



House of Commons
International Development
Committee

**Delivering the goods:
HIV/AIDS and the
provision of
anti-retrovirals**

First Report of Session 2005–06

Volume I

Report, together with formal minutes

*Ordered by The House of Commons
to be printed 29 November 2005*

HC 708-I
Published on 1 December 2005
by authority of the House of Commons
London: The Stationery Office Limited
£0.00

International Development Committee

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

Current membership

John Barrett MP (*Liberal Democrat, Edinburgh West*)
John Battle MP (*Labour, Leeds West*)
Hugh Bayley MP (*Labour, City of York*)
John Bercow MP (*Conservative, Buckingham*)
Malcolm Bruce MP (*Liberal Democrat, Gordon*)
Richard Burden MP (*Labour, Birmingham Northfield*)
Quentin Davies MP (*Conservative, Grantham and Stamford*)
Jeremy Hunt MP (*Conservative, South West Surrey*)
Ann McKeichin MP (*Labour, Glasgow North*)
Joan Ruddock MP (*Labour, Lewisham Deptford*)
Mr Marsha Singh MP (*Labour, Bradford West*)

Powers

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

Publications

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

Committee staff

The staff of the Committee are Alistair Doherty (Clerk), Hannah Weston (Second Clerk), Anna Dickson (Committee Specialist), Katie Phelan (Committee Assistant), Jennifer Steele (Secretary) and Philip Jones (Senior Office Clerk).

Contacts

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

Footnotes

In the footnotes of this Report, references to oral evidence are indicated by 'Q' followed by the question number. A transcript of the oral evidence is available on the International Development Committee website (at <http://www.parliament.uk/indcom>).

Contents

Report	<i>Page</i>
Summary	3
Background	5
1 Delivering the goods: HIV/AIDS and the provision of anti-retrovirals	6
Introduction	6
Global targets for HIV/AIDS treatment	6
Gaps in existing HIV/AIDS treatment provision	7
User fees and access to ARVs	8
Policy coherence on HIV/AIDS	8
Intellectual Property Rights and access to ARVs	10
IMF influence on public health investment	11
The significance of prevention	12
Formal minutes	14
Witnesses	15
Written evidence (to be published in Volume II of this Report)	15
List of unprinted written evidence	16

Summary

In July 2005, at the G8 summit in Gleneagles, G8 leaders made a commitment to: “as close as possible to universal access to [HIV/AIDS] treatment for all those who need it by 2010.” As the second largest donor on HIV/AIDS, the UK has a special responsibility to maintain global commitment to this goal. DFID should establish a transparent monitoring system which will allow year-on-year external evaluation of how many people are being treated, and whether they are getting access to quality treatment.

DFID must continue to work to expand the capacity of developing countries to utilise flexibilities in the TRIPS agreement, to gain access to affordable medicines. The WTO needs to undertake a review of the implementation of the TRIPS agreement, to assess whether it has compromised public health in developing countries. Donors need to work together to ensure sustainable and predictable funding for HIV/AIDS programmes, to prevent the IMF from dissuading countries from investing in their public health infrastructure. If universal access to treatment is to be achieved, the particular needs of vulnerable groups including children, intravenous drug users and men who have sex with men, must be addressed.

DFID must work hard to ensure that its progressive policies are actually implemented on the ground. All government departments must work together to ensure that their policies on HIV/AIDS are coherent. In particular there needs to be greater cross-Whitehall coordination over policy on individuals with no right to reside in the UK, and HIV/AIDS treatment.

Universal access to HIV/AIDS treatment will only be achieved if treatment programmes are accompanied by a scaling-up of evidence-based HIV prevention programmes. Given the increasingly moralistic tone of prevention programmes implemented by the United States, and their preference for bilateral donor relations, DFID has a crucial role to play as a leader in the wider global response to HIV/AIDS.

Background

In July 2005, at the G8 summit in Gleneagles, G8 leaders made a commitment to:

“...working with WHO, UNAIDS and other international bodies to develop and implement a package of HIV prevention, treatment and care, with the aim of as close as possible to universal access to treatment for all those who need it by 2010.”¹

This commitment was reaffirmed at the UN Millennium Review Summit, in New York, in September 2005. On 19 October, the Committee announced that it would inquire into HIV/AIDS and the provision of anti-retrovirals (ARVs), inviting organisations and individuals with relevant experience and expertise to submit written evidence.

We received written memoranda from 17 individuals and organisations, and took evidence from two sets of witnesses at Westminster. We would like to thank the following individuals who gave oral evidence: Dr Mandeep Dhaliwal, Head, Care & Impact Mitigation, International HIV/AIDS Alliance and the Stop AIDS Campaign; Dr Tom Ellman, Medical Adviser, Médecins Sans Frontières (UK); Ms Sandra Black, Senior Policy Advisor, HIV/AIDS Department, World Health Organisation (WHO); Mr Ben Plumley, Director, Joint United Nations Programme on HIV/AIDS (UNAIDS) Executive Office; Mr Hans-Martin Boehmer, Head of Human Development Group, Policy Division; Ms Robin Gorna, Senior AIDS adviser and team leader, Policy Division; and, Mr Daniel Graymore, Private Sector Adviser, Global AIDS policy team, Policy Division, Department for International Development (DFID).

1 G8 post-summit communiqué, Gleneagles, Scotland, July 2005

1 Delivering the goods: HIV/AIDS and the provision of anti-retrovirals

Introduction

1. The HIV/AIDS pandemic is a global health emergency. Coordinated international action is imperative, both to prevent further transmission of HIV, and to provide care and treatment for those living with AIDS. Without such comprehensive action, progress towards meeting at least 6 of the 8 Millennium Development Goals (MDGs) by 2015, will be significantly retarded.

2. Establishing clear global agreement on the goal of universal HIV/AIDS treatment for all those who need it by 2010 has, therefore, been one of the key achievements of the UK government's focus on development during its European Union (EU) and G8 presidencies in 2005. **We commend DFID for the important role which it played in securing the G8 commitment to universal anti-retroviral treatment provision by 2010.**

Global targets for HIV/AIDS treatment

3. The last global HIV/AIDS treatment target was WHO's '3 by 5' campaign, which aimed to get 3 million people in developing countries onto ARVs by 2005. Although it is unlikely that this target will be met,² the initiative has been significant in providing: "proof of concept — proving that you could bring combination therapy that had been proven in rich industrialised countries and make it work in resource-poor settings."³ In their memorandum to the Committee, DFID told us "The target has served as an effective advocacy tool for increased political commitment to treatment, and mobilising countries and communities to respond", but that "There have been criticisms of the '3 by 5' initiative that it has been highly 'vertical' — imposing new targets on countries that may not accord with existing planning processes."⁴ Mr Ben Plumley from UNAIDS told us that the strategy which UNAIDS and WHO are developing to achieve the new 2010 universal treatment goal aims to avoid this pitfall by using a 'bottom up' approach based on individual country plans for increasing ARV provision.⁵

4. It is right for UNAIDS and WHO to emphasise the importance of country ownership in the design of their strategy to achieve the 2010 universal treatment goal. But this approach should not allow an abdication of responsibility for meeting the goal at a global level. G8 governments must acknowledge that in making their commitment to

2 The WHO '3by5' initiative was launched in September 2003, at which point there were 400,000 people living in low- and middle-income countries who had access to ARVs. By the end of June 2005, this figure had been increased to 1 million (UNAIDS and WHO, *Progress on Global Access to HIV Antiretroviral Therapy, an update on '3 by 5'*, June 2005).

3 Q 3 [Mr Ben Plumley, UNAIDS]

4 Memorandum submitted by DFID, paragraph 29

5 Q 4 [Ben Plumley]; see also Q 5 [Ms Sandra Black, WHO]

universal treatment, they also took on responsibility for ensuring their commitment is realised.

5. We intend to scrutinise the contribution which DFID makes to realising this global goal over the next five years. This will be difficult unless DFID undertakes to publish data on progress towards the goal between now and 2010. We accept that simple numerical targets for the number of people on treatment may not be the most appropriate measure of success, and that progress towards the target may be initially slow, as healthcare systems and other infrastructure are established. We recommend that DFID establishes a transparent monitoring system which will allow year-on-year external evaluation of how many people are being treated and whether they are getting access to quality treatment. In addition, we recommend that DFID considers the inclusion of a target on access to HIV/AIDS treatment when it formulates its Public Service Agreement for the next comprehensive spending review period, 2007 to 2010.

Gaps in existing HIV/AIDS treatment provision

6. Much of the evidence given to the Committee identified gaps in existing provision of ARVs, including access to drugs for nomadic groups,⁶ intravenous drug users,⁷ men who have sex with men,⁸ and children. Many of the written memoranda we received focused on issues which hamper the provision of drugs to children, including:

- a lack of investment in the development of paediatric ARVs by pharmaceutical companies,⁹ for whom research into paediatric formulations: “always comes second”;¹⁰
- paediatric formulations of ARVs currently available are up to 6 times more expensive than equivalent adult treatments,¹¹ and Polymerase Chain Reaction (PCR) tests for diagnosing HIV in infants under 18 months are not affordable;¹²
- ARVs are not packaged in child-friendly doses (adult pills must be crushed, or children persuaded to swallow unpleasant tasting syrups);¹³
- limited availability of antibiotics (particularly cotrimoxazole) to treat opportunistic infections in children;¹⁴ and,

6 Memorandum submitted by ACORD, paragraph 2

7 Q 14 [Sandra Black]

8 Q 17 [Dr Mandeep Dhaliwal, International HIV/AIDS Alliance and Stop AIDS Campaign]

9 Memorandum submitted by UNICEF, paragraph 9

10 Q 16 [Ben Plumley]

11 Memorandum submitted by UNICEF, paragraph 9

12 *ibid*, paragraph 7

13 *ibid*

14 Memorandum submitted by Working Group on Orphans and Vulnerable Children, of the UK Consortium on AIDS and International Development, paragraph 4

- a lack of age-specific data on children who could benefit from ARVs,¹⁵ and of research on the distribution, metabolism and efficacy of ARVs in young children.¹⁶

7. We commend both the decision of the United Nations Children's Fund (UNICEF), under the leadership of Ann Veneman, to launch its global campaign 'Unite for Children, Unite Against AIDS', and the support which DFID has given to this campaign. We encourage DFID to continue to raise the profile of children's access to HIV/AIDS care and treatment in its interactions with national governments, UN agencies and other donors. We recommend that DFID also makes an effort to ensure that the HIV treatment needs of other vulnerable groups, including nomadic groups, intravenous drug users and men who have sex with men, are not neglected in the international push to expand access to ARVs.

User fees and access to ARVs

8. We heard evidence from Dr Mandeep Dhaliwal of the International HIV/AIDS Alliance, and Ms Sandra Black of the WHO, that user fees are an additional and unnecessary obstacle to treatment access, and to the efficiency and equity of treatment programmes.¹⁷ As Ben Plumley pointed out, there is some evidence that users are more likely to use condoms when they are required to pay a small charge to obtain them,¹⁸ but the Committee heard no evidence that adherence to ARV drug regimens is improved by user fees. User fees do not contribute significantly to the cost of ARV programmes, and therefore do not improve the long-term sustainability of ARV programmes.¹⁹ **We were surprised to discover that UNAIDS' position is not in line with the emerging global consensus on removing user fees for HIV/AIDS-related treatment. We are aware that international statements are in no way binding on national and international bodies. However, we believe that an international policy statement supporting the principle of free access to HIV treatment at the point of service, would be influential in the global debate. We therefore recommend that DFID works with WHO and UNAIDS to issue such a statement, and more importantly, to translate this into practice.**

Policy coherence on HIV/AIDS

9. In 'Taking Action: the UK Government's strategy for tackling HIV and AIDS in the developing world', published in July 2004, DFID emphasised the importance of 'comprehensive HIV programming'; that is, coherence between HIV/AIDS policies and

15 Memorandum submitted by UNICEF, paragraph 6

16 Memorandum submitted by Nyumbani, paragraph 5

17 Q 18 [Mandeep Dhaliwal, Sandra Black]; see also Q 19 [Dr Tom Ellman, MSF (UK)]

18 Q 10 [Ben Plumley]

19 Alan Whiteside and Sabrina Lee, *The "Free by 5" campaign for universal, free antiretroviral therapy*, PLoS Medicine, 2 (8), August 2005.

wider poverty reduction and governance strategies. In its memorandum to the Committee, the Stop AIDS Campaign²⁰ expressed its concern:

“...about the translation of [DFID’s] commitments at a country-level. Many of our partners are experiencing problems with DFID’s in-country delivery, finding DFID offices are not yet oriented towards comprehensive HIV programming, let alone a concern to reach universal access to treatment by 2010.”²¹

Ms Robin Gorna, from DFID, reminded us that priorities for HIV/AIDS programming are determined at a country level by in-country DFID teams, rather than dictated from London. She added that the Department is planning to undertake an interim evaluation of the implementation of ‘Taking Action’ at the end of 2006, which will examine the degree of coherence between DFID’s HIV programming and its poverty reduction and governance work. **It is essential that the progressive policies set out in ‘Taking Action’, DFID’s strategy on tackling HIV and AIDS in the developing world, are reflected in the HIV/AIDS policies and programmes which in-country DFID teams implement. We await the outcome of DFID’s interim review of ‘Taking Action’. In the meantime, we urge DFID to address any possible disparities between their policy and practice on comprehensive HIV programming.**

10. Although DFID is the lead Department on HIV/AIDS in Whitehall, the issue cuts across the work of several other Departments. We were encouraged to hear about the examples of cross-Whitehall working on HIV/AIDS undertaken by the ‘Cross-Whitehall Coherence Group on Tackling HIV and AIDS in the Developing World’ and the ‘Cross-Whitehall Group on Access to Medicines.’²² We were told, however, of a lack of coherence between the Home Office, the Foreign and Commonwealth Office (FCO) and DFID in relation to the provision of free ARV treatment to individuals who have failed in their asylum applications, and the deportation of those living with HIV who have no right to reside in the UK.²³ We were concerned to hear that the Home Office only “occasionally” consults DFID and the FCO regarding the availability of ARVs in countries to which they propose to deport individuals living with HIV.²⁴ Robin Gorna told the Committee that this subject would be addressed at the next meeting of the cross-Whitehall group on HIV in developing countries. **We accept that cross-Whitehall working on HIV/AIDS is in its early days, and commend the progress which has been made thus far. We request that DFID informs us of the outcome of the discussion in the cross-Whitehall group on HIV in developing countries, regarding the coherence of HMG policy on individuals with no right to reside in the UK and HIV/AIDS treatment.**

20 The Stop AIDS Campaign is an initiative of the UK Consortium on AIDS and International Development, consisting of more than 70 UK development and HIV/AIDS groups.

21 Memorandum submitted by the Stop AIDS Campaign, paragraph 2.4

22 Q 29 [Ms Robin Gorna, DFID]; Q 30 [Mr Daniel Graymore, DFID]; memorandum submitted by DFID, paragraph 78

23 Memorandum submitted by Professor Tony Barnett; memorandum submitted by National AIDS Trust

24 Q 31, Q 32 [Robin Gorna]

Intellectual Property Rights and access to ARVs

11. The agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), introduced in 1995, requires countries to grant patent protection to pharmaceutical products for a minimum period of 20 years. In November 2001, the WTO agreed that TRIPS: "...does not and should not prevent Members from taking measures to protect public health", implying that poor countries should be able to manufacture, buy and import cheap generic copies of more expensive, patented drugs if they perceive a threat to public health. In August 2003, the WTO announced a new temporary agreement, intended to allow generic copies made under compulsory licences to be exported to countries that lacked production capacity, provided certain conditions and procedures were followed. In their submission to the Committee, DFID described the August 2003 agreement as: "a balanced framework that respects the importance of intellectual property rights and the need for countries to have the flexibility to import generic medicines where needed."²⁵ Others, including Médecins Sans Frontières, have argued that the August 2003 solution is too complex to be used by developing countries.²⁶ Mr Daniel Graymore, from DFID, admitted that:

"...following the agreement in Cancún to waive the clause that made it difficult for countries which do not have their own industry to import copies, that the process has been fraught on occasions. It is a very complicated agreement and there are lots of different levels that need to be addressed."²⁷

Mr Graymore went on to explain that the TRIPS-waiver had deliberately been agreed in advance of generic-producing countries, such as India, beginning to implement TRIPS after becoming fully compliant with the agreement on 1 January 2005. He suggested that it is therefore too early, as yet, to judge the real impact of the waiver.²⁸

12. We strongly encourage HMG to lobby the European Commission, to make representations in the WTO, that the WTO should undertake a review of the implementation of TRIPS, to assess whether the agreement has compromised public health to any degree. We further recommend that DFID continues to work with other donors to build the capacity of low- and middle-income countries routinely to use TRIPS safeguards, such as compulsory licences and government use provisions, to facilitate the production and export of affordable medicines, particularly second-line ARVs.

25 Memorandum submitted by DFID, paragraph 81

26 Médecins Sans Frontières, *MSF to WTO: re-think access to life-saving drugs now*, 25 October 2005.

27 Q 39 [Daniel Graymore]

28 Q 40 [Daniel Graymore]

IMF influence on public health investment

13. According to ActionAid, fiscal constraints imposed by the IMF are discouraging government spending on public health in low- and middle-income countries.²⁹ This issue was raised in oral evidence by Dr Tom Ellman, Medical Adviser to Médecins Sans Frontières (UK).³⁰ Mr Hans-Martin Boehmer, from DFID, explained that the IMF may advise countries against planning to pay for long-term commitments, such as recruiting more health workers, using unpredictable sources of funding, such as donor financing (as opposed to more predictable flows, such as domestic tax revenues).³¹ Mr Boehmer went on to say, that if a country went against IMF advice and decided to finance the recruitment of health workers using what the IMF judged to be an unpredictable source of financing,³² the Fund could withdraw its support for a country's fiscal framework. This, Mr Boehmer admitted, could have very serious consequences for a country's receipt of funds from other donors:

“Donors do not have the fiscal capacity to assess: “Is this a sound fiscal framework or not?” But they do provide budget support or other support through the national budget. If the IMF says, “We do not advise that this is a sound fiscal framework,” many donors would shy away from putting their money into the budget.”³³

14. The Committee understands the IMF's rationale for encouraging countries to minimise risks when designing their fiscal framework. We are, however, concerned to hear that IMF fiscal advice may dissuade countries from investing in their public health infrastructure, particularly since this is key to the expansion of ARV programmes. We encourage DFID to continue working with the IMF and other donors to increase the coordination and long-term predictability of donor funding for HIV/AIDS, in order to enable countries to use donor finance to fund long-term health infrastructure commitments.

29 Rick Rowden, *Changing Course: Alternative approaches to achieve the Millennium Development Goals and fight AIDS*, ActionAid, September 2005; Rick Rowden, *Blocking Progress: How the fight against HIV/AIDS is being undermined by the World Bank and the International Monetary Fund*, ActionAid, September 2004.

30 Q 23 [Tom Ellman]

31 This raises the issue for donors of how to increase the predictability of their funding, an issue that DFID is working on in response to the work of the High Level Forum on Health MDGs (see <http://www.who.int/hdp/hlf/en/>).

32 Whether this was domestic tax revenue or a predictable supply of donor financing, such as that which DFID has undertaken to provide to the Government of Malawi over the next ten years; Q 34 [Mr Hans-Martin Boehmer, DFID].

33 Q 46 [Hans-Martin Boehmer]

The significance of prevention

15. We hope that the G8 commitment to universal ARV provision by 2010 will add valuable impetus to the case for rolling out ARV treatment in the global South. But the relatively new focus on treatment should not be allowed to displace the important work which has been done on HIV prevention. We were surprised to hear, for example, that only 20% of the US\$15 billion committed by President Bush for the President's Emergency Plan for AIDS Relief (PEPFAR) will be spent on HIV prevention, while a total of 70% will be spent on HIV treatment and palliative care.³⁴ Many of the witnesses who gave oral evidence to the Committee stressed that HIV prevention and treatment are 'two sides of the same coin',³⁵ and that in a best-case scenario, treatment, prevention and strengthening health systems should work together in a virtuous cycle.³⁶ **Expanding access to HIV treatment should not be seen as a simple, technical fix to the pandemic. We believe that a scaling-up of HIV prevention must form an integral part of all programmes to expand access to treatment. We commend DFID for the important role it played in securing international agreement on UNAIDS' new prevention policy 'Intensifying HIV prevention',³⁷ and urge the Department to continue to balance its work on HIV treatment with sustained attention to HIV prevention.**

16. Sandra Black, Ben Plumley and Mandeep Dhaliwal told the Committee that there is a strong body of research supporting the 'ABC' approach to prevention.³⁸ The 'ABC' approach refers to comprehensive HIV prevention programmes which promote Abstinence, Being faithful to one partner and using Condoms. However, written memoranda received by the Committee emphasised the continuing need for research into the complex range of factors which affect HIV transmission and determine the efficacy of HIV prevention strategies.³⁹ **The Committee is convinced that it is essential for all HIV prevention programmes to be firmly evidence-based, and encourages DFID consistently to analyse the HIV prevention work it undertakes, in order to determine what works.**

34 See <http://www.avert.org/pepfar.htm>

35 Q 2 [Sandra Black, Ben Plumley]; Q 9 [Sandra Black]; Q 43 [Robin Gorna]

36 Q 9 [Mandeep Dhaliwal]

37 UNAIDS, *Intensifying HIV Prevention: policy position paper*, August 2005, UNAIDS

38 Q 9 [Mandeep Dhaliwal], Q 10 [Ben Plumley]

39 Memorandum submitted by Professor Tony Barnett; memorandum submitted by Professor Alan Whiteside

17. We were concerned to hear that the United States' emphasis on abstinence within its HIV prevention work⁴⁰ risks undermining a comprehensive response to HIV transmission,⁴¹ particularly given that the US is the largest donor on HIV/AIDS. As Mandeep Dhaliwal told us: "An over-emphasis on one of the letters of ABC is not evidence-based prevention".⁴² The current US preference for building bilateral donor relations also risks undermining the coordinated approach promoted by multilateral agencies and instruments, such as UNAIDS and the Global Fund to fight AIDS, TB and Malaria. **The Committee recommends that DFID maintains its "very lively dialogue with the US"⁴³ on the issue of HIV/AIDS, and does all it can to support national governments to maintain ownership of their individual country plans to tackle HIV/AIDS. In any situation where evidence-based policy is not being implemented, we expect DFID firmly to express their concern.**

40 One third of total PEPFAR funding for HIV prevention is earmarked for abstinence-only prevention messages (see Harinder Janjua, *Act Now; access to care and treatment, meeting the AIDS challenge*, October 2005, Stop AIDS Campaign).

41 Q 7 [Tom Ellman]; Q 13 [Mandeep Dhaliwal]

42 Q 13 [Mandeep Dhaliwal]

43 Q 55 [Robin Gorna]

Formal minutes

Tuesday 29 November 2005

Members present:

Malcolm Bruce, in the Chair

John Battle

John Barrett

Hugh Bayley

John Bercow

Richard Burden

Mr Quentin Davies

Mr Jeremy Hunt

Ann McKechin

Joan Ruddock

The Committee deliberated.

Draft Report, (Delivering the Goods: HIV/AIDS and the provision of anti-retrovirals), proposed by the Chairman, brought up and read.

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

Paragraphs entitled 'Summary' read and postponed.

Paragraphs entitled 'Background' read and agreed to.

Paragraphs 1 to 17 read and agreed to.

Postponed paragraphs entitled 'Summary' read again and agreed to.

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

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

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order 134.

Ordered, That the Appendices to the Minutes of Evidence taken before the Committee be reported to the House.

Several papers were ordered to be reported to the House.

[Adjourned till Thursday 1 December at 1.45pm]

Witnesses

Tuesday 22 November 2005

Ms Sandra Black, Senior Policy Advisor, HIV/AIDS Department, WHO, **Dr Mandeep Dhaliwal**, International HIV/AIDS Alliance and Stop AIDS Campaign, **Dr Tom Ellman**, Medical Advisor, MSF (UK) and **Mr Ben Plumley** Director, UNAIDS Executive Office

Mr Hans-Martin Boehmer, Head of Human Development Group, Policy Division, DFID, **Ms Robin Gorna**, Senior AIDS adviser and team leader, Policy Division, DFID and **Mr Daniel Graymore**, Private Sector Adviser, Global AIDS policy team, Policy Division, DFID

Written evidence (to be published in Volume II of this Report)

Written evidence submitted by witnesses who also gave oral evidence

Department for International Development
Stop AIDS Campaign

Other written evidence

Agency for Cooperation and Research in Development (ACORD)

Professor Alan Whiteside

Help the Hospices

International Planned Parenthood Federation (IPPF)

Professor Tony Barnett

Merck & Co Inc

National AIDS Trust (NAT)

Nyumbani

UNICEF

Working Group on Orphans and Vulnerable Children of the UK Consortium
on AIDS and International Development.

List of unprinted written evidence

Additional papers have been received from the following and have been reported to the House but to save printing costs they have not been printed and copies have been placed in the House of Commons library where they may be inspected by members. Other copies are in the Record Office, House of Lords and are available to the public for inspection. Requests for inspection should be addressed to the Record Office, House of Lords, London SW1. (Tel 020 7219 3074) hours of inspection are from 9:30am to 5:00pm on Mondays to Fridays.

African Medical and Research Foundation (AMREF)

Coca-Cola Africa Foundation

GlaxoSmithKline

International Labour Office (ILO)

Nestlé UK