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Committee

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

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Oral and written evidence

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Oral evidence

Taken before the International Development Committee on Thursday 22 October 2009

Members present

Malcolm Bruce, in the Chair

John Battle
Hugh Bayley

Mr Mark Lancaster
Andrew Stunell

Witnesses: **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, gave evidence.

Q1 Chairman: Good morning and thank you very much for coming to help with this annual inquiry on HIV/AIDS progress. I wonder for the record if you could introduce yourselves.

Mr Podmore: My name is Mike Podmore and I am HIV and AIDS Policy and Advocacy Adviser at the VSO (Voluntary Service Overseas). I have been asked by the Consortium, according to Sally, to join her in representing the UK Consortium on AIDS and International Development because VSO has been very active in the Consortium for many years. We currently Chair the Consortium and co-chair the Care and Support Working Group and we are active members of the Gender and Prevention Working Groups.

Ms Joss: Hello. I am Sally Joss, Co-ordinator of the UK Consortium on AIDS and International Development. The UK Consortium has over 80 members and we have made a collective submission to this Committee on this inquiry.

Mr Bermejo: My name is Alvaro Bermejo. I am the Executive Director of the International HIV/AIDS Alliance.

Ms Murphy: Good morning. My name is Fionnuala Murphy and I am from Interact Worldwide and I am an Advocacy Manager working on universal access.

Q2 Chairman: Thank you. You know how we operate on this Committee and, as I said, we do an annual review of progress which we have done for the last three or four years. Can I also say that there are four of you. I do not want to inhibit any of you. At the same time you do not need to comment on every question because we might overstay our time frame. Starting with you, Alvaro, you probably share some of the views of the Committee that, yes, you welcome the department's monitoring and evaluation framework but we are still left wondering how you quantify and evaluate what is going on and you obviously made a criticism of that and also the cross-Whitehall working. How do you think we could do it better?

Mr Bermejo: We certainly welcomed the initiative at the beginning in the sense that it was very innovative, it was one of the first times that DFID was really involving civil society in setting up the indicators they were going to use. That was very positive, but 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, so there are two different issues. One is the ability to measure progress, in which I think there are some advances and we certainly welcome the baseline as it has been produced but we will comment on it in a minute, but I think we also need to remember it is not just an issue of indicators; it is also a lack of definition of what success will look like. Once we invest all this money what is the outcome we expect to see at the very end? Measuring that and having that defined properly I think is something that still remains to be done. I would say it is better than before. For the previous one we did not have a baseline. Now we have a baseline. It can still be improved along the way. We do not just have to say, "Okay, that is what there is". It can be improved, for example, by ensuring that the civil society engagement that there was at the beginning in designing the process continues. What we have had for this baseline right now is DFID country offices sending country reports back to DFID that nobody has seen. Then DFID collates them and produces this baseline which you cannot really track back to any particular country, so it really does not enable a discussion to happen at country level where civil society and other players, government, et cetera, could get engaged in contributing to that feedback from the country, and it also limits our ability here to provide anything for oversight and contributions. I think there are opportunities there to improve but I would say it still is a step forward from where we were when it was the previous strategy, that by the time we got to the mid-term evaluation review we really had no baseline to compare with.

Q3 Chairman: Thank you for that. That somewhat bears out what we were saying before you came in the room, and I wondered if others would wish to comment on that. What it seems to us, when you look at their report, is that when you ask for it you get some quite useful information which is quantified and yet it is not aggregated and it is not generally available. It does rather give the impression that if they were simply to publish their country programmes on the website we would be

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three-quarters of the way where we want to be and I just wonder whether anybody else wants to comment on that or add to what Alvaro said about it.

Ms Joss: I think it is very difficult also to know how much DFID country offices use the AIDS strategy to plan what they are going to do as far as programmes, et cetera, are concerned. The Consortium very much would want to commend DFID for the introduction of the baseline. This is 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. I think also 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.

Mr Podmore: I would like to concur with all that has been said. We also applaud the fact that DFID has linked its strategy to these global targets and indicators. As Sally said, there are challenges of attribution. DFID has actively engaged in and led on the process of improving and fostering coherence internationally of agreed indicators, and so I would like to applaud DFID for leading in some of those areas, particularly co-chairing the Indicators Technical Working Group of the UNAIDS Monitoring and Evaluation Reference Group. They have been working with the Care and Support Working Group of the Consortium to model a process of independently reviewing HIV and AIDS indicators for that working group, so, with all the challenges that DFID has with its own monitoring and evaluation, it has made some steps forward but is leading well at the international level in terms of global indicators.

Q4 Andrew Stunell: I think it leads on from that that DFID has allocated £6 billion to strengthen health services and there is clearly a tension, maybe even a conflict, about how that feeds back into AIDS services. Even some of your evidence comments on that. Do you believe that DFID has got the mechanisms in place to support the AIDS programmes you would want to see?

Mr Bermejo: This was one of the questions last year, I remember, as well. As I said then, I think it still has proven to be the case that it is a good strategy to strengthen health systems. In terms of the impact it is going to have on HIV/AIDS, it is going hopefully to increase the coverage of treatment programmes and it is going to deal with one element of prevention, which is the bigger prevention that can be done within the health service, the prevention of mother-to-child transmission and blood safety, but it is not going to curb the epidemic. To do that we need to work beyond the health system to really prevent new sexually transmitted infections and new infections transmitted through the sharing of injecting equipment. We clearly need a strategy that strengthens health systems but goes beyond that. To the extent that DFID has that it certainly has

declared that that is the intention. The money is not following. 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. We have known for ages that healthcare services alone cannot do that. We need to get to the other prevention activities. In terms of how health systems will affect treatment and allow us to sustain treatment programmes, there is a second issue which I would highlight, which is that we are still seeing evidence of enormous stigma and discrimination within the healthcare workforce and the healthcare system preventing access for people living with HIV. There is a very interesting indicator that I would use to illustrate that. For example, if one looks at Latin America, probably Chile is one of the countries that has the best health systems in South America. That is an epidemic that is mostly affecting men who have sex with men, as it is in the whole southern cone, and injecting drug users, mostly male, so it is a country where most of the doctors, the health services, tend to suspect HIV infection in men. Women are diagnosed later and in many cases missed because doctors do not tend to think of women as being affected by HIV. But then when one looks at who is on treatment one sees that 90 % of the women who need treatment are on treatment but only 40 or 50 % of the men are on treatment that need it, and that is a reflection of what is happening in that healthcare system, which is that these males, who are mostly gay men and other men who have sex with men or injecting drug users, are not wanting to access that health system because of stigma and discrimination and they are dying as a consequence. We really need therefore to acknowledge that there is work to be done and I think the main thing we need to push DFID and other players to do is to make sure that as we focus on strengthening health systems we put in indicators that allow us to track what impact this is having on access to services from vulnerable groups and that does not exist right now. We need to build that in because, if not, this mainstreaming might come at a big cost for the HIV epidemic.

Q5 Andrew Stunell: Can I just ask you to follow through on that? Year on year, and you said we asked the same question last year, is what you are reporting to us now anecdotal or would you say that there is clear evidence that there is this discontinuity between the two programmes or the two streams of work?

Mr Bermejo: I would say there is clear evidence. This is happening. It is not just a phenomenon that is DFID related. It is happening with other players as well but I think we see more and more recapturing of the response by the medical establishment, this feeling that the health service can deal with the HIV epidemic now. We see that, in spite of the rhetoric, as money gets tighter what countries tend to do, because it is the reasonable political response, is to make sure that people at least that are on treatment continue getting treatment and if the resources are

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narrowing that means that prevention suffers even more. 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.

Q6 Chairman: There is also slight discontinuity in any case in that DFID says that, and that was really the thrust of our inquiry last time, how you can measure that, but quite often in the country programmes they tell you what they are doing about prevention though that is not part of their declared strategy.

Mr Podmore: Can I just build on what Alvaro said because he talked, quite rightly, about prevention but, in particular with the focus on treatment there, care and support is basically the often-forgotten pillar of universal access and it is also something that suffers a great deal as a result of a focus on health system strengthening that is about just public health systems, hospitals and clinics. Often in sub-Saharan Africa in particular, where health systems are struggling and not reaching the poorest communities, the result is, because of the success of treatment, more and more people living longer, needing a broader range of long-term care and support services, who is delivering those services? It is poor women and children in communities, and currently, through health system strengthening with a narrow conception, those people are not being recognised and given the resources they need, so we very much urge DFID to have a broad conception of health system strengthening that stretches from hospitals all the way to the home. They have emphasised social protection as being maybe one important way that they can support care and support in communities but we really urge DFID to have a very broad conception of social protection that 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.

Ms Murphy: I would also like to pick up on this point. I think we all know here, and it has been discussed, that outside of the health system, outside of even a focus on HIV, if we want to tackle HIV there is need for a focus on poverty eradication, on education, on women's rights and lots of other areas. My colleagues have talked already about the important role that non-state actors play in those responses. What I have understood from DFID is that there is money from other budget lines which is going towards initiatives which link, for example, violence against women with HIV, which link education and HIV, and that is good news, but what is concerning is that we have now seen this framework that will measure how the £6 billion is being spent in relation to HIV; will that also encompass these other pots of money from other budget lines? Also, in terms of money that is going to civil society organisations, for example, through

PPAs¹, some of that money is used to deliver HIV services and HIV programmes, so will there also be a counting on that as part of the reports on this strategy? The other point that I would like to make, and it links into the question that you asked in the written submission process around integrated funding, is that the health system strengthening and integrated funding work together and I know that what we found interacted, in a study that we did in Ethiopia a while ago when we looked at the national health plan, was that, while there was an acknowledgement that reproductive health, which is an area that links very closely with HIV, was an important area and needed prioritisation in Ethiopia, when it came to the targets and indicators there were not appropriate targets other than maternal health. There were no targets on other integrated health issues. What we know about health system strengthening is that while, of course, a strong health system is critical to delivering an effective HIV response, it is not a given that just because you have a strong health system you will therefore deliver on some of these neglected areas. That links with Alvaro's point about the fact that in Chile, because of stigmatisation towards men who have sex with men, services are not reaching the people, so I think we need to go further in this promotion of health strengthening and really think how can we make sure that the health planning process includes targets and indicators but also goes on to deliver in terms of access to HIV services.

Q7 Mr Lancaster: That takes us on really nicely to the next question, which is about the integration with other programmes. There is an acceptance that effective AIDS strategy should be integrated with other disease programmes, TB and malaria. I am asking you to comment on how effective you think DFID's approach to this is and whether or not those who need it most are getting the support.

Ms Joss: I would like to reiterate what came in in a separate submission and was also included in the Consortium submission from a member of the Consortium, Results UK. They were saying how they feel that both DFID and the International Development Committee should be acknowledged for recognising the importance of integrating the response of HIV services with TB and malaria and other disease programmes. In March 2009, earlier this year, Results UK did a survey of the DFID country offices to see whether there was a level of collaboration and integration in these programmes, and half the DFID offices surveyed said that first of all they expected the co-infection rates of TB and HIV to rise considerably over the next five years, and half the offices also agreed that there was insufficient collaboration on TB and HIV programmes in the countries where they were working. However, stating that there was insufficient collaboration does actually indicate that there is a recognition that there is a need for integration and that that integration of programmes has already started, so I think that that is a real advance. It is insufficient at this present time

¹ Partnership Programme Agreements

and there is room for improvement, obviously, but there is that recognition and there is that acknowledgement that this needs to happen between programmes. Unfortunately, the M&E² 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 as well. Results UK are very keen that DFID should review their practice paper, *The Challenges of TB and Malaria Control*, and that this TB strategy should be run in parallel with achieving universal access so that the strategies are intertwined and that there should be clear monitoring and evaluation targets for HIV and TB integration. They also feel that 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. They also feel that there should be research done into new drug regimes. I think it is very important to realise that it is not just TB and malaria but that there are also co-infections like hepatitis that need to have an integrated programme with HIV services.

Q8 Mr Lancaster: So, having pointed out the shortcomings, how in practice should DFID improve the effectiveness of tracking?

Ms Joss: I think the answer is that 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.

Q9 Chairman: The areas that we have already touched on are the marginalised groups, and indeed two years ago, I think it was, we focused particularly on that in our report. Again, anecdotally in different countries we know that DFID does take these issues on, but do you think that they could do more in a more co-ordinated way, and do you think there is a strategy or is it just that in some countries they decide that is the way to go and in others they do not? What could be done to make dealing with those problems, so the drivers of the epidemic in most places, more attractive?

Mr Bermejo: There are two things. One, this is a particular question where we need to look across Whitehall and not just at DFID because I really think that on these issues of raising the case and supporting the case for marginalised and vulnerable groups in many of the countries the FCO should have and does have a role as well, and a little bit of that is included in the report, but we need to realise that if we are looking at controlling the global epidemic there are a number of countries that are middle-income countries that are critical for that—the Russias, the Ukraines, the Chinas, Brazils, South Africa. Those are critical for the response, with the exception of South Africa, but even there it is

particularly the most at-risk populations, and certainly in all the other countries it is men who have sex with men and drug users, that are the main drivers of the epidemic who are always going to be unpopular from a political point of view and where we need the FCO, where DFID is no longer there in any of these countries, to play a role. We really need to look at the role that they can play in creating a policy environment where these groups can access services and are empowered to take prevention measures and, funnily enough, and that is in a way the irony of it, from a scientific technical point of view, in terms of knowing what to do to control those epidemics that are concentrated in particularly vulnerable groups, we know what needs to be done. What we still have not succeeded in doing is in creating the policy space for those things to happen, and in that effort to create policy space DFID can be important but FCO can be even more critical.

Q10 Chairman: On that point have any of you done any evaluation of what the FCO is doing? As far as we are aware the FCO does not even have a budget for this, it does not appear to have any expertise, so do you have any indication of whether the FCO, apart from having the responsibility, is doing anything?

Mr Bermejo: We have done a little bit of work with the FCO, but in cases where there was blatant violation of human rights hitting the media we have liaised with the FCO and the FCO has supported measures to try and address the issue of MSM jailed in Senegal or in a number of other countries. What we have not seen is a systematic approach to the issue or any strategy but then it would be difficult for us to see it, partly because the cross-Whitehall group that meets here does not make public any of its minutes or its agenda or anything.

Q11 Chairman: We are going to ask you about that but can I ask the question from the other end? I take exactly the point you are making but do you have any practical evidence—you mentioned Senegal where the FCO are doing something, or at least did do something, or perhaps the other way round—where they should be doing something and are not?

Mr Bermejo: Senegal was one case where they were detained, where we were in contact with the FCO, the FCO was in contact with their French partners, where was a strategy to release these people from prison and re-integrate them back in the community, where the FCO was active. We have seen some other statements in eastern European countries, in particular around Gay Pride and some other activities there, but I would say that we have also seen some work done with UNODC³ and at the international level with some of the agencies from the FCO to try and create a policy environment, but at country level there are only a few cases, the ones I have mentioned—eastern Europe and Senegal, that I am aware of. There probably are others.

² Monitoring and Evaluation

³ United Nations Office on Drugs and Crime

Q12 John Battle: Just to follow through the case of reaching marginalised peoples, we have just done a report, and I am massively exercised by urbanisation, and Mike is dead right in one sense—can we get beyond the healthcare systems, and I think he used the phrase “from hospital to home”. I like the idea of that, getting down to reach the parts that never get reached, but the trouble is that 10 % of the world have not got a home in formal settlements, and for those in shanty towns, you have not got an address so you are not registered. I just wonder, internationally as well as DFID, and I am not taking the focus off DFID, whether there are any strategies to gauge the need at that level and bring them in to rebuild it from the street level to the hospital rather than the other way round?

Mr Podmore: Yes, I think there very much are opportunities there. Firstly, it is obviously about having a very clear strategy about how you are building your community response, which obviously DFID is leading in some part by being such a significant donor to the Global Fund and the Global Fund is providing significant funds to community-based responses, so that is really important, but there needs to be more. One of the great problems is that it is just not known what is happening largely at community level, partly because donors, international institutions largely, are not funding research into that area. We just do not know. For example, in terms of M&E, of care givers, we have no international nor many national stats about how many volunteer care givers there are at national level and people just have no idea about what the cost of care is to people in communities, so until we start funding that sort of work we are not going to be able to know how we can best do that. A lot of our NGOs are really trying to build that work and be able to bring care givers, for example, to international platforms to speak for themselves and raise it as an issue. I am harping on about care and support but it is equally about community based prevention. I think people just are not aware of what is happening.

Q13 Chairman: Does the Foreign Office actually have a proactive strategy? I think the impression I am getting is you are saying no.

Ms Murphy: I wanted to raise the issue of women and girls. Women and girls are not a minority but they are vulnerable and they are marginalised in many parts of the world. In African countries people have a picture of those under the age of 25, but three-quarters of them are young women so it gives an indication of women’s vulnerability. The DFID White Paper has recently pledged triple funding for services to tackle gender-based violence up to £120 million per year, and I think that is a really exciting development, but there is obviously much more that needs to be done. The DFID strategy talked a lot about the vulnerability of women and girls and the evaluation framework pledged that detailed targets and indicators on progress made for women and girls would be included in national plans. We have not seen those national baseline reports. Maybe there is more about that in there but it is important that those are developed so that we can really see

exactly what is being done for women and girls. The reason that this is important is that it really links with women’s access to services and from the baseline we know that access to PMTCT⁴ is still much too low. I think it is about a third of women who need PMTCT services. One of the reasons for this is the simple fact of what happens to women in many communities when they are diagnosed as HIV positive. A woman can be thrown out of her home and have her children and her 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, and ICW have documented cases of women being tested without their consent. It is not a surprise that women will just avoid antenatal care altogether and that is very worrying as well. 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.

Q14 John Battle: Thank you for that approach as well because my instincts tell me that you have to build systems from the base up and not the top down, and sometimes measuring from the top means they never reach the parts they are supposed to reach. One of the groups that we were drawn to the attention of by World Vision was people with disabilities who are really written off. Women, children and adults with disabilities are out of the frame when it comes to this agenda. If I am abusive about the Foreign Office, they used the term “in the field” when I was a minister there. That meant going to an embassy somewhere. At least in DFID going “into the field” means leaving the embassy and going somewhere, so we are making some progress. If I remember rightly I think it was Vietnam and Hanoi where we saw a project where the Foreign Office and DFID were working well together and had gone into a local project in the centre of the city, the downtown part of the city. I am just wondering, with the social protection schemes, do those programmes reach the parts that we need to be getting to? Are they geared to them? It is social protection but, if you like, the poorest of the poor are not included in them. What is your view about reaching some of the groups and the people? I am thinking of street children, the way you articulated the needs of women who are written off. How many people are we writing out of the

⁴ Preventing Mother to Child Transmission

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frame and not even getting the research done? I know it is not just a DFID question but is DFID's social protection programme geared in the right direction?

Ms Joss: You are right in mentioning World Vision because World Vision, as one of the members of the Consortium, has written about social protection. I do not know if I can answer your question fully but I think what World Vision is saying is that they notice very clearly that social protection and cash transfers do a lot to help households. It means quite often that nutrition is immediately improved, that children's health is immediately improved and girls go to school, for example, but there are many groups, which is exactly what you are indicating, which are left out of those because they are not in households, street children, for example, often children with disabilities. 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. We are looking at family support, child protection, getting children out of orphanages and into the community where they can be looked after by families. One of the main points that World Vision was making in its submission was that there have to be welfare support services along with the cash transfer schemes, and they are very much asking what has happened to the enormous momentum that there was around the announcements of cash transfers and then the extra announcements and the further £200 million that was announced at the G20 London Summit. Somehow, between London and Pittsburgh that has got lost and the momentum has gone, so the questions that World Vision want to ask are what is happening on social protection cash transfers and what is DFID doing for welfare support services?

Mr Podmore: Can I add very briefly to that? We emphasise the fact that we need to have and DFID needs to be promoting a really broad conception of social protection. In UNAIDS currently one of the nine priority areas that they identified for their outcome framework over the next few years was social protection and they threw in a whole range of different things, but one of the things that was not particularly mentioned was the community response, and so as well as welfare systems, pensions, food and nutrition support and, of course, cash transfer and a whole range of different services, and including in that free or subsidised health and education, we need to really be talking about this broad conception so we are not limiting it to channelling funds just through government. I thought it was great that you brought up people who were living with disabilities. It is a particular area that I think is forgotten in the international policy discussions. I am encouraged to see that DFID mentioned people with disabilities in the strategy and they mentioned one funding of ZAFOD, the Zambian Federation of the Disabled, but I think there really needs to be increased and directly focused support for disabled persons' organisations in-country so that they can influence policy dialogue

and also for DFID to support innovative projects that disabled people's organisations are trying to promote so that they can participate in the planning and delivery of HIV services, because 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. They are just left behind so we would also recommend that DFID actively supports advocacy networks such as the African campaign on HIV and AIDS and disability and other national networks like that.

Q15 John Battle: Sometimes, and I am smiling now, the word "community" can be a kind of portmanteau word and everybody is hidden underneath that umbrella. In our report last year we emphasised the need to get to civil society, another great umbrella. In my neighbourhood when I was first elected in 1987 we had seven inner city local community groups. We have now got 700, so what I suggest is a great myriad reach of civil society there, but has DFID got a strategy to get to those civil society organisations, because otherwise what you find is that those that catch a bit of media attention, the bigger ones, Hoover up the money and the ones we need to get to, who are actually on the ground floor level or in the hidden-away corners, are not the ones that are being reached and supported? Have DFID got a strategy to get into the complexity and depth of civil society where the most marginalised are?

Mr Bermejo: I would say no, and let me explain a little bit why. I think our logical reaction is to a situation where they have less and less staff both on the ground and here and thus are looking to reduce their transactional costs, the amount of time that it takes to mobilise resources and support. These groups, which are very diversified, which are small, take up a lot of time of people and so their strategy in a way logically is to go more towards budget support, multilateral where you can, with one contract, get hundreds of millions of dollars out rather than having to deal with small community groups. I think that is the driver that is behind what is happening in DFID. I think there are other solutions to this issue, which is a bigger issue than DFID, so they are not going to be able to solve it. We have seen in some countries the creation by a number of donors of civil society funds where they all pool their resources and then they hire a technical management agent, whether it is KPMG or Deloitte or some other organisation, to manage that process in Uganda or in Kenya in the south to support those southern NGOs, and that and PPAs here might be a strategy but it is difficult to see how it could be done. I think it is a good question to DFID. I think their only reaction is this natural one, "You know what? We do not have the staff any more to be able to do this", and we need to address that issue.

Mr Podmore: I think also DFID's funding through PPAs should not be forgotten. It is not actually something that is mentioned in the M&E or in the strategy, the funding that it gives to organisations

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like ours, who in some ways really specialise in building capacity of those organisations on the ground, whether it be through volunteers, through funding capacity support, a whole range of interventions.

Q16 John Battle: PPAs being the partnership agreements?

Mr Podmore: Yes.

Q17 Mr Lancaster: I am tempted to pick up on Sally's comments about World Vision. I have the honour of having their headquarters in my constituency and Stuart Kean and others constantly make that point. I thought it was worth putting that on the record.

Ms Joss: Oh, you know him?

Q18 Mr Lancaster: I certainly got that message. We have already touched on it slightly with Ms Murphy's comments but I just wanted to move on slightly to access to anti-retroviral treatment. Great progress has been made but we are clearly still going to miss the 2010 target. You have answered partly why that is going to be but can you expand on that and say what more we could be doing to try and push that issue forward?

Ms Joss: I will start and I am sure we are probably all wanting to comment on this. Yes, we are going to miss the target but I think it needs to be said that there has been a massive increase in the numbers of people on treatment. There is a 30% increase in one year and there has been a ten-fold increase over five years, but that is still not enough to curb the epidemic. I think the report that came out from the All Parliamentary Group on AIDS called *The Treatment Time Bomb* explains very clearly what is going to be happening, which is that as people become resistant to drugs they will have to move on to the more expensive drugs, for example the Global Fund work on a basis that there will probably be a 5% migration from first generation to second generation drugs per year, so 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. We really commend that the Government and DFID are taking this issue so seriously and recognising the threat that countries have, and we really welcome most definitely the UK Government's and particularly DFID's financial and moral support for UNITAID and the idea of patent pools. We believe very strongly that the idea of a patent pool and handing over the patent rights to UNITAID and allowing others who need access to those patents to be able to use them in exchange for a royalty payment is a definite step forward. This means that the pharmaceutical companies do not lose out completely because they still get their royalty payments and it also means that there is a chance of generic production. Very clearly, in figure 2 of *The Treatment Time Bomb*, it shows that until there is generic competition the branded companies do not

drop their prices. What we would very much like to see is the International Development Committee adding its voice to the call for a patent pool. We feel also that we would like not only for you to add your voice to the call for a patent pool but it is absolutely key to involve pharmaceutical companies. There needs to be increased pressure on pharmaceutical companies. They do not make much of a profit on drugs that are sold to poor developing countries; the profits are made here, so we really ask for a real push and pressure to be put on pharmaceutical companies to put people before profits and to exhibit some sort of social responsibility. Already Gilead, which is one of the pharmaceutical companies that makes HIV drugs, has publicly endorsed the idea of patent pools, so it is not impossible. It is also key that the UK maintains its support because at present the patent pool is an idea but it is very likely that the business case for the patent pool will be put to UNITAID board this December and so it is key that the UK Government maintains its support for the use of patent pools.

Mr Bermejo: I will not repeat the patent pool issue but it is a really important one where we think the International Development Committee should make a contribution as well. I would like to come back to the bigger picture of treatment and the sort of feeling that to some extent the view from the UK has been that the Global Fund and the Americans are dealing with this so let us leave it to them. They have got much more money and they are supporting most of the people on treatment in the world, which was (and still is) the case, but clearly the Americans are also looking at how to offload what they are now calling the treatment mortgage for these toxic assets, as sometimes you hear in Washington these days. I think it is really important that we have a concerted effort and collaboration on how that happens. You can see why the Americans are thinking like this. You can see what the Global Fund can do, but it is really important that the UK engages in that dialogue and does not just leave it for others to deal with because there is the issue that Sally has mentioned of second-line drugs but there are other issues there as well. First, WHO⁵ 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. We have equally a situation where one of the drugs that we call first-line is only first-line in developing countries. Here 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. However, we should not be using it in developing countries either so we can clearly see a future scenario where, even if you do not continue increasing the number of people on treatment, there is not the money to afford the current people on treatment as they move towards more expensive drugs. We are convinced that that and the current

⁵ World Health Organisation.

economic and financial crisis and the opportunities that that provides make a strong case to be pushing for something like a currency transaction levy that would allow billions more to be available for the health MDGs⁶, including the HIV response and the Global Fund. If not, we are going to see more and more of what we are seeing already and the truth is that there are already a number of countries which are saying, "We do not put a single person more on treatment". That is the situation we are confronted with right now.

Q19 Chairman: I think you have answered some of the questions we were going to ask anyway, so that is absolutely fine. One of the concerns I have is just what you have just mentioned, stopping treating people. You are saying we cannot afford to treat them and what happens when the money runs out unless you bring the prices down, but I have also heard that the side effects of some of these drugs will create a whole range of other problems. I happen to have a particular interest in deafness and I know that some of the cheapest antibiotics being prescribed in developing countries are the prime cause of the rising incidence of deafness in those communities. You are raising a whole can of worms here, that they are not getting cheap effective drugs; in other words, they are getting the junk dumped on them. We are not solving the problem; we are creating more problems. That is essentially what you are saying.

Mr Bermejo: Yes. I would not call them junk, I think that is a bit excessive, just in the sense that they are still saving lives, but at an added cost that they should not be paying in terms of their own health and the side effects, in that sense they are junk, yes.

Q20 John Battle: In a sense my question follows on not just the Global Fund but DFID published its White Paper, *Eliminating Poverty; Building our Common Purpose* in July, and there is a shift in that to support from multilateral sources, more money would go through the fund, there would be more emphasis on fragile states. How will that affect DFID's programmes for HIV/AIDS, as you would see it?

Ms Murphy: This is something that we talked about a little in our submission under the second question on approaches to health system strengthening. Interact Worldwide flagged up some concerns about funding the interactive tools of the World Bank which I know some of my colleagues on the Panel would share. The World Bank's own evaluation of this produced a report earlier this year looking at the World Bank's health, nutrition and population programmes and that report found that something like a third of all the funds that had been dispersed had been spent ineffectively, and when it came to HIV programmes in Africa the toll was much higher. We would question the UK's insistence that the World Bank is a good partner through which to channel health systems funding. We know that the UK is interested in working with the World Bank to

try and take up some of the recommendations that were contained in the report and we hope that the UK will continue to do that, but at the same time we would prefer to see a rebalancing of funding so that not so much is going towards an institution which has been shown to be ineffective, and also which in the past has very strongly promoted user fees for health services which many of us would feel are counter productive and exclude the poorest people. On the other hand Mike talked about the Global Fund, which is an institution which, although it is not by any means perfect, has made a lot of moves to reach out to communities and to fund the community response. It is funding health system strengthening. It also has a new gender strategy along with a sexual orientation and gender identity strategy. It has also been making moves to fund programmes which integrate HIV with reproductive health and reproductive health with malaria, so the Global Fund has a lot of strong points, yet the UK is not paying its fair share to the Global Fund at present. The figures are in a lot of our submissions. We would ask for that decision to be thought about a bit more carefully in terms of how the funds are divided up.

Q21 John Battle: It is a White Paper and submissions can go in to respond to it now.

Ms Joss: Can I just back what Fionnuala was saying with some of the statistics? It is said that over the past decade, over an evaluation of World Bank's health projects, that only two-thirds showed satisfactory outcomes, and in Africa the results were particularly weak with 73% of the projects failing to achieve satisfactory outcomes.

Mr Podmore: We do strongly believe that there needs to be a re-evaluation of the balance of how money is being spent. We recognise that DFID is going to fund the World Bank but we want them to proactively, as they are doing, work with the World Bank to ensure that they address those really clear issues. One of the ways that DFID is doing that with the Consortium is by conducting an ambitious evaluation of the community response to HIV and AIDS which is already welcome considering what we were talking about before. It is that sort of work that I think is really critical, that DFID puts the same critical eye on the World Bank that it seems to be placing on the Global Fund.

Ms Joss: Just to say a bit more about the project that the Consortium on AIDS is involved in with the World Bank and DFID, the World Bank is evaluating over the next couple of years the community responses to HIV and AIDS programmes. We are like a conduit which can enable the World Bank and DFID (although not quite so much) to be able to access people who are working on the front line and people who are working in community and grassroots organisations.

Chairman: Thank you very much indeed. That is extremely helpful. I think you have given us some ammunition, if you like, to put to the Minister immediately. Obviously, this is something which not

⁶ Millennium Development Goals.

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only have you helped us with in the past and which we will continue to do and have undertaken to do, certainly till next year when we get to the end of the

five-year programme. I do not know what we will do after that. Thank you very much; it has been very helpful to us.

Witnesses: **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, gave evidence.

Q22 Chairman: Good morning, Minister, and thank you very much indeed for coming to help us with this single session on our annual report on progress on tackling HIV/AIDS. For the record, could you introduce your team.

Mr Foster: Of course, and thank you, Mr Chairman. It is always good to appear before the Committee. I am obviously Mike Foster, Parliamentary Under-Secretary at the Department for International Development.

Mr Robb: I am Alastair Robb and I have just finished working as a DFID adviser in DFID Uganda.

Mr Ash: And I am Jerry Ash. I am acting Team Leader for AIDS and Reproductive Health in the Policy Division of DFID.

Q23 Chairman: First of all, you will know from past reports that the Committee recognises that the Department does a lot of very good work in tackling HIV/AIDS, but we have a problem in evaluating it and measuring it and the way that DFID presents it. Certainly, in the evidence session we have just had, that has been reinforced by the witnesses who have said that the tracking mechanisms, the evaluation and the quantification really of what is being done is still imperfect, so, first of all, do you accept that is the case and, if so, how do you think you can improve it so that you demonstrate effectively in more identifiable terms really what the Department are doing to tackle this epidemic?

Mr Foster: Certainly, we appreciate that monitoring and evaluation is not an easy task to do and that complexity does provide us with a test. If then that is also matched up with wanting to have a rigorous evaluation to make sure that what is published does reflect as closely as possible what is going on on the ground. In terms of the detail, clearly what we have done with our AIDS Strategy and then the baseline assessment, it is very much geared at the strategic end rather than at a sort of more operational level, but there are projects and the DFID-based projects are on the website so that people can actually see what the outcomes are and they are available on the website, but we are keen to listen to the views of others who think we can do more, mindful of course that we do not want to spend valuable resource just measuring for no benefit and mindful of course of the arguments of aid effectiveness and trying to balance the need for detailed measurements against using numbers and data that are already available.

Q24 Chairman: I think the Committee accepts that we spend too much on trying to produce statistics and that is not the prime purpose, but I think there

are some concerns as to indeed how the allocation is determined between prevention, treatment and care, and also quite often in your publications you give good examples by country, but you do not aggregate them across the piece, so you say, "Well, that's very practical. Why do you not just add them all up?" and we say, "Well, we're able to say we have done that much on prevention, that much on care", and so on, so I completely accept your strictures and the Committee does not wish you to waste resources simply producing statistics, but it seems to me there is quite a lot of information inside the Department which is not simply being collated in a way which would actually reinforce the case that you wish to make and which the Committee wants you to make.

Mr Foster: Certainly, in terms of the country-led examples, what we try and do is make sure, when we are dealing with HIV/AIDS, that each country is treated very much in its own individual right. We have to look at the epidemic in-country, so our approach to, let us say, a country in Asia might be different from a country in Africa because of the nature of the epidemic being different in those particular countries, and that addresses why we tailor different methods in each country, but on the point about measurement, if the Committee were to recommend something that is feasible and we could do without additional resource going on just a compilation of statistics, then we will listen of course, Chairman.

Q25 Mr Lancaster: Minister, you have already published the template which country offices and regional divisions will report on their performance against commitments in the AIDS Strategy, so, when those templates are filled in, will you publish them in full?

Mr Foster: I am not sure whether the approach is to publish them all in full. We certainly do it on a project basis. Jerry, do we plan to do it?

Mr Ash: Well, we will certainly listen to the Committee's recommendations. As you acknowledged, we published a fairly detailed template in the M&E Framework on the last World AIDS Day and we will be using that to kick off the process of the first of the series of two-yearly reports, the first of which will be due to be published on World AIDS Day 2010, and we will seriously consider publishing the country returns in full.

Q26 Mr Lancaster: If I may, I am going to press you on it. Judging from what the Minister has just said, there is no extra money being spent on these because

these templates are going to be filled in and the information will be there, so what have you got to hide?

Mr Foster: Mr Lancaster, I do not think anyone is hiding information. It is literally just a matter that it will require extra work to be done even if material is available in the template as somebody has got to put it all together in a format that people want to see. That said, if that were a recommendation from the Committee, of course we would look at it seriously. If it is addressing a concern that is out there amongst civil society or amongst committee members, then I am very much open to looking at it.

Q27 Mr Lancaster: I think many of us feel strongly, "Let's look at the wider issue". All three parties are committed to 0.7%, but I think in the current climate we have to do everything we can, do we not, to explain to British taxpayers how their money is being spent. As we have seen through the processes here in Parliament, transparency must be the best possible thing, so it just strikes me that, if you have a document which is going to be filled in anyway, why would it not be published?

Mr Ash: Exactly.

Mr Foster: I am not going to go down the road of the 0.7—

Q28 Mr Lancaster: No, but it just as to why.

Mr Foster: I understand what you are saying and you could have a debate on that, but I do agree entirely with you, particularly in the current climate, about making sure that the UK taxpayer knows exactly what they are getting for their money, and that is an important buy-in from them to enable DFID to actually do the work that it does, and it is something which certainly officials right across the board are aware of and there is ministerial interest in this particular matter as well.

Mr Robb: I would maybe just say from a country perspective that we would be very happy for the returns to be used in any way that they are needed both to ensure the transparency, but also to make it clear what we are doing at country level. I think your point also about aggregating data is a very good one so that we have a bigger story to tell rather than just single country stories, which would make quite a strong impact with the public.

Q29 Chairman: Well, as I say, when you look at the aggregate, there is quite a lot of quite good information, but it does not give you the whole picture. Minister, if I could say it on a general basis, having chaired this Committee for the last four years and having done quite a number of visits, whenever we go to a particular country as a committee, we usually get a first-class briefing from DFID in detail as to how the money is being spent, what the priorities are and where it is going, so it is given to us, but that is not on the website of the country situation, so it seems to me that there is a lot to be said for putting that kind of information. It also helps, if I may say, the civic society groups and the politicians in those countries because that information is something they can then engage their

own governments and their own ministers with, so I am not necessarily asking you for immediate responses to that, but I would really commend to you that I think there is quite a lot that the Department could do within the resources you have got which would make it open and more transparent to everybody's benefit, particularly on this issue. Just to finish on this point, you also in your White Paper are putting more money through the multilateral agencies, which different members of the Committee may have different views about, but I think collectively we do not fundamentally disagree with and we recognise the role of these agencies. However, we have just had evidence on health, for example, that the World Bank outcomes, particularly in Africa, have been somewhat disappointing in a number of areas, so how, if you are putting more money through an organisation like the World Bank, can you ensure that you are able to monitor it effectively and also to influence the World Bank to ensure that some of the DFID approaches may improve the outcomes?

Mr Foster: Our perspective, Mr Chairman, is that money channelled through the multilateral route gives us the ability to influence what decisions are made because we are a major funder of organisations like the World Bank and in other multilaterals, where we will have a seat on the board, it gives us clear direction as well, and the prize for us is that, if we make the changes that, we believe, are necessary to improve the effectiveness of the multilaterals, and that is, as you say, in the White Paper a very key theme for DFID to pursue, the real prize is the bigger bang that you get from that than just doing stuff bilaterally. We can have the most fantastic practice as DFID with our bilateral money, but, if we can make the change multilaterally, the benefits are far greater, and that is the direction of travel for us.

Q30 Chairman: I think yes, Minister, the Committee would accept that, and this Committee has a good relationship with the World Bank and I have met with them on more than one occasion.

Mr Robb: Just to highlight the point that the Minister has made, DFID often at country level does not have the same level of resources in terms of money and human resource. So our way of dealing with the multilaterals is to lift the game of these partners at country level. For example, in Kenya at the moment we have been involved in the latest World Bank project by helping to develop the project, and to review the project in-country. With the UN there is a huge capacity. In fact I think it is about 400 people working in the UN on AIDS within the Eastern, Central and Southern Africa region, and we are looking at getting them to lift their game so that that capacity can be maximised. It is about the fact that we do not have all the resources and how we influence them, particularly at country level, which allows us to have more ability to achieve results.

Chairman: And we have seen some good examples of that on our visits.

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Q31 Mr Lancaster: Can I just pick up on the Minister's comments about the multilaterals. Two days ago, we had the replenishment of the Caribbean Development Bank and a reception here upstairs, but it was the seventh replenishment, and what was clear from that was that some of the conditions that we had applied to the sixth replenishment had not been met, and they were only minor conditions. For example, when we had the replenishment of the Asian Development Bank, some of the money was conditional, so, whilst I accept and agree exactly with what the Minister is saying, it does seem sometimes that, as you move forward through replenishments of these multilaterals, the regional banks especially, we seem to be forgetting what has happened in the past and, whilst we make an agreement at the time, when we move on to the next replenishment, we are not really holding these banks to account to the degree that we should and applying these conditions, so I was really interested in the Minister's comments on that.

Mr Foster: I am not sure that I agree with that, Mr Lancaster, having been involved in the discussions prior to agreement of the replenishments, and very much in terms of the decision that is taken as to whether we replenished the Caribbean Development Bank, being one of the ones that I had responsibility for, what you have highlighted is exactly the type of conversation that we have with the bank and it is because we have a relatively large shareholding within the Caribbean Development Bank that it enables us to have that leverage over change. By and large, if memory serves me, I think they did comply with nearly all we asked of them at the sixth replenishment and then for the seventh one we put fresh conditions for change on them, and I think that is a very useful carrot to offer a multilateral like that.

Q32 John Battle: If I may, without dismissing the banks, switch from the banks to the people really and ask about what are sometimes referred to as the most marginalised people, but who, I think, are the poorest of the poor which some of the strategies never ever reach. I think that, particularly on this agenda, DFID has made a big commitment to strengthening the health systems, but, as one of our witnesses said, the health systems need to be worked right through from the hospital to the home, and that was the expression. Now, my own caveat there would be that 10% of the world's population do not have what we would recognise as a home and they are live effectively on the street or in these informal communities. People with disabilities, adults and children, street children, child labourers, child workers, sex workers; there are whole groups of people that the strategies never seem to get down to and among, other than some vague attempt to get through, perhaps if I said, prominent or attractive civil society organisations. I just want to ask, understanding that we have to get into the complexity of civil society organisations, what progress is DFID making to get the strategies to reach the parts that no one is yet really reaching or even analysing to assess the need?

Mr Foster: First of all, Mr Battle, there is a recognition with marginal groups that, by their very nature, it does mean that society is putting them to one side and it is more difficult to do and approach them in a more general manner. In some cases, it is because of the illegal nature of their activities which also adds an obstacle to—

Q33 John Battle: Sometimes they just have not got an address because they live in a informal settlement, a shanty town or a favela.

Mr Foster: We recognise that there is a real problem which we have to pay particular attention to. Perhaps I can give a couple of examples where we know our work has proved that we can make a difference. I think you and I and the Chairman went to see the Chengdu treatment centre where there was methadone treatment and commercial sex workers were also treated there, and that was an example where DFID had had a pilot project that has actually proved so successful that the Chinese authorities have actually taken it on board to mainstream it, so, in effect, we were recognising with our particular project work that there was a problem, we highlighted it, showing the authorities that it could be done and then enabled that to become mainstream. We have also done the same in India where we are providing budget support, but channelled through key civil society organisations that can deliver on the ground because it is not always easy to go through the government machinery, as you quite rightly pointed out, Mr Battle, and then there are other areas where we have highlighted particular problems, and I know Alastair would want to talk about this. African lorry routes, transport routes, have a particularly high incidence of HIV/AIDS because of the nature of the lifestyles that are led. Now, we have recognised that in terms of some of the work that we have pinpointed on them, and perhaps, Alastair, you would want to say a bit more.

Mr Robb: Just, first of all, to agree fully with your concerns about marginalised people who do not access health services. DFID's approach is not just a singular approach. We are building the health system, making it more accessible through the abolition of user fees, and also improving the quality because everybody who accesses that care needs that quality care. At the same time, we recognise that those services are not sufficient, particularly in terms of access, for the poorest and most marginalised. To enable those people, we are providing support to civil society organisations that can outreach, and we are also doing work with social protection, including cash transfers to the most needy so that they are more able to access healthcare, education, et cetera. On the issue about AIDS and truckers and knowing that some of these people are particularly at risk to the disease, this is part of knowing our epidemic and knowing both the people who are more at risk of becoming infected or of transmitting the disease, but also the people who are more likely to suffer the consequences of becoming infected so that our

response, the national response that we are supporting, can be better suited to addressing those people.

Q34 John Battle: I think what I am pressing you on is that I am looking for a much stronger marginalised participation strategy right across development and then, if am going at it from the angle of HIV/AIDS, there are whole swathes of people at the bottom written off, frankly, in the systems. I would even argue with you that social protection is okay, but it does not reach the parts it needs to, that you need an address and a home, and I go back to that point again of people who are out on the street, so are you confident, and I am thinking of the White Paper, I did not, frankly, good though it is, feel that there was a strong enough dynamic coming through and a strategy to move, not that DFID staff should all become outreach workers, but to have a strategy to build connections to get the people to go to meet the people. Without that happening, and it is hard work, it is costly work, it is time-consuming work, but I am not yet confident that I am seeing the outline of a strategy there. Am I being unfair?

Mr Foster: I would say yes. Very much the core work on tackling poverty means that the most vulnerable, and you mentioned the street children as a good example, are excluded from all sorts of links to their society because of the fact that they are living in the street. I think that, if you saw some of the work, and I think you are going to Bangladesh shortly and I am hoping that you will go to see some of the work that we do with street children in Dhaka, you will see the project that DFID runs which not only is primarily about education, but actually that is used as a taster, as a vehicle to getting wider access to do with health concerns.

Q35 John Battle: I think that is my exact point, and it just does not apply to DFID. What I worry about is governments, including our own and including in my own inner-city neighbourhood, where we have pilot projects and then we snuff out the pilot, good though it might be, before the full oven has got going, so I am looking to see how you see, and I have seen good projects, like in Vietnam, how these projects become developed. You mentioned the phrase that they become, I think you said, mainstreamed, so how do they do that? Have we got a strategy to get from those beacon projects to a full-blown one and one which pushes other international organisations as well? I just do not quite think we are there yet, but I need it to be a stronger theme.

Mr Foster: I think by what you have said yourself, Mr Battle, it is a fact that the UK and in your constituency, we are not there yet, and we are clearly not going to be there yet in terms of the sorts of countries that we are working with, but very much the direction for us about supporting health systems in the broadest sense rather than just vertical funding streams, the argument that I know you went through last year in a similar inquiry, that is exactly why we want to have the investment in broad health systems so that we can get to reach people by means of employing more health visitors, more health

workers, reaching targets that were laid out in our strategy of 2.3 per thousand. That enables us to have a better chance of reaching the very people that you describe.

Q36 Chairman: I should say that our Report on Urban Poverty is published today and it covers quite a lot of the point about how you serve the millions of people who are out of reach of quite a lot of these systems, which actually brings me on to another question which was raised in the context of this, that you were making commitments for £200 million for social protection across eight African countries, but you have not identified, or you have identified, but you have not given the information as to which countries they are, so are you able to tell us now? I think that, when the Secretary of State initially mentioned it to us, he said there was an objective evaluation process and he could not at that point tell us which countries, although he had a number in mind, but surely, 15 months on, you should be able to.

Mr Ash: I think I am right in saying that it is not a fixed or static number that we intend to work in. I believe we are working in at least eight countries across Africa. They may change certainly over the seven-year long-term implementation time-frame of the Strategy, but I believe that at the present time we are working in Zimbabwe, Kenya, Zambia, Malawi, South Africa, Sierra Leone and Rwanda, and that, as programmes are developed, more may be added and as programmes come to an end, other countries will come off the list.

Q37 Chairman: Are you going to be able to give us, and I am not asking for it now, any detailed information on that? It is, after all, £200 million over three years and that is quite a lot of money and we need to have some indication of how it is being spent and also whether this is additional money or whether it is within the existing programme, but targeted in this particular way.

Mr Foster: We can give you examples, Mr Chairman, of the nature of the work that we do with social protection at the country level and that might help describe how the system works. Alastair, can you talk about some African stuff?

Mr Robb: I can. In terms of actually what we do on social protection, in addition to the monies that we provide, we have been at the forefront of creating social protection policies with countries, including in Uganda where most recently the Vice President, as a result of DFID's lobbying, has ensured that social protection is now part of the National Development Plan. So it is an important part of our work. It is not just the monies that we bring to the table, but also the policy dialogue. A lot of the work that we are doing at the moment is looking at cash transfers and ensuring that money goes to the poorest, and the people that you are talking about, I agree with you, those people that are really out of reach of the whole system are not going to be the ones that necessarily benefit from this, but there are a huge number of very poor people who will benefit from cash transfers, and over time we will be doing analysis to assess how

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that impacts on their lives, including how it impacts on children, orphans and vulnerable children, and people with HIV.

Q38 Chairman: I am sure the Committee would be very supportive of the objectives, and I think we would just like more information. The Consortium on AIDS and International Development, I think it was the VSO member, said in their submission to us, related to this and the eight countries and I thank you for the answer there, “Unfortunately, DFID have still not defined which countries these are”, well, you have partially answered that question, “so monitoring progress remains impossible. We eagerly await more news on how this funding has been distributed and to which countries”, so it seems to me in your interests to make a little bit more information available about that so that people can make a judgment as to how effective it is. I do not think we are disputing that it is a good idea, but we would like some indication of what the outcomes are.

Mr Foster: It is a fair point and it goes back to where we started the session from about information which, I know, civil society is keen to see and, as I say, we will look at what we can do.

Q39 Mr Lancaster: Sticking with money, the Global Fund in July announced a \$3 billion deficit for their programme in 2010. What assessment have you made as to why this has happened and what impact is it going to have on the HIV/AIDS Strategy?

Mr Foster: Obviously, we are aware of the figure that you have just described. In terms of the UK commitment, we made the long-term commitment for £1 billion for the Global Fund and made it over a long timescale as well so that there was certainty and predictability about the cash being made available. Clearly, any shortfall in the amount that the Global Fund will have an impact on the ground in terms of the treatments that are available and the preventative methods that are accessible for people who are in need. In terms of what we are doing about that, there is a route of lobbying to encourage other countries to pay their fair share. We think we are paying our fair share as the United Kingdom and taking a lead on that front, but we are aware in the current climate that not every country takes the same priority to international development spend as we do here in the UK.

Q40 Mr Lancaster: A couple of years ago, the UK led by doubling its replenishment of the African Development Bank to £116 million and other countries followed, so, given the deficit, is the UK going to lead again by helping to fill this deficit?

Mr Foster: Well, in terms of our contribution, I think we set the direction that we would like others to follow by setting out a long-term commitment, so we were not looking at just annual change, we were saying, “Look, here is a seven-year programme for £1 billion”. In terms of an example of what the UK’s individual contributions are year on year, last year, 2008, we put £50 million into the Global Fund and this summer we have just handed over £115 million,

so our contribution has indeed doubled year on year, but it is part of a £1 billion long-term commitment, and I think it is the long-term commitment, Mr Lancaster, that people need to make to make sure that the Global Fund has the predictability of finance to enable them to plan their work. Without that predictability, it makes it very difficult to do proper work on the ground.

Q41 Mr Lancaster: I think that is absolutely right and I agree with the Minister wholeheartedly on that, but it does not answer the question of how we are going to plug this gap, so how does the Minister anticipate that the \$3 billion deficit will be filled?

Mr Foster: Well, I think that there are discussions that we can have with the G8, as leading funders of the scheme, to try and leverage in more support from them, I think there are other avenues to support the work of the Global Fund perhaps through innovative health financing options which can make up some shortfall in the cash, and I think we have to also try to make what money is in and has been pledged work better, to make it more effective on the ground. I think there is a job for us to do with others on that front as well, but it is a lobbying exercise, Mr Lancaster, and it is very difficult. We are not in a position to tell others to pay their fair share. There are opportunities, I am sure, for CSOs internationally to make and to do their lobbying, which is perhaps another direction of travel, and they have been highlighted in the public as a route that they can follow to put pressure on their governments to fulfil the payment of what is only seen as a fair share towards the Global Fund.

Q42 John Battle: I would like to ask about the Cross-Whitehall Strategy Group. We would all agree generally with joining up government and there is a strategy to pull together the Home Office and the FCO and they have got a clear remit. The remit says, “The Home Office, FCO and DFID will work together to improve the international environment for harm reduction” by increasing the coverage of HIV prevention, and the rest of it. I sometimes think, whether at ministerial level or department level, one department, rightly, is taking the lead and trying to get the others and corale them together, but ends up doing all the work and the others are not quite joining in, so my question comes in the most friendly way to say: is DFID getting enough support from the other departments, are they taking it seriously and are there enough personnel gathering round it, and is there a budget? Could you tell us a bit about the Cross-Whitehall Working Group.

Mr Foster: It is an informal group. It is a meeting of officials and not ministers.

Q43 John Battle: It meets how often?

Mr Foster: It meets on a quarterly basis. The last meeting was on 7 October and the meeting before that was on 15 July, but it is an informal meeting of officials. In terms of what it discusses, Jerry?

Mr Ash: Well, it was very useful in both developing the Strategy and in helping develop the Monitoring and Evaluation Framework and the subsequent

baseline. I believe that the other government departments represented on it are committed to it and the issues that we deal with, but I am not sure I could go very much further than that in committing colleagues in other departments to do more or to commit more resources.

Q44 John Battle: I assume you and your section are the secretariat of it, that you keep the notes of the meetings and you run it and organise it and they come along?

Mr Ash: That is correct, yes.

Q45 John Battle: I am just pressing on the depth of their commitment to it really. Do you publish the notes of the meetings? I know they are informal, but are they shared around?

Mr Ash: No, we have not published the minutes of the meetings as yet, but we are happy to consider doing so, if the Committee would want it.

Q46 John Battle: Harm reduction in fact is a massive issue and to take, as with everything, the myopic world which operates around my constituency, we have a huge prison, so the Home Office might well need to be there. Am I daft to ask why the Health Department are not on the group?

Mr Ash: They are.

Q47 John Battle: Are they? I thought it was just the Home Office, DFID and FCO.

Mr Ash: No, certainly not.

Q48 John Battle: So it is Health as well?

Mr Ash: The Department of Health are fully represented.

Q49 John Battle: Good. Do they make any contribution in funding and support then?

Mr Ash: I am not aware of the Department of Health putting official development assistance into AIDS. On a domestic basis, research and issues like that, I am sure they are fully active, but they play a full part in the group.

Q50 John Battle: Do not get me wrong, I am encouraged you get together, but I am just stating it and make sure DFID does not carry all the work of it, that we share the work and perhaps other bigger departments can make a bigger contribution, and we might learn, and hopefully internationally, from what is going on by sharing the information and knowledge through that group. That could be quite an exciting, pioneering development actually.

Mr Foster: What I can do, Mr Battle, is perhaps write to you with some more information about the Cross-Whitehall Group, who is on the group and how it is funded so that it enables the Committee to then make an informed decision as to what they make ask of us.⁷

Q51 John Battle: Okay, but I think you know where I am coming from on that.

Mr Foster: Yes, I understand fully.

Q52 John Battle: As a second question, DFID, rightly, in the last 10 years has been promoting whole programmes to the poor, poor countries, fragile states, so there was some withdrawal, rightly, from middle-income countries. Then there is a bit of a gap and I am now picking up that the Foreign Office seems to have been invited to take the lead role, particularly in HIV/AIDS, in middle-income countries. I wonder what that means. Have they got expertise? Do they have people in the field that can work on HIV/AIDS, have they a budget, or are they just keeping a watching brief on it? I am just interested in what the Foreign Office is doing in middle-income countries.

Mr Foster: First of all, just to explain again, Mr Battle, exactly why we have moved DFID offices out of middle-income countries, it is because they have graduated to middle-income status and 90 % of our spend is on the low-income. I know it is well-rehearsed, but that is why those decisions have been taken. Then it is left with the Foreign and Commonwealth Office having a watching brief over the work on HIV/AIDS, and, Alastair, you have got some examples.

Mr Robb: I was going to give examples of countries where we do work together and maybe Jerry would like to talk about the middle-income. In the countries where we work together because we still have a presence, for example, Burma, the Foreign Office were really important in enabling us to enter into Burma to do the important bits of work on HIV. So DFID, with the Foreign Office, led the way in tackling an epidemic in a very fragile state through a joint UN programme, which has grown to include others now working on the epidemic. We are at all times keeping the EU common position and, with the advice of the Foreign Office, ensuring that we are working in that politically sensitive environment in the best way. The UK Ambassador in Burma has also sat on the board of this initiative for the three diseases, so they are very active and very important.

John Battle: Burma is a good case and actually, if I may say, a brilliant example of absolutely excellent work by Foreign Office staff and ambassadors there working with DFID together in a very difficult situation, if I can put it that way.

Chairman: We put on record, John, also that the increase in the funding was as a direct result of the recommendation of this Committee!

Q53 John Battle: Indeed! Could you give me any examples and, for example, one which we ought to keep an eye on big time, Brazil?

Mr Ash: I do not have an example of how the FCO is supporting the implementation of the strategy in Brazil. In the baseline, we had talked about some of their activities in countries, like in Singapore where they have supported local NGOs, in the Solomon Islands where, using their strength and expertise in human rights, they worked with the Australian Government to make progress with the Government

⁷ Ev 40

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on voluntary counselling and testing, and also they have supported and worked with DFID in Nigeria on human rights strategies.

Mr Foster: Obviously, Jerry mentioned it is in the baseline, but also what the Foreign Office do and what they do in middle-income countries will of course be a feature of the biennial reports that we publish as well in terms of what we are committed to on that.

John Battle: It is just that in this area of public policy perhaps more than others, the integration across income countries might be slightly more important than in other areas that I might emphasise where there is a strong emphasis on poverty and poor policies, and I am totally behind that, but in HIV you might find it does not simply cut across the poverty bracket, as it were, and, without taking into account middle-income countries, the whole strategy could be undermined as well. I think I have made my point clear.

Q54 Chairman: The Gleneagles Summit, which was now four years ago, secured very substantial commitments from the international community and a very specific pledge to achieve universal access to HIV/AIDS treatment by 2010. I think we know that that target is not going to be hit, but the question I want to ask first is: to what extent has the economic downturn affected the commitment of those other G8 countries specifically in this area? We know of countries that have cut their aid, but are you able to evaluate where they have specifically cut their commitment to achieving this target?

Mr Foster: Certainly, it is on the record, Mr Chairman, our position on the long-term commitment to aid, and Mr Lancaster recommitted his side to it as well, the 0.7 %. As you know from events earlier in the autumn, the Prime Minister said that we will be looking to legislate for that as well, so the United Kingdom's position in terms of whether we have been affected by the economic downturn is very much a clear case that we are committed to carry on with our spending programme. In terms of some of the threats that have been posed by funding decisions of other countries, we are aware obviously of other countries starting to shy away from commitments that they may have made as part of the EU towards the 0.56 and then the 0.7 target, and I think those countries are well documented and are known. We believe there is a strong case for the "fair share" argument of spending on HIV/AIDS and we know that we are there already as the United Kingdom. In terms of what we are trying to do to encourage others where there are concerns, first of all, the Kaiser Foundation and UNAIDS actually do a measurement, they actually do the check to see who is paying their fair share, and that is good information to be made available for us in lobbying. Through the G8, I think, there is a role for us there and holding governments to account for their commitments. For the first time in July this year, the G8 published an interim accountability framework showing individual country progress towards their G8 commitments, including their spending on health, which we also think is a step forward, and we

will be pushing actually for a target on HIV/AIDS spend from 2010 onwards and we are supported by the Canadians. They assume the Presidency of the G8 in 2010 and they are very keen on making accountability the central part of their Presidency, so we think there is some work that we can do now, but also there is some potential to show exactly where we can hold governments to account for the commitments that they have made.

Q55 Chairman: But, given that there are people who have cut back, our previous witnesses gave testimony to the fact that a great deal has been achieved, in other words, an awful lot of people are getting treatment that were not getting treatment and, had that commitment not been made, that presumably would not have happened, but it is not going to achieve the target, so you are left with two problems. What happens in 2010 when you miss the target, what are the implications, and also of course, having achieved the target, how do you sustain it? The worst of all idiocies would be to get to 2010 and say, "Ah well, we've achieved 80 %", or 70 %, "and now we're going to stop funding".

Mr Foster: I think again that justifies the logic of our approach on health system financing rather than perhaps whole-project or vertical-led financing in that, if you have achieved a target, you pat yourself on the back and psychologically you just sort of move on to work out what the next target is you want to aim for, whereas, if we have got health systems generally being funded, it needs some mainstreaming before it does make it easier to cement and build in as a permanent feature of healthcare in particular countries so that we do not fall foul of the idiom that you have just described. It also, I think, from what you said, reinforces our argument about prevention being the focus of our work on HIV/AIDS because that tends to be the area that can be cut if there are limits on spending. It is easier to cut prevention work than it might be treatments that people are already being given and are embarked on, so our focus on prevention, I think, will help deal with some of the unintended consequences of cuts in funding.

Q56 Chairman: We had again in the previous evidence session some indications that some governments in developing countries are saying, "Well, we're going to stop adding people to the treatment list", so one of their responses for not having funding is to say, "Well, we have enough difficulty treating the people we have got and we are not going to add any more", which clearly means that you have got a growing problem.

Mr Foster: And again, from what they have said, the best course of action in the longer term is to focus more and more on the prevention. In preparation for this hearing, Mr Chairman, we have been looking at the prevention bit and there is a phrase which has cropped up which I was determined to get on the record in this particular committee hearing, and I think it comes from Uganda, Alastair, and it is, "You can't mop the floor properly until you've turned the

tap off”, and that is very much central to the message about prevention being the direction for us to make the most impact in dealing with HIV/AIDS.

Mr Robb: I just want to add a very quick comment from a country perspective where I think there is a level of complacency about HIV that, by not hitting this target. It will further highlight the actual problem in-country where we are seeing rising numbers of new infections. In Uganda, a country that was once stated as a success, even during the time when prevalence was coming down in the mid-1990s, there was a rising number of new infections per annum. It does give us a bit more momentum behind why prevention matters, the focus that DFID is putting on prevention.

Q57 Chairman: Perhaps a separate question comes in there which I did not anticipate, but are we in a better environment for the prevention mechanisms? Are we in a better across-the-piece acceptance that some of the more difficult issues can be addressed?

Mr Robb: I think we are in a much better position than we were and I think that, in part, that is due to DFID working with the UN to bring the evidence to the table about why prevention matters, knowing your epidemic and knowing where we are in an epidemic and understanding that it is not about a single prevention strategy, it is about, in the same way as you have combination treatment, having combination prevention.

Chairman: I think John Battle might want to come to that in a minute.

Q58 Mr Lancaster: Building on that in a way and the implications of the DFID White Paper published in July where we saw a move towards multilateral funding rather than bilateral funding, and we have talked about that already, there was a feeling really from witnesses that perhaps DFID is de-prioritising HIV/AIDS, quoting a reduction in the number of staff, so I guess, Minister, we are really after not just reassurance that that is not the case, but also perhaps some form of evidence that demonstrates that the Department’s commitment to this is strong and will continue.

Mr Foster: I would have argued that the fact that we had the AIDS Strategy, that we have had that baseline assessment, that we are doing the biennial reports, against that baseline, it would reinforce the fact that actually DFID is as committed as ever to working on HIV/AIDS, and the fact that we have this £6 billion commitment to health systems on top of the £1 billion to the Global Fund would suggest that the resources are also being put in to deal with HIV/AIDS. Health systems, we think, are the right direction for us to go and we believe that other donors are in agreement with that, so I would counter any argument which says we were de-prioritising HIV/AIDS; I do not think we are at all.

Q59 Mr Lancaster: But there certainly was a consistent theme that this is the perception, so why then do you think this perception has been allowed to grow? Is that the fault of the Department? Have you felt engaged or what? It is definitely there.

Mr Foster: I do not hold the view, so it is difficult for me to work out why that perception is there. I can only envisage that it is because other health issues have perhaps come more to the fore as a concern, so, if you take maternal health as an issue, suddenly it has become more important in terms of the public eye perhaps. That is not to say that we are de-prioritising our HIV work or spending more attention now on maternal health, it is just that, in terms of lobbying, in terms of perhaps press attention, maternal health is perhaps getting a greater share of the attention than HIV/AIDS did, or perhaps it is taking some of the attention away from HIV/AIDS, but it is not taking away resource and it is not taking away our commitment.

Q60 Chairman: I just want to pursue the question on fragile states because the change in the priority in the White Paper does raise the question as to whether or not the countries that have a significant AIDS incidence, but are not decreed as fragile, might actually suffer from a reprioritisation, or at least how can you assure us that they will not?

Mr Foster: In terms of what we said about the White Paper and the movement to this greater emphasis on fragile states, what we said is that it was 50% of new money, new bilateral spend, which will go on fragile states, so the core funding that we have announced already, the £6 billion and the £1 billion to the Global Fund, that is not going to be diverted to work in fragile states. In terms of the need in fragile states, there is still a need there to deal with HIV/AIDS and it is perhaps different from what you might have in Sub-Saharan Africa and it requires us to look very much at a country-specific problem, but, for example, in a post-conflict situation you are often coming to terms with the poor treatment of women and violence against women which can often be a particularly bad transmitter of HIV/AIDS. That is an area where perhaps our work on fragile states would deal with an issue on HIV/AIDS which would not have cropped up, but which I think is important that we deal with.

Q61 John Battle: The American strategy, the President’s Emergency Plan for AIDS Relief, as it is sometimes referred to under its acronym of PEPFAR, means that there have been some changes both in American policy, but also in budget. I just wonder what is our relationship with that strategy now, our conversations with the Americans, and how you feel that the PEPFAR changes are helpful and whether the budget change is in the right direction.

Mr Foster: We very much welcome the change, not just in this, but perhaps other areas of policy as well from the Obama Administration. Certainly, their budget commitments on global health and what they said on sexual reproductive health and rights we have welcomed, the focus on broader health issues is perhaps more in line with what DFID has been doing itself, including child and maternal health and family planning which clearly have some benefits on HIV/AIDS as well, and the robust funding mechanisms that they are looking to bring in, again

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we welcome that, so we think that actually, by the changes that President Obama has made in his Administration, it enables us to have perhaps an even closer working relationship between DFID and USAID actually on the ground.

Q62 John Battle: In terms, say, of policy, fine, but, if it stretches the budget from five years to six, we might be worse off, which is what they have done.

Mr Foster: We think they are making some very positive noise about the amount of money that they are putting into the system about how it is going to be spread. Perhaps as an example in-country, Kenya is a good example, Alastair, of the work that we have done with the Americans.

Mr Robb: Yes, I think we are getting very good working relationships at country level, and PEPFAR, working less vertically through its own initiative and working with us and co-operating with national governments, so setting up partnership agreements so that it is consistent with the overall AIDS or health strategy, indicates their commitment to working better and achieving wider sets of outcome.

Q63 John Battle: So there is an in-country discussion with the Americans where you are working together?

Mr Robb: Yes.

Q64 John Battle: Which is good, and at the policy level, is there a discussion at the Washington level as well, so is DFID helping to jointly formulate the policy?

Mr Ash: Yes, there certainly is. At the policy level, we talk to the US on AIDS issues, on maternal and child health, on sexual reproductive health. We have been having discussions with them over several years and that is continuing and working well.

Q65 Chairman: Certainly, the Committee had an early meeting with USAID representatives very shortly after President Obama was elected, and indeed no doubt they were visiting other

departments as well, in which they were openly saying, "We can now work alongside DFID", whereas previously we were not doing so, so are you telling us that this is really happening on the ground?

Mr Foster: Yes, and the advantage is that, under their old way of running it, it would have been very much project-led with no incentive to have the partnerships and collaborative working that they are now free to have, and obviously some of the restrictions they used to have about where they worked, with those disappearing, it just gives them more freedom to work with us and others.

Chairman: They certainly appear to be liberated in their approach.

John Battle: May I suggest that we might also need to keep an eye on the budgets to make sure that they are not reduced so that the impact is that less people get assistance, if we are not careful, which is difficult perhaps.

Q66 Chairman: Well, thank you. There are one or two issues you have said you will write to us to give us more information.

Mr Foster: Of course, Chairman.

Q67 Chairman: May I just make the usual point that we have a very tight timescale on this one.

Mr Foster: Because you are reporting on World AIDS Day.

Q68 Chairman: That is our objective, so obviously anything you can give us, the quicker you can give it to us, the better. Perhaps I can also repeat the point that I think there is a lot you could do from the data you have in the Department to publicise it more effectively on your website and in other ways which would actually be in everybody's interests, and we may come back to that.

Mr Foster: That has come across loud and clear.

Chairman: We are obviously going to be doing a report on your annual report and we may repeat that then. Thank you very much indeed; it has been very helpful.

Written evidence

Written evidence submitted by the American Pharmaceutical Group

The American Pharmaceutical Group (APG) welcomes the continued and influential interest by the Committee in the implementation of DFID's strategy on HIV/AIDS. This submission sets out the APG's views on:

- monitoring and evaluation of DFID's Strategy;
- systems strengthening; and
- the impact of the commitment to universal access to anti-retroviral treatment on the effectiveness of care and treatment for women.

The Appendix has a short note about the APG, which has focussed mainly on sub-Saharan Africa, where some 7 million people are estimated to need antiretroviral therapy.

MONITORING AND EVALUATION OF DFID'S STRATEGY

1. The strategy set out in 2005 was a commitment to universal access to comprehensive HIV prevention, treatment, care and support by 2010.

2. This strategy has been seen by many as an aspiration rather than a realistic target. By end-2007 just 31% of those needing HIV treatment were receiving it (Source: AVERT, Sept 2009), and some countries are re-defining what is meant by universal access. A modified approach by the Government is something that the Committee may wish to consider.

3. A key issue in providing medicines to large numbers of people is whether the drugs prescribed are effective and achieving the desired outcomes. Issues such as inadequate supplies, irregular compliance and (often arising from these factors) drug-resistance, are just some of the reasons why drugs may aggravate rather than improve the conditions of sufferers.

4. The Committee touched on these matters in its November 2008 Report when it referred to the lack of outcome indicators in DFID's programme. In response, the Government stated that it was not feasible, practical or desirable for the strategy to set out specific budget allocations, targets and outcome indicators. We understand the difficulties with so many countries involved, but we would suggest that the use of sample surveys should be considered. This would indicate whether there is a real problem and its extent.

5. The Committee also referred to the Monitoring and Evaluation Framework, which had not then been published. The Government issued a document soon after, with a template of questions for DFID country offices. Again, it would be helpful to have an update from DFID on the progress of this work.

SYSTEMS STRENGTHENING

6. The APG strongly supports health systems strengthening.

7. The research-based pharmaceutical industry's ability to contribute to enhanced access to medicines in poorer countries depends entirely on the environments in which it operates.

8. Self-evidently, the pharmaceutical industry can best (and sometimes only) operate in the absence of civil war and with politically stable and effective governments.

9. However the need for a proper infrastructure goes deeper. The role of the pharmaceutical industry in the provision of medicines depends upon:

- Quality-assured manufacturing.
- The proper collection and storage of medicines on arrival.
- The reliability of governments, and the absence of any corruption.
- Good transport distribution and regular re-supply.
- Healthcare professionals to administer the medicines and to monitor outcomes. Many see the inadequate numbers of healthcare professionals as the single most important obstacle to proper treatment.

10. To maximise the industry's current contribution to improving access to medicines, the APG has given its support to the UK Government in its commitments to:

- Build and strengthen healthcare capacity and infrastructure, especially in Low Income Countries.
- Ensure appropriate incentives are put in place to encourage the development of new medicines for neglected diseases.

- Promote patient health by establishing reliable intellectual property infrastructures in middle income countries (the private sector and public research institutions depend on such rights).
- Reinforce efforts to combat illicit diversion and counterfeit drugs in both humanitarian and commercial markets.

11. We understand the point made by others to the Committee that the tangible effect of health system strengthening on combating HIV/AIDS is difficult to judge, but this should not be a reason for failing to press ahead with this policy. The Committee may wish to consider asking for more evidence from the Government on how health system strengthening is working out in practice.

12. We share the concern in the Committee's Report that HIV/AIDS specific funding can distort priorities and undermine systems strengthening. In some countries, wider health needs are being neglected in order to give priority to HIV/AIDS, although this is not seen in the countries as justified by the scale of this disease compared to others. The Government response to the Committee's Report showed that this problem "will be worked out in detail over the coming months"; the Committee may wish to request an update.

THE IMPACT OF THE COMMITMENT TO UNIVERSAL ACCESS TO ANTI-RETROVIRAL TREATMENT ON THE EFFECTIVENESS OF CARE AND TREATMENT FOR WOMEN

13. The Committee estimated in its report that some 1.8 million children in sub-Saharan Africa were infected with HIV/AIDS and stated that 90% of paediatric HIV is due to Mother to Child Transmission (MTCT).

14. Mother to Child Transmission (MTCT) occurs when an HIV positive woman passes the virus to her baby. This can occur during pregnancy, labour and delivery, and after birth through breastfeeding.

15. We note that in most high-income countries, new HIV infections among children has been virtually eliminated by wide implementation of an evidence-based package of interventions. This is built around the use of antiretroviral drugs, elective caesarean section and the avoidance of breastfeeding.

16. We understand the reluctance of governments and agencies to become involved in discouraging breast-feeding in the developing world by HIV-positive mothers, because this goes against cultural traditions. This widespread reluctance to speak out means that one important way of tackling paediatric HIV without the use of drugs is being forfeited. In addition, some mothers switch between breastfeeding and other fluids of foods in the early months, which produces a higher transmission risk. We would welcome the Committee looking into this issue more closely and making recommendations.

17. Drugs for adults can also secure healthier children. Antiretroviral (ARV) therapy for the mother can reduce the risk of transmission substantially. Where inadequate capacity precludes long-term ARV therapy, single-dose therapy for the mother, combined with short-term treatment for the infant can be highly beneficial. However there are different challenges in treating children as the typical antibody diagnosis cannot be used for children under 18 months. A diagnosis for the virus itself is difficult and expensive paediatric antiretroviral therapy requires dosing by weight. Few healthcare workers in developing countries are trained to provide paediatric ARV therapy many paediatric formulations are still in syrup form, which require refrigeration and tend to have a bitter taste.

We would welcome the Committee considering further drug treatment to reduce with paediatric HIV.

APPENDIX

THE AMERICAN PHARMACEUTICAL GROUP (APG)

The APG represents all the major American pharmaceutical companies which are also based in the UK.

The Group believes that basic healthcare should be independent of where people live. About 2 billion people, one-third of the world's population, do not have access to essential healthcare services and medicine; many of them live in low income countries.

APG member companies are committed to enhancing access to medicines in Low Income Countries (LICs) in Africa through a variety of measures, including:

- Research and development of new medicines for diseases disproportionately affecting developing countries.
- Humanitarian programmes, product donations and product access programmes that provide medicines at significant discounts, or at no profit levels.
- Capacity building programmes, ranging from local health care professional skills development, to technology transfers going to companies based in LICs.

Together, these individual programmes improve and extend the lives of millions of the world's most disadvantaged people.

The members of the APG already make a real difference to the quality of healthcare and lives around the world through a variety of individual initiatives and philanthropic programmes. These are set out in the APG brochure “Access to Medicines” (see www.apg.uk.com).

Written evidence submitted by AMREF

STRENGTHENING COORDINATION AND COMMUNITY CAPACITY AND PARTICIPATION IN THE HIV AND AIDS RESPONSE: THE CASE OF AMREF’S MAANISHA PROJECT IN KENYA

ACRONYMS

- NACC: National AIDS Control Council
- MoH: Ministry of Health
- M&E: Monitoring and evaluation
- CSOs: Civil Society Organisations
- MSM: Men who have sex with men
- IDU: Injecting drug user
- PLHIV: People Living With HIV/AIDS
- PMTCT: Prevention of Mother to Child Transmission
- HCBC: Home and community-based Care
- PSOs: Private Sector Organisations
- GoK: Government of Kenya
- OVC: Orphans and vulnerable Children

ABOUT AMREF

1.1 AMREF is Africa’s leading health development organisation. AMREF’s mission is to improve the health of disadvantaged people in Africa as a means for them to escape poverty and improve the quality of their lives. Founded in 1957 as the Flying Doctors of East Africa, AMREF has since expanded and has a continental and international reputation for delivering effective health programmes and developing innovative models for health delivery in Africa. In 2005, AMREF became the first African organisation to receive the Gates Award for Global Health, in recognition of its extraordinary contribution to improving health in Africa’s poorest communities.

1.2 AMREF is a truly African organisation. AMREF’s headquarters are based in Nairobi, Kenya, and it has large, multi-sectoral country programmes across Ethiopia, Kenya, South Africa, Southern Sudan, Tanzania and Uganda. AMREF employs more than 800 people, 97% of whom are African health and development professionals. AMREF places African communities at the centre of all its work, particularly children, young people, women of reproductive age, and the health workforce in poor remote and informal urban emergency settings. AMREF seeks to work effectively in partnership with governments, communities and the private sector across Africa.

SUMMARY

1.3 This paper describes problems of co-ordination and the lack of community capacity and participation in Kenya’s HIV and AIDS response. It goes on to describe the *Maanisha* project, co-funded by DFID and Sida, which was designed by AMREF and its partners to address these gaps. Specifically, *Maanisha* is strengthening efforts made by civil society organisations (CSOs) and private sector organisations (PSOs) at the grassroots in Kenya to reduce the incidence of HIV and AIDS and improve the quality of life among those infected and affected. *Maanisha* is recognised by the Government of Kenya and development partners as a successful and replicable model of comprehensive HIV and AIDS programming.

WHAT IS THE PROBLEM?

1.4 The prevalence of HIV among adults aged 15–49 years in Kenya has risen from 5.3% in 1990 to 7.1% in 2007. There are now more than 1.4 million PLHIV.¹ The epidemic is marked by considerable gender and geographic disparities: between 15–64 years, there are five females infected with HIV for every three males infected. Out of the country’s eight administrative provinces, two have a prevalence well above the national average—Nyanza province (14.9%) and Nairobi province (8.8%).¹ By 2006, approximately 1.5 million people had died due to AIDS, leaving a cumulative total of an estimated 1.7 million orphans aged 0–17 years.² There are about 150,000 children aged 0–14 years living with HIV in Kenya. Between the years 1979–89 and 2006, Kenya witnessed a decline in life expectancy from 61.9 years to 50.5 years,² which has largely been attributed to the interplay between HIV and AIDS and poverty.

¹ National AIDS/STD Control Programme, Kenya Ministry of Health, 2008: <http://www.aidskenya.org/>.

² UNGASS (2006), Country Report—Kenya: <http://www.nacc.or.ke/2007/index.php>

1.5 Kenya's National AIDS Control Council (NACC) is responsible for co-ordinating the country's HIV and AIDS response and has led the formulation and implementation of the National AIDS strategic plan (2005–06 to 2009–10) as well as the new HIV and AIDS strategic plan (2009–10 to 2012–13). Kenya's HIV and AIDS response has evolved from managing HIV and AIDS as a purely medical problem, to recognising the public health significance of the epidemic and applying a social model to HIV and AIDS programming. This has meant a shift from largely health facility-based interventions to a greater balance between health facility and community-based interventions, and greater involvement of communities, including beneficiaries, civil society and the private sector. The current plan (2009–10 to 2012–13) advocates for a multi-sectoral and comprehensive response encompassing: prevention, treatment, care and support; mainstreaming of HIV in key sectors; community-based programming in support of universal access and social transformation; and effective stakeholder co-ordination.³

1.6 Two recent assessments carried out by AMREF have highlighted important gaps in the HIV and AIDS response in Kenya.^{4, 5} These gaps are:

- Poor co-ordination and weak participation of communities.
- Insufficient capacity of communities to design and implement interventions to address HIV and AIDS and inadequate resources for them to do so.
- Failure to address the underlying causes of the high prevalence and negative impact of HIV among the most-at-risk categories.

These gaps are set out in greater detail below:

Poor co-ordination and weak participation of communities

1.7 AMREF found that a third of CSOs in Kenya were failing to follow national guidelines on HIV and AIDS implementation, and only a minority had reported to the NACC or used the harmonized HIV and AIDS indicators stipulated in Kenya's national monitoring and evaluation framework.⁵ Linkages between CSOs and government structures in Kenya were extremely weak and there was a clear disconnect between what CSOs were doing and what the formal health system desired them to do. Failure of CSOs to align their interventions with government policies and guidelines was largely to lack of information and the poor inclusion of CSOs in local government reviews and planning processes. The assessments also highlighted the weaknesses of decentralised NACC and MoH M&E and information systems: databases were found to be incomplete, HIV and TB activities were inadequately integrated, and key stakeholders were poorly involved in key planning processes.

Insufficient capacity

1.8 AMREF Kenya found that local CSOs lacked sufficient organisational and technical capacity to design, implement and monitor effective HIV and AIDS interventions. For example, out of the 70 CSOs surveyed by AMREF in 2004, only 20% were found to have elected leaders, 15% had annual plans to guide implementation, 53% had financial procedures in place, 22% used finances efficiently, and only 68% had a constitution. AMREF also found considerable funding and sustainability gaps among CSOs in Kenya, and inadequate systems in place to track performance and resource utilisation, making it difficult to assess the efficiency and effectiveness of community interventions.

Poor quality services for the most at risk

1.9 AMREF's assessment also revealed a low quality of HIV and AIDS services for the most-at-risk in Kenya,⁶ both in health facilities and in the community. For example, whilst Kenya's training curriculum on home and community-based care (HCBC) recommends 11 days of training, many CSOs were found to be training caregivers for as little as three days and were also lacking the appropriate HCBC kits. Health facilities were providing minimal to no services to at-risk populations: less than 5% of health facilities were effectively addressing the needs of IDUs and less than 30% were addressing the needs of sex workers. Only a fifth of the health facilities were offering specific youth friendly services. Little was being done to address the underlying drivers of the epidemic, including traditional/cultural practices, gender inequalities, and violations of human and legal rights particularly among women and girls, and high-risk sexual practices. AMREF found that 50% of widows in the Lake Victoria Basin Region of Kenya undergo sexual cleansing, a high risk sexual practice.

³ Draft Kenya National AIDS Strategic Plan, 2009/10—2012/12): http://www.aidsportal.org/Article_Details.aspx?ID=10873.

⁴ AMREF (2004), HIV and AIDS Needs Assessment, Lake Victoria Basin Region—Kenya.

⁵ AMREF (2005), Baseline Study on HIV and AIDS Knowledge, Attitude, Behaviour and Practice in Western and Nyanza Provinces, Kenya.

⁶ Most-at-risk populations are those at higher risk of infection and the negative social impacts of infection; they include: people living with HIV, widows, orphans, sex workers, men who have sex with men, injecting drug users, adolescents and youth, people with disability, mobile populations such as long distance truck drivers and fishermen.

WHAT IS THE MAANISHA PROGRAMME DOING?

2.1 *Maanisha* is AMREF's community-focused HIV and AIDS programme in Kenya, which aims for a sustained reduction in HIV incidence and reduced HIV-related mortality and morbidity, and the social protection of HIV infected and affected persons in the country. "*Maanisha*" is a Swahili word that means "giving meaning to". The programme covers all districts in Nyanza, Western and Eastern provinces, and the Lake Basin Districts of the Rift Valley province. The project is being implemented in partnership with the NACC, MOH, CSOs and PSOs. It is funded by the UK Department for International Development (DFID) and the Swedish International Development Cooperation Agency. The total cost of the programme is US\$30 million for five years (2007–12).

2.2 The specific objectives of *Maanisha* are:

- To build the capacity and capabilities of CSOs and PSOs to design and implement quality HIV and AIDS interventions.
- To promote safer sexual behaviour and practices among at risk and vulnerable groups.
- To strengthen facilitation, harmonization and co-ordination mechanisms between CSOs and GOK structures.
- To support CSOs/PSOs to improve quality of life for PLHIV, OVC, and widows/widowers through increased access to quality treatment, care and support services.
- To develop and strengthen a knowledge base for positively influencing policy and practice in HIV and AIDS programming.

See Annex 1 for full conceptual framework.

DESCRIPTION OF SPECIFIC INTERVENTIONS

Strengthening capacities of grassroots CSOs and PSOs

2.3 Grassroots CSOs and PSOs in Kenya provide important prevention, care and support services and ensure HIV and AIDS interventions are accessible and acceptable, and relevant to the needs of communities and households. *Maanisha* strengthens the capacity of CSOs and PSOs in four provinces of Kenya to implement HIV and AIDS interventions in two ways: grant making and capacity strengthening (includes both technical capacity and organisational strengthening). Organisations are strengthened in eight areas⁷ using the "Organisational Development and Systems Strengthening (ODSS) approach", implemented by programme staff and NACC staff via CSO mentoring (AMREF has also developed an ODSS manual for grassroots CSOs). The mentoring programme for each organisation is designed based on results from an ODSS scanning tool, which establishes the capacity of CSOs and PSOs in all eight components of the ODSS.

Strengthening co-ordination and harmonization between government structures and CSOs

2.4 *Maanisha* applies three strategies to strengthen co-ordination and harmonization: (a) strengthening M&E and information systems; (b) enhancing co-ordination and collaboration between NACC/MoH and CSOs; and (c) enhancing CSO alignment to national standards. The first involves working with NACC staff to strengthen district information management systems and improve CSO input into the national HIV and AIDS M&E system. It includes: mentoring CSOs on M&E; supporting CSOs to access and utilise reporting tools aligned to the National M&E framework; and supporting the strengthening of NACC databases. The second strategy involves strengthening co-ordination fora at district and provincial levels. It includes: lobbying NACC and other stakeholders to initiate the fora; providing start-up funding and technical support; and rallying players to recognise the leadership role of the NACC. *Maanisha* also improves the involvement of CSOs in local planning processes by strengthening networking capacity among CSOs, sensitising them on participation in stakeholder fora, and lobbying the NACC and MoH for the inclusion of CSOs in key review and planning fora/processes. The third strategy—enhancing alignment of CSO interventions to national standards, is achieved via CSO mentoring, as well as the dissemination of national policies and relevant guidelines to CSOs.

Grants scheme

2.5 *Maanisha* has implemented a grant scheme targeting CSOs and PSOs. The scheme is closely linked to the capacity building component, and constitutes what AMREF calls the "*Twin Approach*". This approach ensures that organisations receiving funding have the required organisational/management and technical capacity to utilise these resources effectively. The scheme consists of the following elements: demand

⁷ The eight areas are: leadership, governance and strategy development; financial management and budgeting; administration and human resources management; networking and advocacy; community ownership and accountability; project design and management; sustainability; and knowledge management.

creation, capacity assessment of CSOs and PSOs, provision of grants, strengthening of CSOs' and PSOs' financial management systems, and financial mentoring & monitoring. *Maanisha* creates demand for funding in two ways: the "call for applications" approach (creating demand among CSOs and PSOs for resources and then calling for applications); and the "proactive approach" (actively seeking groups that target the most at risk populations, and then building their capacity to apply and qualify for grants). 60% of *Maanisha's* resources are allocated as grants to CSOs and PSOs, and the grants range in size from USD 7000 to USD 20,000 per year. The *Maanisha* project implementation team receives, records, and undertakes the initial review and assessment of submitted applications. External regional and national technical committees then review the applications before grants are disbursed to qualifying organisations. When an application is successful, *Maanisha* conducts capacity assessments for prospective CSOs and PSOs, and financial management and systems strengthening training to improve skills and understanding of financial management procedures and reporting requirements before funds are released. The *Maanisha* team then mentors and monitors CSOs and PSOs during quarterly and "spot" visits, increasing their compliance with contractual obligations, utilisation of funds according to approved budgets and work plans, maintenance of records and realisation of projects targets. *Maanisha* has developed and applied a simplified financial management model—the Pot Model, to guide CSO and PSO capacity strengthening in financial management.

Prevention of HIV infection

2.6 In order to prevent new HIV infections and re-infections, *Maanisha* promotes the adoption of positive sexual behaviour and practices especially among at risk populations and special groups (eg youth, MSM, IDU, PLHIV) by funding and building the capacity of CSOs/PSOs to implement the following interventions: promotion of abstinence, being faithful and reduction of number of sexual partners; condom promotion and distribution; promotion and advocacy for expanded access to HIV counseling and testing; information, education and communication; prevention with positives; and promotion of male circumcision.

Care and support

2.7 The *Maanisha* project bridges gaps in the continuum of care and support between the formal health system and the community. It facilitates collaboration between MoH officials (including district HIV and AIDS co-ordinators and district home and community-based care co-ordinators) and CSOs/PSOs, and provides CSO/PSOs with MoH approved home- and community-based care guidelines, diaries, tally sheets, notebooks, referral forms, and education and communication materials, as a means of aligning their activities to the national HIV and AIDS strategy. The programme has also enabled funded CSOs and PSOs to form or develop linkages with support groups—an important part of the referral system, where PLHIV can go for psychosocial and spiritual support. To facilitate this, *Maanisha* distributes a community referral tool to support groups, developed by the MoH, which is recognised and accepted by health facilities. As part of strengthening the referral system, CSOs and PSOs also support the transportation of clients in need of medical attention to local health facilities.

2.8 The *Maanisha* programme also enhances the capacity of communities to provide care and support by funding CSOs and PSOs engaged in the provision of home and community-based care, care and support for orphans and vulnerable children, and support for PLHIV and widows. CSOs and PSOs are able to use these funds not only to provide better direct care to beneficiaries, but also to train home and community-based caregivers and counselors to provide services to PLHIV, youth and other categories of most-at-risk populations and special groups. In Kenya, home and community-based care includes basic clinical care such as the identification of adverse drug effects and referral, basic palliative care, nutritional counseling and education, and psychological and emotional support to PLHIV and their families. Consequently, funded CSOs and PSOs also procure home and community-based care kits, and distribute them to local caregivers. The programme also funds organisations providing sustainable nutritional support to PLHIV, and those that support orphans and vulnerable children to access formal education, food and nutrition, social protection, medical care and psychosocial support.

Mainstreaming of cross cutting issues

2.9 Addressing the underlying drivers of the epidemic, including social and cultural factors, gender inequalities, stigma and discrimination, legal and human rights violations, participation of beneficiaries, poverty and food insecurity is a key component of the *Maanisha* project. *Maanisha* addresses these issues by engaging with communities, community leaders and policy makers to create an enabling social, cultural and policy environment for desired social and behaviour change. For example, it funds CSOs to engage in prevention activities; trains CSOs and community members on key underlying drivers of the epidemic, especially on social cultural and gender analysis, and legal and human rights; works with cultural leaders eg councils of elders to help integrate principles of HIV and AIDS prevention, care, and support in cultural

practices and reduce harmful traditional practices that result in spread of HIV and worsen its impact; and links CSOs with microfinance institutions to enable them to access funds and initiate sustainable income generating activities.

Knowledge Management

2.10 The *Maanisha* programme identifies key lessons learned and best practices to influence future HIV and AIDS programming, particularly in resource constrained settings. The programme promotes replication of these practices among CSOs and PSOs, and shares them with policy makers for incorporation into national implementation frameworks.

ACHIEVEMENTS OF *MAANISHA*

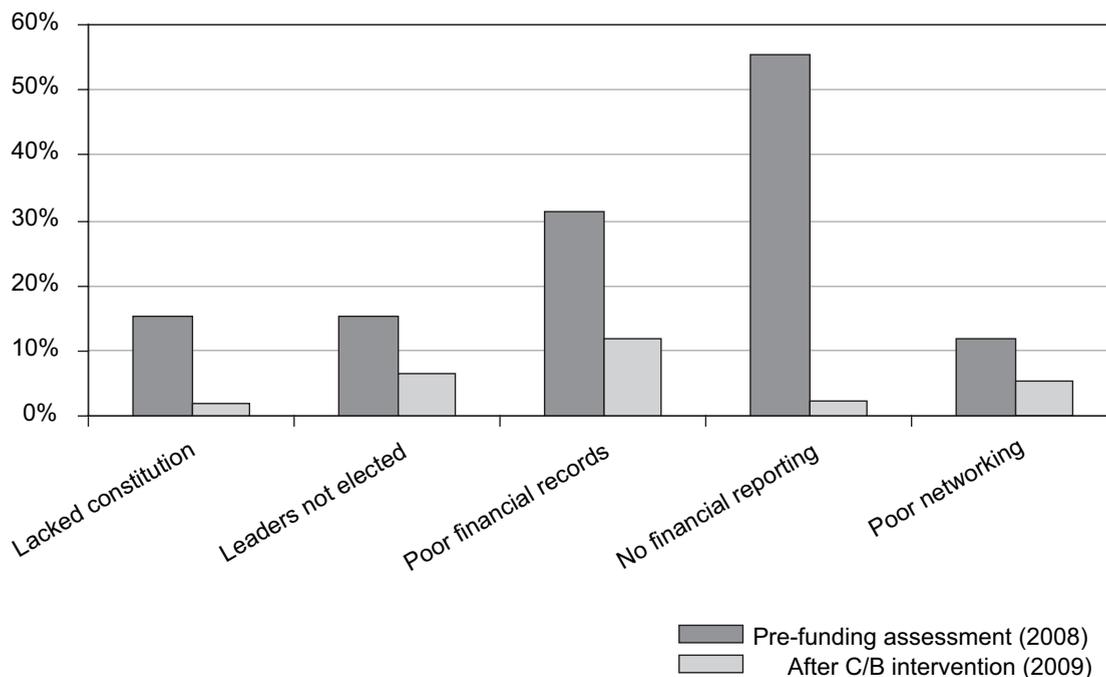
The key strengths and achievements of *Maanisha* are as follows:

Using the ODSS to strengthen the capacity of grassroots CSOs and PSOs

3.1 As of June 2009, *Maanisha* was funding and mentoring 536 CSOs/PSOs, which in turn were reaching more than 500,000 most-at-risk and vulnerable people with quality prevention, care and support services. Based on before and after training and mentoring assessments, funded organisations now have improved management and governance (figure 1). Earlier assessments based on a quasi-experimental study design⁸ revealed similar benefits in capacity enhancement of CSOs as a result of the *Maanisha* intervention. In a recent client satisfaction survey,⁹ 86% of CSOs rated *Maanisha* as good to excellent with regards to the effectiveness of capacity building, management of inquiries and complaints, waiting time for grants, and treatment of clients with respect/courtesy/fairness.

Figure 1

PERCENTAGE OF CSOs/PSOs SHOWING CAPACITY GAPS BEFORE & AFTER TRAINING & MENTORING



The innovative grants scheme

3.2 *Maanisha* today funds 536 CSOs: [as per funding round five] 85% are CBOs, 6.1% PSOs, 11% NGOs and 3% are FBOs. Most of the grantees (85%) are grassroots organisations, which have direct contact with targeted beneficiaries. The funded CSOs are reaching diverse beneficiaries including at risk and vulnerable populations (see Table 2 below).

⁸ AMREF, 2007. (<http://www.amref.org/search/poster/>)

⁹ AMREF, 2009. Client satisfaction survey.

Table 2*MAANISHA* FUNDED CSOs'/PSOs' BENEFICIARIES (ROUND 5)

<i>Target</i>	<i># sub-grantees (CSOs & PSOs)</i>	<i># beneficiaries</i>
OVC	315	22,367
Youth	303	458,079
Married couples	TBD	TBD
PLHIV	275	34,663
Widows/widowers	223	18,963
PWD	108	4,145
CSW	59	12,124
Migrant people	28	—
IDU	20	1,210
Prisoners	15	3,584
MSM	13	452

The funded organisations are implementing prevention, treatment, care and support activities as outlined in table 3 below:

Table 3

ACTIVITIES IMPLEMENTED BY SUPPORTED CSOs/PSOs

<i>Intervention</i>	<i># sub-grantees (CSOs & PSOs)</i>
HIV Testing and Counseling	85
Behaviour Change Communication	270
PMTCT support	63
Prevention with Positives	22
Home and Community-based Care (HCBC)	246
ART Adherence	72
Psychosocial Support	107
Food and Nutrition	251
OVC support	315

Improved facilitation, co-ordination and harmonization

3.3 As of June 2009, *Maanisha* had strengthened the capacity of 117 NACC structures, with 97% showing an increase in knowledge and skills to support and supervise CSOs/PSOs. Today, there is evidence of enhanced co-ordination between NACC/MoH and CSOs, coupled with greater harmonization of CSO interventions to national standards. *Maanisha* has helped shape the design and rollout of the World Bank funded Total War against AIDS (TOWA) project implemented by NACC in Kenya, including embedding the capacity building of CSOs as a key component. Other specific recent short-term outcomes include: 56% of *Maanisha*-supported CSOs/PSOs in programme scale up areas are now assisted by NACC staff (up from 22% at baseline in mid 2008); from January to June 2009, 40 CSOs/PSOs in pilot regions received specific support from MoH staff, and 164 grantees (31%) participated in stakeholder co-ordination/planning fora; and grantees reporting to NACC using the national reporting tool has increased from 12% to 98%. There are also strong signs of an emerging co-ordination model based on regular joint stakeholders meetings, co-ordinated support to CSOs, information sharing between key stakeholders, harmonization of reporting tools, and involvement of key stakeholders in planning and implementation processes, and synergy in resource mobilisation and utilisation among key implementing partners.

Prevention of HIV infections and mainstreaming of underlying factors

3.4 The *Maanisha* project has enhanced the ability of 270 CSOs to design and implement HIV prevention interventions. Specifically, the project has increased knowledge among trainers-of-trainers (TOTs) on safer-sexual practices, who in turn have facilitated the training of more than 20,000 peer educators and reached more than one million people with specific prevention messages, including over 300,000 young people in schools and 12,160 males on male circumcision. Other key outputs and short-term outcomes include: 162,530 people trained on proper condom use; 10 voluntary and counseling centres strengthened, which have provided services to more than 26,250 people (including those with disabilities); 107,932 IEC materials distributed (4,218 of them in Braille); 2,916 CHWs trained to support counseling and testing, 2,783 CHWs trained to support PMTCT; and 8,522 PLHIV reached with "prevention with positives" (PwP) interventions. The *Maanisha* project has also trained 9,884 PLHIV and 11,469 community members on human rights advocacy during the period January to June 2009. Consequently, 878 cases of human rights violations have since been handled, and 447 of the cases have been concluded (including cases concerning widows recovering property lost through disinheritance after death of their spouses).

Improving quality of life of PLHIV, OVCs, and widows/widowers

3.5 The project has supported 246 CSOs to provide HCBC, and strengthened referral and linkage mechanisms between CSOs and health facilities. It has also facilitated 72 CSOs to support adherence to ART, 251 CSOs to offer nutritional support to PLHIV, and 351 CSOs to offer OVC care and support. As a result of these activities, the following outputs and short term outcomes have been realised: 264 CHWs and 8,505 caregivers have been trained in HCBC (and consequently 23,147 PLHIV have been provided with quality HCBC services); 5,521 clients have been referred by CSOs/PSOs to health facilities; farming initiatives by PLHIV support groups have improved (21,553 PLHIV have been provided with sustainable nutritional support); sustainable OVC support initiatives have been developed by CSOs, which has meant that 27,139 OVCs have accessed primary support, 2,222 have accessed HIV counseling and testing, and 1,478 have accessed ART; and CSO training on adherence support has meant that an additional 13,794 PLHIV have been supported to adhere to ART.

Knowledge management

3.6 The project has developed and rolled out a knowledge management strategy, orientated 149 CSOs/PSOs on knowledge management, and identified and pursued key advocacy issues. As a result of these efforts, CSOs have documented 362 human interest stories, while project staff have documented two best practices and a paper on “approaches for enhancing aid effectiveness among grassroots CSOs”. Today, many CSOs are also replicating prevention, treatment, care and support interventions, learnt from other CSOs during exchange visits and review meetings.

KEY LESSONS LEARNED

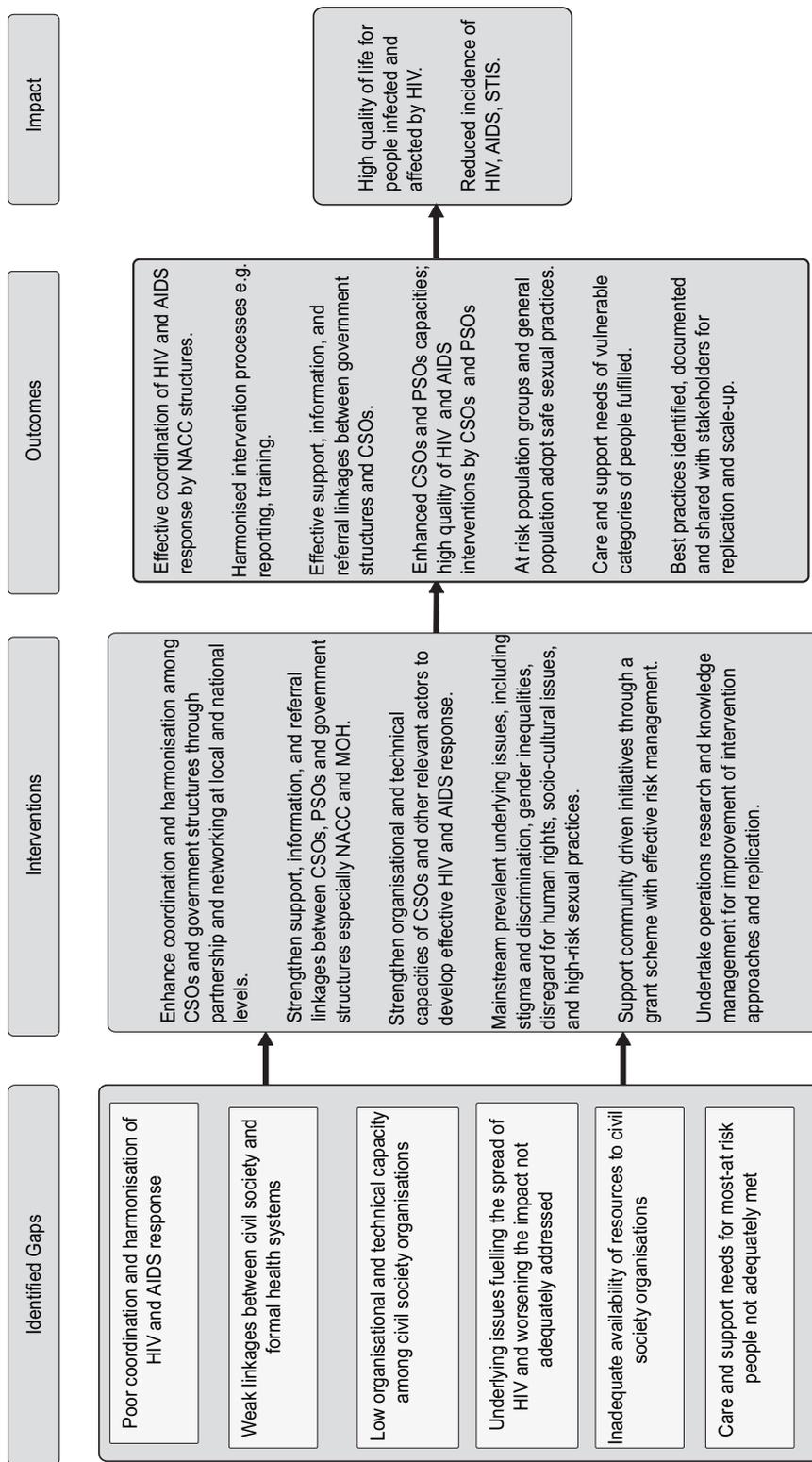
3.7 The implementation of the *Maanisha* project has demonstrated several key lessons for future HIV and AIDS programming. The most important of these are:

- Grant-making to CSOs and PSOs should include a comprehensive capacity building programme to enhance quality of interventions. The capacity building programme should cover capacity needs assessment prior to disbursement to reduce risk and inform the capacity building process for each CSO and PSO.
- Involving government structures in the co-ordination of HIV and AIDS efforts, including the training and mentoring of CSOs and PSOs at a local level, significantly improves the relationship between government structures and CSOs and PSOs. It also increases the sustainability of capacity building efforts at a local level and improves the co-ordination of interventions. However, for this to happen, the capacity of government structures must also be built and government personnel must be provided with transport to enable them to visit CSOs and PSOs.
- It is important to invest in the strengthening of co-ordination and harmonization mechanisms at provincial and district levels to improve the HIV and AIDS programming environment. However, to be effective, co-ordination efforts should involve key government agencies as well as civil society, including grassroots CSOs; and promote wide stakeholder involvement, information sharing, leadership, harmonization of implementation and reporting frameworks, and synergy in resource mobilisation and utilisation.
- Mainstreaming factors underlying the spread and impact of HIV and AIDS across the programme is an effective way of creating community behaviour change and enhancing the quality of care and protection among at risk populations. Key underlying issues needed to be addressed include: human and legal rights violations, gender inequalities, and prevalent harmful socio-cultural practices.
- Door-to-door counselling and testing is a more effective way of increasing access to HIV counseling and testing services. Anecdotal evidence from CSOs/PSOs indicates that people prefer mobile, door-to-door counselling and testing than static VCT centres.
- There are many innovative best practices being implemented by CSOs/PSOs in Kenya. These are practices which if replicated and scaled up would significantly enrich the national response against HIV and AIDS. Consequently, AMREF in Kenya will work with the NACC and other partners to promote knowledge management as a significant component of HIV and AIDS programming.
- Peer-to-peer learning is an effective way to fast track the replication of best practices. AMREF is supporting carefully planned exchange visits between CSOs/PSOs, which in the future will include exchange visits between CSOs/PSOs in “old” *Maanisha* areas and scale up areas.
- It is possible to access hard-to-reach population groups including sex workers, MSM, and prisoners with prevention, treatment, care and support interventions by supporting those CSOs/PSOs that include these groups in their membership, to design and implement context specific interventions.

CONCLUSION

3.8 The *Maanisha* project demonstrates the important role that civil society plays in improving the HIV and AIDS response in Africa. In many African nations, civil society provides health care services to more than half the population. Recognising their role, building their capacity and co-ordinating their work at a local level are essential. In Kenya, there remains work to be done: the CSO response is poorly co-ordinated, communities have weak capacity, minimal access to resources, and their participation in HIV and AIDS mitigation is limited; the underlying factors of high HIV prevalence among most-at-risk populations are also poorly addressed. Governments across Africa must seek new ways of engaging CSOs and better leveraging their work. *Maanisha* provides an evidence-based, replicable model of comprehensive HIV and AIDS programming, designed for resource poor settings, which can significantly improve the effectiveness of national HIV and AIDS responses.

THE MAANISHA CONCEPTUAL FRAMEWORK



Written evidence submitted by the All Party Parliamentary Group on AIDS

September 2009

Q1 *The process established by DFID for monitoring the performance and evaluating the impact of the Strategy*

(a) It is too early to tell how effective the strategy itself and the M&E process will be since we have not got our first set of data. Since the first set of data will simply be a baseline, even having received it, it will still be impossible to monitor the impact of the strategy.

(b) In the absence of two sets of statistics for comparison it would be useful to know the mechanics of how, one year on, the priorities laid out in the strategy have been translated into priorities at country-level offices and have some concrete examples of changed programming to reflect the strategy.

Q2 *Progress on health systems strengthening and on an integrated approach to HIV/AIDS funding*

(a) One of the problems of having health systems strengthening as a goal is that it is difficult to measure. The World Health Organization (WHO) defines health systems as “all the organisations, institutions, and resources that are devoted to producing health actions.” However there is no agreed definition of what a strong health system looks like.

(b) Success across a range of disease specific goals is measurable and can reflect the strength of a health system and its ability to deliver health outcomes. This is why the APPG believes it is important to set and monitor disease specific goals as part of health systems strengthening.

(c) A 2009 report by Action (Action to Control TB internationally) called, “Living with HIV, Dying of TB” says, “DFID’s increasing focus on health system strengthening and sector-wide approaches (SWAs) to health has resulted in a reduction in support for targeted disease control programs and presents challenges for the accurate monitoring and evaluation of its impact on TB-HIV.” (page 36)

(d) The Global Fund has adopted health systems strengthening as part of its funding portfolio, this has been partly as a result of DFID pressure. The APPG welcomes this development, since it complements the Global Fund’s disease specific programmes.

Q3 *Integration of HIV/AIDS prevention, treatment and care with other disease programmes, particularly tuberculosis and malaria*

(a) There has been international improvement on integrating HIV and TB programmes together, and DFID has been an important advocate and instigator of this change. A 2008 survey reported in Action’s (a consortium of TB organisations) “Living with HIV, Dying of TB” 2009 and conducted by DFID itself for the APPG on TB found that 12 out of 24 DFID country offices surveyed felt that there was insufficient TB-HIV collaboration to address their national TB epidemic.

Q4 *The effectiveness of DFID’s Strategy in ensuring that marginalised and vulnerable groups receive prevention, treatment, care and support services*

(a) It is impossible to know this in the absence of any data since the inception of the strategy.

(b) The APPG believes that the Foreign Office has a particularly important role to play in this aspect of the AIDS strategy, because of its human rights work for the rights of men who have sex with men (MSM) and because problems faced by vulnerable groups such as MSM or injecting drug users are often not an issue about resource, but about political will. Diplomacy is therefore very important. The APPG will be interested to hear about how DFID and the FCO are working together on these issues, as they committed to do in the strategy (Page 59). Whilst data may not yet be available, examples of actions taken to progress this agenda would be useful.

Q5 *The effectiveness of social protection programmes within the Strategy*

(a) The APPG cannot comment in the absence of any data since the inception of the strategy.

Q6 *Progress towards the commitment to universal access to anti-retroviral treatment and its impact on the effectiveness of care and treatment, particularly for women*

Progress towards Universal Access, the importance of maintaining UK leadership and momentum

(a) We are off track on the Goal of Universal Access to HIV treatment, care, support and prevention. This goal was established under UK leadership of the G8 in Gleneagles in 2005. If future goals are to be taken seriously, it is important that the international community and the UK in particular reflects on what it can do to accelerate progress and when they think Universal Access can be achieved by. Glossing over a failure to meet the target, however shared that failure is, will undermine political credibility on not just this issue, but a whole range of developmental goals.

(b) The All Party Parliamentary Group on AIDS in partnership with the International AIDS Society is therefore calling for a high-level meeting to be convened in early 2010, to agree on a way forward for accelerating progress, and to demonstrate continuing political commitment. Without such an early meeting the issue is likely to be subsumed in the run-up to the UK election.

(c) Despite being off target, there has been considerable progress towards universal access. Over a third of those who need HIV treatment have access to it—and achievement that would have seemed almost impossible a decade ago. DFID should build on this success.

(d) Access to treatment should have other positive effects, such as limiting the number of children newly orphaned by AIDS, sustaining family livelihoods, and reducing onward transmission of HIV, since treatment reduces an individual's infectiousness.

The importance of prevention and the challenges of funding it

(e) Prevention of mother to child transmission has also been scaled up very effectively, through the work and funding of organisations such as the Clinton HIV/AIDS Initiative, UNITAID and UNICEF. Nonetheless, too many children are still born with HIV, they will need treatment for the rest of their lives. PMTCT must be a top priority if we are to manage the epidemic.

(f) It is less easy to measure the impact of prevention programmes other than PMTCT. There will often be pressure on Governments and donors to de-prioritise such prevention in favour of instant and measurable “wins” such as new people on treatment. Urgent work needs to be done to help countries decide on the most effective treatment:prevention spending ratios. DFID could help support such research.

Long-term access—planning beyond the MDGs

(g) The All Party Parliamentary Group on AIDS recently published a report on long-term access to HIV medicines in the developing world. “The Treatment Timebomb” report urged the UK Government and other leaders to consider the likelihood of treatment cost per individual rising over the next two decades as more people become resistant to first-line treatments. It also highlighted some projections done by epidemiologists at University College London and Imperial College London on the numbers of people needing HIV treatment by 2030. The figure cited in our report of 55million people (compared to 9 million now) is a conservative one. The combination of high treatment prices and high numbers in need, makes for what the report describes as a “treatment timebomb”.

(h) We therefore urge DFID to consider in advance how treatment prices can be minimised before huge numbers of people with HIV find their basic treatments stop working. Work on this is already in progress. The Access to Medicines team and DFID should be commended for the support they are giving to UNITAID for the establishment of a patent pool, which would address the price of improved first-line and second-line medicines and help stimulate the development of new medicines for developing country settings. This project is currently being held up, not by lack of political will, but by the reluctance of pharmaceutical companies to engage in dialogue with UNITAID on the issue. It would be most useful for the IDC to add its weight to DFID's call for companies to engage with UNITAID on the patent pool.

(i) A full list of recommendations directed at DFID from the report is attached as an Annex to this response as is a copy of the report itself—The Treatment Timebomb (not printed).

Q7 *Additional Comments*

(a) Part of the DFID strategy is the cross Whitehall Working Group on HIV/AIDS. This features both in the initial strategy and the M&E document. The All Party Parliamentary Group on AIDS believes that policy coherence across Whitehall on HIV/AIDS is very important, and has identified several areas where it is not evident.

(b) The most pertinent Whitehall inconsistency to this inquiry is universal access to HIV treatment in the UK. The Universal Access target applies to all signatories, including those in the developed world. There are still a number of asylum seekers who are not eligible for free HIV treatment in the UK, since such people are also not eligible to work and are therefore living in poverty, this sometimes means they are denied access to life-saving treatment. The APPG does not necessarily argue that such people should be allowed to stay indefinitely by virtue of their HIV status, but that whilst they are here, and in many cases the Home Office recognises that they cannot safely go home in the short term, they should be treated free of charge. The numbers of people who fall into this category are very small, and the cost implications are minimal (we are happy to supply data if this is useful); however the APPG feels strongly as a matter of principle that if we are asking developing countries to provide universal access then we should provide it ourselves in the UK.

(c) Given the importance of the cross-Whitehall working Group—to which DFID provides an informal secretariat—the APPG feels it is under-resourced. It has no budget and no additional staff time has been allocated to ensure follow up between meetings. Indeed the secretariat and overview functions are being carried out by a sexual and reproductive health team at DIFD which has significantly reduced in staff numbers over the last three years. Currently the group meets in private without making public its agenda or minutes. Whilst the APPG on AIDS recognises there may be advantages to full and frank discussions without minutes between departmental representatives, it does feel there needs to be some transparency and accountability from the from the cross-Whitehall group. We invite them to suggest solutions.

RECOMMENDATIONS FOR DFID FROM RECOMMENDATIONS IN THE TREATMENT TIMEBOMB REPORT

- HIV is a long-term condition and funding will be needed to maintain progress well beyond the MDGs, even if the MDGs are achieved. People with HIV need treatment for life. DFID should work to catalyse discussions with its counterparts and the multi-lateral organisations it works with to agree on a common message to drive and maintain progress beyond 2015.
- It is difficult to measure the impact of prevention and prevention activities can be an easy target for cuts in a numbers-driven environment. DFID, preferably in partnership with other key HIV players such as UNAIDS, should support the development of best-practice recommendations for treatment/prevention spending ratios. The recommendations would differ for different epidemic types and there would be an understanding that recommendations would need to be further adapted locally. They would provide a starting point for health departments and major donors.
- All donors, including DFID should promote PMTCT of HIV that is more sophisticated than giving just a single dose of Nevirapine to expectant mothers. Nevirapine is much better than nothing but too many babies continue to be born HIV+.
- There is a need for research on common opportunistic infections associated with HIV and the cost of treating them so that AIDS programmes could include realistic financial allocations for the treatment of such infections. This fits in with DFID's integrated approach to health.
- DFID is already working on an independent analysis of the costs and benefits of various models of pharmaceutical company access programmes, which we are pleased to see. This was one of the recommendations in the report.
- DFID should support developing countries to use their TRIPS flexibilities to promote public health. They should discourage the adoption of TRIPS+ measures (that typically limit flexibilities) in European Economic Partnership Agreements (EPAs) with developing countries. This is an area for consideration by the Cross-Whitehall Working group, because of its implications for The Department for Business, Innovation and Skills.
- DFID should continue to advocate for the establishment of a UNITAID patent pool for HIV medicines.
- Countries have to make difficult decisions about the types of treatment they are prepared to fund. For example they need to decide whether they provide cheap treatments that are difficult to tolerate and adhere to, but cover more people, or whether they provide more expensive, more tolerable treatments. DFID should help fund health economists in its partner countries who can inform national aids strategies.
- DFID, in communication with its counterparts from other donor countries and with UNITAID, should look into the workability of a prize fund for key missing HIV/TB medicines and diagnostics.

Written evidence submitted by the Department for International Development

EXECUTIVE SUMMARY

1. The UK AIDS Strategy *Achieving Universal Access* sets out how the Government will assist developing countries to reach the goals of Universal Access (UA) and halting and reversing the spread of HIV. It makes comprehensive prevention a priority and shows how we will continue to promote the needs and rights of women, young people, children and vulnerable groups. It also sets out the commitments required to accelerate progress towards building a long-term, sustainable response.

2. Implementation of the seven-year Strategy is at an early stage; much of the required data are not yet available and it is not possible to provide a rigorous assessment of impact at this point in time. We published our planned process for monitoring and evaluating the Strategy in December 2008. Subsequently, in October 2009 *Achieving Universal Access: a 2008 Baseline* was published. We draw the attention of the Committee to this document, which sets out the basis for our future reporting—with a first report due in 2010. This memorandum focuses on main achievements and challenges since the launch of *Achieving Universal Access*.

3. We believe that it is time to move on from the protracted international debate on the merits of disease-specific versus horizontal health financing. Stronger health systems are critical to tackling AIDS. The evidence we provide in this memorandum demonstrates our commitment to strengthening health systems through progress in the International Health Partnership Initiative and country-level support, and through promoting the integration of HIV/AIDS with other health services, malaria and TB services in particular.

4. This memorandum provides evidence of the Government's commitment to expand services for marginalised and vulnerable groups by continuing to pioneer work on harm reduction and supporting international advocacy efforts for an equitable provision of services to men who have sex with men.

5. In *Achieving Universal Access*, we committed to reviewing the effectiveness of social protection in meeting the needs of OVCs. There is a strong international consensus on the need for a stronger focus on comprehensive social protection systems and programmes to support children and families affected by AIDS. In the light of this, we remain confident that our approach is strongly supported by current evidence and emerging global best practice.

6. Expansion of access to anti-retroviral (ARV) treatment, and its impact on the effectiveness of care and treatment, particularly for women, are critical areas. The memorandum provides evidence of our efforts to increase the affordability and availability of ARVs and to expand access to treatment by women, particularly by supporting the scale up of prevention of mother to child transmission services, as well as our support to global advocacy on women and girls.

7. Finally, despite progress being made, we recognise that more needs to be done to reach Universal Access to prevention, treatment, care and support, and we highlight several specific challenges which will continue to drive our and the international community's efforts.

INTRODUCTION

8. The Government welcomes the International Development Committee (IDC) inquiry into the implementation of its HIV/AIDS Strategy, *Achieving Universal Access*, published in June 2008. This provides an opportunity to assess progress a year on from the Strategy's launch and as we approach the challenging 2010 targets, which the international community has set for universal access to comprehensive HIV prevention, treatment, care and support.

9. The Government's new White Paper: *Eliminating World Poverty: Building our Common Future*, reaffirms our commitment to the goal of universal access to comprehensive HIV prevention programmes, treatment, care and support, and our determination to meet our existing financial commitments to respond to the HIV/AIDS epidemic. This includes spending up to £6 billion on health systems for better health and HIV outcomes and £1 billion to the Global Fund for AIDS, TB and malaria. The White Paper also commits us to delivering on other promises we have made, including our work on increasing access to medicines by supporting fairer pharmaceutical markets for the poor.

10. *Achieving Universal Access*, our response to this challenge:

- reiterates our commitment to play a leadership role, helping developing countries to reach the goals of Universal Access and halting and reversing the spread of HIV;
- prioritises HIV prevention—as the best means to minimise the impact of the disease on future generations;
- sets out how we will continue to promote the needs and rights of women, young people, children, and vulnerable groups, and how we will support countries in providing stronger health, education and other basic services;
- prioritises UK support for an international system involving strong partnerships, from community to international level;
- includes commitments on prevention, sustainable treatment, social protection for those made vulnerable by the disease, and £6 billion for stronger health systems and services up to 2015—for improved health and HIV outcomes.

11. We published our planned process for monitoring and evaluating the Strategy in December 2008. Subsequently, in October 2009 *Achieving Universal Access: a 2008 Baseline* was published. We draw the attention of the Committee to this document, which sets out the basis for our future reporting—with a first report due in 2010.

12. It is too soon to attempt a full and rigorous assessment of the impact of the seven year strategy. Implementation is at an early stage and much of the required data are not yet available. This memorandum focuses on main achievements and challenges since the launch of *Achieving Universal Access*. We want to highlight the following specific challenges:

- Curbing the growth in new infections through effective behaviour change programmes (eg reducing concurrent multiple partners and unsafe sex).
- Unblocking obstacles to scaling up prevention to meet Universal Access targets (such as widespread stigma and discrimination against people living with HIV).
- Ensuring long-term sustainability of programmes for treatment, care and support in the light of the financial crisis and increasing demands for anti-retroviral treatment—defusing what the All Party Parliamentary Group on AIDS have called the “treatment timebomb.”
- Integrating AIDS programmes into broader health care provision, and in particular reproductive maternal and child health services, to ensure that efforts to curb the AIDS epidemic also impact on these related MDGs and that the synergies for integrated services are exploited where possible.
- Ensuring the international community maintains its financial commitments to tackling AIDS in the midst of an unprecedented global financial downturn.

- Ensuring that national governments can increase and sustain their financial allocations to HIV and AIDS budgets.

13. This memorandum provides a snapshot of progress at this early stage. Below is our response to the six issues highlighted by the Committee.

1. *The process established by DFID for monitoring the performance and evaluating the impact of the Strategy*

14. *Achieving Universal Access* commits us to action in five priority areas:

- Priority 1: Increase effort on HIV prevention; sustain momentum for treatment; to 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: Turning the strategy into action.

Effective monitoring of performance and evaluation of impact are core components of this.

15. The Government published *Achieving Universal Access—Monitoring performance and evaluating impact*, on 1 December 2008. This plan, developed in consultation with civil society, commits us to assess progress against the UK priorities for action in *Achieving Universal Access* through an independent evaluation and a series of biennial reports.

16. Our aim, throughout the monitoring and evaluation process, has been to provide an accurate picture of progress towards Universal Access and to capture the particular contribution made by the UK, without creating new burdens of reporting that could deflect energies from implementation.

17. Our work in-country supports the implementation of national HIV and AIDS plans. Decisions about DFID supported programmes are taken at country level, in collaboration with national governments and other partners. Information from these programmes will form the basis of our future reports, together with information on our multilateral engagement, from DFID corporate performance systems and other Government Departments, as well as global data.

18. It is important that we use internationally and nationally agreed targets and indicators—such as the Millennium Development Goal and United Nations General Assembly Special Session on HIV/AIDS (UNGASS) indicators and country-specific indicators. This approach is in line with the Paris Principles on Aid Effectiveness and the “Three Ones” principles.

19. The Government published the baseline report in October 2009, available at www.dfid.gov.uk. A copy is submitted with this memorandum. This report gives a snapshot of the global situation when *Achieving Universal Access* was published in June 2008.

20. This provides the basis for our future reporting. We have committed to report on our performance once every two years—starting with a first progress report to be published for World AIDS Day in December 2010. We will publish a second progress report for World AIDS Day 2012 and a third one for World AIDS Day 2014.

21. In addition, DFID will commission an independent review after three years of the strategy period. The evaluation report will be published for World AIDS Day in 2011. This will allow time for lessons to be learned, which can help inform the remaining years of the strategy.

2. *Progress on health systems strengthening and on an integrated approach to HIV/AIDS funding*

22. Recent years have seen much international discussion on the relative merits of “vertical”—or disease-specific—and “horizontal”—or systems-focused—approaches in tackling diseases like AIDS and in improving global health. We believe that stronger health systems are needed to scale up the AIDS response and achieve universal access. Equally, an effective response to AIDS serves as a platform from which other MDGs—for example those on reproductive, maternal and newborn health—can be reached.

23. In the long term, however, sustainable funding for health systems and services provides the strongest foundation for Universal Access; and that is why, in 2008, the Government pledged to spend £6 billion on health systems and services to 2015. Stronger health systems will facilitate the scale up of preventative measures, such as prevention of mother to child transmission of HIV. They will help more effectively address co-morbidity of HIV with TB, malaria and other diseases and they will help deliver ARVs to those who need them.

24. The baseline report shows that DFID spent £776 million on health systems and services in 2007–08. Since the launch of the Strategy in June 2008, the estimated spend for 2008–09 is £959 million.

25. The UK has made a 20 year commitment to UNITAID which could see us providing as much as £760 million up to 2027. Our Research Strategy for 2008–13 outlines how DFID will double its investment in research, including health, to £220 million a year by 2010. The new research strategy includes a focus on developing drugs and vaccines for HIV and AIDS, TB, malaria and other diseases that most affect poor people.

26. New signatories to the International Health Partnership (IHP), launched in 2007, which seeks to strengthen health systems and sector wide approaches, bring the total number of developing countries participating to 13. Country compacts, through which donors commit to coordinated support to national health plans, are now being implemented in Ethiopia, Mozambique, Nepal and Mali. Progress made includes that on simplifying World Bank procurement agreements with UNICEF (to be extended to other UN agencies), and on a joint assessment approach to national health and disease strategies, which integrates work on assessment of HIV/AIDS plans. The Global Fund to fight AIDS TB and Malaria (The Global Fund) piloted the joint assessment approach for its first funding applications based on national disease strategies.

27. An IHP working group on monitoring and evaluation is guiding work to strengthen country health systems surveillance. This work consolidates health systems and disease specific indicators, including those on HIV and AIDS, and makes them accessible to countries and donors.

28. The UK is mobilising support behind the recommendations made by the Taskforce on Innovative International Financing for Health Systems, co-chaired by the Prime Minister, which reported in July to the G8 Summit. The Taskforce report includes recommendations for raising additional finance for health systems, channelling resources effectively, and ensuring effective monitoring and accountability. The UK will contribute towards an expanded International Finance Facility for Health Systems. The UK also strongly supports the recommendation to establish a joint health systems funding platform for the Global Fund, GAVI Alliance and the World Bank.

Examples of the UK's support

29. In **China**: DFID's health programme focuses on pro-poor health system reform and development, TB control and HIV and AIDS control. Our bilateral aid is aligned with the Government of China's priorities: innovation, complementarity, risk taking, and poverty focus. Since 1999, DFID has committed more than £100 million to health and HIV/AIDS support for China. This approach has shown good results. For example, DFID's support to the China Basic Health Services project (£21 million between 1999 and 2007) helped improve access by 47 million people to basic health services in 10 provinces in the mid and west of China. In addition, 12 million of the poorest people enrolled in the medical financial assistance scheme. Independent evaluations have also shown that the project has achieved increased immunisation and promoted birth in hospitals with skilled attendants present, resulting in falls of 40% in maternal mortality in the counties covered.

30. China's HIV and AIDS programmes are well integrated with sexual and reproductive health services. Increasing coverage of services to Injecting Drug Users (IDUs) is currently the highest priority at this stage of the epidemic. DFID has supported pioneering work amongst the most at risk populations, including IDUs. The work consisted of awareness raising, peer-to-peer outreach, needle exchange and methadone maintenance (MMT) treatment. The MMT was particularly successful and in July 2006 was approved by the Chinese Government for nationwide roll-out. By 2007 MMT was being provided through 397 clinics in 22 provinces, with 88,000 IDUs enrolled. Coverage has continued to increase. Accurate figures will be available at the end of 2009.

31. In addition, DFID supports care services for persons living with HIV/AIDS (PLWHA) nationally and in seven provinces. By end 2008 over 31,000 PLWHA were receiving ARVs and over 28,000 received treatment for opportunistic infections, having exceeded targets set.

32. In **Cambodia**: DFID supports the health sector in partnership with the World Bank, AusAID, UNICEF, UNFPA, France and Belgium. DFID has contributed £35 million as part of a pool of over \$130 million to support the government's 2008–15 health strategy. The strategy gives priority to maternal and child services, including reproductive health, for the rural poor and will benefit around 10 million people in 24 rural provinces. The programme will expand successful innovations including health equity funds to pay for hospital costs for the poor, performance based contracts with rural district health service providers and performance pay schemes for staff. Expected outcomes include: 21,000 under five child deaths averted; 1,300 women deaths prevented; increase in the number of women giving birth in a hospital or health centre from 95,000 to 180,000 a year; and increased public primary care and hospital clinic visits from 7.5 million to over 11 million a year.

33. This support includes the training of government staff in safe abortion care and counselling—by end 2008 an additional 129 midwives and doctors have been trained in the delivery of safe abortion care. In addition, DFID supports the government's 100% condom use programme, which is seen as a mainstay of Cambodia's HIV prevention strategy. The expansion of family planning and safe abortion services is expected to contribute to further reductions in HIV prevalence, and to prevention of mother to child transmission of HIV.

34. In **Kenya**: DFID has spent about £25 million on health and HIV/AIDS in 2008–09, focusing on strengthening the delivery of essential health services, health systems, malaria, and reproductive health. The Insecticide-Treated bed-net (ITN) programme delivered DFID's 14 million new bed-nets in March 2009, reducing under five mortality and putting Kenya on-track to meet MDG 6. HIV prevalence has halved in

the last 10 years, from over 10% in the mid 1990s to 5.1% in 2006. DFID support has helped provide anti-retroviral drugs to 230,000 people, and supported provision of home-based care to 64,000 people living with HIV/AIDS and 110,000 orphans and vulnerable children.

35. In Ethiopia under the umbrella of the IHP, DFID has been at the forefront of efforts to help the Ministry of Health establish the “MDG Performance Fund” to support the implementation of the Health Sector Development Programme, focussing on strengthening health systems and services for women and children, including reproductive health, malaria and HIV/AIDS control. Indicative funding of \$240 million has been pledged to the fund over the next three years.

36. In Ethiopia HIV prevalence was 2.1% in 2006–07 with wide variations across regions. There has been a steep increase in the number of people living with HIV who have accessed ART in recent years, with ART now provided free of charge. The number of people started on ART has increased from 8,276 in 2004–05 to 180,000 in 2009. The percentage of people needing ART who are accessing it is estimated at 58%. The health systems’ strengthening initiatives described above have allowed an expansion of health workers and facilities in the country leading to improvements in ARV provision as well as other health essential commodities and services in the country.

37. In **Sierra Leone**, a DFID supported youth reproductive health programme has resulted in a 19% increase in the level of sexually active young people who are faithful to regular sexual partners; and condom use has increased by 36% amongst the group. There was also a 7% increase in young people who were able to identify major symptoms of sexually transmitted infections and an increase of 9% in the number of young people who were able to identify methods of contraception and prevention of HIV transmission.

3. *Integration of HIV/AIDS prevention, treatment and care with other disease programmes, particularly tuberculosis and malaria*

38. *Achieving Universal Access* recognises the important links between AIDS and other diseases and highlights the need for more integrated care. It is too soon to provide a detailed assessment of progress against Strategy commitments in this area. There are, however, important points we wish to highlight to the Committee and, below, we provide country examples that give a flavour of the work we now have in progress.

39. There are particularly close links between HIV and tuberculosis. The AIDS epidemic has been largely responsible for the doubling or tripling of TB incidence rates in Sub Saharan Africa in the last 15 years. About 15% of new TB cases globally are HIV positive; in Sub Saharan Africa it is 70%.

40. At an institutional level, many countries have historically separated TB treatment services from general health services which has made the integration of diagnosis, treatment and care more difficult. There has been great progress in scaling up integrated TB/HIV activities, but these need to be further expanded to cover all cases of co-infection. The majority of HIV-positive TB cases do not know their HIV status, and the majority of HIV-positive TB patients who do know their HIV status do not have access to antiretroviral therapy. The biggest challenge to integration in resource limited settings is human resources.

41. The relationship between malaria and HIV is not as close as that between TB and HIV. But there are nevertheless some important links.

42. For example, malaria increases blood levels of HIV, making patients more than twice as likely to transmit the virus to a sexual partner. HIV also makes people more susceptible to malaria, especially in those with advanced immunosuppression, which may have accelerated the spread of malaria in places where HIV is highly prevalent. For both of these reasons, efforts to prevent and treat one disease will synergistically lower incidence of the other. There is also often little integration between planning and service delivery of HIV/AIDS and malaria programmes—an important issue in the context of shortages of skilled health personnel.

43. *Achieving Universal Access* supports the integration of AIDS services with other health services, including TB. Our commitment to spend £6 billion over seven years to 2015 to strengthen health systems and services, includes the integration of HIV and TB services. We are also committed to work with international partners to support countries with health worker shortages to provide at least 2.3 doctors, nurses and midwives per 1,000 people, which will help build the capacity of health systems to manage HIV and TB co-infection issues.

44. The Global Fund is at the forefront of work on integrating HIV/AIDS prevention treatment and care with that of TB and Malaria. The UK Government have made a long-term commitment of up to £1 billion from 2008–15 to the Fund, in addition to the £6 billion on health systems and services announced in the Strategy. We have provided £524 million to date to support the Global Fund to fight AIDS, TB and Malaria—our principle support to the provision of TB drugs.

45. DFID advocated for further integration of HIV and TB services during the Global Leaders’ Forum on HIV/TB, held at the United Nations on 9 June during which important principles for further progress were successfully negotiated and reflected in the document “Call for Action on HIV/TB.” These include: the need to scale-up efforts to deliver universal access to TB and HIV prevention, treatment, care and support

services by 2015; the need to strengthen health systems and services; the integration of health services, including HIV and TB; and to increase investment and facilitate research to promote development of better tools for prevention, diagnosis and treatment of TB.

46. We will also work to integrate HIV with other disease programmes by: implementing the International Health Partnership (IHP) as described in our response to question 2 above.

Examples of country level support

47. The first formal assessment of progress at country level will be made in our 2010 report. In the meantime, examples of our country work include:

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

49. **Zambia** is implementing two joint HIV/TB projects under the auspices of the Zambia AIDS Related TB (ZAMBART) Project, a collaborative effort between the University of Zambia, School of Medicine and the London School of Hygiene and Tropical Medicine. The work focuses on the overlap between HIV and TB in order to improve the quality of life of people affected by the dual epidemic. DFID is providing £3.75 million to this project for the period 2006–11.

50. We are also providing support directly to strengthen national TB programmes. For example, in **China**, DFID has allocated £23 million over seven years towards reducing TB morbidity and mortality through an effective and sustainable National TB control programme focused on the poor.

4. *The effectiveness of DFID's Strategy in ensuring that marginalised and vulnerable groups receive prevention, treatment, care and support services*

51. In 2006, the Committee focused its inquiry on marginalised groups and emerging epidemics. It identified “four key populations” in which new epidemics were driven: sex workers, injecting drug users, men who have sex with men (MSM) and prisoners.

52. *Achieving Universal Access* makes clear that understanding and addressing the needs of these groups will be fundamental to tackling the epidemic outside Sub-Saharan Africa. The strategy places the needs and rights of these groups at its heart, and we will continue to advocate for increased, evidence-based responses for these groups.

53. *Achieving Universal Access* identifies four priorities for action:

- supporting the empowerment of People Living With HIV (PLWH) and vulnerable groups;
- ensuring that gender analysis is integrated within national AIDS plans, and that targets and indicators are developed to measure the impact of AIDS programmes on women and girls;
- promoting and taking action on neglected and sensitive issues—including adolescents sexual and reproductive health and rights (SRHR); the needs and rights of MSM, and harm reduction; and
- working with our partners to ensure increased action against HIV stigma and discrimination.

54. It includes a specific commitment to work in countries where injecting drugs is a major driver of the epidemic to increase the coverage of harm reduction services for injecting drug users.

55. In addition to ensuring support for groups marginalised by responses to HIV, we need to focus on groups particularly vulnerable to the epidemic. Foremost amongst these are women and girls.

56. It is too soon to provide a detailed assessment of the Strategy's effectiveness in supporting marginalised and vulnerable groups. We will focus on this in future reports. The following examples, however, demonstrate that important work is underway.

Examples of HMG's work with vulnerable populations include

57. Data shows that men who have sex with men (MSM) are nearly 20 times more likely to be infected than the general population in low and middle-income countries. Despite this fact, less than 2% of global funding for HIV-related programming is directed at MSM. In an effort to combat soaring HIV rates among gay, bisexual, and other MSM we have recently (May 2009) approved a grant of £755,000 over three years to the Global Forum on MSM and HIV. This funding will support implementation of a new international advocacy strategy promoting equitable access for MSM to effective HIV prevention, care and treatment services in developing countries.

58. In Nigeria DFID has supported the BBC World Service Trust (BBCWST) to develop radio and television programmes on HIV and AIDS. A subsequent survey estimated that over 12 million vulnerable youths were reached with reproductive health and HIV messages through 6,000 episodes of the radio programmes aired by 95 radio stations across Nigeria. The TV drama “wetin dey” attracted more than 6 million people in nine months.

59. DFID's work on HIV and AIDS in **China** focuses on helping the poorest and most vulnerable people have access to prevention treatment and care. DFID has supported pioneering work with injecting drug users, sex workers and MSM. This has enabled more than 25,000 IDUs receive Methadone Maintenance Treatment, 386,000 people receive VCT, more than 31,000 be put on ARVs, more than 28,000 PLWHAs receive care for opportunistic infections, as well as 212,000 people from high risk populations and 2.2 million youth receive behaviour change communication programmes.

60. In **Pakistan** HIV infection is low among the general population (fewer than 0.55% are infected) but has increased rapidly in groups at high risk of infection, including drug users and sex workers. DFID support to the National AIDS control Programme helps these groups protect themselves and helps control the epidemic. For example, female sex workers are more likely to use condoms: the percentage using a condom during their last sex act increased from 34% in 2005–06 to 45% in 2006–07. Intravenous drug users are more likely to use clean needles and syringes: the percentage using new needles and syringes in the last month increased from 22% in 2005–06 to 48% in 2007–08.

61. In 2008–09, DFID made a substantial contribution to curb the spread of HIV in Vietnam by funding the Government's HIV prevention programme. DFID funding has increased the availability of condoms for sex workers, with over 95% of street-based sex workers and 65% of sex workers working in clubs and bars gaining access. Transmission among drug users drives the country's epidemic. There is compelling evidence¹⁰ that increasing the availability and utilisation of sterile needles contributes significantly to reductions in the rate of HIV transmission. Accordingly, the project distributed 15 million clean needles and syringes to drug users in 2008, an increase from zero in 2004 to 15 million in 2008. The programme now accounts for 75% of all needles distributed across the country. During the year DFID also contributed to the start-up of a long-resisted methadone treatment programme, piloting treatment with 800 patients, and to be scaled up in 2009–10.

62. In **Argentina**, the FCO has sponsored a local NGO to promote humane and evidence-based drug policies in Latin America during a two day regional conference. Supporting this type of events is key from a harm reduction perspective since HIV transmission cannot be reduced amongst IDUs in environments where stigma and discrimination drive government policies.

5. *The effectiveness of social protection programmes within the Strategy*

63. Robust evidence shows that Social Protection can strengthen families affected by HIV and AIDS. A recent review of 300 documents by the International Food Policy Research Institute highlights how 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. That is why *Achieving Universal Access* pledges the UK to spend £200 million on social protection programmes; and to work in at least eight African countries to develop social protection policies and programmes that provide effective predictable support for the most vulnerable households, including orphans and vulnerable children.

65. This policy reflects findings that have come out of the Joint Learning Initiative on Children and AIDS (JLICA) and the Inter-Agency Task Team on children and AIDS sub-group on social protection, for which DFID has been the co-chair. In *Achieving Universal Access*, we promised to review the effectiveness of our approach in meeting the needs of OVCs in the light of the biennial Global Partners Forum (GPF) on Children Affected by HIV and AIDS.

66. At the 2008 GPF, held in Dublin, there was a strong consensus on the need for a stronger focus on comprehensive social protection systems and programmes to support children and families affected by AIDS. In the light of this, we remain confident that our approach is strongly supported by current evidence and emerging global best practice.

67. The need for social protection has become more acute with the global economic crisis. The Government's new White Paper *Eliminating World Poverty: Building our Common Future*, sets out DFID's aim to help build social protection systems to get help to 50 million people in over 20 countries over the next three years. The G20 London Summit agreed to make resources available for social protection to help the most vulnerable, including through contributions to the World Bank's Vulnerability Framework and Rapid Social Response Programme. DFID committed £200 million to the World Bank to support social protection programmes and we are working with the World Bank on how this money will reach the poorest households. Bilateral expenditure on social protection activities in 2007–08 was £45.5 million.

¹⁰ "Policy brief: Provision of sterile injecting equipment to reduce HIV AIDS transmission". WHO 2004.

68. On expanding partnerships to deliver the strategy, DFID is a signatory to the Joint Agency Statement on Child-Sensitive Social Protection, launched by partners (including Unicef and the World Bank) in August 2009.

Examples of country level support to improve social protection policies include

69. Presently, the UK supports social protection responses and social welfare ministries in a range of countries most affected by the epidemic such as Zimbabwe, Kenya, Zambia, Malawi, Rwanda and Mozambique. Bilateral support is also provided via UNICEF's Children and AIDS Regional Initiative (CARI), covering South Africa, Botswana, Angola, Namibia, Swaziland and Lesotho. DFID also supports the provision of south-south technical support on social protection system development from the Government of Brazil to Kenya, Ghana, Angola and Mozambique.

70. In **Kenya**: DFID supports (£122.6 million over 10 years) cash transfers for orphans and vulnerable children, a Social Protection strategy, and a Hunger Safety Net Programme in fragile pastoralist arid areas (450,000 people). This uses innovative private partnerships and technology for transfers to enhance poor people's inclusion and access to local markets.

71. In **Mozambique**: DFID has made a long-term commitment (£20 million over the period 2008–18) to help the Government improve and expand its unconditional cash transfer programme for vulnerable households, mainly headed by older women caring for orphans and vulnerable children (expected to reach 500,000–700,000 beneficiaries), and to help develop a strategic framework for social protection.

72. In **South Africa** results from the Kwa-Zulu Income Dynamics Study contributed to a better understanding of the impact of social grants on child welfare outcomes, such as better nutritional status and lower incidence of stunting. This evidence has helped accelerate the extension of the child support grant to 12 million recipients.

73. In **Botswana**, DFID's support through UNICEF's CARI, has provided a social policy adviser to the Department of Social Welfare for 12 months, and has supported a review of direct social assistance programmes, with government shifting from provision of food baskets to coupons for households caring for orphans.

6. *Progress towards the commitment to universal access to anti-retroviral treatment and its impact on the effectiveness of care and treatment, particularly for women*

74. While significant progress has been made in improving access to HIV treatment over recent years, 70% of people who need the drugs still cannot get them. Access to anti-retroviral treatment (ARVs) for all who need them is a key element of Universal Access. We seek to address this through our long-term support to the Global Fund, our research programme and our health systems strengthening work.

75. *Achieving Universal Access* commits the UK to work with others to reduce drugs prices. DFID is collaborating with the Clinton Foundation HIV/AIDS Initiative (CHAI) on a project to reduce the prices of key first and second line ARVs for AIDS (and also anti-malarial drugs). We have also supported UNITAID's efforts to develop an operational plan for a patent pool for ARVs.

76. This project seeks to improve the affordability, availability and level of quality assurance for AIDS and malaria drugs provided by Indian and other manufacturers, and to increase capacity in African countries to access these drugs. This complements efforts by governments, international agencies and regional groupings to strengthen programmes for the control of AIDS and malaria. A key target of the three year programme is to help reduce spending on ARVs by more than \$100 million by 2011 in low and middle income countries (other than Thailand and Brazil), compared to what would have been spent for the same medicines in 2008.

77. On 6 August 2009, the Clinton Foundation announced two important and complementary agreements between CHAI and pharmaceutical companies, as a result of the work part-funded by DFID (£9 million between 2008–09 and 2011–12). These agreements will result in better and more affordable second-line treatment options:

- agreement with Matrix (an Indian generic drug manufacturer) to provide a once daily four drug second line therapy at \$475 per annum in 2009, and \$425 per annum in 2010. For the first time, a second-line ARV regimen will be available for under \$500 annually; and
- agreement with Pfizer to provide the TB drug rifabutin at \$1 per 150mg dose (\$90 for a full six month treatment). Treatment with rifabutin avoids complications with important second line drugs that people with HIV may be taking. This means the cost of the most effective treatment for TB in patients using second-line ARVs has been reduced substantially. TB is the leading killer of those living with HIV.

 FOCUS ON WOMEN

78. *Achieving Universal Access* highlights the particular challenge of improving access to ARVs for HIV positive pregnant women, in order to prevent transmission to the unborn child. Latest data show encouraging trends in the expansion of Prevention of Mother to Child Transmission (PMTCT) services for women and children. However, we are still far from reaching the 80% target set by 2010 and more needs to be done. Working with others at national and international level, the UK is strongly committed to strengthening efforts to scale up PMTCT services.

79. Mother to child transmission of HIV has been virtually eliminated in developed countries. This is because in these countries, women of reproductive age have access to high quality family planning and maternity care services into which HIV prevention, treatment and care has been integrated. DFID works to ensure that women in poor countries have the same choices and opportunities.

80. Through the High Level Task Force for Innovative International Financing for Health Systems, which the Prime Minister co-chairs with Robert Zoellick, we are also leading efforts to secure additional resources to help countries build the stronger health systems required to make durable progress on maternal and newborn mortality, including through enhanced access to PMTCT services.

81. We also provide core funding to UNICEF, WHO, and UNAIDS (US\$ 42.3 million, US\$54.7 million and US\$38 million respectively per year), working to end mother to child transmission of HIV. In addition to core funding, DFID has provided more than US\$1.5 million to an “Accelerating Action for Children Affected by HIV and AIDS” programme. DFID has also recently become a member of the Inter-agency Task Team on Prevention of Mother to Child Transmission (co-convened by UNICEF and WHO). And on 21 May we held a consultation with UK stakeholders in collaboration with the AIDS Consortium to discuss ways to accelerate the scale up of PMTCT services.

82. More broadly, the Strategy recognises gender inequality as a key driver of HIV infection and regards empowering women to negotiate safer sex as a key element of prevention. In our evidence to last year’s inquiry, we pledged support for UNAIDS advocacy for women and girls, including the development of gender guidelines to help countries assess and mitigate the impact of AIDS on these and other vulnerable groups. We are delighted that these guidelines were agreed at the UNAIDS Programme Coordinating Board (PCB) in June this year.

83. It is worth noting that efforts to improve access of ARV for women globally have received particular attention. In fact, emerging evidence suggests that the international community has been more successful at providing ARV to women than to men.¹¹

Examples of country level support

84. In **Zambia** DFID has provided financial and technical support (£20 million, 2003–09) to strengthen coordination and the expansion of PMTCT services through the “Strengthening the AIDS Response” (STARZ) programme. This support included training 520 provincial trainers, developing a communication strategy and 100 community meetings conducted in 12 of the 72 districts. By December 2006, 500 public facilities in districts were providing PMTCT services representing a 262% increase from 2004, while 80,000 pregnant women were being tested for HIV, representing a 29% increase from 2004. The overall percentage of HIV-positive pregnant women who received ARVs increased from 18% in 2004 to 47% in 2007.

85. DFID is now providing £5.5 million to support a multi-sectoral response to tackling HIV, including support for further expansion of PMTCT services. New figures for PMTCT coverage will be available later this year.

86. Access to ARV treatment for other PLWHA has also expanded significantly, with 200,000 people receiving ARV at the end of 2008, compared to just 3,000 in 2003.

87. In **Zimbabwe** DFID is providing £25 million to support a programme which addresses maternal and newborn health, including HIV/AIDS. A key component has been to maintain access to family planning—the rate of contraceptive prevalence in the country has increased from 55% in 1999 to 60% in 2006 and continues to increase, even as the economy and most basic services have declined. HIV prevalence rate has declined from 18.1% in 2006 to 15.2%¹² in 2008, partly due to the high availability of male and female condoms. DFID’s contribution to the Expanded Support Programme for HIV and AIDS has given access to ARV treatments for more than 25,000 people.

88. Similar work supported by DFID in other focus PSA countries is also achieving significant results. In **Malawi** for example, access to ARV has increased dramatically from 3,000 in 2003 to over 147,000. DFID Malawi is contributing £14 million to the national response over four years, seeking to ensure that there is a proper balance between prevention, treatment and care.

¹¹ *The Lancet*, Vol 374, July 2009.

¹² Report on the Global Epidemic, 2008.

89. And in **Mozambique**, DFID's support has contributed to an increase in the number of health units offering PMTCT services from 386 in 2007 to 744 in 2008. As a result, the number of HIV positive pregnant mothers receiving treatment to prevent HIV transmission to their babies increased from 24,320 in 2007 to 46,848 in 2008. The total number of patients receiving ARV has also increased dramatically, from zero in 2001 to 118,937 in 2008.

Supplementary written evidence submitted by the Department for International Development

November 2009

Thank you for inviting me to give evidence to the International Development Committee inquiry on HIV and AIDS. During the session, I promised to write to you with further details of the composition and funding of the Informal Cross-Whitehall Group on Tackling HIV & AIDS in the Developing World.

I attach the latest terms of reference for this group. Core members are DFID, the Foreign and Commonwealth Office, the Department of Health and the Home Office, although other Departments can be involved as required. As an informal coordination group, it has no dedicated budget. The costs, which are largely staff time, are met from existing resources.

The group is next due to meet in December. I will ask them to consider how best to address the concerns about transparency that were raised at the evidence session.

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Mike Foster

TERMS OF REFERENCE

THE INFORMAL CROSS-WHITEHALL GROUP ON TACKLING HIV AND AIDS IN THE DEVELOPING WORLD

OBJECTIVES

1. To support implementation of "*Achieving Universal Access: The UK's strategy for halting and reversing the spread of HIV in the developing world*" by monitoring the commitments set out in the strategy, in line with the plans set out in the associated monitoring and evaluation document.
2. To exchange information about policy initiatives and directions related to *Achieving Universal Access* and other related issues.
3. To identify opportunities for closer co-operation across departments to maintain UK and International political momentum, provide briefing, and consider new policy directions.
4. Where necessary and appropriate, explore and resolve issues of potential incoherence between domestic and international policies relating to HIV and AIDS. These issues can be proposed by members of the group, or by external stakeholders (eg civil society, parliamentary committees).
5. Where appropriate ensure coherence with other related HMG policies and strategies and seek opportunities to exploit synergies between them.
6. To link with existing Whitehall coordination mechanisms including the Access to Medicines Working Group, and the Government's Global Health Strategy, "*Health is Global*".

MANAGEMENT ARRANGEMENTS

- The Secretariat for the Cross-Whitehall Working Group on tackling HIV and AIDS in developing world will be provided by DFID.
 - The Group will meet up to 4 times each year, with those Departments who have made explicit commitments in *Achieving Universal Access*. One of these meetings will include representatives from a wider group of Departments.
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Written evidence submitted by the Global Fund

1. The Global Fund to fight AIDS, Tuberculosis and Malaria (TGF) is an international health financing mechanism dedicated to attracting and disbursing additional resources to prevent and treat HIV/AIDS, Tuberculosis and Malaria. Created in 2002, as a public private partnership it has to date committed US\$ 15.6 billion in performance based program funding for approximately 140 countries. To date, the Global Fund supported-programmes have saved 3,000 lives a day. 2.3 million people are under ARV treatment. 5.4 million are receiving effective TB treatment, and the Global Fund is a sole financier of Extreme Drug-Resistant TB programs. Evidence from several malaria endemic countries shows declines in malaria cases and child mortality of up to 50% where high coverage of effective prevention and treatment has been achieved, including in Rwanda, Zanzibar, Eritrea and Burundi. The Global Fund plays also a critical role in harm reduction and TB treatment being the largest or sole financier.

2. The Global Fund welcomes the opportunity to provide evidence and information on the implementation of the UK strategy for halting and reversing the spread of HIV in the developing world. As a financing institution that relies on its many public, private and civil society partners for program implementation, the Global Fund has no field representation. Thus it can report primarily on how DFID's active engagement in the Global Fund Board and Committees have contributed to the Global Fund's operational policies and funding decisions and less on how the strategy is being implemented at the country level.

3. The technical leadership and financial support that the UK has provided to the Global Fund since its inception in 2002 should be underlined. It is the third largest donor to the Global Fund having contributed £ 414 million (or US\$ 660 million) up until the end of 2008. Under a long term Memorandum of Understanding (MOU), the UK has pledged a further £1 billion for the period 2009–15, of which £115 million has already been received. This represents a strong commitment to the Paris Declaration on Aid Effectiveness and the Strategy's objective of "providing long-term, performance-based and predictable resources to countries and partners in support of a sustainable global response to AIDS beyond 2010". DFID is working together with the Secretariat of the Global Fund to explore methods to achieve further multi-annual pledges from other donors.

4. In line with its approach to multi-year funding, the above UK pledge is conditional upon evidence of high quality demand, strong performance and sustainable impact. This approach is very much in line with several of the founding principles of the Global Fund as regards transparency, accountability and performance based funding. Under the MOU, a logical framework is being finalised based on agreed key performance indicators that will allow verification that the conditions for the UK pledges have been met. The MoU has also led to a commitment for reinforced cooperation between DFID and the Global Fund at the country level in search of greater efficiency gains.

5. While the financial support and the predictability it provides has been greatly appreciated, the UK's contribution to the Global Fund's policy agenda has been equally valuable and follows many of the objectives set out in the strategy. Some of the main contributions are listed under the relevant issues below.

Progress on Health Systems Strengthening (HSS) and on an integrated approach to HIV/AIDS funding

6. DFID has been a vocal supporter of HSS in the Global Fund Board and the Fund remains committed to providing resources for HSS. To date, some US\$ 4.2 billion or 35% of TGF funding has been invested into HSS efforts in support of the fight against the three diseases through two different mechanisms, either through grants in single disease areas or through cross-cutting HSS section attached to a disease proposal.

7. DFID has been extremely supportive of the ongoing discussions between the World Bank, GAVI and the Global Fund, which aim to better align the respective HSS frameworks. This would allow for joint HSS funding and programming in support of nationally owned development plans.

8. The Global Fund is a strong supporter of the International Health Partnership (IHP) mechanism and has signed the IHP Global Compact. The Global Fund is an active participant in the HIP Scaling-up Reference Group and contributes also to the working group on National Strategy Application (NSA) and to the one on Monitoring and Evaluation. The Global Fund has adopted the Paris Declaration on aid effectiveness and is measuring itself against the Declaration targets. In that spirit, the Global Fund is currently piloting funding of NSA, applications based on National Strategies validated by civil society and development partners in the field. It also continues to working on improving harmonization and alignment through the review of its architecture for a simplified and greater alignment which should be implemented starting 2010.

Integration of HIV/AIDS prevention, treatment and care with other disease programmes, particularly tuberculosis and malaria

9. As a co-signatory of the Paris Declaration, the Global Fund has adopted the performance indicators on harmonization and alignment, including the conclusion of TGF funded programs into National Budgets. This is a critical step to ensure integration with National Health Plans.

Progress on work involving marginalised and vulnerable groups

10. DFID highlights the need for priority actions for the empowerment of people living with HIV and promotion of the rights and care of marginalised and vulnerable groups. In relation to the Global Fund, this commitment has been evident in the Board discussions on the "Gender Equality Strategy" and "Sexual Orientation and Gender Identity Strategy" (SOGI). Following their approval in November 2008 and May 2009, respectively, the Global Fund has been working on implementation plans and will shortly begin concrete activities.

11. Those two strategies were elaborated to encourage a positive bias in funding towards programs and activities that address gender inequalities and strengthen the response for vulnerable and marginalised groups, including addressing needs of women and girls, men who have sex with men (MSM), transgender, bisexual, and lesbian populations.

12. In 2008, the Global Fund has made further efforts by including gender related questions in the forms and guidelines to countries wishing to submit proposals for Global Fund financing. Some UN agencies, Civil society organisations—including those supported by DFID and other bilateral organisations, assisted countries to target gender related issues in their proposals such as Sexual and Reproductive Health and HIV integration for better and effective access to prevention service. The Global Fund has also increased the number of harm reduction proposals for injection drug users and is now the largest supporter of harm reduction intervention in the world with nearly US\$ 900 million committed to grants that include harm reduction.

Progress towards the commitment to universal access to Antiretroviral Treatment (ART) and its impact on the effectiveness of care and treatment, particularly for women

13. By end 2008, the Global Fund supported comprehensive AIDS treatment programmes in 137 countries. It is a major contributor to treatment scale-up, presently supporting around 50% of all people on antiretroviral treatment globally, around 50% of those on treatment in Africa and, if Thailand is excluded, about 75% of those on treatment in Asia. ART coverage in low and middle-income countries stood at 42% of a total of 9.5 million people in need, up from 33% at end 2007. Coverage was slightly higher among adult women (45%) compared to adult men (37%). At the end of 2008, an estimated four million people were receiving ART worldwide, half of them through the Global Fund's investments.

Written evidence submitted by Help the Hospices

30 September 2009

ABOUT HELP THE HOSPICES

Help the Hospices is the UK national charity for the hospice movement. Help the Hospices' international programme supports the development of hospice and palliative care worldwide through advocacy, information, organisational development support and grants.

Help the Hospices is a member of and provides the secretariat for the Worldwide Palliative Care Alliance, a network of hospice and palliative care organisations around the world.

GENERAL COMMENTS ON THE STRATEGY

In the HIV strategy, Help the Hospices welcomed the inclusion in DFID's HIV strategy of a priority action "supporting international, national and community-level strategies for care, including palliative care, that promote and protect human rights and that relevant to the local epidemic."

The recognition that "good quality palliative care and home-based care must be made more available as part of a comprehensive approach to AIDS services" was welcomed as was the acknowledgement that "oral opiates, including oral morphine, must be made routinely available for pain management" was also welcomed.

SUMMARY OF MAIN POINTS AND RECOMMENDATIONS

1. We are keen to see the publication of the baseline study and how DFID will measure progress in relation to their priority action around supporting international, national and community level strategies for care, including palliative care for people living with HIV.

2. We urge DFID to be transparent and open about the work they are undertaking to meet their priority objectives and to make this information more easily accessible.

3. We urge DFID to hold regular meetings with civil society in the UK to ensure we, and our partners worldwide, are well informed and can support DFID meet their objectives.

4. We welcome DFID's continued role working with the UK Consortium on AIDS and International Development.

ABOUT HOSPICE AND PALLIATIVE CARE AROUND THE WORLD

Palliative care and HIV

Palliative care

Palliative care is a vital component of the overall continuum of care for people living with and affected by HIV, and should be an integral part of a comprehensive public health approach.

The World Health Organization (WHO) defines palliative care as "an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual."

“Palliative care is an essential component of a comprehensive package of HIV/AIDS because of the variety of symptoms they can experience—such as pain, diarrhoea, cough, shortness of breath, nausea, fatigue, fever and confusion. At the community level, lack of palliative care places an unnecessary burden on hospital or clinic resources.” WHO definition of HIV palliative care

Palliative care adopts a comprehensive approach to the care and support of patients, families and carers including pain and symptom control, end of life care, psychosocial, spiritual and bereavement support. It is delivered from the point of diagnosis alongside curative treatment until the end of life. A number of models have been developed around the world utilising the skills of healthcare professionals, community health workers, volunteers, families, friends and carers.

Palliative care is provided in a variety of settings including hospitals, residential hospices, community health centres and the home. In resource-limited settings, the focus is largely on community and home-based care. Palliative care is delivered in government health systems as well as voluntary and faith-based health systems.

1. *Palliative care and HIV*

Palliative care is universally recognised as an essential component of the HIV treatment and care continuum and yet UNAIDS acknowledges that it “*is one of the most neglected aspects of healthcare*”.¹³ The benefits of palliative care in supporting people living with HIV have a strong evidence base and are recognised around the world.

Palliative care and treatment

Palliative care supports adherence treatment¹⁴ and should be delivered alongside treatment from the point of diagnosis as:

- there is a high prevalence of pain and symptom throughout the trajectory of the disease which needs to be controlled;
- anti-retrovirals (ARVs) are associated with high symptom prevalence and burden;¹⁵
- physical, psychological and global symptom burden is associated with poor adherence; and
- late presenters require advanced disease care.

Palliative care and prevention

- Hospice and palliative care team visits to a family member or community member living with HIV can be one of the most effective times for teaching prevention and behavioural change.
- Hospice and palliative care outreach programmes can reach large numbers of HIV patients, particularly the most stigmatised and marginalised, in both urban and rural settings.
- Hospice and palliative care is often an entry point for voluntary counselling and testing programmes.
- Hospice and palliative care can help to reduce stigma in communities.

Palliative care at the end of life

AIDS continues to be a life-threatening disease. The reality is that many patients do not have access to ART, have developed problematic or even life-threatening complications from ARVs or are no longer able to take them. AIDS patients often present late and palliative care is the only option. It provides:

- compassionate care;
- pain control;
- control of distressing symptoms;
- emotional, social and spiritual support to patients; and
- bereavement support for families and carers.

¹³ UNAIDS. *Palliative Care* [online]. Available from: http://www.unaids.org/en/Issues/Prevention_treatment/palliative_care.asp [Accessed 23 July 2008].

¹⁴ Harding R, Norwood S, Leake-Date H, Fisher M, Edwards S, Arthur G, Anderson J, Johnson M. Successive switching of anti-retroviral therapy is associated with high psychological and physical burden. *International Journal of STD & AIDS* 2007; 18(10):700–704.

¹⁵ Harding R *et al.* Is antiretroviral therapy associated with symptom prevalence and burden? *International Journal of STD & AIDS* 2006; 17(6):400–405.

2. *Hospice and palliative care and HIV—what needs to be done?*

While palliative care is acknowledged in many national, bilateral and multilateral HIV policy and strategy documents, there is a long way to go to make hospice and palliative care accessible to all. The following actions need to be taken:

- Eliminate barriers in the laws and regulations for effective use of opioid analgesics such as morphine.
- Make palliative care drugs, including oral opioid analgesics available and accessible.
- Awareness of and commitment to palliative care by bilateral agencies, multilateral agencies, International NGOs, Civil Society, funders and governments.
- Clarity of terminology in international and national strategy and policy documents on the package of care, and the role of palliative care within it.
- Inclusion of palliative care in Government health policy and systems, HIV national strategies and National Cancer Control programmes.
- Integration of palliative care in undergraduate and postgraduate curricula of medicine, nursing, research, and other disciplines.
- Training, support and supervision of community health workers and non-professional caregivers.
- Evidence-based research on palliative care.

3. *An innovative example of hospice and palliative care service delivery*

Uganda

Hospice and palliative care services began with the founding of Hospice Africa Uganda in 1993. After extensive advocacy, the Government of Uganda included palliative care as an essential part of its national health policy and strategic plan in 2000. Morphine is provided free of charge by the Government. In March 2004, a Statutory Instrument was signed by the Minister of Health authorising palliative care nurses and clinical officers to prescribe morphine as part of their clinical practice, thereby increasing access to palliative medication.¹⁶

4. *Further information*

For more information about hospice and palliative care around the world, please contact the following organisations:

Worldwide Palliative Care Alliance www.thewpca.org

International Association for Hospice and Palliative Care www.hospicecare.com

REGIONAL HOSPICE AND PALLIATIVE CARE ASSOCIATIONS

African Palliative Care Association www.apca.co.ug

Asociación Latinoamericana de Cuidados Paliativos <http://www.cuidadospaliativos.org/>

Asia Pacific Hospice Palliative Care Network www.apfn.org

European Association of Palliative Care www.eapcnet.org

National Hospice and Palliative Care Organization (US) www.nhpco.org

Canadian Hospice Palliative Care Association www.chpca.net

Written evidence submitted by Interact Worldwide

1. Interact Worldwide welcomes the opportunity to feed into the inquiry. We are a UK based NGO working in sexual and reproductive health and rights and HIV and AIDS with implementing partners in developing countries including Ethiopia, India, Malawi, Uganda and Pakistan. Our partners are engaged in efforts to scale up a comprehensive and integrated response to sexual and reproductive health, including maternal health and HIV services.

2. Interact Worldwide will comment on the following questions raised by the IDC:

- the process established by DFID for monitoring the performance and evaluating the impact of the Strategy;
- progress on health systems strengthening and on an integrated approach to HIV/AIDS funding;
- integration of HIV/AIDS prevention, treatment and care with other programmes;

¹⁶ Wright M and Clark D. *Hospice and palliative care in Africa*. Oxford: Oxford University Press; 2006.

- the effectiveness of DFID’s Strategy in ensuring that marginalised and vulnerable groups receive prevention, treatment, care and support services; and
- progress towards the commitment to universal access to anti-retroviral treatment and its impact on the effectiveness of care and treatment, particularly for women.

The process established by DFID for monitoring the performance and evaluating the impact of the strategy

3. As members of the IDC are aware, last November DFID released a document setting out the process they will use to evaluate the impact of their HIV and AIDS strategy *Achieving Universal Access*. In it DFID commits to producing a report every two years, with the first one due at the end of 2010, as well as a mid-term evaluation to take place in 2011. Below, we give some comments on the technical details of the process and on our concerns in relation to what exactly is to be monitored.

4. The biennial reports which DFID propose will give an overview of their work at country, regional and multilateral level and will highlight successes, challenges and areas for future action. Progress will be assessed against the priorities identified in *Achieving Universal Access*, as well as against the DFID Corporate Performance Systems and international targets such as the MDGs, UNGASS targets etc.

5. While limiting reporting to every two years will make it difficult for civil society to gain an up to date understanding of what progress DFID is making, given DFID’s limited staff capacity on HIV and AIDS Interact Worldwide is broadly supportive of this proposal. We would emphasise the need for open communication between DFID staff and civil society in the period between reports, so that an accurate understanding of DFID’s commitments is possible, leading to more fruitful dialogue in national and international forums and deepened partnerships in developing countries.

6. As mentioned above, DFID is also proposing a mid-term evaluation to take place in 2011. They have suggested that a representative of civil society with expertise in monitoring and evaluation will be included in the evaluation team. Interact Worldwide would like to make some basic points concerning this evaluation:

- The evaluation should focus on lessons learnt from the first stage of the strategy’s implementation, and the follow up process needs to ensure that these lessons are translated into changes in the second stage. It is particularly important that any evaluation be completed and a follow up action plan drawn up and implemented early in the strategy’s lifetime.
- There appears to be some overlap between the functions of the mid-term evaluation and the biennial reports, with both appearing to include a monitoring and an evaluation component. It may be more strategic for DFID, given limited resources, to focus on making the most of the biennial reports and ensuring that recommendations from these are followed through.
- Civil society involvement in any monitoring and evaluation process needs to be as open and transparent as possible. To this end, civil society should be able to select its own representative (according to skills criteria set out by DFID) and where possible civil society representatives should be able to engage in dialogue with their colleagues in the wider NGO community.

7. Beyond the technical process, Interact Worldwide also has some concerns relating to the criteria against which DFID’s work will be evaluated. The priorities and some of the key actions proposed in the monitoring and evaluation framework are open to broad interpretation. For example, by pointing to relatively general activities many country offices will be able to say they have met targets to “support the empowerment of people living with HIV and vulnerable groups” and “promote and take action on neglected and sensitive issues including adolescents’ sexual and reproductive rights”. Interact Worldwide would have liked the monitoring and evaluation framework to be based on more specific and measurable targets, as this would have provided for a more robust assessment framework. The vagueness of the DFID priorities makes it all the more important that country offices are encouraged to develop their own detailed targets and indicators, and that the reporting and evaluation processes focus on outcomes.

8. This point links in to the issue of data collection. In the past, DFID have had difficulty tracing exactly where their money is going and particularly whether it is bringing benefit to vulnerable and marginalised groups. It is important that DFID reporting systems can establish where money has gone and who has benefited.

Progress on health systems strengthening and on an integrated approach to HIV/AIDS funding

9. Interact Worldwide would first like to make a general comment on integrated funding. During last year’s IDC enquiry many organisations raised concerns about the use of a single funding target for health systems including the HIV response. While a strong health system is a key component of the AIDS response, other sectors including education, legal reform, women’s empowerment and poverty alleviation all have a role to play, as do non state actors such as NGOs, social movements and community based organisations. While we have been assured by DFID staff that these sectors are continuing to receive DFID funding it is unclear what funding commitments have been made with in other sectoral lines of the DFID budget and whether these are sufficient for the project cycle of the HIV and AIDS strategy.

10. Until DFID's first progress report is released it will be difficult to comment in detail on their efforts in terms of health systems strengthening and funding, and whether this has led to improvements in service delivery and access. However, we can comment on DFID's work with bodies including the International Health Partnership, the World Bank and the Global Fund for AIDS, TB and Malaria.

The International Health Partnership and related initiatives (IHP+)

11. The IHP+ was launched in 2007 and aims to improve the way international agencies, donors and developing countries work together to develop and implement national health plans. It aims to harmonize funding around a single national health strategy, thus reducing the administrative burden for country governments and promoting long term planning. While development of the national health plan is country-led, donors including DFID play a role in inputting into this process.

12. While Interact Worldwide supports the IHP+ goals in terms of harmonization and improving effectiveness, we are concerned that in some cases the IHP+ has led to a marginalisation of sexual and reproductive health, an area that links closely to HIV and AIDS. For example a study completed by Interact Worldwide in Ethiopia earlier this year (attached) found that scaling up reproductive health services had not received sufficient attention in the IHP+ country compact. Moreover, the national health plan had not linked with existing reproductive health initiatives including the UNFPA Global Programme on Reproductive Health Commodity Security.

13. While focusing on health systems strengthening, it is critical that health planning efforts (including through initiatives like the IHP+) lead to gains in specific health areas such as HIV, sexual health, family planning etc. This is in line with the fifth Paris Principle—managing for results.

14. Within the IHP+ system basic criteria already exist against which national plans are assessed, and better results could be assured through the inclusion of criteria on reproductive health and its integration with HIV services, as well as on ensuring access to services for vulnerable and marginalised groups. As DFID sit on the board of the IHP+ this is something that they could push for at international level.

The World Bank

15. A recent study by its own evaluation office (EIG) found that up to one third of funds that went to the World Bank's Health, Nutrition and Population Programme had been spent ineffectively. The EIG report highlighted major blockages around performance, ensuring outcomes that benefit the poor, monitoring, accountability, risk assessment, efficiency and coordination with other sectors. The study recommended that the Bank take the following measures in order to improve its performance:

- Intensify efforts to improve its performance.
- Renew its commitment to delivering results for the poor, including greater attention to reducing high fertility and malnutrition.
- Build its own capacity to help countries make health systems more efficient.
- Enhance the contribution of other sectors to HNP outcomes.
- Improve evaluation and governance.

16. As a major donor to the World Bank, DFID should take action to ensure these recommendations are followed up. Moreover, given these findings we would urge the UK government to reconsider its reliance on the World Bank to deliver for the health sector overall and for SRH.

The Global Fund for AIDS, TB and Malaria (GFATM)

17. The GFATM has played a vital role in generating increased ODA targeted towards meeting MDG 6. To date, the GFATM has approved funding of US \$11.4 billion for 550 programmes in 140 countries. It provides a quarter of all international financing for AIDS, two-thirds for TB and three quarters for malaria. In addition, the GFATM has developed a range of policy initiatives to enhance country-led efforts to address the target diseases and benefit other health indicators, including:

- Explicit recognition and funding opportunities to support the strengthening of public, private and community health systems. Funding can support strengthening of systems where weaknesses and gaps constrain the achievement of improved disease outcomes.
- Adoption of a strategy for Gender Equality which guides Global Fund efforts to encourage a positive bias in funding programs and activities that address gender inequalities and strengthen the response for women and girls.
- An explicit recognition of the importance of linking sexual and reproductive health and rights and the three diseases. The Gender Equality Strategy and materials supporting proposal development highlight the importance of increased linkages. They state that funding can be requested to provide access to HIV prevention through integrated health services, especially for women and adolescents through reproductive health care. More funding has been secured in recent Rounds for RH commodities including contraceptives.

- A separate but complementary strategy on Sexual Orientation and Gender Identities was approved and should support community organisations targeting HIV prevention within vulnerable communities.
- Explicit recognition of and funding to support community systems involved in the responses to the three diseases. Scaling up the response to the three diseases will not be successful without strengthened community systems.

18. A key challenge for the GFATM at present is a severe funding shortfall, which will impact on the amount of grants that can be fully funded. This sends a worrying message to countries looking to the Global Fund to provide sustainable funding for life-saving interventions. Donors must help to fill the gap by paying their fair share.

19. The Secretary of State has indicated that there will not be an additional UK pledge beyond the £1 billion announced at the launch of the strategy to cover the period 2008–15. Interact Worldwide and colleagues have called on the UK to increase its pledge for the period up to 2010 by £183 million, on top of our current pledge of £360 million for that period. This is the UK's fair share based on our share of total donor income (5.7%).

20. Alongside considering increases to their financial contribution, the UK can provide key technical assistance to civil society and ministries in their country level roles in order to ensure they are requesting GFATM funds for programmes which integrate HIV, reproductive health and gender.

Integration of HIV/AIDS prevention, treatment and care with other disease programmes, particularly tuberculosis and malaria

21. On the question of how HIV and AIDS responses are being integrated with other health services, we must broaden the set of cohorts to include sexual and reproductive health and rights (SRHR). Causes of poor SRHR and HIV and AIDS are intimately related and have common drivers: poverty, gender inequity, marginalisation, stigma, discrimination and denial. To separate the responses divorces them from the reality in which sexual and reproductive behaviour takes place and is, in turn, contributing towards the lack of progress being made to address issues such as maternal death, unintended pregnancy and HIV and AIDS. Indeed, the revised strategy states as a priority “supporting the integration of HIV and AIDS with TB, malaria and SRHR including maternal, newborn and child health services”.

22. While limited information will be available until next year's report, Interact Worldwide has some concerns around the declining emphasis placed on SRHR services in the context of health systems strengthening. As set out above, evidence from an Interact Worldwide study in Ethiopia found that SRHR services had been marginalised in the national health plan and harmonisation between reproductive health initiatives and the IHP+ country compact had not taken place. Furthermore, the commitment in DFID's Strategy to “work with others to intensify international efforts to increase to 80% by 2010 the percentage of HIV infected pregnant women who receive ARV treatments to reduce the risk of mother to child transmission” seems to construe PMTCT narrowly as the provision of drugs to prevent vertical transmission and does not consider the full scope of interactions between HIV and sexual, reproductive and maternal health.

23. WHO guidelines state that comprehensive PMTCT also includes delivery and post-partum care, HIV treatment for women, infants and their families as appropriate, SRH services including family planning and dual protection advice for women and their partners. PMTCT services should also recognise the high levels of violence faced by women in some countries and adapt the way they work accordingly.

24. Services which meet a wide range of needs are more likely to be taken up by women, leading to better health outcomes for women, their partners and children. By limiting its approach to a narrow definition of PMTCT services the UK is failing to reach vulnerable women. This is worrying given that the UK is leading an EU wide action team on HIV prevention, focussed on PMTCT. Interact Worldwide and others raised these issues at a recent Open Space Day on PMTCT at DFID but there has been little communication on how discussions from that day will influence DFID policy going forward.

The effectiveness of DFID's strategy in ensuring that marginalised and vulnerable groups receive prevention, treatment, care and support services

Women and girls

25. The recent DFID White Paper announced a tripling of funding for security and justice, with an emphasis on preventing gender based violence, to £120 million per year. This is a welcome announcement which we hope will lead to a reduction in all forms of sexual and gender based violence.

26. DFID's strategy acknowledged that women and girls increasingly bear the brunt of HIV and AIDS and recognised that this was largely due to the denial of women's rights. Violence against women was flagged as a particular concern.

27. The implementation framework accompanying the strategy pledged to ensure inclusion of targets and indicators on women and girls in national AIDS plans. While this commitment was made over a year ago, we have no information on whether countries have developed these targets and indicators. We believe that DFID should be leading by example by ensuring these indicators are speedily developed and then showcasing them in order to encourage other countries to follow suit.

28. DFID also pledged to work with others to halve the unmet need for family planning including male and female condoms by 2010, and to achieve universal access to contraception by 2015. This target has the potential to yield considerable results in improving the status and health of women and girls. Yet currently DFID has an outdated position paper on sexual and reproductive health and rights which is not considered a comprehensive approach to fulfilling the International Conference on Population and Development Programme of Action. A new maternal health strategy was due this year—which may have dealt with family planning and a range of SRHR interventions—but Ministerial approval to postpone this strategy until 2010, most likely after the next general election, has now been given.

29. In this context, it is unclear how DFID plan to meet their commitment on family planning and indeed what they have done so far on this target. In fact, many organisations working on SRHR are hearing from partners in developing countries that the growing emphasis on health systems strengthening on the part of donors is actually leading to reduced investment in vital services such as family planning.

30. Increasing access to female condoms—the only female-initiated method which protects against both STIs and unintended pregnancy—is particularly important. Currently demand for the female condom far outweighs supply yet this commodity is not prioritised on country procurement lists and is largely overlooked by donors and UN technical agencies. One obstacle is cost; the average price of a female condom is 40 pence—up to 30 times more expensive than a male condom.

31. The UK could take a number of steps in order to comply with its commitment on female condoms including:

- Working with others to bring down the cost of female condoms and to assure supply sustainability through UNITAID and Access RH, an initiative of the Reproductive Health Supplies Coalition which DFID now chairs.
- Providing sustainable funding for female condom programmes both in terms of helping to create demand and in funding supplies.

Men who have sex with men

32. Receptive anal sex is a sexual behaviour that increases risk of HIV transmission exponentially. Yet in many societies, discrimination and social marginalisation prevents men who have sex with men (and other sexual minorities) from accessing the services they need within the health system. Criminalisation of same sex relations can also deter men who have sex with men from being open with health workers about their sexual behaviours and health needs. The resulting lack of information can lead to increased risk of infection with HIV and STIs and also to reduced likelihood of diagnosis and effective treatment.

33. Gender-based violence against sexual minorities who are seen as deviating from gender norms is widespread and often legitimised by discriminatory laws against same sex relations (currently in place in more than 70 countries). The recent DFID White Paper announced plans to tackle gender based violence and ensure access to justice for survivors. This is a welcome announcement which we hope will lead to a reduction in all forms of sexual and gender based violence.

34. Wider promotion of the rights of sexual minorities is also important in order to ensure their health, livelihoods and life satisfaction. The FCO has already stated “we do not think that democratic governance and sustainable development can take place where groups of people are excluded from enjoying their human rights” and has developed a programme for promoting the human rights of LGBT people. We hope that going forward DFID can work with the FCO to implement this programme and promote the health and rights of sexual minorities around the world.

Progress towards the commitment to universal access to Anti-retroviral Treatment and its impact on the effectiveness of care and treatment, particularly for women

35. While the number of people accessing HIV treatment has now grown to at least 4 million, until the first DFID report next year we will not know what role UK funding is playing in this nor what impact it has had on women’s access to treatment.

36. In developing countries women are often diagnosed with HIV during pregnancy. Care at this stage may focus on preventing onward transmission to her baby while neglecting the woman’s wider health and psychosocial needs. It is vital that PMTCT services cater to women’s wider needs in line with WHO guidelines. This will increase uptake and ensure better health outcomes for women and children.

37. In addition, women are often unable to take time away from work or family responsibilities and may lack the resources to travel to hospital. Where HIV treatment is integrated with other services (such as family planning, nutrition counselling, and treatment for opportunistic infections) and provided at primary care

level, it is more likely that women will be able to access and adhere to it. Health care workers should also be trained in gender so they are able to understand the issues faced by women and offer them appropriate treatment and services accordingly.

Written evidence submitted by the International AIDS Vaccine Initiative (IAVI)

30 September 2009

ABOUT THIS DOCUMENT

This document provides written evidence from the International AIDS Vaccine Initiative in response to the IDC call for submissions issued on 17 July 2009 and in relation to an inquiry into DFID's Annual Report and Resource Accounts for 2009 as well as the recently published White Paper.

BACKGROUND TO IAVI

1. IAVI is a global not-for-profit, public-private partnership (PPP) working to accelerate the development of a vaccine to prevent HIV infection and AIDS. Founded in 1996, IAVI researches and develops vaccine candidates, conducts policy analyses and serves as an advocate for the field. IAVI supports a comprehensive response to HIV/AIDS that balances the expansion and strengthening of existing HIV prevention and treatment programs with targeted investments in new AIDS prevention technologies. It also works to ensure a future vaccine will be accessible to all who need it.

2. IAVI is committed to promoting AIDS vaccine research and education worldwide, engaging communities in the trial process, and improving clinical infrastructure in areas hardest hit by the global epidemic. With five offices worldwide (New York, Amsterdam, New Delhi, Nairobi, and Johannesburg), IAVI collaborates with the public and private sectors in both western and low- and middle income countries.¹⁷

3. IAVI welcomes the opportunity to submit evidence for this IDC enquiry focused on DFID's Annual Report and Resource Accounts for 2009; as well as the recently published White Paper, *Eliminating World Poverty: Building Our Common Future*.

KEY POINTS

4. Given IAVI's core business, this submission will focus on DFID's role in supporting new prevention technologies for HIV/AIDS; specifically an AIDS vaccine. We are aware that a range of other organisations and consortia will be making separate submissions which cover the depth and breadth of DFID's work as set out in the White Paper and Annual Report.

5. Broadly, however, IAVI wishes to commend DFID for its strong leadership in the international development arena; demonstrable in its unwavering commitment to staying on-track to allocate 0.7% GDP as Official Development Assistance (ODA) by 2013, despite the current global financial crisis; and the sustained momentum and dedication in galvanising donor and recipient governments alike around the achievement of the Millennium Development Goals. DFID support in 2009 has resulted in tremendous successes, including: the provision of anti-retroviral drugs (ARV) for HIV treatment to 100,000 people; the distribution of over half a billion condoms; and the training of 60,000 health care professionals.

6. Despite real gains on some MDG targets, such as under-five mortality, progress in meeting targets on HIV/AIDS in many countries remains off-track. Despite tremendous advances in HIV prevention efforts and in the treatment of HIV disease, an estimated 7,500 people are newly infected with HIV every day. Of further concern are the future generations of newly HIV-infected individuals who will require access to ARV's. Demand forecasting for access to ARV's estimate that 55 million people will require these life saving medicines by 2030 (today less than 4 million people have access to ARVs).¹⁸ The need for new prevention technologies is stark.

7. IAVI in partnership with the Futures Institute developed an AIDS vaccine impact model, assessing various HIV/AIDS prevention and treatment strategies. The modelling revealed that an AIDS vaccine could substantially alter the course of the HIV/AIDS pandemic and reduce the number of new infections; even if vaccine efficacy and population coverage levels were relatively low and other programs for treatment and prevention had been scaled up. The results from the modelling showed that a potential AIDS vaccine would not have to be 100% effective nor have to reach 100% population coverage to have effect. For example, a vaccine with only 50% efficacy and being administered to only 30% of the population could potentially reduce HIV incidence in the developing world by one-quarter over 15 years.¹⁹

¹⁷ For more information on IAVI's work visit <http://www.iavi.org>

¹⁸ All Party Parliamentary Group on AIDS (2009) *The Treatment Timebomb Report of the enquiry of the APPG on AIDS into long-term access to HIV medicines in the developing world*.

¹⁹ Between 2015–39: IAVI (2009) *Estimating the Impact of an AIDS Vaccine in Developing Countries* Policy Brief 20 August 2009.

8. A range of vaccine efficacy and coverage scenarios were modelled to assess the potential impact of a new AIDS vaccine on the pandemic (low, medium, high and very high) with a variety of other factors combined, including: selective population targeting; incomplete achievement of universal access targets; and whether or not the vaccine would protect against HIV infection and reduce probability of onward transmission. Even the most modest vaccine efficacy (30%) and coverage levels (20%) could avert 2.1 million new infections worldwide. The most optimistic scenario could avert 12 million new infections (efficacy of 90% and 40% population coverage). Vaccination as a prevention strategy is also cost effective, significantly off-setting direct treatment and care costs, as well as the wider economic and social costs of HIV disease. The need for a vaccine as part of an integrated prevention and treatment strategy therefore is compelling.

9. DFID is cognisant of the current challenges in preventing and treating HIV/AIDS and the need for a range of new tools to prevent the spread of HIV. In 2008, DFID announced a new £220 million fund for research and development on the discovery and development of new prevention technologies for a range of diseases, including HIV/AIDS, as part of their new Research Strategy.²⁰ DFID has adopted a portfolio approach supporting a range of organisations, such as public private product development partnerships, to spur innovation at all stages of the R&D continuum. DFID's support and financial commitment in the R&D sector is designed to provide predictable, long-term funding to actors engaged in the discovery and development of new public health tools.

10. In this interconnected world, no one individual, government, institution or private sector company holds the answer to eradicating HIV from the globe. The discovery, development and distribution of an AIDS vaccine require the greatest minds and resources from both the public and private sectors. Product development partnerships are strongly positioned to mobilise these diverse parties, bringing together talent and expertise, wherever they reside, to bear on the health issues that affect the developing world. The IAVI partnership model links leading vaccine design laboratories in academic, biotechnology, and big pharma settings with vaccine development expertise in industry and clinical investigators in the developing world. The combination of a private sector approach focused on effective and flexible management and decision-making on portfolio choices, with the mission of a public sector entity and the stringent oversight requirements of a non-profit, provide a hybrid solution to address the specific needs of a fast changing environment. This industry-NGO hybrid culture has enabled IAVI to achieve key milestones since its founding, for instance successfully translating novel technologies into seven candidate vaccines tested in eleven countries, a rate of development unprecedented outside of industry. The IAVI model therefore adds considerable value to the investment made by DFID on behalf of the British taxpayers.

11. DFID is to be commended for its bold support of R&D efforts to develop new tools for diseases which disproportionately affect poor countries and for the emphasis and priority it places on prevention efforts more broadly. DFID is the largest bilateral government donor in research and development, investing in efforts now which will safe-guard future generations. The United Kingdom's leadership on supporting research for, amongst other tools, better HIV prevention, as demonstrated by the DFID launch of a five year research strategy culminating in the announcement of strong and long term financial support to Product Development Partnerships, including IAVI, has been pivotal to a sustained effort in AIDS vaccine research. DFID's strong political and financial support as IAVI's first public sector donor, dating back to 1998, close to IAVI's inception, has been critical to help IAVI accelerate the design and development of AIDS vaccines, as well as to obtaining critical long term support from other public sector donors. This sustained and flexible support has been key to the establishment of a collaborative scientific programme involving researchers throughout the world through clinical trials in Africa, India, Europe, and the US.

12. With recent good news from the AIDS vaccine field there is considerable reassurance that DFID's research strategy, reinforced in the White Paper, is sound, moral and ethically right. Recently two new broadly neutralizing antibodies on the HIV virus were discovered, the first to be discovered in more than a decade, that will allow researchers to try to exploit the newfound vulnerability on the virus to craft new approaches to designing an AIDS vaccine, specifically for the countries that need it most. The announcement of the Thai trial, a phase III trial of a prime-boost vaccine combination, moreover is the first proof that an AIDS vaccine candidate confers protective benefits in humans.²¹

RECOMMENDATIONS

13. The comprehensive response mounted against HIV and AIDS and supported by DFID, needs to be sustained, and in many areas increased, to ensure continued scientific progress for all types of interventions and innovations, particularly in AIDS vaccines. As IAVI continues to focus on, and address the challenges posed by AIDS vaccine research and development, sustained and flexible resources are crucial to scale up research efforts. The AIDS vaccine field is entering a renaissance period where substantial investments in preclinical and clinical vaccine development efforts are likely to create major breakthroughs in challenges impeding AIDS vaccine development. It is imperative that these investments are safeguarded and continued to bring us closer to our mission of developing an AIDS vaccine for the world. Investment in research and

²⁰ DFID (2008) *Research Strategy 2008-13* © Crown Copyright, 2008.

²¹ For more information on the Thai trial visit <http://www.hivresearch.org/>

development processes for vaccine discovery moreover require long term predictable and flexible financing. There is an urgent need to reinforce institutional grant funding with innovative financing mechanisms which overcome problems of lack of predictability and provide longer term revenue flows.

Written evidence submitted by the International HIV/AIDS Alliance

September 2009

The International HIV/AIDS Alliance (the Alliance) welcomes this opportunity provided by the International Development Committee to contribute to the review of the Department for International Development's Strategy "*Achieving Universal Access*". This submission will draw on the Alliance's global experience of working with populations key to the HIV epidemic, and as a civil society organisation active in service delivery, capacity building and advocacy at both national and international levels. The Alliance will address in this submission all six areas of focus identified by the Committee for this enquiry.

I. THE INTERNATIONAL HIV/AIDS ALLIANCE

1. Established in 1993, the International HIV/AIDS Alliance (the Alliance) is a global partnership of nationally-based organisations supporting community action on AIDS. Currently working in over 40 countries—those threatened by emerging epidemics, as well as those already heavily affected—the Alliance emphasises the importance of working with people who are most likely to affect, or be affected by, the spread of HIV. DFID has funded the Alliance through a Programme Partnership Agreement (PPA) since 2004. In the Caribbean, the Alliance is currently implementing a HIV/AIDS programme with DFID support of £2 million.

II. THE PROCESS ESTABLISHED BY DFID FOR MONITORING THE PERFORMANCE AND EVALUATING THE IMPACT OF THE STRATEGY

2. As noted in previous submissions to this Committee in 2008, dividing the process of Strategy development from the development of a monitoring, evaluation and accountability strategy posed challenges. The development of "*Achieving Universal Access*" Strategy ("the Strategy") would have benefitted from an integrated process of indicator selection to ensure that the Strategy from the outset was committing to measurable deliverables and commitments.

3. In many ways, the process established by DFID to develop the M&E framework presented a groundbreaking approach in engaging civil society in the monitoring process of the Strategy and in making the framework more relevant for those involved in the implementation of the Strategy. Following DFID's request for civil society involvement in the development of its M&E framework, the UK Consortium on AIDS and Development set up an "Indicators" Working Group' (IWG), of which the Alliance was a member. Whilst the IWG was asked to focus the development of indicators, it was able to provide support and expertise to inform other parts of the framework. DFID's 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.

4. Based on the Alliance's assessment of the process, 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 recognised 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.

5. 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.

6. So despite DFID's commitment to an inclusive approach, the methodology and nature of the process limited the extent to which civil society engagement was meaningful due to several factors. Collectively, these elements of the process presented challenges to the ability of the IWG to be fully representative. We hope very much that as this work progresses that this process will be improved and that the M&E strategy will benefit from a more rigorous consultation process.

7. Recommendation:

- Future efforts to engage civil society should adopt an approach that allows for more thorough engagement of all partners in the development of the M&E framework. Recommendations for good practice from HM Government COP on consultations²² should inform consultation efforts across HM government's departments.

²² <http://www.berr.gov.uk/files/file47158.pdf>

III. PROGRESS ON HEALTH SYSTEMS STRENGTHENING AND ON AN INTEGRATED APPROACH TO HIV/AIDS FUNDING

Progress on Health Systems Strengthening

8. Since the launch of “*Achieving Universal Access*” and the announcement of the UK government’s plans to spend £6 billion on strengthening health systems and services, there has been limited information available on the use of these funds. Since the launch of the Strategy, the UK government has made the following commitments:

- an estimated £450 million until 2011 to support national health plans for eight IHP+ countries at the UN High Level Event on the Millennium Development Goals in September 2008;
- £40 million to the Affordable Medicines Facility for malaria and an increase in malaria research spending to at least £5million per year by 2010; and
- £50 million to fighting neglected tropical diseases.²³

Despite the Committee’s request,²⁴ it remains unclear how these commitments and the £6 billion committed under “*Achieving Universal Access*” will contribute to strengthening health systems and services to support the achievement of universal access.

9. The International Health Partnership and Related Initiatives (IHP+) presents an opportunity to DFID to allocate resources to health systems strengthening, however implementation progress has been slow. While the IHP+ aims to improve the effectiveness of health aid delivery, the IHP+ has not been able to address the initial key concern of financing gaps for health in its focus countries. In Ethiopia, the first country to sign a compact, a funding gap of between US\$1.56 billion to US\$2.84 billion was identified.²⁵ However, in response, donors, including DFID, allocated just a fraction of what was required.

Threatening universal access to HIV prevention

10. 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. Universal access to HIV prevention cannot be achieved solely by investing in health systems and services and is often an area that formal health systems ignore. 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.

11. An area where the UK has been taking a lead is through its role in the EU Action Team on Prevention, under the European Programme for Action to confront HIV/AIDS, Tuberculosis and Malaria in External Action.

12. The Alliance notes the Committee’s finding in point 14 of the 12th report of session 2007–08. The Alliance fully agrees with the principle that health service access should always be seen as an opportunity to support prevention efforts and that in the case of prevention of mother to child transmission and TB prevention and management this is especially critical.

Supporting an integrated approach

13. The Alliance is concerned about the adopted position that “parallel systems” are inherently inefficient or more likely to result in lack of co-ordination than HIV services integrated into broader health systems—usually interpreted as systems run only by the state. Much of health systems strengthening does not refer to a broad system which integrates community level systems into the continuum of care in an effective and sustainable way.

14. Community level systems play a critical role in ensuring access for and involvement of marginalised populations in HIV services. In many places, “stand alone” ARV treatment programmes have been developed or implemented due a lack of capacity in the broader health system, and in response to the high levels of stigma and discrimination experienced by people with HIV in health services. Addressing stigma and discrimination in broader health systems is critical to ensuring successful integration or a broader health system role in HIV treatment and care. However there is little evidence of overt plans to address this in many health systems integration plans or discussion documents. This is something that needs to be addressed before integration is attempted, not after evidence of systematic discrimination becomes known.

²³ “Health in Crisis: Why in a time of economic crisis Europe must do more to achieve the health MDGs”; Action for Global Health; 2009; (http://www.actionforglobalhealth.eu/media_publications/afgh_policy_reports/policy_report_health_in_crisis/policy_report_health_in_crisis)

²⁴ Point 20 of the 12th report of session 2007–08.

²⁵ Compact between the Government of the Federal Democratic Republic of Ethiopia and the Development Partners on Scaling Up For Reaching the Health MDGs through the Health Sector Development Programme in the framework of the International Health Partnership; Ethiopian Federal Ministry of Health; August 2008 (http://www.internationalhealthpartnership.net/CMS_files/documents/ethiopia_country_compact_EN.pdf)

15. It is simplistic to imagine that a parallel system is inherently less effective and efficient than a large, multi-departmental system, as “parallel” systems with effective communication and co-ordination mechanisms could provide a more effective and integrated service than administratively “integrated” systems with poor internal communication and co-ordination. In Ukraine, where ARV procurement, supply and distribution has recently been “integrated” into the health system after many years of effective delivery through community organisations, evidence shows that it has resulted in significant problems in continuity of supply due to inefficient systems and a lack of commitment within the state agencies.

16. Evidence suggests that integration of the community level systems can result in reductions of hospital readmissions of chronically ill patients, better co-ordination of care, and increased access to services through the delivery of high quality, cost-effective home based care. In Uganda, health workers identified the referral system operated by the Alliance’s Network Support Agents (people living with HIV providing support and services linked to the formal health system) helped increase the number of people living with HIV served and also made reporting more efficient and effective.

17. Recommendation:

- DFID should publish the breakdown of its spending on health systems strengthening along with mechanisms to collect evidence of impact on health and HIV indicators.
- Through its leadership role in the IHP+, DFID needs to ensure more rapid implementation at the country level, which includes efforts to fill financing gaps for health in the IHP+ focus countries.
- DFID should demonstrate how it is meeting its commitment to universal access to prevention, including by urgently exploring and supporting immediate investments into HIV prevention measures that may need to be addressed outside the formal health system.
- DFID should ensure that gains in the HIV response are not lost through its focus on HSS, by addressing stigma and discrimination before integration of HIV responses into public health systems is attempted.
- DFID’s approach to integrated funding for AIDS should recognise the role of community systems and through its funding and policies ensure adequate support to this sector.

IV. INTEGRATION OF HIV PREVENTION, TREATMENT AND CARE WITH OTHER DISEASE PROGRAMMES, PARTICULARLY TUBERCULOSIS AND MALARIA

18. The continued lack of concrete strategies and approaches for integration of HIV with other disease programmes from DFID gives rise to concerns that support for integration may not be nuanced enough to take into account the complexities of HIV. While the benefits of integrating HIV with other disease may provide gains from the funding and policy perspective, this may not always be the case at the level of service access and delivery. Furthermore, a nuanced and well-developed approach to integration is required to avoid any compromise on quality and access, and setbacks in the delivery of HIV-related services.

19. While the Strategy clearly recognises the need for linkages and integration between SRHR and HIV, it still remains unclear how DFID intends to support integration. 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.

20. The Maternal Health and SRHR strategy, initially planned for mid-2009, has been postponed indefinitely and therefore this opportunity in the last year to concretise DFID’s actions in this area was not realised. 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 supported the operationalisation of the emphasis on linkages with HIV outlined in the Strategy.

21. The Committee recommended in its 12th report of session 2007–08 that DFID presses particularly the Global Fund to do more to support the integration of services. DFID staff from the AIDS and Reproductive Health Team expressed interest in the Alliance’s experience of securing Global Fund resources for integrated services. However, this has not yet translated into an increase in resources for the Global Fund to support its scale up of integrated programmes.

22. The Alliance notes that neither DFID’s strategy nor the Committee’s review last year highlighted the urgent need for greater integration between Hepatitis C and HIV responses among people who use drugs. HIV and HCV co-infection affects large numbers of injecting drug users and the two diseases interact to produce more rapid disease progression and higher rates of mortality and morbidity. While the same proven interventions for HIV prevention among drug users also prevent transmission for HCV, diagnostic and treatment outcomes for both could be significantly enhanced with greater integration of mostly lacking responses to HCV and HIV. 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.

23. Recommendations:

- Specific approaches to ensure integration of HIV with other disease programmes need to be developed and published as part of the Strategy and its M&E Framework.

- DFID's approach to integration needs to be more nuanced, taking into account the particularities of the HIV response, the strength of health systems and the social and legal context, to avoid any compromise on quality and access, and setbacks in the delivery of HIV-related services.
- DFID should ensure that integration and linkages between SRHR and HIV address SRHR comprehensively, and are not limited to family planning. These efforts should be guided by and clearly defined within the overdue Maternal Health and SRHR Strategy.
- Efforts to address HCV infection need to be incorporated into HIV responses for people who use drugs to ensure more impact of DFID support on health outcomes for these communities.

V. THE EFFECTIVENESS OF DFID'S STRATEGY IN ENSURING THAT MARGINALISED AND VULNERABLE GROUPS RECEIVE PREVENTION, TREATMENT, CARE AND SUPPORT SERVICES

24. Effective programmes for marginalised groups are central part of the Strategy. The Alliance looks forward to continue supporting DFID's work in this area and strongly recommends that DFID develops clear plans for how the UK Government will act on the commitments it has made in its Strategy to marginalised populations.

25. The Alliance has had productive meetings with the FCO in relation to their role in the implementation of the Strategy. However we are unclear about how the FCO and DFID are taking this work forward as there has been limited communication with UK stakeholders. This may have resulted in missed opportunities for synergies and collaborative advocacy.

26. The Alliance also welcomes DFID's ongoing support for the International Harm Reduction Association and for DFID's excellent advocacy work in support of HIV prevention at the UNGASS High Level Meeting on Narcotic Drugs held in Vienna in June 2009. DFID has made a new commitment to supporting the work of the Global Forum on HIV and MSM. The Alliance applauds this commitment as a significant step in ensuring strengthened advocacy and commitment globally to meeting the HIV prevention needs of this critically important and underserved population.

27. In a number of countries, including Senegal, the work of DFID and the FCO in supporting local advocacy has also helped to protect the rights of this highly vulnerable population. Conversely, the withdrawal of DFID staff and offices from some countries, such as Nepal, presents risks to the continuity of important programmatic interventions targeting vulnerable populations, and threatens to undermine universal access commitments.

28. Recommendations:

- That the FCO and DFID develop and publish plans to address the needs of marginalised groups, which includes predictable and sustainable financing for community responses most effective at reaching marginalised groups.

VI. THE EFFECTIVENESS OF SOCIAL PROTECTION PROGRAMMES WITHIN THE STRATEGY

29. Based on the Alliance's programming experience supporting children affected by HIV and AIDS, 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. These include children with disabilities, street and working children and those most rarely mentioned, children of people who use drugs and of sex workers.

30. Social protection programmes in general, and those programmes that promote community targeting of vulnerable families, an important positive approach in social protection programmes, are in danger of excluding these families due to stigma and discrimination by community members and institutions. Criminalisation of sex work, of drug use and of these communities contribute to the difficulties in identifying children and families in need and ultimately excludes them from services because of fear of police harassment, legal action and separation of children from their families.

31. The success of DFID's commitment to cash transfer and social protection programmes will depend on DFID's efforts to address the underlying structural causes of children's and their families' vulnerabilities, such as criminalisation, stigma and discrimination and broader human rights violations. In addition to ensuring the participation of affected and marginalised communities in the development of social protection programmes, social protection programmes must be provided in an environment that ensures the realisation of these communities' rights.

32. Recommendations:

- As social protection programmes, including cash transfers, are at risk of not reaching the most marginalised children affected by AIDS there is a need for direct support for efforts to address underlying structural causes of children's and their families' vulnerabilities to complement.

VII. PROGRESS TOWARDS THE COMMITMENT TO UNIVERSAL ACCESS TO ANTI-RETROVIRAL TREATMENT AND ITS IMPACT ON THE EFFECTIVENESS OF CARE AND TREATMENT, PARTICULARLY FOR WOMEN

33. Despite DFID's commitment to universal access in the Strategy, the leadership in this area shown by DFID in the past appears to be waning. DFID's contributions to the HIV response are increasingly tied to improvements in health services and systems, rather than targeted HIV-related outcomes. If this is the case, then DFID's approach risks undermining and reversing the hard-won progress made to date towards universal access to treatment. The Global Fund to Fight AIDS, TB and Malaria, for example, faces a severe funding shortfall of approximately \$4 billion for the 2008-2010,²⁶ despite providing ARVs to more than 2 million people living with HIV. We welcome DFID's long-term commitment to the Global Fund, however £1 billion over seven years, does not represent the UK's fair share to support the Global Fund's efforts to, among other things, sustain and increase access to ARV treatment.

34. There has been tremendous progress made on increasing the number of HIV positive people who receive treatment. There is an urgent need to maintain a focus on these gains to ensure uninterrupted access to ARV treatment, and consistent drug supply chains to reduce the frequency of drug stock-outs, to not only save the lives of those already on treatment and those in need in future—but also to reduce the likelihood of drug resistant HIV. In order to make progress on this important issue, we welcome DFID's strong support for UNITAID's patent pool, which has enabled the cost of treatment for HIV, TB and malaria to be reduced at the country level.

35. Recommendations:

- DFID should ensure that its focus on health systems strengthening does not undermine progress to universal access to HIV treatment and provide its fair share to the Global Fund by increasing on its current pledge by £183.5 million for the period 2009–10 to enable ongoing and future treatment programmes.

Written evidence submitted by KANCO (The Kenyan AIDS NGOs Consortium)

ABOUT KANCO

1. Established in 1990, KANCO is a national network of NGOs, CBOs and Faith Based Organisations, the Private Sector, Research and Learning Institutions involved in HIV/AIDS and TB work in Kenya. KANCO is also the Linking Organisation to the International HIV/AIDS Alliance (UK) in Kenya.

2. We have stated our vision to be a Kenyan society free of HIV & AIDS and TB. Our mission is to provide leadership, promote collaboration and enhance capacity among CSOs and other stakeholders to respond to HIV & AIDS and TB at the community level.

3. Our core values are:

- *Integrity*—We value truthfulness, fairness, honesty and transparency in our internal and external relationships, communication and transactions.
- *Excellence*—We value professionalism and timeliness, and seek credibility in all that we do. We are committed to the highest professional standards
- *Collaboration*—We value the collective wisdom that emerges when individuals work together as a team.
- *Innovation*—We value and support innovation. We encourage informed risk-taking that holds the promise of enhancing organisational learning.

4. More information is available here: <http://www.kanco.org/FW266/html/Index.html>

DFID COMMITMENT TO HIV/AIDS TB AND MALARIA PROGRAMS IN KENYA

1. Kenya is experiencing an increase in HIV prevalence with more than 1.4 million Kenyans living with HIV/AIDS and a national prevalence of 7.4%.²⁷ This translates to an increase in the number of people in need of treatment, care and support, and subsequently an increase in the number of OVCs. The TBHIV co-infection rate is currently estimated at 50–60%. Although TB continues to be the leading killer of people living with HIV in the country, it is yet to implement screening of PLHA for TB country wide as a way of enhancing TB support to PLHIV. TB case notification rate stands at 329 per 100 000 having risen from 54 per 100 000 in 1991. This signifies a six fold increase in the past 15 years. To get out of the HBC bracket the case notification rate needs to come down to less than 300 per 100 000 cases.

2. The World Health Organisation (WHO) estimates that only 80% of the TB cases are detected in Kenya indicating that the rest 20% continue to transmit TB. Though Kenya has been acknowledged for achieving the WHO's target (85% treatment success rate, case detection rate 80%), much still needs to be done to reduce

²⁶ Updated Demand Estimate 2008–10; Global Fund to Fight AIDS, TB and Malaria; Caceres, Spain, 30 March to 1 April 2009; (http://www.theglobalfund.org/documents/publications/replenishment/caceres/Resource_Needs_2008-2010_en.pdf)

²⁷ Kenya AIDS Indicator Survey (KAIS) preliminary report 2007.

the rising incidence of TB in Kenya. Kenya's efforts in addressing TB have also been hampered further by the emergency of the Multi drug Resistant TB which is not only difficult to treat, but also expensive to manage. This thus requires extraordinary measures, in order not to negate the progress made in the fight against both TB and HIV. The first case of the Extensive Drug resistant TB (XDR-TB) has been reported in the country. Over 500 MDR-TB cases are recorded but the figures could be more. One way to achieve this is to ensure more bilateral and multi lateral support to TB and TBHIV programs.

3. The response to the two epidemics in Kenya is highly dependent on bilateral and multi lateral support. These include the PEPFAR, USAID GFATM and DFID. DFID does not provide general budget support to Kenya. Instead its funds are managed by financial management agents or through special government accounts, or are provided direct to civil society. Currently around 50% of DFID aid is allocated to health and HIV/AIDS, focusing on health systems, malaria, reproductive health and strengthening the delivery of essential health services.

4. By March 2009 DFID gave 59 million to run for over six years targeting malaria control. Additional DFID support is contributing to the roll-out of new anti-malarial combination therapies, improving the response to epidemics, and to the funding of net retreatment and communication programmes.

5. For HIV/AIDS, DFID gave a \$10 million per year for a six year program which has concentrated on prevention and orphan support. Prevention activities have focused on high risk groups such as fishing communities and young adults, using innovative behaviour change interventions. To prevent new infection, DFID funded the social marketing of condoms since 2003, with the aim of distributing 172 million condoms by the end of 2009.

6. Funds that have benefited the civil society projects from DFID include: support to development of home-based care and HIV counseling and testing guidelines adopted nationally, access to home-based care, HIV testing and supporting to Post-rape counseling policy development. DFID also support ARV programs and with its support, 161,000 people had been provided with anti-retroviral drugs by March 2008.

7. More funds amounting to \$40 million on HIV/AIDS programs to support the Total War against Aids (TOWA program) over a five year period were approved in April 2008. This fund was co-funded with the World Bank.

8. In 2008 after the Global leaders forum, the UK Government supported the principles in the "Call for Action on HIV/TB", including the need to scale-up efforts to deliver universal access to TB and HIV prevention, treatment, care and support services by 2015; the need to strengthen health systems and services; the integration of health services, including HIV and TB; and to increase investment and facilitate research to promote the development of better tools for prevention, diagnosis and treatment of TB. Later in the year DFID signed a five year grant with the Stop TB Partnership that saw 4 million pounds go into global TB control (2008–11).

9. In addition to these recent commitments, the UK Government has made a long-term commitment of £1 billion (2007–15) to the Global Fund to fight AIDS, Tuberculosis and Malaria and a 20-year commitment to the international drugs purchase facility UNITAID (2006–26), which is helping to increase access to and affordability of HIV and TB drugs. Despite the global recognition of the growing TB and TBHIV burden, further actions are required at country level through DFID offices.

10. It is however worth noting that DFID does not have direct support for TB programs in Kenya. Reports from DFID Kenya indicate that DFID supports general Health Systems Strengthening in various national health sectors through Health systems strengthening initiatives. For example the National TB program benefited from \$ 206 700 of the DFID funding in 2008 which supported budgets like the human resources, Health Management Information System and other related expenses. Despite this support, the National TB program still reports a funding gap in the national TB response. The lack of direct funding to TB initiatives makes it difficult to assess the direct impact of DFID's support to the TB situation in the country. There is however a proposal for integration of TB into their health programs due for discussions in November 2009. This however will largely depend on DFID's prioritisation and the eventual approval of the same.

11. It is increasingly becoming clear that though DFID's is committed to "*Achieving Universal Access*", by investing £6 billion over seven years to 2015 to strengthen health systems and services, including the integration of HIV and TB services. Countries like Kenya with high TBHIV co-infection need to be supported more to achieve both universal access and MDG targets. This thus necessitates the need for DFID to translate global leadership on TB into country support it is also important to note that effective HIV/AIDS programming that is likely to have real impact cannot fail to focus on the close existing interaction between HIV and TB. More targeted funding to focus on the TB initiatives will greatly impact on the war against HIV/AIDS. In this respect the civil society appeals to DFID to diversify its support and integrate specific TB and TB-HIV related interventions in its supported health programs as they greatly support health systems.

RECOMMENDATIONS

- DFID should prioritise the integration of TB to the health programs, to be discussed November 2009.
- Integrate specific TB and HIV interventions within Health System Strengthening in Kenya.
- DFID should continue to increase support for HIV and HIV-TB services in Kenya.

Written evidence submitted by the DFID Funded Research Programme Consortium (RPC) on Research & Capacity Building in Sexual & Reproductive Health and HIV in Developing Countries (SRH&HIV) of the London School of Hygiene and Tropical Medicine, the MRC Social & Public Health Sciences, Glasgow and other collaborators²⁸

30 September 2009

EVIDENCE PROVIDED FOR: "PROGRESS TOWARDS THE COMMITMENT TO UNIVERSAL ACCESS TO ANTI-RETROVIRAL TREATMENT (ART) AND ITS IMPACT ON THE EFFECTIVENESS OF CARE AND TREATMENT, PARTICULARLY FOR WOMEN"

1. This document is written from the perspective of the academic communities at the London School of Hygiene and Tropical Medicine (LSHTM) and the MRC Social and Public Health Sciences Unit (SPSHU), Glasgow and collaborators in Ghana, Tanzania, South Africa, and others in the UK. For this particular inquiry of the International Development Committee, we have focused on one aspect of provision of ART care in Uganda, based on work conducted by RPC Partner MRC SPSHU with the MRC/UVRI Uganda Research Unit on AIDS (a partner from our wider RPC network), who are jointly supervising a doctoral study to investigate how masculine identity affects the take-up of ART in Uganda.

2. When antiretroviral therapy (ART) first became widely available in low income countries, there were policy concerns that it would be accessed primarily by men, since they have greater control of economic resources and more confidence to make use of services. International observers and agencies, and feminist commentators have consistently emphasised the need to ensure that women are not forgotten in the expansion of AIDS treatment and care. The theory that gender inequities often affect women's access to and interaction with health services (eg Braitstein *et al*, 2008; Silvester *et al*, 2005) has prompted arguments in support of more affirmative action with regard to women's and girls' access to ART as well. Although, the 2006 WHO/UNAIDS progress report on global access alluded to the absence of evidence of systematic gender bias in access to ART, it nonetheless acknowledged the existence of gender inequities, with women receiving more in some countries and men in other countries.

3. Emerging evidence now suggests that men may in fact be more disadvantaged with regard to accessing ART in most low and middle income countries. According to the WHO/UNAIDS/UNICEF 2008 global report on the HIV epidemic, in most of these countries, women are receiving more than the expected coverage of antiretroviral therapy. At the end of 2007, 56% of those receiving antiretroviral therapy were women, while they represented 52% of people in need. In sub-Saharan Africa, data from 32 countries revealed that 61% of the people receiving antiretroviral therapy in this region were female, while they represent 57% of the people in need (WHO/UNAIDS/UNICEF, 2008). In east and southern Africa, it had earlier been observed that in those areas where ART has been made widely available at low cost or at no cost, women utilise ART at greater rates than men (UNAIDS/UNFPA/UNIFEM, 2004).

4. The trend towards gender discrepancy in ART uptake is evident in the ART roll out programme in Uganda, with men tending to be fewer. In a recent survey of 336 facilities providing ART across the country, the data from a sub set of 175 facilities that had sex disaggregated data for their 69,058 clients showed that 37% (25,929) were males and 63% (43,129) were female (MoH, 2008). The findings reported in a 2008 article by Braitstein *et al* provide further useful insights into gender patterns of access to ART in Uganda and other resource limited settings. Of the 22 HAART centres they surveyed in SSA, women were over represented in 13 centres compared to the UNAIDS estimated proportions of HIV infected adults who are women. They found that in 2 of the 5 centres covered by the survey in Uganda, women were overrepresented compared to the UNAIDS estimated proportions of HIV infected adults who are women (Braitstein *et al*, 2008). Men are also likely to access ART later in the disease progression than women. Braitstein and colleagues further report that at initiation to ART, women were less likely than men to have AIDS; suggesting that men might be delaying to seek care for symptoms.

5. The variations in uptake of ART in Uganda do not seem to be due to substantially different rates of testing among women and men. In the 2004–05 Uganda sero-behaviour survey, it was found that 11% of men and 13% of women aged 15–49 have ever been tested for HIV and received their results. But in the 12 months preceding this survey, an equal percentage (4%) of men and women had been tested for HIV and received their test results. Although during the sero-behaviour survey itself women were slightly more likely to be tested for HIV compared to men, the main reason for the difference could have been the higher percentage of eligible women who were interviewed in the survey (MoH/ORC Macro, 2006). This survey

²⁸ Contributors to this piece: Mr Godfrey Siu and Daniel Wight, MRC Social and Public Health Sciences Unit, Glasgow (danny@msoc.mrc.gla.ac.uk)

also reports that overall, 25% of men who are HIV positive know their status compared to 15% of women who are HIV positive. Earlier studies have also reported that women are significantly less likely to receive voluntary counselling and testing (VCT) than men (Nyblade *et al*, 2001).

6. There are several possible explanations for greater take-up of ART by women than men, amongst those infected with HIV:

- it might reflect men's general treatment seeking behaviour for most illnesses;
- women may be more familiar with medical treatment, due to child-bearing, and therefore more ready to access treatment;
- women's responsibilities for dependents might give them greater motivation to maintain their health;
- men might be more reluctant to publicly acknowledge that they are HIV +ve, which might relate to greater vulnerability to HIV/AIDS related stigma;
- HIV/AIDS health promotion, and HIV testing, might take place primarily in female-dominated contexts and therefore exclude men (WHO/UNAIDS, 2006; Baker & Ricardo, 2005; Bila and Egrot, 2009), for instance women may be accessing treatment from sites offering prevention of mother to child (PMTCT) services;
- men might avoid testing because they anticipate that they would be blamed for their infection whereas women's infection would be attributed to their male spouses; and
- it might reflect a different age profile of those in need of treatment, women generally being younger and therefore having more reason to want to prolong their lives.

7. Therefore, even though wider access to ART is now increasingly realistic, there is a need to pay greater attention to the dynamics of access and factors that may prevent use of ART by men. In their progress report on global access to ART, WHO/UNAIDS (2006) called for continued monitoring of gender and ART to both identify gender bias and improve understanding of how and why individuals access treatment. In view of the emerging evidence suggesting male under representation in ART treatment programmes, it seems as if male socialisation, traditional ideas about masculinity and gender roles could present barriers to men in accessing treatment for HIV/AIDS (Bila and Egrot, 2009; Braitstein *et al*, 2008; Greig *et al*, 2008).

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Written evidence submitted by NAT (the National AIDS Trust)

INTRODUCTION

1. NAT (the National AIDS Trust) welcomes the opportunity to present a short submission to the International Development Committee for its inquiry into “HIV/AIDS: Progress on Implementation of DFID’s HIV/AIDS Strategy”.

2. NAT is the UK’s leading charity dedicated to transforming society’s response to HIV. We provide fresh thinking, expert advice and practical resources. We campaign for change.

3. We work primarily on HIV policy issues in the UK, but we also advocate for donor support for research and development of new prevention technologies, such as vaccines and microbicides, and we are engaged in HIV policy at the European level, being represented on the Steering Committee of AIDS Action Europe and on the EU’s HIV/AIDS Civil Society Forum (which our Director of Policy also co-chairs).

UNIVERSAL ACCESS AND THE NEEDS OF MSM IN DEVELOPING COUNTRIES

4. An issue increasingly recognised as important to the global response to HIV is addressing effectively the HIV epidemic amongst men who have sex with men in developing countries. For too long there was neglect of the rights and HIV-related needs of MSM in many developing countries, and in particular sub-Saharan Africa. Research is increasingly demonstrating how essential it is to address this aspect of the HIV epidemic in all countries, including those with an as yet poor record on MSM rights (see for example *The Lancet* 1 August 2009 Vol 374 “Men who have sex with men and HIV/AIDS in sub-Saharan Africa”).

5. In the last five years a global movement, supported by pre-meetings at the last two International AIDS Conferences in Toronto and Mexico City, has focussed international and donor attention on this issue. The Global Forum on MSM and HIV (MSMGF)²⁹ has also been established to campaign and work to ensure increased investment in HIV services for MSM worldwide. Currently it is estimated that only 2% of global funding for HIV-related programming is directed at MSM. Only one in 20 MSM worldwide are estimated to receive HIV-related services. Surveillance, research and reporting on the MSM epidemic remain very weak in most countries.

6. DFID announced in August this year a three-year grant of US\$1.2 million to the Global Forum on MSM and HIV. It is the first government agency to support the MSMGF substantially and directly. NAT considers this to be an effective way of contributing to the universal access commitment and also ensuring appropriate services for one of the key marginalised groups affected by HIV. NAT commends DFID for its vision in supporting this important rights-based work and trusts this will be sustained.

PREVENTION

7. NAT commends DFID for its longstanding commitment to tackling HIV and AIDS in the developing world. The UK has shown great leadership on HIV and in championing the rights of vulnerable groups. The Government has also taken a central role in the international community, particularly through the Group of Eight (G8) and United Nations, to help secure international commitments for achieving universal access to comprehensive prevention programmes, treatment, care and support. Under the new strategy, Achieving Universal Access, DFID will continue to be a strong global leader and support further resources for tackling HIV.

8. NAT welcomed DFID’s unprecedented commitment to spend £6 billion between 2008 and 2015 to support health systems, including HIV activities, in developing countries. NAT particularly welcomed the commitment by DFID to increase by 50% funding available for the research and development (R&D) of HIV vaccines and microbicides. Vaccines and microbicides form an important part of a combination HIV prevention. Just as no single drug or medical approach is effective in treating a person living with HIV, a combination approach and an enabling environment are needed to help people prevent HIV transmission. Strategies must offer people, including those living with HIV, real choices which meet their different and changing needs and that address the contexts in which decisions are made.

9. Investment in R&D for new HIV prevention tools (NPTs) such as vaccines and microbicides today will pay significant future dividends. In the best case, widespread availability of new prevention methods will dramatically increase the impact of HIV prevention efforts and open the possibility of bringing the HIV and AIDS pandemic to an end. The recent announcement of an encouraging vaccine trial in Thailand—the first to demonstrate efficacy in humans—makes the case for DFID’s commitment to new prevention technologies.

²⁹ See www.msmsgf.org

10. Policy and advocacy relating to the support and development of NPTs forms an important element of the work plan of NAT. However, there is also a clear need for social research into NPTs to complement scientific R&D and to ensure the products will be acceptable to and used by those who need them most. Social research will enable an effective assessment of likely uptake of these new products, when available, and of their fit with existing prevention technologies such as condoms (this will be especially important in relation to partially effective new prevention technologies). We trust that DFID will not only continue to support long-term and predictable funding streams for NPT R&D but also fund the social research necessary to ensure appropriate uptake for vaccines or microbicides once they are developed.

CONCLUSION

11. NAT commends DFID's HIV strategy for continuing investment in vaccine and microbicide development, and for its engagement and investment in addressing the HIV-related needs of men who have sex with men across the world. Both have been far-sighted and bold initiatives, which have led the way for other donors. We hope the International Development Committee in its report might:

- congratulate DFID on its work on the HIV-related rights and needs of men who have sex with men around the world;
- congratulate DFID on its ongoing support for new prevention technologies;
- encourage DFID to continue to support these important strands of work; and
- encourage DFID also to advocate for such work and support in relevant international forums, including to the European Union, which remains a significant provider of development assistance.

September 2009

Written evidence submitted by One World Action

“HIV & AIDS is not just a health issue. It is a gender, development, human rights, and socio-economic issue”.

Emily Sikazwe, Executive Director, Women for Change, Zambia

1. With its demographic, social and economic impact, the HIV/AIDS crisis has become more devastating than war. In many countries, AIDS has progressed to a full-blown development catastrophe affecting all sectors of society, rolling back years, and in some cases decades, of hard-earned development gains.

2. With the spread of HIV/AIDS, the social networks of many communities are eroding, and the informal social institution of the extended family is silently breaking down. More and more young girls and women, wives, mothers are affected by the epidemic, and structures that have strengthened the stability of the socio-economic fabric are being torn apart.

3. Women lose resources and rights once their husbands die. Elderly people are left without care and dying alone. Elderly women are increasingly becoming care providers of orphans and sick family members when they themselves should be looked after. A new generation of orphans brought up in poverty will soon give rise to a generation of illiterate youth.

4. DFID's fight against HIV/AIDS can only be undertaken successfully when there is a clear focus on women, putting them at the centre of their strategy and implementation, and ensuring that women take full control of their own bodies. The strategy needs to fight against gender imbalances and cultural practices that perpetuate power relations inimical to women's health. HIV/AIDS in Africa and the rest of the world is about power and about women's lack of it. Unless DFID contributes to breaking down these barriers, they will not succeed in fighting the HIV/AIDS pandemic.

GENDER AND HIV/AIDS

5. Women are not just another “vulnerable group”, they represent more than 50% of the population and the gender inequalities that render them more vulnerable to HIV/AIDS must be addressed if we are to effectively reduce the spread of the epidemic and prevent more families sinking into poverty.

6. Women are particularly vulnerable to HIV infection. For example there are six women infected for every five men. This is often due to the pressure of poverty and the inequalities between men and women.

7. Men who often control the family income can spend it on other sex partners since sex is being traded for money. Women, in particular, are under pressure to exchanging sex for the money they need to support themselves and their families. For economic and cultural reasons, young women often have sex with older men who do not reveal their HIV status and refuse to protect themselves.

8. There are many sexually transmitted infections (STIs) that go untreated for long periods of time. An untreated STI makes a person more susceptible to infection with the HIV virus. While this is true for both men and women, it is easier for men to know that they have an STD. Men also have better access to health care.

9. In marriage, it is difficult for a woman to refuse to have sex with her husband, even if she knows that he has other sexual partners. It is also difficult for a woman to convince her husband to use a condom if he is having sex with other women. It is even more difficult for a woman to leave her husband, even if she knows she is in danger of being infected and cannot get him to change his behaviour.

10. Cultural practices and traditional beliefs contribute to increased risks of being infected. Men's attitudes and sexual practices are putting not only themselves, but also their wives and partners at risk.

11. There are statistics from almost every country in the world showing that sexual violence against women is at the heart of women's increased risk of infection. Sexual violence against women by their partners is rampant. In some countries, the first experience of sex for many girls is rape. Sexual abuse of teenage girls by a relative or a friend of the family is common. Commercial sex and rape during times of war, sexual violence in refugee camps and amongst displaced populations, sexual services and coercion in situations of economic or social dependency among students, or at the work place, all put women at high risk. Sexual violence against women is culturally and socially excused, and often accepted.

12. It is critical for DFID's HIV/AIDS strategy to have a strong gender focus and address the unequal power relations between men and women that expose women to greater risk of HIV/AIDS. DFID needs to also acknowledge and directly address the barriers that women face in accessing and adhering to treatment (poverty, food insecurity, gender inequalities, violence etc).

13. Men are part of the problem and must be part of any solution that DFID develops. For example, gender sensitive interventions that address men's socialisation are key to encouraging men to go for voluntary counselling and testing and providing support to their pregnant wives.

HIV/AIDS IS A HUMAN RIGHTS ISSUE

14. Prevention strategies put the blame for the spread of the HIV virus on women, not on men. This reflects a gender-biased conception of morality and religion. The clear divide between "good women" and "bad women" often determines the right to information and access to health care and prevention. But these divisions are becoming blurred, as all women have become a high-risk group.

15. The over-emphasis on HIV prevention and cure, at the expense of treatment has resulted in an overall reduction in the budget allocation for serious problems that affect women such as anaemia, nutritional deficiencies, injuries due to violence, maternal health and others. Access to health care by poor women is becoming more and more remote.

16. The pressure to introduce mandatory testing, especially of target groups, surfaces repeatedly. If implemented, it will amount to custodial violation of a woman's right to self-determination. An alarmist and stigmatising HIV & AIDS programme can result in practices of concrete disincentives. In practice it is the woman who is tested because she seeks health care during her pregnancy. In many cultures, Sexually Transmitted Infections (STIs) are called "women's diseases".

17. If a woman is identified as being HIV positive, she will be blamed and deprived of food and shelter by her family. These poor, abandoned and homeless women, who are entirely dependent on the government for their food and shelter, will be totally compromised in their bargaining power and right to refuse mandatory testing. The issue of informed consent is shrouded in the reality of women's social and economic dependency.

LESSONS FROM WOMEN FOR CHANGE, ZAMBIA

18. As an organisation, Women for Change prioritise the following in their fight against HIV/AIDS in Zambia.

- (i) Intensifying advocacy for policies and practices that are gender-sensitive, just and effectively respond to the plight of the poor and those affected and or infected by HIV/AIDS.
- (ii) Creating public awareness on rights of people/women living with HIV/AIDS.
- (iii) Intensifying activities in gender analysis and awareness-raising to ensure that both women and men are sufficiently gender sensitive and able to act on gender issues that perpetuate contraction and transmission of HIV/AIDS infection.
- (iv) Through the gender programme Women for Change challenge the power relations that perpetuate the spread of HIV/AIDS such as sexual cleansing, sexual violence, abuse and rape in homes.
- (v) Working with traditional leaders to advocate for the banning of negative cultural practices that put women and men at risk of contracting the virus.
- (vi) Support interventions aimed at enhancing the quality of life for orphans and vulnerable children especially girl children by:
 - (a) Facilitating support to the orphans and providing them with school requisites.
 - (b) Facilitating capacity building for the out-of-school orphans to enable them to look after themselves.
 - (c) Facilitating the attainment of food security for families caring for orphans.

- (vii) Working towards poverty eradication in the communities where they work because of the link between poverty and HIV/AIDS.
- (viii) Intensifying advocacy on the plight of HIV/AIDS orphans and vulnerable children including social support for orphans and widows in HIV/AIDS prevention.

Annex 1

ONE WORLD ACTION (OWA)

OWA was founded by Glenys Kinnock on 21 December 1989 in memory of Bernt Carlsson, the former Swedish UN Commissioner for Namibia who died in the Lockerbie aircraft bombing in 1988 while travelling to the signing ceremony of the Namibian independence agreement.

Today, although we are an organisation of just 15 full time members of staff (well supported by a fantastic team of volunteers) we work with 41 partners in 19 countries in Asia, Africa and Latin America and have gained a sound reputation for our work on governance, democracy and gender.

Our partners overseas include other non-governmental organisations, community and co-operative movements, women's organisations, disabled people's organisations and trade unions. Though diverse in kind, they have a common commitment to strengthening local institutions and giving people a say in the decisions that shape their lives.

We believe poverty is about the lack of power, so we work with the poorest, most marginalised people, to enable and empower them to transform their own lives.

Annex 2

WOMEN FOR CHANGE, ZAMBIA

Women for Change (WfC) is a gender focused non-governmental organisation operating in nine districts of Southern, Western and Central Provinces of Zambia. The organisation recently extended its work to two chiefdoms in Lundazi and Petauke of Eastern province. The total number of direct beneficiaries is 236, 205, with an estimated number of 26,500 indirect beneficiaries. WfC also works with traditional leaders. The Traditional Leaders programme is currently at the Southern Africa Development Community (SADC) level.

Other core programmes of WfC are:

- Gender Analysis and awareness raising.
- Human Rights Education.
- HIV and AIDS sensitisation.
- Economic Empowerment.

Written evidence submitted by RAISE

October 2009

The Reproductive Health Access, Information and Services in Emergencies (RAISE) is developed by Columbia University's Heilbrunn Department of Population and Family Health in the Mailman School of Public Health and Marie Stopes International (MSI). The initiative aims to address the full range of RH needs for refugees and internally displaced persons (IDPs) by building partnerships with humanitarian and development agencies, governments, United Nations (UN) bodies, advocacy agencies and academic institutions. This enquiry provides us the opportunity to address the pressing reproductive health (including HIV/AIDS prevention, care and support) needs of refugees and Internally Displaced Persons (IDPs).

1. INTRODUCTION

1.1 In 2006 there were 24.7 million people with HIV in sub-Saharan Africa, the region of the world experiencing the highest concentration of global emergencies.³⁰ In sub-Saharan Africa, 57% of adults with HIV are women, and young women aged 15 to 24 are more than three times as likely to be infected as young men.³¹

1.2 HIV and STIs spread—and kill—most quickly in populations affected by poverty, social unrest and lack of health infrastructure; factors commonly present in humanitarian emergencies. There may be an increased vulnerability of refugees and Internally displaced persons (IDPs) to HIV/AIDS due to specific factors such as:

- movement of people and mix with populations with high and low prevalence;
- opportunistic infections are unlikely to be treated when health resources are lacking;

³⁰ UNAIDS/WHO (2006). "AIDS Epidemic update: December 2006".

³¹ Ibid.

- urgent needs for blood transfusions and lack of universal precautions;
- scarce health resources and supplies; and
- increased sexual violence that enhance the risk of HIV and STI transmission.

1.3 Studies have shown that the risk of HIV among women who have experienced intimate partner violence may be up to three times higher than among those who have not.³² According to UNAIDS, in the Democratic Republic of Congo, HIV prevalence “varies from 1.7% to 7.6% depending on the region, and may be as high as 20% among women who have suffered sexual violence in areas of armed conflict.”³³

1.4 For people living in emergency settings, services for prevention and treatment of HIV/AIDS are often limited. Antiretroviral therapy (ARV) and Prevention of Mother to Child Transition (PMTCT) programs for HIV positive pregnant women can be harder to access or unavailable in humanitarian settings, which increases the risks of childbirth for the woman and the risk of transmission to the child.

1.5 Male and female condoms can prevent unwanted pregnancy and protect against the transmission of HIV/STIs. Access to condoms and family planning services allow those affected and unaffected by HIV to prevent unwanted pregnancies, reduce further HIV transmission.

1.6 Skilled attendance at delivery is one of the indicators of progress towards achieving MDG5, the most off track of all MDGs. Encouraging women to deliver in a health facility to ensure access to PMTCT may increase the number of institutional deliveries and hence contribute to efforts to reduce maternal mortality.

2. POLICY AND FUNDING ENVIRONMENT FOR RH INCLUDING HIV/AIDS IN EMERGENCIES

2.1 According to a study of disbursements of official development aid (ODA) for RH activities in 18 conflict-affected countries between 2003 and 2006, there is an inequity of RH ODA disbursement between conflict-affected and non-conflict-affected countries. An annual average of 4.4% of all ODA disbursed to sampled conflict-affected “least-developed countries” (LDCs) was allocated to RH activities, compared to 8.9% in sampled non-conflict affected.³⁴

2.2 Of the annual average of \$509.3 million ODA for RH, only 1.7% was disbursed to support family planning activities compared to 46.7% to support HIV/AIDS control efforts.³⁵

2.3 A review of the policy environment of RH in emergencies showed that policies related to gender-based violence and HIV/AIDS are well represented, compared to those related to family planning and emergency obstetric care.³⁶

2.4 The Ugandan Policy for the Reduction of Mother-to-Child HIV transmission in Uganda (May 2003)³⁷ refers to the following:

- (a) Women with HIV infection who are pregnant should be treated with either: Nevirapine at the onset of labour and Nevirapine syrup to the baby within 72 hours of birth; Zidovudine from 36 weeks of gestation until one week after delivery and syrup to the baby for the first week after birth.
- (b) Voluntary Counselling and HIV Testing within the antenatal clinic is recommended for pregnant women, with at least two laboratory tests: one for screening and another for confirmation.

2.5 The SRH policy of Congo (2004)³⁸ refers to PMTCT. The more recent Congolese SRH policy (2008) is very strong on PMTCT especially in well equipped facilities.

2.6 The National RH strategy of Sudan (2006) refers to PMTCT, one of the objectives is scaling up PMTCT services from 5 to 45 sites by 2010.³⁹

3. PMTCT IN CONFLICT AFFECTED SETTINGS—FINDINGS FROM SELECTED FACILITIES

3.1 Although there is a “facilitating” policy and funding environment for HIV/AIDS services in conflict affected settings (see point 2 above) a baseline study of selected service delivery sites in 2007 showed VCT and PMTCT services were severely lacking. As part of baseline activities, RAISE supported partners conducted assessments of the status of health services available at all sites identified for support through the RAISE Initiative. Assessments were conducted in Uganda, DRC and Sudan.

³² The Global Coalition on Women and AIDS (2004). Violence against Women and HIV/AIDS: Critical intersections, Intimate Partner Violence and HIV/AIDS, WHO.

³³ UNAIDS. “Congo”. <http://www.unaids.org/en/CountryResponses/Countries/congo.asp>

³⁴ Patel, P *et al.* (2009). Tracking Official Development Assistance for Reproductive health in Conflict-Affected countries. Plos Medicine.

³⁵ Ibid.

³⁶ Ettema, L, Tanabe, M *et al.*, Determining Donor Commitment Through Policy Analysis: Examining the Policy Environment for Reproductive Health in Crisis Settings. RAISE RH in emergencies conference, Kampala, Uganda, 2008. http://www.raiseinitiative.org/conf2008/raise_book_of_abstracts.pdf

³⁷ The Ugandan Policy for the Reduction of Mother-to-Child HIV transmission in Uganda (May 2003) <http://www.aidsuganda.org/npdf/PMTCT%20Policy.pdf>

³⁸ Republique Democratique du Congo Ministere de La Politique Nationale et Plan Directeur de Developement de la Sante de la Reproduction a Sante Publique. Programme National de Sante de La Reproduction PNSR (Juin 2004).

³⁹ Republic of Sudan Federal Ministry of health The National Strategy for Reproductive Health 2006–10 (August 2006).

3.2 In the 60 facilities in the three countries assessed:

- Only six women with unknown HIV status had been tested in the past 12 months in the maternity/labour ward in 60 facilities:
 - In the 10 facilities in Uganda, four women had been tested in the past 12 months.
 - In the 29 facilities in DR Congo, two women had been tested in the past 12 months.
 - In the 21 facilities in Sudan, no women had been tested in the past 12 months.
- Only nine mothers and nine newborns received PMTCT during the last 12 months in the 60 facilities:
 - In the 10 facilities in Uganda, five women received PMTCT during the last 12 months.
 - In the 29 facilities in DR Congo, four women received PMTCT during the last 12 months.
 - In the 21 facilities in Sudan, no women received PMTCT during the last 12 months.
- In the 60 facilities a total of 60 staff to provide pre and post-HIV counselling was available and in total 40 staff for PMTCT provision:
 - The 10 facilities assessed in Uganda had in total 26 staff available to provide pre and post-test counselling and in total 14 staff to provide PMTCT.
 - The 29 facilities assessed in DRC had 21 staff available to provide pre and post- test counselling and 16 staff available for PMTCT.
 - The 21 facilities in Sudan had 13 staff available for pre- and post-test counselling and 10 staff available for PMTCT.
- Only five of the 60 facilities assessed had nevirapine (200 mg tablets) available and only four facilities had nevirapine (liquid/suspension) available:
 - Only two of the 10 sites in Uganda had Nevirapine tablets available and only two sites had nevirapine (liquid/suspension) available.
 - Only three of the 29 facilities in Congo had Nevirapine tablets available and only two sites had nevirapine (liquid/suspension) available.
 - In Sudan nevirapine (tablets or liquid) was not available at all.
- HIV rapid testing kits were available in 12 of the 60 facilities:
 - Two of the 10 sites in Uganda had HIV rapid testing kits available.
 - Six of the 29 facilities in Congo had HIV rapid testing available.
 - Four of the 21 facilities in Sudan had HIV rapid testing available.
- Lack of supplies, training, policy and management issues were the main reasons mentioned for the lack of testing and PMTCT services.

4. DFID

4.1 DFID recognises the importance of HIV/AIDS prevention and treatment in emergency situations, noting that the proportion of People Living With HIV (PLWH) is four times higher in fragile states than in other low income countries, and the capacity of these states to respond is lower (DFID 2006). The same document highlights the need for post-conflict states to ensure due attention is paid to HIV in both humanitarian relief settings and during longer-term development processes.

4.2 DFID HIV/AIDS Strategy, *Achieving Universal Access* (June 2008) refers to AIDS responses in fragile states and humanitarian contexts and also refers to the DFID White Paper (2006) in this regard. The HIV/AIDS strategy recognises the fact that “women and children caught up in conflict face increased risk of abuse, violence and trafficking and are at higher risk of HIV infection”.

4.3 Whilst the 2009 DFID White Paper—*Building Our Common Future* makes reference to HIV/AIDS, it does not specifically reference the need to address the challenge of HIV/AIDS in humanitarian settings or fragile states.

5. RECOMMENDATIONS

5.1 We urge the IDC to prioritise an examination of DFID's track record on supporting capacity building for delivering HIV/AIDS and other essential reproductive health services in humanitarian settings since the publication of the 2008 AIDS strategy.

5.2 DFID must support and encourage humanitarian agencies to develop the skills and capacity required to address the paucity of HIV/AIDS and integrated RH services in humanitarian settings as shown by the RAISE baseline study.

Written evidence submitted by RESULTS UK

30 September 2009

ABOUT RESULTS UK

Part of a global movement, RESULTS UK is a non-profit advocacy organisation which works internationally to generate the public and political will to end poverty. Currently, our work focuses particularly on education, health, microfinance and water and sanitation.

We currently lead a network of more than 30 organisations in the UK Coalition to Stop TB provide the secretariat to the APPG on Global Tuberculosis, and belong to the Advocacy to Control TB Internationally (ACTION) network and the Stop TB Partnership. We also belong to the Action for Global Health Network, the UK AIDS Consortium and the British Overseas NGOs for Development network (BOND).

SUMMARY

RESULTS UK welcomes the International Development Committee Inquiry into progress on implementation of DFID's HIV/AIDS Strategy "*Achieving Universal Access*". It is encouraging that the IDC are maintaining their commitment to examine HIV/AIDS issues annually.

It is very positive that the need for HIV-TB integration was incorporated into the HIV/AIDS strategy, and DFID has worked to apply this priority through central policy and in many partner countries. There are still gaps to be filled, but we believe this strategy will achieve long term benefits, not only in addressing the co-epidemic of HIV and TB, but in strengthening the global health sector.

We are however concerned at this early stage to ensure that there be stronger provisions for monitoring and evaluation. This is elaborated upon in the following submission.

Structurally, we are hopeful that DFID will continue to enhance the efficacy of its support, both bilateral and multilateral. It is, moreover, important that the international community continue to scale-up its response to HIV and HIV-TB.

KEY RECOMMENDATIONS

To DFID

- Introduce specific indicators within the Monitoring and Evaluation framework for *Achieving Universal Access* to evaluate progress toward *all* the strategy's objectives, including indicators for HIV-TB integration.
- In cooperation with partner governments, record bilateral investment in HIV and HIV-TB as an input indicator.
- Review *The Challenge of TB and Malaria Control* Practice Paper (December 2005) and develop a comprehensive and fully integrated TB strategy.
- Continue to share best practice between DFID country offices and with donor partners, in line with the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action.
- Specify how the Government's commitment to spend £6 billion on health services and systems by 2015, (announced at the launch of DFID's revised strategy for tackling HIV/AIDS in 2008) will be spent.
- Continue to emphasise improved health systems through national HIV-TB programming.

To the IDSC

- Investigate ways DFID and the Treasury can better foster policy reform at the IMF.
- Conduct an inquiry into the World Bank's Health, Nutrition and Population Strategy, including a review of the strategy's Monitoring and Evaluation Framework. This should be completed as a priority, considering the recent IEG report into the World Bank's Health Nutrition and Population Strategy, which showed that over the past decade, only 29% of freestanding AIDS projects achieved satisfactory outcomes. The report also identified that M&E "remains weak" and "evaluation is almost nonexistent," a reason why the portfolio has performed so poorly. Consequences of poor

M&E include irrelevant project objectives, inappropriate project designs, unrealistic targets, and an inability to measure the effectiveness of interventions. The report calls this a “great concern” considering the new HNP strategy stresses the intent to focus on results.⁴⁰

- Recommend that DFID review the Practice Paper *The challenge of TB and Malaria Control* (December 2005) and develop a new Strategy to address global tuberculosis, prior to next World TB Day, 24 March 2010.

The following submission addresses in detail the specific focus areas outlined in the call for evidence.

1. *The process established by DFID for monitoring the performance and evaluating the impact of the strategy*

1.1 Given that DFID’s HIV/AIDS Strategy was launched in 2008, the timing of this inquiry presents challenges in evaluating the impact of implementation over this short time frame. It is clear that the monitoring and evaluation framework complementing the HIV/AIDS Strategy will be crucial to measure the longer-term performance and impact, and we hope that the Committee continues to track this M&E framework closely.

1.2 DFID have stated that addressing HIV-TB co-infection is a priority and have committed to do more to support the integration of HIV/AIDS and TB Services.⁴¹ However, despite ongoing recommendations for the need for specific targets to address HIV-TB co-infection, along with clear steps outlining how these targets will be achieved, these were not incorporated within the HIV/AIDS Strategy Monitoring and Evaluation framework. DFID’s overall Public Service Agreement (PSA) targets (as detailed in the 2008 DFID Annual Report), include no HIV-TB indicators and no TB indicators for Africa where the burden of TB is greatest.

1.3 It is therefore crucial that the Monitoring and Evaluation Framework be reviewed to include HIV-TB targets in order to have some way of assessing the outcomes of DFID’s efforts in this area. Due to the lack of specific measurables for each country office on HIV-TB integration (as well as integration of HIV with other services such as Malaria, maternal, newborn and child health) it may not be possible to attribute outcomes to DFID and to evaluate the impact of the strategy.

1.4 Individual country offices are not required to provide comprehensive and equivalent data on HIV-TB activities. Qualitative evidence collected by RESULTS UK from five DFID offices in Africa,⁴² all of which stated in 2008 that there was “insufficient collaboration” between HIV and TB programmes,⁴³ suggest there have been positive steps toward implementing integrated services, and improvements on the ground. This is, however, not true across the board. One office stated DFID itself had not made progress toward integration in their country, and the feedback suggested there was variance in progress.

1.5 We noted that DFID’s work in some countries is as facilitator, encouraging collaboration and the exchange of best practice between national health services, and other actors such as the WHO, USAID and the US President’s Emergency Plan for AIDS Relief (PEPFAR). This is a positive and encouraging role for DFID and this type of work will no doubt effect a greater paradigm shift toward better HIV-TB integration. However the impact of this cannot be audited without proper outcome indicators.

1.6 Suggestions for targets that could be used to monitor the progress of a DFID supported country in achieving HIV-TB collaboration have been provided to DFID previously, and are once again attached as Appendix A.

1.7 We strongly urge that DFID also specifically record how much bilateral funding will be devoted to HIV and HIV-TB. This should include funds incorporated within the £6 billion commitment to strengthening health systems, and should be broken down by year and on a country to country basis. This will further transparency, and help civil society gauge the priority given to HIV-TB. Solely measuring financial input is not the same as measuring progress. However, by eliciting this data, DFID will be able to evaluate mechanisms and monitor progress in HIV-TB integration where it *ought* to have been made (based on financial investment), as well as convey to country partners the importance of HIV-TB integration to the success of the strategy. This a repetition of a recommendation made by the ACTION network in March 2009.⁴⁴

1.8 DFID should also demand a clear strategy for HIV-TB integration, as well as routine monitoring and evaluation of HIV-TB indicators, from multilateral organisations with considerable HIV programme investment. Priority should be given to the World Bank, who recently stated that the aim of their new Health, Nutrition and Population Strategy is to ensure that all health sector operations (including HIV/AIDS projects) incorporate TB control and prevention strategies to the extent possible.⁴⁵ Although the Bank

⁴⁰ In April 2009, the World Bank’s Independent Evaluation Group (IEG) issued an evaluation of the Bank’s entire Health, Nutrition and Population (HNP) lending portfolio from 1997 to 2007: [http://lnweb90.worldbank.org/oed/oeddoelib.nsf/DocUNIDViewForJavaSearch/2DDDEC31CBF08D36852575B5006B34ED/\\$file/hnp_full_eval.pdf](http://lnweb90.worldbank.org/oed/oeddoelib.nsf/DocUNIDViewForJavaSearch/2DDDEC31CBF08D36852575B5006B34ED/$file/hnp_full_eval.pdf)

⁴¹ Most recently reiterated in a letter from Ivan Lewis to the UK Coalition to Stop TB (18 May 2009).

⁴² DFID Offices in the Democratic Republic of Congo, Kenya, Malawi, Uganda, Zambia (September 2009).

⁴³ ACTION, Living With HIV, Dying of TB, March 2009: Table 12, (March 2009).

⁴⁴ Advocacy to Control TB Internationally (ACTION): Living with HIV, Dying of TB, (March 2009) Page 41.

⁴⁵ Letter to the APPG on Global Tuberculosis from Ajay Tandon, Acting Director, HNP, The World Bank (August 2009).

identified a number of projects in Sub-Saharan Africa that incorporate TB control, they have still not identified mandatory monitoring and evaluation indicators to track and assess efforts against TB-HIV co-infection. We feel that this is an area which demands attention from the Select Committee.

2. *Integration of HIV/AIDS prevention, treatment and care with other disease programmes, particularly tuberculosis and malaria*

2.1 Data published in March 2009 reported that 12 of 24 DFID country offices felt “insufficient TB-HIV collaboration” is a challenge to addressing the TB epidemic. Over half of these offices also expected rates of TB-HIV co-infection to rise over the next five years.⁴⁶

2.2 At present, the integration of HIV-TB services appears to have been unevenly prioritised in DFID’s work in the last 12 months.⁴⁷ While progress has been made, there is still a lack of integration in a number of high burden countries. Acknowledging that the epidemic has country specific characteristics, RESULTS UK urges DFID to re-emphasise the need for tailored integrated service delivery, and that a framework for such be incorporated into all Country Assistance Plans.

2.3 We were pleased to note that Health Advisors were briefed in HIV-TB⁴⁸ and discussed best practice during their 2009 retreat, suggesting DFID centrally are giving integration some priority. Where progress has been seen at country level, RESULTS UK commends DFID’s policy work facilitating enhanced integration of HIV and TB services in the succeeding twelve months. In particular, a strong dialogue with PEPFAR in both Uganda and Kenya, seems to have translated its commitment to lead a “global response to fully integrate HIV prevention, treatment and care with TB services at the country level”⁴⁹ into practice. There were also several examples of DFID consulting on national HIV-TB strategy, and some instances where enhanced policy was being successfully practised on the ground, as in Northern Uganda.

2.4 In Malawi, a history of HIV-TB coordination was built on with the formulation of a national strategy to integrate HIV and TB services using shared sites for HIV-TB clinics, the effective screening and cross-referral of patients and the efficient use of ART. Even though this is not functioning perfectly, robust evaluation is in place.⁵⁰

2.5 The advanced integration and concurrent evaluative monitoring in Malawi provides a model, and we would urge the sharing of this best practice from the in-country DFID staff and partners, such as Lighthouse Malawi, to other national offices and partners.

2.6 The strategy commits to increase funding for research into an AIDS vaccine and microbicides. However, it does not make any similar commitment to increase funding for new tools for TB which will be crucial to reducing morbidity and mortality among people living with HIV/AIDS. A new regimen of drugs is required that can combat TB in a shorter time period and that are compatible with ART. New diagnostics that can detect all forms of TB in people living with HIV/AIDS (PLWHA) and that can be used in low resource settings are urgently needed. However, as reported by the APPG on AIDS in July 2009, TB (and Malaria) R&D is particularly neglected due to low commercial value.⁵¹

2.7 DFID have clearly acknowledged through *Achieving Universal Access* the need for disease specific strategies to tackle global epidemics, and that integration of these strategies can play an important role in the strengthening of broader health systems. We acknowledge and support DFID’s work on broader systemic health challenges- challenges that may otherwise harm the efficacy of any disease focused programming- and encourage the promotion of HIV-TB integration as a benchmark of national health system strengthening.

2.8 RESULTS UK acknowledges that “vertical” disease-focused programmes can be problematic if improperly imposed on existing healthcare structures, as happened in Uganda, where healthcare professionals were precipitately diverted from mainline services to HIV work.⁵²

2.9 However, it should be noted that recent research shows that health systems can substantially benefit from a well-planned national disease response.⁵³ Through national programmes, newly trained health workers can develop transferrable skills; infrastructure can be improved with renovation and new building; distribution networks can be grown; monitoring practice can be enhanced and useful data collected; all these

⁴⁶ Advocacy to Control TB Internationally (ACTION): Living with HIV, dying of TB (March 2009) Page 26.

⁴⁷ Based on RESULTS UK feedback from DFID offices in Malawi, the DRC, Zambia, Kenya and Uganda (September 2009), when asked “In your country of work, have DFID been able to move forward with integration of HIV-TB services in accordance with *Achieving Universal Access*?”

⁴⁸ Mark Rotich, DFID Kenya (September 2009).

⁴⁹ PEPFAR: Tuberculosis and HIV/AIDS, <http://www.pepfar.gov/documents/organization/114192.pdf>

⁵⁰ Lighthouse Malawi: Integrated TB and HIV services at Martin Preuss Centre—Initial Findings http://www.mwllighthouse.org/index.php?searchword=hiv+tb&ordering=&searchphrase=all&Itemid=1&option=com_search

⁵¹ APPG on AIDS: The Treatment Timebomb (July 2009) Page 29.

⁵² Alasdair Robbs, DFID Uganda Office (Sept 2009).

⁵³ International Union Against TB and Lung disease: How health systems in sub-Saharan Africa can benefit from tuberculosis and other infectious disease programmes [Unresolved issues] (2009) <http://www.ingentaconnect.com/content/iuatld/ijtld/2009/00000013/00000010/art00004>

benefits are transferrable to the health system at large. These broader outcomes can be treated as goals for national HIV-TB programmes in accordance with WHO guidelines,⁵⁴ and DFID should seek to facilitate these benefits.

2.10 Due to the changing face of the TB epidemic, with an increasing threat of drug resistant strains and the impact of TB on PLWHA, there is a clear need for a DFID strategy outlining the UK's response to Tuberculosis. RESULTS UK strongly urge the Select Committee to recommend that DFID review their practice paper *The challenges of TB and Malaria control* (December 2005) and develop a comprehensive strategy on TB which fully integrates with DFID's overarching health related goals. This TB Strategy should run in parallel to Achieving Universal Access and identify clear monitoring and evaluation targets for HIV-TB integration. DFID's HIV/AIDS Strategy will save many more lives if it is coupled with a clear strategy to address TB in all high burden countries.

3. Progress on health systems strengthening and on an integrated approach to HIV/AIDS funding

3.1 *Achieving Universal Access* recognises that “the availability of sufficient numbers of trained and motivated health workers, who are adequately paid and located where they are most needed” is crucial to the effective building of health systems and a pre-requisite for scaling up the provision of HIV/AIDS services.

3.2 A recent review of strategies to promote health systems strengthening (HSS) found that the majority of donor programmes for HSS (with the notable exception of Malawi) “consist . . . mainly of training approaches as part of different programmes to strengthen the health sector. In general there is relatively little focus on more comprehensive responses to [Human Resources for Health] development.” Even in Malawi the review notes that “support for national salary reforms still appears to be regarded as a government domain where donor contributions may be problematic if not sustained”.⁵⁵

3.3 In much of the world there remains a “health workforce crisis”; numbers of health workers have not increased at the rates needed to be able to provide universal access to HIV/AIDS and HIV-TB services. There are many reasons behind this issue, including emigration and the impact of HIV/AIDS on health workers themselves, but fundamentally the main barrier is governments' inability to employ sufficient workers due to budget restrictions that lead to too few health workers being employed by the government and low remuneration offers for those who are employed. In Uganda, the DFID office reported that 50% health worker absenteeism is a primary retardant to progress. Comprehensive reform of the government's ability to employ health workers, including of national salary systems, is therefore crucial to solving the crisis.

3.4 To a large extent the crisis is simply a question of lack of resources, and in order to tackle this DFID should look into increasing its funding, encouraging other donors to do the same (and to provide this extra aid as long-term flexible financing that can meet requirements to be spent on recurrent costs) and developing innovative financing streams for health such as a currency transaction levy.

3.5 However, external restrictions on governments' macroeconomic choices also impact resources available for healthcare. Over the past few decades the restrictive macroeconomic policies promoted by the IMF have been increasingly recognised as a constraint to scaling up the response to health crises in the developing world. Historically, the IMF has directly restricted the ability of governments to hire additional health workers through imposing “wage bill ceilings” which restrict the amount that a government can spend on public sector workers. In 2007 the IMF recognised that wage bill ceilings had in many cases been damaging, and agreed to use them only in exceptional circumstances. However, this has not led to a big enough change in the ability of developing countries to hire adequate numbers of health workers. In many countries wage bill ceilings remain a government policy, despite the evidence that many more health workers are needed to reach the MDGs in the majority of developing countries. Part of the reason for this remains the IMF's stance.

3.6 The IMF promotes very low inflation and fiscal deficits, restricting the choices that developing countries can take about what macroeconomic policies to follow. Evidence shows that investments in health and education lead to high economic growth, but despite this the IMF's insistence on low fiscal deficits can prevent countries from making investments that pay off. The basic issue is that the IMF assesses returns on investments in a short time-frame—typically three to five years—because it is a short-term actor, whereas the returns from health and education investments are seen properly only in a much longer time-frame. There also remain concerns over the diversion of aid to build foreign currency reserves, which similarly restricts the level of resources that can be spent on healthcare.

3.7 As an example, Kenya's health sector, although not one of the most under-staffed in the continent, has a significant worker shortage. The most recent figures available show that the country has 1 physician and 12 nursing or midwifery personnel per 10,000 population, against a WHO recommended minimum of 23 healthcare professionals per 10,000 population.⁵⁶ This in a country with an HIV prevalence of between 7.1 and 8.3%, and therefore a severe HIV-related strain on the health system.

⁵⁴ Contributing to Health System Strengthening—Guiding principles for national tuberculosis programmes (WHO 2008) http://whqlibdoc.who.int/publications/2008/9789241597173_eng.pdf

⁵⁵ “A cross-country review of strategies of the German development cooperation to strengthen human resources”, Ricarda Windisch, Kaspar Wyss and Helen Prytherch, *Human Resources for Health* 2009, 7:46, see <http://www.human-resources-health.com/content/7/1/46>
Although this article focuses specifically on the German Development Agency it reviews overall donor strategies in countries including Malawi, Tanzania, Cameroon and Rwanda in which DFID has a significant role.

⁵⁶ WHOSIS, accessed on 8/9/09, see <http://www.who.int/whosis/en/>

3.8 Kenya's severe health worker shortage has its roots in the country's IMF restructuring programmes over the past few decades. The IMF imposed a hiring freeze to reduce the size of the civil service, which preventing sufficient hiring of health staff between 1993 and 2005. An interview in 2009 with a key respondent at the Division of TB and Leprosy (DTLP) within the Ministry of Health revealed that one of the factors limiting the testing and diagnosis of TB (the biggest killer of HIV-positive people) in Kenya remains the shortage of laboratory technicians.⁵⁷

3.9 Between 1999 and 2007 Kenya had a PRGF arrangement with the IMF, under which the country borrowed SDR 112.5 million (about US\$170.4 million). During the 2008 Article IV consultation a disagreement arose between the IMF and the Kenyan Government over the appropriate level for the fiscal deficit. The Government set the budget deficit at 5.3%, but were urged by the IMF staff team to reduce this to 4.5%. In order to do this, the IMF suggested that "foreign-financed investment spending [be] executed in line with rates of the recent past (rather than the 100% execution rate assumed in the budget). This would still allow for real spending growth of some 2% (versus 5% in the budget)."⁵⁸ In effect this would mean that foreign aid continued to be diverted into paying down the fiscal deficit rather than expansion of pro-poor spending. This is a recent discussion, and raises concerns that the IMF continues to negatively impact on social sector spending in developing countries, lessening the impact of donor attempts to strengthen health systems through its advice to member country governments, even in the absence of a financial programme.

3.10 In response to recent macroeconomic shocks (drought, food, fuel, and financial) Kenya applied in March 2009 for funding from the IMF's Exogenous Shocks Facility. A freeze on recruitment has once again been instigated, and it is unclear how long this is intended to be in place. Under the ESF agreement there will be a temporary increase in borrowing rates, allowing the fiscal deficit to increase to 5.2%. However, this remains below the deficit originally budgeted by the Kenyan Government before the impact of the exogenous shocks was felt, meaning that anticipated public investment (which was to be financed under the original budget) will have been squeezed out by the impact of the shocks. Even more concerning, the fiscal deficit is projected to be *smaller* than average over the medium term in order to make up for the temporary increase, which will squeeze limited health budgets even further.⁵⁹

3.11 In fact, the swift rebound of fiscal deficits to normal or even lower than normal levels in 2010 is a feature of many of the recent crisis agreements with low-income countries. To deal with the greater-than-expected impact of the financial crisis on government revenues, 79% of the low-income countries that reached an agreement with the IMF between April and August 2009 saw their fiscal deficit limits increased by an average of 1.4% between the two reviews conducted 2009. However, 70% of these countries are expected to decrease their fiscal deficits again by an average of 1.3% in 2010 (meaning that the 2010 agreements almost wipe out the temporary increases seen in 2009), while 80% of these countries will have to reduce their deficit by an average of 1.7% of GDP between 2009 and 2011, meaning that in the short to medium term countries are being told to reduce their deficits in the face of recession. This is in stark contrast with the IMF's advice to G20 nations not to end the "fiscal stimulus" too soon. In addition, of the nine countries in this set that had sufficient data to track projections for spending on priority social sectors, at their mid 2009 reviews five were planning to spend less on social sectors such as health in 2008 and 2009 than they were 6 months earlier.⁶⁰

3.12 In 2007 the Kenyan Government agreed that the Clinton Foundation, the Global Fund, and PEPFAR will fund the salaries of more than 2,000 additional health workers for a limited period, after which the government will take over.⁶¹ This is an extremely positive move, but it remains to be seen what effect the new lower fiscal deficit in the medium-term will have on the ability of the government to take on these new staff. Donors should ensure that pressure is applied to the IMF to allow Kenya the fiscal space to absorb these additional health workers into the national budget.

3.13 Kenya's case illustrates that although the IMF has made adjustments to its short-term policy to address the unprecedented global economic crisis, in the long-run its policies remain a barrier to scaling up investments in key workforces, and will prove a significant impediment to achieving the health systems strengthening goals of "*Achieving Universal Access*". The IMF is not a development agency, and takes a very short-term approach to macroeconomic policy. There is an urgent need to better integrate IMF programmes with longer term development work, to ensure that needs for investment in social sectors are accommodated in short-term budgetary and macroeconomic decisions.

3.14 At a recent meeting Christian Mumssen, Division Chief for the Strategy, Policy and Review Department at the IMF, admitted to RESULTS that the linkages between investment, growth and fiscal balance are not the IMF's expertise. Mr Mumssen called on other development partners to assist the IMF

⁵⁷ "Evidence of the impact of IMF fiscal and monetary policies on the capacity to address the HIV/AIDS and TB crises in Kenya", Julius K Korir and Urbanus Kioko, Centre for Economic Governance and AIDS in Africa and RESULTS Educational Fund (REF), 2009, p 40.

⁵⁸ "Kenya: 2008 Article IV Consultation/Staff Report; Staff Supplement; Public Information Notice on the Executive Board Discussion; and Statement by the Executive", International Monetary Fund, 2008.

⁵⁹ "Kenya: Request for Disbursement Under the Rapid-Access Component of the Exogenous Shocks Facility/Staff Report; Staff Supplement; Press Release on the Executive Board Discussion; and Statement by the Executive Director for Kenya", International Monetary Fund, 2009.

⁶⁰ Global Campaign for Education, (forthcoming 2009) "Update: Education on the Brink" (Title to be confirmed).

⁶¹ "Investment in HIV/AIDS programs: Does it help strengthen health systems in developing countries?", Dongbao Yu, Yves Souteyrand, Mazuwa A Banda, Joan Kaufman and Joseph H Perriens, *Globalization and Health* 2008, 4:8.

in this area.⁶² It seems clear from this comment that DFID should take a greater role in IMF negotiations—including at country level—to provide evidence to support the returns on investments in health and education and to help determine suitable levels of financing for key social and development sectors. Currently there is an evident disconnect between development policy and the IMF, with the IMF restraining the effectiveness of donors' attempts to support health systems strengthening.

3.15 RESULTS recommends that the International Development Select Committee investigate this issue further, ideally through a joint inquiry with the Treasury Select Committee to look into the coherence between DFID's work and the representation of the UK on the IMF Board, which is managed through HM Treasury.

APPENDIX A

SUGGESTED TB/HIV INDICATORS TO MONITOR THE PROGRESS OF DFID SUPPORTED COUNTRIES IN ACHIEVING TB/HIV COLLABORATION

1. TB treatment for PLWHA in care.
 - Number of adults and children enrolled in HIV care who have started TB treatment.
2. HIV testing of TB Patients.
 - Proportion of all registered TB patients with documented HIV status recorded on the TB register.
3. ART in TB Patients with HIV.
 - Proportion of HIV-positive registered TB patients given ART during TB treatment.
4. TB status assessment in PLWHA in care: Intensified TB case-finding among People living with HIV.
 - Number of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit.
5. Proportion of HIV-positive TB patients who receive co-trimoxazole preventive therapy (CPT).
 - Number of HIV-positive TB patients who receive (at least one dose of) CPT during their TB treatment.
6. Proportion of adults and children newly enrolled in HIV care given treatment for latent TB infection.
 - Number of adults and children newly-enrolled in HIV care who are started on isoniazid preventive therapy (IPT) for latent TB infection.
7. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV.
 - Number of adults with advanced HIV infection who are currently receiving ART in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) and who were started on TB treatment (in accordance with national TB programme guidelines).

Written evidence submitted by the UK Consortium on AIDS and International Development

30 September 2009

The UK Consortium on AIDS and International Development welcomes the opportunity to write a submission to the International Development Committee Inquiry on “HIV/AIDS: Progress on Implementation of DFID's HIV/AIDS Strategy.”

The UK Consortium on AIDS and International Development is a group of more than 80 UK based organisations working together to understand and develop effective approaches to problems created by the HIV epidemic in developing countries. It enables each agency to bring its own expertise and experience to be shared and used to help all members improve their responses to the epidemic, through information exchange, networking, advocacy and campaigning. The Consortium has a number of working groups made up of member agencies and others who meet to strengthen their capacities through sharing good practice and developing collective policy position and advocacy initiatives. The Stop AIDS Campaign is the campaigning arm of the Consortium.

The UK Consortium's submission is a collaborative effort, which includes text from individual member agencies, which have produced their own submissions. These have been cited where there is an extract or quote directly from the text they have written. The Executive Summary draws the most salient points or recommendations from the answer to each question.

⁶² Meeting hosted by ODI on Wednesday 9 September 2009.

EXECUTIVE SUMMARY

Q1 *The process established by DFID for monitoring the performance and evaluating the impact of the Strategy*

The strategy would have benefited from an integrated process of indicator selection to ensure a commitment to measuring deliverables.

Q2 *Progress on health systems strengthening and on an integrated approach to HIV/AIDS funding*

- DFID should publish the breakdown of its spending on health systems strengthening along with mechanisms to collect evidence of impact on health and HIV indicators.
- Through its leadership role in the IHP+, DFID needs to ensure more rapid implementation at the country level, which includes efforts to fill financing gaps for health in the IHP+ focus countries.
- DFID's should ensure that gains in the HIV response are not lost through its focus on HSS, by addressing stigma and discrimination before integration of HIV responses into public health systems is attempted.
- DFID's approach to integrated funding for AIDS should recognise the role of community systems and through its funding and policies ensure adequate support to this sector.

Q3 *Integration of HIV/AIDS prevention, treatment and care with other disease programmes, particularly tuberculosis and malaria*

DFID to review their practice paper *The Challenges of TB and Malaria control* (December 2005) and to develop a comprehensive strategy on TB which fully integrates with DFID's overarching health related goals. This TB Strategy should run in parallel to Achieving Universal Access and identify clear monitoring and evaluation targets for HIV-TB integration.

Q4 *The effectiveness of DFID's Strategy in ensuring that marginalised and vulnerable groups receive prevention, treatment, care and support services*

The limitations to reach marginalised groups inherent in DFID's focus on health systems strengthening need to be counteracted with the development and publication of plans by the FCO and DFID to address the needs of marginalised groups, which continues predictable sustainable financing for community responses most effective at reaching marginalised groups.

Q5 *The effectiveness of social protection programmes within the Strategy*

Social protection is an essential contribution to providing a safety net for the poorest, including those who are infected and affected by HIV.

Q6 *Progress towards the commitment to universal access to anti-retroviral (ARV) treatment and its impact on the effectiveness of care and treatment, particularly for women*

- DFID should ensure that its focus on health systems strengthening does not undermine progress towards universal access to HIV treatment, prevention and care & support services.
- DFID's continued and increased support to The Global Fund is critical with the Fund now supporting 2.3 million people on ARVs (as of June 09). The Global Fund to Fight AIDS, TB and Malaria faces a severe funding shortfall of approximately \$4 billion for the 2008–2010.⁶³
- We particularly welcome DFID's support of the UNITAID patent pool and their call for pharmaceuticals to get involved. It would be most useful for the IDC to add its weight to DFID's call for pharmaceutical companies to engage with UNITAID on the patent pool.
- PMTCT must be a top priority if we are to manage the epidemic.

1. *The process established by DFID for monitoring the performance and evaluating the impact of the Strategy*

1.1 DFID has made a real effort in the new AIDS Strategy launched last year to improve on the lack of any measurable targets and indicators in the first AIDS strategy launched in 2004. Civil society was also involved in the process of developing an M&E framework—see below.

1.2 It is too early to tell how effective the M & E process for monitoring the performance and evaluating the impact of the AIDS strategy launched in June 2008 will be, since the baseline position is unpublished and the first progress report will be published for World AIDS Day in 2010.

1.3 Even with the above statistics, overviews and reports produced in 2010, it will still be difficult to know exactly what DFID is doing and how effective the AIDS strategy is or what impact it might be having for the following reasons:

- 1.3.1 *Lack of targets and indicators in the Priorities for Action:* The “targets” in the Priorities for action are not SMART eg “Spend £6billion on health systems and services by 2015”, “Spend

⁶³ <http://www.reuters.com/article/middleeastCrisis/idUSL3579451>

over £200 million to support social protection programmes”, “Increase prevention of mother to child transmission”. As a result reporting against these targets remains vague and therefore progress is difficult to measure.

- 1.3.2 *Inability to distinguish DFID’s role amongst other players*: DFID are rightly working with others towards the harmonisation of services, however this poses problems when trying to find out what a single actor like DFID has done. The targets in the strategy cannot easily be measured eg “work with others to intensify international efforts”, “Intensify efforts to increase the coverage”, “Work with others to reduce drug pricing and increase access to more affordable treatment”.
- 1.3.3 *Difficulty of collecting accurate data*: this was a major problem for the interim evaluation of the last AIDS strategy. It has to be understood by all that this is a problem in all services in poor countries. The last strategy had a spending budget/target attached to the strategy. The new AIDS strategy does not have a spending target and therefore it will be even more difficult to track spending within a general health budget.
- 1.3.4 *The template for DFID country offices asks questions rather than measurements*, which is good for describing activities in-country but not for measuring progress. It is unclear to external organisations the extent that DFID country offices use the strategy/M&E template to guide their decision making or the development of their own country strategies and interventions.

1.4 However we applaud the fact that DFID has linked its strategy to global targets and indicators, although clearly challenges of attribution remain. This year DFID has actively engaged and led on the process of improving and fostering coherence of internationally agreed indicators. DFID currently co-chairs the interagency Indicators Working Group of the UNAIDS Monitoring and Evaluation Reference Group. It is working closely with the Care and Support Working Group of the UK Consortium on AIDS and International Development to review global care and support indicators to input into the upcoming review of UNGASS indicators. Together, DFID and the UK Consortium on AIDS and International Development have modelled a new independent review process for global indicators that the Indicators Technical Working Group of the UNAIDS Monitoring and Evaluation Reference Group has now endorsed. (VSO)

1.5 Sufficient funding for and meaningful review of these global targets needs continued commitment at the highest level. This is particularly true of the target of Universal Access to Treatment, Prevention, Care and Support by 2010 proposed and led by the UK Government at the G8 in 2005. We urge the Minister for International Development and the Prime Minister to lead on this again next year to ensure a review of progress on this target is undertaken at the 2010 G8 and UN MDG review and that clear new achievable commitments are made. (VSO)

1.6 The process established by DFID to develop the M&E framework presented a groundbreaking approach within the Department of International Development in engaging civil society to assist in developing a monitoring process.

- 1.6.1 The Consortium was told it was a consultative process and we had no responsibility for the final product.
- 1.6.2 The UK Consortium welcomed the engagement of civil society and set up an “Indicators Working Group’ (IWG), composed of members with experience in M&E. This small group of six experts informed DFID from evidence based good practice and the direct experiences of monitoring HIV responses. Whilst the Indicators Working Group was asked to focus on the development of indicators, it was also able to provide support and expertise to inform other parts of the framework.
- 1.6.3 DFID’s commitment to the process and involvement of the IWG was clearly shown through the continued engagement of staff and the openness and honesty with which meetings were conducted.
- 1.6.4 Unfortunately, despite DFID’s commitment to an inclusive approach, the methodology and nature of the process limited the extent of civil society engagement. The application of Chatham House rules to the IWG proceedings limited the ability of the IWG to consult and engage the Consortium members it was representing. This undermined the credibility of the consultation.

RECOMMENDATIONS

- The strategy would have benefited from an integrated process of indicator selection to ensure a commitment to measuring deliverables.
- Future efforts to engage civil society should adopt an approach that allows for meaningful engagement and includes a more equal role for all partners in decision-making. Recommendations for good practice from HM Government COP on Consultations⁶⁴ should inform consultation efforts across HM government’s departments.

⁶⁴ <http://www.berr.gov.uk/files/file47158.pdf>

2. Progress on health systems strengthening and on an integrated approach to HIV/AIDS funding

2.1 There is no doubt 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. There is a sense that DFID are de-prioritising HIV, evidenced by the reduction of clear funding commitments to HIV in the strategy, their criticism of vertical funding programmes and a serious reduction of the number of staff in the AIDS and Reproductive Health Team. This has a big impact on the capacity to drive the AIDS strategy forward within DFID or to continue to play the leading role in global HIV policy discussions. (VSO)

2.2 DFID's commitment to £6 billion for health in the HIV strategy remains controversial in that there is no commitment as to what percentage of that will be spent on HIV. There are very few HIV-specific funding targets. This is a worrying message, as without clarification the implication is that broader health system strengthening should be promoted at the expense of funding for HIV. (VSO)

2.3 Since the launch of "*Achieving Universal Access*" and the announcement of the UK government's plans to spend £6 billion on strengthening health systems and services, there has been limited information available on current or future use of these funds. Since the launch of the Strategy, the UK government has made the following commitments:

- 2.3.1 an estimated £450 million until 2011 to support national health plans for eight IHP+ countries at the UN High Level Event on the Millennium Development Goals in September 2008;
- 2.3.2 £40 million to the Affordable Medicines Facility for malaria and an increase in malaria research spending to at least £5 million per year by 2010; and
- 2.3.3 £50 million to fighting neglected tropical diseases.⁶⁵ (International HIV/AIDS Alliance)

Contribution to World Bank and Global Fund

2.4 In mid December 2007 Douglas Alexander announced the UK will contribute £2.134 billion to the World Bank over the next three years. This contribution makes the UK the largest donor to the World Bank over this funding period. The announced commitment of DFID to the Global Fund on AIDS TB and Malaria was £1 billion over seven years until 2015. The long term nature of this commitment is exemplary, but the amount is insufficient considering the fact that the Global Fund announced in July a budget shortfall of about \$3 billion in order to simply maintain and finance programs planned for 2010. DFID should be congratulated as a leading donor but encouraged also to re-analyse this funding balance as well as to push other donors to commit more funds. (VSO)

2.5 This setting of the funding balance should also be based on an honest evaluation of how effectively the money is being spent. This was demonstrated clearly by a comparison of the evaluation reports of the World Bank Independent Evaluation Group (IEG) for their "Health Nutrition and Population Portfolio" for 1997–2007 and that of the Global Fund for AIDS, TB and Malaria. The World Bank's report states that only 18% of their HIV projects in Africa were satisfactory. The Global Fund report stated however that 69% of their projects met the highest rating.⁶⁶ (VSO). The following findings of the IEG are of particular concern:

- 2.5.1 Over the past decade only two-thirds of World Bank health projects showed satisfactory outcomes. In Africa the results were particularly weak, with 73% of projects failing to achieve even satisfactory outcomes.
- 2.5.2 Only half of the Bank's health support was focussed on the poorest people, and much of the Bank's spending ended up helping the richest 20% of people.
- 2.5.3 Only 29% of freestanding HIV projects had satisfactory outcomes and in Africa the figure was only 18%.
- 2.5.4 These findings should influence a re-evaluation by DFID of the effectiveness of prioritising spending through the World Bank.

International Health Partnership

2.6 While the International Health Partnership and Related Initiatives (IHP+) would present an opportunity to DFID to allocate resources to health systems strengthening, implementation progress has been slow, the implementation progress has been slow. Further, while the IHP+ aims to improve the effectiveness of health aid delivery, the IHP+ has not been able to address the initial key concern of financing

⁶⁵ "Health in Crisis: Why in a time of economic crisis Europe must do more to achieve the health MDGs"; Action for Global Health; 2009; (http://www.actionforglobalhealth.eu/media_publications/afgh_policy_reports/policy_report_health_in_crisis/policy_report_health_in_crisis)

⁶⁶ World Bank Independent Evaluation Group, 2009 Improving Effectiveness and Outcomes for the Poor in Health, Nutrition and Population (p.xvi). The Global Fund for AIDS, TB and Malaria, 2009, ScalingUp For Impact: Results Report, P 55.

gaps for health in its focus countries. In Ethiopia, the first country to sign a compact, a funding gap of between US\$1.56 billion to US\$2.84 billion was identified.⁶⁷ However, in response, donors, including DFID, allocated just a fraction of what was required. (International HIV/AIDS Alliance)

Community health systems—stigma and discrimination

2.7 Much of the “health systems strengthening” rhetoric does not refer to a broad system that integrates community level systems into the continuum of care in an affective and sustainable way. Community level systems play a critical role in ensuring access for and involvement of marginalised populations in HIV services. Evidence suggests that integration of the community level systems can result in reductions of hospital readmissions of chronically ill patients, better co-ordination of care, and increased access to services through the delivery of high quality, cost-effective home based care. (International HIV/AIDS Alliance)

2.8 In many places, “stand alone” ARV treatment programs have been developed or implemented due a lack of capacity in the broader health system, and in response to the high levels of stigma and discrimination experienced by people with HIV in health services. Addressing stigma and discrimination in broader health systems is critical to ensuring successful integration or a broader health system role in HIV treatment and care. However there is little evidence of overt plans to address this in many health systems integration plans or discussion documents. This is something that needs to be addressed before integration is attempted, not after the fact once evidence of systematic discrimination becomes known. (International HIV/AIDS Alliance)

2.9 We are pleased to see that DFID has responded by collaborating with the World Bank to start to address these issues by conducting an ambitious evaluation of the community response to HIV and AIDS with a view to increase resource allocation. They have enlisted the support of the UK Consortium to facilitate full civil society engagement. (VSO)

RECOMMENDATIONS

- DFID should publish the breakdown of its spending on health systems strengthening along with mechanisms to collect evidence of impact on health and HIV indicators.
- Through its leadership role in the IHP + , DFID needs to ensure more rapid implementation at the country level, which includes efforts to fill financing gaps for health in the IHP + focus countries.
- DFID’s should ensure that gains in the HIV response are not lost through its focus on HSS, by addressing stigma and discrimination before integration of HIV responses into public health systems is attempted.
- DFID’s approach to integrated funding for AIDS should recognise the role of community systems and through its funding and policies ensure adequate support to this sector. (International HIV/AIDS Alliance)

3. *Integration of HIV/AIDS prevention, treatment and care with other disease programmes, particularly tuberculosis and malaria*

3.1 DFID have stated that addressing HIV-TB co-infection is a priority and have committed to do more to support the integration of HIV/AIDS and TB Services.⁶⁸ However, despite ongoing recommendations for the need for specific targets to address HIV-TB co-infection, along with clear steps outlining how these targets will be achieved, these were not incorporated within the HIV/AIDS Strategy Monitoring and Evaluation framework. DFID’s overall Public Service Agreement (PSA) targets (as detailed in the 2008 DFID Annual Report), include no HIV-TB indicators and no TB indicators for Africa where the burden of TB is greatest. Due to the lack of specific measurables for each country office on HIV-TB integration (as well as integration of HIV with other services such as Malaria, maternal, newborn and child health) it may not be possible to attribute outcomes to DFID and to evaluate the impact of the strategy. (Results-UK)

3.2 Individual country offices are not required to provide comprehensive and equivalent data on HIV-TB activities. Qualitative evidence collected by RESULTS UK from five DFID offices in Africa,⁶⁹ all of which stated in 2008 that there was “insufficient collaboration” between HIV and TB programmes, suggest there have been positive steps toward implementing integrated services, and improvements on the ground. This is, however, not true across the board. (Results-UK)

3.3 Data published in March 2009 reported that 12 of 24 DFID country offices felt “insufficient TB-HIV collaboration” is a challenge to addressing the TB epidemic. Over half of these offices also expected rates of TB-HIV co-infection to rise over the next five years.⁷⁰ (Results-UK)

⁶⁷ Compact between the Government of the Federal Democratic Republic of Ethiopia and the Development Partners on Scaling Up For Reaching the Health MDGs through the Health Sector Development Programme in the framework of the International Health Partnership; Ethiopian Federal Ministry of Health; August 2008 (http://www.internationalhealthpartnership.net/CMS_files/documents/ethiopia_country_compact_EN.pdf)

⁶⁸ Most recently reiterated in a letter from Ivan Lewis to the UK Coalition to Stop TB, 18 May 2009.

⁶⁹ DFID Offices in the Democratic Republic of Congo, Kenya, Malawi, Uganda, Zambia.

⁷⁰ Advocacy to Control TB Internationally (ACTION): Living with HIV, dying of TB (March 2009) Page 26.

3.4 We were pleased to note that Health Advisors were briefed in HIV-TB⁷¹ and discussed best practice during their 2009 retreat, suggesting DFID centrally are giving integration some priority. Where progress has been seen at country level, RESULTS UK commends DFID's policy work facilitating enhanced integration of HIV and TB services in the succeeding 12 months. (Results-UK)

3.5 The strategy commits to increase funding for research into an AIDS vaccine and microbicides. However, it does not make any similar commitment to increase funding for new tools for TB which will be crucial to reducing morbidity and mortality among PLWHA. A new regimen of drugs is required that can combat TB in a shorter time period and that are compatible with ART. New diagnostics that can detect all forms of TB in PLHIV and that can be used in low resource settings are urgently needed. However, as reported by the APPG on AIDS in July 2009, TB (and Malaria) R&D is particularly neglected due to low commercial value.⁷² (Results-UK)

3.6 Due to the changing face of the TB epidemic, with an increasing threat of drug resistant strains and the impact of TB on PLWHA, there is a clear need for a DFID strategy outlining the UK's response to Tuberculosis. RESULTS UK strongly urge DFID to review their practice paper The challenges of TB and Malaria control (December 2005) and to develop a comprehensive strategy on TB which fully integrates with DFID's overarching health related goals. This TB Strategy should run in parallel to Achieving Universal Access and identify clear monitoring and evaluation targets for HIV-TB integration. DFID's HIV/AIDS Strategy will save many more lives if it is coupled with a clear strategy to address TB in all high burden countries. (Results-UK)

4. *The effectiveness of DFID's Strategy in ensuring that marginalised and vulnerable groups receive prevention, treatment, care and support services*

Concerns

4.1 There is still no clear plan as to how DFID will act on the commitments it has made in its Strategy to marginalised populations. Neither the FCO nor DFID is proactive or transparent in communicating work plans and planned activities in these areas to UK stakeholders. This has resulted in missed opportunities for synergies and collaborative advocacy. (International HIV/AIDS Alliance)

4.2 Continued staff turnover, the overwhelming dominance of the discussion on health systems strengthening and what appears to be a downgrading of the role of the AIDS and Reproductive Health team within DFID have all contributed to a lower profile for DFID in many international fora and to limited visibility and accessibility of DFID staff. (International HIV/AIDS Alliance)

4.3 It is essential that DFID continues to find and increase direct and numerous ways to deliver significant funding, training and capacity building support to community-based responses to reach out to marginalised groups delivered by civil society. This is vital because there remain significant concerns over the extent to which government strengthening of public health systems will actually increase access to services for the most disadvantaged or excluded in society. Public health services are often not accessible due to factors such as distance, cost, discrimination or cultural dynamics. For example, injecting drug users often cannot access government health services because drug use is illegal and people living with HIV sometimes do not access public health services due to discrimination from staff. In the short to medium term, and until public health systems are dramatically improved, civil society organisations can often target and provide services more quickly and effectively to the hardest to reach communities. (VSO)

Recent DFID funding of Marginalised Groups

4.4 Nonetheless, despite these limitations, the last 12 months have seen some progress in this area:

- 4.4.1 DFID remains supportive of the efforts of the International HIV/AIDS Alliance in relation to IDU, sex workers, transgender people and other marginalised populations.
- 4.4.2 DFID continues to give ongoing support for the International Harm Reduction Association and accomplished excellent advocacy work in support of HIV prevention at the UNGASS High Level Meeting on Narcotic Drugs held in Vienna in June 2009.
- 4.4.3 DFID has made a new commitment to supporting the work of the Global Forum on HIV and MSM. This commitment is a significant step in ensuring strengthened advocacy and commitment globally to meeting the HIV prevention needs of this critically important and underserved population. (International HIV/AIDS Alliance)
- 4.4.4 DFID has funded a national survey on prevalence of HIV and sexually transmitted infections among male and transgender sex workers in Pakistan (See website case study "AIDS Survey highlights at-risk groups in Pakistan", 28 November 2008). DFID has funded a national survey on prevalence of HIV and sexually transmitted infections among male and transgender sex workers in Pakistan (See website case study "AIDS Survey highlights at-risk groups in Pakistan", 28 November 2008). (VSO)

⁷¹ Mark Rotich, DFID Kenya (September 2009).

⁷² APPG on AIDS: The Treatment Timebomb (July 2009) Page 29.

Human Rights

4.5 We hope that DFID will continue to fund such work so that there is more awareness of the existence and needs of these groups and they have greater access to health and HIV services. This applies particularly to IDUs, sex workers, males who have sex with males, transgender and intersex. We would also be interested to hear the extent to which DFID is working with the Foreign and Commonwealth Office to institute and defend the rights of these groups. (VSO)

4.6 In a number of countries, including Senegal, the work of DFID and the FCO in supporting local advocacy has also helped to protect the rights of this highly vulnerable marginalised population. Conversely, the withdrawal of DFID staff and offices from some countries, such as Nepal, presents risks to the continuity of important programmatic interventions targeting vulnerable populations, and threatens to undermine universal access commitments. (International HIV/AIDS Alliance)

Gender

4.7 DFID's commitment to gender equality in the strategy was very welcome and responded to many of the issues and recommendations VSO and Action Aid highlighted in our 2007 policy report on women's access to HIV services *Walking The Talk*. In research from 13 countries it was found that systemic gender inequality means that poor rural women are among those hardest hit by the HIV pandemic and have minimal access to publicly funded HIV services.⁷³ There is limited evidence of DFID's implementation of the strategy but it has made some case studies available on the DFID website and in the Gender Equality Action Plan Africa Division document. The projects cited are primarily in the two areas where women's access is most limited and under-resourced—prevention and care and support. Of those listed that focused on prevention, we highlight DFID Nigeria's work training women as peer educators to improve understanding of sexual and reproductive health and make condom use more acceptable. This is key work in a continent where 75% of those infected between the age of 15 and 24 are women.⁷⁴ Of those listed on care and support, DFID Zimbabwe and DFID Zambia's work on care for the carers stand out as essential work because most carers for people living with HIV are women, often older women, who seldom receive any recognition, support, training, or equipment to help them do their amazing work.⁷⁵ (VSO)

People with Disabilities

4.8 A particularly vulnerable group whose needs have largely been sidelined in HIV policy at national and global level are persons with disabilities (PWDs). We were encouraged to see the reference to PWDs in the DFID strategy and DFID's funding of ZAFOD (Zambian Federation of the Disabled). Direct and focused support is essential to enable disabled persons' organisations to participate in the development and evaluation of guidelines for HIV service delivery, National Strategic and operational plans, and National AIDS councils. The need to mainstream the HIV/AIDS needs of PWDs into national policies for effective handling is urgent. Governments and donors should seek to support innovative projects initiated by PWDs that are deemed to address their specific health needs. At regional level, DFID should actively consider supporting advocacy networks such as The African Campaign on HIV/AIDS and Disability. The Campaign aims to reduce the vulnerability of disabled people to the impact of HIV by promoting HIV policies, programmes, information and services that genuinely include them. (VSO)

RECOMMENDATIONS

- The limitations to reach marginalised groups inherent in DFID's focus on health systems strengthening need to be counteracted with the development and publication of plans by the FCO and DFID that directly address the needs of marginalised groups and continues predictable sustainable financing for community responses most effective at reaching marginalised groups.

5. *The effectiveness of social protection programmes within the Strategy*

5.1 Social protection is an essential contribution to providing a safety net for the poorest, including those who are infected and affected by HIV. One of the clear and welcomed funding commitments in the HIV strategy was for £200 million for supporting social protection programmes over next three years in at least eight African countries. Unfortunately, DFID have still not defined which countries these are and so monitoring progress remains impossible. We eagerly await more news on how this funding has been distributed and to which countries. (VSO)

5.2 The success of DFID's commitment to cash transfer and social protection programmes will depend on DFID's efforts to address the underlying structural causes of children's and their families' vulnerabilities, such as criminalisation, stigma and discrimination and broader human rights violations. In addition to

⁷³ VSO and Action Aid, *Walking The Talk: Putting women's rights at the heart of the HIV and AIDS response*, 2007.

⁷⁴ The DFID Nigeria case study and a DFID Uganda case study of DFID's work on raising awareness of domestic violence with the police force can be found in *Gender Equality Action Plan Africa Division 2009–2012*, p 6 and 8.

⁷⁵ DFID case studies on care for the carers are on the DFID web site—*Caring for the carers in Zambia* 21 November 2008; *New Dawn of Hope for HIV help in Zimbabwe*; *HIV no barrier to doing business in Zimbabwe* 29 July 2009.

ensuring the participation of affected and marginalised communities in the development of social protection programmes, social protection programmes must be provided in an environment that ensures the realisation of these communities' rights. (International HIV/AIDS Alliance)

6. *Progress towards the commitment to universal access to anti-retroviral (ARV) treatment and its impact on the effectiveness of care and treatment, particularly for women*

Treatment

6.1 Despite being off target, there has been considerable progress towards universal access. More than 4 million people in low- and middle-income countries were receiving antiretroviral therapy (ART) at the close of 2008, representing a 36% increase in one year and a ten-fold increase over five years, according to a new report released on 30 September 2009 by the World Health Organization (WHO), UNICEF and the Joint United Nations Programme on HIV/AIDS (UNAIDS).⁷⁶ This achievement would have seemed almost impossible a decade ago. DFID should build on this success because, despite this progress, at least 5 million people living with HIV still do not have access to life-prolonging treatment and care and the target date of 2010 is now only one year away.

6.2 There is still much work to be done to make ARVs affordable and accessible to the remaining 58% of people who still do not have access to treatment. In this regard we particularly welcome DFID's support of the UNITAID patent pool and their call for pharmaceuticals to get involved. The Access to Medicines team in DFID should be commended for this. This proposal has the potential to dramatically lower the costs of existing HIV treatments and help stimulate the development of new medicines for developing country settings. It forms part of the Government's commitment to "work with others to reduce drug prices and increase access to sustainable treatment over the long term". This project is currently being held up, not by lack of political will, but by the reluctance of pharmaceutical companies to engage in dialogue with UNITAID on the issue. It would be most useful for the IDC to add its weight to DFID's call for pharmaceutical companies to engage with UNITAID on the patent pool.

6.3 In addition to its work on the UNITAID patent pool, DFID's continued and increased support to The Global Fund is critical with the Fund now supporting 2.3 million people on ARVs (as of June 09). The Global Fund to Fight AIDS, TB and Malaria, for example, faces a severe funding shortfall of approximately \$4 billion for the 2008-2010.⁷⁷

6.4 The challenge of ARV access is even greater for children living with HIV who, in Sub-Saharan Africa, "are about one third as likely to receive antiretroviral therapy as adults".⁷⁸ A renewed focus from DFID on the rollout of paediatric ARVs is an imperative. (VSO)

6.5 UNAIDS/WHO 2007 statistics gathered in 25 low and middle income countries in 2007 showed that although women accounted for 51% of people living with HIV, 57% of those receiving treatment were women. This shows that women are accessing treatment more effectively than men. However concerns remain around women's adherence to treatment due to stigma and fear of revealing their status and there is no consistent global collection of data on adherence to treatment. (VSO)

6.6 There is an urgent need to maintain a focus on gains that have been made to date in addressing the HIV epidemic. This is critical to ensure uninterrupted access to ARV treatment, to ensure consistent drug supply chains and to reduce the frequency of drug stock-outs, to not only save the lives of those already on treatment and those in need in future—but also to reduce the likelihood of drug resistant HIV. (International HIV/AIDS Alliance)

6.7 The All Party Parliamentary Group on AIDS recently published a report on long-term access to HIV medicines in the developing world. "The Treatment Timebomb" report urged the UK Government and other leaders to consider the likelihood of treatment cost per individual rising over the next two decades as more people become resistant to first-line treatments. It also highlighted some projections done by epidemiologists at University College London and Imperial College London on the numbers of people needing HIV treatment by 2030. The figure cited in our report of 55 million people (compared to 9 million now) is a conservative one. The combination of high treatment prices and high numbers in need, makes for what the report describes as a "treatment timebomb".

Prevention

6.8 DFID and the UK Government's commitment at the 2005 G8 and at the UN General Assembly in 2006 was Universal Access to comprehensive prevention, treatment, care and support by 2010. While certainly essential, access to anti-retroviral treatment is not enough on its own. As Alan Whiteside comments, delivering treatment without prevention is like mopping the floor with the tap running. Prevention and care and support have received the least focus of funds and support and now require serious attention by the international donor community. (VSO)

⁷⁶ <http://www.who.int/hiv/pub/2009progressreport/en/index.html>

⁷⁷ <http://www.reuters.com/article/middleeastCrisis/idUSL3579451>

⁷⁸ UNAIDS Global Facts and Figures 2008, p. 2.

6.9 It is widely accepted globally that work on prevention is in crisis and needs urgent attention. The WHO 2008 progress report noted that an estimated 2.5 million people were newly infected with HIV in 2007—which means that for every two people placed on treatment, five more become infected. DFID has led on prevention globally and should continue to do so. For example, DFID has taken on leadership of the EC Task Team on Prevention. (VSO)

6.10 It is less easy to measure the impact of prevention programmes other than PMTCT. There will often be pressure on Governments and donors to de-prioritise such prevention in favour of instant and measurable “wins” such as new people on treatment. Urgent work needs to be done to help countries decide on the most effective treatment: prevention spending ratios. DFID could help support such research.

PMTCT

6.11 Prevention of mother to child transmission has also been scaled up through the work and funding of organisations such as the Clinton HIV/AIDS Initiative, UNITAID and UNICEF. Nonetheless, too many children are still born with HIV, they will need treatment for the rest of their lives. PMTCT must be a top priority if we are to manage the epidemic.

6.12 Shocking statistics still remain regarding HIV positive pregnant women’s access to anti-retroviral treatment to avoid mother to child HIV transmission. As of 2007, only 33% of pregnant women were receiving PMTCT.⁷⁹ DFID’s HIV strategy committed to work with others to intensify international efforts to increase coverage of PMTCT to 80% by 2010. To this end, DFID organised a workshop on PMTCT with the UK Consortium in May 2009 and produced concrete recommendations on scale up. Prevention of mother to child transmission has also been scaled up very effectively, through the work and funding of organisations such as the Clinton HIV/AIDS Initiative, UNITAID and UNICEF. Nonetheless, too many children are still born with HIV, they will need treatment for the rest of their lives. PMTCT must be a top priority if we are to manage the epidemic. (VSO)

Care and Support

6.13 HIV care and support is the often forgotten pillar of Universal Access, largely because donors and national governments have left it to poor communities to provide often without support. Strengthening health systems must include direct resources and support for community-based responses, home-based care organisations and carers—particularly women who provide the majority of care and support in the family and community. As mentioned above, DFID is supporting some excellent in-country home-based care, and therefore should take advantage of this to play a much stronger role raising the profile of care and support in global HIV policy discussions. The proposed DFID funded conference with the UK Consortium on AIDS and International Development on Care and Support in 2010 would be an important opportunity to move forward in this area. (VSO)

RECOMMENDATIONS

- DFID should ensure that its focus on health systems strengthening does not undermine progress to universal access to HIV treatment, prevention and care & support services.
- DFID’s continued and increased support to The Global Fund is critical with the Fund now supporting 2.3 million people on ARVs (as of June 09). The Global Fund to Fight AIDS, TB and Malaria faces a severe funding shortfall of approximately \$4 billion for the 2008-2010.⁸⁰
- We particularly welcome DFID’s support of the UNITAID patent pool and their call for pharmaceuticals to get involved. It would be most useful for the IDC to add its weight to DFID’s call for pharmaceutical companies to engage with UNITAID on the patent pool.
- PMTCT must be a top priority if we are to manage the epidemic.

Written evidence submitted by UNICEF

1. The UK National Committee for UNICEF welcomes the opportunity to make a submission to the International Development Committee’s inquiry into progress being made in the implementation of the Government’s strategy for fighting HIV in the developing world “Achieving Universal Access—the UK’s strategy for halting and reversing the spread of HIV in the developing world”.

2. UNICEF, the United Nations Children’s Fund, is mandated by the United Nations General Assembly to advocate for the protection of children’s rights, to help meet their basic needs and to expand their opportunities to reach their full potential. UNICEF is guided by the United Nations Convention on the Rights of the Child and strives to establish children’s rights as enduring ethical principles and international standards of behaviour towards children.

⁷⁹ Ibid.

⁸⁰ <http://www.reuters.com/article/middleeastCrisis/idUSL3579451>

KEY POINTS

- It is too early to state how far progress has been made in implementing the Government's 2008 strategy as a full detailed appraisal of current activities is yet to be made public.
- DFID must ensure that children's rights are placed at the centre of the implementation of the HIV strategy.
- While UNICEF UK welcomed the £6 billion commitment to strengthening health systems and fully supports the needs to improve health systems in developing countries as the backbone of the HIV response; it remains unclear which specific activities and initiatives this money will fund.
- It currently remains unclear how critical programmes that 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 will be addressed within the implementation of the strategy.

3. 2009 marks the 20th anniversary of the United Nations Convention on the Rights of the Child (UNCRC), which the UK Government ratified in 1991. Ratification committed the UK Government to protecting and ensuring children's rights both within the UK and through its international development policy. It is therefore important that in evaluating the implementation of the HIV Strategy the extent to which it uses a rights based framework, as well as how it contributes to the fulfilment of children's rights around the world is addressed.

4. It is becoming increasingly clear that without a massive scale up of resources we will miss our Universal Access targets in 2010. New statistics show that despite some remarkable gains in other areas, much work is still needed to reach the global target of universal access by 2010. For example in 2008, only approximately 38% of children in developing countries in need of treatment for HIV received it. Pregnant women and children are still accessing treatment at lower rates than the general adult population (38% of children in need of treatment receiving it, compared to over 43% of adults in need).⁸¹ It is unclear what will happen to the HIV and AIDS agenda after this. Therefore, the comprehensive implementation of this HIV Strategy must ensure that the UK, as global frontrunners in the international HIV response, maintains the momentum and efforts invested in tackling HIV.

5. As the UN prepares to review the MDGs in 2010, thoughts will turn to what the post 2015 framework should be. The question is important and the UK expects to engage in a debate over a range of options. But this should not distract us or others from the primary task—over the next five years, to pursue the delivery of the MDGs, including Goal 6 to reverse the rate of HIV infections, as quickly as we can.

6. This submission covers several of the questions posed by the Committee in their enquiry; responses on our experience are detailed below.

The process established by DFID for monitoring the performance and evaluating the impact of the Strategy

7. As the first baseline report from the Government on the implementation of the HIV strategy is yet to be made public, it is difficult to analyse in detail the process established to monitor and evaluate its impact. However, the monitoring and evaluation framework published on 1 December 2008 to accompany the strategy did not provide a demanding framework for evaluation with the use of quantitative indicators.

8. We hope that this framework for evaluation will capture and monitor the broad intent of the strategy, beyond the specific priorities for action, and ensure action across all areas highlighted as important.

9. It also remains difficult to track UK financial resources available for HIV and, within this, how much is allocated to prevention, treatment and care and support activities. While we welcomed the significant financial commitment made within the strategy for health systems strengthening a breakdown for how this has been, and will be, spent is yet to be provided. Without clearer information on actual and intended spending on HIV activities it will remain challenging to monitor the performance and impact of the HIV strategy.

10. As part of monitoring the effective implementation of the HIV Strategy there is an urgent need to prioritize high quality data. Quantitative and qualitative data is a prerequisite to identifying both those most at risk, including young people, and evaluating programmes. Data must be disaggregated by factors such as sex, age, marital status, wealth quintile and geographical location can drive better programming. As part of monitoring the performance and impact of the Strategy more emphasis should be given to improving the quality of available data. As a world leader in international development and a key player in international fora DFID plays an important role in improving the collection of data on HIV and AIDS both for its programmes and for ensuring this inputs into improved HIV programming at all levels.

⁸¹ *Towards Universal Access: Scaling Up Priority HIV/AIDS Interventions in the Health Sector*, 2009 WHO, UNAIDS and UNICEF.

Progress on health systems strengthening and on an integrated approach to HIV/AIDS funding

11. While UNICEF UK welcomed the £6 billion commitment to strengthening health systems and fully supports the need to improve health systems in developing countries as the backbone of the HIV response; it remains unclear which specific activities and initiatives this money will fund.

12. HIV and AIDS has a cross cutting impact on the development agenda. In many countries, especially in the high prevalence countries, HIV remains an emergency and in these areas the response to HIV requires activities beyond the health system. It currently remains unclear as to how these programmes will be funded. For example, programmes to improve life skills education for in and out of school youth 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.

13. While five people are infected with HIV for every two that are placed on antiretroviral treatment there is an urgent need to scale up action on preventing HIV infections. With 45% of new infections taking place in young people, addressing new infections within the 15–24 year age group is critical to addressing the HIV epidemic.⁸² Yet to do this young people need access to information on how to protect themselves against HIV infection and they need access to youth friendly HIV services that are integrated within existing health provision. In addition, to this young people also need a safe and supportive environment that enables them to use both the knowledge and access to health services to reduce their risk and vulnerability to HIV infection. While the financial commitment to health systems is crucial in providing aspects of this spectrum of service provision it remains unclear where financing for the creation of safe and supportive environments will be provided. As evidence from Tanzania and Zimbabwe demonstrates without access to this kind of environment HIV prevention efforts will continue to have a limited long term impact.⁸³ Integration of HIV/AIDS prevention, treatment and care with other disease programmes, particularly tuberculosis and malaria

14. It is as yet too early to say how much progress has been made in improving the integration of HIV programmes with other disease programmes. However, as mentioned above the provision of integrated youth friendly services is critical in improving the HIV and AIDS response for young people.

15. HIV prevention, diagnosis, treatment and care should be integrated within existing health infrastructures, which must be youth friendly. Young people need to receive appropriate prevention counselling as part of voluntary testing and prevention of mother to child transmission services. Those living with HIV need information about how to live a positive and healthy lifestyle, how they can influence the progression of the disease, what their treatment and care options are, and how to prevent transmission to others.

The effectiveness of social protection programmes within the Strategy

16. UNICEF UK welcomed DFID's continued support for social protection within the HIV Strategy. Social protection remains a key way to reduced vulnerabilities to global challenges, such as the global recession, climate change and HIV and AIDS.

17. In the implementation of this support it is essential that social protection programmes are child sensitive and AIDS inclusive, as is outlined in the June 2009 statement supported by DFID, UNICEF and other partners.⁸⁴ This recognises those children's experiences of poverty and vulnerabilities are multidimensional and differ from that of adults. Thus, social protection should be focused on addressing the inherent social disadvantages, risks and vulnerabilities that children may be born into as well as those acquired later in childhood due to external shocks. This is therefore best achieved through integrated child protection approaches.

18. While it is too early to evaluate the progress made in implementing these commitments within the Strategy in order to reduce vulnerabilities DFID should review the design and implementation of social protection policies to ensure they are child sensitive and AIDS inclusive in order to maximise impact.

Written evidence submitted by VSO**INTRODUCTION**

VSO is an international development agency that works through volunteers overseas, and also on return to their country of recruitment. It works in more than 40 developing countries in Africa, Asia and Latin America, recruiting skilled women and men from North and South, and from a range of professions. VSO groups its work under six goal areas: education, secure livelihoods, participation and governance, disability, Health and HIV and AIDS.

⁸² UNICEF UK 2009, *Preventing HIV with Young People: The Key to Tackling the Epidemic*.

⁸³ Mema Kwa Vijana and Regai Dzive Shiri. *Rethinking how to prevent in young people: Evidence from two large randomised controlled trials in Tanzania and Zimbabwe*. Policy Briefing Paper No. 10 Nov 2008.

⁸⁴ DFID, Help Age International, Hope and Homes for Children, Institute for Development Studies, International Labour Organisation, Overseas Development Institute, Save the Children UK, UNICEF and UNDP. *Advancing Child Sensitive Social Protection*, June 2009.

VSO has HIV and AIDS programmes in 18 countries across Africa, Asia and the Pacific. Our objective is to combat stigma, support prevention and increase the availability of treatment, care and support for those infected and affected by HIV and AIDS. We tackle the impact of HIV and AIDS through volunteer placements; advocacy initiatives to encourage policy change; networking activity to build links between communities and governments; small grants to support awareness-raising and income generation activities; training events, international conferences and learning exchanges. The focus of our global HIV advocacy work *AIDS Agenda* is on the key intersection between HIV and gender. Inequality between women and men continues to be a major driver of the HIV and AIDS pandemic and we advocate for three key approaches: direct empowerment of women; the constructive involvement of men; and addressing the immediate needs of women infected and affected by HIV and AIDS.

In Africa, where HIV and AIDS are widespread and have a devastating impact on the lives of millions of people, a strong feature of our work is supporting HIV prevention and home-based care services for people and children infected and affected by HIV. In Asia and the Pacific, where HIV and AIDS is not yet as widespread, VSO works with groups vulnerable to infection to raise awareness about how to prevent the spread of HIV. We also work to increase public understanding about the stigma some groups face and how this affects their ability to access the information and healthcare advice they are entitled to.

1. *The process established by DFID for monitoring the performance and evaluating the impact of the strategy*

1.1 The omission of an M&E plan from the strategy when it was launched led to considerable skepticism about how and whether DFID would be able to deliver its ambitious and wide-ranging strategy.

1.2 We would like to praise DFID for actively involving civil society (in the form of the UK Consortium on AIDS and International Development) from the start of the development of their M&E processes for their HIV and AIDS strategy. VSO fed substantially into the care and support and gender indicators that the Consortium M&E working group suggested to DFID.

1.3 The resulting M&E plan “Monitoring performance and evaluating impact”, launched in December 2008, established a process of producing “a baseline position from which to review progress” to be “published in the first half of 2009”. Unfortunately this has not yet appeared. The first planned review of progress is December 2010. Therefore a proper analysis of DFID’s implementation of its strategy is impossible at this time. This submission is based therefore on our organizational awareness of DFID’s HIV work over the last year.

1.4 It is unclear to external organizations the extent to which DFID country offices use the strategy to guide their decision making or the development of their own country strategies and interventions. A document similar to the “Gender Equality Action Plan: Africa Division 2009–12” for the HIV strategy would be most welcome.

1.5 The M&E plan also makes no mention of the role of PPA implementing partners in delivering DFID’s HIV strategy. We recommend that the work of PPA implementing partners is also taken into account in the M&E for the HIV strategy.

1.6 We also recommend that DFID country offices work with partners in-country to agree on a common co-ordinated M&E system to significantly reduce the burden of multiple reporting processes, and harmonise in line with the principle of the Three Ones.⁸⁵ In some sectors DFID country offices are already attempting to do this with (eg DFID Sierra Leone). VSO has recently developed one M&E process model across our 18 HIV country programmes to report to DFID and this could be shared and co-ordinated with other partners. It assesses three work streams—(1) the scale and significance of our programmes, (2) the use of inclusion as a proxy to measure the system strength of service delivery and (3) focus group discussions and surveys to better understand beneficiaries’ definitions of quality services and whether they are receiving them.

1.7 We applaud the fact that DFID has linked its strategy to global targets and indicators, although clearly challenges of attribution remain. This year DFID has actively engaged and led on the process of improving and fostering coherence of internationally agreed indicators. DFID currently co-chairs the interagency Indicators Working Group of the UNAIDS Monitoring and Evaluation Reference Group. It is working closely with the Care and Support Working Group of the UK Consortium on AIDS and International Development, which VSO co-chairs, to review global care and support indicators to input into the upcoming review of UNGASS indicators. Together, DFID and the UK Consortium on AIDS and International Development have modeled a new independent review process for global indicators that the Indicators Working Group of UNAIDS Monitoring and Evaluation Reference Group has now endorsed.

1.8 Sufficient funding for and meaningful review of these global targets needs continued commitment at the highest level. This is particularly true of the target of Universal Access to Treatment, Prevention, Care and Support by 2010 proposed and led by the UK Government at the G8 in 2005. We urge the Minister for

⁸⁵ The “Three Ones” principles, agreed in 2004, aim to achieve the most effective and efficient use of resources, and to ensure rapid action and results-based management: One agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners; One National AIDS Coordinating Authority, with a broad-based multisectoral mandate; One agreed country-level Monitoring and Evaluation System.

International Development and the Prime Minister to lead on this again next year to ensure a sober review of progress on this target is undertaken at the 2010 G8 and UN MDG review and that clear new achievable commitments are made.

2. *Progress on health systems strengthening and on an integrated approach to HIV/AIDS funding*

Progress on health system strengthening

2.1 There is no doubt 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.

2.2 VSO applauds DFID and the UK Government's strong leadership globally over the last few years on health system strengthening. This has been demonstrated, for example, through their championing of the International Health Partnership (IHP) and most recently by announcing at the UN that the UK chaired Taskforce on Innovative International Financing for Health Systems has access to an additional \$5.3 billion for health systems. This would grant over 10 million people access to free services.

2.3 We welcome DFID's adherence to the Paris principles of country ownership by channeling significant funding for health through Direct Budget Support (DBS). However, we remain unclear how DFID will specifically monitor the use and effectiveness of this money for health systems strengthening. There is a strong need for the development of clear DBS indicators.

An integrated approach to HIV/AIDS funding

2.4 In the context of the need for a global focus on health system strengthening and better integration between HIV and health responses, DFID's commitment to £6 billion for health in the HIV strategy makes sense. However, 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. This sends a worrying message that broader health system strengthening should be promoted at the expense of funding for HIV. We ask that DFID openly counters this message by highlighting the importance of addressing HIV⁸⁶ and, crucially, committing the needed funds to those bodies that have a proven track record of both addressing HIV and building the health system at the same time.

2.5 The need for getting the funding balance right between horizontal and vertical funding is an ongoing challenge. In mid December 2007 Douglas Alexander announced the UK will contribute £2.134 billion to the World Bank over the next three years. This contribution makes the UK the largest donor to the World Bank over this funding period. The announced commitment of DFID to the Global Fund on AIDS TB and Malaria was £1 billion until 2015, which is substantial but insufficient considering the fact that the Global Fund announced in July a budget shortfall of about \$3 billion in order to simply maintain and finance programs planned for 2010. DFID should be congratulated as a leading donor but encouraged also to re-analyse this funding balance as well as to push other donors to commit more funds.

2.6 This setting of the funding balance should also be based on an honest evaluation of how effectively the money is being spent. This was demonstrated clearly by a comparison of the evaluation reports of the World Bank Independent Evaluation Group and that of the Global Fund for AIDS, TB and Malaria. The World Bank's report states that only 18% of their HIV projects in Africa were satisfactory. The Global Fund report stated however that 69% of their projects met the highest rating.⁸⁷

2.7 We are pleased to see that DFID has responded by collaborating with the World Bank to start to address these issues by conducting an ambitious evaluation of the community response to HIV and AIDS with a view to increase resource allocation. They have enlisted the support of the UK Consortium on AIDS and International Development to facilitate full civil society engagement and VSO is actively involved.

2.8 Finally, there is a sense that DFID may be de-prioritising HIV, evidenced by the reduction of clear funding commitments to HIV in the strategy, their strong criticism of vertical funding programmes and a serious reduction of the number of staff in the AIDS and Reproductive Health Team. This has a big impact on the capacity to drive the strategy forward within DFID or to continue to play a leading role in global HIV policy discussions.

4. *The effectiveness of DFID's Strategy in ensuring that marginalised and vulnerable groups receive prevention, treatment, care and support services*

4.1 It is essential that DFID continues to find and increase direct and numerous ways to deliver significant funding, training and capacity building support to community-based responses delivered by civil society. This is vital because there remain significant concerns over the extent to which government strengthening of public health systems will actually increase access to services for the most disadvantaged or excluded in

⁸⁶ HIV prevalence globally may have leveled off but there are still 33 million people living with HIV (UNAIDS 2008 figures) and the HIV prevalence rates in some of the world's poorest countries are nothing short of national emergencies (eg 26.1% in Swaziland). This has been exacerbated by the financial crisis that has forced many poor countries to reduce treatment and prevention budgets (eg Tanzania announced a reduction of national HIV prevention budgets by 25%).

⁸⁷ World Bank Independent Evaluation Group, 2009 Improving Effectiveness and Outcomes for the Poor in Health, Nutrition and Population (p xvi). The Global Fund for AIDS, TB and Malaria, 2009, ScalingUp For Impact: Results Report, P 55.

society. Public health services are often not accessible due to factors such as distance, cost, discrimination or cultural dynamics. For example, injecting drug users often cannot access government health services because drug use is illegal and people living with HIV sometimes do not access public health services due to discrimination from staff. In the short to medium term, and until public health systems are dramatically improved, civil society organizations often target and provide services more quickly and effectively to the hardest to reach communities.

4.2 DFID's commitment to gender equality in the strategy was very welcome and responded to many of the issues and recommendations VSO and Action Aid highlighted in our joint 2007 policy report on women's access to HIV services *Walking The Talk*. In research from 13 countries we found that systemic gender inequality means that poor rural women are among those hardest hit by the HIV pandemic and have minimal access to publicly funded HIV services.⁸⁸ As noted earlier, there is limited evidence of DFID's implementation of the strategy but it has made some case studies available on the DFID website and in the Gender Equality Action Plan Africa Division document. The projects cited are primarily in the two areas where women's access is most limited and under-resourced—prevention and care and support. Of those listed that focused on prevention, we highlight DFID Nigeria's work training women as peer educators to improve understanding of sexual and reproductive health and make condom use more acceptable.⁸⁹ This is key work in a continent where 75% of those infected between the age of 15 and 24 are women. Of those listed on care and support, DFID Zimbabwe and DFID Zambia's work on care for the carers stands out as essential work because most carers for people living with HIV are women, often older women, who seldom receive any recognition, support, training, or equipment to help them do their amazing work.⁹⁰

4.3 We note also that DFID has funded a national survey on prevalence of HIV and sexually transmitted infections among male and transgender sex workers in Pakistan.⁹¹ We hope that DFID will continue to fund such work so that there is more awareness of the existence and needs of these groups and they have greater access to health and HIV services. This applies particularly to IDUs, sex workers, males who have sex with males, transgender and intersex. We would also be interested to hear the extent to which DFID is working with the Foreign and Commonwealth Office to institute and defend the rights of these groups.

4.4 A particularly vulnerable group whose needs have largely been sidelined in HIV policy at national and global level are persons with disabilities (PWDs). We were encouraged to see the reference to PWDs in the DFID strategy and DFID's funding of ZAFOD (Zambian Federation of the Disabled). Direct and focused support is essential to enable disabled persons' organisations to participate in the development and evaluation of guidelines for HIV service delivery, national strategic and operational plans, and national AIDS councils. The need to mainstream the HIV needs of PWDs into national policies for effective handling is urgent. Governments and donors should seek to support innovative projects initiated by PWDs that are deemed to address their specific health needs. At regional level, DFID should actively consider supporting advocacy networks such as The African Campaign on HIV/AIDS and Disability. The Campaign aims to reduce the vulnerability of disabled people to the impact of HIV by promoting HIV policies, programmes, information and services that genuinely include them.

5. *The effectiveness of social protection programmes within the Strategy*

5.1 VSO believes that social protection is an essential contribution to providing a safety net for the poorest, including those who are infected and affected by HIV.

5.2 One of the clear and welcomed funding commitments in the HIV strategy was for £200 million for supporting social protection programmes over next three years in at least 8 African countries. Unfortunately, DFID have still not defined which countries these are and so monitoring progress remains impossible. We eagerly await more news on how this funding has been distributed and to which countries.

6. *Progress towards the commitment to universal access to anti-retroviral (ARV) treatment and its impact on the effectiveness of care and treatment, particularly for women*

6.1 Globally good progress has been made to get ARVs to those who need them, with more than 4 million now on ARV treatment.⁹² However, there is still much work to be done to make ARVs cheaper and accessible to the remaining two thirds who still do not have access to treatment. In this regard DFID's continued and increased support to The Global Fund is critical with the Fund now supporting 2.3 million people on ARVs (as of June 09). We also particularly welcome DFID's support of the UNITAID patent pool and call for pharmaceuticals to get involved.

6.2 The challenge of ARV access is even greater for children living with HIV who, in Sub-Saharan Africa, "are about one third as likely to receive antiretroviral therapy as adults".⁹³ A renewed focus from DFID on the rollout of paediatric ARVs is an imperative.

⁸⁸ VSO and Action Aid, *Walking The Talk: Putting women's rights at the heart of the HIV and AIDS response*, 2007.

⁸⁹ The DFID Nigeria case study and a DFID Uganda case study of DFID's work on raising awareness of domestic violence with the police force can be found in *Gender Equality Action Plan Africa Division 2009–12*, p 6 and 8.

⁹⁰ DFID case studies on care for the carers are on the DFID web site—*Caring for the carers in Zambia* 21 November 2008; *New Dawn of Hope for HIV help in Zimbabwe*; *HIV no barrier to doing business in Zimbabwe* 29 July 2009.

⁹¹ DFID website case study 'AIDS Survey highlights at-risk groups in Pakistan', 28 November 2008.

⁹² WHO, UNAIDS & UNICEF, *Towards universal access: Scaling up priority HIV/AIDS interventions in the health sector*, September 2009 progress report <http://www.who.int/hiv/en/>

⁹³ UNAIDS *Global Facts and Figures 2008*, p 2.

6.3 UNAIDS/WHO 2007 statistics gathered in 25 low and middle income countries in 2007 showed that although women accounted for 51% of people living with HIV, 57% of those receiving treatment were women. This shows that women are accessing treatment more effectively than men. However concerns remain around women's adherence to treatment due to stigma and fear of revealing their status and there is still no consistent global collection of data on adherence to treatment.

6.4 Shocking statistics also remain regarding HIV positive pregnant women's access to anti-retroviral treatment to avoid mother to child HIV transmission. As of 2007, only 33% of pregnant women were receiving PMTCT.⁹⁴ DFID's HIV strategy committed to work with others to intensify international efforts to increase coverage of PMTCT to 80% by 2010. To this end, DFID organised a workshop on PMTCT with the UK Consortium in May 09 and produced concrete recommendations on scale up.

6.5 As mentioned in section 1, DFID and the UK Government's commitment at the 2005 G8 and at the UN General Assembly in 2006 was Universal Access to comprehensive prevention, treatment, care and support by 2010. While certainly essential, access to anti-retroviral treatment is not enough on its own. As Alan Whiteside comments, delivering treatment without prevention is like mopping the floor with the tap running.⁹⁵ Prevention and care and support have received the least focus of funds and support and now require serious attention by the international donor community.

6.6 It is widely accepted globally that work on prevention is in crisis. The WHO 2009 progress report noted that an estimated 2.7 million people were newly infected with HIV in 2007⁹⁶—which means that for every two people placed on treatment, five more become infected. DFID has led on prevention globally and should continue to do so. For example, DFID have taken on leadership of the EC Task Team on Prevention.

6.7 HIV care and support is the often forgotten pillar of Universal Access, largely because donors and national governments have left it to poor communities to provide often without support. Strengthening health systems must include direct resources and support for community-based responses, home-based care organisations and carers—particularly women who provide the majority of care and support in the family and community. As mentioned above, DFID is supporting some excellent in-country home-based care, and therefore should take advantage of this to play a much stronger role raising the profile of care and support in global HIV policy discussions. The proposed DFID funded conference with the UK Consortium on AIDS and International Development on Care and Support in 2010 would be an important opportunity to move forward in this area.

Written evidence submitted by World Vision

September 2009

INTRODUCTION

1. World Vision is a Christian relief, development and advocacy organisation, dedicated to working with children, families and communities to overcome poverty and injustice. Building on our previous submissions to the Committee on HIV and AIDS, we welcome this opportunity to provide evidence relative to children affected by HIV & AIDS.

Question 1: *“the process established by DFID for monitoring the performance and evaluating the impact of the Strategy”*

2. With the AIDS Strategy in place for just over a year, DFID has had little time to implement the priority actions, and so comprehensive evaluation is therefore difficult. DFID has provided little comment on the impact of the strategy, and has not published the Baseline position report, which makes it difficult to comment on the type and detail of data that will eventually be available.

3. Before the publication of the Monitoring and Evaluation Framework (M&E Framework) for the AIDS Strategy there were high expectations that it would provide answers to several important questions about how the strategy would be implemented and monitored. However, the principal question of exactly what will be UK Government's contribution towards achieving the Strategies' goals and how will that be monitored, has 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.

⁹⁴ Ibid.

⁹⁵ Presentation to UK Consortium on AIDS and International Development AGM, 16 Sept 2009.

⁹⁶ WHO, UNAIDS & UNICEF, Towards universal access: Scaling up priority HIV/AIDS interventions in the health sector, September 2009 progress report <http://www.who.int/hiv/en/>

RECOMMENDATIONS

4. The M&E process must be open, transparent and fully engaged with civil society. While the involvement of members of the UK Consortium on AIDS and International Development in the Indicators Group was very welcome, there were restrictions on the scope of that involvement. This involvement needs to be expanded, to include engagement in the independent review of the Strategy.

5. Detailed data about the projects and programmes funded by DFID in each country must be accessible, even if they are not included in the Baseline report itself. These data will enable partners in country to learn about the specific work that DFID is supporting, especially related to the priority actions, and assess the UK Government's contribution towards achieving international targets.

Question 2: *“progress on health systems strengthening and on an integrated approach to HIV/AIDS funding”*

6. HIV is more than a health issue. Several components of an effective HIV response fall outside of the remit of the health sector, including many HIV prevention interventions, strategies to address stigma and discrimination and care for groups such as orphaned or vulnerable children. These components must be funded alongside increasing investments in health systems and services to better address health related elements. The lack of data on health spending makes assessment of its impact very difficult.

RECOMMENDATIONS

7. DFID should publish details on how and where they will spend the allocated £6 billion for health systems and services up to 2015, including making available a breakdown of expenditure against this target in the year since it was announced. This will allow transparency and scrutiny of their progress.

Question 3: *“integration of HIV/AIDS prevention, treatment and care with other disease programmes, particularly tuberculosis and malaria”*

8. World Vision is concerned about the neglect of children's issues regarding the integration of HIV with malaria and TB.

Malaria and HIV

9. The effects of interactions between malaria and HIV are particularly deleterious to maternal and infant health. Co-infected pregnant women are at increased risk of anaemia, preterm birth and intra-uterine growth retardation, and many children born to women with dual malaria and HIV infection therefore have low birth weight and are at higher risk of death during infancy.

10. The presence of HIV results in a poorer response to both intermittent preventative treatment (IPTp) and clinical treatment of malaria during pregnancy. Furthermore, there is a risk of adverse drug reactions if sulfadoxine-pyrimethamine (used for IPTp) and cotrimoxazole, for opportunistic infection prophylaxis, are taken together, as both are sulfa-containing drugs.

11. Two key interventions: use of long-lasting insecticidal nets and use of well-targeted indoor insecticide spraying to control transmission of the parasite can be effective in different circumstances. Strategies must reflect local need.

RECOMMENDATIONS

The UK government should:

12. Encourage UN agencies and pharmaceutical companies to ensure that the necessary research to evaluate potential interactions between malaria and HIV drugs is undertaken.

13. Ensure increased funding and resources consistent with the Roll Back Malaria Partnership Global Malaria Action Plan goals for prevention, treatment and research and development.

14. Provide sufficient resources and technical support to National Malaria Control Plans to achieve universal access to LLINs for prevention of malaria and to Artemisinin Combination Therapies ACTs for treatment.

Tuberculosis (TB) and HIV

15. Children, particularly under 5s, are extremely vulnerable to contracting TB from adults in the household as the risk of TB infection increases with the degree of contact. Children with HIV are at increased risk for contracting TB and specifically for developing TB meningitis.

16. Diagnosis of TB in HIV-infected children is notoriously challenging, particularly in children living with HIV. This can lead to underreporting of the problem of co-infection in children. Treatment is also difficult as paediatric drug formulations are not available for TB and there are still not enough suitable for people living with HIV.

17. TB infection itself can lower the CD4 cell count in children, and exacerbates the immunodeficiency caused by HIV. Compared with children without HIV, children living with HIV have a six-times greater risk of dying from TB. The vast majority of co-infected children live in resource-limited countries.

18. BCG is the only TB vaccine but is not recommended in HIV-infected children. Because of the difficulty excluding children with HIV when the vaccine is given (at birth) many children with HIV, or who become HIV-infected post-natally, will be vaccinated anyway. Some may develop life-threatening systemic BCG infections and BCG IRIS.

RECOMMENDATIONS

The UK government should:

19. Encourage pharmaceutical companies to conduct the pharmacokinetic studies which are desperately needed to determine the optimal doses for TB drugs for children of different ages and sizes, especially for second-line drugs and new drugs in development. This should be done with consideration to when TB medications are taken along side ARVs.

20. Support research to improve diagnosis of TB for those with HIV, particularly children.

21. Encourage pharmaceutical companies to produce a TB vaccine that is affordable for southern health systems, safe and effective for children living with HIV.

Question 4: *“the effectiveness of DFID’s Strategy in ensuring that marginalised and vulnerable groups receive prevention, treatment, care and support services”*

Children with disabilities

22. Children and adults with disabilities are routinely ignored and marginalised because of fear and misunderstanding around disability. They are often left out of 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.

23. There is widespread and mistaken belief that disabled people are not sexually active and are not at risk from HIV infection. This misapprehension is doubly damaging and dangerous as children and adults with disabilities are two to three times more likely to face sexual abuse and violence.

RECOMMENDATIONS

THE UK GOVERNMENT MUST ENSURE:

24. Disabled children and adults, across impairments, are included and targeted in prevention, treatment, care and support services.

25. Physical access for people with disabilities to treatment and support services.

26. Action is taken to target and reach children out of school, not least to highlight their visibility and equal worth in communities, and to ensure they understand methods to protect themselves from HIV.

27. Messages on HIV awareness and prevention are in a form accessible for people with hearing, visual or intellectual impairments.

Street children

28. Street children are 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.

29. 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.

RECOMMENDATION

30. A comprehensive range of HIV services need to be made available so that those outside of traditional settings can also access a full range of prevention, treatment care and support services.

Question 5: *“the effectiveness of social protection programmes within the Strategy”*

31. World Vision welcomed the allocation of £200 million within the AIDS Strategy to develop social protection policies and programmes in at least eight African countries, as well as the announcement of a further £200 million at the G20 London Summit to support the Rapid Social Response Fund.

32. However, there will be many competing demands for this money. Vulnerable households with children will be just one group. World Vision is concerned that there is a danger that funding for social protection will be regarded as limited to providing cash transfers, which whilst important, are only one part of the required package of policies and services needed to care and protect vulnerable children affected by HIV &

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

RECOMMENDATIONS

The UK Government must:

33. Work with governments and international development partners to implement the key steps for promoting child sensitive social protection as outlined in the Joint Statement on Child Sensitive Social Protection.

34. Support the robust operations research agenda for strengthening social welfare systems, in support of social transfers that was agreed at a meeting on Social Welfare and Cash Transfers, held in Carmona in April 2009.⁹⁷

Question 6: *“progress towards the commitment to universal access to anti-retroviral treatment and its impact on the effectiveness of care and treatment, particularly for women”*

35. While rapid developments have been made over the last two years in the number of adults accessing antiretroviral therapy, treatment for children has not kept pace. Children remain about one third as likely to receive antiretroviral therapy as adults. HIV infection progresses aggressively in children without optimal HIV treatment and care. HIV & AIDS accounts for 5% of deaths in children younger than five years of age in Africa and was the leading cause of death in five countries in and southern Africa in 2004.

36. Despite the increase in the number of children under age 15 in low- and middle-income countries who receive antiretroviral treatment to almost 200,000 in 2007, those children currently on treatment still only represent 10% of children who need it. This is despite the target being for 80% of children to access HIV and AIDS treatment by 2010.

37. Early treatment with antiretrovirals within the first few months of life can dramatically improve the survival rates of children with HIV. A recent study in South Africa found mortality was reduced by 75% in infants living with HIV who were treated before they reached 12 weeks of age.

38. There are several barriers to children receiving antiretroviral treatment, such as the treatment being more complicated due to the special formulations of the medication needed. When versions for children do exist, they are often not adapted for use in resource-limited settings (eg they need refrigeration or access to safe drinking water. Paediatric formulations are not a priority for pharmaceutical companies as 90% live in resource poor countries. Patents can provide barriers for generic companies to develop alternative drugs.

39. There are additional issues such as mothers who are living with HIV are frequently victims of abuse, including stigmatization, violence, and property rights violations, and unable to care for their children.

RECOMMENDATIONS

The UK government must:

40. Work with other governments to set targets to ensure effective and equitable access to antiretroviral therapy for children with HIV.

41. Continue to support UNITAID’s patent pool for second generation and child-friendly HIV treatments. This pool will enable all patent owners to combine their expertise in order to produce better and cheaper medicine for children.

42. Encourage pharmaceutical companies to ensure their paediatric formulations are heat stable and available in appropriate doses and packaging for use at community level.

43. Reduce distribution barriers and increase the global supply of high-quality, low-cost lifesaving medicines for children and their families, including ARVs, drugs to treat opportunistic infections, and first and second-line regimens to ease dosing and administration.

Prevention of Vertical Transmission

44. Transmission of HIV from mother to child is the route by which 90% of all children living with HIV are infected, but in 2008 only 34% of pregnant women living with HIV in low and middle-income countries in need of antiretroviral treatment received it. 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 antiretroviral treatment, more than half of these children will die before their second birthday.

45. Progress has been made over the past few years towards preventing vertical transmission. In 2007 in sub-Saharan Africa, the proportion of HIV-positive pregnant women receiving antiretroviral prophylaxis to reduce the risk of transmission was 34%, up from 11% in 2005. Despite this recent increase, this remains

⁹⁷ Communiqué: Social Welfare and Cash Transfer Meeting, Carmona Spain, 22–24 April
http://blog.case.edu/msass/2009/07/10/Communique_-_Cash_Transfers_and_Social_Welfare_Services.pdf

far short of the international target of 80% coverage by 2010. An unacceptable two thirds of pregnant women living with HIV remain without access to these crucial services that prevent transmission to their children.

46. Although health systems are weak in many of the countries that have the highest burden of HIV, more than 70% of all pregnant women in these countries make at least one antenatal care visit. This provides an excellent opportunity for delivering prevention of mother to child transmission (PMTCT) interventions and engaging these women and their children in a comprehensive continuum of HIV prevention, care and treatment services. Nevertheless, 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.

RECOMMENDATIONS

The UK government should:

47. Assess global barriers to scale-up of PMTCT services and publish a plan of action to increase quality coverage.

48. Promote integration of PMTCT+ within routine MNCH and reproductive health care services.

49. Support national governments in their development and implementation of national PMTCT+ plans to reach universal access to PMTCT+ for all pregnant women including access to a continuum of anti-retroviral treatment, counselling and support services after delivery.

50. Increase budget support to the health sector, particularly through the sector wide approach (SWAPS), to ensure health systems can effectively and equitably deliver comprehensive services.

51. Support community-based organisations to mobilise community members to play an active role in creating awareness about entitlements to PMTCT+ services and monitoring their access to them.
