



House of Commons
International Development
Committee

**Delivering the goods:
HIV/AIDS and the
provision of anti-
retrovirals: Government
Response to the
Committee's First Report
of Session 2005–06**

First Special Report of Session 2005–06

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International Development Committee

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First Special Report

On 1 December 2005 the International Development Committee published its First Report of Session 2005–06, *Delivering the goods: HIV/AIDS and the provision of anti-retrovirals*, HC 708. On 14 February 2006 we received the Government's response to the Report. It is reproduced as an Appendix to this Special Report.

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

Appendix: Government response

Paragraph 2 '...We commend DFID for the important role which it played in securing the G8 commitment to universal anti-retroviral treatment provision by 2010.'

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

Paragraph 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.'

Progress has been swift since Gleneagles – and the UK has played a leading role in steering action to fulfil the commitment. The UN General Assembly have asked for a report on progress to a special high level meeting on AIDS in early June. To translate these commitments into action, and prepare this report, the UK is co-chairing with UNAIDS a Global Steering Committee on Scaling Up Towards Universal Access (GSC).

The GSC has over 40 members — from all G8 members, other donors, developing countries, the African Union, civil society and others. The UK has pressed the GSC to clarify, prioritise and unblock the major obstacles that impede scale-up of comprehensive AIDS programmes. Country and regional consultations are underway throughout the world to inform the GSC's deliberations. The GSC met for the first time on 9 and 10 January and made substantial progress on questions of monitoring and accountability.

We appreciate the vital role of targets in mobilising efforts, and recognise the huge success of 3 by 5 in so doing. We also stress — with other GSC members — the importance of distinguishing between targets for advocacy and accountability, and specific targets and milestones used to plan and deliver effective responses. This is why discussions to date at the GSC have indicated that instead of new global targets countries should be encouraged and helped to set their own milestones and targets. And they will be urged to align their own plans — reflecting their own circumstances — with a core set of existing targets and indicators. We expect the core set of indicators and targets will include the number of people on treatment, as well as meaningful indicators and targets on prevention and care. This way the international community can track progress and ensure accountability.

DFID's reporting on universal access will be based on the agreements reached by the GSC, and focussed on the indicator sets gathered by UNAIDS' co-sponsors, including WHO. DFID's role will be to work with UNAIDS (including WHO) in their monitoring rather than establishing an additional system.

DFID will continue to use the existing PSA sub-targets to monitor HIV prevalence in its focal countries in Africa and Asia during the period 2005–8. The 2007 Comprehensive Spending Review which is now underway will provide the background for the development of PSA targets for the period 2008 to 2011. Decisions on the precise formulation of targets for our engagement in Africa, Asia and with the wider international community will therefore be contingent on this process. The recommendations of the committee and other stakeholders on AIDS will be taken into account in any revisions.

Paragraph 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.'

As noted above, the UK is co-chair of the Global Steering Committee on Scaling up Towards Universal Access, (GSC) which is due to report to the UN General Assembly High Level meeting in June 2006. The GSC is considering the obstacles to scaling up comprehensive AIDS programmes, including access to treatment. Early discussions have already highlighted the need to unblock obstacles to treatment for children, including the lack of adequate diagnostics and treatments for children, and the poor disaggregation by age and gender of reporting on treatment.

The UK is hosting with UNICEF the Global Partners Forum on Children Affected by AIDS (GPF) in early February. One of the 6 discussion streams of the GPF is access to treatment and care for children with HIV and AIDS. Discussions at the Global Partners Forum will feed into the work of the Global Steering Committee.

The UK agrees that it is important that the treatment needs of people in vulnerable groups are met. This is why we highlighted the importance of responding to the needs of the most vulnerable groups of people in our HIV and AIDS Treatment and Care Policy, published in 2004. We have pressed WHO to disaggregate the data around treatment access and uptake, and will continue to do so.

Paragraph 9 ‘...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.’

DFID country offices are working with host governments, UN agencies, other donors, civil society and other stakeholders to implement ‘Taking Action’.

DFID’s Africa Division has gone a long way in integrating the UK Strategy into its regional and 16 priority country programmes, which cover Southern, East, Central and West Africa. The main focus of DFID country programmes in Africa has been to strengthen national multisectoral responses to deliver comprehensive HIV and AIDS prevention, treatment and care services. There has been a strong emphasis on supporting national political leadership and implementing the "three ones" principles (i.e. one national plan, one national coordinating body and one monitoring and evaluation system), improving coordination of international development partners as well as investing in strengthening health and other social services to respond to the epidemic (e.g. Malawi). In countries, where it is more difficult to work directly with government, we have been supporting UN agencies and civil society organisations to deliver HIV and AIDS services to vulnerable groups and key target groups such as women and children. For example, in Zimbabwe, DFID has designed a large programme of support to address the needs of children affected by AIDS which will be delivered by UNICEF and other national development partners.

DFID is providing support to the response to HIV and AIDS in 9 countries in Asia: India, China, Bangladesh, Pakistan, Nepal, Cambodia, Vietnam, Indonesia, and Burma (through the UN). A new programme of support for Indonesia was approved in 2005.

DFID offices in Asia are making strenuous efforts to work with partners to implement ‘Taking Action’, to strengthen the development and implementation of multisectoral national plans, and the harmonisation of donor efforts. In particular we are strengthening our focus on vulnerable groups, women and young people. DFID is well placed to support the national response in countries like Bangladesh, Pakistan and India, through our long-standing engagement with the health sector and clearly stated position on sexual and reproductive health and rights. We are well placed to support scaling-up of the delivery of services for harm-reduction amongst injecting drug users in Indonesia, Vietnam, and China. DFID is the largest bilateral donor supporting HIV and AIDS in China.

In the Europe, Middle East and Americas Division, spending target projections for HIV and AIDS will see a doubling of spending by the end of the three year period. Significant areas of progress have been in the Central Asian Republics, working alongside the World Bank on a programme targeting regional dimensions of the epidemic and a DFID programme supporting harm reduction services in Kyrgyzstan, Uzbekistan and Tajikistan; in the Caribbean working to tackle stigma and discrimination, where the issues are now being much more widely and openly debated, as well as stimulating a stronger response from the private sector; and in Latin America, where DFID is working jointly with UNAIDS and GTZ to provide support for a new International Centre for Technical Cooperation, based in Brazil, designed to provide technical and management support to National AIDS Programmes across Latin America. A new programme is being designed to support AIDS prevention and treatment in the Overseas Territories.

Paragraph 10 ‘... 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.’

The Government notes this request and has placed these issues on the agenda of the next meeting of the Cross-Whitehall Coherence Group on AIDS, and will come back to the Committee in due course.

Paragraph 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.’

DFID welcomes the Committee's interest in TRIPS. However, it would not be appropriate to lobby the WTO for a review of TRIPS at this time. The agreement seeks to balance public interest with private incentives, and we believe it does so successfully. Concerns regarding TRIPS' impact on public health are largely concerned with the degree to which the agreement limits access to generic copies of patented medicines. The Doha Declaration on TRIPS and Public Health (2001) and the Decision on 30 August 2003 to allow countries with no, or insufficient, capacity in their pharmaceutical industry to import copies of patented medicines were expressly designed to maintain access to generic copies of patented medicines in developing countries. The 30 August 2003 Decision was initially agreed on a temporary basis. WTO Members agreed on 6 December 2005 to make it permanent and an integral part of the TRIPS Agreement. The TRIPS flexibilities were agreed in the context of all but least-developed country members of the WTO being required to fully comply with the entire TRIPS agreement in 2005 at the latest. Least

Developed Countries benefit from a longer transition period regarding patent protection on pharmaceuticals, which they are not expected to implement before 2016. It is now important that we monitor these agreements to see if they are successful.

The Government notes the Committee's second recommendation and will continue to work with other donors and international partners to build capacity in developing countries to use TRIPS safeguards. DFID has been funding several programmes to increase capacity to use TRIPS, including funding legal research on implementation, a *TRIPS Resource Book* and we are now exploring — in partnership with international organisations — provision of on-the-ground technical assistance to developing countries to help them make the most of TRIPS. We will continue to take this forward. We have also supported the Government of Ghana, through the Ghana National Drugs Programme to develop a national access to medicines programme.

Paragraph 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.’

The Government agrees with the Committee’s recommendation and will continue to work for improved coordination and long-term predictability for the reasons the committee cites.

Paragraph 15 ‘... 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’, and urge the Department to continue to balance its work on HIV treatment with sustained attention to HIV prevention.’

Paragraph 16 ‘... 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.’

The Government agrees. Only balanced and comprehensive responses, tailored to national priorities and country-led needs, can be effective. We will work to ensure that the UK’s contribution, alongside that of other donors, secures such a balanced approach. To mark World AIDS Day last year the EU adopted a Statement on HIV Prevention for an AIDS Free Generation. The Statement, agreed by all 25 Member States, recognises that without a massive scale up of HIV prevention, the trend in increasing numbers of people being infected will continue, posing a major threat to affected countries’ ability to sustain

progress in tackling the epidemic and in providing AIDS treatment. The Statement underscores that prevention of new infections must remain the cornerstone of a comprehensive AIDS response and identifies the following as critical components of a comprehensive and evidence based response:

- a) Universal access to sexual and reproductive health information and services for women, men and young people;
- b) Provision of accessible and integrated health promotion and harm reduction services for drug users;
- c) Reliable access to essential sexual and reproductive health commodities including male and female condoms and essential harm reduction commodities;
- d) Universal access to education and provision of life-skills and sexuality education;
- e) Integration of HIV prevention interventions, including voluntary counselling and testing for HIV, into other health;
- f) Action to confront and address gender based violence and to provide protection and support to victims of violence;
- g) Support investment in the development of new biomedical prevention technologies including microbicides and vaccines;
- h) Promote the adoption of good workplace practice in all places of employment.

Paragraph 17 ‘... The Committee recommends that DFID maintains its “very lively dialogue with the US” 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.’

The Government accepts this recommendation and will take every opportunity to pursue this in countries where we work together, and through bilateral dialogue between our governments. But we will — as we always have — continue to work with US colleagues to promote country-led evidence-based and effective approaches to tackling the HIV epidemic.

Department for International Development
14 February 2006