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Committee of Public Accounts

**Department for
International
Development:
responding to
HIV/AIDS**

**Fourteenth Report of
Session 2004–05**

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oral and written evidence*

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Committee staff

The current staff of the Committee is Nick Wright (Clerk), Christine Randall (Committee Assistant), Emma Sawyer (Committee Assistant), Ronnie Jefferson (Secretary), and Luke Robinson (Media Officer).

Contacts

All correspondence should be addressed to the Clerk, Committee of Public Accounts, House of Commons, 7 Millbank, London SW1P 3JA. The telephone number for general enquiries is 020 7219 5708; the Committee’s email address is pubaccom@parliament.uk.

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Summary

The Department for International Development (the Department) leads the United Kingdom's contribution to the global response to the HIV/AIDS epidemic. It does so through its own country programmes; through funding of multilateral development institutions; and through support of relevant research and knowledge generation programmes. The Department is the second biggest donor on HIV/AIDS having spent some £270 million in 2002–03. In 2004 it announced that the United Kingdom would spend at least £1.5 billion over the next three years on bilateral and international efforts to combat the disease.

The speed and scale of response

Over the last two decades at least 65 million people have been infected and 20 million have died of HIV/AIDS. Whilst committed to tackling HIV/AIDS, the Department's overall response has been slow, as has that of the international community. The Department now has a strategy to help deal with the epidemic. But the strategy is unclear, amongst other things, on the balance between the development and humanitarian aspects of the epidemic. This distinction affects which countries receive DFID bilateral support to combat HIV/AIDS.

Multilateral partners

The new strategy is also unclear on the balance between bilateral and multilateral programmes. The Department provides nearly half of its aid budget to multilateral development institutions, but these organisations often have different priorities and the Department has little direct control over how multilateral partners use the funding it provides. In 2002–03 only 4% (£57 million) of its multilateral funding was spent on HIV/AIDS. The Department seeks to influence the policies and plans of its multilateral partners. Most of its plans for dealing with multilaterals do not refer to HIV/AIDS, however, including the plan for the European Commission, which receives 60% of the Department's multilateral funding. The Department has no control over the use to which the majority of the funds it provides to the Commission is put and only 2% of the Commission's aid budget is spent on HIV/AIDS. Where the Department does have discretion it is reluctant to withdraw or reduce funding even though it considers its own bilateral HIV/AIDS support to be more effective.

Country responses

The Department's bilateral programmes at country level have to operate against a dynamic background. Social, cultural, economic and political factors; the national capacity to respond; and the work of other donors can all affect the shape and focus of the Department's HIV/AIDS support. However, country plans often lack a considered assessment of the environment in which country teams have to operate. The Department's 2004 HIV/AIDS strategy recognises the importance of helping vulnerable groups, such as women and children, as central to its response. But, at country level, an assessment of the

impact of prevailing cultural, political and social conditions on the vulnerability of different groups is often lacking.

More generally, HIV/AIDS undermines the capacity of developing countries to cope with the epidemic because of the impact it has on their workforce and economy. But between 1997–98 and 2002–03 only 1% (£3.6 million) of the Department's country-level expenditure was spent on mitigating the social and economic impact of the disease. The impact in the health sector has been exacerbated by the migration of doctors and nurses to work in developed countries, including the United Kingdom.

Country HIV/AIDS programmes are seeing a shift in emphasis in the balance between prevention and treatment. In the past, the Department spent four times more on prevention than on support for treatment. The fall in antiretroviral drug prices has been a key factor in the Department seeking to increase support for treatment. However, prices have not fallen uniformly across developing countries, and may not have fallen enough to enable the poorest countries to afford effective treatment programmes.

The continued effectiveness of the Department's country-level HIV/AIDS programmes will depend, in part, on knowing what works in tackling the epidemic, and why. The Department supports HIV/AIDS-related research and knowledge generation programmes, but country teams have found difficulty in receiving information about the knowledge generated, and they often feel overwhelmed by the large amount of information available globally.

Conclusions and recommendations

1. **Some countries with lower HIV prevalence rates attract priority status in preference to still poorer countries with higher prevalence rates.** A balance has to be struck between developmental and humanitarian factors, and between bilateral and multilateral responses. The Department should devise clear criteria to help strike those balances in practice.
2. **Many multilateral institutions supported by the Department devote little of their budgets to HIV/AIDS.** Of the £1.4 billion the Department gave to multilaterals in 2002–03, only an estimated £57 million was used on HIV/AIDS, despite the impact of the epidemic on achieving global poverty reduction goals. The Department has made no special efforts to change their priorities. It should use its funding of multilaterals as a lever for change.
3. **Only an estimated £19 million of the almost £1 billion the Department provides to the European Union annually is spent on HIV/AIDS.** The Department should enlist the support of other European Union Member States to strengthen the European Union's response to HIV/AIDS. With the Foreign and Commonwealth Office, it should identify and work with other sympathetic Member States to secure a change in priorities, enlisting the support of new Member States in particular. Changed priorities need to be reflected in the next seven-year budget framework, which must be in place before 2007. The Department should be prepared to reduce or withdraw support to the European Development Fund where it has evidence that funding would be used ineffectively
4. **Women and girls may have limited power to protect themselves against infection, and lack access to sexual and reproductive health services or education.** The Department should identify country by country those most vulnerable to the disease and say how it intends to reach them. Appropriate responses could include meeting the educational and care needs of HIV/AIDS orphans; supporting the development of laws to protect vulnerable groups; and actively supporting voluntary sector responses to the disease.
5. **The Department should examine why the prices of antiretroviral drugs vary across the developing world and help to negotiate reductions.** Drug prices have fallen for developing countries, but only half as much in some countries as in others. The Department should identify developing countries who are seeking to manufacture generic AIDS drugs, and those who could supply them to other developing countries, and provide technical, legal and administrative support as necessary.
6. **Between 1997–98 and 2002–03, only 1% (£3.6 million) of the Department's country-level HIV/AIDS expenditure was used to support developing countries' efforts to reduce the impact of HIV/AIDS on the community as a whole.** The Department should give higher priority to mitigating the wider social and economic impacts of the epidemic. It plans to work with others to provide adequate nutrition, but should also take steps to address the impact which AIDS has on household poverty and the capacity of public services.

- 7. The recruitment of health workers from developing countries into the National Health Service threatens those countries' efforts to maintain a sustainable response to HIV/AIDS.** Arrangements to prevent active recruitment of skilled health workers from developing countries, without the agreement of those countries, should be tightened. The Department of Health's Code of Conduct, which is intended to control such recruitment, is not well-monitored and does not apply to indirect recruitment via the private health sector. The Department should work with the Department of Health to establish effective monitoring of the Code's implementation and explore its extension to cover indirect recruitment.
- 8. The Department's country plans for responding to HIV/AIDS are poorly prioritised and would benefit from an assessment of a country's capacity to respond to the epidemic.** The Department's country programmes are rarely based on an explicit assessment of factors such as the government's capability to deliver an effective response; the work and priorities of other donors; the activities of NGOs and the voluntary sector; and the quality of information about the epidemic's status. The Department should assess these factors to identify where its efforts can be best directed.
- 9. The Department's country teams should have better access to information on why successful programmes have worked.** The Department's recently launched HIV/AIDS web-portal provides information and guidance on HIV/AIDS which is designed to meet the needs of staff running country programmes. The Department should monitor usage of the portal, and act on feedback from country staff.

1 The scale of response to the epidemic

1. The scale of the epidemic is illustrated in **Figures 1 and 2**. At least 65 million people have been infected with HIV over the last two decades and about 20 million people have died of AIDS, nearly three million in 2003 alone.¹ In 2003, nearly 5 million people were newly infected with HIV.² By 2010, an estimated 25 million children worldwide will have lost at least one parent to the epidemic.³ The epidemic deprives developing countries of their most productive people, erodes the capacity of governments to provide essential services and stops or reduces economic growth.⁴

Figure 1: The global distribution of adults and children living with HIV/AIDS at the end of 2003

Region	Adults and children living with HIV/AIDS (million)²	Adult¹ prevalence %²
Sub-Saharan Africa	23.1–27.9	6.9–8.3
East Asia	0.45–1.5	0.1–0.2
Oceania	0.021–0.046	0.1–0.3
South & South East Asia	4.1–9.6	0.4–0.9
Eastern Europe & Central Asia	0.86–1.9	0.4–0.9
Western Europe	0.46–0.73	0.2–0.4
North Africa & Middle East	0.2–1.4	0.1–0.6
North America	0.52–1.6	0.3–1.0
Caribbean	0.27–0.76	1.4–4.1
Latin America	1.2–2.1	0.5–0.8
Global Central Estimate	37.8	1.1
Global Range	34.6–42.3	1.0–1.2

Notes:

1. Adults are defined as individuals aged between 15–49 years
2. The ranges represent the low and high estimates

Source: 2004 Report on the global AIDS epidemic, UNAIDS 4th Global Report, June 2004

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- 1 C&AG's Report, *Department for International Development: responding to HIV / AIDS* (HC 664, Session 2003–04) , para 1.4
 - 2 *2004 Report on the global AIDS epidemic*, UNAIDS 4th Global Report, June 2004, p10
 - 3 *Taking Action: The UK's strategy for tackling HIV and AIDS in the developing world*, DFID, July 2004, foreword; Ev 15
 - 4 Q 9

Figure 2: Deaths due to HIV/AIDS

Region	Adult and child deaths due to AIDS during 2003 (000) ¹
Sub-Saharan Africa	2,000–2,500
East Asia	22–75
Oceania	<1.3
South & South East Asia	290–700
Eastern Europe & Central Asia	32–71
Western Europe	<8
North Africa & Middle East	9.9–62
North America	8.3–25
Caribbean	23–59
Latin America	65–110
Global Central Estimate	2,900
Global Range	2,600–3,300

Note:

1. The ranges represent the low and high estimates

Source: 2004 Report on the global AIDS epidemic, UNAIDS 4th Global Report, June 2004

2. The Department is committed to tackling the epidemic and has been involved in HIV/AIDS programmes since 1987.⁵ But its overall response has been slow, as has that of the international community as a whole. The Department issued its first formal strategy on HIV/AIDS only in 2001⁶ and currently spends 5% of its budget on HIV/AIDS,⁷ some £270 million in 2002–03. This makes the Department the second biggest donor on HIV/AIDS after the United States,⁸ but it must be set against a current estimate by the Joint United Nations Programme on HIV/AIDS (UNAIDS) of some £4 billion needed to tackle the epidemic.⁹ In the 2004 Spending Review, the Government announced that the United Kingdom will spend at least £1.5 billion between 2005–06 and 2007–08 on bilateral and international efforts to combat HIV/AIDS.¹⁰

3. The shortfall in international funding threatens the success of global initiatives such as the ‘3 by 5’ programme run by the World Health Organisation and UNAIDS to provide

5 Q 3

6 *ibid*

7 Q 7

8 Q 27

9 *Taking Action: The UK's strategy for tackling HIV and AIDS in the developing world*, DFID, July 2004, p17

10 *2004 Spending Review: New Public Spending Plans 2005–2008*, HM Treasury, July 2004 (Cm 6237)

treatment to three million people by 2005.¹¹ The Department published in July 2004 a new strategy to raise the profile of HIV/AIDS within the international community.¹² The strategy describes how the Department aims to address, along with the international community, the need to close the funding gap; strengthen political leadership; improve donor co-ordination; and support more effective HIV/AIDS programmes.

4. The Department sees HIV/AIDS as a development and a humanitarian issue, in line with current international thinking. However, its strategy is not clear on the balance between these two perspectives, between bilateral and multilateral programmes, or between the risk of future spread of the epidemic and dealing with current crises. The Department saw that the scale of the epidemic and the speed with which it was taking hold in many countries required an emergency response to meet immediate needs.¹³ And in some countries, such as Zimbabwe, the lack of government co-operation leads the Department to restrict its efforts to humanitarian support.¹⁴

5. The balance between humanitarian and developmental perspectives has important consequences. For example, some poor countries with the highest HIV prevalence rates in the world are not in the 20 countries in which the Department currently focuses its HIV/AIDS support.¹⁵ The Department told us that it gave priority to the poorest countries that were least able to raise resources themselves. Other countries with large-scale epidemics had resources which they could re-allocate to tackle HIV/AIDS but had decided not to give it priority.¹⁶ The Department saw its approach as reflecting its policy of focusing aid on those most in need. At the same time, four Asian countries, including India and China, feature in the current Public Service Agreement target for HIV/AIDS even though they are among the less deprived “low income” nations and currently have low rates of HIV/AIDS prevalence. From 2005–06, when the extra funding will become available, a further five Asian countries will be added to the target.¹⁷

11 Q 28

12 *Taking Action: The UK’s strategy for tackling HIV and AIDS in the developing world*, DFID, July 2004

13 Q 21

14 Qq 40–42

15 The Department’s 2003–06 Public Service Agreement identifies 16 African countries (Democratic Republic of Congo, Ethiopia, Ghana, Kenya, Lesotho, Malawi, Mozambique, Nigeria, Rwanda, Sierra Leone, South Africa, Sudan, Tanzania, Uganda, Zambia and Zimbabwe) and 4 Asian countries (Bangladesh, India, China and Pakistan) which are key to achievement of its poverty reduction targets, including those relating to HIV/AIDS.

16 Qq 62–63

17 The Department’s 2005–08 Public Service Agreement identifies nine Asian countries which are key to the achievement of its poverty reduction targets: Afghanistan, Bangladesh, Cambodia, China, India, Indonesia, Nepal, Pakistan and Vietnam. The 16 African countries remain the same as for the 2003–06 Public Service Agreement.

2 Getting the most from development partners

Reprioritising multilateral efforts on HIV/AIDS

6. In 2002–03, the Department spent some £1.4 billion, 43% of its aid budget, through multilateral organisations, which have a crucial role to play in a coordinated, effective global response to HIV/AIDS.¹⁸ Multilateral institutions often have different priorities from those of the Department, however, with HIV/AIDS having less importance. The Department estimates that only £57 million (4%) of its 2002–03 multilateral funding was spent on HIV/AIDS. The Department seeks to influence and monitor the policies and plans of multilateral institutions. But 8 out of 14 of its associated Institutional Strategy Papers do not refer to HIV/AIDS, including that for the European Commission, which receives 60% (£850 million) of the Department's multilateral funding.¹⁹

7. The majority of the Department's aid funding of the European Commission is provided under treaty obligations and the United Kingdom has no control over the level of funding or the use to which it is put. In the past, the European Commission's distribution of aid has been governed more by developing countries' historical ties with Member States than by the needs of the poorest countries hardest hit by the epidemic. Consequently, 58% of Commission aid has gone to middle-income countries.²⁰ The Department works with the European Parliament and United Kingdom MEPs, in particular, to refocus the Commission's aid on those countries which have the highest HIV prevalence rates. But the Foreign and Commonwealth Office, rather than the Department, takes the lead in discussing the distribution of Commission aid. Little headway has been made to date in refocusing this aid on poorer countries, and currently only 2% of the Commission's aid budget is spent on HIV/AIDS.²¹

8. HIV/AIDS was last addressed by the European Council in June 2004, although without substantive discussion of how to tackle the epidemic.²² When the United Kingdom takes up the European Presidency in 2005, it will make the issue of tackling HIV/AIDS in Africa a centrepiece.²³ The Department considers that 2005 represents a critical opportunity to refocus the European Commission's distribution of aid in favour of the poorest countries. However, the Department has yet to make much progress on ensuring that new Member States are aware of the issues involved.²⁴

9. The Department has more discretion over the funding it provides to the European Development Fund and considered that some of the work supported by the Fund, particularly in Africa, was more effective than the European Commission's general aid

18 C&AG's Report, para 3.3

19 *ibid*, paras 2.14, 3.4, 3.6

20 Qq 5, 54–57, 83

21 Qq 5, 34–36, 44

22 Qq 48–51; Ev 17

23 Qq 31–33

24 Qq 45–47, 82

budget. However, the Department considered that neither route was as effective as its own bilateral HIV/AIDS support.²⁵ But it is reluctant to withdraw its discretionary funding of the Commission, which totalled £132 million in 2002–03,²⁶ and to re-channel it as bilateral aid. The Department prefers to support the Commission’s work, including providing quality assurance capacity for Commission-funded country programmes, so as to help improve the way the Commission works in the HIV/AIDS field.²⁷ If that can be achieved, all the Commission’s funding will be more effective, not only that of the United Kingdom.

Measuring the effectiveness of multilateral organisations in tackling HIV/AIDS

10. The Department has little direct control over how multilateral partners use the funding it provides and how much reaches those people who are suffering with HIV/AIDS.²⁸ With the exception of contributions to the European Union budget, the Department could reduce or stop funding to multilateral institutions if it felt that funds were not being used in a way which helped to achieve the Department’s objectives.²⁹ But it is not well placed to assess the performance of these bodies on HIV/AIDS. Of the five multilateral institutions with a key role in the global HIV/AIDS response, the Department had not reviewed progress against its strategy for working with them in three cases. And for the two it had, neither strategy contained HIV/AIDS-related objectives. The Department accepts that Institutional Strategy Papers should include a greater focus on HIV/AIDS as these strategies are updated.³⁰

11. Where the Department is not satisfied with an institution’s performance, it makes further funding conditional upon improvements in the institution’s systems. In the case of its support for the Global Fund to Fight AIDS, Tuberculosis and Malaria, for example, the Department made financing conditional on the Fund improving the way it worked with developing countries. It would consider removing funding from a multilateral partner if its performance was sufficiently poor, but only as a last resort.³¹ Effective action, however, depends on strong analysis of good performance information, both of which are often lacking.

25 Qq 68, 86–87

26 *Statistics on International Development 1998/99–2002/03*, DFID, 2003, p154

27 Qq 110–112

28 Qq 52, 66–67

29 Qq 8, 83–85, 107

30 C&AG’s Report, para 3.6, 3.8; Qq 18, 103

31 Qq 8, 107–108

3 Supporting an effective response

Helping the most vulnerable

12. In developing countries, certain groups are especially vulnerable to HIV/AIDS. For women, young people and children this can be because of relatively low status in their societies. Other high risk groups include sex workers and drug users. Mobile groups such as migrant workers and military personnel are also vulnerable to contracting and spreading the disease.

13. Women and girls often lack the power to control their sexual activity, and do not have access to sexual and reproductive health services or opportunities to receive HIV/AIDS education. World Vision told us that children orphaned or made vulnerable by HIV/AIDS can lack food, shelter, clothing or health care. They may have to leave school or care for parents or siblings who are suffering from AIDS. Without parental guidance and protection they may become vulnerable to HIV infection themselves. By 2010, the number of children orphaned by HIV/AIDS is expected to double to 25 million.³²

14. The Department's new HIV/AIDS strategy makes women and young people the central focus for improving national HIV/AIDS programmes. In particular, the Department has identified providing orphans with access to education and health services, and treatment for parents who are ill from the disease, as key factors in supporting children. The strategy also highlights the need for treatment and care programmes to include the needs of children.³³

15. If these messages are to be effective they need to be reflected in recipient governments' poverty reduction strategies. 40% of countries with a generalised HIV/AIDS epidemic have no national policy to provide essential support to orphans and vulnerable children.³⁴ The United Nations has identified the development of such strategies by 2003 as a key factor in the achievement of its 2001 Declaration of Commitment on HIV/AIDS.³⁵

16. The Department's existing plans for those countries which are central to achievement of its key targets on HIV/AIDS often lacked an assessment of prevailing cultural, political and social factors and their impact on possible HIV/AIDS responses.³⁶ Such factors often influence which groups are most vulnerable to the disease. Successful responses, such as those in Uganda, Thailand and Brazil, have paid special attention to vulnerable groups, often involving NGOs or other civil society groups in service delivery or coordination.

32 Ev 15

33 Qq 12, 74

34 Ev 16

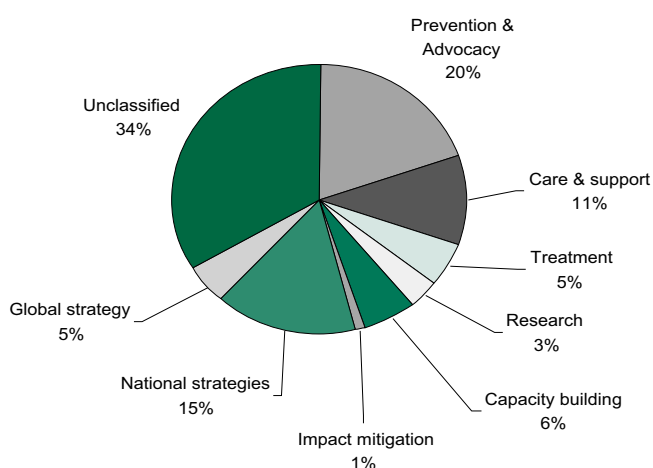
35 *Declaration of Commitment on HIV/AIDS*, United Nations General Assembly, Special Session on HIV/AIDS, 25–27 June 2001

36 C&AG's Report, paras 4.5–4.6

Prevention and treatment

17. The Department's 2001 HIV/AIDS strategy³⁷ placed most of its emphasis on supporting prevention, in keeping with international best practice of the time, and the Department has spent significantly more on prevention than on treatment.³⁸ Between 1997–98 and 2002–03, country expenditure on prevention programmes was four times higher than on support for treatment (Figure 3).

Figure 3: Proportion of DFID country-level HIV/AIDS expenditure by type of intervention, 1997–98 to 2002–03



Source: C&AG's Report: Department for International Development: responding to HIV / AIDS (HC 664, Session 2003–04), Figure 15

18. The Department now wishes to change the balance between prevention and treatment. Its 2004 HIV/AIDS strategy shows that treatment and care are now seen as fundamentally important in tackling HIV/AIDS,³⁹ because of:

- the increased need, with infection rates rising in many countries, to alleviate the impact of the epidemic by keeping public sector workers and parents alive; and
- a significant fall in the price of antiretroviral drugs making treatment an affordable option for more countries.⁴⁰

19. The fall in drug prices has resulted from pressure on pharmaceutical companies from people living with HIV/AIDS and developing country governments to address the lack of access to treatment and the inequity this represents. The Prime Minister, through the G8, and the Department, through its Access to Medicines Team, have also been working to encourage pharmaceutical companies to introduce differential prices for their drugs so that poorer countries pay less.⁴¹ But prices for poorer countries have not fallen consistently:

37 HIV / AIDS Strategy, DFID, May 2001

38 Q 7

39 *Taking Action: The UK's strategy for tackling HIV and AIDS in the developing world*, DFID, July 2004, pp 43–44

40 Qq 2, 12

41 Qq 26, 30

some have benefited from reductions of as much as 95% whereas for others the reduction has been between 40 and 50%.⁴² These reductions may not be sufficient for the poorest countries to afford effective treatment programmes. Some countries may not be able to negotiate price reductions and may require support to do so. In addition, more information is needed on why antiretroviral drug prices vary across the developing world so that the scope for further price reductions, and the countries which may require help in negotiating lower prices, can be identified more easily.

20. Lower prices for antiretroviral drugs produced by pharmaceutical companies in developed countries have made treatment more affordable for many developing countries. But for the poorest countries, with the highest incidence of AIDS, affordable treatment programmes are often still out of reach of those in need. In these circumstances, the ability to import from other developing countries such as Brazil and India, who are able to manufacture antiretroviral drugs through their own pharmaceutical industries at much lower cost, represents a way forward.⁴³ In the past, western pharmaceutical companies have blocked such exports on the grounds of protecting their intellectual property rights.⁴⁴ But flexibilities allowed by the World Trade Organisation's agreement on Trade-Related Aspects of Intellectual Property Rights are intended to safeguard more affordable access to generic drugs by the least-developed countries. The Department is committed to increasing access to medicines, including antiretroviral drug treatments, and issued its plans for making progress in this area in June 2004.⁴⁵

21. Effective treatment programmes depend on patients taking drugs for the rest of their lives. They often do not do so: they may forget or stop because they begin to feel better, or they may feel the need to share their drugs with others in their family because they are too poor to be able to afford treatment for everyone. The Department recognises that it takes special skills at local level to persuade patients of the need to carry on with treatment and to support them during that treatment. In some developing countries, however, the shortage of doctors and nurses at local clinics jeopardises the ability to provide adequate support, which is an important factor in the delivery of a successful response.⁴⁶

Alleviating the social and economic impact of HIV/AIDS

22. HIV/AIDS is also devastating the capacity of developing countries to cope with the epidemic more generally. Public sector workforces are struggling to deal with the resulting increased demands for their services, while their numbers are being reduced as staff die from the disease. In Zimbabwe, 50% of all inpatients in one study were infected with HIV; and in Swaziland people living with HIV/AIDS occupied half the beds in some health-care centres in 2001. Malawi and Zambia are experiencing a five to six-fold increase in health-worker illness and death rates. Other sectors are affected as well, including education, agriculture and the private sector.⁴⁷

42 Qq 25, 77

43 Q 78

44 Q 29

45 *Increasing access to essential medicines in the developing world: UK Government policy and plans*, DFID, June 2004

46 Qq 80–81

47 C&AG's Report, Appendix 3

23. Only 1% of DFID's country-level expenditure in the period 1997–98 to 2002–03 supported mitigation of the social and economic impact of the epidemic in developing countries (Figure 3 above). The Department's new HIV/AIDS strategy acknowledges the wide-ranging impact of the epidemic. It identifies access to food needed for an active and healthy life, and its links to vulnerability, as a particular problem and will provide guidance to its staff on the interaction between HIV, nutrition and treatment. But, whilst acknowledging that HIV/AIDS also affects household poverty and the capacity of public services, the strategy does not indicate appropriate responses.⁴⁸

24. The impact of HIV/AIDS on the health sector in developing countries is made worse by the migration of doctors and nurses to take up better employment opportunities in developed countries including the United Kingdom. Migration depletes already overstretched health services. The Department of Health's Code of Practice on the international recruitment of healthcare professionals⁴⁹ states that the National Health Service should not carry out targeted recruitment in developing countries unless a country has specifically invited the United Kingdom to do so. The Department did not think that direct recruitment from developing countries into the National Health Service was happening but acknowledged that health workers from developing countries were recruited into the private health sector.⁵⁰ The Code of Practice does not apply to this type of recruitment, or to overseas staff recruited privately who subsequently move into the National Health Service.

25. Recent research indicates that the National Health Service has incomplete data on the number of health workers it employs who have been trained in developing countries, and underdeveloped systems for implementing the Code and monitoring compliance with it.⁵¹ The Department and the Department of Health are considering whether the Code can be tightened up and applied to the private sector.⁵²

26. The private sector in developing countries is also a key partner in alleviating the impact of the epidemic. In some countries, companies are losing significant numbers of their workforce to the disease leading to reduced labour productivity and supply, and contributing to a slowing or stopping of economic growth. The private sector in countries such as South Africa has taken a leading role in the treatment and care of workers and workers' families, and also in prevention. The Department discusses with United Kingdom-based companies operating in developing countries their workplace policies on HIV/AIDS. Some companies, particularly some multinational corporations, have forward-looking workplace policies, having recognised the value of a healthy workforce. But others, particularly domestic small to medium sized enterprises in countries hardest hit by the epidemic, struggle to employ good practice. The Department has an important role to play

48 *Taking Action: The UK's strategy for tackling HIV and AIDS in the developing world*, DFID, July 2004, p 47

49 *Code of Practice for NHS employers involved in the international recruitment of healthcare professionals*, Department of Health

50 Q 23

51 J. Buchan and D. Dovlo (2004), *International recruitment of health workers to the UK: a report for DFID*, (DFID Health Systems Resource Centre, February 2004); A. Willetts and T. Martineau (2004), *Ethical international recruitment of health professionals: will codes of practice protect developing country health systems?* Liverpool School of Tropical Medicine, January 2004

52 Q 24

in spreading best practice to companies which could do more to support their workforce in the face of HIV/AIDS.⁵³

4 Achieving balanced and informed country programmes

27. The circumstances in which HIV/AIDS takes hold are different in each country, as are the stage and nature of the epidemic's development. A broad range of social, cultural, economic and political factors influence vulnerability to the disease. The capacity of the public, private and voluntary sectors in each country to respond also differs. In addition, other donors may be active in tackling the epidemic. It is against this dynamic background that the Department's country teams need to design and implement their response to HIV/AIDS. But country plans often lack a considered assessment of these factors.⁵⁴

28. The Department has sought increasingly to design its country programmes to support the achievement of national poverty reduction strategies. It has engaged with some governments, such as in Uganda, to increase recognition of HIV/AIDS in national strategies as a key factor in reducing poverty. These strategies may focus on HIV/AIDS but often lack detail on the planned response, its funding or how progress will be monitored. This leaves the Department with inadequate information on national plans or progress against them. The Department relies on data collated by multilateral institutions to assess the effectiveness of aid, as measured against its high level Public Service Agreement targets. But this information lacks the detail to determine the success of individual HIV/AIDS programmes within countries. And developing country information systems are inadequately developed to permit monitoring of activities to combat HIV/AIDS.⁵⁵

29. Allied to the Department's focus on supporting national poverty reduction strategies is its increasing use of general budget support. But it has little direct control over how recipient governments use these funds,⁵⁶ or how far they support HIV/AIDS programmes. The Department relies largely on systems of accountability and governance within countries receiving budget support, including relying on NGOs, other civil society organisations and local communities to hold government to account for the use of funds.⁵⁷ But the Department does not know how much of its budget support is applied to tackling the epidemic.⁵⁸ As national poverty reduction strategies often do not provide details of HIV/AIDS plans, or the means to measure progress, it is harder for those who need the support to hold their government to account in the way the Department describes. There are risks, therefore, in relying on developing countries' systems to ensure that HIV/AIDS programmes benefit fully from budget support. In Tanzania, the Department is working with the Ministry of Finance which is seeking to encourage other ministries to spend more on HIV/AIDS by creating ring-fenced budgets for this purpose.⁵⁹

54 C&AG's Report, paras 4.6–4.7 and Appendix 2

55 *ibid*, paras 4.1, 4.3–4.4, 4.7; Q 17

56 30th Report from the Committee of Public Accounts, *Department for International Development: maximising impact in the water sector* (HC 446, Session 2002–03)

57 Qq 4, 13–16

58 C&AG's Report, para 2.13

59 *ibid*, para 4.18

30. Where the Department considers that the risk of misuse of budget support is too high, or the public sector does not have the capacity to deliver effective HIV/AIDS programmes, it channels HIV/AIDS funding through NGOs rather than the government. The Department recognises that NGOs also have a key role in changing social attitudes to the disease and it funds NGO information campaigns designed to bring about such change.⁶⁰

31. As well as working with recipient governments and NGOs, the Department seeks to develop partnerships with other donors as part of its country-level response to HIV/AIDS. It has established a joint task force with the United States in a number of countries, particularly in Africa. The Department seeks to improve coordination between donors through these coalitions so that HIV/AIDS funding supports national poverty reduction strategies rather than donors' preferences. But there is not always a full meeting of minds with some donors who may have different priorities to the Department, or limitations on how they can use their funding. The Department seeks to support approaches which include the full range of services to people living with HIV/AIDS on the ground that it is more effective. In countries such as Uganda reversal of rising prevalence rates has included support for effective prevention and education programmes promoting the value of abstinence, reduced sexual activity and the use of condoms as part of a wider approach to tackling the epidemic. Other donors may concentrate on supporting only certain types of service or approach.⁶¹

32. The Department's country plans also need to be informed by experience elsewhere. Despite the alarming scale of the HIV/AIDS epidemic there are also signs of progress. Of the 20 countries which are key to the Department achieving its Public Service Agreement targets, prevalence rates in 13 have either fallen or stabilised between 2001 and 2003.⁶² There are also particular success stories in countries such as Uganda, Thailand, Brazil and Senegal which have succeeded in halting the spread of the disease. The Department has drawn three lessons from their experience:⁶³

- the need for national political leadership in developing a comprehensive and multifaceted response to the epidemic – for example, in Uganda success was partly linked to donors' efforts, including those of the Department, but much of the credit lay with the government and people of Uganda;⁶⁴
- the need for early and decisive action; and
- the importance of programmes targeted at groups particularly susceptible to contracting and spreading the disease, such as commercial sex workers and truck drivers.

33. Knowing what works in tackling the epidemic, and why, and disseminating such information and examples of success are vital to the Department's country teams as they seek to fashion effective responses to HIV/AIDS. The Department supports HIV/AIDS-

60 Qq 42–43

61 Qq 64, 70–73, 75, 92–95, 97–102

62 *2004 Report on the global AIDS epidemic*, UNAIDS 4th Global Report, June 2004; *Table of country-specific HIV/AIDS estimates and data*, UNAIDS 2003; Q 69

63 Qq 10–11

64 Q 39

relevant research and knowledge generation programmes.⁶⁵ But country teams have difficulty in receiving information from knowledge programmes, whilst they often feel overwhelmed by the large volume of information available globally.⁶⁶ The Department launched an Internet-based repository of HIV/AIDS-relevant information and guidance in August 2004 to make it easier for its staff and development partners to gain access to such data.⁶⁷

34. The Department emphasises the importance of evaluating the impact of its work and has doubled its funding in this area.⁶⁸ But the Department has yet to carry out its first comprehensive evaluation of the impact of its HIV/AIDS programme of work, even though it has been supporting HIV/AIDS-related work since 1987. An evaluation planned for 2003 has been deferred until 2006, partly to allow the Department to wait for the Comptroller and Auditor General's Report.⁶⁹

65 C&AG's Report, paras 5.2, 5.7

66 *ibid*, para 5.9

67 *ibid*, para 2.8

68 Qq 37–38

69 *Taking Action: the UK's strategy for tackling HIV and AIDS in the developing world*, DFID, July 2004, p 66

Formal minutes

Wednesday 9 March 2005

Members present:

Mr Edward Leigh, in the Chair

Mr Ian Davidson
Mr Brian Jenkins

Mr Gerry Steinberg
Jon Trickett

The Committee deliberated.

Draft Report (Department for International Development: responding to HIV/AIDS), proposed by the Chairman, brought up and read.

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

Paragraphs 1 to 34 read and agreed to.

Conclusions and recommendations read and agreed to.

Summary read and agreed to.

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

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

Ordered, That the provisions of Standing Order No. 134 (Select Committees (Reports)) be applied to the Report.

[Adjourned until Monday 21 March at 4.30 pm]

Witnesses

Monday 28 June 2004

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Mr Suma Chakrabarti, Mr Graham Stegmann, Mr Richard Calvert, and Ms Robin Gorna, Department for International Development

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Oral evidence

Taken before the Committee of Public Accounts

on Monday 28 June 2004

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Allan
Mr Richard Bacon
Mrs Angela Browning
Mr David Curry

Mr Ian Davidson
Mr Frank Field
Jim Sheridan
Mr Alan Williams

Sir John Bourn KCB, Comptroller and Auditor General, and Mr Nick Sloan, National Audit Office further examined.

Mr Brian Glicksman, Treasury Officer of Accounts, further examined.

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL: Department for International Development: responding to HIV/AIDS (HC 664)

Witnesses: Mr Suma Chakrabarti, Permanent Secretary, Mr Graham Stegmann, Director, Africa Division, Mr Richard Calvert, Director of Finance and Corporate Performance, and Ms Robin Gorna, Head of HIV/AIDS Policy Team, Department for International Development, examined.

Q1 Chairman: Good afternoon, welcome to the Committee of Public Accounts. Perhaps I could start by welcoming to our session as a visitor the President of the Dutch Court of Auditors, Mr Stuiveling, who is here. You are very welcome to our committee. Of course, we welcome back to this meeting on the Comptroller and Auditor General's Report on HIV/AIDS in the developing world Mr Suma Chakrabarti, who is the Permanent Secretary and Accounting Officer for the Department of International Development. Would you like to introduce your team?

Mr Chakrabarti: Chairman, on my immediate right is Mr Richard Calvert, who is Director of Finance and Corporate Performance; on my immediate left is Ms Robin Gorna, who heads our HIV/AIDS team in DFID, and on the far left Graham Stegmann, who is Director for Africa.

Q2 Chairman: Mr Chakrabarti, do you think you have got the balance right between prevention and treatment? You spend about four more times on prevention than treatment. Is the balance right?

Mr Chakrabarti: The balance needs adjusting; there is no doubt about that. That is what the new strategy, which we will issue in July, is partly about. As the Report quite rightly states, the strategy we had in 2001 put most of its emphasis on prevention, and very strongly so; and that was in line with international best practice at the time. Some things have changed though, and we need to change our strategy. The things that have changed in particular are, at developing country level, seeing the prevalence rates, particularly amongst 15-49 age group, which mean that public service delivery, for example, cannot keep up unless we do something

about keeping many of those public sector workers alive—so there are economic and social issues which have come through in the last three years. The other thing is that the price of treatment drugs has fallen drastically, making it a much cost-effective approach. Whereas in the past a country like Brazil, which is reasonably well off compared to many of the countries we deal with, could afford to be in both prevention and treatment, in places like Uganda and others, it is very much on prevention only. I think we are going to see many of the African and south Asian countries focusing on both, and we are going to try and support that.

Q3 Chairman: Research on this subject has been around since the mid 1980s, but we read in this Report and the references particularly in paragraphs 1.9 to 1.11 that it was only in 2001 that you really got your strategy going. Why did you wait so long?

Mr Chakrabarti: The first AIDS programmes from DFID were back in 1987 in fact, but the first strategy came along in 2001 because that is when the numbers of prevalence and what was happening on the ground in countries came through, and the UN launched its declaration at the time; so political commitment internationally really only began to come through just after the turn of the century. That is why we brought the strategy out at that time. This is not to say we were not working in this area; we had over 500 projects in this area before that even.

Q4 Chairman: Others can come in on that if they wish to. There is a mention on page 28, particularly in paragraphs 4.16 and 4.17 about the aid you channel through general support to nations' budgets. What I would like to ask you is that if this

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aid is being channelled through to nations in a more general sense, how can you be sure it is actually getting through to the people who need it on the ground, who are often the most vulnerable?

Mr Chakrabarti: Part of what we do of course, when we channel aid through budgets, is to look at country systems for getting the aid delivered to poor people in villages, communities and so on. I can give you examples of that. Take education in Uganda, where one of the things we have been doing is trying to strengthen the accountability of the Government to people in villages, so that the money they say is devoted to, let us say, education, which arrives through budget support does get spent on schools and so on. Giving voice to people in the communities to hold their parliamentarians and governments to account is part of the process we are trying to play to improve the accountability and make sure things do get done on the ground. It is the same with HIV and AIDS: we will be encouraging the civil society working in HIV and AIDS again to hold governments to account. It is not to bring the money in and then not checking whether the outputs are there.

Q5 Chairman: One of the problems of this is that a large proportion of the aid you give is done multilaterally rather than bilaterally. The key partner for you is the European Commission, and mention is made of this on page 20, paragraph 3.6. The European Commission document apparently makes no mention of HIV and AIDS. Is this not rather worrying? Does it not show a lack of priorities on the part of the Commission?

Mr Chakrabarti: The Commission is upping its game on HIV and AIDS, but we agree that it needs to do more in this area. I think that only 2% of Commission aid budget is currently spent on HIV and AIDS. They want to do more too. In part—and going back to earlier hearings—it is a reflection of the distribution of European Union aid: the fact that 42% of EC aid is spent in low-income countries, and therefore 58% in middle-income countries, but the highest prevalence rates for HIV and AIDS are in poor countries. Their own distribution of their aid works against doing more in the AIDS area, and they need to change that distribution. As you know, we have been championing that shift. They are doing some more. The EC has worked very hard on the Global Health Fund to try and improve the performance of that fund. I am hopeful that some of the unspent money that is in the EDF—and this was reported on by the All-Party Group a week ago in its report on AIDS—will go into HIV and AIDS.

Q6 Chairman: You criticise them for their support, but the proportion of your budget that is directly related to HIV/AIDS is 5%. Would that be a fair guess? You have some difficulty in monitoring what you spend, do you not?

Mr Chakrabarti: I do not think we have a difficulty in monitoring what we spend.

Q7 Chairman: Just for the sake of the record, then, outline exactly what you spend directly on HIV/AIDS and what proportion of the total budget it is and how much.

Mr Chakrabarti: It is about 5%, as you say. We are going to increase that; it is part of the strategy that will come through in July. There is a table in the Report which gives some indication of the distribution of the spend as well. As we said earlier, there has been not enough spending on treatment and a lot more on prevention, and we need to correct that balance. However, in terms of how effective we are on the ground, the Report is quite clear. Paragraph 4.19 says that our programmes and projects have been largely successful, so I think we have a reasonable story to tell on that front.

Q8 Chairman: A general point: there has been a lot of criticism about the lack of controls in regard to this money which is going to some of these countries, the poorest countries in the world. I just wondered whether you are sufficiently pugnacious in dealing with other agencies. There are obviously glaring weaknesses that we see coming through in this Report, and we still do not have a clear idea of whether this money is getting through to the people who need it. If your partners are not performing, why do you not threaten to either cut the resources you give to them, or re-distribute it, or do more bilaterally? Are you being sufficiently strong?

Mr Chakrabarti: I think we are. That is very much part of our dialogue. I can give you a couple of concrete examples. The Global Health Fund was created a few years ago to tackle AIDS, TB and malaria. Early work on that by the fund was not to our liking. It did cut across some developing countries plans, and so on; and we took this up both at ministerial and at my level, with quite a lot of evidence. We said we could not really provide more funding for the fund unless it smartened up its act. As it happens, that has worked: the fund has improved quite a bit in the last year and is working better with developing countries. Some of the transaction costs are being reduced. We have managed to improve the performance of the fund through that approach, so we are not totally tender and can be as tough as we need to be as well.

Q9 Chairman: Over the last two decades 65 million people have been infected and 20 million people have died. Are you satisfied with the response of the international community to what is probably the single greatest problem facing the developing world?

Mr Chakrabarti: No. It is quite clear that those statistics are frightening, and if you go to some of the countries we visit, you can see what it is doing. I was in Malawi recently, where public services simply cannot be delivered because many people were either dying from AIDS or migrating away from Malawi to other places where they can earn better salaries. The impact of AIDS on public service delivery is immense; the impact on economies is very great—up to 1.5% can be knocked off many African economies' growth rates through AIDS. Some estimates are that by 2020 one-fifth of Africa's GDP

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will have been lost by this, so this is serious stuff, and the most serious development challenge, along with economic growth, that I can see in Africa.

Q10 Chairman: Are you impressed with what has been achieved in Uganda because of their strategy, compared with South Africa, and can you draw any lessons from that?

Mr Chakrabarti: I am impressed. Robin, who is an expert in this area, can add to this, but I draw three lessons from successful examples like Uganda, Thailand, Senegal and Brazil.

Q11 Chairman: What are the three lessons?

Mr Chakrabarti: Firstly, political leadership. If you do not have serious political leadership around this issue, which sees it not just as a health issue but as a national development issue, then you will not get anywhere. President Museveni made it a national development issue and said that basically Uganda's future was riding on trying to sort this problem out. That has not been the case in some other countries, including South Africa, as you know. In Thailand similarly, that national leadership is there. The second is early and decisive action. One of the least known statistics is that Thailand and South Africa had the same prevalence rates back in 1990; they do not today. The Thais took very early and decisive action. The South Africans also have quite a decent health system compared with many other African countries, but did not take that same decisive action—and you know the rest. The third area is in targeted programmes from time to time, which really do make a difference. The Thais concentrated particularly on commercial sex workers as a way of tackling the prevalence rate, and Uganda concentrated particularly on the trucking routes around Lake Victoria, which made a massive impression quickly on the prevalence rates. Those are three broad examples of what works.

Q12 Mrs Browning: We received a letter today at very short notice, which was sent to us in advance of this meeting, by World Vision,¹ asking members of the Committee to press that it is important that the Department make children affected a priority for the forthcoming strategy. Can you give us any information as to whether children will become a priority and how?

Mr Chakrabarti: I will ask Robin to set out the details. Children will be a priority. Orphans have to be a priority. There are 14 million orphans now because of HIV and AIDS. The number of single-headed households in Africa is disastrous socially. It has to be a priority, and it has been a neglected area in my view.

Ms Gorna: In our analysis for the strategy we have identified that women and young people need to be the central focus because, as has already been outlined, the impact of the disease is so acute because it is predominantly affecting those young people. There are 14 million orphans to AIDS and it is estimated that by the end of the decade there will

be some 20 million orphans. In terms of the re-balancing that the strategy will herald, it is a re-balancing to incorporate care and treatment alongside prevention in many of our programmes, but also very much to look at mitigating the impact on society, in particular looking at how we can support orphans. There are three key threads to supporting orphans and other children made vulnerable by HIV and AIDS. One is ensuring that they are able to go to school. That is obviously an issue for all children, but children orphaned by AIDS and children living in families who are caring for large numbers of orphans excluded from school. Access to education is clearly important. Access to health services and care services is also important for all children, but obviously those children who are themselves living with HIV or AIDS and have been infected by their parents. Finally, there is treating parents, which is why the re-balancing of the strategy is important. We need to treat workers but we also need to treat parents, because the longer a child's parents stay alive, the better their hopes of survival and education.

Q13 Mrs Browning: Mr Chakrabarti, when you were answering the Chairman's earlier questions, specifically relating to Uganda you talked about holding governments to account. I want to make sure you fully understood what you are saying here. Who exactly holds governments to account?

Mr Chakrabarti: In Uganda, as I understand it, the government has to say explicitly when it is pushing money through the system what it is going to be spent on, and that has to be filtered all the way down to local villages. If the government is saying, "with this amount of money we are going to build five schools" they have to lay that out for the villagers, and the villagers can hold them to account on that.

Q14 Mrs Browning: I am a bit concerned to hear you say that because my understanding is that across the piece, in terms of developmental aid, for whatever purpose, it is quite legitimate and proper for the UK Government to look to the receiving government in terms of good governance and standards of probity and making sure that the money goes to the purpose it was meant for. Where that has not worked in the past, government has used NGOs more than putting money directly into an overseas government. Why is that different for the money going for these purposes, because it seems to me that the people themselves are least well equipped to hold their own government to account?

Mr Chakrabarti: I would argue that in Uganda they have shown they can hold their governments to account, and you can see how the standard of debate in the Ugandan parliament has improved over recent years.

Q15 Mrs Browning: The standard of debate has improved?

Mr Chakrabarti: Yes, if you look at parliamentary debate and how they ask questions of government, and there is a press in Uganda that is holding the government to account—this has changed quite

¹ Ev 15–17

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radically in the last ten years. This does not preclude us from using NGOs as well. We would use NGOs in certain situations. However, one of the fundamental things that this Government is trying to do with this aid programme is build more effective states. That means, without money, trying to build public financial management systems, build better accountability, anti-corruption commissions, parliamentary ombudsmen, public accounts committees—the sorts of things we are used to here to try and improve that accountability. That is what budget support is trying to underpin as well.

Q16 Mrs Browning: I would hope that you would make some judgment in terms of getting money to the people who really need this money. While improving governance is highly laudable—and I do not criticise it in any way—surely the priority has to be to get the money or the resources to deal with this ever-increasing problem? Unless you are 100% sure that the money is going in that way—

Mr Chakrabarti: If our money was simply going into a government account—and, frankly, improving the quality of buildings of ministries of finance—this would not be useful at all.

Q17 Mrs Browning: How would you know?

Mr Chakrabarti: That is why we have the public service agreement, which this Committee looked at two years ago, which it helped to improve. It sets out the whole set of development goals—infant mortality rates, maternal mortality rates, which we are trying to improve in these countries. We get data then from these countries, through the international system, which measures whether the aid is having an impact or not.

Q18 Mrs Browning: Would you look at 3.8 on page 21? It states: “Due to the lack of HIV/AIDS-related objectives in many of DFID’s institutional Strategy Papers, DFID has not formally assessed progress in this area. Of the five key multilateral development institutions, no annual reviews have been carried out for three. Where reviews had been done, on the European Commission and the United Nations Development Programme, the Institutional Strategy lacks any HIV/AIDS-related objectives against which to measure progress.” Why is that?

Mr Chakrabarti: Because our approach to institutional strategy papers in the past—and this is changing now—was very much the focus on governance of those institutions and to use executive boards to focus on issues like HIV. Take as an example the World Bank, which is the biggest donor around: in the past we would have used the institutional strategy to try and improve the governance, the financial standing and those sorts of issues for the World Bank, as shareholders of the World Bank. We would have used our interventions of the executive board to try and improve the quality of HIV/AIDS programmes, their strategies and so on. What we recognised, and I think the executive board is absolutely right on this, is that we need to bring those two elements together; you cannot really run two different approaches, different channels, to

try and influence the World Bank; so the next institutional strategy for the bank, which is out in the summer, will undoubtedly have HIV/AIDS as a major theme.

Q19 Mrs Browning: Paragraph 3.9 states: “The justification for the level of funding to the main multilateral development institutions, in support of DFID’s HIV/AIDS objectives, was not always well documented.” Why was that?

Mr Chakrabarti: We think they were well documented actually. In relation to the World Bank, let us take our contribution to the World Bank’s concessional arm, which is called IDA, the major instrument by which they work in poor countries. That would have taken account of a whole range of issues. For example, at the last IDA 13 replenishment, just two years ago, HIV/AIDS was one of the reasons for the size of our contribution, and that was well documented at the time; but the World Bank is a generalised organisation, dealing with not just AIDS but many other issues in development. If you take our contributions to WHO, again a generalised organisation, HIV/AIDS would have been one of those reasons. Recently, we made a special contribution to WHO for HIV/AIDS for its treatment initiative, the 3 by 5 initiative as it is known. That is quite clearly, as is well documented, aimed at trying to improve performance on HIV/AIDS; so I do not wholly accept this paragraph.

Q20 Mrs Browning: But you did make changes in 2003, as we read at the end of paragraph 3.9: “In 2003, DFID established a Multilateral Finance Allocation Committee . . .” Was that the solution to the problem?

Mr Chakrabarti: That is part of the solution. That is one part and the other part is the one I mentioned earlier, revising the institutional strategy papers; so they properly reflect the priority moving to HIV/AIDS. We found in the past that many decisions on multilateral aid was simply built up over time, so essentially driven by historical relationships. The reason we have this committee is to take a fresh look at what is effective, and which institutions are effective—going back to the Chairman’s earlier question, are we being tough or are we not—and adjust allocations accordingly.

Mrs Browning: Thank you. I am afraid my time is up. I have other questions, but maybe I might catch the Chairman’s eye later.

Q21 Jim Sheridan: Mr Chakrabarti, would you regard HIV/AIDS as a humanitarian problem or as a longer term educational/developmental problem?

Mr Chakrabarti: To be honest, I find it very difficult to answer that question because one part of me, the human non-bureaucrat part of me, sees this as a quite clear moral, ethical, humanitarian issue, that many of our fellow citizens are dying in such numbers and we could all be doing something about it, so there is that impulse, motivation, guiding some of our work. It is also quite clearly a big development issue because of the reasons I gave earlier: the impact

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it is having on the economies of these countries and on public service delivery. It is both in my mind, but primarily it is a development issue and that is why we are involved in this.

Q22 Jim Sheridan: Can I say that I personally have been extremely lucky not to have seen anyone die of HIV/AIDS. I assume that you have. What impact has that had on you?

Mr Chakrabarti: I am loathe to bring up personal stories, but since you invite me—I started my career in Botswana, which has the highest prevalence rate in the world. I go back from time to time, and I was there two months ago and saw my best friend. He is still alive, but nearly all our friends have died. It has quite a big personal impact, and it is the same for all of us who have worked in developing countries; all of my colleagues would have similar stories.

Q23 Jim Sheridan: One of the things that genuinely concerns me is the money that has been invested in trying to help people with AIDS, while very much welcome at the same time we as a government and many other governments in the Western world are then taking away the people who are capable of treating people with AIDS, for our own interests. That cannot be right, surely?

Mr Chakrabarti: There is a real need to look at migration policy properly on this. You are quite right that if you went to somewhere like Malawi, as I did, to find many of its workers migrating either to other parts of Africa, South Africa in particular, or into the NGO private sector—because they are paying a lot more in Malawi than the public sector—or migrating to UK and America, that clearly is having an impact. It is not as if our colleagues in the Department of Health are not aware of this, they are. They have codes of conduct which state that we should not be recruiting directly into the NHS. I do not think that is happening. What I think is happening is that there is recruitment into the private sector in the UK, and after some time in the private sector some of those workers are migrating on into the NHS; so you will find Malawian nurses in the NHS who worked in UK nursing homes to start with. There is an issue of whether we should look at our migration codes of conduct to see whether we can tighten them up.

Q24 Jim Sheridan: Have you raised these concerns with Government departments? Do you have a strategy for trying to stop this migration from countries suffering severely from HIV/AIDS?

Mr Chakrabarti: We are in dialogue with the Department of Health about this, and they recognise the issue; it is not that there is not a meeting of minds and they are also troubled by it. We are looking at whether the codes of conduct can be tightened up and in particular applied to some of the more unscrupulous private sector recruiters. That is where the action needs to be.

Q25 Jim Sheridan: Could you or would you make a distinction between funding those who are already infected with HIV, or preventing others getting

infected with HIV? Can you make a distinction in terms of priority? If you have a limited amount of resources, should they be going to prevention, or trying to address a cure?

Mr Chakrabarti: In the past, the answer would have been prevention in poor countries because the cost of the drugs was such that it would have prohibited any but the very well off from accessing the drugs. Because drug prices have fallen, in some cases by up to 95%, but certainly by 40% or 50% in many countries, treatment for a wider set of people is now possible. A balance can be drawn in a different area now than it would have been some years back.

Q26 Jim Sheridan: Why has the price of drugs reduced so significantly?

Ms Gorna: There has been massive pressure on pharmaceutical companies from people living with HIV and AIDS and from developing country governments about the inequity of the lack of access for people living in poor countries. The Prime Minister also convened the high-level working group on access to medicines which reported in 2002, and related to that we have been working through the G8 through the access to medicines initiatives there, working very closely with companies. A number of the pharmaceutical companies have taken very brave steps forward to reduce prices, and have differential prices for poor countries and rich countries.

Mr Chakrabarti: In developing countries like Brazil or India, they have pharmaceutical industries of their own and are able to copy the drugs and produce them at much cheaper rates. Brazil's prices dropped when they started doing that—local manufacturers.

Q27 Jim Sheridan: As a government, would you agree that we are doing enough; or is there more we can do? The leaders of the major countries in the world have just met at the G8. Do you think as one of the leading countries in the Western world that we are doing enough, either singularly or collectively, to stem the problem of HIV/AIDS, and what advice would you give the Government?

Mr Chakrabarti: The UK's track record is rather good in comparison with some others. We are the second biggest donor in this area after the US. As a share of national income we give more on AIDS than all other countries bar Ireland, so we have got a pretty good story. However, given the scale of the problem out there, I do not think any country is really doing enough, including the UK, and that is what the strategy will set out—the need for all of us to do more—and therefore the other members of the G8 as well needing to do more. I have one note of caution. Doing more in an undisciplined way, whereby all donors do their own thing, would not be a sensible thing, because that would end up with those very same countries ending up with loads of little projects, not having the resources then to manage them. We do need to work through country-based systems with the relevant countries in charge, and we actually put our money into pools in those

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countries, which are managed by them. More money, but in a disciplined manner, is quite important.

Q28 Mr Allan: I am going to start with Appendix 1, which may be a strange place to start in the Report, towards the end on page 34; but it is quite helpful because it is the United Kingdom's call for action on HIV/AIDS, and hopefully it sets goals on which we can start to test you as to whether or not we have achieved them. Talking about a couple of the numbers goals, the ones coming from the UN plan: 25% fewer young people should be infected with HIV/AIDS by 2005, and 3 million people, 2 million in Africa, should be receiving treatment by the end of 2005. We are half way there—this is in 2003. How do you feel about those goals? How close are we to achieving them?

Mr Chakrabarti: I think it would be a stretch to achieve them. Robin knows more about the first one, but the one I know more about is the WHO one, which is the 3 million receiving treatment by the end of 2005. Given the amount of money in the system currently, we need governments of the G7 to really cough up, frankly, to make this happen in time; it is only a year and a half away. Otherwise, what will happen is that countries like Malawi will be faced with the appalling choice of who you give anti-retrovirals to.

Q29 Mr Allan: A lot of the debate taking place around the drug treatments is linked in to the debates taking place in the World Trade Organisation about intellectual property protection. Do you, as a department, have input into that? You are coming from quite a different angle, where presumably it would be much better if drug companies in Brazil and India could export their drugs; but it is the pharmaceutical companies that are blocking that, and they export their generic drugs. Do you have input into that?

Mr Chakrabarti: We do have input into it. We have an Access to Medicines team which very much worked up some of the things that the Prime Minister raised in the G8 on access to medicines and getting prices of drugs down, as Robin mentioned earlier. We have had quite a strong input into this.

Q30 Mr Allan: So there is a DFID voice, saying "make these drugs cheaper".

Mr Chakrabarti: Yes. This has been one of the areas where DFID has had a good voice within Whitehall, for a change.

Q31 Mr Allan: Can I now talk about the stronger political direction in the second section. "The UK Government will make HIV/AIDS in Africa the centrepiece of our presidencies in 2005 of both the G8 and the EU." Can we expect in particular there to be a shift in the multilateral aid priorities that are a result of that? As referred to in the Chairman's questioning earlier, a half of DFID aid goes to the EU. The EU aid programmes are inadequate in terms of their reference to HIV/AIDS, as compared

with the UK's direction. When we have the presidency of the EU, does that mean we will be trying to change the thrust of EU policies?

Mr Chakrabarti: It is always an interesting question as to whether you have more power when you are in the presidency or less power; and several ex-ministers here may be able to comment better than I. Certainly over the next year and a half, we will harass, pressurise and influence the EU and others to do more in this area, while we have the presidency of the G7 in particular.

Q32 Mr Allan: It is quite strong language to say it will be a centrepiece, though, is it not?

Mr Chakrabarti: It will be. I think you will find the Prime Minister and other ministers focusing very much on Africa, climate change and HIV/AIDS in the next year and a half, in terms of the issues that my department deals with.

Q33 Mr Allan: It has not changed since 2003. The warm words will be backed up by firm action!

Mr Chakrabarti: Yes, and political leadership is crucial. That is why the Prime Minister is now one of the co-chairs of International AIDS Trust, along with ex presidents Clinton and Mandela, because he obviously cares passionately about this issue.

Q34 Mr Allan: In terms of understanding the EU multilateral aid, the direction of that and the strategy is set by a regular Council of Ministers, is it? The DFID Secretary of State sits down with the other ministers, and they agree the EU aid disbursements.

Mr Chakrabarti: If only that was the case; then we might get a more rational distribution of EU aid. No, it is Foreign Office ministers who have the lock on distribution of EU aid.

Q35 Mr Allan: The British voice is the Foreign Office minister.

Mr Chakrabarti: But of course our Foreign Office takes the DFID brief and argues the case, but it can easily be overwhelmed by several other countries.

Q36 Mr Allan: If we want to influence it, then it is the specific individual that will be sitting there agreeing the policy is the UK Foreign Office minister.

Mr Chakrabarti: There are a number of issues there, and firstly the question of the Member States: the foreign ministers argue the case. There is also the question whether within the European Commission there is a sufficient motor, sufficient incentives, to also do something about this. I happen to think actually that the top levels of the European Commission on development—those officials are very strongly seized of the need to do more in this area. Where they can, they have been trying to do so. You also need a development commissioner in the EU who will fight this corner hard.

Q37 Mr Allan: I suspect this will be returned to. Can I turn to a couple of specific points. On page 14, table 5 is a set of comparators for donors and how their HIV/AIDS strategy money is spent. There are a

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number of columns listing four different donor organisations. The thing that stands out from those figures is the monitoring and evaluation bit of DFID's money is much higher than everything else. Should we be worried about that, as a public spending committee; that monitoring and evaluation, which might carry less positive connotations than some of the other bars, is higher for the UK's aid than anyone else's?

Mr Chakrabarti: No, it is because we care about making sure that our inputs turn into the outputs we want, which is why we put quite so much emphasis on monitoring and evaluation. The UK has always been strong on that, so you will not see that sort of bar just for HIV/AIDS, you will see it for most other programmes.

Q38 Mr Allan: It does not surprise you?

Mr Chakrabarti: No, and if anything, in the PAC in the last two sessions I have been in front of you, you said that we should do even more in this area, and I have just doubled the budget of the evaluation teams.

Q39 Mr Allan: *Touché*. Moving to some of the specific country plans that have been referred to, Uganda is held up as the model of how things can be turned round—and you have referred to it yourself. Table 14 on page 26 shows differing trends in HIV/AIDS prevalence in urban areas, and Uganda has been sliding down in a very positive way. Does DFID claim some responsibility for that? Is that a success story? Were you engaged with that?

Mr Chakrabarti: We were, and we would obviously claim some part of the success. Attribution of the success to just DFID would be a mistake; there is no one-for-one match between what we do and the trends, if you like; but we have been part of a collective effort. I think the major credit goes to the government and people of Uganda, rather than donors. Donors have obviously chipped in, helped, improved the policy and delivered some of this, so we would take some of the credit.

Q40 Mr Allan: In Zimbabwe, in the same table the prevalence is very sustained and high there. How are you able to operate in Zimbabwe at the moment? You still have programmes there, do you not?

Mr Chakrabarti: A few humanitarian programmes, but I think we are also working in AIDS and feeding, food aid. They are the two things we are doing currently in Zimbabwe.

Q41 Mr Allan: Are you still able to function at this stage?

Mr Chakrabarti: With some difficulties, but, yes, just about.

Q42 Mr Allan: Because the governmental co-operation is not there, which you said was the key.

Mr Chakrabarti: That is right. We cannot run a development programme there, so we are having to work very much through the NGOs, and this is one of those situations where you need NGOs to do this because the government systems are not working.

Q43 Mr Allan: The other country where the figures are contentious is South Africa, in terms of the record of statements by the president. How are things working in South Africa currently? Are they going to have an active and positive programme there and a good relationship?

Mr Chakrabarti: We do have an active and positive programme. It is quite a large programme in South Africa. The bit I know most about, which is very successful, and where South Africa is a bit of a beacon for the rest of Africa, is the information that NGOs and others can put out about how to cope with HIV and AIDS. We fund a programme called Soul City, which is shown on South African TV, but is also shown around other parts of Africa. It has had quite an impact on people's attitudes and how to cope with HIV and AIDS and so on. That has been a good thing. Mr Stegmann might want to say something about the rest of the South African programme.

Mr Stegmann: If I pick up the distinction between South Africa and Zimbabwe, one of the key distinctions I would draw is that South Africa has very vigorous non-governmental advocacy campaigns, which are open, so there is no hiding the impact of HIV. Where the issue in both countries has become slightly more difficult is when you want to roll out very large programmes, particularly on the treatment side, and you want to go through government systems, where there has been a distinction raised. That is the issue currently in Zimbabwe. In South Africa we have been working very much through NGOs on changing social attitudes, and we are starting to work also with the private sector, which is very innovative in this area; they have seen the impact on their own workforces and on the areas from which they draw their workforces. They have been fairly progressive in looking at impact mitigation.

Q44 Mr Curry: Mr Chakrabarti, Appendix 1, *Call for Action*, has one national strategy, one national AIDS commission, and one way to monitor, known as the three ones, which is a wonderfully Maoist expression, is it not? It is the sort of thing that was scrawled on mausoleums in Peking. It is astonishing that it comes from a British department. However, as you guessed, I want to explore the European Union aid programme. Even without waiting for the constitution, whatever its fate, the European Parliament is now a very much bigger organisation and has representatives from 10 countries which were not previously members of the European Union and have no colonial legacy. What efforts are we making within the European Parliament with its co-decision-making powers to try and get the European Parliament to share our view of the priority of AIDS so that we can do something about a budget, which, quite clearly, does not share our priorities?

Mr Chakrabarti: Obviously, we have been working with various members in the European Parliament, and in particular the UK MEPs from all the parties, on trying to get firstly the distribution of EU assistance right, so it is more focused on poor

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countries that obviously have the AIDS problem to a much greater extent, and we have been taking up AIDS issues with the Commission. On other Member States, the new Member States, we are very much focused on trying to get them to recognise some of the issues they need to grapple with on European aid. They have been much more focused, however, on aid from Europe to near neighbours, in other parts of eastern Europe and Central Asia. They are less focused on the countries that have the highest prevalence rates for HIV and AIDS. At the moment, I would not say we are making that much headway on this front.

Q45 Mr Curry: I remember when we had a great enlargement thrash at the Foreign Office, and Government ministers were delighted to be seen with, on their arms, all the more romantic young ladies who had been elected for Baltic States and this sort of thing, but we have not really made a serious attempt yet at lobbying the new European Parliament before it really gets bedded in, have we?

Mr Chakrabarti: We started, but . . .

Q46 Mr Curry: You would acknowledge that that ought to be done?

Mr Chakrabarti: Yes.

Q47 Mr Curry: Because there is a co-decision-making role?

Mr Chakrabarti: We have a strategy to lobby the new European Parliament and also the new development commissioner, whoever he or she is, in the autumn. That will be quite crucial. At the same time, Gareth Thomas, our Parliamentary Under-Secretary of State has also been visiting a number of these new Member States to talk to them about some of these issues as well.

Q48 Mr Curry: We are about to have a new president of the Commission, and it looks as though the Portuguese Prime Minister will be persuaded to take that post. Portugal itself is a country with a significant colonial legacy; and the Commission President is an influential person. When budgets begin to be put together, once they are put together into the Commission, it takes an awful lot of disentangling, so if the Member States do not have the primary point, they are very reactive in many ways in the budget-making process. What conversations do you think the Prime Minister might want to have with this gentleman—after all, he has six months to go before he takes up his job—to try and persuade him to come round to it? If we think this is so important, and if as you say it bites into the economic as well as social structures of African countries in particular, and if the loss to GDP and development has such a multiplier effect, why is it that somehow nobody seems quite to have this sense of urgency we have? Is that true, or are there too many entrenched interests here?

Mr Chakrabarti: I think that in part it is because it has not really impacted on us directly as yet. Therefore, the moral imperative is the only imperative that drives politicians to deal with some

of this. Having said that, what has been the mission of DFID in the last year and a half in terms of European Union aid? It is to get these sorts of issues higher up in the ranking of European Union priorities, not just for our own government but for all governments, so that these issues are discussed by the Commission President, with the Prime Minister and others.

Q49 Mr Curry: The Prime Minister is quite hot on moral issues, is he not, really? When was this last discussed at a European summit? When did the heads of government seek to give an orientation of the priorities?

Mr Chakrabarti: Apparently yesterday, is the answer.

Q50 Mr Curry: It was, the—

Ms Gorna: The summit with America on Friday I believe; and part of the *communiqué* addresses HIV and AIDS and a new agreement between the EU and the US. That agreement focuses on HIV and AIDS as part of the summit *communiqué* there.

Q51 Mr Curry: With respect, that is not the same thing, is it, as a European summit that is specifically there to give guidance to European policy? Has that happened? Has the Prime Minister raised this in a summit meeting?

Mr Chakrabarti: I doubt it but we can check.² What I certainly would like—and this is what I was trying to say—is that this issue, the whole issue about where Africa is, which the Prime Minister also cares quite deeply about, should become part of the normal discourse in Council of Europe sessions and others. It is Mr Barosa who is going there. He was the minister in charge of aid initially, when your party was in power here, and some of us have actually worked for him. He does care about Africa in particular; so maybe there is an opportunity here to get this discussed in a way that it was not in the past.

Q52 Mr Curry: Let us say it were to happen so that we felt more comfortable with the contribution of the European Union: would you think the delivery mechanisms from the European point of view are in place to make sure we get down to where it is needed? What comes out of the Report quite clearly is that in many ways there is sheer uncertainty of working out what money ends up at the level of the village or of the customer, as it were?

Mr Chakrabarti: I think the European Union has improved, but I would not say it is at the front rank of delivery agents in the aid business—clearly not, given the number of evaluations showing that they need to improve in this area. What it can do, and what it does do—because aid is a collective effort—is work more with some of the other donors like DFID, which has a stronger presence on the ground. I would want the European Union to do, say in Kampala to set an example, is use DFID, the

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Norwegians or whoever, to help deliver more of its programmes through them, not just doing it directly itself.

Q53 Mr Curry: Looking at the bilateral programmes of other European Union countries, we would normally expect, would we not, to find that people like the Dutch, the Danes, the Swedes, might well share our priorities? Are there countries that would have a similar orientation of their aid to ourselves, and do you find them to be a substantive ally?

Mr Chakrabarti: The Dutch are one of our main allies in all this. It is very much the Scandinavians, the Dutch, the Germans, the Irish and us, who work very closely together, both in regard to the Commission but also on the ground in developing countries.

Q54 Mr Curry: The main problem presumably is the Spanish, having captured the aid programme when they entered the European Union! Is that fair to say? It is not unfair really, is it?

Mr Chakrabarti: We can certainly say that the Spanish MEPs' control of the European Parliament Budget Committee does have some influence on the distribution.

Q55 Mr Curry: That is why so much aid goes to—in many ways, it is the half-poor who are benefiting at the cost to the poor.

Mr Chakrabarti: Yes. That is why Latin America does quite so well.

Q56 Mr Curry: It is a bit like the sugar regime really, is it not?

Mr Chakrabarti: Yes. That is why Latin America certainly does so well out of the distribution. That is also one of the reasons why we keep talking to the British MEPs to see if we can work—

Q57 Mr Curry: This is not just a technical issue of budgetary distribution; there is quite a lot of history of a way a country sees itself and sees in itself the way it represents external areas, and it advocates on behalf of parts of the world within the European Union, is it not?

Mr Chakrabarti: Yes. I think what is really curious about it is that when it comes to the European Union, the same country that, if it was a World Bank spending, would take a very technical view and decide on technical merits, will, when it comes to the European Union, take a very political view of historical relationships and so on. Different criteria are being used for essentially money that could go for the same purposes. We apply technical criteria essentially to both instruments, and that is where the argument is really.

Q58 Mr Davidson: I want to pick up a point that was made about partnerships. Can I clarify the extent of your partnerships with the private sector in all of this, both in terms of openness about the perils of AIDS and also in terms of the policies they follow to try and combat it. I have just come back from Namibia, and I was struck by the contrast between

some Western firms that were entirely open and had good programmes, and other Western-based firms that were very unwilling to tell us anything at all. I was not sure whether or not there was a programme either for your department, dealing with UK firms, or via the EU, with EU firms, to encourage best practice.

Mr Chakrabarti: I will ask Robin to answer that because there is quite a lot of detail there. The general answer is that we are trying to get best practice flowing from the better firms to those that are laggards in this area, and also by improving our own workplace policy. Robin will say more about the private sector.

Ms Gorna: What we know about a successful response is that in any country a successful response will engage government, civil society and the private sector; and we clearly see that in the countries that have been most effective in responding to AIDS. There is a group called BEAD—Business Exchange on AIDS and Infectious Diseases—that is headquartered here in London, and we work very closely with them. That brings together the multinationals located in the UK, working to discuss work on AIDS. As has been said, we are working with them around their workplace policies. Until recently in southern Africa a great deal of the treatment and care was being provided by the private sector; so looking at how they most effectively care and treat their workers and workers' families, but also looking at their role in prevention, is a key element of our work.

Q59 Mr Davidson: Are there examples of particular good practice, firms that you could name to us as examples that others should follow?

Ms Gorna: The ones that are mostly highlighted are Heineken, Diageo, Anglo-American; they all have particularly forward-looking workplace policies, but there are a number of other companies that are developing and strengthening their approaches. We see that as an important role that we can play.

Q60 Mr Davidson: Which firms do you think are not doing particularly well in this area?

Ms Gorna: I could provide a note on that. I am not sure I could list some at this particular point.³

Q61 Mr Davidson: That would be very helpful. It was certainly our experience that some firms were quite prepared to be open about not only the testing they had done and the figures they had produced from the workforce that were positive. There was a Spanish fishing firm where we had to drag out of them eventually that 55% of the men that went to sea were infected. Clearly, by not discussing that at all, they were obviously taking no steps to address it. It seems to me that Western-based firms have a responsibility to lead in all of this, and I wondered whether you agreed with that, and what you were doing about it?

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Mr Chakrabarti: We agree. As Robin said, we are doing something. It is interesting that the firms you mentioned that are doing well on this realised very early on the impact it has on their bottom line, their balance sheet, if they do not solve this problem; because these workers are very valuable to them and therefore they need to act on that problem.

Q62 Mr Davidson: The chart on page 12 on prevalence rates seems to exclude Botswana and Namibia, which I had the impression had the highest rates. I wondered why that was.

Mr Chakrabarti: I do not think for any particular reason. These are the public service agreement countries. DFID has small amounts of aid in both countries, but they are not the major aid countries. There are 20 public service agreement countries.

Q63 Mr Davidson: I am conscious that Botswana and Namibia might be seen as being more middle-income countries, but in Namibia particularly the distribution of income is enormous, and therefore the proportion of people in dire poverty is as high as in some of those that would otherwise be classified as poor countries. To what extent does your policy therefore take account of that?

Mr Chakrabarti: We do think about those issues, but all the research we have on when aid is most effective shows that essentially aid should be allocated quite strongly to the poorest countries, who have least ability to raise the resources themselves. In places like Namibia, Brazil—another good example of this—there are resources that the governments could re-allocate and re-distribute if they wished to. There is an issue about donors substituting for a lack of political will in some of these countries to re-distribute resources to where they are most needed. It does not mean to say they are very well off, but they are clearly better off than Uganda.

Q64 Mr Davidson: Picking up a point on partnership, when I have been abroad one of the things that struck me is the difficulty sometimes placed in the way of partnership by the policies imposed either by the American Government or by Catholic agencies. We were recently visiting a Catholic AIDS organisation, which had a lot of good material and was doing a lot of good welfare work, but was making it clear that on orders from head office they would not provide condoms, and they would refer people on to other agencies. There is a break in the chain there, yet we in the European Union were funding them. To what extent are we willing to provide those who are only partial service providers as distinct from full service providers?

Mr Chakrabarti: Frankly, a strategy that does not provide condoms and relies just on abstinence or being faithful is unlikely to succeed on its own, so our preference clearly would be to have the full range of services.

Q65 Mr Davidson: If it is unlikely to succeed, why do you give them the money?

Mr Chakrabarti: Are we giving them the money directly, or is it through the European Union?

Q66 Mr Davidson: It is through the European Union.

Mr Chakrabarti: Which we would have no control over. If it is budgetised—

Q67 Mr Davidson: Let us be clear. We are giving them money through the European Union, over which we have no control.

Mr Chakrabarti: There are two parts to the European Union aid budget; there is the European Development Fund, EDF, over which we have some control quite clearly, because that is voted and the parliament here votes the money through; and then there is a budgetised part of the European aid budget over which we do not have any control. We argue for it to be re-focused all the time, but the parliament here is not involved in voting that money through, so we have less control, quite clearly.

Q68 Mr Davidson: We would be better, would we not, in controlling the direction of our own aid budget, where we are handling more of it from this end rather than from Brussels?

Mr Chakrabarti: At the moment, I would say that undoubtedly our bilateral programmes are more effective.

Chairman: That was an important answer that you gave just now, so before we finish our session you might consider how you might amplify that, because it might form an important part of our report.

Q69 Mr Williams: Do you find you very often despair of it all?

Mr Chakrabarti: I am an optimistic person, not just because that is my sunny character, but really because if you look at the Department over the last 50 years, a lot has been achieved. With some of the most difficult problems progress has been made against them. This is also an area where we can make progress. The UN data will come out in July, but from what I have seen from these 20 countries that I have talked about with Mr Davidson, we have data now on HIV prevalence rates for 18 of them, comparing 2001/2003. In 14 of them, the prevalence rate has either stabilised or fallen. This is at the margin, but this is the beginnings of some progress, so I would not take too much of it but there are certainly signs of progress.

Q70 Mr Williams: But it is progress against a track record of 65 million extra infections, is it not? Do you, frankly, think it is effective or helpful to you—I cannot ask you whether you think it is morally defensible or not—for an organisation to publish a document *Family Values Versus Safe Sex*, which says that condoms may be the main cause of the spread of AIDS?

Mr Chakrabarti: Do I think that is helpful?

Q71 Mr Williams: Yes. Do you think it is helpful at all?

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Mr Chakrabarti: No, I do not think that is helpful.

Q72 Mr Williams: No. Do you think it is irresponsible, because it is trying to force people not to use a measure that you said you needed to have available if you are to have an effective range of treatment?

Mr Chakrabarti: It flies in the face of evidence.

Q73 Mr Williams: Cardinal Trujillo said, “condoms are fuelling the epidemic; it is like putting out a fire with petrol”. This is not only unscientific, but it is actually criminally irresponsible, is it not?

Mr Chakrabarti: I do not agree with the Cardinal, let us put it like that.

Q74 Mr Williams: On the *Panorama* programme last night they were talking about Zambia and saying—and I do not know whether or not these figures stand up—half the population will die of AIDS, but they then went on to say that most HIV babies die before their third birthday. Is that correct?

Mr Chakrabarti: I do not know the case in Zambia.

Ms Gorna: I do not know the exact figures for Zambia. The case is indeed that, without treatment, most babies born with HIV will die early in life. One of the issues that our new strategy will tackle is the problem that there are inadequate treatments for children, because very few children are born with HIV in rich countries; the majority are in poor countries, and the drugs are not available to treat them.

Q75 Mr Williams: It is certainly not helpful to you, is it, when an organisation of that influence, the Roman Catholic Church, mounts such a calculated campaign to undermine what you are trying to achieve?

Mr Chakrabarti: I think it does not help the debate.

Q76 Mr Williams: I am sure it does not. It does not help as well when you get politicians who are in denial, like the leaders in South Africa, who were for years refusing to admit the existence of the problem. This is why I asked were you in despair, when you get a government like the United States government, because of the political influence, the number of votes that are affected by the birth control issue, which actually cuts back on the aid it is making available. You said you are optimistic, and I believe you are optimistic, based on what you are saying to us, but you do not have much ground for optimism, based on some of the enemies you have, do you?

Mr Chakrabarti: My optimism is based on the success stories that we discussed earlier in the hearing—Uganda, Brazil, Senegal, Thailand—and the fact that prevalence rates are stabilising in many countries, and falling in some as well. We are starting from a pretty serious base, obviously, I admit that, in many of these countries, and there is a lot more to do. The key point that comes out from your questioning, for me, is the importance of political leadership, that it was given in a very strong way in a number of these countries. In South Africa I wish the leadership had been stronger.

Q77 Mr Williams: How far has the selfishness of the US pharmaceutical industry been overcome? They said they were making concessions in pricing, and so on, and availability. Is that a meaningful change?

Mr Chakrabarti: I think in a large number of cases their prices have dropped by about 40%—90% overall, and I think 40% for many of the US suppliers.

Q78 Mr Williams: How is that in terms of affordability?

Mr Chakrabarti: It has clearly improved for a number of people, but for many very poor people it is probably not enough. Therefore domestic manufacture in places like Brazil or India have made a major difference. When I was in Malawi it was interesting to see that it was essentially Indian drugs that were being put into Malawi—anti-retroviral drugs—rather than American ones.

Q79 Mr Williams: Do you think we should say to the EU that we are not going to provide money for their multilateral activities unless they refuse to give it to organisations which calculatingly will not provide a comprehensive range of remedies?

Mr Chakrabarti: I think we should certainly have a dialogue with them. I do not know the particular case, obviously, but I am quite happy to take it up. As I said earlier, there are parts of the EU budget where we could have more influence than other parts. In the case of Africa, actually, the budget for the European Development Fund, we do have a lot of say. Graham’s staff worked directly with the EU on their Africa programmes. So if this is a case to do with Africa then I think we perhaps can have a bit more dialogue with them and have some purchase on it.

Q80 Mr Williams: Even if the drugs were available, how are we managing to cope with the problem of convincing the recipients of the drugs that these are things that now have to be taken literally for ever; that just because they are feeling better they cannot now drop them? Are we getting that message over, do you think?

Mr Chakrabarti: That obviously does require very specific skills in interacting with the people in the health systems—doctors, nurses, and so on—and there are examples where people have clearly forgotten to take their drugs after a while, or have decided not to, or have shared their drugs because they are so poor that they cannot afford to have drugs for all the members of the family; so there are lots of issues. I think the bigger issue quite often is around who gets the drugs; who chooses, and by what criteria do they choose who gets the drugs?

Q81 Mr Williams: And whether there is the support infrastructure, obviously particularly in Africa, where the drugs are available on a continuing basis.

Mr Chakrabarti: That is right. If you go to some clinics in some of these countries you will find that the shortage of skilled doctors and nurses locally is very serious, and therefore the support system, if you like, the infrastructure, is quite parlous.

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Mr Williams: I think the Report focuses on one or two areas where you yourselves could be more effective in the use of your funds, but even if you were fully effective, in relation to the scale of the problem it still would not make all that much difference, and you are not particularly inclined to concentrate on that. Chairman, I know my time is limited; I have finished my line of questioning. I congratulate you on your resilience; I think would just despair in your situation.

Chairman: There are a couple more questions, I think, from Richard Bacon and from Richard Allan.

Q82 Mr Bacon: Mr Chakrabarti, when your Secretary of State appeared before the European Scrutiny Committee recently he said that the EU's multilateral funding was not fit for the purpose. I asked him if he would say it was fit for the purpose, and he said no, he would not even begin to say that it was fit for the purpose. When do you think the EU multilateral funding will be fit for the purpose?

Mr Chakrabarti: My view is that we have one last great opportunity to try to get the EU's aid sorted out so that it is focused in the right countries and doing the sorts of things all of us would probably want it to do. This is not to say that there are not pockets of EU aid which are working; there are; but overall it is still mis-allocated to many better-off countries, and needs to be in the poorer countries. That is basically in the next six to nine months, because we are running up to the next financial perspectives; and that is when we have maximum leverage. But we have some difficulties here. There are some new member states who have joined who may not share our views on some of these issues. As I said earlier, the view taken of what the purpose of that aid is does differ from the UK view, which is that it should be a much more technically determined approach, to a much more political approach taken by some of the other member states. We are working with the Dutch and with Sweden and Germany particularly, trying to perform this.

Q83 Mr Bacon: Is the position of the government that if in the next six to nine months you are not able to persuade the EU to change its priorities and to undertake the spending in a way that is fit for the purpose, that we should then seek other ways to deliver those monies, rather than through the EU?

Mr Chakrabarti: The government does not have the freedom of manoeuvre—no UK government would at the moment—because the European Union aid is budgetised, the bit that does not go to Africa, the Pacific and the Caribbean; the rest of it is a treaty obligation. So the government does not have the opportunity to really say “Well, we're not then financing it”. It is just a budget share that goes.

Q84 Mr Bacon: Why cannot the government say in the Council of Ministers that “This money is not fit for the purpose. We don't want to fund it any more”?

Mr Chakrabarti: I think the government—

Q85 Mr Bacon: My question is, is that the position of the government? Is that what the government would do?

Mr Chakrabarti: I am not sure the government would do that. I do not know. Ministers have not had that proposition put to them; but the government has been playing a very tough line on this, not just through the Foreign Ministry route but also through the Finance Ministry route, and I think that is quite important. In the past we have tended to always go down the Foreign Ministry route and argue through Foreign Ministers the argument of change, and so on, but actually what we decided is that Finance Ministers are more likely to be interested in effective aid spending—and actually, as we know, Gordon Brown is rather interested in this; so he has taken a lead in this area as well.

Q86 Mr Bacon: You mentioned that the Africa programme worked better than some other parts of the EU operations. Would you say that the Africa programme was fit for the purpose?

Mr Chakrabarti: Not fully, no, but it is better. It is a comparative judgement I am making, but it has improved. There are still large sums in the Africa programme, the EDF—the European Economic Fund—which—

Q87 Mr Bacon: So really you are comparing just how bad something is with something else that is bad, rather than saying it is adequate?

Mr Chakrabarti: It is certainly better in my view than some of the budgetised programmes in the EU; but it is also better than some of the bilateral programmes, not necessarily the UK's, but some other bilateral programmes.

Q88 Mr Bacon: It is the UK taxpayers' money you are dealing with here, is it not?

Mr Chakrabarti: Absolutely. That is why I spend quite a bit of my time trying to improve the situation, and, more importantly, perhaps, Graham's team in Africa, his country officers, spend a lot of their time trying to improve the performance of EDF on the ground.

Q89 Mr Allan: To pick up a couple of the other Call for Action points, it says that we will press for a special session on HIV/AIDS at the UN Security Council in early 2004. Did we push, and did the door open, if we did?

Ms Gorna: We have been in a number of discussions through the New York office around this. There is actually activity under way on peacekeeping forces in the UN, and it is at a particular point in development where it was not appropriate or useful to take it back to the Security Council. The Security Council has once addressed AIDS, and in the context of their resolutions they have taken forward important measures on strengthening the work with peacekeeping forces, because in most cases most countries' peacekeepers or armies are about four or five times more likely to be infected with HIV than

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the general population. There is work in train, and it is felt in terms of the order of business that it would not be helpful to go back to the Security Council. We are reviewing with them when the best timing would be, and we hope that that will be able to be taken forward within the next 12 months.

Q90 Mr Allan: The other one, “We will double our core funding of the UNAIDS”. Is that happening? Has it happened?

Mr Chakrabarti: It has happened, has it not?

Ms Gorna: Yes.

Q91 Mr Allan: We have doubled our core funding of UNAIDS?

Mr Chakrabarti: That has happened. We think a lot of UNAIDS, actually; we think it is a very good outfit.

Q92 Mr Davidson: I am frequently critical of people who come in front of us, deservedly so, since we get more than our fair share, I think, of plonkers and wasters appearing here, but I am certainly extremely supportive of what you are doing, and think you are doing a remarkable job in exceptionally difficult circumstances. I echo Mr Williams’ point, that your optimism—I have a slight feeling that anybody who is optimistic in these circumstances must be slightly demented, or does not understand the scale of the problem. However, what I wanted to pick up was in terms of cooperation and coordination, and to some extent it follows on the other points. We have heard much of coalitions of the willing in other contexts. Given that we do seem to be on the same wavelength as a number of countries, both within the EU—I am not quite sure, though, to what extent there are other countries on the same wavelength outside the EU—to what extent is there a possibility of forming some other coalition or group of alliances which would actually enable us to combine efforts and focus in the areas that we think are more productive, rather than having our money siphoned off to support efforts on moral grounds, or Spanish foreign policy?

Mr Chakrabarti: In the context of HIV and AIDS and some other development policies we have been working particularly hard also with the Canadians and Norwegians—obviously not part of the EU—and we are making headway there. Also in this area we are working with the Americans on the ground. This has been developing over the last nine months; we have a joint task force now with the Americans in a number of countries, five countries in Africa. There was a recent meeting, I think in Johannesburg, was there not, on the task force, where again we are trying to basically coordinate better with them, because they have put a lot of new money into this area, and the importance of actually making sure that money is spent in the way that the developing countries want, rather than the way we donors prefer, is part of that game.

Q93 Mr Davidson: To what extent does the American money come with a commitment to flat earth philosophy?

Mr Chakrabarti: Flat earth philosophy?

Q94 Mr Davidson: Yes.

Mr Chakrabarti: You had better define “flat earth philosophy” for me in this context.

Q95 Mr Davidson: Americans are very much driven by internal American politics, and a whole number of restrictions, either driven by moral arguments in the United States, and again it comes back similarly to the question of the Catholic church, and I was certainly under the impression from contacts we had in Africa that there were a number of ties attached to American funding which then restricted other people who were participating in any joint project, because the American view was that “Unless it’s done our way we will not fund it at all”, because if they were funding quite a substantial proportion of it, that would bring the whole project down. You seemed to be quite enthusiastic there about working with the Americans, which was not the impression I had that many of your colleagues had.

Mr Chakrabarti: I think it is a continual dialogue with the Americans to try and find common cause, if you like. It is certainly true, because of the influence of Congress in the way aid money is doled out in the US, much more earmarking, more special interests—the capture, if you like, of their aid budget—that we cannot have a complete meeting of minds on a lot of these issues, and I do not think we should expect that. The question really is to make sure that on the ground are we doing things which are fully consistent with developing countries’ own priorities as opposed to our preferences. That is what we are trying to work closely with. Graham, were you at the Johannesburg meeting?

Mr Stegmann: Yes. I chaired the UK side and Tobias chaired the US side, or in his absence Ambassador Lange. I think, as Suma said, what we have done is to have a dialogue at country level with the Americans, and indeed with others who are active in the same field, about some of the issues which are indeed in your Report: What is the balance needed in any particular country? What is the nature of the epidemic there? What would be most effective? Then I think recognising some of the limitations, the prior conditions which are there on some parts of the American money, to see how we can work together rather than step on each others’ toes and, as importantly, to try and build a single performance measure so that we are all monitoring against the same criteria rather than establishing different criteria, sucking in skilled resources to monitor our programme or their programme. I think it is very much at the start of the process, but I think we were all, from the country side, encouraged by the degree to which we had a common appreciation of the problem.

Q96 Jim Sheridan: I think it is rather fortuitous that we are meeting here tonight on the same night as the Human Tissues Bill. Can I refer to a document released by the Association of Medical Research Charities, which refers to HIV/AIDS and haemophiliacs, and I think they say quite clearly that

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identifying and tracing the blood donor of HIV/AIDS and haemophiliacs was dependent on tracing the blood samples. Should this Bill change that in any way, in the sense that donors would not have to give their permission for blood samples? Would that impact in any way on your research into HIV/AIDS?
Mr Chakrabarti: I am not sure I know the answer to that. Does anyone? I think we will have to give you a note on that—sorry.⁴

Q97 Chairman: Where does the picture on page 8 come from, please?

Mr Sloan: We believe it is part of the Straight Talk programme in Uganda. It is a Ugandan programme.

Q98 Chairman: Uganda? You see that picture on page 8, do you, Mr Chakrabarti?

Mr Chakrabarti: Yes.

Q99 Chairman: Do you think that the prevention and education strategy which you spoke warmly about in Uganda is going to have a continuing effect, apparently as it has had, given the figure, the graph, that Alan showed you?

Mr Chakrabarti: Do I think it is going to continue having an impact?

Q100 Chairman: Yes.

Mr Chakrabarti: I am positive about progress made in Uganda. This has been, if you like, part of the strategy in Uganda: keeping your virginity, being faithful, but also the supply of condoms and various other messages as well. This is not the only message on its own.

Q101 Chairman: But this programme is working in Uganda, the overall programme?

Mr Chakrabarti: The overall strategy, yes.

Q102 Chairman: The number of strategies is working?

Mr Chakrabarti: I think Uganda is doing rather well compared with most of the other states we deal with in this area.

Q103 Chairman: Thank you very much. Could I just try and tease out one or two questions at this point about bilateral and multilateral aid. We know that over 5% of our bilateral aid goes towards HIV/AIDS; we know that only around 4% of multilateral aid goes on HIV/AIDS. Can you please look at paragraph 3.6 of the Report, and you will see that only six out of 14 papers on the government's funding relationships with multilaterals mention HIV/AIDS as a big issue. Is that a satisfactory state of affairs, do you think?

Mr Chakrabarti: No, it is not. That is why I mentioned that the revisions of these strategies will have AIDS up-front as one of the key themes that we will pursue with these organisations from now on.

Q104 Chairman: If we now look at paragraph 2.5 you will see there at country level little guidance on whether staff should route money through multilateral organisations or other agencies. Do you see that, paragraph 2.5?

Mr Chakrabarti: Yes.

Q105 Chairman: Is this a satisfactory state of affairs?

Mr Chakrabarti: This, I think, is a slight misunderstanding. I think at country level, country teams have full delegation to work out for themselves what is the best route. We do not say to them “You must put it through a multilateral”, or “You must do it directly”. This will differ in different circumstances. I do not think necessarily we are going to give them orders from London as to how they necessarily ought to be channelling their funds; they will differ in different places.

Q106 Chairman: Why do we have so little information on the effectiveness of the EU budget in regard to HIV/AIDS? What more can we do on this front?

Mr Chakrabarti: I think pressure obviously from DFID will continue to get better information on the effectiveness of the EU programme, whether it is HIV/AIDS or any other area, but we do need to have constant pressure also from Parliament here. I welcome enquiries that Parliament has, because that does have an impact in Brussels; they do take notice of that. I also think working with the European Parliament, as I mentioned earlier, needs stepping up further in terms of getting pressure from there on the Commission.

Q107 Chairman: As a last question, given the problem that we have identified in the course of this hearing, if some of your multilateral partners do not have sufficiently robust systems to track where this money is going, is there anything more you want to say about what sort of pressure we could use? You used, I think in response to Mr Allan, words like “harass” and “pressure”. Is there anything more that we can do?

Mr Chakrabarti: I think, fundamentally, if we think the performance of an institution which is important to resolving this crisis is not up to scratch, then our funding, to the extent that we have freedom to determine this, should be conditional on improvements in their systems, and measurable improvements. So, for example, the Global Health Fund, I think if we are going to put more money into this fund—I say it has improved, it has improved, undoubtedly because of the pressure last year, and because of some good work by its own people—but if we are going to put more money into it we may want to see more improvements.

Q108 Chairman: “Our funding should be conditional”—that is another way of saying that if necessary we should be prepared to pull out of the multilateral programme if they are not delivering?

Mr Chakrabarti: If at the limit a multilateral institution was completely hopeless, of course, that is what we would do.

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Chairman: I think now Mr Field is inspired to come in.

Q109 Mr Field: The Chancellor in another context has talked about regional aid, which is currently spent through European organisations, actually being spent through the Treasury. Would you favour such an approach with our overseas aid—

Mr Chakrabarti: In other words, should the aid be channelled back—?

Q110 Mr Field: Spent by you via country channels through the European institutions?

Mr Chakrabarti: I would favour going further down the route we are currently going, which is in countries—to take an example, in Tanzania—where the European Union had difficulty in spending its budget to start with, they do not necessarily spend it through us, but they piggyback on our advice, and use our people on the ground, experienced people, to provide them, if you like, with the due diligence, the quality assurance, so that they can spend their money, and they can piggyback therefore on collective effort rather than trying to do things on their own. I think they have been open to that way of working. I do not see necessarily them needing channel the money through us, particularly if they were putting it into a government's budget.

Q111 Mr Field: I was putting it the other way round, that if in fact the whole of the budget was spent by you rather than part of it being siphoned off into Europe, do you think British taxpayers would get a bigger effect for their expenditure given the objectives the government set for your department, if you did not have to share your budget in this way?

Mr Chakrabarti: I think you might get a short-term gain, but in the long term I think, frankly, other countries will not want to do it that way, they will want to put their money through the European Union, let us say, for political reasons. So therefore, taking their interests into account, for any one member state, again to improve the European Union's aid budget quality is actually quite important in itself. We are one of the best donors—clearly the OECD ranks us very highly—but there are other good donors around as well. The World Bank's IDA would be a great example to us all, actually, of how to make aid effective.

Q112 Mr Field: If I understand you correctly, you are saying we should hang in there, because by hanging in there would improve the performance of the expenditure of other countries?

Mr Chakrabarti: Yes. I think there are some really good examples of that I can give. On the European Union front there are one or two examples—Afghanistan, I think, have done better than in some other places. I can give the example of Japan, recently, where Japan is not one of the like-minded donors at all, they had rather traditional commercial-driven programmes, many of you will probably remember, from ten years ago. It has moved quite radically, as we have basically been helping the reformers of the Japanese system—Japan has a very large budget still—to do the right things. In Vietnam, for example, they have actually joined like-minded donors, rather amazingly, and therefore improved the quality of their aid.

Chairman: Mr Chakrabarti, thank you very much. May I thank you and your colleagues for appearing before us this afternoon on what is obviously a vitally important subject. As a Committee we are concerned with value for money, and our report will focus on that aspect of your work.

 Memorandum submitted by World Vision

THE FORGOTTEN CHILDREN OF THE AIDS CRISIS

HIV/AIDS

Research is now showing that HIV/AIDS causes much more long-term damage to national economies than previously assumed. Because AIDS kills mainly young adults, it weakens the mechanism through which human capital is accumulated and transmitted across generations. The regional average life expectancy for sub-Saharan Africa is 47, but without the impact of HIV/AIDS, it would be 62 years. With adequate spending on well-targeted programmes an astounding two thirds of the projected 45 million new infections this decade could be prevented.

Orphans and vulnerable children

More than 13.4 million children under the age of 15 have lost their mother or father or both parents to AIDS, and that number is rising fast. Nearly 80% of these orphans live in sub-Saharan Africa and the number of double orphans alone in Africa is predicted to increase by 180% from 1990 and reach a staggering 7.8 million by 2010. With more than 40 million people living with HIV and infection rates rising rapidly, the number of orphans will increase sharply in the years to come and the impacts will continue for at least the next two to three decades. By 2010, the total number of children orphaned by HIV/AIDS is expected to double to 25 million. In addition to those children orphaned, there are millions more children who are highly vulnerable because their parents are suffering from AIDS or because their families are heavily affected by the epidemic. There are also more than three million children living with HIV/AIDS.

Children orphaned or made vulnerable by HIV/AIDS experience a wide array of problems. In addition to the severe psychosocial distress of losing one or both parents, they may also lack food, shelter, clothing, or health care. They may be forced to drop out of school or required to care for chronically ill adults or younger siblings. They may face discrimination, abuse, or exploitation. Without parental guidance and protection, they may themselves become vulnerable to HIV infection. In many communities, traditional ways of caring for orphans and vulnerable children (OVC), such as the extended family system, are being severely strained by the multiple, mutually exacerbating impacts of HIV/AIDS. The challenge is to find ways to help communities care for the unprecedented number of children and families rendered vulnerable by HIV/AIDS.

In most cases, girls are the most heavily impacted; they are more likely to drop out of school to care for family members, they are at greater risk of abuse, and they are much more vulnerable to infection. Prevention and care programmes have typically failed to address girls' vulnerability to HIV/AIDS, and these gaps must be addressed through strategic interventions to address gender inequality at the local to international levels.

In addition to the psychological, social and livelihood impacts, the long-term economic implications of continuing to neglect the needs of OVC are increasingly being recognised. A recent World Bank study indicated that countries such as South Africa could face economic collapse within several generations unless the AIDS epidemic is combated. The deaths of young skilled adults are undermining the basis of economic growth by diminishing the human resources available to the community. It is imperative to keep infected people alive, especially parents, so they can continue to live productive lives and take care of the next generation. If nothing is done, the progress made in recent development programmes will be wiped out and the chance of achieving the Millennium Development Goals will become even more remote. A World Vision report on the these economic implications of HIV/AIDS concludes: "If countries are to avoid the very worst economic and developmental scenarios that AIDS might bring, then investment in the future of OVC will be essential."¹

World Vision welcomes DFID's commitment on HIV/AIDS and particularly the recognition that DFID's response to orphans and vulnerable children is "being stepped up" and that it expects them to be a "key priority" in the new UK strategy on HIV/AIDS, including the need to mainstream an orphans and vulnerable children perspective into DFID's support for basic services in country programmes. However more can be done.

WHAT CAN BE DONE?

National policies

40% of governments in countries with generalised epidemics have no national policy to provide essential support to orphans and vulnerable children, which is an Article 65 UNGASS commitment that was supposed to have been fully achieved by the end of 2003.

- In this regard, World Vision are calling on DFID to advocate for and provide support for the completion of national orphans and vulnerable children strategies, with time bound action plans, in all countries with generalised epidemics.
- We also believe it is important for DFID to advocate with national governments for the establishment of orphans and vulnerable children secretariats to act as strong inter-agency coordination bodies and assist the mainstreaming of orphans and vulnerable children issues across government departments. They will be essential for effective implementation of national orphans and vulnerable children strategies and action plans.
- Furthermore, DFID should advocate for the development and enforcement of legislative frameworks which protect the rights of orphans and vulnerable children.

UNGASS Commitments

The principal commitment for responding to the needs of orphans and vulnerable children and their carers is spelled out in Articles 65–68 in the Declaration of Commitment from the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS made in June 2001. These articles set out targets to be achieved by 2003 and 2005 and we look to the UK government in the HIV/AIDS strategy to give time bound and measurable commitments for its contribution to the Declaration of Commitment.

¹ Don Brandt, *Meeting Basic Needs of OVC: A Global Imperative with Emphasis on Education and Health Care in Africa*, in Kelly Currah and Alan Whaites, *False Economies—Why AIDS-Affected Countries are a Special Case for Action*, 2003, World Vision International, Monrovia.

UK Governments HIV/AIDS Strategy

It is vital that the actions which are included in the new HIV/AIDS strategy should be translated into action by DFID field offices. Our concerns are based on the level of coverage currently given by Field Offices, especially in the Country Assistance Plans, as outlined above.

World Vision strongly recommends the use of a standardised approach for DFID's response to ensure that DFID Field Offices in countries with generalised epidemics do explicitly include orphans and vulnerable children, although they should be given flexibility to decide specific programme content at country level. It is essential that Field Offices have an explicit responsibility to include orphans and vulnerable children within their Country Assistance Plans and budget guidelines, in order to guide their discussions with national governments. If they do not have such an explicit standardised framework, DFID will find that their discussions will come to reflect the low priority often accorded by governments to ministries and departments responsible for children, which are frequently marginalized and under-resourced. This is reflected in the now widely recognised fact that Poverty Reduction Strategy Papers (PRSPs) rarely mention the needs of orphans and vulnerable children and are therefore unsuitable for directing Direct Budget Support to orphans and vulnerable children needs at present.

DFID must:

1. Make specific, time-bound and measurable commitments, including earmarked resources, to enable the *Framework for the Protection, Care and Support of Orphans and Vulnerable Children living in a World with HIV and AIDS* to be implemented. The commitment to OVCs must be reflected in Country Assistance Plans to guide DFID Field Office policy making. We look to the UK Government to provide political leadership and act as a champion for the Framework with other international donors.
2. Make a commitment to mainstream perspectives on children orphaned and made vulnerable by HIV/AIDS across its programmes including education, reproductive health, governance and livelihoods.
3. Advocate for and provide support for the completion of national orphans and vulnerable children strategies, with time-bound action plans, in all countries with generalised epidemics. This advocacy must extend to including OVC in PRSPs with identified channels for ensuring resources reach the affected children. To assist this process DFID should advocate with national governments for the establishment of OVC Secretariats.
4. Advocate for free universal primary education, the removal of cost barriers to education and interventions to assist keeping children productively in school, including a strategy and action plan for the advocacy and that it includes all secondary school subsidies. Similarly DFID must support and advocate for the removal of all healthcare user charges for children.
5. Support and advocate for the broadening of the social protection safety net for children and carers by including financial transfers/welfare payments to affected families.

World Vision

World Vision is a Christian organisation and one of the world's leading relief and development agencies, currently helping around 100 million people in nearly 100 countries in their struggle against poverty, hunger and injustice, irrespective of their religious beliefs.

The charity's work includes delivering both long-term development and emergency relief in the wake of disasters.

World Vision is already tackling AIDS in a number of programmes, working with communities and with high-risk groups such as sex workers, vulnerable children, teenage girls and migrant workers such as truck drivers and agricultural workers.

25 June 2004

Supplementary memorandum submitted by the Department for International Development

Questions 49–51 (Mr Curry): EU heads discussion on HIV/AIDS

The Heads of EU Member States last discussed HIV/AIDS issues at the European Council on 17 and 18 of June 2004 where Heads of Government agreed the following text as part of the Presidency Conclusions, although without substantive discussion at the meeting itself:

“The European Council again draws attention to the continuing ravages of HIV/AIDS in many of the world's poorest countries: despite some progress, the pandemic is rolling back decades of development effort in Africa and is also spreading at an alarming rate in some other areas. Sustained efforts by the EU and other international partners are essential. The European Council

calls for vigorous follow up by the Union and relevant regional bodies on the outcome of the Ministerial Conference on HIV/AIDS in Europe and Central Asia hosted by the Presidency in Dublin on 23–24 February.”

Question 60 (Mr Davidson): Performance of private companies

There is, as far as we know, no published data on companies that are performing less well in relation to the HIV/AIDS needs of their workforce. Indeed the focus of work in this area has seen to identify and share good examples. It is likely to be the case, however, that many domestic small to medium sized enterprises in countries hard hit by AIDS will be struggling to match the example set by good performers.

Question 96 (Jim Sheridan): Human Tissue Bill

The Human Tissue Bill applies to England, Wales and Northern Ireland. It makes consent the fundamental principle determining the storage and use of human tissue and organs, including blood, for a range of purposes including transplantation and medical research. In the case of living donors, it is proposed that the removal of human tissue will remain subject to existing common law consent requirements (which therefore apply inter alia to the taking of blood samples). Further, where tissue is lawfully removed from living donors, the Bill does not require additional consent to the storage and use of tissue for the purpose of public health monitoring (for example, HIV/AIDS surveillance programmes), or for research where the tissue is anonymous subject to approval by a research ethics committee. The Government believes that the Bill strikes an appropriate balance between protecting the rights and expectations of individuals and families and the need to protect public health and vital medical research. We therefore do not expect this Bill to have an impact on DFID funded HIV/AIDS research.

22 July 2004
