Good morning, everyone, and welcome. This is the International Development Committee session on DFID’s work on HIV and AIDS. I thank our witnesses for joining us this morning. We have two expert panels. I am going to run each for about 45 mins. Welcoming our first two witnesses, our usual practice is we go straight into the questions but please, when you first answer a question, introduce yourself and your organisation. To give a sense of our timescales, we are seeking to cover with the first panel seven different areas over the next 45 minutes.

Let me kick off and invite both of you to respond to the first question. Do you think that HIV and AIDS has been deprioritised, both globally and here? Is it seen in some ways as yesterday’s crisis?

**Shaun Mellors**: Good morning. My name is Shaun Mellors. I am the Director of Knowledge and Influence at the International HIV/AIDS Alliance. You might be able to tell from my accent that I come from South
Africa. I am proudly South African. I am also a person living with HIV. In
response to your question, the answer is “yes” and “no”, and I will
elaborate a bit by focusing on three broad areas in relation to that
question, focusing on deprioritisation, leadership and the reality of the
situation at the moment.

The UN General Assembly agreed to end AIDS by 2030, and that in itself
is a very ambitious and noble task and ask. Part of how we are going to
achieve that is to develop what UNAIDS calls a fast-track strategy, which
DFID has supported, because as we all know DFID sits on the Programme
Coordinating Board of UNAIDS. Part of that fast-track strategy focuses on
reducing new HIV infections to fewer than 500,000 globally, reducing
AIDS-related deaths to fewer than 500,000 and eliminating AIDS-related
stigma and discrimination by 2020—that is less than two and a half years
away.

Unfortunately, we have seen that the decline in new HIV infections has
slowed and efforts to reach fewer than 500,000 by 2020 are already
off-track. Less than 40% of people who are living with HIV still do not
know their HIV status. That impacts on their ability to be able to access
treatment, care and support. We know that the majority of people who
are on treatment are also not virally suppressed, so not being able to be
virally suppressed impacts on the ability to improve their quality of life
but also impacts on people’s ability to reduce transmission of HIV
infection.

What we have also seen is that for many institutions and many
Governments, HIV has become less of a priority because there are other
competing priorities. We can see this in the decline of HIV funding: global
funding for HIV has dropped by 13% between 2014 and 2015, from $8.6
billion to $7.5 billion. While it could be argued that the Global Fund has
had a successful replenishment—and we are very grateful for DFID’s
contribution towards the Global Fund—the current estimates to respond
effectively to HIV is well under what UNAIDS estimate that we require.
We are currently sitting at about $19 billion and UNAIDS estimates that
we need $26 billion. There is a huge funding gap in terms of being able to
respond.

Chair: Thank you. Some of those issues we will come to in a bit more
detail in a moment, but thank you very much indeed.

Mike Podmore: Hi. I am Mike Podmore, Director of Stop AIDS, which is
the UK network of all the international NGOs working on HIV globally. I
would just add a couple of points to what Shaun has really well laid out in
terms of the situation of the global HIV response.

It definitely is being deprioritised globally, and this is because of a
combination of factors, some of which Shaun mentioned, including
competing priorities. However, it is also in part a result of the fact that in
the West it is now a manageable condition because people have access to
ARVs. It is also as a result of many countries around the world ignoring
some of the key drivers of the global HIV response, including gender inequality, criminalisation of key populations, et cetera. Another aspect is the fact that HIV is quite rightly being integrated into broader health programmes, and this is a positive shift but what that is leading to is a dramatic reduction in standalone HIV programmes and a danger that, as HIV is integrated, it became invisible, just as happened to gender many years ago.

There is also an AIDS fatigue. It has been a global priority for decades now and of course donors and international development actors shift to new priorities. This is a real problem. We see that both politically for the UK Government and around the world and for international development NGOs too, both here in the UK and globally. All of this is leading to a political, programmatic and therefore, unfortunately, financial de prioritisation of HIV, yet we are only halfway there in terms of the response.

Q2 Chair: What do you anticipate will be the effect of the new US Administration on this?

Shaun Mellors: That is an interesting question. What we have already seen, particularly yesterday with the announcement that the global gag rule will be implemented, is very concerning. It is going to have a huge impact and has huge implications for women’s health in general, and also for HIV funding and health funding to a number of the multilaterals. We need to watch that very carefully. The only glimmer of hope for us at the moment is that Trump has indicated that the current Global AIDS Coordinator will continue in her position; she has been very good in driving evidence and driving data-driven responses to HIV. We do hope that she will be able to continue, but we are very concerned about the implications of the Trump Administration.

It highlights again the importance of DFID playing an important leadership role, a principal role, in being able to combat some of these ignorant, if I may call it that, approaches to a serious global health challenge. It is imperative that DFID takes up that mantle where others are failing.

Q3 Pauline Latham: The bilateral review was published in December 2016, and it included HIV/AIDS. Is that enough, or do you think DFID should have a specific HIV/AIDS strategy?

Mike Podmore: I just want to start, if you will forgive me, by emphasising the big picture here, which is that DFID has and continues to make very strong and leading financial commitments to HIV globally, and should be strongly praised for doing so. We saw that obviously with the Global Fund commitment of $1.1 billion, which really established their clear demonstration of commitment to end AIDS by 2030. However, this financial leadership has not really been matched by UK political leadership on HIV for a number of years now. You normally hear campaigners calling for donors to put their money where their mouth is,
but in DFID’s case it is a little bit the other way; it is more, “Please put your mouth where your money is.”

DFID Ministers, when we have critiqued them for this, have previously protested that DFID’s money speaks for itself, but there are two strong reasons why that is not the case. The first is the global situation, as we have outlined, in terms of deprioritisation; when leading HIV donors like the UK are not vocally and clearly laying out their stall on HIV, it gives a signal to other donors, and indeed they are deprioritising funding. As we have mentioned, it is also critical to use the funding you are giving to get the best bang for your buck and give a strong political voice, so you need to combine that with political leadership and promoting evidence-based programming, as we mentioned. There are really strong signals: just recently, Priti Patel, the Secretary of State, attending and having a high profile at the Global Fund Replenishment was really important.

You rightly mentioned the bilateral development review. We were really encouraged to see HIV strongly within that. However, the bilateral development review is not an HIV strategy and does not give a coherent picture of what DFID is doing on HIV. It does not give much detail, numbers or indication of spending priorities, particularly at country-level. I do not know if you are going to go on to ask a question about whether they need a strategy. Shall I answer that now?

Pauline Latham: Yes. You might as well.

Mike Podmore: DFID’s last HIV strategy was published in 2011; it was renewed in 2013 and it expired in 2015. It was included in the Reproductive Maternal and Newborn Health Framework for Results but that also expired in 2015. We are in a situation now where there is no co-ordinated vision on HIV and little guidance for staff or indeed external stakeholders about what DFID’s vision is for HIV. We understand that DFID cannot develop a strategy on every single topic—that would take up far too much staff time—but we have to find a happy medium somehow.

We think there are two possible ways to do this. The first is one we were calling for in 2015, which is DFID developing a framework on its global health work, within which it would clearly place its focus on HIV and TB within that. That would fit well with DFID’s focus for HIV integration. However, we would also call for, and have been calling for through our “It Ain’t Over” campaign, DFID to conduct a one-off stock-take review of its HIV work, to get a full picture of what it is doing across its portfolio.

That stock-take review would be able to do four key things. First, it would be able to check whether it is successfully integrating HIV into its broader health and development work. The second is that it would help ensure better coherence across its HIV work and identify underserved areas, particularly in its bilateral programming. Thirdly, it would help bring clarity to what the balance is between its bilateral and its multilateral investments. Fourthly, it would help to articulate a clear message about DFID’s financial, political and programmatic priorities, so that it can really
take a strong stance globally. I am not sure whether DFID will be giving oral evidence but it would be great for the IDC report to come out so that DFID can respond specifically to these points.

Q4  **Pauline Latham:** Given Trump’s pronouncement—and he is not the first President to cut back on reproductive health—do you think it is even more important that DFID have a clear strategy, not just on HIV/AIDS but also on maternal health and reproductive health? Because they have not had a specific one for a while, it is perhaps a good time now to have one. I doubt that DFID will be able to fill the gap created by America dropping out. They talk about international NGOs; if it is international NGOs, there are a lot that are here in Britain as well. How do you think DFID should move forward now with that?

**Mike Podmore:** Move towards having a—

**Pauline Latham:** Having a strategy in the light not only of everything you have said but also in the light of what Trump has said.

**Mike Podmore:** I would just re-emphasise, particularly in that context, it is critical that DFID can really convey a strong, coherent, evidence-based approach to HIV and reproductive health more broadly, as well as sexual reproductive health and rights and global health. It becomes even more critical, particularly with, as Shaun was saying, the global gag rule. It looks likely, as we understand it from analysis, that that is going to be expanded across all of the US’s global health work. It really puts a lot more emphasis on leading global international donors like the UK to step up and have a coherent vision.

Q5  **Jeremy Lefroy:** Good morning. Could I just return to something Mr Mellors said? You said that funding had fallen from $8.6 billion to $7.5 billion. Is that outside funding or does that include local funding by countries themselves?

**Shaun Mellors:** I think it is related to all ODA funding for HIV and AIDS.

Q6  **Jeremy Lefroy:** Right. Do you have any idea how much countries that are in receipt of ODA themselves spend on their own programmes?

**Shaun Mellors:** Yes. We would be able to provide the Committee with that information.

**Mike Podmore:** Not in terms of the global amount but in terms of the global funding for HIV, domestic resources are now more than 50% of global funding for HIV, so there has been a dramatic increase in domestic resource mobilisation globally, and that is only increasing.

Q7  **Jeremy Lefroy:** We are talking globally of more than $15 billion on that basis, if domestic resources are at least as much as ODA.

**Mike Podmore:** Yes. I believe that is right.

Q8  **Jeremy Lefroy:** I want to ask specifically about the Global Fund. Clearly the UK and we as a Committee strongly supported the Global Fund; we
wrote and were very pleased when the Secretary of State increased the amount that the UK committed over this three-year period, and all the all-party groups for Malaria, TB and HIV/AIDS worked together on that.

One thing that we had raised, which we did not expect to see in this round but potentially for future rounds, is the inclusion of neglected tropical diseases, because they affect huge numbers of people, some of whom will be living with HIV/AIDS, and those diseases reduce other people’s ability to fight other infectious diseases. I wondered what your view was on incorporating them, because at the moment they are very much the poor relation. The amount of money they receive compared with malaria, TB and HIV is very, very limited, yet there is a strong correlation, particularly when you are talking about the strengthening of health systems but also the strengthening of people’s resistance to these other infectious diseases. I wondered if either of you have a comment on that.

Mike Podmore: This has been a discussion for a number of years now around the Global Fund: whether it should expand to be a Global Fund for health in total or to expand to take on additional particular issues. There has been an active debate around the support for Hep C, for example, and there would be a strong case to be made for an expansion to something like neglected tropical diseases.

The challenge and the discussion in relation to the Global Fund has always been that if it was going to be expanded, you would not be able to just expand it with the same pot of money. You would have to ensure that there would be a commensurate increase to cover those things. What we do not want is for the Global Fund suddenly to have to take on a much larger remit with the same amount of money, which could make all of the responses to each of the different diseases poorer as a result. However, there could be significant benefits of linking and connecting the responses to many of these diseases, so it has been an active discussion and I suspect it will continue to be so.

Shaun Mellors: I would fully support that and re-emphasise the point that it is really important to have DFID’s voice in these discussions that are taking place at the Global Fund level or at other forums, in terms of defining what a good global response is to the health challenges that we are facing.

Jeremy, I would like to quickly come back to your question on the domestic resources. Although we are seeing an increase in domestic resources, the challenge around the increase is that that increase is not necessarily funding the areas or the components that are important in civil society, such as human rights and sexual and reproductive health rights. The majority of domestic resources to the HIV response are either going to cover treatment or to focus on prevention, but it is not providing the types of funding key populations or the organisations that are working at the frontline need to respond more effectively to HIV.
Jeremy Lefroy: I would like to follow up on that, if I may, Shaun, on the question of local organisations, and I declare an interest as an honorary member of Kilimanjaro Women Against Aids from the time I lived in that area. It seems to me those organisations do wonderful work with very little in the way of resources. To some extent they have kept away from taking on large resources from donors, because often donors come in with their own agenda and want to determine how the organisation is run. I wondered if you could give us some insight into how perhaps DFID could work with such organisations without imposing our own culture on what are often very successful local groups—particularly women’s groups but not necessarily just women’s groups.

Shaun Mellors: It highlights the importance of DFID providing resources beyond just investing in the Global Fund. Providing those resources to the Global Fund is critically important, but ensuring that there are appropriate resources in bilateral programmes is equally important—investing in bilateral programmes that support community groups to almost play a watchdog role in terms of how the funding aimed towards the Global Fund is spent and allocated and utilised properly.

It is also important that community groups who are at the frontline of the HIV response are able to define their responses according to their needs and according to their community needs, but also influence national policy and national priorities to also try to ensure and cover some of those priorities or some of those areas that a number of organisations are seeing as a priority.

We do need to move to that area where community groups have sufficient resources to ensure greater accountability of the taxpayers’ funding, whether that is in the Global Fund money or in bilateral programmes, but to really work with those organisations and understand where they are coming from in terms of their priorities and their needs without necessarily pushing a political agenda.

Jeremy Lefroy: In terms of the question, “What more would you like DFID to do?” you are saying, “Look at bilateral support”. According to one piece of evidence from Stop AIDS, DFID investment in standalone HIV programming has fallen worryingly over the last five years. That would be the area that you would like DFID specifically to look at.

Shaun Mellors: Added to that would be around capacity building of community-based organisations, which is an area that an institution like the Global Fund struggles in. My own organisation implements what we call a rapid response fund, together with the Elton John AIDS Foundation. We issue small grants to members of the LGBT community to respond to emergency or urgent needs. An institution like the Global Fund is not capable of doing that. If DFID is able to be creative in how it allocates and distributes the bilateral funding so that it could be used effectively and creatively by community-based organisations to respond to urgent needs without being caught up in bureaucracy or long application processes, that will be extremely helpful.
Mike Podmore: I would just like to add briefly on that. As Shaun was mentioning, DFID’s funding of civil society organisations through its bilateral country programmes is really important, both on HIV-specific programmes but also through integration, and in the context of changes globally with the US Administration et cetera, that might become even more important.

There are also the new mechanisms through DFID Aid Connect and DFID Aid Direct, and it is unclear at the moment from our discussions with DFID the extent to which HIV will be addressed within those mechanisms. We really hope that it will be a part of that. DFID is giving some really strong funding through the Robert Carr Networks Fund for key population networks and that is really important. However, in terms of the funding for key populations and civil society supporting those most-affected groups, there is still not enough funding globally, and the Global Fund is definitely one of the very important mechanisms but cannot be the only one. There is a need for safety-net funding—I suspect we might come onto this question—particularly in transitioning countries, so that civil society organisations can both provide services but also hold their Governments to account and increase domestic resource mobilisation.

Q11 Dr Lisa Cameron: Good morning, panel. Research indicates that by 2020 only 13% of people living with HIV will be in low-income countries. Given that statistic, what are the implications of DFID withdrawing from middle-income countries for the ability to progress towards the sustainable development goals and to end the AIDS epidemic by 2030?

Mike Podmore: As you rightly say, the picture of the global HIV epidemic has been changing dramatically over the last decade. By 2020, 70% to 80% of people living with HIV will be in middle-income countries. That is not because they are all migrating to middle-income countries; it is because low-income counties are turning into middle-income countries. There is a dangerous misconception that, once a country is classed as middle-income, first, it has sufficient revenue to cover its own development needs, and secondly, that it will and is able to fund the programmes directed for those most in need. DFID has been withdrawing its bilateral HIV programming for middle-income countries for some years now across its international development portfolio but particularly for HIV.

For example, in Vietnam, DFID was funding a really important and impactful harm reduction programme with the World Bank but because Vietnam became a middle-income country, DFID decided that it needed to exit. DFID assumed that the Global Fund and the Vietnamese Government would step in to fill the gap left by that important programme, but the Vietnamese Government was not eager to step in to fund programmes for what it considered a criminalised and dangerous population. Furthermore, the Global Fund was already reducing its funding in Vietnam because many global donors, including the UK, had
been pressuring the Global Fund to reduce its funding in middle-income countries.

The net result is that these Governments often do not have the tax revenue or are not willing politically or able pragmatically to have programmes for those most affected. This is a picture not just in Vietnam but one we are seeing across the globe in many regions, such as Eastern Europe, central Asia, Asia-Pacific, Latin America, Middle East and North Africa and now also in Africa. Many of these countries are dealing with a crisis of poorly planned external donor withdrawal. Many of these middle-income countries have what we call “concentrated epidemics” and that means that the prevalence is low in the general public but high in what we call key populations: men who have sex with men, sex workers, drug-users and transgender people. It is estimated about 40% to 50% of HIV infections globally are amongst key populations, so it just really helps you to have a clear picture of how important this is.

When donors withdraw, country Governments are not ready to step in and, as we have talked about already, civil society no longer has the funds it needs to provide services and hold their Governments to account. This can lead, and is leading, to a resurgence in HIV infections in many countries. We have seen that in countries in Eastern Europe, for example. If donors continue to withdraw funding without ensuring the sustainability of programmes and getting value for money—you have invested all this money to ensure that those programmes continue—then there is no chance that we are going to meet SDG 3.3 on ending AIDS by 2030.

It is not just about the failure to meet that target. What it may well mean is a terrifying rebound of the global HIV epidemic globally that will cost us way more money that we are currently spending and will have a big impact. We have four recommendations.

**Chair:** You have to be really brief.

**Mike Podmore:** The first recommendation is that DFID must use a wider set of nuanced criteria in its investment decisions, in both its bilateral and its multilateral programmes, so beyond just GNI. It is insufficient. The second is that transitions have to happen in a systematic way, based on lessons learned in other country experiences. DFID needs a transitions policy that it can apply, and it needs to build in sustainability in all its bilateral programmes from the beginning. It also needs to consider continuing to make small investments in civil society so that they can continue to deliver services. DFID must also recognise the critical role of multilateral institutions like the Global Fund that are providing critical funding in middle-income countries.

**Stephen Doughty:** Sorry for the late arrival. I should declare an interest as vice-chair of the All-Party Group on HIV and AIDS, because we have a funding and support relationship with Stop AIDS for our secretariat.

There are some points made by Stop AIDS in the submission about the
way that DFID tracks its funding on HIV/AIDS and the fact that the way things are tagged within the DFID system gives perhaps a false or misleading impression of how much is actually being spent on HIV/AIDS-related programming. Could you say a little bit more about that and what you think they need to do to improve things?

Mike Podmore: Sure. I will start by saying that the standalone DFID HIV programmes are adequately tracked. DFID tracks spending on HIV under two separate codes. One is HIV and AIDS including STD prevention, and the other is HIV and AIDS including STD treatment and care, and that is good. However, when HIV spending is integrated into wider health and development programmes, it is not sufficiently tracked or monitored, we believe. DFID uses an HIV marker to tag programmes that significantly affect HIV outcomes. If a programme has an HIV marker on it then 50% of its budget is attributed as HIV spend.

Stephen Doughty: Even if it is not actually happening.

Mike Podmore: Exactly. That 50% is an arbitrary level. It might be 5% or it might be 95%; we do not know. Unfortunately, this reduces the credibility and robustness of DFID’s calculations of its total HIV spend. Just to give you a picture of what we are talking about here, in 2014, DFID spent £48 million on the standalone HIV programmes. However, that is part of £730 million that it spends in total on its HIV bilateral programmes, so you can see that the vast majority is on the integrated HIV programming. We just do not know exactly how much exactly is being spent. The marker also does not measure how successfully HIV is being integrated into those programmes, and it does not require them to monitor HIV outcomes or include HIV indicators in the log frames.

Q13 Stephen Doughty: I want to ask about that. In terms of disaggregating the data, is it possible, for example, to see how much is being spent on particular populations, such as men who have sex with men, the wider LGBT+ community, women or older people? Is it possible to actually see that or is it just an overall headline figure?

Mike Podmore: As far as I know it may be possible to break down, for example, programmes that are focused on women’s empowerment or specific HIV programmes on harm reduction, but there are very few of those now in terms of people who inject drugs. I may need to come back to you on this, but my sense is that it is it is quite difficult to identify the specific amount of funding for a particular population unless it is a specific programme for that population.

Q14 Stephen Doughty: Do you think they need to be much clearer about the breakdown of spending? Is there something they could do with that other marker? You say standalone funding is done well, but what do they need to do with that other marker in terms of separating out HIV-specific funding?

Mike Podmore: We know that it is possible. For example, with DFID’s work on gender and women and girls, they do have a mechanism for
tracking that. Of course we recommend that they would seek to do that for HIV because otherwise how do you really track whether integration is happening? It could just become invisible as we fear it might be. However, that is part of the reason why we have also been calling for a stock-take review because, even as a one-off, it would allow us to speak to all the health advisers in all the DFID country programmes, and to be able to say, “Okay. We can tell you right now this is what we are doing.” We would at least have a picture, perhaps in 2018, to say, “This is what DFID is doing.”

**Chair:** When was the marker introduced? Is that long-standing DFID practice to have the marker or is it a more recent innovation?

**Mike Podmore:** I think for the last couple of years since the integration of HIV has been happening, but I can find out.

**Pauline Latham:** Can you tell me how far DFID-funded programmes on HIV include TB?

**Mike Podmore:** I would preface this by saying that we have to remember that TB is responsible for 1.8 million deaths annually, and that has only been increasing over the last few years. One in three HIV deaths is due to TB. That is the context. DFID has noted the importance of focusing on the delivery of quality integrated HIV and TB services in its 2011 HIV position paper, so it has definitely recognised it; however, it has not always followed through on that.

In 2012 the World Health Organization established guidelines that outlined 12 key collaborative activities to fight HIV and TB together—things like setting up a co-ordinated body for collaborative TB/HIV activities, or providing HIV testing and counselling for people with TB and vice versa. Last year, RESULTS UK, one of our members, produced a report called “From Policy to Practice: How the TB-HIV Response is Working”, and it reviewed the inclusion of those 12 WHO collaborative activities in donor policies and programmes. It looked at the Global Fund, the World Bank, DFID and PEPFAR but it found, unfortunately, that DFID has failed to include many of the vital TB-HIV integration activities in its bilateral programmes.

**Pauline Latham:** Could you give me an example of that? What sort of activities?

**Mike Podmore:** I may have to come back to you with a specific example but certainly it mentioned in terms of its documentation, for example, that only two out of the 12 WHO recommended collaborative activities were actually mentioned in any of DFID’s HIV programme documentation. If they are not mentioning it then you seriously worry about whether they are actually delivering it. DFID ranked last amongst the donors that RESULTS UK looked at, but since that 2014 review, DFID has been improving significantly and it has actually increased the number of collaborative activities by 73% from that 2014 marker. However, there is still a long way to go.
Q18  **Pauline Latham:** Now, how would you say the progress is on reducing co-infection? Is it being monitored and, if so, how?

**Mike Podmore:** As far as I understand it, it is not being monitored.

**Pauline Latham:** Not at all?

**Mike Podmore:** There is not a TB-specific marker, I believe. Where there are specific programmes on HIV and TB then it will be monitored, but I will have to come back to you on that one.

Q19  **Dr Lisa Cameron:** I understand that there was not any ministerial or civil service participation in the AIDS conferences in 2014 and 2016. How important is it for DFID Ministers to be present at international AIDS and HIV conferences, and what is the consequence of Ministers not attending the last two?

**Shaun Mellors:** It is a very relevant question, particularly in the world in which we are living today, because in a changing external political climate it is crucially important that we have strong, credible and principled leadership from DFID influencing global dialogue and policy debate. It was very encouraging to see Secretary Patel at the Global Fund Replenishment meeting, but at a number of other important meetings, including the high-level meeting, the absence of high-level DFID presence was very evident in terms of not only being able to influence discussions and policy decisions but also showing a strong message to the very key populations and the people that DFID is supporting: “Your issues are important to us, they matter to us, we are interested in engaging about the policy around them, and we do want to influence them.” We saw, particularly in the high-level meeting, issues about key populations around the declaration of commitment, and had there been high-level DFID participation and engagement we could probably have ended up with something slightly different in terms of at least making the key populations, who felt so isolated and alienated from the process, a little more as if their lives mattered and that being part of those discussions was important to DFID.

Q20  **Dr Lisa Cameron:** It would have helped to have shaped the discussions and also to give it the key prioritisation that it should have.

**Shaun Mellors:** Without a doubt.

**Mike Podmore:** It did send a strong statement that there was not a ministerial presence there. We would like to praise the fact DFID both included civil society in its delegation to the UN high-level meeting and did make strong statements, but it is just that high-level representation that sends a strong message. However, it is not just at global HIV conferences and international processes. We would also really strongly state that having ministerial statements on HIV and TB in the broader international development fora, whether it be around the SDGs or other issues, is equally important. When DFID is attending a meeting about women and girls and talking about its work there, we really hope that
DFID will talk about its HIV work, because it sends a really strong message about the importance of addressing HIV through a whole range of international development work. I know you are going to be coming onto that in the next session.

**Jeremy Lefroy:** Given that there are many countries around the world that are actively suppressing organisations that raise these particular issues, do you agree that DFID’s role is vital? We mentioned the United States today in terms of the potential withdrawal of funding, but there are, for instance, many Muslim-majority nations that are clearly not recognising the seriousness of the problem, and the Holy See as well. We need to recognise the large number of countries that do not seem to be tackling this seriously.

**Mike Podmore:** Just to reiterate, it is essential that DFID finds both highly vocal ways, where it deems it most appropriate and where it is going to be helpful, to make strong statements about evidence-based programming and supporting and directing funding where infections are and where people need support. That is really important. It is not just about having a loud, strong voice. It is also about knowing where to work behind the scenes and where to be building coalitions of progressive member states, for example. DFID used to be very strong on and was seen as a leader around work on promoting harm reduction as an evidence-based intervention for supporting people who inject drugs.

That sense of leadership globally has been lost now. DFID can be making those coalitions, particularly targeting those countries that maybe could step up and be more progressive but have not currently, so it is not just the same old voices again and again. Increasingly there are countries in Latin America who are willing to stand up and talk about the issue of drugs, for example, or in other countries around sexual reproductive health and rights, working with countries in Africa to stand up and say, “This is what we believe is right”. Playing that role would be very important, just to work around the challenge of people saying, “The West is always telling us what to do”. We need to find nuanced ways to do that but it is important that DFID does do that.

**Chair:** Thank you both very much indeed for your evidence here this morning. Please feel free to stay to hear the second panel.

**Examination of Witnesses**

Witnesses: Anne Aslett, Executive Director, Elton John AIDS Foundation, Beth Benedict, International Director, Restless Development, and Fionnuala Murphy, Head of Advocacy, Harm Reduction International

**Chair:** We move on now to our second panel. We have about 45 minutes and we are going to cover five areas with our second panel. In the same way as with the first panel, when we come to you, please do introduce yourself when you give you first answer. Welcome. I am going to ask Pauline Latham to ask the first question.
Q22 **Pauline Latham:** Thank you very much for coming. Can you tell me how important it is for DFID to have strategies, both on HIV/AIDS and on key populations such as women, girls and youth?

**Anne Aslett:** I am Anne Aslett, the Executive Director of the Elton John AIDS Foundation. Thank you so much for having us here.

As we have heard from the previous panel, the huge problem is that, unless there is an explicit strategy on HIV, the extent to which HIV is impacting women and girls or youth is being lost. Multilateral investments are fantastic and DFID should be absolutely praised for having shown such leadership in that, but without a specific HIV strategy or some kind of marker we work very much as a foundation on the basis that if you are not monitoring something, you cannot understand the difference you are making and you cannot improve it.

I think Mike mentioned the mainstreaming of gender in the previous session. I was looking at a paper from 2011, an ODI report, which had looked at the way gender was mainstreamed on the basis that it would be covered across all areas if it was always in the background, which noted that mainstreaming integral multi-sectoral response can lead to confusion, manipulation or inaction, whereas the development of appropriate indicators for monitoring progress and performance could help to provide a solid basis for action and accountability and is a necessary precondition for an effective use of finance.

It is not only that it makes sense from an investment point of view to know exactly what difference you are making in every context. It is not mutually exclusive with the other agenda for women and girls. The other thing is to recognise that actually, where we all provide this kind of support, a young woman does not differentiate between whether she is vulnerable to HIV or whether she wants to prevent pregnancy, and we need to recognise that and support that whole person. It is possible to do so, so it is very important.

**Beth Benedict:** Hi, everyone. My name is Beth Benedict and I am an International Director with Restless Development. We are a global agency working with young people and we also co-ordinate the Youth Stop AIDS campaign, a youth-led campaign network here in the UK campaigning for a world without AIDS.

I would echo Anne’s point around the need for DFID to have a co-ordinated HIV strategy, specifically with regard to their youth agenda. First, we strongly welcome DFID’s leadership in the youth space and that youth agenda specifically. While that agenda does reference sexual and reproductive health, it does not explicitly reference HIV, and given the significance of HIV for young people as a demographic, we feel that is a missed opportunity.

Addressing HIV and AIDS does really present DFID with an opportunity in terms of operationalising that agenda and putting it into practice. We
would really be encouraging DFID to be working across the Department to be prioritising HIV and also in terms of when they are putting that agenda into practice and enabling that cross-Department approach, which again would be supported by that co-ordinated strategy.

Fionnuala Murphy: Good morning. My name is Fionnuala Murphy and I am Head of Advocacy at Harm Reduction International. Thank you very much for the invitation.

I only want to make some very small points in addition to what has already been said. On a practical level, when any of us think about how we run our organisation or our business, we do not just jump in and start to do. You, as MPs, with your election campaigns, have to have a plan and think about your strategy, and that is the same for all of us. We developed our four-year campaign strategy in July. We conducted an evaluation in January, in the first week when we came back, and then we spent most of last week planning what we are going to do for the year ahead. We have a significantly smaller budget than what DFID has to spend so it is absolutely vital for us to do our work effectively.

In terms of the issues that I work on, if we look back over the last three HIV strategies we can see a prioritisation of the key populations most affected by HIV in each of those. In terms of harm reduction that explicit prioritisation in a strategy has meant funding commitments. We had seven countries receiving DFID funding for harm reduction programmes from 2007 until relatively recently. Now we have no strategy, it is very difficult to argue for further funding or for responses to the funding crisis that is currently facing harm reduction around the world. It is also very difficult to argue for DFID to be making vocal arguments for harm reduction in an international setting. I feel that by having a strategy in place where the UK could look at what its comparative advantage has been in the past and hopefully ensure some continuity with that expertise, the UK could then be making much more strategic decisions about what it funds and what it fights for politically.

Q23 Pauline Latham: Can I go on specifically to Anne? Why do women and girls have such a high risk of acquiring HIV/AIDS, what could be done to reverse this and what do you think DFID is doing?

Anne Aslett: Women and girls are overly vulnerable to HIV for a range of different reasons. Just to recap, there are something like 17.8 million adolescent girls and women living with HIV globally. New infections in 2015 amongst young women aged between 15 and 24 represented 20% of global infections, even though they represent half of that percentage of the population. In areas of sub-Saharan Africa, young women are eight times more vulnerable to HIV acquisition.

What are the reasons behind this? Probably the most significant reason is gender-based violence. Probably everybody on this Committee knows that women are hugely susceptible to that. One in three women in their lifetime will experience some kind of physical or sexual violence. If it is
sexual violence, it is less likely to include any kind of negotiation around safe sex or condom use, and obviously if women are infected with HIV during sexual abuse they suffer increased stigma and discrimination and are even less likely to seek any kind of treatment or get any kind of treatment.

The other massive reason is education. Young women do not stay in school. In sub-Saharan Africa almost 80% of young women do not complete secondary education. They do not therefore have the opportunity to learn about HIV and AIDS and they are much more likely, if they are not in school, to be in early relationships or marriage where again they may be forced into early sexual relationships, with no negotiation of condoms.

It is really interesting that the International Center for AIDS Care and Treatment Program, which is a Columbia University public health programme, looked just six months ago at the number of young women who had experienced sexual violence, and those who had experienced it before 18 years of age. We are talking about something like 78% of women in Zambia, 40% in Nigeria and 47% in Kenya. These are all young women not only experiencing sexual violence before the age of 18 but by a partner or boyfriend, so it is even more difficult to negotiate any kind of protection.

The other is economic dependence. Women typically have less finance and less economic independence than men, which means that they have to make all kinds of trade-offs in this context. They might have to accept non-use of condoms or living with a partner who they know is having sex outside marriage. There are discordant couples. They might marry someone with HIV and not be able to protect themselves or have to engage in sex work because there is not enough money inside the relationship or the marriage. For women living with HIV, economic independence can be further impeded if they have HIV and they are also sick themselves and therefore limited in terms of what they can do and how they can earn money.

The other thing is that, as we touched on in the previous panel, many women and girls face structural barriers to accessing reproductive health and rights. I know we discussed the gag rule, but whether it is that funding is affecting the way that money can be spent, in terms of informing and providing commodities for women and girls, or whether it is that within their own societies there are gatekeepers—parents, mothers-in-law or elders of society—who prevent them from accessing those services, UNAIDS estimates that something like 50% women and girls do not make their own healthcare decisions. There are a whole range of issues which make young women more vulnerable.

What is wonderful and hugely to be applauded is that DFID’s strategy for women and girls really addresses the structural drivers of that, which are girls’ primary and secondary education, economic empowerment, ending
violence and sexual reproductive health and rights. These are exactly the things that need to be addressed if young women are going to be able to be less vulnerable to HIV amongst a whole range of other things.

However, we go back to the same thing. If there is no mention of HIV in DFID’s strategic vision for women and girls, this means that investments that should impact their vulnerability do not. I would echo Shaun and Mike’s comments in the previous panel that what we need is a stock-take of where we are and that DFID should have a specific HIV strategy, which sits within its broader work on women and girls, and youth, so that we have a sense of how much we are achieving, both in terms of the structural drivers but also the specifics for this girl, in this year, at this moment.

Q24 Pauline Latham: Would you say that it is integrated but it is not specified? Is the work being done on that in specific programmes, for instance in maternal, newborn and child health programmes? Is it in there and being done to a degree, but you cannot measure it because it is not specified?

Anne Aslett: That is absolutely right. It is in there. As the previous panel were saying, we do not know whether it makes up 10% or 90%. An example would be when a couple of years ago the foundation worked on a programme to prevent mother-to-child transmission in Dar es Salaam in Tanzania. We looked at approximately 220,000 women over a two-year period. It was about looking at what was the best, most effective and cost-effective treatment regimen for pregnant women. Because that also had DFID funds in it where there was an HIV marker, the other marker was about safe delivery. While we tracked the effectiveness of the two different regimens, and the programme came up with a very clear determinant of what was the best regimen, and the Tanzanian Government then adopted that regimen, it also looked at how effective community home-based care workers were in driving young women towards clinic facility-based deliveries which we know means fewer complications and less risk of morbidity. It upped clinic-based deliveries by 18% and there were a whole range of other markers.

They are not mutually exclusive; both can be done. We feel quite strongly that both should be done in these instances. The risk of HIV is such a huge threat to DFID’s broader aspirations in terms of women and girls that it is a real loss not to have it in there specifically. As I said before, we would feel very strongly that if you do not track it, if it is not explicitly expressed, the risk is that it tends to get lost.

Q25 Stephen Doughty: Those are very helpful points. Can I ask a very specific question? I had quite a shock the other day when I was given the statistic that it is 49 times more likely for transwomen to be living with HIV than the general population. Could you specifically say what is being done, and whether enough is being done, to support the very specific needs of that population and that community?
**Anne Aslett:** The same thing applies. Unless there is an articulated strategy, not only does it get lost within what DFID does, it makes it much more difficult for other players, like the Elton John AIDS Foundation, the International HIV/AIDS Alliance and other bilateral donors, to understand the whole. We imagine this is going to be increasingly more vulnerable with the new Administration in the US but unless we have a clear articulation of where we are trying to get to—and the wonderful thing about DFID’s women and girls strategy and youth strategy is that they are evidence-based; they are not driven by ideology but by evidence—we will not know in terms of populations like trans and they are massively more vulnerable. It is not just about access to services. It is also about legislation and criminalisation and huge stigma of those populations. There is nothing like enough being done. We could come back with more information.

**Chair:** We will come back shortly to some of the issues around some of the key populations.

**Fionnuala Murphy:** I would like to make a small point on that. It was my understanding when I was still working at the alliance that DFID was developing a LGBT area of change. When I was still there, which is a while ago now, we were arguing to see HIV in there. I felt that we were getting quite a lot of resistance. We were hearing arguments about the importance of addressing the structural issues and the legal change and the human rights issues, and there maybe was not a perception that unnecessarily increased vulnerability to HIV infection and denial of HIV treatments and other services were human rights violations in themselves. I cannot speak to how much that has changed but it would be interesting for the Committee to maybe cross-reference whether, where HIV is missing from these two other very important strategies, it is also missing from that document.

**Chair:** That is very helpful. Thank you for that.

**Dr Lisa Cameron:** AIDS is the biggest cause of adolescent deaths in sub-Saharan Africa and the second biggest cause of adolescent deaths globally, whereas in 2000 it did not register in the top 10 causes. We know that adolescents are the only age group in which AIDS-related deaths are still increasing. Why is that happening, what is DFID doing, and what more should it be doing in this regard?

**Beth Benedict:** The numbers that you say speak for themselves in many ways and these are trends that need to be reversed. As Anne said, there is a huge range of reasons why adolescents, particularly girls and young people more broadly, are especially vulnerable to HIV and why they represent a growing share of people living with HIV today. DFID has a key role to play, and an opportunity is presented through the Youth Agenda and its position as a global leader in the AIDS response, to be addressing some of these key causes.
Young people are particularly vulnerable to HIV at two stages in life: in childhood, through mother-to-child transmission, and then into adolescence and as they transition into adulthood. In DFID’s youth agenda they talk about the importance of young people making positive transitions. When they are considering that element of their agenda, considering HIV is critical in that. It is important to note that most adolescents dying of AIDS-related illnesses actually acquired HIV from their mothers, through mother-to-child transmission, and so early diagnosis, access to treatment and adherence to treatment is critically important.

Anne referenced the importance of education, and, again, the lack of accurate and accessible information is one of the key drivers of increasing HIV transmission amongst young people. The importance of that comprehensive HIV and broader sexual and reproductive health education, is, again, critically important.

When you look at national-level plans around HIV and AIDS, young people—again, particularly adolescents—and key populations are often missing from those national level plans. Consequently, strategies and resources that are tailored to the specific needs of those groups are missed and not prioritised. It is very important to note that while key populations face a range of increased vulnerabilities, young people within those populations face additional challenges and vulnerabilities owing to their age, such as age-related restrictions to accessing services and so on.

Coming on to what DFID is doing and could be doing more of, again, reiterating and commending them for their leadership in the youth space and their Youth Agenda, whilst I have made reference to the importance of young people making positive transitions, in the agenda DFID also talks about the role of young people as agents and as advocates. With regard to the role of young people as agents, Mike spoke about the integration of HIV into broader sexual health programming; while in many ways that is broadly welcome, there is still a real strong case for standalone programmes, or approaches or packages specifically tailored to the needs of adolescents, especially girls, broader young people, people living with HIV and key populations. If DFID is to design and deliver effective programmes to meet the needs of adolescents and young people, young people’s leadership in the design of those programmes, and the implementation, the monitoring, and the accountabilities of those programmes, should be really encouraged.

We similarly commend DFID on their financial contribution to the Global Fund, but as outlined in the alliance’s submission we really believe these multilateral investments could be leveraged through increased bilateral investment to the community level. Community-based organisations, particularly youth-led organisations, have a real critical role to play in reaching harder-to-reach groups such as adolescents and young people.
There is very strong evidence around peer-based and community-based approaches to reaching these harder-to-reach groups.

Lastly, with regards to the role of youth voice and young people as advocates which, again, the youth agenda outlines, I have talked about how these groups are often missing from those national-level strategies and plans. Again, we would echo the importance of ministerial and senior civil servant representation and voices in high-level spaces around development and not solely those relating to HIV. DFID is a real proud champion of youth participation in those spaces. We are very proud that two young people supported the UK delegation to both of the last UN General Assemblies. Therefore, we would really hope DFID continues to champion youth participation in those critical decision-making spaces, so that the decisions made are relevant and responsive to those groups that are most at risk.

Q27 Dr Lisa Cameron: Can I ask a quick follow-up? Do we know what the percentage difference is between adolescent girls and adolescent boys affected? When I was in Zambia with RESULTS UK in 2015, we saw fantastic research, which was looking at reducing transmission from mother to baby. How is that being progressed?

Anne Aslett: As far as I know, among adolescents who are becoming infected with HIV, over two-thirds of them are women and girls. Women are seriously disproportionately affected. In terms of mother to child transmission, it has been the most fantastically successful intervention around the world. In many of the countries in sub-Saharan Africa that were looking at one in three pregnant women being HIV positive, in almost every province in South Africa it is now under 2%. In multiple countries, it is under 5%. It has dropped by over half, so it has been a fantastically successful intervention. The difficulty, exactly as Beth has said, is that once you slip below a certain age—in terms of women too but really very young women, who are super-vulnerable—it does not appear in an awful lot of the programming and it is blocked by policy at a government level locally. It is incredibly difficult.

Q28 Chair: Do you know what age, roughly?

Anne Aslett: 15, typically. So there are impediments to even being tested and so on.

Q29 Jeremy Lefroy: I would like to concentrate on reduction programmes. DFID had quite a number and they have all finished now. Do we know why? Were they unsuccessful or was there another reason?

Fionnuala Murphy: Thank you very much for asking that question. It is good to have the opportunity to talk about it. I would like to give you the data answer but maybe the qualitative answer as well.

Seven countries received DFID harm reduction funding. As far as I know, an evaluation has been published for just one of them, which was the Vietnam one, and the evaluation showed that, over nine years, DFID
funding had prevented an estimated 33,000 HIV infections, which is quite a phenomenal number and speaks to the success of the programme.

Q30 **Jeremy Lefroy:** Do we know how much that programme spent?

**Fionnuala Murphy:** I will have to double-check that but I can communicate that back. We also know that across the seven programmes in total some 45 million needles and syringes were distributed, which was an enormous reach. A smaller number of 7,000 people received opiate substitution therapy medicines like methadone or others. We know from the last DFID review of its HIV position paper in 2013 that all of the programmes were judged to be meeting or exceeding their targets. It certainly was not a case of a lack of success.

Where we are problematically is that because we have not seen evaluations of the programmes, it is difficult to know what the learnings were and what the successes were. From a harm reduction advocacy perspective, this is a real loss because the real challenge in getting harm reduction programmes on the ground is overcoming the political resistance. Sometimes the resistance is from the decision-makers, or sometimes it is a perceived resistance among the public. Are we facilitating drug use by providing these programmes? Are we encouraging people? Why should we facilitate people to do something that is considered to be—

Q31 **Jeremy Lefroy:** I very much understand about the political resistance. How many of those harm reduction programmes have been continued by the Governments locally?

**Fionnuala Murphy:** This is one of the essential questions. At the minute, we do not know. We do not know about the domestic funding programmes. With Vietnam we know that the programme continues, but on a smaller scale, and the programme’s own valuation flagged that there were still members of the Government and senior people in the law enforcement agencies who were resistant to harm reduction. Therefore, we know that although the programme is still there, it is fragile. DFID’s own evaluation said that. For the other programmes, we simply do not know. This is a real problem but the other problem is that—

Q32 **Jeremy Lefroy:** I am sorry to interrupt. We have been taking evidence in another session, perhaps on a broader scale, about DFID making provision for transition if they stop funding in a particular area. Are we saying that there was no specific provision for transition to a local government or domestic government programme?

**Fionnuala Murphy:** We do not know because the evaluations have not been published. We are missing massive learning because there is a very simple algorithm being applied here, not just by DFID but across the board, which says, “If we go in and we fund these programmes for whatever amount of time”—let us say five years—“at the end of that time the Government will pick up the tab.” Actually, the process of advocacy is
much more complicated than that. We need to be putting in transitional planning from the very beginning. Even then, sometimes it will not work.

If we look at Uganda for example, I worked with Shaun, Mike and others on the Uganda Anti-Homosexuality Bill. We could never have looked at that situation five years before and said, “We are putting in some funding for HIV services for men who have sex with men now.” We would have thought we would work towards transitioning towards national funding. We could never have predicted what was going to happen in between. We need to have those transitional arrangements in place but also sometimes we need to say, “Although we had them in place, based on an assessment, the country is not ready to transition and we need to look at civil society, or other mechanisms that we can keep funding.”

What is really lost with the lack of these evaluations being published is that the real nitty-gritty of getting these services in place is winning the political arguments and Governments starting to see that it is better for them to control their HIV epidemics than it is for them to be afraid of political resistance around these issues. You know better than any of us that that is such a complicated balance, but there are lessons to be learned and those lessons are not being learned and they are not being distributed.

We talked in the last session about the UK’s role at international conferences. When the UK goes to the Commission on Narcotic Drugs, which happens every year, or the UN General Assembly Special Session on Drugs, which happened last year, the UK delegation is led by the Home Office, and it is often talking about the UK’s successful approach. However, it is usually talking about its successful approach in terms of drug control domestically. When the UK has invested in harm reduction and we know that it has had successes we would love to see those successes being talked about as part of the UK’s successful approach. However, because we have not seen the evaluations, that is not happening.

Chair: That is definitely a point.

Jeremy Lefroy: It seems to me that we must follow this up, Chair.

Chair: Definitely.

Jeremy Lefroy: First, from the point of view of what the point of doing programmes is if they do not continue. There is also the issue of value for money.

Chair: Yes, absolutely.

Jeremy Lefroy: We have also often made the point about programmes needing to be longer-term than they often are.

Chair: Can I seek a clarification on Vietnam specifically? You said that the Vietnamese had continued the programme but on a smaller scale. In the earlier evidence session, there was a mention of Vietnam not
continuing a programme. Is it two different things?

**Fionnuala Murphy:** No, it is the same one. It is definitely being continued but the funding was inadequate. I want to stress that, with the other programmes, we are not saying that they have not continued. We are saying that we do not know what has happened.

**Chair:** I understand the broader point; it was the specific point on Vietnam.

Moving on to some of the other key populations that we have received evidence on and the broader political, social and cultural context that there often is around issues for LGBT communities, men who have sex with men, and sex workers, I do not mind which of you responds—perhaps all of you might want to respond—to the question of how you think DFID could be most effective in ensuring that the populations, such as sex workers or men who have sex with men, have access to HIV testing and treatments in the countries from which DFID is transitioning, so specifically around middle-income countries? I will come back to low-income countries in a moment, but first specifically on the middle-income countries from which DFID is transitioning.

**Fionnuala Murphy:** With the exception of harm reduction, which I have already spoken to, as far as I remember from the stock-take we did on DFID’s key population investments in 2014, which I am sure Stop AIDS can pass on to you, DFID was not particularly funding services for those other populations. There was a little bit of investment on sex work in a couple of African countries. I believe that Nigeria was one and I will have to double-check which the other one was. That might have changed since then but when we did that last stock-take those investments were not there.

**Chair:** In low-income countries as well?

**Fionnuala Murphy:** In both. Of the harm reduction programmes, I believe the Cambodia one also funded some services for sex workers but apart from that, those investments were not there. If transition is a concern, it is more at the level we are at now, where the Global Fund is transitioning out of those countries. There are still practical questions in terms of what DFID can do, whether it is transitioning out of the country or thinking about remaining and being involved. What more can it do? Some of our partner organisations can speak better to this but where the Government are not providing services to those populations, community-based services are very important.

**Anne Aslett:** Shaun mentioned the LGBT fund that we are working with the alliance and the US Government on. Working through civil society can be a huge bridge in terms of being responsive to the needs of very vulnerable populations, but it is also the voice: that thing about putting your mouth where your money is.
What was interesting when we first started the LGBT fund towards the end of last year was that the Government of Tanzania had impounded all lubricant on the basis that it was being used for acts that were not tolerated in Tanzanian society. There was a real concern; there were clinics that were known as LGBT clinics that were being targeted and discriminated against and having to close down with really huge community pressure. The US Government were also able to add their voice to that. Through their ambassadors and through other channels, they very quickly pushed and we were able to provide the data on the ground to say, “This is what is happening. Clinics are closing down because of this kind of violence and discrimination.” Therefore, DFID has a role, particularly in transitioning countries, partly to do with the funding but also, over a longer period of time, to ensure, exactly as Fionnuala was saying, this idea of evidence-based support for something rather than a politically driven agenda, to provide some cover for very vulnerable populations and support civil society to continue doing work there, where possible.

Q36 **Chair:** And you mentioned the proactive positive role that the US has played on the LGBT fund. What do you think is going to happen there?

**Anne Aslett:** Thus far. Yes, very much so. Absolutely, because Ambassador Deborah Birx, who is the Global AIDS Coordinator, is driven by what the evidence is telling her. She is driven by data. This is not an ideological thing. When we know that transgender populations are 40 to 50 times more likely to be infected, and men who have sex with men 10 times more likely, then you have to go where the epidemic is, because, at the end of the day, all of the investments and the leadership that the UK Government have spent should not be squandered. We need to get to the end of this epidemic if we can.

Q37 **Chair:** We heard reference to DFID’s work on LGBT issues. What is your view on how best DFID works on LGBT issues? It is clearly operating in a lot of countries where both the legal position is tough and social and cultural attitudes are generally overwhelmingly hostile. What do you think is the best way of supporting LGBT rights in those countries?

**Anne Aslett:** It is a tiered approach. It is about having an HIV strategy within broader themes. Going through a health lens and saying, “Our first priority is to make sure that people who are vulnerable to HIV get testing and treatment in a non-discriminatory and openly available way” is a less contentious way of dealing with the problem because, mostly, you can go in and say, “What we want to do is save our population and we are doing that in a neutral health lens.”

Beyond that it is about supporting civil society. One of the things we are doing through the LGBT fund is enabling local groups to document cases of abuse. One of the other grantees that we have worked with a lot is the Human Dignity Trust, who have mounted challenges to enable LGBT groups to register as NGOs in Kenya and so on, so you build a civil society. It is something that DFID really knows how to do and has done
over long periods of time, but it is both, because the worry is that the vulnerability is such that unless we keep people alive, unless they have access to testing and treatment—and there are a range of ways of doing that. If it is difficult to work through the public sector, now there are all kinds of technologies that enable home-testing and access to drugs at home and all sorts of things. We are working in Russia with providing home-testing kits to men who have sex with men. It has been fantastically successful. We are also looking at pre-exposure prophylaxis in a country where 800,000 people are infected with HIV and there is no guarantee that you will get treatment if you need it. You would want to protect yourself more than anything. There are a range of medical interventions framed in a health lens rather than a sexuality lens. There is civil society and championing laws and discriminatory practices in a range of different countries.

Q38 **Jeremy Lefroy**: Just talking about data-led interventions, I chair the All-Party Group on Malaria and Neglected Tropical Diseases. We have heard evidence that with some neglected tropical diseases, particularly schistosomiasis, women who get schistosomiasis, and a particular form of it, are much more likely to get infected. We heard in the last session about the importance of joining up work on TB and HIV/AIDS, which I absolutely see. It seems to me that there needs to be an equal—though perhaps the numbers are not as great but certainly a strong—emphasis placed on joining up work on schistosomiasis and other NTDs that mean that people who contract them are much more likely to get HIV/AIDS. Is that something with which you would agree and, if so, how do we do that? Often the malaria, TB and AIDS communities seem to be fairly protective about funding for that and not see the broader picture of all those hundreds of millions of people who are affected by these other diseases that potentially make them more vulnerable to, in this case, HIV/AIDS.

**Anne Aslett**: Yes, there is clear evidence that schistosomiasis and other diseases make young women much, much more vulnerable to HIV. The HIV community would say, “The quickest way to do that is to test women and put them on antiretroviral treatment for HIV because then they are not infectious and we are going to have more bang for our buck by doing it that way.” There is absolutely a case for doing both. I would echo Shaun and Mike’s comment that it would be dangerous to try to expect to do all of those things with the existing amounts of money, but it is an opportunity where DFID could lead too. If you can demonstrate the integration between women and girls and an HIV strategy where the whole is greater than the sum of the parts, you can do the same thing with neglected tropical diseases. To my knowledge, it is not being done terribly well or very systematically. It is a real area where DFID could lead. If you can demonstrate that you can do both and you can reduce the vulnerability of young women to both then that would be fantastic.
Stephen Doughty: I want to ask a completely different question. One of the positives of the populations that have had access to ARVs and the right of sort treatment—recognising there is still a very long way to go for many people around the world—is that people are living longer with HIV. We had a report launched last night with the all-party group with THT about the ageing population living with HIV and AIDS in this country. Do you think there is enough research and enough understanding going on globally into how to deal with ageing populations and their very, very specific needs?

Anne Aslett: No, but with recognition that you cannot do everything. THT’s work has been incredibly useful and pioneering in the context of older people. People over 50 represent a significant population around the world of people infected with HIV. There is more that needs to be done. It has been such a challenge to get people over the barrier of actually getting tested and having treatment and understanding that AIDS is not a death sentence and also understanding, which most people do not, that when you are on treatment you are not infectious; you are 96% less infectious. There needs to be more done but very careful messaging about how that is distributed.

Chair: Can I take us back to the issue we were addressing earlier around the situation in middle-income countries and ask a question around DFID’s performance agreement with the Global Fund and the very strict requirement now that at least 85% of the resources should be directed to low-income or low-middle-income countries? What do you think the effect of that will be on efforts to tackle HIV and AIDS globally? This question is probably best for Fionnuala.

Fionnuala Murphy: We were talking a little bit about this on a call yesterday, so I hope I can speak for other members of Stop AIDS as well. On the level of principle, it is problematic. When the Global Fund was established, the whole point was that it was needs-driven. It is problematic when any donor starts to impose conditions because we could see a ripple effect and, especially now we have Trump in power in America, we could see all sorts of conditions come in, so on the level of principle, it is problematic.

With regard to the last bit of number-crunching that we did, which was very quick and over Skype yesterday, I think the 15% limit is for upper-middle-income countries, if I am right? When we looked at what had been disbursed in the last round, upper-middle-income countries were only receiving about 8%. That is not to say that maybe they should not be receiving more, particularly as the dynamics of epidemics change, but in terms of immediate practical effect, we all breathed a sigh of relief when we made that comparison.

Chair: Thank you very much indeed. Anything else, colleagues? Very unusually, you have been wonderfully concise. We have not taken our full 45 minutes.
Anne Aslett: Just following up on the point about people over 50, the other area in which the UK could really play a role is with—I do not know a great deal about the Ross Fund—the advances in microbicides, for example, has been tremendously exciting and is formulations. One of the things that we know is a huge problem is that in an awful lot of counties—and Russia is a great example of this—there are very poor formulations being given to people. The risks post-50 are going to be much higher than they are with the best-quality formulations. Pushing for good generic formulations of the most recent antiretrovirals and so on would be a tremendous help.

Chair: Thank you very much indeed for coming today and for the evidence that you have given, and to the previous panel. That brings our session today to a close.