess how cash transfers impact on the lives of the poor people receiving them, including children, orphans and people with HIV.⁷¹

41. We are also concerned that there is a lack of clarity within DFID about the countries in which its social protection programmes will operate. Although the Strategy specified that programmes would be developed in eight African countries, when the Minister gave evidence last year he was not able to tell us which countries these would be, as this was still being finalised.⁷² Witnesses in this year’s inquiry expressed concern that, halfway through the funding period for the programmes, DFID had “still not defined which countries these are and so monitoring progress remains impossible”.⁷³ In evidence this year, DFID witnesses told us that there was “not a fixed or static number” of countries where DFID intended to work on social protection, although programmes were currently operating in Kenya, Malawi, Rwanda, Sierra Leone, South Africa, Zambia and Zimbabwe. More programmes might be added in the future as existing programmes came to an end.⁷⁴ The Minister acknowledged the need to make more information available on the programmes and the intended outcomes and undertook to “look at what we can do”.⁷⁵

42. We remain concerned that many of the most vulnerable people affected by HIV/AIDS, particularly children, may be excluded from social protection programmes.

68 Ev 54

69 Q 14 [Sally Joss]

70 Q 37 [Alastair Robb]

71 Q 37 [Alastair Robb]

72 *Achieving Universal Access*, pp 5, 41; Twelfth Report of Session 2007-08, *HIV/AIDS: DFID's New Strategy*, HC 1068-I, para 51

73 Ev 83

74 Q 36

75 Q 38

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.

6 Marginalised and vulnerable groups

43. In our Report last year we said:

If the global effort on HIV/AIDS is to achieve the goal of halting and reversing the spread of the disease, it must be effective in reaching marginalised people, including sex workers, intravenous drug users, men who have sex with men and transgender individuals. If the epidemic is not tackled in these groups it will continue to spread to the general population and the number of people affected will continue to increase. DFID's Strategy acknowledges this reality but does not adequately explain how DFID will ensure that these marginalised people are provided with the prevention, treatment and support services they require.⁷⁶

We asked DFID to provide us with more information about its plans for reaching marginalised groups. DFID's response was that "it is not possible to provide this level of detail in a global strategy", although it did provide some specific examples of its work with high risk groups in India, Kenya and Vietnam.⁷⁷ In China, we saw for ourselves the significant impact which DFID's work with marginalised groups was having. An independent external review of the initial project, which was focused on the poor western provinces, concluded that it had led to a range of positive outcomes, including: increased condom use; reduction in needle-sharing amongst IDUs; sex workers being empowered to negotiate 100% condom use; and a decrease in stigma. DFID subsequently committed £30 million to its HIV/AIDS programme in China over five years to build on this successful work.⁷⁸

44. DFID's Strategy recognises the need to create programmes specifically aimed at disadvantaged and marginalised groups. It notes that the groups most affected by AIDS are women, young people, children, men who have sex with men (MSM), injecting drug users (IDUs), sex workers and prisoners. They are:

- more likely to be living with HIV than the general population;
- less able to deal with the impact of the epidemic; and
- most likely to be failed by existing policies, programmes, support and services.

The Strategy emphasises the need to "address the underlying drivers of their susceptibility and vulnerability. Thus, tackling AIDS means addressing social exclusion and safeguarding human rights."⁷⁹

45. Witnesses agreed that IDUs, sex workers, MSM, other sexual minorities and prisoners are among the most marginalised groups in society and suffer the most discrimination. In many countries the authorities deny the existence of these groups or their behaviour is

76 Twelfth Report of Session 2007-08, *HIV/AIDS: DFID's New Strategy*, HC 1068-I, para 87

77 First Special Report of Session 2008-09, *HIV/AIDS: DFID's New Strategy: Government Response to the Committee's Twelfth Report of Session 2007-08*, HC 235, p 16

78 Third Report of Session 2008-09, *DFID and China*, HC 180-I, paras 48-49

79 *Achieving Universal Access*, p 23

classified as illegal. Access to public health services is often difficult, due to distance, cost, stigmatisation or cultural factors. For example, where drug use is illegal, injecting drug users often do not use government health services for fear of prosecution or because they are subjected to discrimination by health staff.⁸⁰

46. Mike Podmore of VSO identified people with disabilities as a particularly vulnerable group who were frequently forgotten in international policy discussions. He believed that there was a need for “increased and directly focused support for disabled persons’ organisations in-country” to enable them to influence policy dialogue. He said that DFID should support innovative projects that disabled people’s organisations were trying to promote to enable them to participate in the planning and delivery of HIV services. He told us that “often, even in the community, in people’s homes it is people with disabilities who are left behind when everyone else goes to the HIV prevention talk in the community.” He called for DFID to support advocacy networks such as the African campaign on HIV and AIDS and disability, and other similar national networks.⁸¹

47. Similarly, World Vision highlighted that:

Children and adults with disabilities are routinely ignored and marginalised because of fear and misunderstanding around disability. This includes exclusion from HIV prevention and support services. Less than 10% of disabled children in sub-Saharan Africa receive an education and therefore more than 90% miss out on school-based HIV-education programmes. Literacy rates are very low amongst people with disabilities.⁸²

It said that there is a “mistaken belief that disabled people are not sexually active and are not at risk from HIV infection” and that “this misapprehension is doubly damaging and dangerous as children and adults with disabilities are 2-3 times more likely to face sexual abuse and violence.” Street children were also identified as:

[...] one of the most marginalised groups when it comes to accessing HIV-related services and support. Care for orphans and vulnerable children often evolves from home-based care programmes—which by their very nature are poorly suited to reaching children who live or work on the street. Street children are more likely to be sexually active at a younger age. They are unlikely to use testing and counselling or treatment services, access to which often depends on consent from a parent or guardian and a stable, supportive home life. Street children are in great need of HIV prevention services, but rarely receive them.⁸³

Role of civil society in providing HIV/AIDS services

48. In our 2008 Report, we emphasised that “civil society is particularly important in reaching marginalised groups who are much less likely to use services provided by the state.” However, it was not clear to us from the Strategy how DFID would support civil

80 Ev 75

81 Q 14 [Mike Podmore]

82 Ev 86

83 Ev 86

society organisations to undertake HIV/AIDS work and we requested further information. The Government's Response acknowledged "the important role that civil society has within an effective AIDS response" and provided us with examples of DFID support for civil society interventions in a number of countries. These included DFID funding in Nepal for a Challenge Fund managed by the National Association of People Living with HIV/AIDS which worked with 70 community-based organisations providing nutrition support, treatment, care homes and referrals for 5,000 people living with HIV/AIDS.⁸⁴

49. The UK Consortium told us that "in the short to medium term, and until public health systems are improved, civil society organisations can often target and provide services more quickly and effectively to the hardest to reach communities".⁸⁵ However, Alvaro Bermejo of the Alliance believed that DFID's ability to use civil society to reach marginalised groups effectively was hampered by the need to reduce administrative costs. He said "they have less and less staff both on the ground and here [in London] and thus are looking to reduce their transactional costs [and] the amount of time it takes to mobilise resources and support". He said that many of the civil society organisations working in HIV/AIDS were small and "very diversified" and partnership with them took up a lot of time. He felt that efficiency savings were driving DFID towards budget support for multilateral programmes where "hundreds of millions of dollars" could be disbursed without having to deal with small community groups. He suggested that one solution to the current problem of interacting with smaller groups would be for a number of donors to pool their funds and hire a technical management agency to disburse funds to small civil society groups.⁸⁶

50. The impact of a reducing staff headcount on DFID's work has featured in a number of our reports. Specifically in relation to HIV/AIDS, our 2008 Report noted that "staff reductions at DFID may have reached the point where they risk adversely affecting the Department's ability to deliver its objectives in vital fields such as health and social care."⁸⁷ In response, DFID said that the balance of posts in the organisation would move away from general administrative roles to a "greater concentration on professional skills" and that "we expect to employ more staff with political and institutional knowledge about our stakeholders; and with skills enabling them to build relationships and communicate effectively."⁸⁸ We will return to the question of the impact of efficiency savings on DFID's wider operations in our forthcoming inquiry into the DFID Annual Report 2009.

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

84 Twelfth Report of Session 2007-08, *HIV/AIDS: DFID's New Strategy*, HC 1068-I, paras 88-97; First Special Report of Session 2008-09, *HIV/AIDS: DFID's New Strategy: Government Response to the Committee's Twelfth Report of Session 2007-08*, HC 235, pp 16-17

85 Ev 75

86 Q 15 [Alvaro Bermejo]

87 Twelfth Report of Session 2007-08, *HIV/AIDS: DFID's New Strategy*, HC 1068-I, p 109

88 First Special Report of Session 2008-09, *HIV/AIDS: DFID's New Strategy: Government Response to the Committee's Twelfth Report of Session 2007-08*, HC 235, p 19

remain concerned that DFID staff reductions mean that the Department is less well-equipped to do this necessary work than previously.

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.

Gender-based violence

53. In our 2008 Report on Maternal Health we noted that “gender-based violence has a powerful impact on women’s health, and contributes to unplanned pregnancies, abortions and the spread of sexually transmitted infections, including HIV and syphilis.”⁸⁹ In our 2008 AIDS Report we expressed concern about “DFID’s lack of dedicated strategies and funding to address gender-based violence which is closely linked to the spread of HIV.”⁹⁰ In its response, DFID told us that it would address the issue of gender-based violence through its existing Gender Equality Action Plan and through its country programmes. It said that it was “reviewing the level of our work on violence against women, to evaluate where, and how, we can do more on this important issue.”⁹¹

54. DFID announced in its recent White Paper a commitment to include, within its new security and access to justice programmes, measures to support women and girls affected by violence.⁹² We were also encouraged to see that one of the priorities for action in the M&E Framework is: “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.”⁹³ However, the problem of gender-based violence against women and girls and its interaction with HIV/AIDS is still not being addressed directly.

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**

89 International Development Committee, Fifth Report of Session 2007-08, *Maternal Health*, HC 66-I, para 25

90 Twelfth Report of Session 2007-08, *HIV/AIDS: DFID’s New Strategy*, HC 1068-I, paras 67-69

91 First Special Report of Session 2008-09, *HIV/AIDS: DFID’s New Strategy: Government Response to the Committee’s Twelfth Report of Session 2007-08*, HC 235, p 13

92 DFID, *Eliminating World Poverty: Building our Common Future*, Cm 7656, July 2009, p 75

93 *Achieving Universal Access— Monitoring performance and evaluating impact*, p 13

it could do more to tackle it. We recommend that it shares the results of that review with us, in response to this Report.

7 Access to treatment

Anti-retroviral treatment

56. We now turn to consider the provision of anti-retroviral treatment (ART) for people living with HIV/AIDS. As we have noted, 42% of people requiring treatment in low- and middle-income countries received ART in 2008, up from 33% in 2007. However, this is well short of the target of universal access to treatment by 2010 set in Millennium Development Goal 6.⁹⁴ The number of people requiring ART in the future will continue to increase due to a number of causes. Firstly, the number of people becoming infected with HIV is still growing, with new infections continuing to outpace the number receiving treatment. Secondly, the total number of people living with HIV will rise as people receiving ART live longer and continue to require treatment: ART is a lifelong intervention. Thirdly, as the All Party Parliamentary Group on AIDS pointed out in its report *The Treatment Timebomb*, improvements in health systems and the quality of care and support given to those living with HIV will also contribute to people living longer.⁹⁵ Fourthly, as testing programmes become more readily available the number of diagnoses will increase. The International AIDS Vaccine Initiative estimates that 55 million people will require access to ART by 2030.⁹⁶ Alvaro Bermejo told us that:

WHO in the next few weeks will issue new guidelines lowering the time in which you have to start treatment, so asking for people to start treatment with higher CD4 counts because that has been seen to be the most productive approach. That will immediately put millions of people onto our list of those in need of treatment.⁹⁷

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.

Provision of treatment for women and children

58. The particular impact of HIV on women and children and the resulting need for effective treatment remains a serious concern. In sub-Saharan Africa, women now account for almost 60% of the adults living with HIV. HIV is the leading cause of mortality among women of reproductive age worldwide. Maternal morbidity and death have devastating effects on children's health, well-being and survival. More than 90% of children living with HIV are infected through mother-to-child transmission during pregnancy, around the time of birth or through breast-feeding.⁹⁸ For those children born with HIV, early treatment with ART within the first few months of their lives can dramatically improve

94 Millennium Development Goal Target 6b is to "Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it". See <http://www.undp.org/mdg/basics.shtml>

95 All Party Parliamentary Group on AIDS, *The Treatment Timebomb*, June 2009, p 7

96 Ev 49

97 Q 18 [Alvaro Bermejo]

98 World Health Organisation, *Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector*, Progress Report 2009, September 2009, pp 88-89

their survival rates. World Vision said that in South Africa mortality was reduced by 75% in infants living with HIV who were treated before they reached 12 weeks of age.⁹⁹

59. At the United Nations General Assembly Special Session on HIV/AIDS in 2001 the international community committed to reduce the proportion of infants with HIV by 50% by 2010 by ensuring that 80% of pregnant women and their children had access to essential prevention, treatment and care services.¹⁰⁰ In its latest report on progress towards universal access, the World Health Organisation stated that access to services for the prevention of mother-to-child-transmission (PMTCT) in low- and middle-income countries continued to expand: 21% of pregnant women received an HIV test in 2008, an increase from 15% in 2007; 45% of pregnant women living with HIV were receiving anti-retroviral drugs to prevent mother-to-child transmission.¹⁰¹ World Vision told us that:

Without access to services to prevent this 'vertical transmission', about 35% of infants, born to mothers living with HIV, will acquire HIV during pregnancy, labour, delivery or breast-feeding. Without proper care particularly related to breast-feeding and nutrition, as well as anti-retroviral treatment, more than half of these children will die before their second birthday [...] An unacceptable two thirds of pregnant women living with HIV remain without access to these crucial services that prevent transmission to their children.¹⁰²

60. Interact Worldwide highlights that, when women in developing countries are diagnosed with HIV during pregnancy, care at this stage may be focused on preventing onward transmission of HIV to her child, while there is neglect of the woman's wider health and psychological needs. It calls for PMTCT services to cater to women's wider needs in line with WHO guidelines. It believes that action would increase the uptake of HIV testing and ensure better health outcomes for women and their children.¹⁰³

61. Fionnuala Murphy of Interact Worldwide told us of the stigmatisation that women can suffer on being diagnosed with HIV:

[She] can be thrown out of her home and have her children and property taken away from her. She will be accused of bringing the virus into her family. She will face violence from her husband and her in-laws. In terms of a woman who is pregnant and already physically and emotionally vulnerable because of that, plus a HIV positive diagnosis, to put those two things together and expect women to cope with no backup is really impossible and it is no surprise that many women will refuse HIV tests in an antenatal care setting or where they think that those tests will be pushed on them.¹⁰⁴

99 Ev 87

100 United Nations General Assembly, *Declaration of Commitment on HIV/AIDS*, 2001

101 World Health Organisation, *Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector*, Progress Report 2009, September 2009, p 5

102 Ev 87-88

103 Ev 48

104 Q 13

Interact Worldwide had documented cases of women being tested without their consent. The result of this intervention is that some women avoid any form of antenatal care altogether. Ms Murphy continued:

The DFID strategy talks about PMTCT in terms of the delivery of anti-retrovirals to prevent onward transmission of the virus to babies and that is a really important part of PMTCT, but we also need to think about all the other parts, such as meeting the mother's health needs beyond pregnancy and birth but also meeting all of the mother's needs and making sure that women get the counselling they need and also have the backup services so that if they do face violence and eviction they have somewhere to go.¹⁰⁵

62. According to World Vision, despite weak health systems in many developing countries and those that have the highest burden of HIV, more than 70% of all pregnant women in these countries make at least one antenatal care visit. It says that this provides an “excellent opportunity” for delivery of PMTCT interventions and to engage women and their children in a “comprehensive continuum” of HIV prevention, care and treatment services. However:

[...] if PMTCT is to be successful, women must have expanded access to quality reproductive health services, including family planning, antenatal, delivery and postpartum care, and must use the existing services more frequently and earlier in pregnancy than they do currently.¹⁰⁶

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.

First- and second-line drugs

64. Many people in developing countries who are receiving HIV/AIDS treatment are provided with “first-line” drugs. These are drugs which were developed at a relatively early stage. They are usually the most readily available and are comparatively cheap, due to the high volume of usage. Over time patients on first-line drugs may develop resistance to them and they become less effective. This process is accelerated when patients fail to adhere to their treatment programmes, which happens more frequently when people are poor and have little access to health services. Some people on first-line treatments also experience side effects.¹⁰⁷ More patients in developing countries will, over time, therefore need to transfer to more expensive second-line drugs. Alvaro Bermejo of the HIV/AIDS Alliance highlighted that one first-line drug is only prescribed in developing countries: in

105 Q 13

106 Ev 88

107 *The Treatment Timebomb*, July 2009, p 12

developed countries “it is seen as too toxic and with too many side-effects to be able to prescribe it but we call it first-line for developing countries just because it is cheap”.¹⁰⁸

65. The World Health Organisation’s latest report on achieving universal access stated that treatment had become more widely available in recent years, due to a significant decline in the prices of the most commonly used anti-retroviral drugs, with the cost of most first-line regimens decreasing by 10–40% between 2006 and 2008. However, second-line drugs continue to be expensive.¹⁰⁹ The cheapest price for a second-line regimen is US\$590 per patient per year, making it seven times more expensive than the cheapest first-line drugs.¹¹⁰ The Global Fund works on the basis of 5% migration from first- to second-line medicines each year.¹¹¹ Sally Joss of the UK Consortium told us that:

[...] ultimately this is going to mean that the drugs that are cheaper now will go out of use and that more expensive drugs will have to come in and countries will find it extraordinarily difficult to sustain the level of treatment that they presently have and particularly if they want more.¹¹²

WHO found that, in 2008, only 2% of adults on ART were receiving second-line drugs. It cautioned that:

An increase in the use of second-line drugs [...] implies a rise in the cost of drugs for HIV programmes in low- and medium-income countries. This represents a major challenge for country programmes, national authorities and the international development community, who will need to raise additional resources to sustain and expand treatment access.¹¹³

UNITAID and patent pools

66. UNITAID was established in 2006 as a joint initiative between the UK, France, Norway, Chile and Brazil to supply poor countries with lower cost life-saving medicines for AIDS, tuberculosis and malaria. It is administered by the World Health Organisation with a mission “to contribute to scaling up access to treatment for HIV/AIDS, malaria and tuberculosis, primarily for people in low-income countries, by leveraging price reductions for quality diagnostics and medicines and accelerating the pace at which these are made available.” It is now supported by 29 countries and by the Bill and Melinda Gates Foundation.¹¹⁴ DFID has made a 20-year commitment to UNITAID with the possibility of providing £760 million in the period to 2027.¹¹⁵

108 Q 18 [Alvaro Bermejo]

109 World Health Organisation, *Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector*, Progress Report 2009, September 2009, p 74

110 *The Treatment Timebomb*, p 12

111 *ibid*

112 Q 18 [Sally Joss]

113 World Health Organisation, *Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector*, Progress Report 2009, September 2009, p 72

114 <http://www.unitaid.eu/>

115 Ev 33

67. Sally Joss welcomed DFID's "financial and moral support" for UNITAID and highlighted the benefits of patent pools.¹¹⁶ A medicine patent pool functions on a voluntary basis. Patent holders voluntarily submit patents for pharmaceutical production methods and particular medicines. A third party then obtains a licence from the pool to reproduce a single patented medicine, or to use several patents to develop a new fixed dose combination, in return for a percentage of its sales as a fee for each patent used. Licences issued to third parties are restricted to developing countries. Patented medicines are subsequently produced by several manufacturers well before the expiry of a patent term, thereby increasing the availability of certain medicines, increasing competition and lowering the price of AIDS treatment in low- and middle-income countries.¹¹⁷ Patent pools make it easier for researchers to develop combination therapies as they can access permission to use component drugs from a single source, rather than having to negotiate with a number of companies.¹¹⁸ The UK, as a member of the UNITAID board, will consider the agency's proposals for a patent pool at a board meeting in December.¹¹⁹

68. A growing number of people living with HIV and AIDS will require access to anti-retroviral 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 co-operation 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.

116 Q 18 [Sally Joss]

117 <http://www.thecommonwealth.org/files/214504/FileName/CommonwealthHIVMeeting-PatentPoolBriefingPaper.pdf>

118 *The Treatment Timebomb*, p 28

119 HC Deb, 9 November 2009, col 101w

8 Funding for HIV/AIDS programmes

69. The quality and coverage of HIV/AIDS programmes will be directly affected by the overall level of resources which donors make available for this sector. A recent report by UNAIDS states that, based on country-defined targets to achieve universal access by 2010, funding of US\$25.1 billion will be required for the global AIDS response in developing countries in 2010. US\$11.6 billion will be required for HIV prevention and US\$7 billion for treatment. It is expected that one-third of the funding will come from developing countries' domestic public sources and that external sources will provide the remaining two-thirds. It is anticipated that one-third of the funds will be used to finance multi-sectoral programmes, one-third will be directed to strengthening health systems and the remaining third will go towards HIV specific health programmes.¹²⁰

The impact of the global economic downturn

70. At the Gleneagles G8 Summit in 2005 EU member states pledged to allocate 0.7% of Gross National Income (GNI) to Official Development Assistance (ODA) by 2015, with an interim target of 0.56% by 2010. EU countries aimed to double their ODA between 2004 and 2010 from €34.5 billion to €67 billion.¹²¹ The G8 countries also pledged significantly to reduce HIV infections in Africa and to work with WHO, UNAIDS and other international bodies to develop and implement a package of HIV prevention, treatment and care, with the aim of moving as close as possible to universal access to treatment for all who need it by 2010.¹²² In 2008, the United Kingdom was the second largest donor to AIDS programmes, contributing 12.6% of the total disbursements. The United States accounted for more than half (51.3%), the Netherlands 6.5%, France 6.4% and Germany 6.2%. Norway and Sweden each contributed 2.0%.¹²³

71. UNAIDS acknowledges that the global economic downturn has forced governments and civil society to re-examine their development assistance allocations. It notes the International Monetary Fund's forecast that world economic growth would fall from 5.2% in 2007 to 0.5% in 2009, but calls for long-term sustainable financing for HIV programmes to be secured.¹²⁴

72. The DFID Minister restated in his oral evidence the Government's pledge to commit 0.7% of GNI to ODA and said that, despite the economic downturn, the UK was committed to maintaining its spending programme. However, he pointed to the "threats that have been posed by funding decisions of other countries" who were "starting to shy away from commitments that they have made". To address this, the G8 had published for the first time in July 2009 an interim accountability framework which showed progress of

120 UNAIDS, *What Countries Need: Investments needed for 2010 targets*, 2009, p 7. The remainder of the \$25.1 billion is required for the following: orphans and vulnerable children \$2.5 billion; programme support costs \$3.7 billion; prevention of violence against women \$0.3 billion.

121 G8 Gleneagles communiqué, Annex II

122 G8 Gleneagles communiqué, 18 d, p 22

123 The Henry Kaiser Family Foundation, *Financing the response to AIDS in low- and middle-income countries: International assistance from the G8, European Commission and other donor Governments in 2008*, July 2009

124 UNAIDS, *What Countries Need: Investments needed for 2010 targets*, 2009, p 11

individual countries towards the G8 commitments on development expenditure, including health spending. The Minister told us that the UK, supported by the Canadian presidency of the G8, would be pushing for a specific target on HIV/AIDS spending from 2010.¹²⁵

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 reneging 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.

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 set 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.

The Global Fund to fight AIDS, TB and Malaria

75. The Global Fund to fight AIDS, TB and Malaria describes itself as a unique global public/private partnership dedicated to attracting and disbursing additional resources to prevent and treat HIV/AIDS, tuberculosis and malaria. It says that this partnership between governments, civil society, the private sector and affected communities represents a new approach to international health financing. The Global Fund works in close collaboration with other bilateral and multilateral organisations to supplement existing efforts to tackle the three diseases. Since its creation in 2002, the Global Fund has become the main source of finance for programmes to fight AIDS, tuberculosis and malaria. It has approved funding of US\$15.6 billion for more than 572 programmes in 140 countries. The Global Fund provides a quarter of all international financing for AIDS globally, two-thirds of TB funding and three-quarters of malaria funding.¹²⁶

76. DFID's AIDS Strategy reiterated the funding commitment first made in September 2007, to allocate £1 billion over the seven years to 2015 to the Global Fund.¹²⁷ The UK allocation in 2008 was £50 million and in 2009 rose to £115 million.¹²⁸ The UK Consortium told us that the long-term nature of this commitment was exemplary, but believed that the amount was insufficient given that the Global Fund announced in July 2009 a budget shortfall of about US\$3 billion for programmes planned for 2010.¹²⁹ The Minister emphasised the benefit to the Global Fund of the predictability which the UK's commitment provided. He believed that there was "a lobbying exercise" to be carried out in

125 Q 54

126 <http://www.theglobalfund.org>

127 *Achieving Universal Access*, p 51

128 Q 40

129 Ev 73, 82

terms of encouraging other countries to increase their pledges. Whilst the UK, as a leading contributor to the Fund, could attempt “to leverage in more support” from other G8 countries, he believed that “we are not in a position to tell others to pay their fair share” and that there was a role for civil society to put pressure on governments to “fulfil the payment of what is only seen as a fair share towards the Global Fund”. Mr Foster also believed that the Global Fund should make its funding “work better, to make it more effective on the ground”.¹³⁰

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.

Working with other donors

78. In our inquiry last year, the Minister told us that a significant factor in DFID's decision to give such weight to funding health systems had been the need to balance vertical—or disease-specific—funding from other donors.¹³¹ One of the major contributors to vertical funding for HIV/AIDS is the US President's Emergency Plan for AIDS Relief (PEPFAR) which provided US\$19 billion to support national AIDS responses between 2004 and 2008. In July 2008 the US Congress passed an Act that allocated a further US\$48 billion over a five-year period for combating HIV/AIDS, TB and malaria.¹³² US\$39 billion is for HIV/AIDS, US\$4 billion for tuberculosis and US\$5 billion for tackling malaria. The Act also increased the US Government's contribution to the Global Fund to US\$2 billion per annum.¹³³

79. Many AIDS organisations have welcomed the new US Administration's willingness to move away from some of the more controversial aspects of PEPFAR, particularly in relation to prevention. These included restrictions placed on prevention programmes that did not promote abstinence, monogamy, fidelity, and partner reduction. President Obama's election pledge of “best practice, not ideology” and his decision to overturn the controversial “global gag rule” have encouraged hopes for positive changes to PEPFAR policy.¹³⁴ During his election campaign, Mr Obama pledged to increase PEPFAR funding to US\$50 billion by 2013. However, the President's global health initiative, announced in May 2009, has been criticised for undermining this commitment by extending the time-frame for its delivery to six years rather than five. Concerns have also been expressed by

130 Q 40

131 Twelfth Report of Session 2007-08, *HIV/AIDS: DFID's New Strategy*, HC 1068-I, para 12

132 Tom Lantos and Henry J Hyde, *United States Global Leadership Against HIV/AIDS, Tuberculosis and Malaria Reauthorization Act of 2008*

133 <http://www.avert.org/pepfar.htm>

134 The ‘global gag rule’ is the policy which prevented all US non-governmental organizations which received federal funding from promoting abortion services in other countries; see <http://www.avert.org/pepfar.htm>

international AIDS activists over the President's budget request for only US\$366 million in new money for PEPFAR for the financial year 2010. They have said that this will result in a shortfall in funding which will have severe health consequences, including significantly reducing the number of people who receive vital HIV/AIDS treatment.¹³⁵

80. Last year, we recommended that the UK Government take "an early opportunity" to discuss with the new US Administration potential areas of co-operation on HIV/AIDS work, if it should indicate a change in its approach to development funding.¹³⁶ DFID told us that regular bilateral engagement between the UK Government and all branches of the US Government would be "stepped up to take advantage of the possible opportunities that the US administration presents" in the hope of achieving greater alignment between UK and US policy on AIDS prevention, treatment and care.¹³⁷ In evidence this year, the Minister welcomed the changes that had been made to PEPFAR and the budget commitments on global health. He said that the focus on broader health issues was now more in line with DFID's approach, including in child and maternal health and family planning, which would benefit HIV/AIDS programmes and would enable a closer working relationship between DFID and USAID "on the ground".¹³⁸

81. Alastair Robb, Senior MDG Results Adviser at DFID, provided us with an example of the closer working relationship at country level. In Kenya PEPFAR was operating "less vertically", and was working with DFID and the national government through partnership agreements that were "consistent with overall AIDS and health strategy". He believed that this "indicates their commitment to working better and achieving wider sets of outcome".¹³⁹

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.

The implications for HIV/AIDS programmes of DFID's White Paper

83. DFID published its new White Paper, *Eliminating World Poverty: Building Our Common Future* in July 2009. Some witnesses believed that the White Paper was further evidence of an already apparent reduction in the priority DFID gives to HIV/AIDS. They believed that this had been demonstrated by the lack of clear funding commitments for HIV in the AIDS Strategy, DFID's strong criticism of vertical funding programmes and a reduction of the number of staff in DFID's AIDS and Reproductive Health Team. They were concerned that this was likely to have a significant impact on DFID's capacity to drive

135 <http://www.avert.org/pepfar.htm>

136 Twelfth Report of Session 2007-08, *HIV/AIDS: DFID's New Strategy*, HC 1068-I, para 13

137 First Special Report of Session 2008-09, *HIV/AIDS: DFID's New Strategy: Government Response to the Committee's Twelfth Report of Session 2007-08*, HC 235, p 1

138 Q 61

139 Q 62

the Strategy forward and to continue to play a leading role in global HIV policy discussions.¹⁴⁰ Marie Stopes International was clear that the White Paper did nothing to allay these concerns: “Whilst the [White Paper] makes reference to HIV/AIDS, it does not specifically address the challenge of HIV/AIDS in humanitarian settings or fragile states.”¹⁴¹

84. When we put this to the Minister, he told us that “DFID is as committed as ever to working on HIV/AIDS” and that he would “counter any argument that we were de-prioritising HIV/AIDS”. He said that the level of DFID’s funding allocations to HIV/AIDS programmes was a clear indication of its commitment.¹⁴² He did however acknowledge that other important health issues, particularly maternal health, were “getting a greater share of attention” and taking the focus away from HIV/AIDS in the press and in terms of lobbying.¹⁴³

85. Part of the “new approach” set out in the White Paper is a greater focus on fragile states: DFID says that it will “allocate at least 50% of all new bilateral country funding to fragile countries.”¹⁴⁴ The Minister drew attention to the need for HIV/AIDS programmes in fragile and conflict-affected countries, where women were often the victims of violence and where health services frequently collapsed, feeding the spread of HIV and preventing proper treatment.¹⁴⁵

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.

140 Ev 82

141 Ev 64

142 Q 58

143 Q 59

144 DFID, *Eliminating World Poverty: Building our Common Future*, Cm 7656, July 2009, p 71

145 Q 60

9 Cross-Whitehall working on HIV/AIDS

87. In our 2008 Report we stressed that:

If Millennium Development Goal 6 is to be achieved by 2015, and universal access to treatment for HIV/AIDS by 2010, tackling HIV/AIDS in all high-prevalence countries needs to be given a higher priority. Several of these are middle-income countries (MICs), including in southern Africa, Latin America and the Caribbean.¹⁴⁶

We noted that the Strategy envisaged that the Foreign and Commonwealth Office would take on an enhanced role in tackling HIV/AIDS, particularly in middle-income countries (MICs) where DFID has a minimal presence. We emphasised that it was “vital” to ensure that FCO officials were properly equipped to take on these new responsibilities and invited the Government to share with us its detailed planning for this cross-departmental work on HIV/AIDS.¹⁴⁷ In its response, DFID told us that it was still in discussions with the FCO about how they could work together to support a more effective response in middle-income countries, including those with high-prevalence levels and that a set of criteria was beginning developed “to select the number of MICs in which the FCO will focus its efforts on AIDS”. The FCO was exploring ways in which its capacity to work in this area could be strengthened.¹⁴⁸

88. Alvaro Bermejo stressed that countries such as China, Brazil, and South Africa were “critical” in trying to control the global epidemic and that the FCO had a role in “supporting the case for marginalised and vulnerable groups” in countries where DFID did not have a presence.¹⁴⁹ He said that “what we have not seen is a systematic approach to the issue or any strategy” in this respect.¹⁵⁰

89. When we pursued this in evidence with the Minister, he said that the FCO had a “watching brief over the work on HIV/AIDS” in middle-income countries.¹⁵¹ He pointed out that progress on HIV/AIDS activities in middle-income countries would be a “feature of the biennial reports” published by DFID.¹⁵² When we pressed him for examples of effective joint working with the FCO on HIV/AIDS in middle-income countries without a DFID presence, we were told about a project in Burma. Whilst this is interesting work which we applaud, DFID has a staff presence in Burma and it is not a middle-income country. Nor were we provided with any information on the resources, training and expertise which would be provided to the FCO to take on this new task, or how DFID would contribute to ensuring that the HIV/AIDS Strategy was implemented effectively in

146 Twelfth Report of Session 2007-08, , *HIV/AIDS: DFID's New Strategy*, HC 1068-I, para 36. Millennium Development Goal 6 is to: combat HIV/AIDS, malaria and other diseases. Target 6a is: by 2015 halt and reverse the spread of HIV/AIDS

147 Twelfth Report of Session 2007-08, *HIV/AIDS: DFID's New Strategy*, HC 1068-I, para 38

148 First Special Report of Session 2008-09, *HIV/AIDS: DFID's New Strategy: Government Response to the Committee's Twelfth Report of Session 2007-08*, HC 235, p 5

149 Q 9

150 Q 10

151 Q 52

152 Q 53

middle-income countries where HIV and AIDS remain such a significant public health issue.

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.

Cross-Whitehall Working Group

91. In its response to our Report last year, DFID told us that the Cross-Whitehall Working Group on tackling AIDS in the developing world was “the main mechanism” for cross-departmental work on AIDS and that its terms of reference were being revised to make explicit its role in monitoring the commitments made in the AIDS Strategy.¹⁵³ In response to our questions in this year’s inquiry about the Group’s activities, the Minister undertook to send us the Group’s terms of reference. These are published with the evidence received in this inquiry.¹⁵⁴ The Minister told us that “It is an informal group. It is a meeting of officials and not ministers”. The Group has no dedicated budget; its costs “which are largely staff time, are met from existing resources.” The core members, in addition to DFID and the FCO, are the Department for Health and the Home Office, with other Departments being involved “as required”. The Group meets “up to four times a year”. DFID provides the secretariat.¹⁵⁵

92. The Monitoring and Evaluation document makes clear that it is the responsibility of the Cross-Whitehall Working Group to “monitor the implementation of the UK priorities for action across DFID and other government departments”.¹⁵⁶ Witnesses considered the Group to be under-resourced and were concerned that its secretariat was staffed from the AIDS and Reproductive Health Team in DFID, which has been significantly reduced in numbers over the last three years. The APPG on AIDS pointed to a possible lack of transparency and accountability in its work, given that the Group meets in private and its agendas and minutes are not published.¹⁵⁷ When we put this to DFID witnesses, we were told that they would “be happy to consider” publishing the Group’s meeting papers.¹⁵⁸

¹⁵³ First Special Report of Session 2008-09, *HIV/AIDS: DFID's New Strategy: Government Response to the Committee's Twelfth Report of Session 2007-08*, HC 235, p 5

¹⁵⁴ Ev 40

¹⁵⁵ Q 42; Ev 40

¹⁵⁶ *Achieving Universal Access—Monitoring performance and evaluating impact*, p 10

¹⁵⁷ Ev 30

¹⁵⁸ Q 45

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.

10 Conclusion

94. Our 2008 Report on HIV/AIDS broadly welcomed DFID's new AIDS Strategy but pointed to the significant gap left by the absence of a Monitoring and Evaluation Framework. The publication of the Framework and the accompanying Baseline document are welcome developments. The next step will be the first biennial progress report on the implementation of the Strategy, and we look forward to its publication in December 2010.

95. However, effective monitoring and evaluation of the Strategy is only one of the issues of concern that we raised last year. Neither the Government's response to our 2008 Report, nor the evidence we took in this year's inquiry, have allayed our concerns about the extent to which the Strategy will ensure that all those in need of HIV/AIDS care receive it. In particular, it is still not clear to us that children, women and marginalised and vulnerable groups will benefit from DFID's programmes for health service strengthening and social protection.

96. While generally welcoming DFID's focus on fragile and low-income countries, we are concerned that the AIDS epidemic in middle-income countries is not being adequately addressed by the other Government departments to which this responsibility has been passed.

97. As we said last year, HIV/AIDS will continue to present a huge challenge to both developing countries and donors for many years to come. DFID is a lead donor for and supporter of HIV/AIDS services. We are pleased to note the UK's adherence to its funding commitments, but the global economic downturn has cast further doubt on whether other donors' funding pledges will be met. DFID must continue to demonstrate that its focus on this crucial development challenge has not diminished and to put pressure on its donor partners to do the same.

List of recommendations

Monitoring and Evaluation

1. 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 14)
2. A challenge remains, however, 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. (Paragraph 15)

Health system strengthening

3. 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 25)
4. 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. (Paragraph 26)

Integration of HIV/AIDS with other disease programmes

5. 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 33)
6. 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. (Paragraph 36)

Social protection programmes

7. 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. (Paragraph 42)

Marginalised and vulnerable groups

8. 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 51)
9. 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 52)

10. 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. (Paragraph 55)

Access to treatment

11. 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 57)
12. 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 63)
13. A growing number of people living with HIV and AIDS will require access to anti-retroviral 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 co-operation 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. (Paragraph 68)

Funding for HIV/AIDS programmes

14. 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 73)

15. 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 74)
16. 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 77)
17. 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. (Paragraph 82)
18. 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. (Paragraph 86)

Cross-Whitehall working on HIV/AIDS

19. 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 90)

20. 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. (Paragraph 93)

Formal Minutes

Tuesday 24 November 2009

Members present:

Malcolm Bruce, in the Chair

John Battle
Mr Nigel Evans

Mr Mark Lancaster
Andrew Stunell

Draft Report (*Progress on the Implementation of DFID's HIV/AIDS Strategy*), proposed by the Chairman, brought up and read.

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

Paragraphs 1 to 97 read and agreed to.

Summary agreed to.

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

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

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

Written evidence was ordered to be reported to the House for printing with the Report, together with written evidence reported and ordered to be published on 13 October 2009.

[Adjourned till Wednesday 25 November at 3.00 pm.]

Witnesses

Thursday 22 October 2009

	<i>Page</i>
Ms Fionnuala Murphy , Interact Worldwide, Mr Alvaro Bermejo , International HIV/AIDS Alliance, Ms Sally Joss and Mr Mike Podmore , UK Consortium on AIDS and International Development	Ev 1
Mr Michael Foster MP , Parliamentary Under-Secretary of State, Mr Jerry Ash , Team Leader, AIDS and Reproductive Health, and Mr Alastair Robb , Senior MDG Results Adviser, Department for International Development	Ev 9

List of written evidence

American Pharmaceutical Group	Ev 18
AMREF	Ev 20
All Party Parliamentary Group on AIDS	Ev 29
Department for International Development	Ev 31; 40
Global Fund to find AIDS, TB and Malaria	Ev 40
Help the Hospices	Ev 42
Interact Worldwide	Ev 44
International AIDS Vaccine Initiative	Ev 49
International HIV/AIDS Alliance	Ev 51
KANCO (The Kenyan AIDS NGOs Consortium)	Ev 55
London School of Hygiene and Tropical Medicine and the MRC Social & Public Health Sciences Unit, Glasgow	Ev 57
National AIDS Trust	Ev 59
One World Action	Ev 60
RAISE	Ev 62
RESULTS UK	Ev 65
UK Consortium on AIDS and International Development	Ev 70
UNICEF	Ev 78
VSO	Ev 80
World Vision	Ev 84

List of Reports from the Committee during the current Parliament

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

Session 2008-09

First Report	Work of the Committee in Session 2007-08	HC 138
Second Report	DFID Annual Report 2008	HC 220 (HC 440)
Third Report	DFID and China	HC 180 (HC 535)
Fourth Report	Aid Under Pressure: Support for Development Assistance in Global Economic Downturn	HC 179 (HC 1009)
Fifth Report	Sustainable Development in a Changing Climate	HC 177 (1008)
Sixth Report	Scrutiny of Arms Export Controls (2009): UK Strategic Export Controls Annual Report 2007, Quarterly Reports for 2008, licensing policy and review of export control legislation	HC 178
Seventh Report	Urbanisation and Poverty	HC 511
Eighth Report	DFID's Programme in Nigeria	HC 840

Session 2007-08

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

Twelfth Report	HIV/AIDS: DIFID's New Strategy	HC 1068-1&II (HC 235)
----------------	--------------------------------	--------------------------

Session 2006–07

First Report	DFID Departmental Report 2006	HC 71 (HC 328)
Second Report	HIV/AIDS: Marginalised groups and emerging epidemics	HC 46-I&II (HC 329)
Third Report	Work of the Committee in 2005–06	HC 228
Fourth Report	Development Assistance and the Occupied Palestinian Territories	HC 114-I&II (HC 430)
Fifth Report	EU Development and Trade Policies: An update	HC 271 (HC 622)
Sixth Report	Sanitation and Water	HC 126-I&II (HC 854)
Seventh report	Fair Trade and Development	HC 356-I&II (HC 1047)
Eighth report	DFID's Programme in Vietnam	HC 732 (HC 1062)
Ninth report	Prospects for sustainable peace in Uganda	HC 853 (HC 1063)
Tenth report	DFID Assistance to Burmese Internally Displaced People and Refugees on the Thai-Burma Border	HC 645-I&II (HC 1070)

Session 2005–06

First Report	Delivering the Goods: HIV/AIDS and the Provision of Anti-Retrovirals	HC 708-I&II (HC 922)
Second Report	Darfur: The killing continues	HC 657 (HC 1017)
Third Report	The WTO Hong Kong Ministerial and the Doha Development Agenda	HC 730-I&II (HC 1425)
Fourth Report	Private Sector Development	HC 921-I&II (HC 1629)
Fifth Report	Strategic Export Controls: Annual Report for 2004, Quarterly Reports for 2005, Licensing Policy and Parliamentary Scrutiny	HC 873 (Cm 6954)
Sixth Report	Conflict and Development: Peacebuilding and post-conflict reconstruction	HC 923 (HC 172)
Seventh Report	Humanitarian response to natural disasters	HC 1188 (HC 229)