



House of Commons
International Development
Committee

**HIV/AIDS: Marginalised
groups and emerging
epidemics: Government
Response to the
Committee's Second
Report of Session 2006–07**

**Fourth Special Report of Session
2006–07**

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International Development Committee

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Fourth Special Report

On 1 December 2006 the International Development Committee published its Second Report of Session 2006-07, *HIV/AIDS: Marginalised groups and emerging epidemics*, HC 46-I. On 2 February 2007 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 4] We are concerned that DFID's indicators of success are linked primarily to funding targets rather than to outcomes. We recommend that in the interim and final evaluations of *Taking Action*, success is measured against transparent 'outcome indicators' as well as 'funding indicators'. Outcome indicators should set out DFID's contribution to achieving the international targets on HIV/AIDS treatment, prevention and care.

AIDS is a global epidemic and the UK government recognises that it cannot halt the spread of the disease alone. In addition to its spending target on HIV and AIDS of £1.5 billion over the period 2005/6-2007/8, set during its 2005 G8 leadership, the UK government is coordinating with other donors to ensure that the target of delivering comprehensive HIV prevention programmes, treatment, care and support by 2010 is met (as agreed at the United Nations General Assembly High Level Meeting on AIDS, 2 June 2006). In 2005, the UK, as EU President, initiated the process to develop and lead negotiations to achieve an EU-wide statement on HIV Prevention.

Countries have committed themselves to setting ambitious national targets to achieve universal access, a process we lobbied strongly for at the UN General Assembly High Level Meeting on AIDS. Overall global impact will be measured against the aggregated targets and results from countries. We are working closely with UNAIDS and with other international agencies on this important issue.

According to UNAIDS, by the end of October 2006, 84 countries had provided target data, of which 44 countries had set outcome targets for all three programmatic target areas and at least 21 countries had proceeded with costing their strategic plans. It is anticipated that a number of countries will continue with their target-setting process during the course of 2007. The UK, working with G8 partners, is pressing UNAIDS to undertake an early review of the strategic plans and to aggregate country targets to better understand global funding needs.

DFID fully agrees that outcome indicators and a focus on results are necessary *in addition* to financial inputs to meaningfully track progress and we are considering ways to better track inputs, outputs and outcomes. For example, the final evaluation of *Taking Action: The UK's strategy for tackling HIV and AIDS in the developing world* will cover the issue of

transparent outcome indicators as well as input and output targets. However we would question whether donors should seek to attribute specific outcomes to their own support. As donor support is increasingly channelled through general budget support, our role is one that supports partner governments to develop their own systems for monitoring the progress of programmes towards meeting specific outcomes. We believe that country-set targets should achieve the most effective outcomes.

[Paragraph 7] We see a clear contradiction between a policy of routinely charging those failed asylum seekers who want to start a course of treatment after their application has been rejected and Government advocacy of the universal access goal. We believe that undermining the needs of minority groups in this way is a denial of their human rights and weakens DFID's international leadership on this issue. We believe that DFID should play a role in ensuring that asylum seekers living with HIV are not returned to countries where access to ARVs [anti-retroviral therapy] is not practical. We regret that more progress has not been made on these matters since our last report.

The treatment of asylum seekers who are HIV positive involves balancing the needs of the individual with the overall need to ensure that we have a strong immigration system in place. DFID's task is reducing poverty in developing countries, and the right thing to do must be to scale up access to treatment, prevention and care in developing countries to ensure in the future that asylum seekers living with HIV are not returned to countries where access to anti-retroviral therapy is not available. The figures on increasing access to treatment are encouraging; for example, in Sub-Saharan Africa, the number of people on treatment rose tenfold between 2003 and 2006, to over 1 million.

More specifically, HIV positive asylum seekers to the UK whose application is pending are entitled to NHS hospital treatment free of charge until such time as a final decision on their claim, including any appeals, has been made. The eligibility for NHS treatment is set out in the NHS Regulations 1989 (Overseas Visitors Hospital Charging Regulations). Asylum seekers may also register with a GP and most are eligible for free prescriptions on the basis of low income.

Once appeal rights have been exhausted, unsuccessful asylum seekers are expected to return home as soon as possible and are no longer eligible for free NHS treatment. However an easement clause provides for an existing course of treatment to be continued free of charge until the patient leaves the country. Treatment for any new condition is chargeable, although treatment received in an Accident and Emergency Department remains free to all. Some NHS services provided in NHS trusts are free to everyone regardless of the status of the patient. This includes certain diseases, including TB, where treatment is necessary to protect the wider public health. In the case of HIV, only the initial testing and any counselling is free.

The public health risks around TB are different from those of HIV. The routes of transmission are different. TB is an airborne infection not easily transmitted from person to person, and usually requires prolonged close contact with an infectious person. HIV is not airborne but is spread through specific practices and behaviours. Changing those

behaviours can contribute greatly to reducing the public health risk. That is why diagnosis of HIV and associated counselling are free to all.

An asylum seeker's state of health can have no bearing on the outcome of the asylum claim itself, which is decided in accordance with the 1951 UN Convention on the Status of Refugees and its Protocol. A number of people who are HIV positive or have other serious health conditions seek to remain in the UK on human rights grounds. They include both unsuccessful asylum claimants and others who have not applied for asylum but have no lawful basis of stay in this country. Such applications are considered by the Home Office on their individual merits in accordance with the UK's obligations under the European Convention on Human Rights (ECHR). It can be a breach of Article 3 of the ECHR to remove someone from the UK if to do so would constitute inhuman or degrading treatment because of the suffering caused due to their medical condition. However, both the European Court of Human Rights and domestic case law have set a very high threshold for inhuman or degrading treatment in such cases. The House of Lords case of *N* (2005) clearly establishes that states are under no obligation to allow those otherwise liable to removal to remain in their territories for the purpose of receiving medical treatment. If the claimant's circumstances were so extreme that a grant of discretionary leave to remain was appropriate, this would enable the NHS to treat them as resident for the purposes of their Regulations and thus eligible for free treatment.

The NHS needs to devote its resources to treating UK residents who are entitled to receive its services. AIDS affects millions of people worldwide and for that very reason we cannot take on the obligation to provide NHS treatment for anyone with HIV or AIDS who enters the country. However, although charges cannot be waived, treatment would never be withheld if in a doctor's clinical judgement it was immediately necessary to save life or to prevent a condition from becoming life-threatening, regardless of eligibility for free treatment or ability to pay.

[Paragraph 8] We are concerned that *Taking Action*, although billed as the UK strategy on HIV/AIDS in the developing world, is in reality only the strategy of DFID. We recommend that DFID work closely with other Departments, particularly the FCO and the Home Office, to develop a truly integrated strategy for the UK's action on HIV/AIDS internationally. This should draw the FCO fully into the governance and human rights aspects of HIV/AIDS and the Home Office into broader UK advocacy of the international goals on HIV/AIDS, such as universal access to treatment.

The cross-Whitehall relevance and usefulness of *Taking Action* as a strategy is being considered through the current evaluation. We look forward to its findings.

DFID works well with other government departments on HIV and AIDS and has very strong relationships with the FCO, especially overseas and through the UN missions. In 2005, a Cross-Whitehall Working Group on tackling HIV and AIDS in the developing world was set up, comprising the following government departments: DFID, FCO, Home Office, DoH, MOD, No 10, HMT, DTI, NAO, HM Revenue and Customs, Patent Office, Scottish Executive, Welsh Assembly, Northern Ireland Assembly. The group meets approximately three times a year to discuss a range of issues, including:

1. To support implementation of *Taking Action* by HMG by increasing coherence across government departments.
2. To exchange information about policy initiatives and directions related to *Taking Action*.
3. To identify opportunities for closer co-operation across departments to maintain UK and international political momentum, provide briefing, and consider new policy.

To date, the group has considered issues that have required close co-operation between DFID and FCO, and between DFID and the Home Office and Department of Health. These include collaboration to secure a good outcome from the UN General Assembly High Level Meeting on AIDS (June 2006); on the development of a progressive workplace policy on HIV and AIDS agreed between DFID, FCO and the British Council; and on harm reduction interventions in developing countries (involving collaboration with the Home Office and FCO). The group continues to reflect on and respond to the issues raised by the International Development Committee in its annual review of AIDS, including issues on charging and asylum seekers highlighted by the IDC in October 2005 (involving DFID, Home Office and Department of Health); it has also worked closely on AIDS in the context of the G8.

In September 2006, the Health Protection Agency joined the Group. It was also agreed to invite NGOs to the next meeting in 2007, both as observers and to discuss how best to ensure effective future engagement between civil society and the group.

During 2007 we expect the Cross-Whitehall Working Group on tackling HIV and AIDS in the developing world to be an important forum for discussion of what comes after *Taking Action*, which ends in March 2008. It will reflect on the findings of the interim evaluation of *Taking Action*, and on how best to ensure that any future strategy involves effective cross-Whitehall co-operation.

[Paragraph 11] As emerging epidemics become more generalised, we recommend that DFID ensure that its experience of best practice in Africa is put at the disposal of governments elsewhere, including in Asia and Eastern Europe.

DFID already supports South-South collaboration, including mutual learning and skills transfer. However, there are also limitations on transferring examples of best practice due to differing epidemic profiles. For example, the nature of the disease in Africa is considerably different to the epidemiology, causes of HIV transmission, and cultural and behavioural factors in the Asian epidemic. For these reasons, care and sensitivity are needed when designing programmes which encourage lesson learning.

An example of mutual skills transfer is the Brazil STD/AIDS Programme, which has done a good deal of work providing technical, management and logistics technical assistance in the Lusophone countries of Africa. Likewise, there are examples of good practice from Africa being communicated elsewhere. A recent example is the work of faith-based organisations in Southern Africa, who have visited the Caribbean to encourage local faith-based leaders to become involved as "Champions for Change". Skills transfer can also take

the form of study tours. For example, Ukrainian NGOs working with males who have sex with males visited similar projects in the UK, with some success.

In the area of harm reduction, the UK and Australia have a long history of work which is increasingly being drawn on as good practice. Success in addressing injecting drug use, which drives the epidemics in many parts of Asia, comes from within Asia, including Thailand, Cambodia and, more recently, China. In India, lessons learnt from recent reductions in HIV incidence and prevalence in four southern states are being built into the next phase of the Government of India's AIDS control programme, with DFID support.

DFID also supports more informal sharing between countries. Many of the case studies for the current evaluation of *Taking Action* involved DFID staff from one region reviewing programmes in another.

[Paragraph 18] We believe that programmes which address the drivers of epidemics, rather than generalised programmes, will be most successful in combating the spread of HIV/AIDS. Social and legal barriers to effective prevention and treatment programmes for key groups need to be addressed in some countries to ensure successful implementation of national HIV/AIDS strategies. We support such a rights-based approach and recommend that DFID ensure that all national programmes it supports address stigma and discrimination to prevent further marginalisation of those at highest risk of infection. We recommend that, as well as continuing to make these points bilaterally and internationally, DFID make specific efforts to encourage the repeal of restrictive policies, at both domestic and international level, that impede effective services.

We agree with the IDC's recommendation that programmes must address the drivers of an epidemic and—where the epidemic is concentrated in key populations—they must be provided with targeted services to effectively combat the spread of HIV.

HIV and AIDS-related stigma and discrimination have been, and continue to be, the most challenging obstacles to the uptake and use of AIDS services. We welcome the recommendation that an analysis of stigma and discrimination and ways to address them should be integrated into all national programmes. Indeed, through our Country Assistance Programmes (CAPs) and other in-country analyses, we are committed to identifying socially excluded groups. We would expect any new government strategy on HIV and AIDS to commit to actions to address stigma and discrimination.

Stigma and discrimination on the basis of sexuality or health are human rights violations and undermine public health efforts to combat HIV and AIDS. Acts of discrimination deny essential, life-preserving services to those most in need of them. Fear of stigmatisation and discrimination discourages people from seeking information on protection, and from coming forward for voluntary counselling and testing, treatment, care and support. DFID supports approximately 100 projects and programmes throughout the world that aim to reduce stigma, challenge discrimination and promote and protect human rights.

DFID also works to create legislative environments supportive of the human rights of people living with HIV and AIDS and marginalised groups, through revision and reform of

laws and regulations, legal education and rights awareness programmes, and access to justice and legal support. In Asia, DFID supports several programmes on legal reform and the inclusion of the rights of vulnerable groups and women in policies and laws. The programmes concentrate on women's rights (Bangladesh, China, Pakistan), rights of injecting drug users and sex workers (China, Vietnam), and trafficking of children and women into prostitution (China, Nepal). In Ukraine, the Community Centres for Men programme provides legal education and awareness of rights as well as legal support to males who have sex with males. In Tanzania, the project 'Promoting the Rights of people living with HIV and AIDS' provides rights-based community training to raise awareness of the rights of people living with HIV and AIDS—in particular inheritance rights—and ensure that people living with HIV and AIDS have access to redress when their rights are violated.

[Paragraph 20] A series of initiatives will be necessary to maintain momentum towards achieving the challenging targets for tackling HIV/AIDS. DFID should remain open-minded about this and should keep under review the case for further bilateral and multilateral representatives to push for progress in neglected areas of HIV/AIDS advocacy.

The UK works closely with bilateral and multilateral partners to help ensure that the global response to AIDS is comprehensive and that neglected areas are addressed. The UK's Presidencies of the G8 and EU in 2005 achieved major advances in tackling HIV and AIDS, with, respectively, the development of the target to achieve Universal Access to AIDS treatment by 2010 and an agreed EU position on HIV prevention. We are working closely with Germany to help maintain momentum on AIDS during its G8 and EU Presidencies in 2007.

We are also focused on working with the major international AIDS donors—the US, the Global Fund to Fight AIDS, TB and Malaria (GFATM), and the World Bank. GFATM is a key instrument in supporting the global response to AIDS. The UK is working to ensure that GFATM makes the most effective contribution to delivering a robust response to the disease. It is especially important that GFATM performs well in Africa. We are currently reviewing our collaboration with the US to ensure that our efforts are complementary in support of national AIDS programmes.

We will retain an open mind and seek to find innovative and appropriate ways to have the maximum impact on tackling AIDS and meeting the Universal Access goals.

[Paragraph 22] We recommend that DFID ensure that key populations are involved in policy formulation consistently across the range of programmes that DFID designs, implements and funds. We also recommend that DFID ensure that its partners, whether NGOs or national governments, support the involvement of people living with HIV and AIDS and marginalised groups in guiding governments and NGOs in their policy-making and in providing the right services.

DFID remains firmly committed to the active involvement of people living with HIV and AIDS in the response to the disease, and has demonstrated this commitment through *Taking Action*, endorsement of the 2001 UNGASS Declaration on AIDS, the 2006 Political Declaration, and the principle of greater involvement of people living with HIV and AIDS. Organisations of people living with HIV and AIDS have a clear role in representing the interests of HIV positive people. DFID supports networks which strengthen the voice of people living with HIV and AIDS (PLWHA) in policy processes, particularly where decisions are being made that affect their lives. Moreover, people living with HIV and AIDS have demonstrated they can bring about change and have been behind many innovations in HIV and AIDS prevention, treatment and care—treatment literacy and home-based care being just two examples. Through their own initiatives to tackle stigma and discrimination, PLWHA can help build demand for more formal programmes which address stigma and discrimination. They also play an important role holding governments to account for the services provided to PLWHA.

DFID has committed £1.75 million over three years to strengthen global networks of PLWHA and to build their organisations' capacity to contribute to the development and implementation of effective AIDS policies and programmes. We will continue to meaningfully involve representatives of key populations and PLWHA in our activities wherever possible, including through our workplace policy.

Department for International Development
2 February 2007